Domain 2 Proposed Projects

System Transformation Projects

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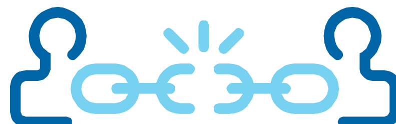
State of the County:
Lack of Alignment, Minimal Coordination, Supply ≠ Demand

Lack of Alignment:

- Highly competitive inpatient environment
- 1-2 person MD practices are common
- Disjointed continuum of care



Minimal Coordination:

- ***Lack of IT Integration***
  - No meaningful use funding for SNF EMR
  - 30% opt in rate for RHIOs (NYS)
- ***Limited Care Management***
  - Limited outpatient coordination compared to need

Supply ≠ Demand:

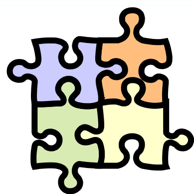
- Overabundance of inpatient capacity
- Lack of primary care and limited behavioral health care access
- Geographic access disparities

Stony Brook Medicine

System Transformation Project Options

Project Number	Create Integrated Delivery Systems
2.a.i	Create Integrated Delivery Systems – evidence based medicine
2.a.ii	Increase certification of primary care practitioners with PCMH cert.
2.a.iii	Health home at risk intervention program
2.a.iv	Create a medical village – hospital infrastructure
2.a.v	Create a medical village – alternative housing & nursing home infrastructure

Create an Integrated Delivery System:
Best Suits County's Needs



Recommendation:

2.a.i 'Create Integrated Delivery Systems that are focused on evidence-based medicine / population health mgmt':

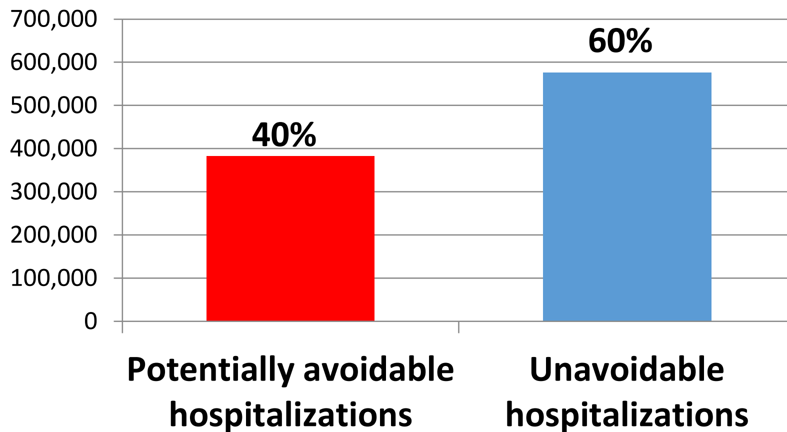
- Umbrella governance
- Right-size inpt and outpt care
- Enhance care coordination
- Enhance data sharing
- Expand primary care
- Rely on CBOs to assist
- Demonstrate cultural competency

…Rationale :

- Broadest of the Domain 2A 'Create Integrated Delivery systems' projects
- Addresses many areas of need
- Aligned with partner interests
- Nearly every PPS in NYS has selected this project
- Considerable financial incentive to participate

Great Care Coordination Needs:
In Hospitals and SNFs for Chronic Disease

Skilled Nursing Facilities



- 72% of these hospitalizations were generated by nursing homes
- 23.5% of people admitted to a post-acute care SNF were re-hospitalized within 30-days

Chronic Disease

- In 2007 over $800M in NYS Mcaid funding spent on potentially avoidable readmissions (PPRs)
- Mcaid recipients with significant mental health and substance abuse needs experienced PPRs 3.5 times more frequently

Major Diagnostic Category	N	Percent of all Medicaid PPRs (%)
Alcohol/Drug Use	12,257	20.9
Mental Health	11,466	19.5
Circulatory	7,254	12.3
Respiratory	4,785	8.1
Digestive	3,685	6.3
SUBTOTAL	**39,447**	**67.1**

Care Coordination and Transitional Care Project Options

Project Number	Implementation of Care Coordination and Transitional Care Programs
2.b.i	Ambulatory Intensive Care Units (ICUs)
2.b.ii	Development of co-located primary care services in the ED
2.b.iii	ED care triage for at risk populations
2.b.iv	Care transitions intervention-to reduce 30-day readmits-chronic disease
2.b.v	Care transitions intervention for skilled nursing facilities
2.b.vi	Transitional supportive housing services
2.b.vii	Implementing the INTERACT project
2.b.viii	Hospital-home care collaboration solutions
2.b.ix	Implementation of observational programs in hospitals

Focus on SNF pts and chronically ill

SNF-based

Focus on SNF pts and chronically ill

Care Coordination and Transitional Care
Project Rationale

…Rationale :

- Projects tackle great areas of need (chronically ill and SNF patients)
- Synergistic effect of selecting these three projects
- Availability of successful, evidence-based approaches
- Availability of leadership with successful track record to guide projects
- Build upon earlier success (e.g. INTERACT)

Project Targeting the Uninsured

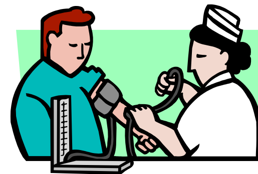
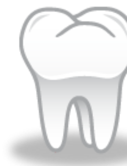
Scope of the 11th Project:

2.d.i ‘Implementation of patient activation activities to engage, educate and integrate the uninsured and low-utilizing Mcaid populations into community based care’:

- Identify & target hotspots
- Promote preventative care
- Enhance utilization of BH, primary care and dental services
- Enhance care coordination with community navigators
- Rely on CBOs to assist

…Rationale:

- Moral obligation to support the population
- As sole PPS, NYSDOH may require the project
- Leverages PPS partners’ strengths
- Considerable financial incentive to participate

Recommended System Transformation Projects (Domain 2)

Project Number	Project Description
2.a.i	Create Integrated Delivery Systems – evidence based medicine
2.b.iv	Care transitions intervention-to reduce 30-day readmissions chronic disease
2.b.vii	Implementing the INTERACT project
2.b.ix	Implementation of observational programs in hospitals
2.d.i	Implementation of patient activation activities to engage, education and integrate the uninsured and low-utilizing Mcaid populations into community based care