

Suffolk Care Collaborative
Building an Integrated Delivery System in Suffolk County

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

Project Charter

Through the Delivery System Reform Incentive Payment (DSRIP) Program, a grant waiver administered by the NYS DOH, \$6.42 Billion Medicaid dollars were allocated to fundamentally restructure the health care delivery system to transition care delivery from a largely inpatient-focused system to a community-facing system that addresses both medical needs and social determinants of health. DSRIP is a 5-year, performance payment-based program with primary goal of reducing avoidable hospital use by 25% over 5 years. At the end of program life, the aim is for the newly-transformed system to be sustainable. Project efforts are focused on achieving improved overall health through integration of behavioral health and primary care, provision of appropriate levels of care management, and care delivery models designed to improve chronic disease prevention and outcomes.

Objective Statement:

To create 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.

To support our engaged/contracted primary care providers and their practice team to achieve NCQA 2014 PCMH Level 3 recognition of their practice as a patient-centered medical home model of care committed to improving patient access, the patient experience, care coordination, outcomes, and meaningful use of health IT, providing culturally and linguistically appropriate services, with processes and performance which are financially incentivized and sustainable.

High Level Deliverables:

1. All PPS providers must be included in the Integrated Delivery System (IDS). 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 Health Home 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 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. Reinforce 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.

Benefits:

- Suffolk County Medicaid members and Uninsured 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), numerous home health programs, 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. Our Community Needs Assessment (CNA) data confirms the presence of significant gaps in care. This project will set out to create a more integrated system with a comprehensive care management model partnering with existing care management organizations in the community to close gaps.
- 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 2014. This project will issue a robust IDS program to include an evaluation of access to support addressing barriers to access.
- The program will provide a platform that allows for promotion of best practice CM standards. The program will contain both IP and Outpatient (OP) CM, partner with existing Health Home resources, embed CMs in PCP practices and Federally Qualified Healthcare Centers (FQHCs). 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 positions to serve the broader Medicaid/uninsured population, leveraging existing community CM resources.
- The program 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.

Assumptions:

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- Significant cause of avoidable readmissions is non-adherence with discharge plans as a result of language issues, health literacy, and lack of engagement with the community health care system.
- Suffolk County Medicaid/Uninsured population suffers from lack of transportation, inherent trust issues in the system, and inadequate PCPs 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.

Constraints:

- Myriad data systems and definitions. To remedy the PPS has created a transition vision for integrated technology model that increases system connectivity and interoperability while maintaining necessary system differentiation required.
- Project budget, available workforce, and resources to contribute to implementation and the sustainability of the project

High-Level Risks:

- Patient attributes unique to the Medicaid and Uninsured population i.e. health literacy gaps, social/family issues, transportation issues, and REAL barriers.
- PPS Coalition Partners may have concerns about sharing data, result in challenges meeting requirements for Meaningful Use and RHIO connectivity. Also cost of technical on-boarding and any EMR build requirements necessary for proper interface of discrete data fields.

Success Criteria:

- Successful completion of all Domain 1 requirements, including meeting patient engagement and project engagement commitments
- Improvement throughout DSRIP Measurement Years across all Domain 2-3 outcome measurers (achievement of 10-20% gap to goal)
- Engagement of all Safety Net SCC Coalition Partners in creating an Integrated Delivery System
- Overall achievement of project objectives
- Sources that influenced the development of the program is accepted by public, community and key project stakeholders

Stakeholder Analysis:

The Integrated Delivery System Program will include PPS partners from across the continuum of care including hospitals, CBOs, SNFs, Health Homes, MCOs, home care agencies, and other social service agencies. Care management and coordination of care will be key to the success of the project and preventing avoidable acute care facility utilization. The Suffolk Care Collaborative's Care Management program will add additional resources to existing agencies and resources within the county.

Closeout Criteria:

- Close out will be managed during the monitoring phase of the project lifecycle and is tentatively scheduled for period ending March of 2020
- Evaluate and ensure all archive data and final project records/documents are filed in a secure location and appropriate to demonstrate achievement of DSRIP metric/project commitments within Domain 1 & 2.
- Archive all project data in a central repository. Include best practices, lessons learned, and any other relevant project documentation.
- Verifying acceptance of final project deliverables/ data sources by the NYS DOH
- Completion of the post-project assessment and lessons learned
- Completion of post-project review and evaluation

Project Strategy:

This program will establish 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 implement a comprehensive population health management strategy – utilizing the existing systems of participating Health Home (HH) partners, care management administrators across Suffolk County as well as preparing for active engagement in New York State's payment reform efforts.