ABSTRACT
The Suffolk Care Collaborative Clinical Integration Strategy focuses on the ability to coordinate care across the continuum through clinically interoperable systems. By transforming the delivery system in Suffolk County, SCC aims to create a model of care that is collaborative and quality driven with the goal of improving patient health outcomes through the delivery of safe, timely, and efficient care.

Suffolk Care Collaborative
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Table of Contents

I. Executive Summary ........................................................................................................ 2
II. Clinical Integration Defined ....................................................................................... 4
III. Creating Clinical Integration .................................................................................. 6
IV. Patient Centered Medical Home and Access to Care ............................................. 8
V. Transitions of Care .................................................................................................... 10
VI. Behavioral Health and Primary Care Integration .................................................... 12
VII. Care Coordination ................................................................................................... 14
VIII. Clinical Quality Metrics & Measurement .............................................................. 16
IX. RHIO Connectivity .................................................................................................. 17
X. Clinical Interoperable Systems ................................................................................. 18
XI. Population Health Management in a Clinically Integrated Network ..................... 20
Executive Summary

A Clinical Integration Needs Assessment was performed for the Suffolk Care Collaborative Performing Provider System (PPS). This Needs Assessment highlights areas within the PPS that require further strategizing in order to meet the healthcare needs of our populations. Below is a summary of this Assessment:

The Clinical Integration Needs Assessment utilized data collected from a number of previously administered surveys in order to create the entirety of our “Needs Assessment”. The below survey data was collected and utilized:

1. Transitions of Care
2. Behavioral Health and Primary Care Integration Readiness
3. Workforce Current State Assessment (PCP version)
4. Workforce Current State Assessment (Organization version)

Additionally, the content discussion of the Care Management and Care Coordination Workgroup meeting was utilized.

The key findings in each area are described below:

Transitions of Care

All 11 hospitals in the PPS were surveyed. Three of the 11 (27%) hospitals were found to be performing some type of Transitions of Care, however all hospitals required additional implementation to reach DSRIP standards.

Behavioral Health and Primary Care Integration Readiness

Twenty-one (21) sites were surveyed which included 8 Behavioral Health sites and 13 Primary Care sites. A score of 6 or above on the survey indicates that the practice is currently formalizing processes and procedures toward a fully integrated and collaborative practice. Six (6) of the 21 sites (28.5%) scored at this level.
Workforce Current State Assessment (PCP Version)

The workforce survey was used to highlight certain areas required for clinical integration which included, Access to Care, Connectivity to the RHIO, and PCMH recognition.

a) Access to Care – This question specifically asked if the service site has extended hours for patient services that occur outside of the normal work week. 116 sites responded to this question and of that number, 94 (81%) currently have increased access to care.

b) Connectivity to the RHIO – 90 sites responded to this question and of that number, 37 sites (41%) are currently connected to the RHIO.

c) PCHM Recognition – Sites were asked if they are currently PCMH recognized and for what year and at what level. Results for PCMH Level 3 2014 were as follows: 129 sites responded and of those sites, 8 (6%) are currently recognized at this level.

Workforce Current State Assessment (Organization Version)

The workforce survey was used to highlight certain areas required for clinical integration which included, Access to Care, Connectivity to the RHIO, and current Care Management staff.

a) Access to Care – This question specifically asked if the service site has extended hours for patient services that occur outside of the normal work week. 69 sites responded and of those sites, 61 organizations (88%) have extended hours.

b) Connectivity to the RHIO – 54 sites responded to this question and of that number, 25 sites (46%) are currently connected to the RHIO.

c) Care Management staffing – The organizations were asked to indicate whether or not they currently employ/staff care management in some capacity. Fifty-seven (57) sites responded to this question and 39 sites (68%) indicated that they do have current care management resources.
Clinical Integration Defined

The Federal Trade Commission defines a Clinically Integrated Network as

- The development and implementation of detailed, evidence-based clinical practice guidelines;
- Limiting participation in the program to providers who are committed to accepting the limitations on independent decision-making which the guidelines entail;
- Measurement and evaluation of each participating provider’s compliance with the guidelines; and
- Investment by all participating providers of time, energy and financial resources in the development and enforcement of the clinical guidelines, as well as the computer infrastructure needed to facilitate such integration.¹

The Suffolk Care Collaborative wishes to expand on this definition and through the work of the Population Health Management/Integrated Delivery System workgroup has formulated the working definition of Clinical Integration as:

Clinical Integration is defined for the PPS as the coordination of care across a continuum of services, including preventive, outpatient, inpatient acute hospital care, post-acute including skilled nursing, rehabilitation, home health services and palliative care to improve the quality and value of the care provided. The coordination of care delivery across a defined population, by providers and support services, works to improve clinical and financial outcomes through disease management, care management, demand management and information technology infrastructure. Clinical Integration results in care that is “safe, timely, effective, efficient, equitable and patient focused” (American Hospital Association).

Specifically, the components that work to support and ultimately drive Clinical Integration include the operations of clinical interoperability and data sharing as well as care transitions and care coordination.

Clinical Interoperability is defined as the extent that the SCC Population Health Platform can receive and interpret shared patient data across the Suffolk PPS. For the SCC Population Health Platforms to be interoperable, it must be capable of receiving clinical data from disparate EMR systems, create a longitudinal record that presents a complete picture of a patient’s medical history and subsequently display and report on that data in a consistent manner. The ability to accurately and consistently display patient data within RHIOs provides the final link towards achieving interoperability across the PPS.

Specifically, Clinical Interoperability allows for ingestion of data and subsequent flow of that data to the RHIOs. Data that will be made interoperable includes ADT data, clinical data, adjudicated claims and unadjudicated claims. It is critical that providers gain access to the patient’s longitudinal record at the point of care.

The goal of Clinical Integration is to create a system that allows a patient to transition across the care continuum through activation, navigation and coordination without fragmentation. Providers will have access to interoperable point of care clinical data that will allow for consistent and effective evidenced based medical decisions.
Creating Clinical Integration

The Suffolk Care Collaborative Strategy for Clinical Integration involves creating a system in Suffolk County that allows for care coordination to occur at each phase of the care continuum through clinically interoperable systems and with the intent of improving quality outcomes. The approach to creating this strategy was to ask the following questions and derive areas for further development.

- At what phases does care coordination need to occur?
- What is the scope of coordination delivered at each phase?
- What mechanisms are in place to ensure successful transition?

Clinical Interoperability

- What systems need to become interoperable?
- How will disparate systems communicate with one another?
- What information will need to be exchanged to successfully manage a patient?

Care Coordination

- What are the clinical quality measures that practices will need to meet in order to improve outcomes?
- How will we monitor and measure that these outcomes were met?
- What programs are available to assist providers in being successful with their patient outcomes?

Quality Outcomes

Through the above exercise, the SCC identified key drivers and mechanism for Clinical Integration and measured the current functionality of those drivers through the Clinical Integration Needs Assessment. Each of these factors will be described in detail herein and the strategy for closing any identified gaps will be discussed.
Key Drivers and Mechanisms for Clinical Integration

- Access to Care
- Behavioral Health & Primary Integrated Care
- PCMH
- Clinical Interoperable Systems (Information Technology)
- Clinical Quality Metrics & Measurement
- Transitions of Care
- Care Management

Clinical Integration
Patient Centered Medical Home and Access to Care

The Patient Centered Medical Home (PCMH) is at the forefront of transforming the delivery of primary care in a model that is patient centered. PCMH facilitates a team based approach to care: provider-led care teams where physicians, nurse practitioners and other professionals work with their staff managing the health needs of the patient. PCMH supports the development of care coordination activities that can be performed by non-provider professionals. In this setting the care team works to the highest capability of license or scope of practice; an approach vastly different from the way healthcare has been provided in the past. PCMH promotes effective communication and the use of health information technology. PCMH model of care has demonstrated the ability to improve the team based approaches to care and allows providers more time to focus on managing the patient’s health; engages all members of the health care team, including the patient, to contribute to the health of the patient; and emphasizes population health management.

The SCC Clinical Integration Needs Assessment highlighted current gaps in the SCC PCMH certified provider network. It is SCC’s belief, that by transforming primary care sites into Patient Centered Medical Homes, we will be well positioned to improve the quality of care provided to our patients and increase access to care for our most vulnerable populations. Care provided in a PCMH is well coordinated and efficient and evidenced based practices are utilized thereby improving the success of a clinically integrated network. Therefore, a strategy has been developed to bring providers (as per the SCC provider engagement speed and scale commitments) to PCMH 2014 Level 3 status with submissions for recognition being completed by September of 2017.

The first step in the PCMH strategy is to contract with providers in the SCC network. Through contracting, greater detail is gained on the status of each practice and provider and relationships are built which facilitate a team based approach to PCMH recognition. Vendor contracts have then been obtained with PCMH specialists (i.e. PCDC and HANYS) which provide a facilitated recognition process for the practice sites.

In addition to direct support to the practices via vendor contracts, SCC relies on the PPS PCMH transformation lead, our Senior Manager, Provider & Community Engagement, to direct and manage the process of recognition for the entire PPS. The Senior Manager leads a monthly PCMH Workgroup which is comprised of key stakeholders in the PPS, including representation and report out from Catholic Health System and Northwell Health on their progress towards transformation.
Through the work of SCC’s Senior Manager, PCMH Workgroup, Vendor Contracts, and Provider sites, PCMH 2014 Level 3 recognition is possible and this transformation will be a foundational building block for the practices’ abilities to continue to provide patient centered, high quality care in a changing healthcare environment. The success of the PPS in improving quality outcomes and becoming clinically integrated relies on our ability to support our provider partner in this transformation.

For more details on the PCMH Strategy, please see SCC Patient Centered Medical Home (PCMH) Strategy (March 7, 2016)
Transitions of Care

The ability to effectively transition a patient from one point of care to another is a clear indicator of clinical integration. The coordination, communication and technological ability to seamlessly transition a patient is paramount in improving health outcomes and reducing unnecessary readmissions and hospital utilization. The Suffolk Care Collaborative has developed a Transitions of Care Model (herein referred to as “the Model”) which speaks specifically to the transitions of high risk Medicaid patients from inpatient or observation status back into the community safely.

SCC’s Clinical Integration Needs Assessment identified that only 3 of the 11 hospitals in Suffolk County were performing some degree of Transitions of Care for post-acute patient needs. A strategy was developed in order to ensure that all 11 hospitals as well as the community partners involved in these patients’ care, can successfully transition patients out of acute care and on to the most appropriate setting. Below is a discussion of the Model and the strategy for implementing the Model.

Dr. Amy Boutwell, subject matter expert in the area of Care Transitions was brought on as a consultant to work with SCC and the Transitions of Care (TOC) Committee in the development of a TOC Model. Her experiences in reducing Medicaid Readmissions can be seen through her work in the AHRQ published paper, Hospital Guide to Reducing Medicaid Readmissions. Through several working sessions, the SCC TOC Committee, comprised of representatives from all 11 hospitals in the PPS, Health Homes, Home Care Agencies, Care Management Organizations, SNFs, and CBOs, agreed upon criteria for identifying High Risk patients, real-time identification of those patients upon hospital registration, early notification of patient and partners of planned discharges, the provision of a written Transition of Care Plan, timely completion of the discharge summary, and initiation of a 30-day Transition of Care Period with PCP updates. Further details of this Model can be found here.

In order to implement this agreed upon Model, SCC has developed a strategy which will result in full operationalizing of the Model by March of 2017. Each of the 11 hospitals has created an Implementation Team which is responsible for the oversight of the TOC Model. The PPS has provided each team with an Implementation Plan, highlighting key steps in their implementation period, as well as training on a Project Management tool called Performance Logic which is used to organize and track their progress. The SCC Project Management Team then meets with the hospital’s TOC Implementation Team to offer support and track progress towards target dates.
In addition to Team meetings to discuss progress, SCC has also developed Learning Collaboratives. These sessions are designed to provide an opportunity for hospital teams to speak to one another about best practices and lessons learned. SCC is planning a joint Learning Collaborative between hospitals doing TOC and Skilled Nursing Facilities (SNF) implementing INTERACT which will allow for true collaboration on reducing readmissions and avoidable hospital utilization.

The Transitions of Care Strategy will be fully implemented by March 31, 2017 at which point data will be collected to ensure that services being offered are meeting the needs of patients and reducing readmissions. Monthly TOC Workgroup Meetings and quarterly TOC Committee meetings will continue to ensure successful implementation and maintenance of the strategy.

For more details on the PCMH Strategy, please see The SCC Transitions of Care Model.
Behavioral Health and Primary Care Integration

Integrated care is the highest level of achievement in an integrated delivery system. Directly embedding services into primary care and/or behavioral health sites embraces the essence of the clinical integration model and this is sought through the SCC program. A given provider’s readiness to begin this process helps to prioritize and deploy resources and support appropriately. The Clinical Integration Needs Assessment identified provider practices that were targeted as “Phase 1” implementation practice sites and indicated those sites that have an increased readiness factor for integration as identified through the North Carolina Center for Excellence MeHAF score. This Needs Assessment did not account for practices that will be targeted for integration and were not yet surveyed. The strategy to fill this gap will be outlined below.

The SCC has committed to engaging primary care and behavioral health providers (as per the SCC provider engagement speed and scale commitments) to integrate care through one of three models of integration. Model 1 allows for a behavioral health specialist to be embedded at a primary care practice, Model 2 allows for primary care provider to be embedded at a behavioral health site, and Model 3 (Impact Model) allows for the creation of a “Depression Care Manager” position in a primary care site to care for the needs of positively screened patients. To facilitate this engagement and successful implementation, SCC has created an “Implementation Specialist” position which is charged with working one on one with each site during implementation to address workflow, screenings, billing concerns, and staffing. The Implementation Specialist assists in securing resources and supporting the practice site through the process.

The strategy for creating this integrated care model operates in a “Phased” roll out with Phases 1-4 being developed. Phase 1 had 21 practice sites which were assessed through subject matter experts, the North Carolina Center for Excellence, to determine their readiness to integrate. Post this readiness assessment, the Program Lead works with the site to determine which Model of care is most appropriate. Throughout this process, resources are being identified to fulfill programmatic requirements. Phase 1 sites will engage in a “kick-off” meeting where toolkits will be reviewed and networking opportunities will be provided. Learning Collaboratives will begin monthly after kick off which allows for lessons learned and best practices to be shared amongst integrated sites with support from the North Carolina Center for Excellence and the Program Lead.
Phase 2 sites (24 practice sites) have begun their initial assessments as of May 31, 2016. This Phase of sites as well as those sites in Phases 3, 4 and beyond will progress through the steps described above in order to achieve integrated care throughout Suffolk County.

This strategy will differ slightly when implemented at the Catholic Health Services HUB sites and Northwell HUB sites, however the oversight for these implementation plans will be monitored by the SCC Project Manager. A Template has been created and is used to monitor all phases of implementation and track sites that have completed their integration plans. This Template is reviewed at bi-monthly committee meetings and will be used to track progress towards full integration.
Care Coordination

The SCC definition of Clinical Integration identifies the ability to coordinate care as the essential component for being a successful clinically integrated network.

“Clinical Integration is defined for the PPS as the coordination of care across a continuum of services, including preventive, outpatient, inpatient acute hospital care, post-acute including skilled nursing, rehabilitation, home health services and palliative care to improve the quality and value of the care provided.”

The SCC Clinical Integration Needs Assessment requested providers to indicate whether or not they currently have employed Care Managers. Fifty seven (57) sites responded to this survey question and of those facilities, 39 sites (68%) stated that they have employed Care Managers. Care Coordination, however must extend beyond the walls of hospitals and facilities and into the community. To address this need, SCC has developed a Care Management and Care Coordination Workgroup to strategize on opportunities throughout Suffolk County.

The Care Management and Care Coordination Workgroup is led by the SCC Director of Care Management and Care Coordination and meets quarterly. Members of this group include representatives from hospitals, SNFs, home care, ACOs, Health Homes, Suffolk County DOH, OASAS, mental health providers, CBOs and the Stony Brook School of Social Welfare. This group also includes members as described above from Catholic Health Services, Northwell Health and Stony Brook University Hospital making this group and the decisions made within the group, PPS inclusive. This workgroup has identified that Care Coordination services are available for all high risk patients discharged from the 11 PPS hospitals through the CHS, Northwell and SCC Care Management Organizations. Additionally, the Northwell Health and Hudson River Healthcare Health Homes support high risk patients with chronic conditions and/or behavioral health diagnoses in the community.

The workgroup has come to an agreement that Care Coordination is available to Medicaid and uninsured patients throughout Suffolk County. Gaps have been identified in five main areas: availability and access to medically appropriate nutrition; safe, adequate, and affordable housing; transportation that allows for medically connected visits that are not otherwise covered by medically necessary Medicaid trips; sharing of resources from agencies throughout Suffolk County that allow for real time ability to identify ways to close gaps in care; and seamless communication and warm hand offs between organizations.
The Workgroup has developed strategies to address these gaps which are described below:

1. Availability and access to medically appropriate nutrition – The Workgroup will look to identify patients eligible for SNAP benefits as well as navigate to food pantries. Members of this workgroup are individually researching organizations that cater to patients with medical dietary needs and will be reporting findings to the Workgroup at least quarterly.

2. Safe, adequate, and affordable housing – The Workgroup has identified organizations that offer housing in this category and members of the Workgroup represent these organizations. Discussions have been had regarding wait list concerns and high need for affordable housing. Opportunities will be further discussed to identify other organizations providing housing and to document gaps in this area as they are identified so that they are documented and can be brought to housing authorities and other county officials for consideration.

3. Transportation for medically connected visits that are not otherwise covered by medically necessary Medicaid trips – It has been identified that while patients may be able to navigate to medical appointments once they are connected to Logisticare or paratransit, they lack the ability to get to places like pharmacies, food pantries and the Department of Social Services for vital service needs. Opportunities to expand on current service delivery will be explored and this Workgroup will continue to brainstorm on ways to improve transportation in Suffolk County.

4. Sharing of resources across agencies – The PPS is working with organizations such as HITE and 211 to host resources through the Suffolk Care Collaborative through efforts in Community Engagement. This Workgroup will look to co-host meetings with Community Engagement efforts in order to develop further strategies that can improve access to resources available throughout Suffolk County.

5. Communication and Warm Handoffs – This workgroup has begun work in this area through the creation of the Care Management and Care Coordination Manual and the Care Management and Care Coordination Contact List. The purpose of these documents is to ensure that members of the group know who to call when they are working with a patient and to better understand services available in order to successfully coordinate care across the continuum. These are living documents and are updated after each meeting with the addition of new organizations and contacts.
Clinical Integration allows for the coordination of care through IT infrastructure with the intention of improving health outcomes. The SCC Population Health Management Roadmap details the SCC strategy for identifying populations and risk stratifying those populations to pull out those requiring care management and further disease management. Clinical Integration, however, lays that foundation by operationalizing core sets of measures to be implemented across the entire network. If all providers who are interacting with a given patient are held to the same clinical quality standards, the ability to move the needle on health outcomes becomes more tangible. The Clinical Integration Needs Assessment required that providers answer to the current degree at which they are asking, educating, and supporting certain quality metrics and programs. Results varied greatly and therefore a specific gap was not identified, but rather a strategy has been developed to address the global need to measure the same quality indicators across the entire network.

SCC has developed a provider level implementation plan for each provider type in the PPS. This plan outlines all quality indicators, as well as other project requirements, that a given provider will be held accountable for. Toolkits for each clinical category as well as a general Clinical Guideline Summary, have been developed and training attestations will be collected for all on boarded providers. Through management of the provider implementation plans as well as the provision of training materials, SCC can identify providers that have initiated and/or have continued to measure and monitor the quality metrics set forth by the PPS.

Post implementation, SCC has developed a performance monitoring and improvement plan which utilizes the clinically interoperable system (described below) to ingest data and create reports. The entirety of this plan can be read in further detail in the SCC Performance Reporting and Improvement Plan.
RHIO Connectivity

The ability of a coalition partner to connect to the RHIOs is essential for data sharing across the network. Coordination of care is more effective when information can be obtained from various sources and for care provided outside of a given network or EMR system. The SCC Clinical Integration Needs Assessment requested that sites report on their current connectivity to a RHIO. Since this Assessment, more detailed work has been completed to identify gaps in connectivity and a strategy has been developed to close this gap.

RHIO Connectivity work has been assigned to a SCC Project Manager and a Workgroup has been developed to address deliverables in this area. Sites that will be connected to the RHIO include skilled nursing facilities, behavioral health sites, primary care providers, non-primary care providers and community based organizations.

The strategy to close this gap begins with Contracting. As providers are contracted with the PPS and IT Assessment of connectivity abilities is completion. The practice is then engaged with NYCIG or Healthix for QE Completion and RHIO training. As each site is contracted, this process will occur and is tracked by the SCC Project Manager. Successful implementation of this strategy will allow for increased coordination of care through shared access to records.
Clinical Interoperable Systems

When operating in a Clinically Integrated Network, SCC will have access to information from many disparate systems available in one centralized location. This data will be used to communicate and coordinate care for patients as well as to measure outcomes and manage subsets of populations (further details of this strategy can be found in the SCC Population Health Roadmap). The Clinical Integration Needs Assessment reviewed the IT Current State Assessment survey which identified technology tools being used throughout the PPS. Gaps were identified in varying levels which included, current state utilization of an EMR, current RHIO connectivity (described above), Meaningful Use attestation, and the ability to leverage discrete data fields within an EMR to meet several quality metric deliverables. A strategy to close the gap in interoperability has since been developed and will be described below.

The IT Task Force, which includes representation from the Catholic Health System, Northwell Health System and Stony Brook University Hospital (herein referred to as HUBs) have worked together to develop a strategy for clinical data sharing and interoperability across the PPS network. At the highest level data is taken from various sources and normalized in single longitudinal record for each patient. As more data is contributed to the platform the accuracy and breadth of the patients’ health record increases thereby increasing the rate of positive patient outcomes and reducing the probability of readmissions. The steps to be taken in order to create a clinically interoperable network are:

1. Complete the technical on-boarding and clinical data acquisition for all attested providers within the given HUB.
2. Where applicable, work with EHR vendors at provider sites to assure that the EMR platform can provide the required discrete and non-discrete data items required to monitor patient outcomes.
3. Match patient records and create a unique longitudinal record for each Medicaid member within the given HUB.
4. Normalize clinical data items from disparate EHR systems into a standard format such that Medicaid members can be tracked across projects and consistent reports can be generated.
5. Develop and maintain patient to provider attributions consistent with the agreements made with the SCC.
6. Identify the Patient Population based on the DOH Roster and agreements made with the SCC.
7. Provide the technical assets and resources required to support the Domain 1 Project specific technical requirements.
9. Provide a data feed of all aggregated and “normalized” patient data records into the SCC Enterprise Data Warehouse for the purpose of PPS wide reporting.
10. Assure that all attested provider EHRs are successfully connected and integrated with their RHIO’s HIE under the umbrella of SHIN-NY requirements and initiatives.

The process detailed above begins immediately after a provider signs the PPS contract. Support is provided from the HUB IT departments throughout the entire process to ensure that systems are on boarded correctly and that data is able to be utilized in a meaningful way. This level of clinical interoperability enhances the coordination of care across the continuum and thereby creates the foundation of the SCC Clinically Integrated network.

For more information on the SCC System Interoperability Plan please see, SCC Clinical Data Sharing and System Interoperability
Population Health Management in a Clinically Integrated Network

In order to be effective population health managers and achieve clinical integration, SCC must have a strong foundation that consists of the following core components; IT Clinical Interoperability/Data Analytics, Care Coordination/Transitions and Provider Engagement/Alignment. The effectiveness of the foundation defines the true ability to be considered clinically integrated and thusly the ability to function as a Clinically Integrated Network (CIN).

Once the foundations described in this Strategy are fully implemented, work can truly begin in the realm of Population Health Management. SCC understands that these concepts are different, but also recognizes the reliance on one another to be successful. When populations of patients are identified as being high risk in the areas of disease management, social determinants, and preventive health, it is the Clinically Integrated Network that these patients interact with. This Network then but be capable of coordinating care, managing transitions, and communicating effectively with one another in order to improve the health outcomes set forth by the Population Health Managers.

The Suffolk Care Collaborative, while currently a Performing Provider System, is also a Population Health Management Organization and through the Strategy described in this document, looks to create a Clinically Integrated Network with which to manage populations of patients, specifically the most vulnerable in Suffolk County.