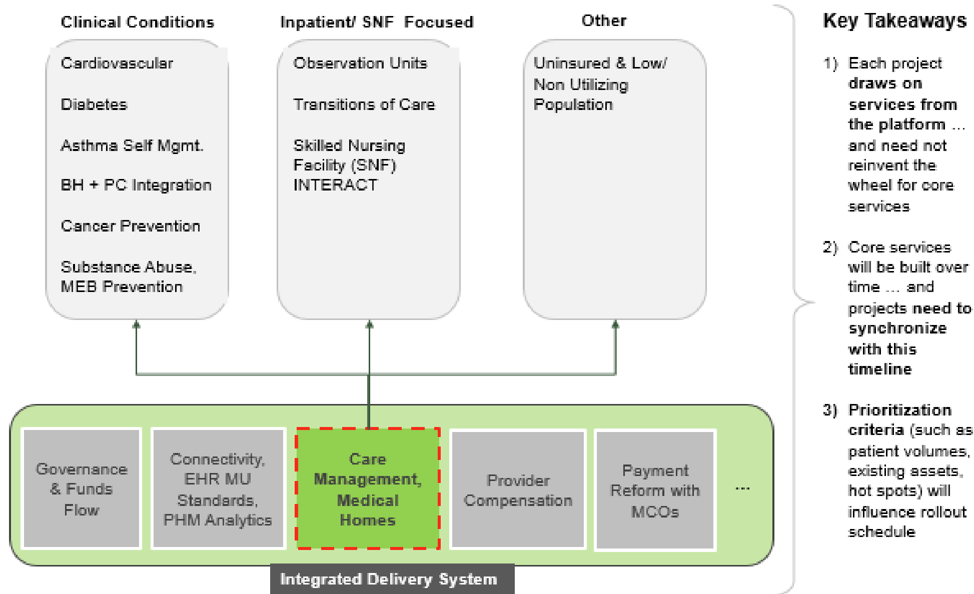
Suffolk DSRIP Project Summary

Overview	Orgs/Providers Affected by Project or Currently Participating	DSRIP Mandates	Intended Outcomes/Success	Specific Suffolk County Geography
2.a.i Create Integrated Delivery Systems that are focused on Evidence Based Medicine / Population Health Management				
This is a foundational PPS project with the following key components: • Care Management structure countywide and support of progress toward Patient Centered Medical Homes (PCMHs) • Whole-person Care (BH, Social, LTC, etc.) • IT Infrastructure • Governance model • MCO interactions, plan for sustainability • Core DSRIP IT platform that has central population, care management, patient portal and informatics capabilities	Project Team members/ involved PPS providers: • Core Stony Brook Team; • Representatives from multiple PPS participants will be involved -Hospitals, SNFs, PCPs, Home Care, Health Homes, etc. Organizations/providers affected by the project: • All Suffolk County health care providers - medical, behavioral, post-acute, LTC, home care, etc. Also leverage support from existing community-based and public resources, and from Medicaid MCOs	• By end of DY3, safety net primary care providers must meet Meaningful Use and 2014 PCMH Level 3 standards • By end of DY3, providers should be connected to exchange/ RHIO/ SHIN-NY and use secure messaging • Monthly meetings with MCOs that drive towards “value-based payment reform”	The PPS will function as an integrated regional health system. Reduced unnecessary utilization related to admissions, readmissions, and ED use Integration – all providers on RHIO Improved quality and patient satisfaction	Spans the entire county; focus on high volume Medicaid zip codes during initial phases.



- This is a foundational PPS project with the following key components:
  - Care Management structure county-wide & support of progress toward Patient Centered Medical Homes (PCMHs)
  - Whole-person Care (BH, Social, LTC, etc.)
  - IT Infrastructure
  - Governance model
  - MCO-interactions, plan for sustainability
- The Care Management philosophy includes:
  - Not a "rip and replace" model, rather it will build on existing infrastructure
  - PPS clinical governance is required by DSRIP to set the standards and metrics for care management – hybrid of central and local elements
  - Embedded Case Manager in high volume primary care practices – regionally located teams of CMs, SWs, and lay "care associates"
  - PCP practices will be supported to function as true medical homes (NCQA L3); use clinical professionals at "top of license" to optimize care
- The IT philosophy includes:
  - Core DSRIP IT platform that has central population, care management, patient portal and informatics capabilities
  - Leverage existing EMR investments across PPS members – and building integration between EMR and core DSRIP platform where necessary
  - Clinical and financial data to be stored centrally in a data warehouse that drives actionable analytics

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2.b.iv Care transitions intervention model to reduce 30 day readmissions of chronic health conditions				
This project will combine current care management resources with newly redeployed and newly hired staff to develop standardized protocols for a transition of care that crosses the inpatient and outpatient care settings. Processes will be developed to strengthen the discharge process (patient education, patient read-back, medication reconciliation, post discharge planning and patient follow-up post discharge.) For patients with behavioral health problems, an ambulatory care/urgent care center will be developed to provide a bridge to outpatient care. The focus will be to stabilize and treat people in immediate crisis while connecting them to ongoing care, including the Health Homes.	Affected Organizations: • All hospitals in the county • Countywide skilled nursing facilities • Countywide primary care providers • Countywide health clinics Current partners: • Brookhaven Memorial Hospital • Hudson River Health • J.T. Mather Hospital • North Shore LIJ • Southside Hospital • Stony Brook Medicine • Southampton Hospital	Use EHR and other technical platforms to track all patients engaged in the project.	• Decrease in Potentially Preventable Emergency Department Visits (PPV) and Potentially Preventable Readmissions (PPR) • Easier access to primary care providers for the patient • Development of an established patient/provider relationship for ongoing health care needs	Initial rollout will be to the hospitals with the largest targeted population with the highest number of Potentially Preventable Readmissions.

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2.b.vii Implementing the INTERACT project				
INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program focusing on the management of changes in a resident's condition, with the goal of stabilizing the patient and avoiding transfer to an acute care facility. • The PPS will develop a training team which will work with an identified facility champion at each SNF – physician or nurse – who will become familiar with and conversant in all aspects of the program. • Ongoing communications among SNF and hospital partners' hospitalist, ED and discharge planning staff will build understanding of individual SNF capabilities. • Periodic case reviews will be conducted between hospitals and SNFs to inform the process.	Suffolk County PPS Nursing Homes Suffolk County Hospitals **Current Team:** • GNYHA • Maria Regina Residence • St. James • Medford Multicare • NCN Rehab • Smithtown Center • Suffolk Rehab • LI Veterans • Gurwin Jewish Nursing and Rehab • Avalon Gardens • Riverhead Care Center	The project will necessitate that all SNFs migrate onto EHR and that system-wide connectivity be created.	This project will result in implementation and active use of INTERACT within the 42 PPS partner skilled nursing facilities, building on the early experiences and success of several SNFs. Reduced unnecessary utilization related to admissions, readmissions, and ED use Improved quality and patient satisfaction	The project will target short-stay patients and long-stay residents of all the SNFs in Suffolk County. This will include Medicare beneficiaries, Medicaid beneficiaries, those who are receiving Veterans' benefits, and those who are private pay and/or currently uninsured.

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2.b.ix Implementation of observational programs in hospitals				
This project will focus on: • Establishing appropriately sized observation units (either dedicated beds or scattered beds) in all hospitals in the county to reduce short stay admissions, thereby minimizing Potentially Preventable Readmissions • Developing an increased number of extended observation beds for behavioral health patients to take some of the burden off the CPEP while also reducing the number of patients referred to inpatient psychiatric services.	Current partners: • Brookhaven Memorial Hospital • Catholic Health System • Good Samaritan Hospital • J.T. Mather Hospital • North Shore LIJ • Southside Hospital • St. Catherine's Hospital • Stony Brook Medicine Affected Organizations • All hospitals in the County • Countywide skilled nursing facilities • Countywide primary care providers • Countywide health clinics	Observation units will need to operate according to the general DOH regulations. Hospitals proposing an extended observation bed unit/area licensed by OMH will need to operate according to OMH regulations if the project is approved.	• Decrease in Potentially Preventable Readmissions through maximized utilization of observation medicine • Enhanced patient services through strengthening the discharge process, including medication reconciliation, post discharge planning and patient follow-up post discharge from observation • Decrease in Potentially Preventable readmissions • Easier access to primary care providers • Decrease in short stay inpatient psychiatric hospitalizations • Established patient/provider relationship for ongoing health care needs	Countywide, with focus on hotspots

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2.d.i Implementation of Patient and Community Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care				
Through CBO partners, proven community-based strategies will be deployed to engage and activate uninsured individuals and low/no utilizing Medicaid members to use primary/preventive services in an appropriate manner, to improve health outcomes and health-related quality of life. • This will be accomplished through geographic partnerships between outreach organizations and primary care providers/organizations. • Existing outreach and primary care workers will be trained in the use of the Patient Activation Measure (PAM) system. • Patients will be assessed on the PAM scale at the outset, and routinely measured to determine changes in activation score.	• Suffolk County CBOs in target population hotspots. • Primary care providers • Emergency room staff • MCOs and MCO care management staff. **Current Team:** • Economic Opportunity Council • Hudson River Healthcare • Catholic Charities • Planned Parenthood • Suffolk County Dept. of Social Services • Maternal Infant Community Health Collaborative • Feinstein Institute • Family Service League • South Oaks/LI Home • Health & Welfare Council of LI	N/A	There will be an increase in primary and preventive care service utilization patterns (visit volume of non-emergent services for target populations). Improved scores on PAM from PPS Pam baseline. Improvements in specific health related behaviors such as self-management behaviors, including following a low fat diet, managing stress in a healthy way and knowing recommended weight, asking about medication side effects when taking a new prescription; disease specific self-management behaviors including those related to hypertension, arthritis and diabetes; and other variables related to health related quality of life	Uninsured and Medicaid enrollees in the region's 'hot spots - (the communities of Shinnecock Hills, East Hampton, Central Islip, Brentwood, Gordon Heights, Noyack, Riverhead, Wyandanch, Aquebogue, and Springs), and areas that do not utilize the health care system, or under-utilize primary/ preventive services.

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3.a.i. Integration of primary care services and behavioral health				
This project is aimed at developing collaborative care models between PCPs and behavioral health organizations. It may involve direct co-location of interdisciplinary clinicians within a site, and/or the establishment a level of collaboration between agencies based on geography, skill set, community needs, etc.	There are approximately 30 CBOs and about 65 PCPs across practices involved in this project. Representatives include but are not limited to hospitals, behavioral health organizations, primary care practices/clinics, residential programs, food banks, peer-run organizations, Health Homes, case management entities, the County and State across departments and agencies (i.e. OMH, OASAS, OPWDD), etc.	1) Clinical sites must participate in RHIO to share information; 2) PCP sites with co-located BH providers must meet PCMH level 3 qualifications by year 3 of DSRIP; 3) PCP sites using the IMPACT collaborative care model must implement the IMPACT model with fidelity; 4) All practices will be required to use the same pre-screen/ screening tools including the PHQ2/PHQ9, AUDIT-C/AUDIT, DAST, and CRAFFT for youth. Metrics that must be met include interventions and follow-up care for specific conditions, i.e. diabetes screening for those with schizophrenia and follow-up care management for children prescribed ADHD medications; 5) Unless certain NYS regulations are waived, all agencies must meet current standards, i.e. space, treatment planning, etc.	Improved access/health outcomes related to behavioral health services for primary care patients seen in a variety of PCP settings and improved access/health outcomes related to primary care for patients being seen in specialty behavioral health clinics. Our goal is twofold: 1) to ensure that patients with behavioral health difficulties are identified early and connected to resources and supports in a timely manner. We hope to improve patient and family engagement, reduce stigma around seeking help for behavioral health difficulties and promoting long-term recovery. 2) To improve access to and use of primary care services for those receiving specialty care in behavioral health settings. We hope to ensure individuals being served in OMH and OASAS licensed programs have primary health needs addressed to keep people healthier and extend the life expectancy among individuals with behavioral health disorders to that of the general population.	Countywide, with focus on hotspots

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3.b.i Cardiovascular Disease: Evidence-based strategies for disease management in high risk/affected populations				
The focus of this project is the implementation of evidence-based best practices for disease management in adults with cardiovascular conditions. This project will adopt strategies from the Million Hearts Campaign which has as its goal the prevention of heart attacks and strokes through proven and effective interventions in clinical and community settings.	The following organizations have agreed to participate in this project: • Hudson River Health • Suffolk County Department on Aging • Ed & Phyllis Davis Wellness Institute at Southampton Hospitals • Retired Senior Volunteer Program of Suffolk County • Medication Adherence Project • King Kullen Pharmacies	80% of PCPs in PPS must participate	• Improvement of delivery system design, • Improvement in medication adherence, • Optimization of patient reminders and supports.	The top location for hospital cardiovascular discharges in Suffolk County along with the highest number of Medicaid beneficiaries are in the following zip codes: • Brentwood (11717) • Bay Shore (11706) • Huntington Station (11746) • Patchogue (11772) • Riverhead (11901) • Lindenhurst (11757)

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3.c.i Diabetes - Evidence-based strategies for disease management in high risk/affected populations				
This project will support implementation of evidence-based best practices for disease management in medical practice related to diabetes. Includes risk stratification to identify those patients at greatest risk for poor outcomes and hospitalization. 1. Care coordination and tracking of highest-risk patients to improve access to care, prescription adherence, diabetes self-management practices and recommended secondary prevention 2. Expansion of countywide diabetes education services with expedited access for highest-risk patients (Certified Diabetes Educators (CDEs), diabetes education classes utilizing the Stanford Disease Model);	Itinerant and fixed personnel to target areas of greatest need, including hospital, practice, and community-based patient care settings.	80% of PCPs in PPS must participate	Improvements in: • Rates of hospitalization/ED utilization among patients with diabetes • Rates of education utilization among high-risk patients • Improvement in diabetes self-management practices (home glucose testing, medication adherence, referral follow up and secondary prevention)	Individuals with "high-risk" diabetes (e.g. A1c >9%, multiple comorbidities including behavioral health, taking insulin, diabetes in pregnancy) **Target geographic regions**: Four Suffolk County zip codes drive diabetes-related admissions and ED visits: Brentwood (11717), Bay Shore (11706), East Patchogue (11772) and Central Islip (11722). The project will be rolled out in these high volume/high prevalence zip codes first and then be extended to the remainder of the county.

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3.d.ii Expansion of asthma home-based self-management program				
Implement an asthma self-management program including home environmental trigger reduction, self-monitoring, medication use, and medical follow-up to reduce avoidable ED and hospital care. The goal of this project is to develop population-based services to address asthma exacerbation factors. Special focus will be on children, where asthma is a major driver of avoidable hospital use, with home-based services provided to those at greatest risk for poor outcomes.	Stony Brook Medicine faculty and voluntary practices, hospital-based providers, HRH clinics, community-based private practitioners, urgent care centers as appropriate, school districts	All PPS providers must obtain Patient-Centered Medical Home Level 3 accreditation from NCQA by Project Year 3. Providers must agree to share data and use population-based health management tools created as part of the health information exchange of the integrated delivery system.	1. Improved asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medical use, and medical follow-up. 2. Better linkage of patients to resources for evidence-based trigger reduction interventions. 3. Training and asthma self-management education 4. Link existing systems to facilitate coordinated care for asthma patients, including social services and support 5. Implement periodic follow-up services, particularly after ED or hospital visit occurs to provide patients with root cause analysis of what happened and how to avoid future events. 6. Improved management of asthma with measurable improvement in medication adherence and reduction in avoidable ED visits and hospitalizations, especially for patients at greatest risk for poor outcomes receiving home-based services.	Countywide, with focus on hotspots

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4.a.ii Prevent Substance Abuse and other Mental Emotional Behavioral Disorders				
This project is geared toward the reduction in the use of substances such as alcohol, drugs and tobacco across the population in Suffolk County. The project has three components: 1) Screening for substance use in hospital emergency departments and for admitted patients, and connecting people to resources, 2) Leverage and expand current prevention efforts targeted toward a reduction in underage drinking, and 3) Reduce the incidence of smoking among those being served on OMH licensed programs.	There are 10 Article 28 hospitals that have been actively represented, 1 Article 31 hospital, approximately 30 CBOs, and representatives from the County DOH and State such as OMH, OASAS, OPWDD, the NYS Quitline and NYS Smoking Cessation Center.	1) All participating hospitals will need to have staff trained in the SBIRT model, 2) All hospitals will need to use specific screening tools such as the AUDIT/DAST/CRAFFT/PHQ for the SBIRT implementation, 3) All OMH licensed programs will be required to implement smoke free policies and train staff about smoking cessation and potential medications for use, 4) All participating hospitals and CBOs will be expected to implement the use of the NYS Quitline "Opt-to-Quit" initiative.	Improved identification of those with or at risk for behavioral health disorders at the hospital point of care, provide education and connect patients to resources as appropriate. The building of stronger relationships between hospitals and local OASAS/OMH providers will be required to achieve this outcome. In addition, an overarching goal of primary prevention in targeted communities will reduce the incidence of under-age drinking, and smoking cessation education, interventions and support will reduce the overall incidence of smoking among persons being served in OMH licensed programs. Successful engagement is: 1) patients with behavioral health difficulties are identified early and connected to resources and supports in a timely manner, 2) patients and community members are more knowledgeable about the health risks associated with drinking and/or drug use and reduce their current use accordingly, as well as delay their first use (for underage youth) 3) patients in OMH specialty clinics are reporting that they are not/no longer smoking.	Countywide

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4.b.ii: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings				
Focus on access to high quality chronic disease preventative care and management in both clinical and community settings. Goal is to partner with Suffolk DOH, PPS members, schools and faith-based organization to ensure that a larger proportion of underserved residents receive appropriate/timely screenings, preventive care/management.	• Hospitals • Clinics • Schools • Churches • Suffolk DOH • Managed care organizations • PPS partners participating in community screening events	Waivers to provide screening tests	Increase access to targeted Suffolk populations to provide preventive screening relating to obesity, cardiovascular disease, diabetes, colorectal cancer with focus on tobacco cessation. Increase in screening access Improvement in following metrics: Improvement in following metrics: 1. % of obese adults 2. % of children and adolescents who are obese 3. % of cigarette smoking among adults 4. % of adults who receive a colorectal cancer screening based on the most recent guidelines (Aged 50-75 years) 5. Asthma emergency dept. visit rate per 10,000 6. Asthma emergency dept. visit rate per 10,000 – Aged 0-4 years 7. Age-adjusted heart attack hospitalization rate per 10,000 8. Rate of hospitalizations for short-term complications of diabetes per 10,000 – Aged 6-17 years 9. Rate of hospitalizations for short-term complications of diabetes per 10,000 – Aged 18+ years	All Suffolk County residents will be targeted to address obesity, behavioral health and smoking. Heart disease, diabetes and childhood asthma will be addressed for all Suffolk residents as a prevention-focused extension of Domain 3 initiatives. Specific targeted zip codes where high incidence rates of lung, colon and breast cancer.