The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Program is to restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. In partnership with hospitals, public health agencies, physicians and community-based organizations, the North Country Initiative is advancing state-wide projects to transform the healthcare system, coordinate care, and improve the health and wellness for our population.

2.a.i

Create an Integrated Delivery Systems that are focused on Evidence-Based Medicine/ Population Health Management

Project Objective:

Create an Integrated Delivery System that are focused on Evidence-Based Medicine/Population Health Management.

Project Description:

This project will require an organizational structure with committed leadership, clear governance and communication channels, a clinically integrated provider network, and financial levers to incentivize and sustain interventions to holistically address the health of the attributed population and reduce avoidable hospital activity. For this project, avoidable hospital activity is defined as potentially- preventable admissions and readmissions (PPAs and PPRs) that can be addressed with the right community-based services and interventions. This project will incorporate medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system – from one that is institutionally-based to one that is community-based. This project will create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services. If successful, this project will eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes.

Each organized integrated delivery system (IDS) will be accountable for delivering accessible evidence-based, high quality care in the right setting at the right time, at the appropriate cost. By conducting this project, the PPS will commit to devising and implementing a comprehensive population health management strategy – utilizing the existing systems of participating Health Home (HH) or Accountable Care Organization (ACO) partners, as well as preparing for active engagement in New York State's payment reform efforts.

Patient Population:

All Medicaid Patients or Recipients

Identified Community Need:

Our Tug Hill Seaway Region has been federally designated as a low income Medicaid Health Professional Shortage Area (HPSA) Therefore, it is critical that we develop a more effective and efficient means for patients to receive care from our limited resources. This project will incorporate medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system from one that is institutional-based to one that is community-based. This project will create an integrated, collaborative and accountable service delivery structure that incorporates the full continuum of services.

NorthCountry Initiative

2.a.i

2.a.i

Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management

Project Milestones	
1	All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.
2	Utilize partnering HH and ACO population health management systems and capabilities to implement the strategy towards evolving into an IDS.
3	Ensure patients receive appropriate healthcare and community support, including medical and behavioral health, post-acute care, long term care and public health services.
4	Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
5	Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year (DY) 3.
6	Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers
7	Achieve 2014 Level 3 PCMH primary care certification and/or meet state determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of Demonstration Year (DY) 3.
8	Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.
9	Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
10	Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes
11	Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.