Suffolk Care Collaborative

DSRIP Demonstration Year 3, Quarter 1

Partner Data Request

Webinar: June 2017

Presented by

Suffolk Care Collaborative (SCC)

Suffolk County Performing Provider System (PPS)

Delivery System Reform Incentive Payment (DSRIP) Program

Learning Objectives:

At the conclusion of the webinar, participants will be able to:

1. Describe the DSRIP Domain 1 Patient Engagement reporting requirements and commitments made to the Department of Health
2. Identify the SCC data request timeline and DOH reporting schedule
3. Explain the patient engagement data specs needed by DSRIP project
4. Discuss the strategy for transmitting Protected Health Information (PHI) to the Suffolk Care Collaborative to meet Patient Engagement Quarterly Reporting Requirements

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DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS

- DSRIP payments are achieved by successfully meeting Domain 1 Process Milestones and Metrics, Pay for Reporting requirements, and meeting and/or exceeding Pay for Performance metrics.
- Patient engagement speed is a Domain 1 Process Measure.
- Domain 1 Process Measure funding is significant, representing approximately **40%** of all payments across the 5 year waiver.
- All Speed and Scale measures tie directly to commitments made in the Project Plan Application submitted by the Suffolk PPS.
- The definition of the term 'Actively Engaged' varies by project and is outlined within this presentation.

Source: NYS DOH Presentation entitled "Actively Engaged Patients: Counting Methodology for Speed & Scale Tables" December 17, 2014

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DOMAIN 1 PATIENT ENGAGEMENT SPEED TARGETS

	DY 1			DY 2				DY 3				DY 4			
Project	Q2: July 1-September 30, 2015	Q3: October 1-December 31, 2015	Q4: January 1-March 31, 2016	Q1: April 1-June 30, 2016	Q2: July 1-September 30, 2016	Q3: October 1-December 31, 2016	Q4: January 1-March 31, 2017	Q1: April 1-June 30, 2017	Q2: July 1-September 30, 2017	Q3: October 1-December 31, 2017	Q4: January 1-March 31, 2018	Q1: April 1 - June 30, 2018	Q2: July 1-September 30, 2018	Q3: October 1-December 31, 2018	Q4: January 1-March 31, 2019
2B4 - TOC	25%	38%	60%	8%	40%	60%	100%	10%	50%	75%	100%	10%	50%	75%	100%
Patient Count	6354	9531	15255	2034	10170	15255	25326	**2543**	12713	19018	25326	2543	12713	19018	25326
2B7 - INTERACT	25%	37%	60%	20%	40%	70%	100%	25%	50%	75%	100%	25%	50%	75%	100%
Patient Count	478	717	1148	382	765	1340	1914	**478**	957	1435	1914	478	957	1435	1914
2B9 - OBS	10%	25%	40%	10%	35%	56%	75%	25%	50%	75%	100%	25%	50%	75%	100%
Patient Count	886	2216	3546	886	3103	4987	6650	**2216**	4433	6650	8866	2216	4433	6650	8866
2D1 – PAM	10%	18%	25%	4%	20%	35%	50%	7%	35%	53%	75%	10%	50%	75%	100%
Patient Count	4542	7950	11356	1817	9085	15899	22712	**3180**	15899	23849	34069	4542	22712	34069	45426
3A1 - BH-PC	5%	10%	15%	4%	20%	35%	50%	8%	40%	53%	75%	10%	50%	75%	100%
Patient Count	2245	4505	6785	1799	8995	15770	22489	**3598**	17991	23849	33734	4498	22489	33734	45059
3B1 - CV	10%	15%	25%	4%	20%	35%	50%	8%	40%	60%	80%	10%	50%	75%	100%
Patient Count	1453	2180	3663	581	2907	5095	7267	**1163**	5814	8734	11628	1453	7267	10917	14556
3C1 - DIABETES	25%	37%	50%	8%	40%	60%	80%	10%	50%	75%	100%	10%	50%	75%	100%
Patient Count	3022	4533	6044	967	4834	7251	9669	**1209**	6044	9066	12094	1209	6044	9066	12094
3D2 - ASTHMA	10%	32%	40%	10%	50%	62%	75%	10%	50%	75%	100%	10%	50%	75%	100%
Patient Count	674	2180	2697	674	3371	4214	5057	**674**	3371	5065	6751	674	3371	5065	6751

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SCC DATA REQUEST SCHEDULE

Demonstration Year & Quarter*	Reporting Period
DY 3, Q1	**4/1/17 – 6/30/17**

- SCC will formally request data on 6/12/17
- Partners prepare reports and conduct QA on data 6/12/17 – 7/14/17
- **Data files due back to the SCC by 7/14/17 (Friday, July 14, 2017)**
- SCC will reconcile data against all partner submissions 6/12/17 – 7/21/17
- SCC will follow up with partner with any questions or concerns 7/21/17 – 7/28/17
- SCC will prepare aggregated file for final metric count 7/28/17

Patient Engagement Data Requests and Excel Data Specifications

SCC DATA REQUESTS EXAMPLES

PDF Document: Patient Engagement Definition

Domain 1 Patient Engagement Data Request

Suffolk Care Collaborative 2biv Transitions of Care (TOC) Project

Request: Please return the attached SCC excel template via BOX by July 14, 2017
For BOX questions or access related inquiries, please contact Kelly Tamburello, Kelly.Tamburello@stonybrookmedicine.edu

Patient Grouper: Medicaid Patient Data (Medicaid may be Primary, Secondary or Tertiary Insurance)
Time Period: April 1, 2017 – June 30, 2017

Project 2biv: Transitions of Care Program

Patient Engagement Definition: As per the definition of actively engaged, patient engagement refers to the number of participating patients with a written care transition plan developed prior to discharge that includes patient self-education, medication reconciliation, and follow-up appointments. Duplicate counts of patients are allowed within 1 DSRIP measurement year, if the patient has multiple encounters, each encounter is counted. For example, if a patient receives TOC care plans on 5 discharges in a year, we count it 5 times in that DSRIP year.

Please see excel template for formatting specifications.

Requested Data Elements:

1. CIN #
2. Patient Last Name
3. Patient First Name

Excel file: Report Template (data input)

	A	B	C	D	E	F	G
1	SCC Project 2.b.iv Patient Engagement Template - Transitions of Care						
2							
3	CIN #	Patient Last Name (All CAPS)	Patient First Name (All CAPS)	DOB (MM/DD/YYYY)	Patient Resident Zip Code (5 Digits)	Location/Site Name	Service Site Zip Code (5 Digits)
4							
5							
6							
7							
8							
9							
10							

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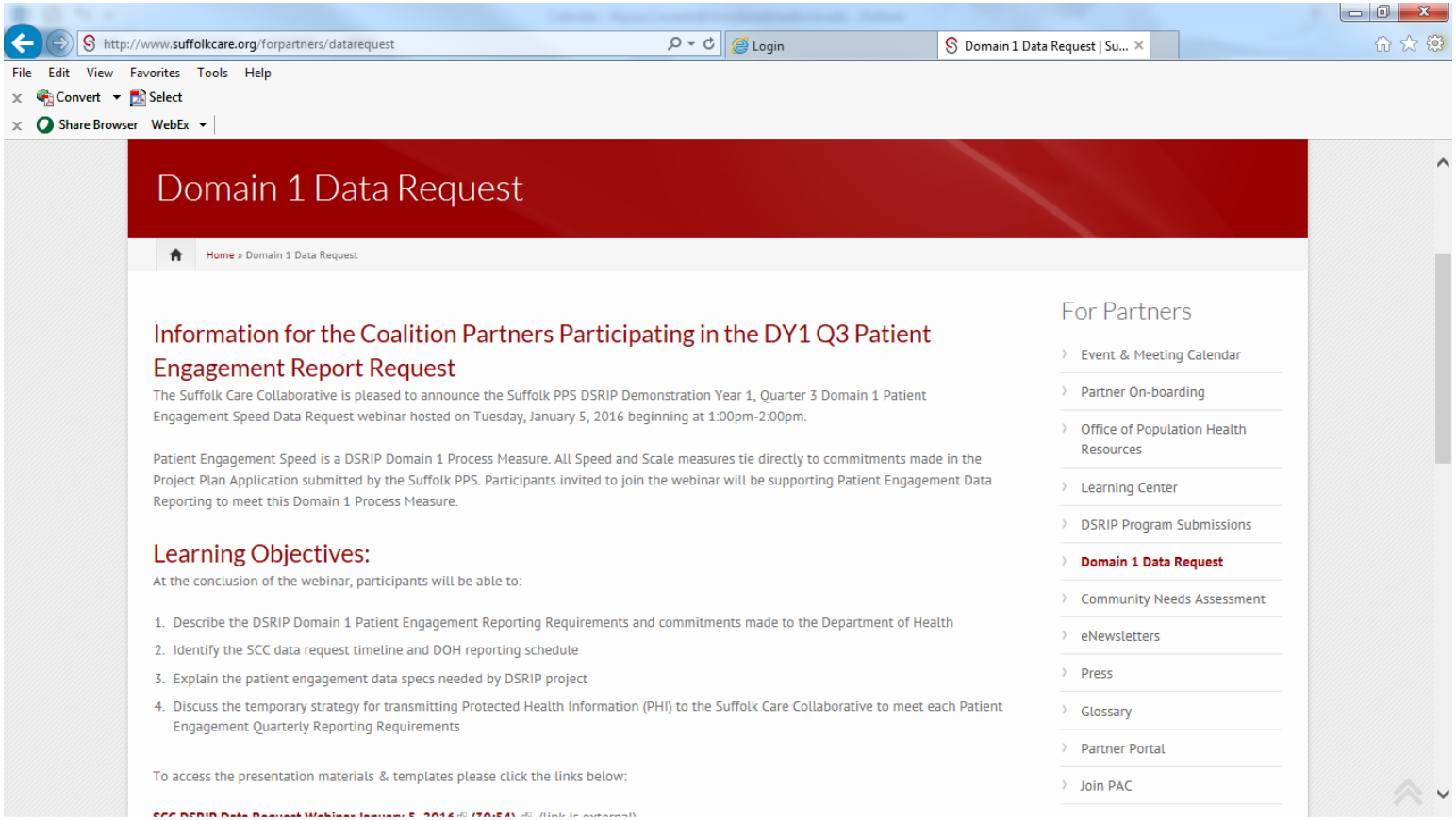
DATA REQUEST WEBPAGE WEBSITE TUTORIAL

http://www.suffolkcare.org/forpartners/datarequest



IMPORTANT UPDATES

- Updated Information has been added to the patient engagement definition for **Project 3ai Models 1&3 (BH-PC): 96160 & 96161** are newly added CPT codes. ***Please Note:*** These CPT codes may be used for other health assessments. The SCC Partner *must confirm* that the code is exclusively used for the screening tools identified in the 3ai Models 1&3 patient engagement definition prior to submitting data to the SCC

- The Patient Engagement Data File format and layout submitted to the SCC *must* be consistent with the SCC Report Templates (Excel file).

- Refer to the SCC Website before each quarterly data submission for updated patient engagement definitions (PDF) and report templates (Excel File): https://suffolkcare.org/forpartners/datarequest

Patient Engagement Data
Key Considerations

Q: What is the payor mix for reporting?

A: Straight Medicaid, Medicaid Managed Care plans, and if either is the primary, secondary or tertiary insurance. Dual eligible with Medicare is also included. The uninsured population is only applicable for Project 2di patient engagement. ***Clarifying information:*** Child Health Plus patients are not to be included in patient engagement reporting.

Q: How do I send PHI data securely to the SCC?

A: Data is sent to SCC through a HIPAA compliant protocol (our secure BOX repository). The same procedure initiated during the DY 1 Q2 reporting period will be followed.

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PROVIDER TYPE SELECTION FOR REPORTING

The following table will help outline "who" you will obtain this patient engagement data from and the time period for this reporting period (DY3 Q1)

Project Name	Provider Type	Time Period
2biv TOC	Hospital Data	April 1, 2017 – June 30, 2017
2bix OBS	Hospital Data	April 1, 2017 – June 30, 2017
2di PAM	Insignia Licensed Tool Database	April 1, 2017 – June 30, 2017
2bvii Interact	Skilled Nursing Facilities (SNF)	April 1, 2017 – June 30, 2017
3ai Model 1	Primary Care Physician (PCP) practice data	April 1, 2017 – June 30, 2017
3ai Model 2	Behavioral Health (BH) practice data with PCP Services	April 1, 2017 – June 30, 2017
3ai Model 3	PCP practice data	April 1, 2017 – June 30, 2017
3bi Cardiovascular	PCP or Non-PCP	April 1, 2017 – June 30, 2017
3ci Diabetes	Hospital, PCP, Non-PCP, or Care Management registry database	July 1, 2016 – June 30, 2017
3dii Asthma	PCP practice data	April 1, 2017 – June 30, 2017

Patient Engagement Definitions

SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: **PROJECT 2BIV (TOC)**

Project Title	**Care transitions intervention model to reduce 30 day readmissions for chronic health conditions**
Actively Engaged Definition	**The number of participating patients with a care transition plan developed prior to discharge.**
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are allowed, provided that they meet the criteria more than once. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- There is no specific definition of a "care transition plan." However, a care transition plan should be consistent with the best practices of CMS' **Community-Based Care Transitions Program and should include core components such as: patient self-education, follow-up appointments, and medication reconciliation (CCDA or Discharge Summary or Discharge Instructions).**
- "Participating patients" refers to those patients who are at a high risk of readmission, particularly those patients with cardiac, renal, diabetic, respiratory and/or behavioral health disorders. These are the same patients who would fit the 3M definitions for successfully prevented readmissions. While the project is specifically focused on certain conditions, any hospitalized patients who receive a care transition plan prior to discharge will count.
- The discharge needs to be accompanied by a care transition plan in order for that patient to count as actively engaged, i.e. if a patient is discharged with the intent to develop a treatment plan within a predetermined number of hours/days/etc., that patient would not count as actively engaged.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: **PROJECT 2BVII (INTERACT)**

Project Title	**Implementing the INTERACT project (inpatient transfer avoidance program for SNF)**
Actively Engaged Definition	**The number of participating patients who avoided nursing home to hospital transfer, attributable to INTERACT principles as established within the project requirements.**
Counting Criteria	A count of patients 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.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The count refers to the number of patients participating in the INTERACT program.
- **Any patient who was transferred to an acute facility (including an ER visit, even if they were not admitted to the hospital) from the nursing home would not count in the actively engaged population.**

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

Project Title	**Implementation of observational programs in hospitals**
Actively Engaged Definition	**The number of participating patients who are utilizing the OBS services that meet project requirements.**
Counting Criteria	A count of patients 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.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- **One utilization unit of the observation services consists of:**
- **One episode of care = APG rate code 1402 billed with CPT/HCPCS code G0378 (without regard to units [hours] attached to the G0378). This may vary by Hospital.**
- **Patients transferred to an Inpatient status from an Observation status would not count**.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: **PROJECT 3AI MODEL 1**

Project Title	**Integration of primary care and behavioral health services**
Actively Engaged Definition	**The total number of patients receiving appropriate preventive care screenings that include mental health/SA.**
Counting Criteria	A count of patients 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.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:
SCC Data request is for: Number of patients screened with **PHQ2 or PHQ9**
OR Number of patients screened using SBIRT tools including both **AUDIT C and DAST**
OR Number of patients screened using SBIRT tools including the **CRAFFT**
OR Number of patients screened using **PSC-17 or PSC-Y**

- The PPS is expected to utilize the preventive care screening based on nationally-accepted best practices determined to be age-appropriate.
- Any staffer working at a PCMH/APCM Service Site who is qualified to perform a preventive care screening can do so
- Appropriate screenings would only count if the PCP is provided the results of the screen and they are incorporated into the medical record.
- The expectation of a co-located primary care-behavioral health site is that there is a behavioral health provider (licensed social worker, psychologist, psychiatric nurse practitioner, psychiatrist) on site engaged in the practice.
- **Preferred data source is abstracted information from the Clinical EHR. Depression screenings may be identified through claims data utilizing CPT codes 96127, 96160, 96161, 99408, 99409, , 3016F. For CPT code 96127, 96160 & 96161 the SCC Partner must confirm that the code is exclusively used for the screening tools identified above prior to submitting data to the SCC. This CPT code may be used for other health assessments.**

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

Project Title	**Integration of primary care and behavioral health services**
Actively Engaged Definition	**The total number of patients receiving primary care services at a participating mental health or substance abuse site.**
Counting Criteria	A count of patients 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.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Primary Care Services are defined as preventive care screenings billed through Current Procedural Terminology (CPT) codes.
- Age 13 and up
- The mental health and substance abuse sites have to be partners in the Network Tool in order to count as sites included from the network list.
- Any staffer working at a Behavioral Health Site who is qualified to perform a preventive care screening as required within the project can do so.
- **The only types of "primary care providers" that may be utilized to provide primary care services within the BH site are participating PCPs, NPs, and physician assistants working closely with a PCP.**

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

Project Title	**Integration of primary care and behavioral health services**
Actively Engaged Definition	**The total number of patients screened using the PHQ-2 or 9 / SBIRT.**
Counting Criteria	A count of patients 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.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:
SCC Data request is for: Number of patients screened with **PHQ2 or PHQ9**
OR Number of patients screened using SBIRT tools including both **AUDIT and DAST**
OR Number of patients screened using SBIRT tools including the **CRAFFT**
OR Number of patients screened using **PSC-17 or PSC-Y**

- **All five principles of the IMPACT model must be in place for a site to count.**
- **Any staffer working within the IMPACT model who is qualified to perform a preventive care screening as required within the project can do so.**
- **Preferred data source is abstracted information from the Clinical EHR. Depression screenings may be identified through claims data utilizing CPT codes 96127, 96160, 96161, 99408, 99409, , 3016F. For CPT code 96127, 96160 & 96161 the SCC Partner must confirm that the code is exclusively used for the screening tools identified above prior to submitting data to the SCC. This CPT code may be used for other health assessments.**

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

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SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS& TARGETS: **PROJECT 3BI (CARDIOVASCULAR)**

Project Title	**Evidence-based strategies for disease management in high risk/affected populations. (18 years or older)**
Actively Engaged Definition	**The number of participating patients receiving services from participating providers with documented self- management goals in medical record (diet, exercise, medication management, nutrition, etc.).**
Counting Criteria	A count of patients 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.
Data Source	EHRs or other IT Platforms (i.e. patient registries or medical records).

Clarifying Information:

- Core components require documentation of patient-driven, self-management goals in the medical record, which are reviewed at every appointment.
- **Information must be updated in the medical record on an ongoing basis and goals should be reviewed at every appointment.**
- Key patient information needs to be available through the HIE throughout the PPS. This is needed so that, for example, a cardiologist and PCP seeing the same patient can access the same information through the RHIO.
- Participating provider systems undertaking this project will be required to engage a majority (at least 80%) of their primary care practices in this activity (as stated in the Domain 1 DSRIP Project Requirements Milestones and Metrics document).

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: **PROJECT 3CI (DIABETES)**

Project Title	**Evidence-based strategies for disease management in high risk/affected populations. (18 years or older)**
Actively Engaged Definition	**The number of participating patients with at least one hemoglobin A1c test within the four most recent quarters .**
Counting Criteria	A count of patients at-risk for or with diabetes 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.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information: As per the definition of actively engaged, patient engagement refers to the number of participating patients with at least one hemoglobin A1c test within the four most recent quarters. Duplicate counts of patients are not allowed within 1 DSRIP measurement year. Counts are not additive across DSRIP years.

The target population should include individuals:

1) **Who have diabetes based on a principal or secondary ICD-9 or ICD-10 diagnosis code as specified in the SCC Domain 1 Patient Engagement Data Request or**
2) **A1C ≥ 6.5 or**
3) **Are "at-risk" for diabetes based on Table 2.2** of the ADA's Diabetes Care website indicating the criteria for testing for diabetes or pre-diabetes in asymptomatic adults). It should be noted that to be considered a patient "at-risk" the individual would have to demonstrate sufficient risk factors or clear cut symptoms prior to official diagnosis as outlined in Table 2.2.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

TABLE 2.2 FOR PROJECT 3CI PATIENT ENGAGEMENT REPORTING METRICS

1. Testing should be considered in all adults who are overweight (BMI ≥25 kg/m2 or ≥23 kg/m2 in Asian Americans and have additional risk factors:
   - Physical inactivity
   - First-degree relative with diabetes
   - High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
   - Women who delivered a baby weighing >9 lb or were diagnosed with GDM
   - Hypertension (≥140/90 mmHg or on therapy for hypertension)
   - HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
   - Women with polycystic ovary syndrome
   - A1C ≥5.7% (39 mmol/mol), IGT, or IFG on previous testing
   - Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
   - History of CVD
2. For all patients, testing should begin at age 45 years.
3. If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results (e.g., those with prediabetes should be tested yearly) and risk status.

Source: http://clinical.diabetesjournals.org/content/diaclin/34/1/3.full.pdf

Project Title	**Expansion of asthma home-based self-management program. (25 years or younger)**
Actively Engaged Definition	**The number of participating patients based on home assessment log, patient registry, or other IT platform.**
Counting Criteria	A count of patients 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.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Any IT platform will count for determining the number of participating patients as long as it is able to meet the requirements of accurately documenting persons participating in the program.
- Any program that meets the project requirements and is based on evidence-based guidelines will count as an "asthma home-based self-management program."

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

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The SCC has a new confidential and anonymous hotline and online reporting system:

1-844-599-8785
or
http://suffolkcare.ethicspoint.com

Why is data integrity a **compliance** issue?

- Because partners are paid based in part on patient engagement reports.
- Ethical stewardship of DSRIP dollars requires ensuring that payment is based on accurate data.

- Your organizations have all contracted to provide true, accurate and complete data.
- We (SCC) promise the same to the State.
- We (SCC staff) do Quality Control (QC) on the data you submit BUT we have very limited time to do so.
- Errors, weaknesses (and fraud) can be identified through QC
- So we must ask you (partners) to do basic QC on your patient engagement reports before uploading them into Box.
- Be prepared to "show your work" – how you arrived at the data in the request.

TOGETHER WE CAN ENSURE OUR REPORTING IS TRUE, ACCURATE AND COMPLETE

1. Representations and Warranties

1.3 Truthful Reporting

In this section, partners agree that all data related to quality, performance and other DSRIP purposes shall be, in all material respects:

- True
- Accurate
- Complete

Upon SCC's request, partners shall certify to the **truth, accuracy and completeness** of the data they submit.

5. Audits

5.2 – PPS Audits. Partners agree to assist SCC with audits of their operations to ensure compliance with the Partner Participation Agreement, including satisfaction of performance measures, right to DSRIP funds, data security, etc.

Note: **audits can include data-related** and other reporting processes, not just financial information and internal controls.

6. Record Retention – Partners agree to keep complete and accurate records and supporting documentation sufficient to enable audits.

- 3 years after Agreement ends or longer if required by law.

Partners also agree to furnish SCC information concerning any compliance issues you identify and to work cooperatively with SCC to remediate any compliance issues, giving reasonable access to your operations for this purpose.

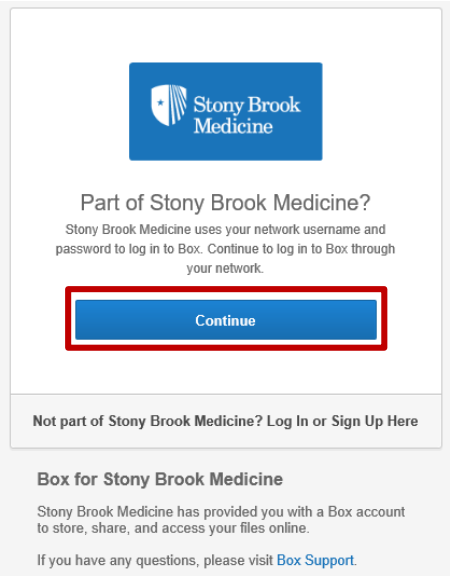
HOW TO SECURELY SEND DATA TO THE SUFFOLK CARE COLLABORATIVE

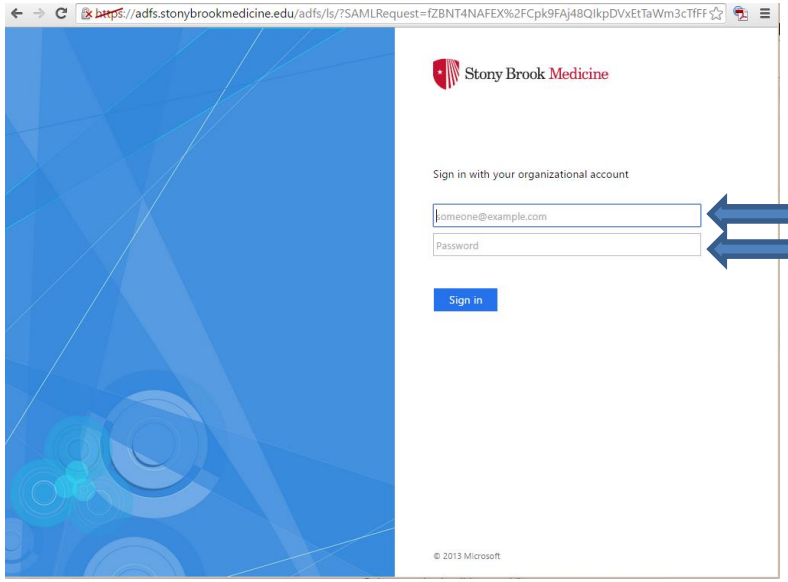
The following steps should have already been completed:

- ✓ Completed SBU ID application processed by IT
- ✓ You will receive an email from SBMIT Identity & Account Management@stonybrookmedicine.edu with your Stony Brook ID number
- ✓ You will receive an email from SBMIT Identity & Account Management@stonybrookmedicine.edu to accept your newly created Computer Account
- ✓ You will be contacted by SBMIT to set-up an appointment for a tutorial of Box. **(Reminder: if it is your first time submitting a file via Box, please wait until you had your tutorial with the SBMIT Box Administrator to upload documents)**

LOGIN TO STONY BROOK MEDICINE'S SECURE BOX FILE REPOSITORY

- Navigate your web browser to https:stonybrookmedicine.box.com
- Select the continue button to login with your UHMC credentials





How to Login:

uhmc**Account ID**
Password

If you encounter any problems logging in to the application, Please call 631-444-HELP

- Refer to the SCC Website for updated patient engagement definitions (PDF) and report templates (Excel File): **Your Patient Engagement Data File format and layout submitted to the SCC *must be consistent* with the SCC Templates located on** https://suffolkcare.org/forpartners/datarequest.
- Make sure to upload your files to the appropriate **sub folder** in Box.
- If this is your first time submitting a file via Box, please wait until you had your tutorial with the SBMIT Box Administrator (your Provider Relations Manager will assist with coordinating your Box training).
- Files are due in Box by **Friday, July 14, 2017**.

For more information, please contact:

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We appreciate your feedback and request your response to our brief survey about this Learning Session.

Thank you!