4.b.ii Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings (Focus Area 3) (This project targets chronic diseases that are not included in Domain 3, such as cancer)

Project Objective: This project will help to increase access to high quality chronic disease preventative care and management in both clinical and community settings for chronic diseases that are not included in Domain 3 projects, such as cancer.

Project Description: The delivery of high-quality chronic disease preventive care and management can prevent much of the burden of chronic disease or avoid many related complications. Many of these services have been shown to be cost-effective or even cost-saving. However, many New Yorkers do not receive the recommended preventive care and management that include screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications. This project is targeted on increasing the numbers of New Yorkers who receive evidence based preventative care and management for chronic diseases.

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. The implementation must address a specific need identified in the community assessment and address the full service area population.

1. Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services.
2. Offer recommended clinical preventive services and connect patients to community-based preventive service resources.
3. Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and other community partners.
4. Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management.
5. Adopt medical home or team-based care models.
6. Create linkages with and connect patients to community preventive resources.
7. Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts.
8. Reduce or eliminate out-of-pocket costs for clinical and community preventive services.

Partnering with Entities Outside of the PPS for this Project
Please provide the name of any partners included for this project outside of the PPS providers. This may include an entity or organization with a proven track record in addressing the goals of this project.

Entity Name
Nassau/Suffolk Hospital Council

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

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 100)

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. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

Three of the top five causes of death in 2014 in Suffolk were chronic diseases including heart disease, cancer and chronic lower respiratory disease. Smoking contributes to all these diseases.

OBESITY: Weight is a serious health concern for adults in Suffolk and, to an even greater degree, the Medicaid/uninsured. The CNA reports that ~7 of 10 adults are overweight, higher than the NYS and national averages.

CANCER: Lung cancer is the leading cause of cancer death in Suffolk. The Suffolk age-adjusted death rate from lung cancer (44.9) exceeds the NYS age-adjusted death rate (41.9). The incidence of lung cancer in Suffolk County (74.0/100,000) exceeds the NYS incidence (64.2/100,000). Female breast cancer has a significantly higher incidence rate in Suffolk compared to NYS, and the US. Colorectal cancer accounts for 9.9% of all cancer cases and 10.2% of all cancer deaths in Suffolk County. Mortality rates for Suffolk County are slightly higher than NYC: NYC male rate is 20.7%, and female rate is 14.8%, compared to Suffolk County rates with males at 21.4% and females at 16.4%.

SMOKING CESSATION: Smoking (adult and pediatric) is a significant contributor to asthma, chronic lower respiratory diseases and cancer in Suffolk. The age-adjusted death rate from Chronic Lower Respiratory Disease for Suffolk County is 33.1 (NYS is 31.4). These gaps will be addressed through the following: 1)Expand efforts of the Long Island Health Collaborative (LIHC); an initiative coordinated by the Nassau/Suffolk Hospital Council focused on reducing the burden of chronic disease based on the NYS prevention agenda goals. LIHC partners with all PPS hospitals, Suffolk/Nassau county health departments, regional governmental agencies, the business community, IT providers, community-based health and human service organizations, and schools. The PPS and LIHC will implement strategies to accomplish goals specific to diseases noted including a public awareness campaign, use of social media/traditional media outlets, legislative policy development and implementation of best practices. 2)Ensure that underserved residents receive screenings in a culturally-sensitive way, with reduction of inherent barriers including out-of-pocket costs, lack of transportation and limitations in health literacy. Incorporate free screening/educational events to reach the largest population. Bring resources into the community such as mobile CT scan for lung cancer screening, mobile mammography, colorectal screening education, and BMI screening. Create a Community "coalition" that includes community member representation to oversee and provide input to all aspects of these

events, with aligned goals built into all hospital Community Service Plans. 3)Build IT platform (Integrated Delivery System project) that will include EHR clinical decision supports, provider/patient alerts, disease self-management, educational materials and self-learning modules. 4)Adoption of the electronic NYS Quitline "Opt-to-Quit" protocol by all PPS providers. 5)Leverage Stony Brook University Hospital's (SBUH) Preventive Medicine, Biomedical Informatics and Population Health Departments to provide data analyses, training and technical assistance. 6)Work with payers to establish education/screening efforts as key components of PPS reimbursement models/risk-based contracts. Share performance data with clinicians within the patient-centered medical home model; align their reimbursement models to drive improvement in preventive measure performance.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population *must be specific and could be based on geography, disease type, demographics, social need or other criteria.*

All Suffolk County residents will be targeted to address obesity and smoking as top priorities across all areas of the county, leveraging existing resources to roll-out effective outreach events, starting in high patient volume, high Medicaid /Uninsured population geographies where the majority of chronic disease and disparities are noted in the CNA.

Cancer prevention/screening will be addressed as an overarching strategy for all Suffolk residents beginning in locations with high cancer prevalence and volume of underserved population and then expanding to other sites across the county. On-site events and work with primary care physicians/PCMHs will target all prevention topics and cancer types, but will particularly emphasize the higher incidence issues in each specific location to make the events more tailored to the needs of that population.

For lung cancer, individuals with a history of smoking who meet the current guidelines for screening will be targeted in specific regions with high lung cancer incidence rates including: Lindenhurst Patchogue, Ronkonkoma, West Babylon, Riverhead, Deer Park and Medford. For colorectal screening the focus will be on educational efforts and reduction to barriers in screening for the population over age 50 or those otherwise with a family history of colon cancer. Specific regions of high cancer incidence will be initially targeted including Blue Point, Medford, Oakdale, Sound Beach, North Babylon, Brentwood, Centereach, Central Islip, Mastic, Mastic Beach, Mattituck and Mount Sinai.

For breast cancer screening, the target population is women aged 40 or older starting in specific high breast cancer prevalence regions; Oakdale, North/West Babylon, Bellport, Commack, Coram, East/West Islip, Huntington and East Hampton. The goal is to initiate activity in high prevalence regions and eventually expand efforts to include the entire county.

c. 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.

POPULATION HEALTH/PREVENTION: 1)SBUH's Program in Public Health assists LIHC with development of metrics for population-level monitoring of wellness outcomes including

smoking cessation and alcohol/other drug misuse. SBUH IT created a secure web-based data entry portal that allows each LIHC "member" to enter site and/or health system specific data at the patient level (de-identified) for pre- and post-intervention metrics. SBUH will be leveraged by the PPS to analyze the population-wide data sorted by type of health issue, by geographic area, and population type (age, gender, race/ethnicity, other). Reports will be shared with LIHC members to assist with population-level planning and integration into hospital Community Service Plans. 2)Nurses across school districts meet regularly for educational forums and sharing of information. This group will be leveraged to facilitate the dissemination of best practices (particularly around obesity and smoking) and engage the districts in Suffolk who serve approximately 260,000 youth. 3)Hospitals/other PPS partners currently collaborate to build public awareness about prevention, i.e. the annual “Paint Brookhaven Pink” initiative to promote breast cancer screening. Learnings from these events will be used to optimize the outcomes of planned PPS events. 4)Leverage current hospital relationships with payers to encourage the use of routine prevention protocols and provider incentives to help achieve prevention goals.

DISEASE SCREENING/SUPPORT: 1)NYSDOH operates a Cancer Services Program (CSP) in Suffolk that provides breast, cervical, and colorectal cancer screening. CSP provides free screenings and reimburses providers to coordinate screening services. The NYSDOH provides online educational materials in multiple languages to raise awareness of the CSP and to inform potential users about eligibility/expected costs. 2)SBUH Professionals/community members have access to the most up-to-date prevention, education/training and treatment protocols/interventions to prevent/manage disease. In 2017 SBUH will open its “MART” tower (Medical/Academic Research Tower), dedicated to bringing research to practice. 3)Health Home, PCMH and FQHC PPS partners who have prevention models built into their current protocols will serve as best practice models for other practices and will be further developed to use evidence-based protocols and optimize the use of their EHRs. 4)Stony Brook School of Dental Medicine mobile dental clinic brings outreach, screenings and treatment to underserved communities and schools. The Dental School can leverage its van at community screening events to do BMIs, provide basic counseling and appropriately refer patients to obesity specialists. 5)The WIC program provides screening and nutrition/education counseling for obesity and will be included in planning for on-site events. The Cornell Cooperative Extension/Expanded Food and Nutrition Education Program assists participants to change attitudes and behavior necessary to improve diet, health and general well-being.

DISEASE MANAGEMENT: 1)Significant RHIO/IT data exchange/analysis/educational capabilities will be expanded through the Integrated Delivery System project. Comprehensive health literacy/patient education efforts will be brought to the community through multiple mediums, including IT and web-based tools to facilitate culturally sensitive population education/disease management. 2)Health Home and Case Management (CM) capabilities currently serve many County residents. The PPS will develop and expand all CM efforts to connect patients with resources and eliminate barriers to prevention of the target chronic conditions.

d. 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.

PATIENT/SOCIOECONOMIC ISSUES: 1)Limited public transportation results in patients not receiving preventive services, cancer prevention screenings, and missing follow-up appointments. SOLUTION: Convenient locations developed for on-site education/screening events, leverage the use of mobile screening resources, and engagement of transportation companies to expand availability of transport resources. 2)Large disparities in Race/Ethnicity/Language and other cultural factors results in need for diverse health literacy/patient education materials that are not being met. SOLUTION: Explore and obtain existing resources and develop those needed with the assistance of national/state experts and PPS partners who know the community.

PRACTICE EFFECTIVENESS: 1)Lack of expanded hours to help improve access to education and screening services. SOLUTION: Work with providers to expand access/hours through the efficiencies recognized within the implementation of the Patient Centered Medical Home model; leverage on-call systems and telehealth options. 2)Trend of clinical office staff not practicing at "top of license" to do education and schedule necessary screenings, which contributes to access issues. SOLUTION: Workforce training/mentoring and build efficiencies into workflows with clearer role definitions to be sure that the necessary education and screenings get accomplished. 3)Lack of education and awareness on the part of providers of current best practice prevention recommendations and community resources. SOLUTION: Provider and office staff education on current recommendations; create tool kits that providers can use to refer patients to available free or low cost education and screening resources in the community. 4)Lack of resources for PCPs to tackle myriad issues. SOLUTION: Align PCPs through pay for performance incentives.

CARE MANAGEMENT: 1)Few warm handoffs or standard routes of communication or registries regarding patients who may be in need of education or screenings. SOLUTION: Leverage a PPS-wide care management documentation platform that includes a registry function and ultimately links with EHRs/RHIO. This will ensure that at every opportunity an individual who is in need of services can be easily identified.

e. 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.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.

Solidify formal relationships through contracts and affiliations. (DYs 1-2). IT connectivity to allow for greater electronic communication among all partners (DY2). Disease self-management apps and modules made available through PPS patent portal (DY2). Increased utilization of screening protocols within hospitals, PCMHs and FQHCs (DYs 2-3). Payer negotiations around improving

HEDIS measure, creating quality incentive programs for providers, better provider rewards for high-quality care while reducing out-of-pocket costs for clinical and community preventive services (DY 3- 4). Community-based prevention programs and coalitions will be enhanced/ to ensure access to all populations (DYs1-5).

2. 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: Tele-health tablets for care managers and community health resources to undertake remote screenings on a mass scale.
Space Rentals – Rent space in community centers and other venues to outreach to the general population with key messages re: obesity, smoking etc.
Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.
Equipment: Purchase of mobile van to conduct mammography screening; purchase of mobile van to conduct lung cancer screening (both requiring necessary equipment for screening)
Supplies: Purchase of brochures, pamphlets, educational materials to be distributed at wellness events

b. Are any of the providers within the PPS and included in the Project Plan PPS 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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Nassau/Suffolk Hospital Council	The hospital council sponsors the Long Island Health Collaborative (LIHC)	12/2014	12/2016	PHIP contractors will be regional data, education, and training resources for their regions and will help guide regional health improvement efforts among a variety of stakeholders – hospitals, the county health departments, community-based social and human services organizations, academic institutions, health plans, unions, home care agencies, nursing homes, behavioral health providers and even the business sector.
PROHEALTH Care Associates, LLP	Medicare Shared Savings			In addition to Medicare Shared Savings program, PROHEALTH also has several value-based incentive programs that focus on their Managed Medicaid population
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

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.

The resources of the PHIP will assist Performing Provider Systems, as they move through the DSRIP process. The specific funding for the 4.b.ii project will be used to go more in-depth than the existing LIHC initiative in the provision of education, on site screening, and reduction of barriers to chronic prevention in the locations within the county that have been identified through the CNA as having high volume/high clinical gaps and evidence of significant disparities in care. Activities will focus on the targeted areas of obesity, smoking and cancer prevention as noted above in the project description. The DSRIP resource dollars will be used for outreach staff, clinical education support, educational materials, costs related to locations for events and costs for the clinical screenings.

3. <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. 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 populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due by 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.

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.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. 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.