Suffolk Care
Collaborative

Consolidated Project Information

Project 2.b.ix Implementation of Observational Programs in Hospitals

Contents

2.b.ix Implementation of Observational Programs in Hospitals

2.b.ix Project Objective & Requirements

This project will reduce inpatient admissions vis-à-vis the creation of dedicated observation (OBS) units for patients presenting to emergency departments (EDs) whose need for inpatient services is not clearly defined or who need limited extended services for stabilization and discharge.

The project must clearly demonstrate the following project requirements:

1. Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.

2. Create clinical and financial model to support the need for the unit.

3. Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.

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. Use EHRs and other technical platforms to track all patients engaged in the project.

2.b.ix 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) Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.		X							X
2) Create clinical and financial model to support the need for the unit.		X							
3) Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.									X
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.	X*	X*	X*						X*
5) Use EHRs and other technical platforms to track all patients engaged in the project.									X

X* indicates safety net providers only

2.b.ix 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	Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.	Observation units established in proximity to PPS' ED departments.	Opportunity assessment for OBS units; Implementation plan for OBS units; Quarterly reports demonstrating successful implementation of project requirements	Provider
		Care coordination is in place for patients routed outside of ED or OBS services.	Care coordination methodology	Project
2	Create clinical and financial model to support the need for the unit.	PPS has clinical and financial model, detailing: - number of beds - staffing requirements - services definition - admission protocols - discharge protocols - inpatient transfer protocols	Baseline clinical and financial model, with periodic updates demonstrating gap to clinical and financial goals	Provider
3	Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.	Standard 30-day care coordination services for safe discharge to community or step-down level are implemented and specifically fitted to short-stay situations.	Care coordination methodology for safe discharge, with short-stay protocol specifications	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 Direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 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
		EHR meets connectivity to RHIO's HIE and SHINNY requirements.	QE participant agreements; sample of transactions to public health registries; use of DIRECT secure email transactions	Provider
5	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

2.b.ix Active Engagement Definition

The active engagement definition for project 2.b.ix is defined as the number of participating patients who are utilizing the OBS services that meet project requirements.

Project	# of Actively Engaged	Attributed Population	% of Attributed	Definition of Actively Engaged	Counting Method
2.b.ix	8,866	148,118	6%	Utilizing Observation services	3

The purpose of counting methods is to estimate the number of patients that will be impacted by a particular project. This feeds the patient scale portion of the application.

Each counting method should be used in conjunction with the definition of "actively engaged" patients for that project.

Summary of counting method 3:

- Counted within a DSRIP year; resets each year
- Patients are to be counted only once
- So long as "at least" one encounter with the patient resulted in A.E. definition being met, it counts towards total

e.g., if a patient visits the PCP 5 times a year but get a1C tested just one of those 5 times, she is actively engaged

2.b.ix 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.b.ix

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.b.ix – OBS							**X**			

Patient Engagement Speed for Project 2.b.ix

Patient Engagement Speed	**DY0 (Baseline)**		**DY1**		**DY2**		**DY3**		**DY 4**	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	0	0	886	3546	3103	6650	4433	8866	4433	8866
Expected # of Actively Engaged Patients	8866	8866	8866	8866	8866	8866	8866	8866	8866	8866

Rationale for Project 2.b.ix

The rationale related to project 2.b.ix implementation speed is as follows:

- Project Implementation will occur more rapidly because most hospitals already have some form of Observation Units in place.

The rationale related to project 2.b.ix patient engagement speed is as follows:

- For this project, Actively Engaged is defined as the number of participating patients who are utilizing the Observation services that meet project requirements

- Patients are counted as those who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years**.**

The patient scale rationale is calculated as detailed below.

Patient Scale Rationale

Total Observation Stays (2013)		Total 1 or 2 day stays.		Total EOB admissions	
Baseline # of Patients	7,975 Stays	**Total PPS discharges**	28,251 Patients	**Annualized # of CPEP visits**	5,510 annual visits
Less CHS OBS admits	7,072 Stays	**27% short stays**	7,628 stays	**Statewide EOB admission average**	11.8%
		15% converted to OBS	1,144 stays		
Total	7,072 Stays	**Total**	1,144 Stays	**Total**	650 Stays

Expected # of Actively Engaged Patients = **8,866 Patients**

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References

Please see pages 31-37 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