Project Domain	**System Transformation Projects (Domain 2)** **A.** *Create Integrated Delivery Systems*
Project ID	**2.a.i**
Project Title	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine/ Population Health Management

Objective

Create an integrated, collaborative and accountable service delivery structure that incorporates the full continuum of care, eliminating service fragmentation while increasing the opportunity to align provider incentives. This project will facilitate the creation of this structure by incorporating the 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 centers around community-based care. 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. These organized IDSs will commit to devising and implementing comprehensive population health management strategies and be prepared for active engagement in New York State's payment reform efforts.

Rationale and Relationship to Other Projects

Reducing avoidable hospital activity requires a new vision, with the formation of an integrated delivery system that is community-oriented and incorporates the full continuum of patient care needs including medical, behavioral, long term care, post-acute and social. In this system, avoidable hospital activity will be defined by potentially preventable admissions and readmissions (PPAs and PPRs) that can be addressed early with the right community-based services and interventions. This new vision 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 populations.
Integrated delivery systems are encouraged to use one of several organizing structures including single governance or joint governance (binding contracts or memoranda of understanding). Regardless of the structure, the IDS will need to demonstrate how it will function as a "coordinated network" and not as configuration of independent organizations. It is also anticipated that, over time, the organizational structure will evolve and the relationships between providers will deepen. An integrated delivery system will expand access to high quality primary care, participate in payment reform, rebalance/restructure health delivery (including hospital and nursing home bed reduction), enhance community based services (especially behavioral health services), and be driven by a comprehensive community needs assessment and an internal emphasis on quality improvement. Increased structural accountability for quality and a more aligned set of service incentives should be key focus areas in this project.

Project Index Score

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Core Components

Each performing provider system will complete the following general steps :

- Develop a clearly articulated governance model for the IDS, with appropriate supporting legal structures. The model of governance should incorporate participating providers and include meaningful consumer and patient representation. The governance model should also promote increased collective accountability for quality of care improvements and key

governance partners should work to develop shared incentive structures that reward collaboration and reduce fragmentation.

- Health Homes (HH) and Accountable Care Organizations (ACOs) are encouraged to consider evolving into IDSs, in concert with other providers. In their current status, HH and ACOs have features of the integrated delivery system envisioned in this strategy; however, they will need to engage a broader group of providers to qualify as an IDS. True integration requires a broader governance structure, broader health information sharing capabilities, real service integration and more in depth vision incorporating a population management strategy than the populations eligible for Health Home or ACO services in their current system.
- Re-balance the health care delivery system in ways that are consistent with the health care needs of the community served by the IDS. Each IDS will need to complete, and continuously update, a comprehensive community-based health needs assessment, that should build on Internal Revenue Service 501 (c)(3) and relevant state requirements. Based upon the assessment, the system will develop and implement a comprehensive strategy and action plan for development of ambulatory/community based health care services, acute care bed reduction, and development of key community partnerships including primary care services, behavioral health services, long term care, pharmacy, school systems (e.g., school based health clinics), social services including social support services, housing, and Health Homes, public safety/criminal justice and local governmental units (health department, SPOA, social services).
- Ensure that patients requiring care coordination receive appropriate health care, including integrated medical and behavioral health care, post-acute care, long term care, social and public health services. These activities should be done in concert with relevant Health Homes and Medicaid Managed Care Plans. It is expected that each IDS will have/develop an ability to share relevant patient information in a timely manner through use of HIT technology so as to ensure that patient needs are met and care is provided efficiently and effectively. Any patients admitted to any hospital in the IDS should have access to well-coordinated discharge planning, including care coordination services. IDS should also employ systems for tracking care outside of hospitals, to ensure that all critical follow up services are in place and recommendations are followed.
- Support EHR linkage by actively participating in the local health information exchange/RHIO/SHIN-NY including supporting notifications/secure messaging. By DSRIP Year 3, all eligible participating providers in the Performing Provider System's integrated delivery system will need to be connected to the local RHIO/SHIN-NY and be actively sharing information across all key clinical partners.
- Expand access to high quality primary care based upon the findings of the community needs assessment. This expansion will require both an increase in primary care capacity as well as a commitment to meeting 2014 Level 3 PCMH standards and/or the standards established by the state for the Advanced Primary Care Model by Year 3 of DSRIP. Since 2014 Level 3 PCMH standards align with EHR meaningful use (MU), all provider practices eligible for EHR meaningful use (MU) also must meet that standard by Year 3. As noted above, practices should also collaborate with regional health information exchanges

(RHIOs) wherever possible and utilize the established health information exchange (HIE).

- Contract with Medicaid Managed Care and other payers as a single system and be paid using a value-driven payment system. Systems will need to prepare to take on performance risk and possibly insurance risk as part of their drive toward payment reform.
- Establish monthly meetings with Medicaid managed care plans to discuss utilization trends, performance issues and payment reform.
- Evolve the provider compensation and performance management systems to reward providers for improved patient outcomes through the provision of high quality, coordinated care. PPSs adopting early implementation of these systems will be awarded additional points.
- Develop process improvement capabilities and strategies such as Lean to ensure efficiency and effectiveness within the delivery system.
- Utilize, where appropriate, community health workers, Peers and culturally competent community-based organizations to assist with patient outreach and navigation.
- Demonstrate a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation, including addressing issues of health disparities. This engagement may take place through community needs assessment activities and other demonstrated stakeholder outreach.

Outcome Metrics
Domain 2 Metrics