Suffolk Care
Collaborative

Consolidated Project Information

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

Contents

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

2.a.i Project Objective & Requirements

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

This project must clearly demonstrate the following 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.

2.a.i Requirements Matrix by Provider Type

	Primary Care Physicians	Hospitals	Clinics	Health Home/Care Management	Behavioral Health	Substance Abuse	Skilled Nursing Facilities/ Nursing Home	All Other	PPS Project Level
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.									X
2) Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.									X
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.									X

	Primary Care Physicians	Hospitals	Clinics	Health Home/Care Management	Behavioral Health	Substance Abuse	Skilled Nursing Facilities/ Nursing Home	All Other	PPS Project Level
4) Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.	X	X			X		X		X
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.	X								X
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									X
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.	X								X

	Primary Care Physicians	Hospitals	Clinics	Health Home/Care Management	Behavioral Health	Substance Abuse	Skilled Nursing Facilities/ Nursing Home	All Other	PPS Project Level
8) Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.									X
9) Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.									X
10) Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.									X
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.									X

2.a.i Milestones & Metrics

Color Legend
Project System Changes
Project Requirements with Specific Time Periods
Project Requirements tied to PPS Speed and Scale Commitments

	Project Requirement	Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
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.	PPS includes continuum of providers in IDS, including medical, behavioral health, postacute, long-term care, and community-based providers.	Provider network list; Periodic reports demonstrating changes to network list; Contractual agreements.	Project
2	Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	PPS produces a list of participating HHs and ACOs.	Updated list of participating HH; written agreements, evidence of interaction.	Project
		Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Periodic progress reports on implementation that demonstrate a path to evolve HH or ACO into IDS.	Project
		Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees.	Project
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.	Clinically Interoperable System is in place for all participating providers.	HIE Systems report, if applicable; Process work flows; Documentation of process and workflow including responsible resources at each stage of the workflow; Other sources demonstrating implementation of the system	Project
		PPS has protocols in place for care coordination and has	Process flow diagrams demonstrating IDS processes	Project

	Project Requirement	Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
		identified process flow changes required to successfully implement IDS.		
		PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.	Contract; Report; Periodic reporting of discharge plans uploaded into EHR; Other sources demonstrating implementation of the system	Project
		PPS trains staff on IDS protocols and processes.	Written training materials; list of training dates along with number of staff trained.	Project
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 directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participation agreement; sample of transactions to public health registries; use of DIRECT secure email transactions	Provider (SN: PCP, Non-PCP, Hospital, BH, SNF)
		PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging	Project
5	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification from CMS or NYS Medicaid	Project
		PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	List of participating NCQA-certified practices; Certification documentation	Provider (SN: PCP)
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.	PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Sample patient registries; EHR completeness reports (necessary data fields sufficiently accurate to conduct population health management)	Project

	Project Requirement	Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
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 DY 3.	Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Status reporting of recruitment of PCPs, particularly in high-need areas; Demonstration of improved access via CAHPS measurement;	Project
		All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	List of participating NCQA-certified practices; Certification documentation	Provider (PCP)
		EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Meaningful Use certification from CMS or NYS Medicaid	Project
8	Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Medicaid Managed Care contract(s) are in place that include value-based payments.	Documentation of executed Medicaid Managed Care contracts; Report demonstrating percentage of total provider Medicaid reimbursement using value-based payments	Project
9	Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Meeting minutes; agendas; attendee lists; meeting materials; process of reporting meeting outcomes/recommendations to stakeholders and PPS leadership	Project
10	Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	PPS has a plan to evolve provider compensation model to incentive-based compensation	Compensation model; implementation plan; consultant recommendations	Project
		Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Contract; Report; Payment Voucher; Other sources demonstrating implementation of the compensation and performance management system	Project

	Project Requirement	Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
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.	Community health workers and community based organizations utilized in IDS for outreach and navigation activities.	Documentation of partnerships with community-based organizations; Evidence community health worker hiring; Co-location agreements/job descriptions; Report on how many patients are engaged with community health worker	Project

2.a.i Speed and Scale Submission

Scale is a measure of the magnitude of providers in the project and the volume of patients affected. Speed is a measure of how quickly project requirements are executed and how quickly patient impact occur. Speed and Scale represent 80% of the points for each project application – and therefore, most significantly impact initial valuation.

Project Implementation Speed for Project 2.a.i

Project	**DY 0 (2014)**		**DY 1 (2015)**		**DY 2 (2016)**		**DY 3 (2017)**		**DY 4 (2018)**	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
2.a.i								x		

Rationale for Project 2.a.i

The rationale related to project 2.a.i implementation speed is as follows:

- Project Implementation begins with a small number of providers that address a larger percentage of patients
- 100% of providers meeting all project requirements is realistic with the assumption that the PPS will be able to meet requirements and individual providers who are not compliant are eligible to be dropped from the PPS

References

Please see pages 3-14 in the Suffolk Care Collaborative DOH Application for additional project related information.

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/stony_brook_university_hospital/stony_brook_project_plan.pdf