
Millennium
COLLABORATIVE CARE
Igniting Healthcare Change in WNY

Care For The Future

Igniting Change; Driving Results

Al Hammonds, Jr., CSSBB
Executive Director

Anthony J. Billittier IV, MD, FACEP
Chief Medical Officer

Care For The Future

Igniting Change; Driving Results

Lessons Learned

https://www.youtube.com/channel/UCkChsuMlpInGeOq1wRlrbJQ

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We've Come a Long Way…

- In 273 days !!!
  - 8 months and 29 days
  - 39 weeks
  - 6,552 hours
  - 393,120 minutes
  - 23,587,200 seconds
- SEPT. 30 = mid-point of DY2

Vision

Millennium Collaborative Care will be a champion for the underserved population, an innovator, and healthcare transformer.

Mission

Millennium Collaborative Care is a diverse, innovative, community-based collaboration to enable healthier people, better care, and smarter spending for all in Western New York.

Streamlining Governance

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Streamlining Governance

Board of Managers

Governing Bodies

- Compliance/Governance Committee
- Physician Steering Committee
- Finance Committee
- Clinical Quality Committee

Geographic Councils

- Niagara Orleans Healthcare Organization
- Southern Tier Council

Advisory Entities

- Community-Based Organizations Task Force
- IT Data Committee
- Project Advisory Committee
- “Voice of the Consumer” Sub-Committee
- Workforce Development Work Group

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CBO Planning Retreat

Wednesday, September 7
Millennium Collaborative Care
1461 Kensington Ave.
Buffalo, NY 14215
2:30pm – 5:00pm

Wednesday, September 28
The Resource Center
200 Dunham Ave.
Jamestown, NY 14701
10:00am – 12:00pm

Help us, help you put the pieces together, to transform the health of our communities

Please RSVP to Rachel Laster at rlaster@millenniumcc.org or 716-898-1966

Representatives of Community-Based Organizations Task Force to attend

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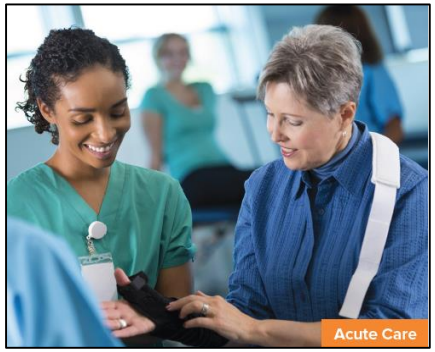
Building Organizational Sustainability: People Strategy

New Integrated Approach



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Igniting Change through…
Community-Based Organizations

- Maternal & Child Health
- Since November of 2015, we have enrolled more than 500 mothers or expectant mothers into the Community Health Worker Home Visiting Program.

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Igniting Change through… Faith-Based Organizations

- Million Hearts®
- National Best Practice Program
- Cardiovascular Disease Prevention
  - Greater Buffalo United Church Ministries
  - University at Buffalo School of Nursing
  - Kenneth Lee Gayles, M.D., Cardiologist, Gayles Medical; Project Champion

To date, over 222 participants have participated in screenings held at seven churches and one community event.

Igniting Change through…
Law Enforcement

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Igniting Change through…
Housing Providers

Since August 2015, over 15,000 recipients have participated in the Millennium Patient Activation Measure® (PAM®) process to identify the motivations of recipients (uninsured, non and under-utilizing populations) to seek healthcare.

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Igniting Change through…
County Governments

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Igniting Change through…
County Mental Health

ACASA Allegany Council on Alcoholism & Substance Abuse, Inc.

Resources for Growth and Prevention

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Igniting Change through…
Funds Flow

- $3M in direct contracts to providers and CBOs
  - **Funded 78 Community Health Workers**

Igniting Change through…
Funds Flow

- Master Participation Agreements (MPA)/Contracts to Safety Net Providers
  - Distributed $10 M in DY1
  - Distributing $12 M for DY2

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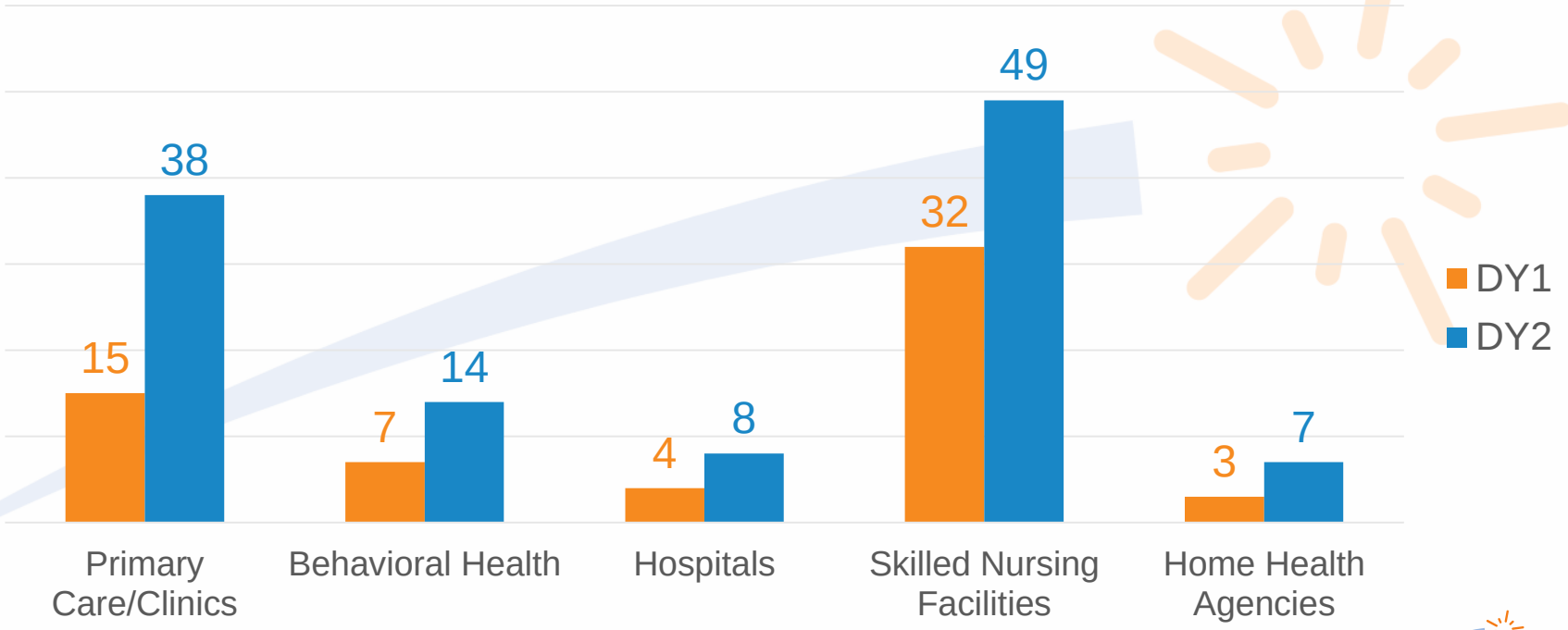
DY1–2 Partners



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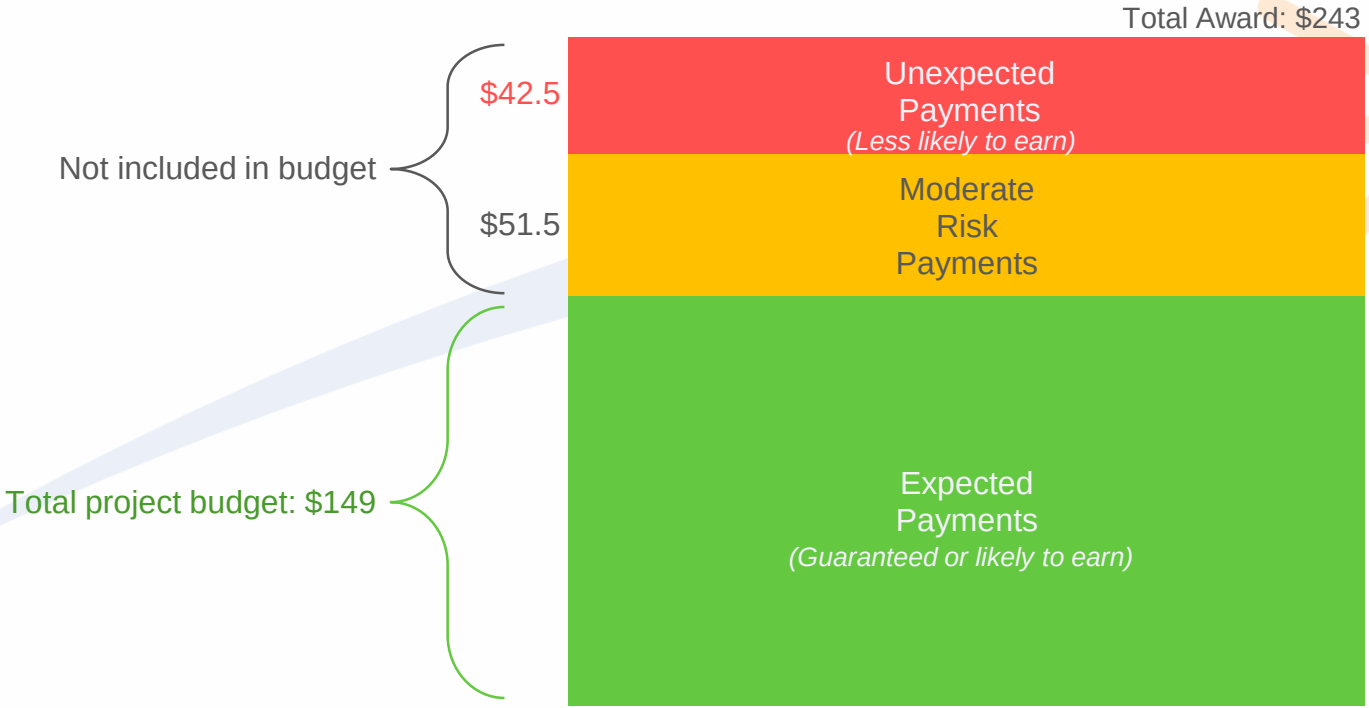
Sustainability:
DSRIP Funding vs. Millennium Budget



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DSRIP Year 1 Scorecard Summary

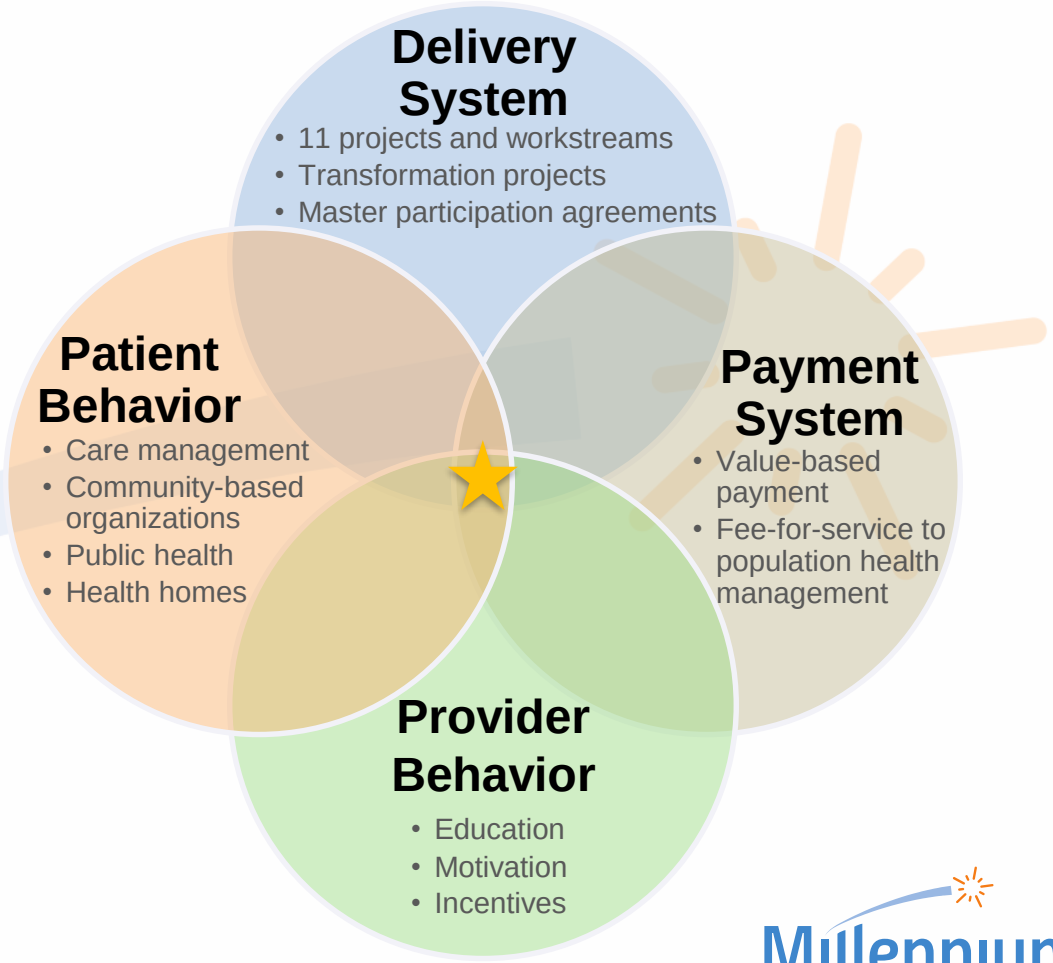
- **Achieved 98% of required deliverables**
  - **579 out of 591 Achievement Values (AVs)**
  - 1 deliverable, for Cultural Competency/Health Literacy, was not accepted by the independent assessor in the third quarter

- **Achieved 98% of possible funds**
  - **$29.8M out of $30.3M**

Sustaining/Increasing Change

Anthony J. Billittier IV, MD, FACEP
Chief Medical Officer

Four Areas of Change Necessary for Success



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Population Health Challenge

1. Allegany
2. Cattaraugus
3. Chautauqua
4. Erie
5. Genesee
6. Niagara
7. Orleans
8. Wyoming

+ 250,000 Medicaid lives

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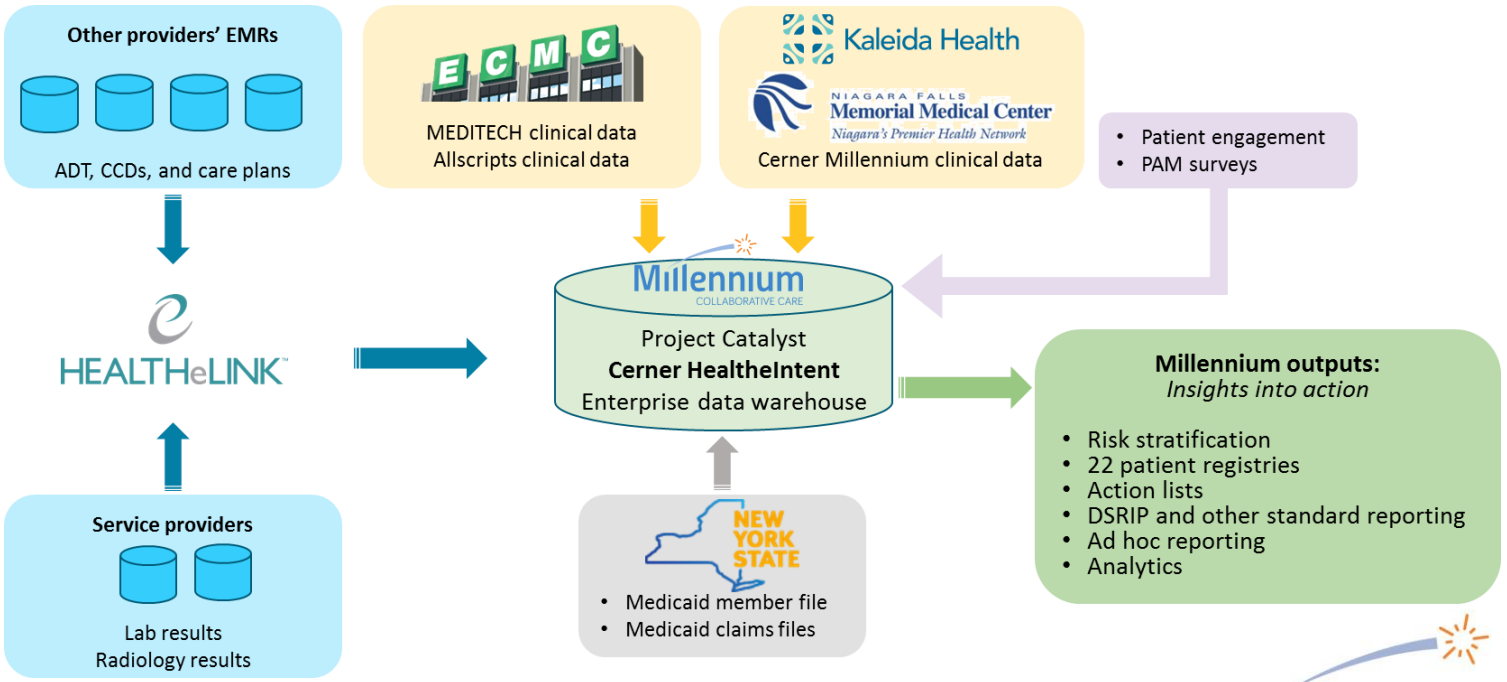
Data Strategy: Cerner HealtheIntent



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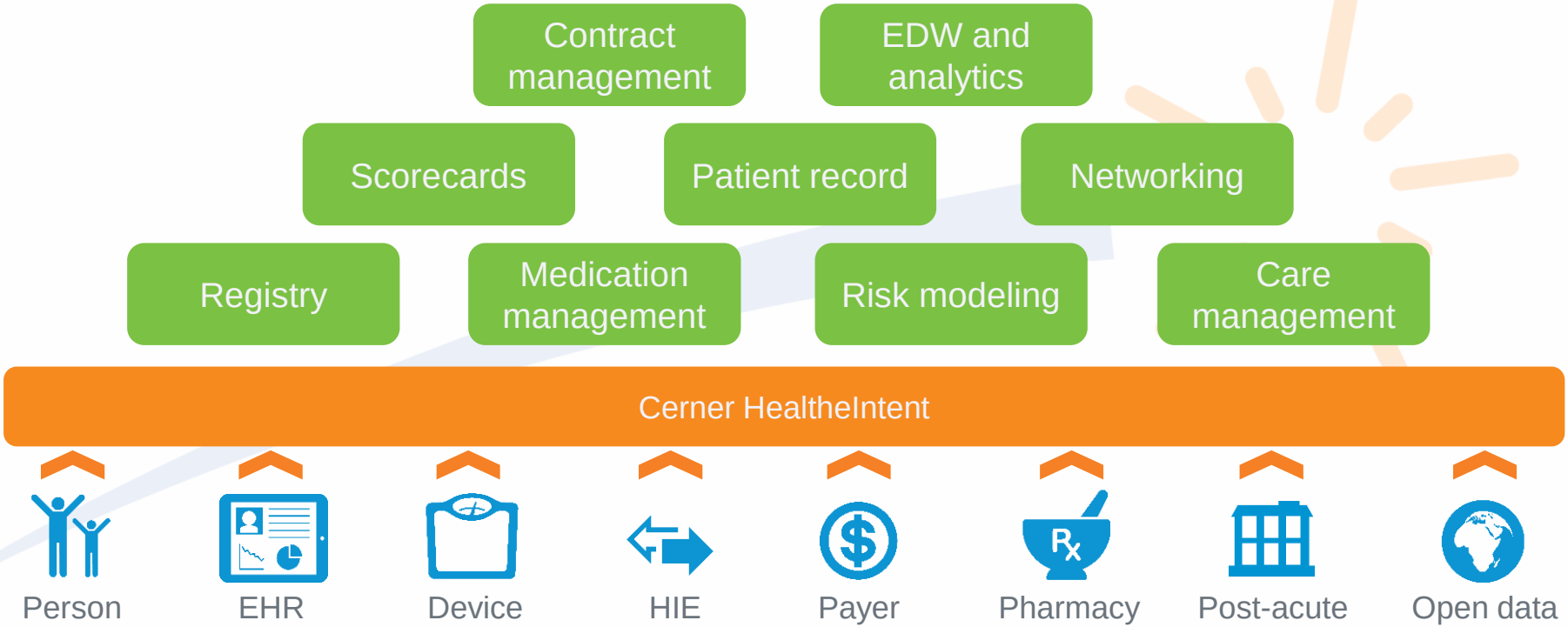
Enabled by Our Technology Platform



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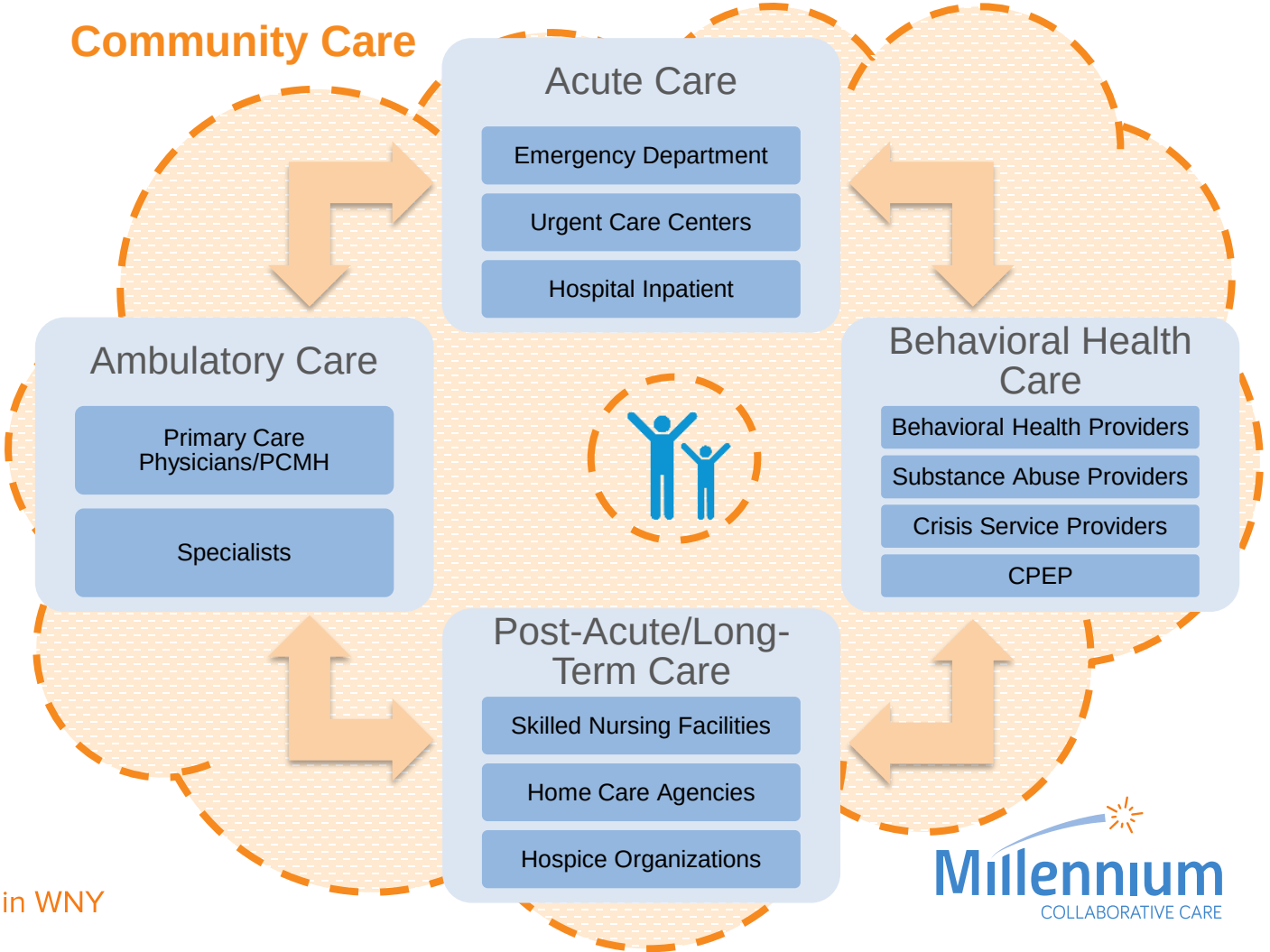
Integrating the Delivery System



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The Future: Health Homes

- Health Homes are not a place. They are **FREE** community care management services. Health Homes serve eligible high need/high cost Medicaid beneficiaries with multiple and chronic conditions.

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What is a Health Home?

- A Medicaid care management service model in which:
  - All individuals' caregivers communicate with each other
  - All individuals' needs are addressed
- Care is coordinated by a care manager who oversees and helps provide access to needed services to:
  - Ensure improved health
  - Avoid ER visits and hospital stays
- Various organizations provide services that will help that individual achieve their goal to stay healthy
- **Collectively these services are called a Health Home**

Reference: health.ny.gov

What is a Health Home? (continued)

- Participation is not mandatory but is encouraged
- The Health Home benefits the individual as a whole, not just his or her chronic conditions
- The care manager helps develop a care plan that is consistent with the goals of the individual
- It is free of charge

Eligible Population

- Medicaid eligible AND:

Either

- 2 chronic conditions (asthma, diabetes, COPD, obesity, substance abuse impacting patient's ability to function, etc.)

OR

- 1 single qualifying condition:
  - HIV/AIDS
  - Serious mental illness (bipolar disorder, schizophrenia, etc.)

Determinants of Medical, Behavioral, and/or Social Risk Can Include:

- Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission)
- Lack of or inadequate social/family/housing support
- Lack of or inadequate connectivity with healthcare system
- Non-adherence to treatments or medication(s) or difficulty managing medications
- Recent release from incarceration or psychiatric hospitalization
- Deficits in activities of daily living such as dressing or eating
- Learning or cognition issues

How Do Health Homes Work?

- **Patients can be referred by:**
  - Primary care providers
  - Managed care organizations
  - **Any provider organization**
  - NYS Department of Health
  - Emergency departments
  - Inpatient/outpatient providers
  - Self referrals
- Patients are assigned a care manager who provides person-centered navigation of both:
  - Healthcare services
  - Social determinants of health needs (assisting with linkage to housing, transportation, behavioral health, nutrition, social services, etc.)
- **PCP relationship is retained**

Why a Health Home?

- Helps patients with complex medical, behavioral, and long-term needs navigate the healthcare system more effectively
- Goal: to improve their health, stay linked with their PCP, and decrease healthcare costs
- Core services free to patients include:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care
  - Referrals to community and social supports
  - Use of health information technology (HIT)to link services

Health Home Providers in WNY

- Greater Buffalo United Accountable Healthcare Network: **GBUAHN** (www.gbuahn.org)
- Health Home Partners of WNY: **HHPWNY** (healthhomewny.com)
  - Catholic Health
  - Spectrum Human Services
  - Evergreen Health Services of WNY
- Health Homes of Upstate New York: **HHUNY** (carecoordination.org)
  - Western: Lake Shore Behavioral Health
  - Southern: Chautauqua County Dept. of Mental Hygiene
- Niagara Falls Memorial Medical Center: **NFMMC** (nfmmc.org)

Coming Soon!
A Health Home for Children

- Targeted Start Date: 12/1/2016
- Eligibility: 2 or more chronic conditions OR one medical condition and risk of a second OR serious mental illness
- Age: Newborn to 18 years
- Children's Health Homes in WNY will include:
  - Kaleida Health's Oishei Healthy Kids
  - Encompass
  - Children's Health Home of Western New York (CHHWNY)
  - Niagara Falls Memorial Medical Center (NFMMC)

How to Make a Referral

- Use Universal Referral Form which is available on MCO websites and Health Home websites
- Contact Health Home directly via website or phone

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