Suffolk Care

Collaborative

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PROJECT APPROVAL & OVERSIGHT PANEL MEETING

Friday, January 22, 2016

Presentation by:

Joseph Lamantia, Chief of Operations for Population Health
Linda Efferen, MD, Medical Director
Kevin Bozza, Director, Network Development & Performance
Alyssa Scully, Director, Project Management Office
Kelli Vasquez MSW, Director, Care Coordination

Suffolk Care Collaborative
Stony Brook University Hospital (Suffolk PPS ID#16)
www.suffolkcare.org

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PRESENTATION OBJECTIVES

- Partner Composition & PPS Governance
- Funds Flow Model & SCC Coalition Partner On-boarding Program
- Workforce Highlights
- Patient Centered Medical Home (PCMH) Practice Transformation
- Primary Care & Behavioral Health Integrated Care Program (3ai)
- County Collaboration & Community Based Organization Engagements
- Best Practices

WHO WE ARE

Our vision to become a highly effective, accountable, integrated, patient-centric delivery system has positioned us well to make an important contribution to the DSRIP program.

Some of the many goals will include the capacity to enhance patients' self-care abilities, improve access to community-based resources, break down care silos and reduce avoidable hospital admissions and emergency room visits.

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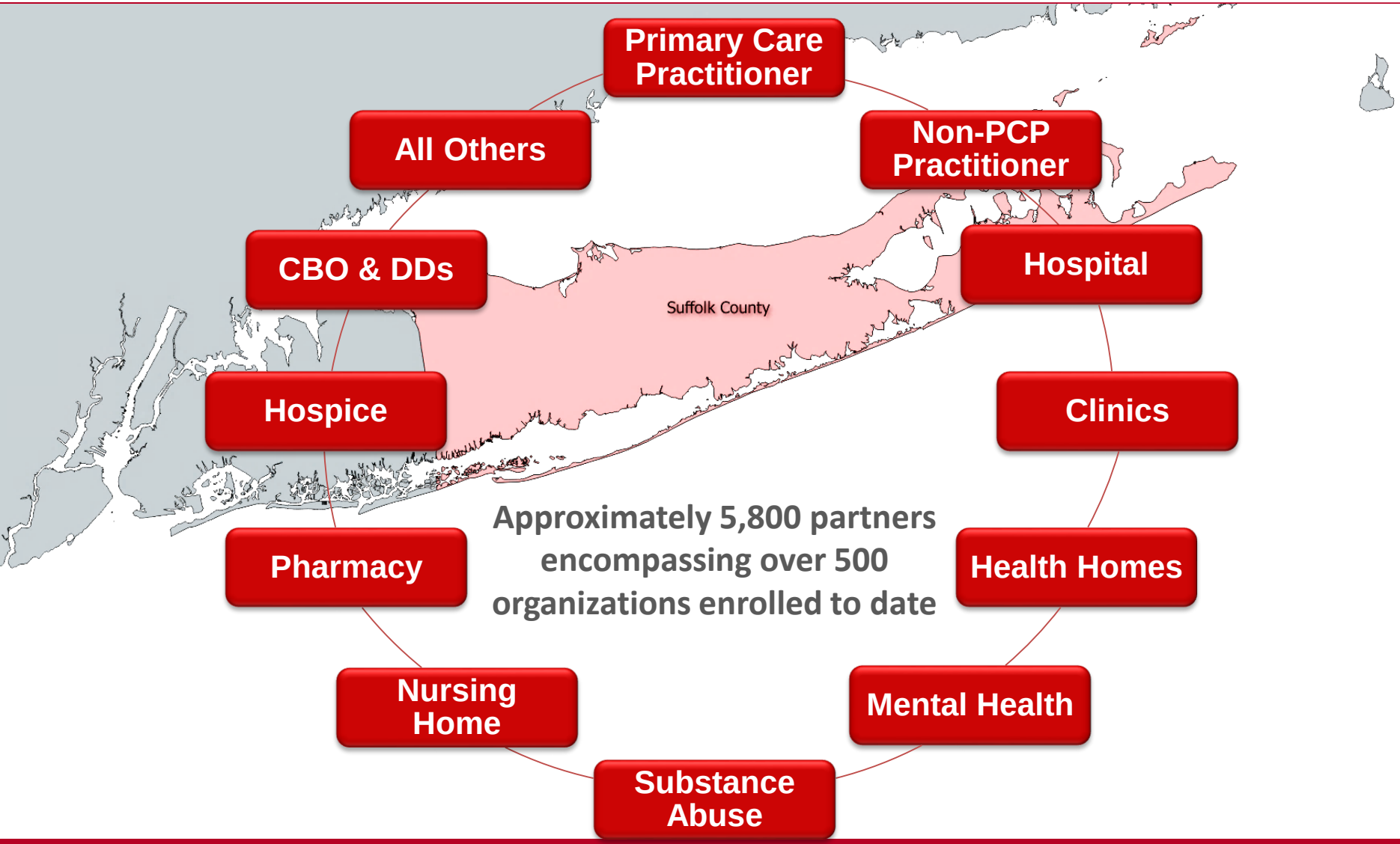
SCC PARTNER NETWORK COMPOSITION



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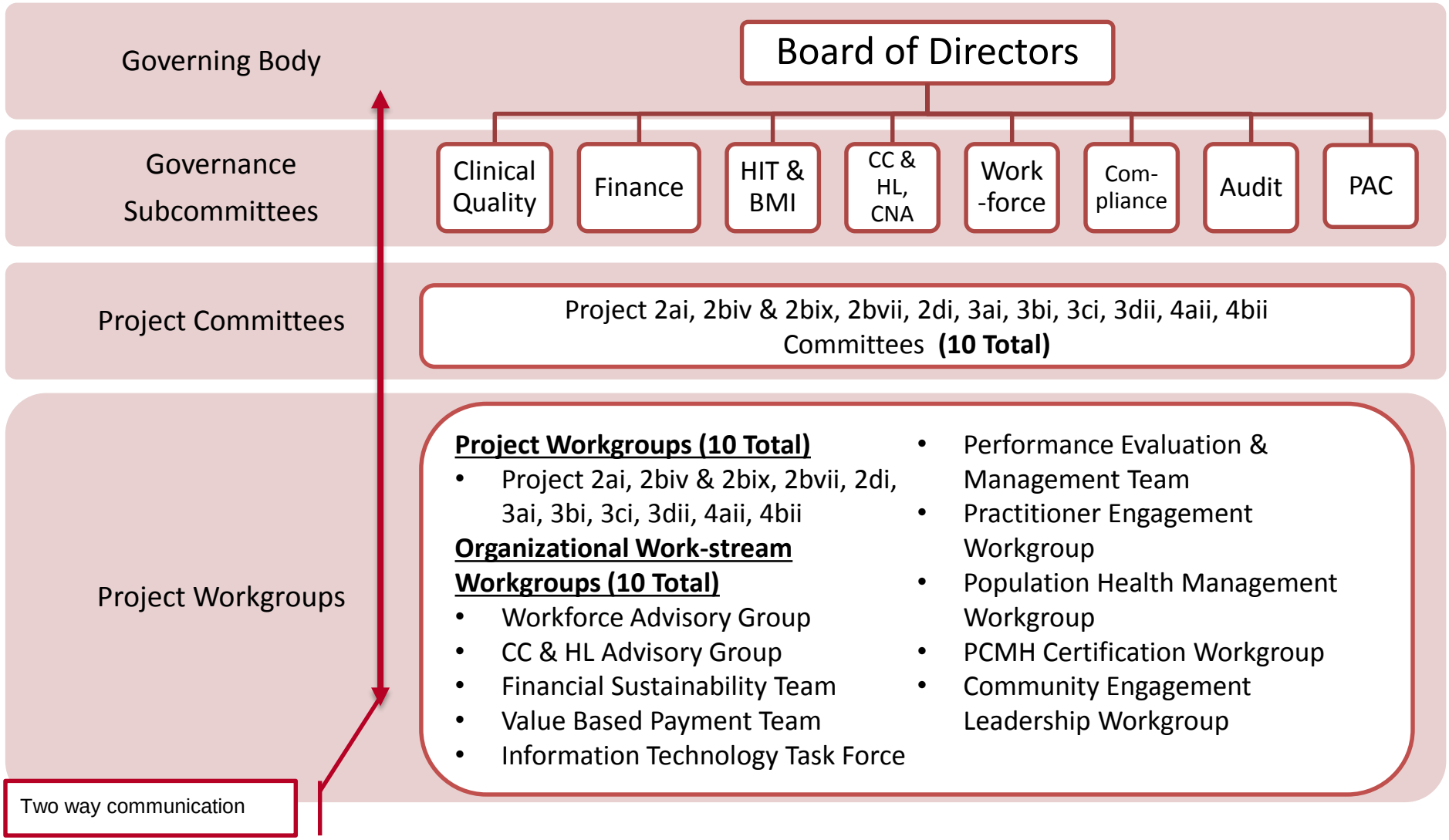
GOVERNANCE



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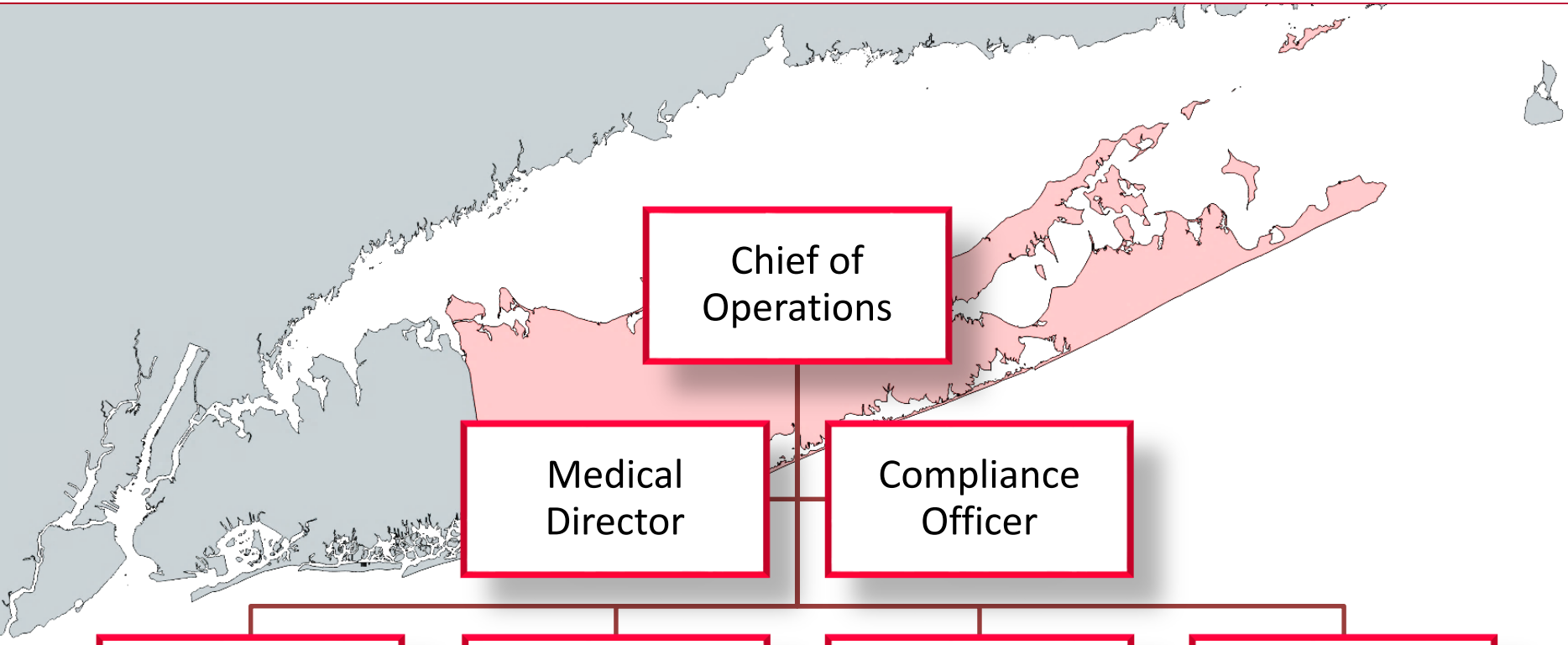
SUFFOLK CARE COLLABORATIVE CENTRAL SERVICE ORGANIZATION



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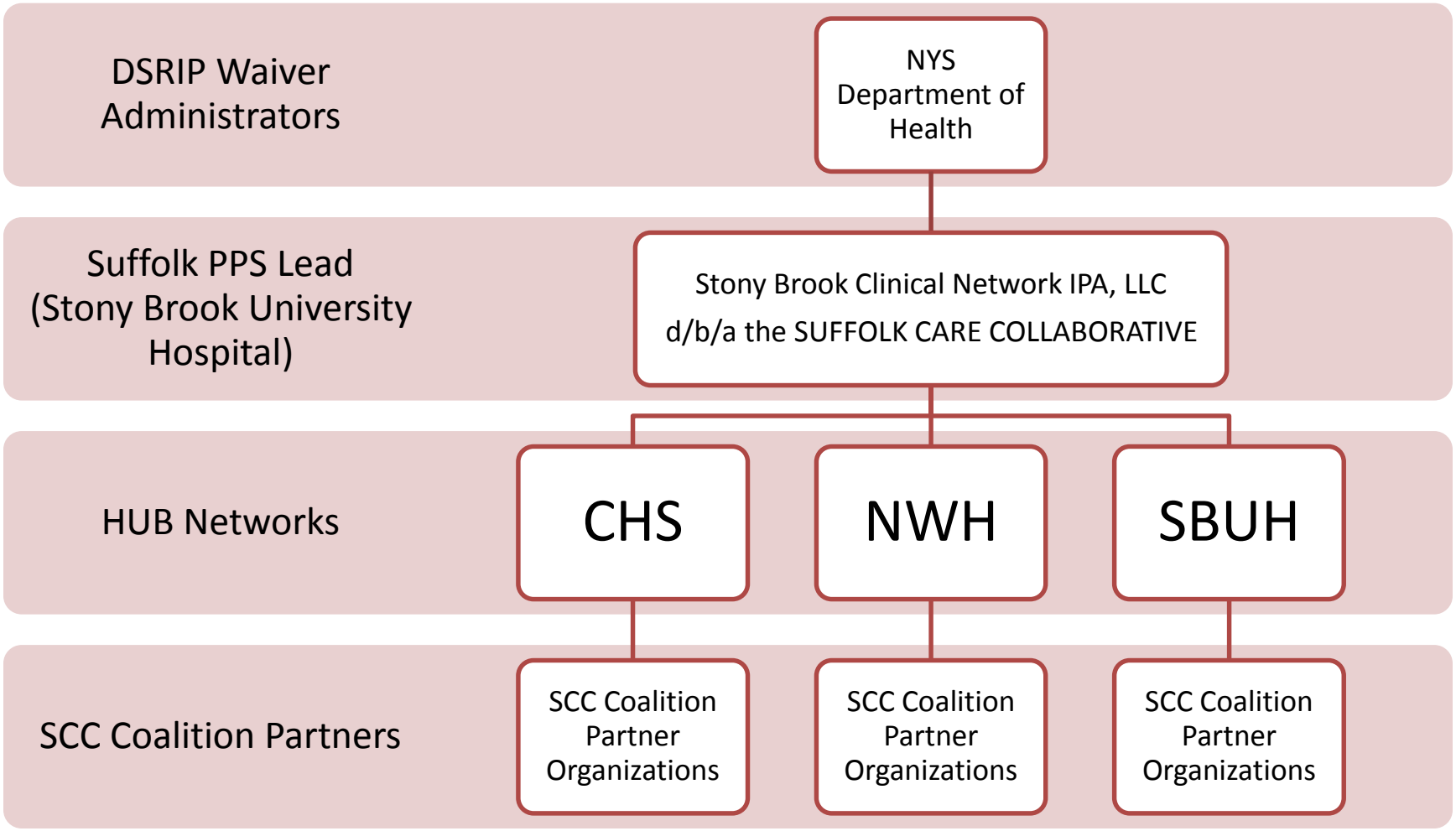
HUB MODEL
TABLE OF ORGANIZATION



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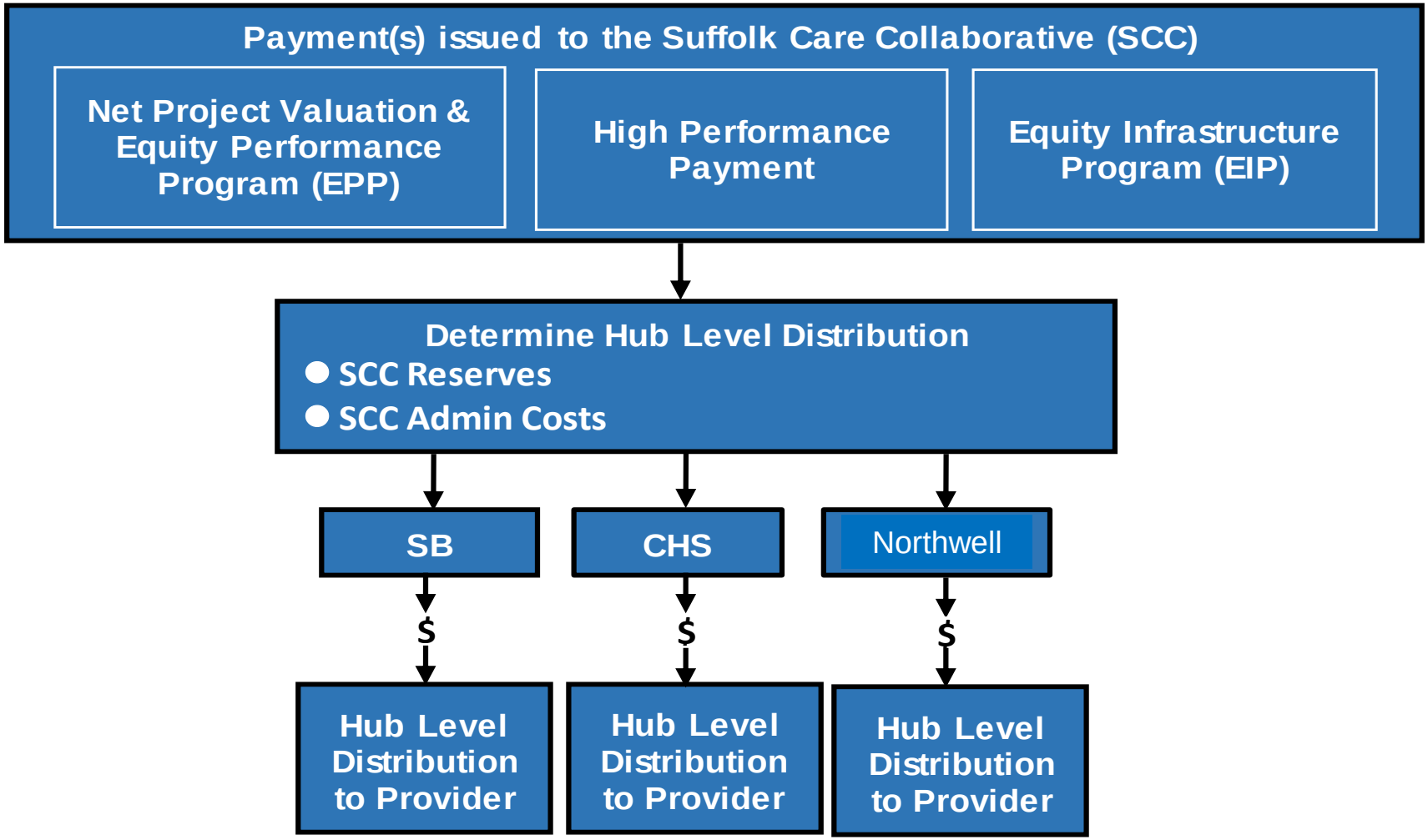
HUB LEVEL FUNDS FLOW DISTRIBUTION



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FUNDS FLOW DISTRIBUTION MODEL

PPS Level Payment Summary:

- Project specific payments based on the payment categories identified in the award letter of SCC's total valuation amount ($298M)
- Project specific tracking of high performance payments, as well as state wide reductions

Budgeted Expense Categories:

- Budget categories as per the DOH drilled down to the project level
- Funds flow plan provides for project & provider specific implementation costs

Provider Performance Distribution Pool:

- Distribution of performance based bonus/incentive payments to providers
- Individual providers are eligible to receive distribution from their applicable provider type pools based on performance criteria

	PPS Level Payment Summary						Budgeted Expense Categories								Provider Performance Distribution Pool									
Project	PPS Level DSRIP Project Payments	Public Equity Infrastructure	High Perfo	Less Reco	Less Stat	Adjusted PPS Level Payment for Distribution	Implementation Costs	Revenue Loss	Cost of Servi	PPS Level	Other	Admin Costs	Vendor Proci	Total PPS Level Costs and Reserves	Total For Provider Distribution	PCP	Hospital	SNF/ Nursing Home	Hospice	Clinics	Case Man	Mental Health	Substance	Pharmacy	CBO	Other	Total
Actual >>>>	$ 202,809,633	$ 53,074,460	##	$0	$0	$ 255,884,093	$ 103,667,449	$ 17,597,406	##		##	##	##	$ 149,891,632	$ 105,992,461											
2.a.i	$ 20,187,314	$ 5,282,938				$ 25,470,252	$ 10,318,875	$ 4,280,114	#		#		#	$ 21,579,201	$3,891,051	$1,361,868	$1,361,868	$389,105	##	##	##	##	##	##	##	##	$3,891,051
2.b.iv	$ 15,500,973	$ 4,056,542				$ 19,557,515	$ 7,923,422	$ 3,174,664	#		#		#	$ 11,739,678	$7,817,837	$1,563,567	$6,254,270	$0	##	##	##	##	##	##	##	##	$7,817,837
2.b.vii	$ 14,779,998	$ 3,867,866				$ 18,647,863	$ 7,554,891	$ 1,914,024	#		#		#	$ 10,080,665	$8,567,198	$856,720	$1,713,440	$5,140,319	##	##	##	##	##	##	##	##	$8,567,198
2.b.ix	$ 12,977,559	$ 3,396,175				$ 16,373,734	$ 6,633,563	$ 3,492,035	#		#		#	$ 10,662,744	$5,710,990	$0	$5,710,990	$0	##	##	##	##	##	##	##	##	$5,710,990
3.a.i	$ 14,059,022	$ 3,679,189				$ 17,738,212	$ 7,186,360	$ 867,855	#		#		#	$ 12,808,090	$4,930,122	$2,711,567	$0	$0	##	##	##	##	##	##	##	##	$4,930,122
3.b.i	$ 10,706,486	$ 2,801,844				$ 13,508,330	$ 5,472,689	$ 819,785	#		#		#	$ 6,735,619	$6,772,711	$3,386,355	$0	$0	##	##	##	##	##	##	##	##	$6,772,711
3.c.i	$ 10,814,633	$ 2,830,146				$ 13,644,778	$ 5,527,969	$ 828,065	#		#		#	$ 6,803,656	$6,841,122	$5,130,842	$0	$0	##	##	##	##	##	##	##	##	$6,841,122
3.d.ii	$ 11,175,120	$ 2,924,484				$ 14,099,604	$ 5,712,235	$ 1,132,920	#		#		#	$ 9,888,943	$4,210,661	$3,368,529	$0	$0	##	##	##	##	##	##	##	##	$4,210,661
4.a.ii	$ 7,209,755	$ 1,886,764				$ 9,096,519	$ 3,685,313	$ 419,868	#		#		#	$ 4,403,596	$4,692,923	$0	$2,111,815	$0	##	##	##	##	##	##	##	##	$4,692,923
4.b.ii	$ 6,128,292	$ 1,603,749				$ 7,732,041	$ 3,132,516	$ 447,829	#		#		#	$ 3,833,998	$3,898,043	$3,898,043	$0	$0	##	##	##	##	##	##	##	##	$3,898,043
2.d.i	$ 79,270,481	$ 20,744,764				$ 100,015,245	$ 40,519,616	$ 220,246	#		#		#	$ 51,355,443	$48,659,802	$12,164,951	$4,865,980	$0	##	##	##	##	##	##	##	##	$48,659,802
Total	$ 202,809,633	$ 53,074,460	#	#	#	$ 255,884,093	$ 103,667,449	$17,597,406	#	#	##	#	##	$149,891,632	$105,992,461	$34,442,442	$22,018,363	$5,529,424	##	##	##	##	##	##	##	##	$105,992,461

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FUNDS FLOW FOR PERFORMANCE PAYMENT DISTRIBUTION

Performance Factor: Defined as a "trigger event," upon successful completion would qualify a partner for a funds flow distribution.

Example for primary care providers:

#	Performance Factor	Description	Frequency of payment

1	Engagement	• Sign-on Commitment
		• Completing SCC On-boarding Program
		• Agreement to ongoing:
		  • Good citizenship, Patient engagement reporting, Data sharing
		  • Participation in Population-wide-prevention programs (D4)
			Recurring

2	PCMH Certification	• Receipt of NCQA 2014 Level 3 PCMH Certification • Stage 2 Meaningful Use certification from CMS	One-time
3	Technical On-boarding	• Work with SCC's Information technology teams to achieve technical data integration and system interoperability between the Partner's source system and the Suffolk PPS Population Health Platform.	One-time
4	Clinical Improvement Programs (Domain 3)	• Meet requirements of Primary & Behavioral Health Integrated Care Program • Meet requirements of Cardiovascular Health Wellness & Self-Management Program • Meet requirements of Diabetes Wellness & Self-Management Program • Engagement in Promoting Asthma Self-Management Program	One-time
5	Domain 2 & 3 Outcome Measures	• The Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided.	Recurring

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THE SCC ON-BOARDING PROGRAM

Four parts to the SCC On-boarding Program:

- Part 1: Coalition Partner Participation Agreement
- Part 2: On-boarding Program Required Documents
- Part 3: Current State Assessment Survey
- Part 4: Educational Materials

Features:

- Designed to properly enroll our Partners into the DSRIP Program
- Defines roles and responsibilities for participation in Participation Manual posted on webpage
- Provides an orientation to DSRIP & the SCC
- Outlines payment procedures that are based on the achievement of performance factors tied directly to DSRIP projects
- SCC On-boarding webpage: http://www.suffolkcare.org/forpartners/onboarding
- Recorded webinar: https://www.youtube.com/watch?v=cmETCb-lvTE&feature=youtu.be

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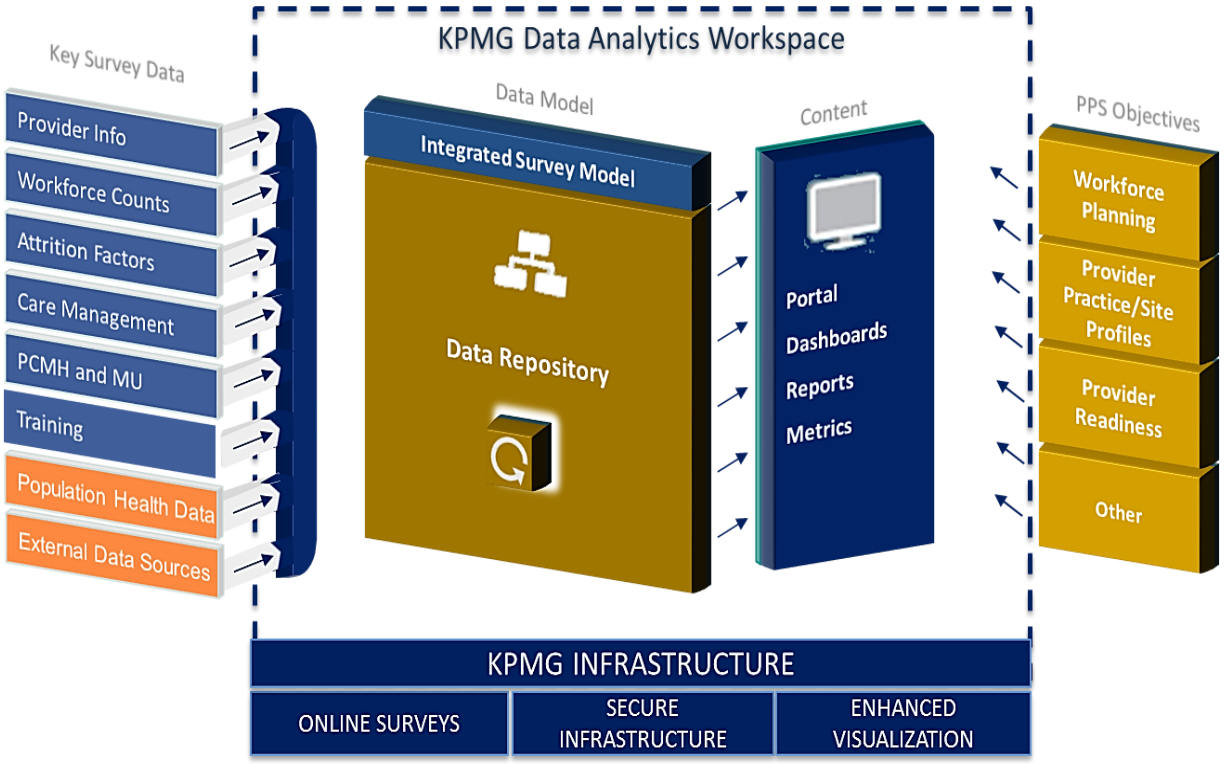
WORKFORCE DATA ANALYSIS



SCC Workforce Strategies

- ✓ Distributed Current State Assessment/Workforce Assessment Survey to SCC Partners (PCP, Hospitals, SNF, CBOs etc.)
- ✓ 50% Survey Response Rate
- ✓ Building Data Analytics Workspace to inform the Target State Model
- ✓ Leveraging National Benchmarks and Statistical Models to Project the Type and Number of Positions by Project
- ✓ Refining Target State Workforce Model with input from Hubs, Key Partners, and Project Leads

KPMG cutting through complexity

Commercial PPS team

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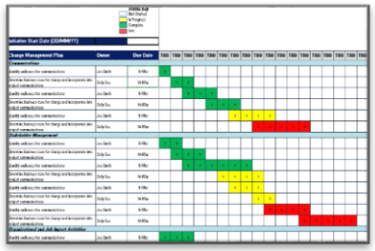
WORKFORCE ENGAGEMENT & TRAINING

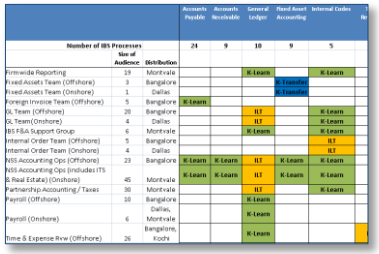
Engagement & Collaboration

- COLLABORATION: Universities, Professional Associations, Community-based Organizations
- ENGAGEMENT: Leadership Action Plans and Employee Engagement Plans



Emerging Titles/ Career Ladders

- EMERGING TITLES: Position Data Collected from Partners through Workforce Survey
- CAREER LADDERS: Workforce Training Strategy Meetings with Project Leads to discuss career pathways, ladders and lattices for all impacted employees



Performance Outcomes

- EVIDENCE-BASED GUIDELINES: Training focused on workforce skill development in new care delivery models
- WORKFORCE COMPETENCIES: Evaluating new skills and credentials needed to support achievement of clinical outcome measures

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PRIMARY CARE ENGAGEMENT HIGHLIGHTS

Patient Centered Medical Home (PCMH) Practice Transformation Program

- Developed contracting plan prioritizing partners for PCMH transformation
- Established SCC PCMH Certification Workgroup
- Initiated Vendor Contract to support practice transformation
  - Initial engagement: 20 practice sites, 80 providers
- Education:
  - Onboarding program developed to include PCMH education
  - SCC Learning Center to support ongoing PCMH provider education (website)

Supporting Our Primary Care Providers:

- Current state assessment survey to identify potential gaps
- Embedding Care Management in practices with large populations of high risk complex patients
- Identifying alignment of DSRIP requirements with current initiatives i.e. MU, PCMH, PQRS
- Providing a web/app Community Based Resource Guide to support patient navigation to medical, behavioral & socio-economic community-based resources


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Office of Population Health - Stony Brook Medicine Health Sciences Tower, Stony Brook, NY 11794-8520 | Tel: (631) 638-2227 | Fax: (631) 638-1009 | suffolkcare.org

Patient-Centered Medical Home

The patient-centered medical home (PCMH) is the future of primary care and the foundation for the transformation of our healthcare system. We want you to be a part of it!

The PCMH model is a nationally acclaimed program accredited by the National Committee on Quality Assurance (NCQA). Since 2008, NCQA has been recognizing PCMH practice models. PCMH is the most widely adopted medical home model in the country. More than 34,500 clinicians at more than 6,800 practice sites have attained PCMH designation.

To learn more about how the Suffolk Care Collaborative can support this effort please contact:

Althea Williams, MBA
Sr. Manager, Provider and Community Engagement
Office of Population Health
Stony Brook Medicine
Health Sciences Tower, Level 5, Rm 058
Stony Brook, NY 11794-8520
Phone: (631) 638-1392 Fax: (631) 6318-1009
Email: althea.williams@stonybrookmedicine.edu

The Benefits

Work Environment
- Workflows and efficiencies customized to your practice
- Practitioners working at the top of their license/certification
- Team-based approach to providing care
- Achieve recognition for the work you are already doing

Patient Care & Outcomes
- Improved communication between you, your staff and patients through patient portals and other innovative communication vehicles
- Enhanced patient and staff satisfaction
- Access to tools to manage your patient populations i.e. disease registries, health information exchanges
- Care coordinated and integrated across all elements of the healthcare system

Financial Incentives
- Providers will be able to share in DSRIP funds once our Performing Provider System (PPS) is successful in meeting the DSRIP program's metrics
- Incentives and enhanced payment for achieving PCMH recognition

Prepare Now
- Pay-for-Performance Models i.e. DSRIP
- Value-based Payment

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PRIMARY & BEHAVIORAL HEALTH INTEGRATED CARE PROGRAM (3AI)

Model 1 BH → PC	Model 2 PC → BH	Model 3 IMPACT

Phase One Active Implementation Sites:

- 72 PCP's across 15 PCP sites
- 55 BH providers across 6 BH sites

Implementation Schedule

1. SCC Practice Sites Identified & Engaged (4 months)
2. Current State Assessment (4 months)
3. Practice Site Implementation Plan Start – End (6 months)
4. Learning Collaborative (Educational Engagement) (6 months)
5. Monitoring Program (through March 2020)

Workgroup & Committee Participating Stakeholder Highlights

- Association for Mental Health and Wellness
- Division of Community Mental Hygiene - Suffolk County Government
- Office of Mental Health
- Developmental Disabilities Institute (DDI) NY
- South Oaks (Article 31)
- OASAS Long Island Field Office
- Northwell Health (NWH)
- Catholic Health Services of Long Island (CHS)
- Stony Brook University Hospital (SBUH)
- Family Service League of Long Island
- HRHCare
- Primary Care Providers
- Behavioral Health Providers

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COUNTY COLLABORATION ON CULTURAL COMPETENCY & HEALTH LITERACY

Cultural Competency and Health Literacy:

- Established a **Community Needs Assessment, Outreach and Cultural Competency/Health Literacy Committee & a Cultural Competency/Health Literacy Workgroup**
- Developed **Cultural Competency/Health Literacy Strategy Plan** including a PPS wide definition for CC/HL
- Workgroup collaborates with Project Leads/ Workgroups and the **Clinical Governance Committee** to review patient education material for CC/HL appropriateness
- **Project lead participates in and is a co-facilitator** (with 3 other PPSs and PCG) for the All-PPS CC/HL Workgroup
- Partnership with **Long Island Health Collaborative-Population Health Improvement Program (LIHC-PHIP):**
  - Participates in CLAS Workgroup
  - Identifying possible Cultural Competency and Health Literacy training vendors

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COUNTY COLLABORATION & CBO ENGAGEMENT ON NYS PREVENTION AGENDA & HOSPITAL COMMUNITY BENEFIT PLANS

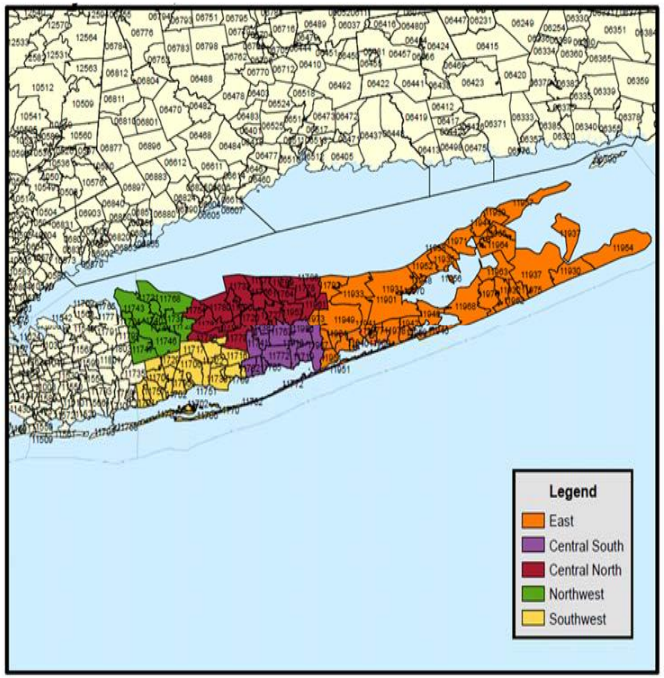
- **Representation** across all 11 DSRIP Projects, Board of Directors, Governance Committees, organizational work-streams workgroups, and PAC meetings include multiple Suffolk County Department of Health Divisions, CBOs, SNFs, HHs **contributing to project planning and implementation.**

- Established a **Community Engagement Leadership Group** currently developing the SCC Community Engagement Plan

- **Long Island Health Collaborative-Population Health Improvement Program** (LIHC-PHIP) partnership:

  - Collaborative partner on upcoming CBO Summit. A county-wide initiative to support the CNA & **Hospital Community Benefit Plan**

- **Collaborating** with Suffolk County Department of Labor Licensing & Consumer Affairs to identify local Consumer Resource Centers and their meeting dates.



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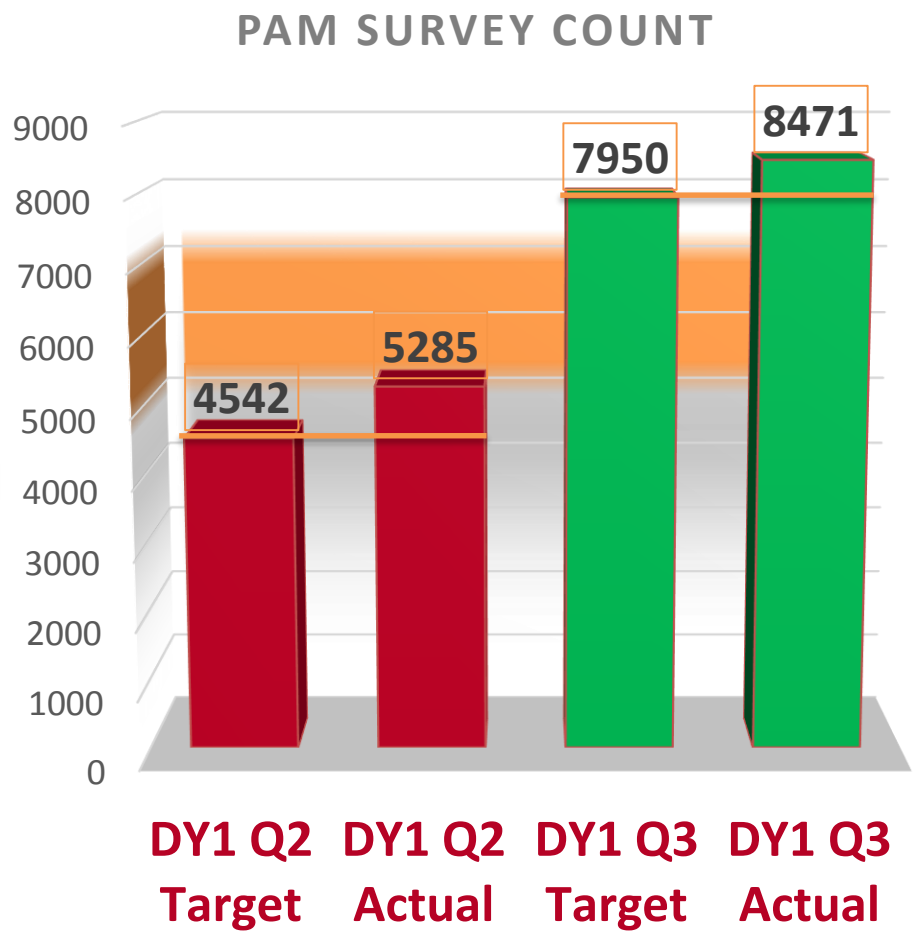
COMMUNITY BASED ORGANIZATIONS LEAD COMMUNITY HEALTH ACTIVATION PROGRAM (CHAP) (2DI)

Project 2di Workgroup (left to right)
Front row: Michael Miller, *Intern, HRHCare;* Roberta Leiner, *Chief, Patient Engagement, HRHCare;* Amy Solar-Greco, *Project Manager, SCC;* Tara Larkin-Fredricks, *Director of Special Projects, MHAW;* Anne Stewart, *Director of Programs, EOC*; Gwen O'Shea, *President/CEO, HWCLI* **Back row:** Halim Kaygisiz, *Director of Health Outreach Services, EOC;* Andrew Lehto, *Director,Community Outreach & Engagement of Special Populations, HRHCare;* Michael Stoltz, *CEO, MHAW* **Not Pictured:** Adrian Fassett, *President/CEO*, *EOC*; Paula Fries, *COO, MHAW;* Pedro Martinez, *Outreach Worker, EOC*; Sarah McGowan, *MHAW;* Trevor Cross, *Community Liaison, HRHCare*; Nalini Purvis, *VP Community Initiatives, HRHCare*



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COLLABORATION TO SUPPORT NYS PREVENTION AGENDA & DOMAIN 4 INITIATIVES

Hospital Emergency Department SBIRT Implementation Initiative

- SCC has partnered with OASAS to build an SBIRT Training Strategy facilitated by two new OASAS Certified SBIRT Trainers
- SBIRT Training for participating Suffolk County Hospital Emergency Department staff initiated in December 2015

Community Resource Partnership with HITE Community Connections

- We've developed a community resource directory through a new partnership with Greater New York Hospital Association (GNYHA), to integrate Health Information Tool for Empowerment (HITE) on the SCC website

HITE
Health Information Tool for Empowerment

Suffolk County Tobacco Cessation Promotion Initiative

- OMH Clinics are participating on the SCC Tobacco Cessation Workgroup with the goal of initiating provider tobacco cessation education County-wide.

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BEST PRACTICES

- Project Advisory Committee Membership
  - Membership directory just over 1,100
- Communication Strategies: eNewsletters
  - Synergy and DSRIP In Action
- Website at www.suffolkcare.org guide for partners/providers, community and project stakeholders
- 5-year Funds Flow Model that allows for predictive analysis
- Care Managers/Community Navigation Fieldwork Experiences
- MAX Series Participation
- Engagement of Dr. Amy Boutwell for TOC
- Significant School involvement

Synergy
Suffolk Care Collaborative
The newsletter of the Suffolk Care Collaborative – The Performing Provider System of DSRIP

DSRIP IN ACTION

Quarterly PAC Meeting Participation

Text SUFFOLKCARES to 22828 to join our eNewsletters!

Question & Answers