Domain 2 Projects

2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management

Project Objective: Create an Integrated Delivery System focused on Evidence-Based Medicine and 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.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

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 health care 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 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 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.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

Suffolk County Medicaid/Uninsured members are served by a fragmented set of providers and payers: 6 Managed Care Organizations (MCOs), 11 acute hospitals, 3 Health Homes, many physicians, Skilled Nursing Facilities (SNF), home health, Behavioral Health sites, substance abuse clinics, etc. There are no defined mechanisms to ensure effective clinical communication, share data on patient care gaps or accomplish the care redesign needed to meet PCMH standards. The CNA data confirms the presence of significant gaps in care that a more integrated system with an effective care management model and sufficient primary care resources can help to close.
OVERUTILIZATION: In 2011/2012, the average of the Inpatient (IP) Prevention Quality Indicators for discharges reveals a significant excess in observed vs. expected rate. In 2011 there were 83K Potentially Preventable ED Visits which rose to 86K in 2012. Three out of 8 participating Suffolk hospitals have Potentially Preventable Readmission rates above expected value.
ACCESS: Suffolk County has only 84.9 Primary Care Providers (PCPs) per 100K population (NY State average of 109.5). 66% of Medicaid adults reported difficulty or delay in obtaining healthcare services in the past year. POPULATION BASED GAPS: 5% of the population is linguistically isolated, 10% of those over age 25 have no high school diploma. 40.2% of Medicaid adults (versus 18.7% of total population) have a depressive disorder.

FROM KEY INFORMATION INTERVIEWS: Significant gaps in case management (CM) standards, metrics, and coordination exist. Knowledge of population health management is low. IT systems do not connect with each other.
ADDRESSING IDENTIFIED GAPS CARE MANAGEMENT: The PPS will provide a platform that allows for promotion of best practice CM standards. The program will contain both IP and Outpatient (OP) CM units, a Special Needs Unit for complex cases, leverage existing Health Home resources, embed CMs in PCP practices and Federally Qualified Healthcare Centers (FQHCs), in emergency rooms; and with 24x7 call coverage. Regional pods will be created so CMs can work as a team and focus on local challenges, while leveraging local resources. The IP CM function will use existing hospital resources but create standardization in how that function promotes better hand-offs to the OP setting. The OP function will require hiring additional nurse, social worker and Care Associate (lay worker) positions to serve the broader Medicaid/uninsured population, leveraging existing community CM resources.
SUPPORT PCMH AND "ADVANCED MEDICAL HOME" (AMH) MODEL DEVELOPMENT: The PPS will work with participating PCPs to help redesign their office and patient care practices to meet the needs of the population they serve and move them to Level 3 NCQA PCMH recognition by the end of DY3, ideally moving many practices to the more effective AMH model as published nationally by Geisinger.
MCO INVOLVEMENT: The PPS will leverage existing value-based arrangements with payers to shift provider compensation to align with outcomes as measured by quality, utilization and cost metrics. Formal interaction between Medicaid MCOs and providers will occur monthly through a PPS/MCO liaison team that will focus on payment models that will lead to sustainability of the IDS.

b. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

SPECTRUM OF CM SERVICES: The IDS will leverage assets at: 1)Health homes – FEGS, North Shore LIJ and Hudson River Health (HRH); All county DOH clinics (converting to FQHC-like entities under HRH) 2)eight hospitals; six payers – leverage existing CM programs and resources 3)Residency programs at Stony Brook, Mather – (e.g. have residents provide care in community FQHCs).
Mobilize resources to support IMPROVED CARE MANAGEMENT PROCESSES: Warm handoffs between IP, OP and SNF settings. Hold Case review meetings regularly. Use abbreviated notes in EHR to relay information. Use checklists for handoffs at transitions with application of disease-specific protocols, operating protocols (when to call, how often …) and risk stratification to identify high risk patients.
TECHNOLOGY: Use of local RHIO. Safety Net providers already have high connectivity. Knowledgeable Meaningful Use resources exist within the PPS with strong understanding of what needs to be done across PPS partners. Experienced IT team in Population Management platforms, Patient engagement, Care Management tools and Analytics with architecture already completed. Financial incentives will help drive PCMH adoption.
Core assets will help the PPS create and expand CARE MANAGEMENT TECHNOLOGY: Create CM documentation system that captures care plans, productivity, outcomes, care gaps etc. separate

from the EHR and interoperable across all CM entities. Establish governance for managing data, identify key gaps in care provision, utilization, medication adherence.
MCO INVOLVEMENT & REIMBURSEMENTS: Utilize existing P4P programs; Expand the premium dollar that goes into risk contracts; Capitalize on relationship with Health First Medicaid MCO given its joint provider ownership that includes a number of the PPS hospitals who currently have a risk relationship with this Medicaid MCO.
CULTURAL COMPETENCE AND HEALTH LITERACY: Leverage and build upon existing network of care management agencies that have deep knowledge of the communities they serve. Provide patient information and support to address and improve health literacy.

c. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project, and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

STRUCTURAL CHALLENGES: PPS members that have concerns about sharing data. Challenges meeting requirements for Meaningful Use and RHIO connectivity. STRUCTURAL REMEDIES: Create a PPS IT Governance Team that develops data access and security standards and protocols addressing Provider concerns, support interventions assisting PCP practices in technology and EHR implementation, create best practice examples around advantages of RHIO participation and how patient RHIO consents can be obtained.
TECHNOLOGY DIVERSITY CHALLENGES: Myriad data systems and definitions . TECHNOLOGY DIVERSITY REMEDIES: Communicate PPS transition vision for integrated technology model that increases system connectivity and interoperability while maintaining necessary system differentiation required.
CARE MANAGEMENT CHALLENGES: Variation in CM provided. No common standards, protocols and governance. CM REMEDIES: Create a model for uniform PPS governance of CM standards and protocols. Provider Challenges: Provider shortages particularly in primary care and behavioral health. Lack of participation of smaller rural PCP practices in the IDS. Provider Remedies: IDS includes interventions to improve efficiency in PCP practices and capacity (PCMH). Geographic provider shortages addressed by the PPS, leveraging support from PPS providers who have expanded provider capacity in rural areas (HRH, Brookhaven Hospital). Increased PCP practice engagement promoted through communication of resource and financial support to support redesign efforts.
PROVIDER CHALLENGES: Lack of provider financial alignment; reduced utilization reduces revenue across multiple provider types. PROVIDER REMEDIES: Re-write provider contracts to include risk/rewards mechanism that create incentives for providers to move metrics on cost, quality and utilization.
PATIENT CHALLENGES: Patient factors unique to the Medicaid and Uninsured population i.e.

health literacy gaps, social/family issues, transportation issues, and REL barriers. PATIENT REMEDIES: Protocols that ensure barriers are addressed in each phase of project implementation, with oversight by a Community Advisory group that includes representation from the patient population and advocacy groups. Telephonic and in-person translation services offered to overcome language barriers.

d. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

2. <u>System Transformation Vision and Governance</u> (Total Possible Points – 20)

a. Please describe the comprehensive strategy and action plan for reducing the number of unnecessary acute care or long-term care beds in parallel with developing community-based healthcare services, such as ambulatory, primary care, behavioral health and long term care (e.g. reduction to hospital beds, recruitment of specialty providers, recruitment of additional primary care physicians, hiring of case managers, etc.). The response must include specific IDS strategy milestones indicating the commitment to achieving an integrated, collaborative, and accountable service delivery structure.

The PPS will leverage the core components of the IDS project to create the clinical and utilization results needed to reduce the number of IP admissions and to reduce unnecessary acute and long term care beds in Suffolk County hospitals. This project will emphasize the importance of: preventing patients from using the ED as their point of primary care, effective treatment of chronic disease in the OP setting and effective use of care transition processes to ensure that patients get the best outcomes possible. These goals will be achieved through the use of embedded CMs within a County-wide care management platform, primary care practice (PCMH) redesign, and linkage with all appropriate community resources. The care management and practice redesign will improve access to care, improve quality outcomes, and reduce avoidable IP admissions and readmissions. This will allow an opportunity to "right size" the number of acute and long-term care beds in the County.
AN EFFECTIVE CARE MANAGEMENT SYSTEM IS THE CORE APPROACH TO CREATE RESULTS WITHIN THE IDS: A core component of the IDS project will be the design and implementation by the end of DY 1 of an effective County-wide care management system that will leverage existing community resources and optimize the results of the PCMH. This system will be based on a community nurse CM model that provides an embedded CM for higher volume PCMHs to support the patient care process, and then will be supplemented with a regionally-based team of CM, Social Worker (SW) and lay care associate support for smaller PCP practices. Efforts will be made to integrate existing community care management resources (such as Health Homes) with new PPS resources that together will leverage standardized protocols, processes and measures across Suffolk County to help to achieve reduction in avoidable admissions.
PRIMARY CARE REDESIGN: The PPS will work with participating Primary Care practices to help redesign their office and patient care practices to meet the needs of the population they serve, both in access to care and in quality outcomes. These practices will document

Level 3 NCQA PCMH recognition by the end of DY3, ideally moving many practices to the more effective AMH model as published nationally by Geisinger Healthcare System. The IDS will work to institute structural practice changes by the end of DY1 to implement PCMH or AMH. Chief among these changes are the creation of expanded practice hours, improved scheduling systems, and creation of more access to Urgent Care locations for afterhours care. In higher patient volume areas of the County with limited patient access, the PPS will build-out additional provider resources, leveraging existing sites of care such as FQHCs to add capacity including PCPs and BH providers, both described as areas of shortage in the CNA.
DEVELOPMENT OF MEDICAL NEIGHBORHOOD: Medical Neighborhoods will leverage existing community resources to provide 360 degree coverage and create a closely-linked referral system between PPS providers. A PPS-wide care management platform will be implemented by the end of DY1 to ensure connectivity with all PPS providers. The PPS will work with community leaders and Community Based Organizations to create access to housing, food, and other social services for the Medicaid/Uninsured population.
IMPACT OF SOCIOECONOMIC ISSUES: Suffolk County Medicaid/Uninsured population suffers from lack of transportation, inherent trust issues in the system, and a lack of PCPs willing to treat this population. These issues drive patients to seek care in less than optimal settings. The care management system, IT and governance components of the IDS project will incorporate consideration of these needs in all implemented projects. This will result in a predicted impact on the number of admissions, ED visits, and therefore on the number of acute care and/or long-term beds in the County.
APPROACH TO ADDRESSING EXCESS INPATIENT CAPACITY IN SUFFOLK COUNTY: Within Suffolk County there is an opportunity to reduce certified beds counts within several bed categories as these categories demonstrate sub-optimal occupancy rates significantly below the targeted 85 percent. These include medical/surgical beds (78.51 occ), neonatal (68.57 occ), OB/GYN (58.00 occ), pediatric (43.74 occ), rehab (61.36 occ), and newborn bassinets (40.89 occ). 1)Meetings will be held with Suffolk County PPS hospital leadership. The objective will be the development of a data-driven plan to understand where there may be excess inpatient bed capacity and opportunities to repurpose that capacity in support of the population's health needs. 2)Third-party facilitator guided conversations will leverage objective data about current and future use of beds, the calculated impact of the DSRIP projects, as well as factor in each hospital's plans for growth and the projected demand for these beds stemming from other populations (e.g. Medicare and commercial patients). This group will review the demand for other types of care (e.g. ambulatory surgery) by submarket within Suffolk County. 3)This group will develop principles for targeting beds for possible closure/repurposing and growth of new, complimentary services, and a plan (work plan and budget) to make these changes within the County over the 5-year DSRIP implementation period. 4)This group will continue to meet throughout the 5-year period to ensure that the work plan is followed and that the budget is on target.
LONG-TERM CARE: 1)A similar process will occur to convene representatives of the PPS nursing care facilities. Current occupancy data available for 38 of the 42 total nursing homes is 91.37%. Woodhaven Nursing Home in Port Jefferson Station and Riverhead Care Center have significantly lower current occupancy rates of 67.10% and 75.70%. Suffolk County can reduce its nursing facility bed capacity by 50 beds. Utilization data and demand projections combined with the facilities' strategic plans for growth will define the PPS' ability to reduce nursing home bed

capacity. 2)Several services are not presently offered by any of Suffolk's nursing home facilities: adult day health care, HIV/AIDS, behavioral intervention services, coma services, dementia programs, hospice, limited transfusion services, and pediatric care. These needs will be taken into account in the planning process for bed capacity and an addition of specific services may be warranted.

b. Please describe how this project's governance strategy will evolve participants into an integrated healthcare delivery system. The response must include specific governance strategy milestones indicating the commitment to achieving true system integration (e.g., metrics to exhibit changes in aligning provider compensation and performance systems, increasing clinical interoperability, etc.).

The PPS will develop a governance strategy that will move all participating PPS Providers into a system that truly functions in an integrated manner to optimize clinical goals, patient experience and financial results. The following components within the governance structure and function will fully integrate all PPS providers into the IDS.

GOVERNANCE STRUCTURE: The structure of the governance system itself will be a key component of the plan to move to a fully integrated system through the participation, learning and growth promoted by this structure. The components will include the following: 1)A Board of Directors that is representative of the PPS. 2)Subcommittees of the Board include Clinical, IT, and Financial Governance. 3)Project Teams will include a Physician Champion, an Administrative lead and a Project Manager; these teams report to the Clinical Governance Committee. Board subcommittees will provide leadership and oversight needed to effectively implement the IDS and other PPS projects. The Clinical Governance Committee will provide the clinical oversight needed and will also be accountable for reaching the PPS key milestones as outlined below. It will work closely with the IT Governance Committee in gaining adoption for and implementing the PPS technical solutions for care management, inter-operability of EHRs and optimization of use of the RHIO. The Financial Governance Committee will oversee all financial/budget models and funds flow within the PPS.

GOVERNANCE STANDARDS: Key standards by which governance will agree to operate will be an important component to gain PPS provider support within the IDS structure: Commitment to a "participatory" approach; Commitment to transparency; Effective communication routes; Effective access to all key data/information; Consistent approach to address issues that arise with individual PPS providers; Commitment to a significant focus on the future/strategy as opposed to simply operations. Key governance functions will support the PPS in its move toward a fully implemented IDS: Board Subcommittee oversight of all key PPS functions with a rapid response to areas with unfavorable results to include a request for and follow-up on assigned corrective action. Sessions for PPS participants that will help inform and educate them on topics such as principals of population management, analysis of data trends, and design of value-based purchasing models. Review of PPS provider "health" of their operational /financial status, with processes to assist those who need to redesign their business models to maintain viability. Monitor PPS provider participation and performance with corrective action process to correct areas of poor performance. The PPS will ensure that key milestones are achieved such as: 1)Hold PAC meetings and track attendance rates, DY 0. 2)Convene at least two PPS training sessions, DY 1. 3)Implementation of a care management documentation and registry tool, DY 1. 4)Complete primary care physician recruiting plan, DY 1. 5)Monthly meetings with MCOs to discuss

utilization trends, performance issues, and payment reform, DY 1. 6)PPS safety net providers are sharing EHR systems with local health information exchange and sharing health information among clinical partners, DY 3. 7)All safety net and non-safety net providers recognized as Level 3 PCMH, DY 3.

3. Scale of Implementation (Total Possible Points - 20):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

5. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Technology: Acquisition of software platforms needed to execute analytics and connectivity to the RHIO for population health.
Care Management: Set-up space for CM call center for 24 x 7 access. Remote tele-health equipment for care managers in the field (e.g., wireless tablets). Laptops, printers etc. for care management personnel. Care Management documentation system (with embedded licensed, clinical protocols) for recording interventions, metrics, etc.
PCMH certification: IP costs associated with helping practices achieve PCMH Level 3

certification, including EMR-upgrade investments to meet MU standards.
Physical PC facilities: Potentially, NP-clinics and/ or mobile units to enhance the access to care in non-conventional primary care settings that can act as extensions to the existing system.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/ Other Initiative	Project Start Date	Project End Date	Description of Initiatives
St. James Rehabilitation and Healthcare Center	NY RAH Project	September 23, 2012	September 22, 2016	Reducing Avoidable Hospitalizations
Town of Smithtown Horizons Counseling and Education Center	Federal BLOCK grant preceded Medicaid redesign; also participating in "Reconnecting Youth" Program			Reduce smoking among patients with MEB disorders

Name of Entity	Medicaid/ Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Town of Babylon Division of Drug and Alcohol Services: Beacon Family Wellness Center				Prevent SA in town of Babylon residents through education and treatment services and partnership in community coalitions. Reduce/prevent mental illness symptoms in patients in SA programs. Provide smoking cessation education/resources to town of Babylon residents and patients in SA program
Long Island Association for AIDS Care	Health Homes			Case management / care coordination

Name of Entity	Medicaid/ Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Association for Mental Health and Wellness	Development of Health Homes			Transition of TCM to HH Care Management
Sayville Project -Stony Brook University	NYS Medicaid Health Home Initiative			Care management to persons w/ chronic health and behavioral health population
Outreach Development Corp.				Care Coordination Program with FEGs Health Home
Central Island Healthcare & Daleview Care Center				NuHealth DSRIP

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project

Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.