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DSRIP Independent Assessor

Mid-Point Assessment Report

Suffolk Care Collaborative PPS

Appendix PPS Narratives

November 2016 **www.health.ny.gov** **Prepared by the DSRIP Independent Assessor**

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DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting the overall organizational efforts to date.

PPS Name: State University of New York at Stony Brook University Hospital

Highlights and successes of the efforts:

Organizational Work Stream: Clinical Integration

The Clinical Integration Organizational Work Stream consists of two milestones completed by June 30, 2016. Milestone 1 in this work stream called for performing a clinical integration needs assessment and Milestone 2 is the culmination of that assessment into the development of a Clinical Integration Strategy. Clinical Integration is a topic covered in the Population Health Management Operating Workgroup (now the Population Health Management/Integrated Delivery System Workgroup (PHM/IDS)).

Kelli Vasquez, LCSW, Senior Director of Care Management and Care Coordination, leads the Clinical Integration Organizational Work Stream tasks and approach, in collaboration with Linda Efferen, MD, MBA, SCC Medical Director, and the Project Manager for 2ai, Alyeah Ramjit, MS, MHA to develop agendas, workplans and facilitation of the above described workgroup.

Kelli Vasquez, LCSW had prior leadership experience as the Assistant Director of Care Coordination for an Independent Physician Association and Accountable Care Organization. Prior to these roles, Ms. Vasquez held clinical positions in various healthcare fields including outpatient hemodialysis, medical-surgical discharge planning, adult and pediatric inpatient psychiatric care, and outpatient mental health counseling. Currently, she is charged with leading the Suffolk Care Collaborative Care Management Organization and all Care Coordination projects and programs for the PPS.

Linda Efferen, MD, MBA is the Medical Director for the Suffolk Care Collaborative, Office of Population Health, Stony Brook Medicine. She came to Stony Brook from South Nassau Communities Hospital, where she served as Senior Vice President & Chief Medical Officer and Clinical Professor of Medicine at Hofstra North Shore-LIJ School of Medicine. Prior to that, she was affiliated with the NSLIJ Health System as Associate Chair in the Department of Medicine at Long Island Jewish Medical Center after serving as Division Chief for Pulmonary and Critical Care Medicine at SUNY Downstate. A member of many professional organizations, she has held leadership positions at the local, state and national levels. A graduate of Fordham University and the Sackler School of Medicine in Tel Aviv, Israel, Dr. Efferen is board-certified in internal medicine, pulmonary disease, critical care medicine and palliative care.

Alyeah E. Ramjit, MS, MHA holds the position of Project Manager, Integrated Care. Prior to her work at SCC, Ms. Ramjit was employed by AgeWell New York as a business liaison for Medicare Part D operations and has over 5 years of clinical healthcare experience as an Emergency Medical Technician. She holds a Master's Degree in Clinical Nutrition from the New York Institute of Technology as well as a Master's Degree in Health Administration from Hofstra University.

The Workgroup responsible for Clinical Integration, PHM/IDS, includes stakeholders from all 3 HUBs: Catholic Health System, Northwell Health, and Stony Brook University Hospital. Clinical leads, project managers and IT personnel are all represented in this group for each HUB. The workgroup also consists of members of the Population Health

Management Software tool and consultants for Care Management who have attended and added meaningfully to the group and its work.

Work done in several of the Projects, including Transitions of Care and Behavioral and Primary Health Integration, have utilized Subject Matter Experts. Their work has been highlighted and incorporated into the Clinical Integration Needs Assessment and the strategies described in the Clinical Integration Strategy.

Project development strategy

To begin work in Clinical Integration, the scope of work and definition of Clinical Integration was developed by consensus. The Population Health Management Operating Workgroup met monthly on or about the 4th Monday of each month and input from Project Committees and key project stakeholders was received in order to ensure alignment with projects and work being done across the PPS. Clinical Integration in the Suffolk Care Collaborative is defined as:

"Clinical Integration refers to 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 value of the care provided. The coordination of care delivery across the 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). "

This definition is the culmination of research on industry standards, brainstorming and collaboration and it takes into account a patient's ability to seamlessly travel throughout the continuum of care. In order to determine the current level of clinical integration operating throughout Suffolk County, the Clinical Integration Needs Assessment was developed. The Workgroup determined that the best method and approach for completion of this assessment was to utilize existing survey methods occurring throughout the projects and to identify key areas within those surveys that call specifically for elements of clinical integration. The development of the surveys was agreed upon by the Workgroup and members had an opportunity to add/edit questions in their project and work stream areas. The Needs Assessment was therefore a comprehensive look at the current state of clinical coordination and IT infrastructure.

After surveys were complete in several areas across the PPS, results were brought together in the Clinical Integration Needs Assessment. This provided an opportunity to aggregate data from hospitals, SNFs, PCPs, Non-PCPs, CBOs, and Behavioral Health sites and to map out where services were currently available in Suffolk and where there were gaps. This geo-mapping was done in conjunction with Samuel Lin, Project Manager who is also leading the 'Hot Spot' Strategy for SCC in conjunction with the Biomedical Informatics division of Stony Brook Medicine. While this information was not a formal hot spotting exercise, it was a preliminary view into our network and the gaps that would need to be closed in order to clinically integrate.

After completion of the individual surveys being used across the projects, data was collected, reviewed and described in the Clinical Integration Needs Assessment. This data was sourced from interviews with all 11 hospitals in the PPS for the Transitions of Care survey, results of the Behavioral Health and Primary Care Integration Readiness assessment, qualitative responses from the Care Management and Care Coordination Workgroup, and select questions from the Current State Workforce Survey for PCPs and Organizations.

Clinical Integration will need to occur across the entire PPS and is therefore considered HUB neutral. Members of each HUB are represented on the Workgroup and have approved the approach and final documents coming out of this work stream. Additionally, in completing the Needs Assessment, an exercise was done to combine integration plans and priorities for each HUB into one master document which provides a view of the entire network.

Project implementation/execution

After completion of the Clinical Integration Needs Assessment, work began on the Clinical Integration Strategy. This strategy delineates the approach to implementing Clinical Integration techniques across the PPS. Work on this strategy began with a presentation of the findings of the Needs Assessment to the workgroup with subsequent iterative exercises performed in the workgroup to identify gaps in integration, discuss a plan to fill those gaps, and to align decisions with current Project Work. The Clinical Integration Strategy looks at key drivers for integration which the Workgroup has defined as Access to Care, Patient Centered Medical Home Recognition, Behavioral Health and Primary Care Integration, Care Management and Care Coordination, Transitions of Care, Clinical Quality Metrics and Measurement, and Clinically Interoperable Systems. Each of these areas was analyzed for the gaps identified through the Needs Assessment and then the strategies being implemented to mitigate those gaps. Successful Clinical Integration will occur when all areas' strategies have been deployed.

After completion of the Strategy, training was developed in order to ensure that our internal PPS staff as well as our PPS Partners have a clear understanding of our Strategy and its implementation. Training attestation forms have been and will continue to be collected as more partners are contracted and on-boarded. This training has also been implemented into the SCC New Hire Orientation for all new staff.

Each Clinical Integration driver has a strategy for implementation. There are challenges for clinical interoperability related to disparate EMRs and/or lack of EMRs throughout the network. This has an impact on connectivity to RHIOS, data sharing through interoperability, concurrent tracking of clinical metrics, and recognition of practice sites as a PCMH. Additional work is currently being done to review alternative means of collecting data from practices (such as through billing claims and manual chart extraction) as well as researching available programs to assist in EMR (i.e. TCPI).

Milestone #1 for Clinical Integration, "Perform a clinical integration 'needs assessment'" was completed on March 31, 2016. Milestone #2 for Clinical Integration, "Develop a Clinical Integration Strategy" was completed on June 30, 2016. Both Milestones were reviewed and approved by the PHM/IDS Workgroup and the Clinical Governance Committee. Approximately, 860 providers within 281 sites will be clinically integrated.

The Clinical Integration Needs Assessment and Clinical Integration Strategy have been approved by clinical leadership representative of all three HUBs are shared throughout the PPS. The creation of our Clinically Integrated Network is a work in progress and the PPS is currently engaged in activities to further integrate providers. As partners are contracted and begin to "technically onboard" the ingestion of data will be completed and will allow for performance monitoring and improved coordination of care. Monthly meetings with the Managed Care Organizations are under way where discussions on future Value Based Purchasing programs are being discussed. SCC has also partnered with the local PHIP program, Long Island Health Collaborative for work in Cultural Competency and Health Literacy.

Throughout the development of the Clinical Integration Needs Assessment and Strategy, it was important for the Workgroup as well as for the PPS Stakeholders to have a clear understanding and agreement on the concepts of Clinical Integration and how they differ and impact Population Health Management. It is the approach of the SCC that Clinical Integration lays the foundation for Population Health Management work to be completed. Successful coordination of care through clinically interoperable systems allows for segmentation and risk stratification of populations as well as provides the framework to engage patients in their health care. This was an important distinction and one that has shaped our Clinical Integration Strategy as well as provided a true path towards becoming an integrated delivery system.

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PPS Name: State University of New York at Stony Brook University Hospital

Highlights and successes of the efforts:

Organizational Work Stream: Financial Sustainability (including Funds Flow, Budget, Value Based Payment & Compliance)

Monitoring Network Partner Financial Health

The Financial Sustainability Workgroup, a subcommittee appointed by the PPS Finance Committee and approved by the PPS Board of Directors in December 2015, assists the PPS in its responsibility to assess the financial health of PPS network partners. The members are drawn from each of the three HUBs within the PPS. The Workgroup created and administered a Financial Stability Survey to network partners in December 2015 to gather baseline financial metrics. As a next step a Financial Sustainability Strategy document was drafted, which sets forth a process for monitoring and assessing the financial health of network partners, and for acting upon indications of financial distress or fragility. The Financial Sustainability Strategy document was approved by the PPS Finance Committee in March 2016.

Survey responses from network partners were assessed in accordance with the Financial Sustainability Strategy. "Watch List" status is considered for any respondent partner with results showing any of the following:

1) Negative total margin for the most recent 2 years consecutively; or
2) Negative total margin plus 3 fails (not meeting benchmark) on metrics 1-9 (operating margin, current ratio, days cash on hand, cash flow to total debt, debt ratio, fixed asset financing ratio, return on total assets, total asset turnover, and operating cash flow margin) for the most recent year; or
3) Four or more fails in metrics 1-9 (listed above) for the most recent year.

The Workgroup communicated with the partners that met "Watch List" criteria and obtained satisfactory explanations from these partners about mitigating circumstance. No further action was indicated. The Financial Stability Survey was administered a second time in June 2016 to the partners on the "Watch List," and data collection is still in progress.

Compliance

The PPS Compliance Committee, a Board subcommittee, met five times since March 2015 to oversee the Compliance Program, which the PPS certified to the NY OMIG under SSL 363(d) initially (March 2015) and annually (December 2015), and under the Deficit Reduction Act initially (December 2015). Milestone #3 was reported as complete for the DY1 Q3 Quarterly Report. The Board-approved Compliance Plan and Work Plan for DY2 are operational. Notable accomplishments to date focusing on data integrity include facilitating the implementation of a new quality control program for population-health data-analytics project management at the PPS Lead, and a review of the PPS's control environment for patient engagement data handling during DY1 Q2 and Q3. The Compliance Officer participates in the statewide PPS Compliance Professionals networking group's biweekly calls to promote best practices in the PPS context.

Individual participation in the Compliance Program is an expectation included in job descriptions for Suffolk Care Collaborative Central Service Organization and Care Management Organization hires and is assessed and recognized at the time of performance review. The onboarding process for PPS Lead network partners is leveraged to engage contracting entities in compliance and HIPAA training and attestations, and to obtain a copy of partner OMIG certifications. The Participation Agreement includes provisions holding partners accountable for data integrity and compliance, subject to

audit; and webinars for partners about performance reporting emphasize these terms. The PPS website's Compliance and HIPAA Programs pages post Compliance Plan documents for easy public access.

Funds Flow

The Funds Flow Budget and Distribution Plan were approved by the PPS Board of Directors in November 2015. This Plan was communicated to the network at the December 2015 quarterly Project Advisory Committee meeting where it met with general acceptance. This plan will help to promote and fund required change, reward performance and incentivize behavior and establish the architecture for payment reform. A lot went into developing the Funds Flow Budget and Distribution Plan. The SCC and KPMG interviewed all the project leads, project managers, Finance Committee members, Board Members, and key stakeholders. After taking all the inputs into consideration, the funds flow framework and guiding principles were developed.

Further, in each of the Participation Agreements, a Funds Flow methodology is included which sets forth the specific performance factors by provider type that need to be achieved in order to receive performance payments. A 5 year Funds Flow Model has been developed with the assistance of KPMG. This will be used to guide the operationalization of the performance distribution plan to providers.

Value Based Payment

The VBP Workgroup, a subcommittee appointed by the PPS Finance Committee and approved by the PPS Board of Directors in December 2015, assists the PPS in its responsibility to complete all of the organizational work stream milestones and tasks. Member are drawn from all three hubs. The VBP workgroup was created to:

1) Work with MCOs and other payers to develop value based contracts
2) Perform the baseline assessment of value based payments within the PPS
3) Analyze PPS strengths and weaknesses of current value based payments strategy
4) Develop an education and communication strategy
5) Develop the value based payment plan

The VBP Workgroup created a VBP Survey which it sent to network partners in April 2016. Its purpose is to gauge the VBP landscape of our partner organizations to develop a detailed baseline assessment of revenue linked to VBP, preferred compensation modalities for different provider types, and MCO strategy.

Further, since April 2015, the SCC has held monthly calls with the five MCOs with which it is paired to discuss the transition from FFS to VBP. These calls allow the MCOs and the SCC to discuss and strategize for project-specific milestones involving VBP. Once the SCC VBP Plan is approved by the Board of Directors in September 2016, the each of the HUBs will work with the MCOs in operationalizing the VBP Plan.

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PPS Name: State University of New York at Stony Brook University Hospital

Highlights and successes of the efforts:

Organizational Work Stream Narrative: Governance

The State University of New York at Stony Brook University Hospital Performing Provider System (PPS) (aka "Suffolk PPS" or "Suffolk Care Collaborative") is operating under the "New Co" Stony Brook Clinical Network IPA, LLC. This "New Co" was approved by CMS as Safety Net under the vital access provider exceptions under DSRIP on January 14, 2015.

Governance Model

Early 2014 the SCC's governance structure was initiated with the design of the principal governing committee of the SCC, the Board of Directors (BOD), which includes 21 representatives from various stakeholders from the SCC partnerships. In addition, the BOD maintains:

1. Seven sub-committees to provide guidance in the following areas: (i) Clinical; (ii) Finance; (iii) Community Needs Assessment, CC & HL and Outreach; (iv) Health Information Technology and Biomedical Informatics; (v) Workforce; (vi) Compliance; and (vii) Audit. Further defined in each Governance Committee Charters.
2. Eleven individual Project Committees to represent each DSRIP project chosen by the PPS. These Committees were constituted in September 2014 and have continued to evolve with new members joining. Further defined in the DSRIP Project Committee Charter. An example of a function is the development of project-specific protocols, which are recommended and reviewed then through the Clinical Governance Committee.
3. The Project Advisory Committee (PAC), which was formed in August 2014, is open to a managerial representative selected by their PPS partner entity, if they have 50+ employees or if unionized the SCC requires representation of a workforce representative as well. To date, there are over 1,000 members on distribution list. Representation across the health care delivery continuum including but not limited to: hospitals, physician groups, nursing homes, FQHCs, Health Homes, home care agencies, behavioral health and substance abuse, DDI, Medicaid managed care plans, food banks, housing organizations, OMH, OASAS and other public sector agencies and health care advocacy coalitions.

Each of these levels of governance have been established and are fully functional. The Suffolk Care Collaborative takes an inclusive approach to participation – there are multiple opportunities for partner entities to participate in various governance forums. In addition, representation highlights on the BOD specifically includes, patient advocates, "HUB-leadership," Community Based Organizations, Health Home/Primary Care Providers, Care Management Agencies, Behavioral Health, Post-Acute Care/Skillen Nursing Facilities, Physicians and Hospitals.

With the successful achievement of Milestone 1 of Governance, the SCC submitted the final governance structure, sub-committee charters, as well as Stony Brook Clinical Network IPA, LLC bylaws which are written in the form of an Operating Agreement.

Stony Brook Clinical Network IPA, LLC d/b/a Suffolk Care Collaborative

The Stony Brook Clinical Network IPA, LLC funds a central service organization that administers the DSRIP program for Suffolk County. This central service organization has rebranded itself to the Suffolk Care Collaborative (SCC). The SCC is led by Joseph Lamantia, Chief of Operations for Population Health at Stony Brook Medicine as well as Executive Director for the Suffolk PPS and Linda Efferen, MD, MBA, FACP, FCCP, FCCM, Medical Director, Suffolk PPS. Dr. Efferen leads the SCC's clinical governance structure as we've defined it through the completion of Governance Milestone 2.

The SCC's central service organization has many functional departments, including, the Project Management Office (PMO), led by Sr. Director of the PMO, Alyssa Scully, MHA, PMP, the Care Management Organization, led by Sr. Director of Care Management & Care Coordination, Kelli Vasquez, LCSW, and the Network Development & Performance Office, led by Sr. Director for Network Development and Performance, Kevin Bozza, MPA, FACHE, CPHQ, RHIT.

The SCC has recently staffed a *Transformational Leadership Team* charged with providing direction, subject matter expertise, and technical assistance to partners implementing programs and business development opportunities within programs. This group includes, Althea Williams, Director for Practice and Community Innovation, Jennifer Kennedy, Director for Care Transitions Innovation, and Susan Jayson, Director for Behavioral Health Integration.

"HUB Model"
The SCC is designed into 3 HUBs, the Stony Brook University Hospital HUB (SBUH HUB), Northwell Health System HUB, and Catholic Health Services of Long Island HUB. The HUBs operate collaboratively within all 3 levels of governance and project stakeholder engagements through workgroups and committees. During the implementation phase of each DSRIP Program, the SCC has defined HUB-assignments by provider enrolled in the PPS-network, whereby any owned and/or affiliated provider under the Northwell Health System and Catholic Health Services of Long Island Health System are supported by "PMOs" from each of the "HUBs." This allows for the health systems engagement with their medical staff and existing longstanding relationships with community providers and services. The remaining network providers or "all other" operate under the SBUH HUB. The SBUH HUB does not have its own PMO, work taking place is integrated into the SCC's PMO.

The SCC PMO has engaged each HUB to understand a collective approach towards implementation of our programs. Some programs such as DSRIP project 2di are "HUB neutral" where our efforts are collaborative under 1 PPS-wide program, other programs such as DSRIP project 3dii are "HUB-specific" where the Northwell HUB and CHS HUB are leveraging existing programs and resources to target DSRIP populations and providers. This is further defined under each project mid-point assessment narrative.

Collectively, the processes, structures and approaches developed with HUBs input has positioned all participating network providers, regardless of "HUB" to participate in a DSRIP program that is organized, consistent and positioned to meet the challenges of the future payment system. Regardless of "HUB," providers will be held accountable for patient outcomes and overall healthcare cost, participate in population health management through a clinically integrated network, share data, and explore ways to improve population wide health – ultimately resulting in the capability to participate in a level of VBP by CY 2020.

Governance System Review Plan
The Governance model initiated a *Governance Guidelines & Governance Review Plan*, which was approved by the BOD in November of 2015. This plan outlines governance guidelines in the form of Leadership, Composition, Accountability, Transparency, and Stakeholder Engagement, Supporting Policies and Procedures and Evolution of Governance Structure. In addition the plan outlines an Evaluation of Governance Structure and Processes, whereby it is the BODs responsibility to conduct reviews of the performance of the PPS's governance bodies not less than annually. Just recently, at the close of DSRIP Demonstration Year 1, the SCC initiated the first review – Board and Executive Committee Member Survey's - through an online survey tool, results are currently being received and tabulated. Conclusions and results will be presented at the next BOD meeting.

Governance Reporting & Evaluation Process
Under the successful completion of Governance Milestone 4, the establishment of a governance structure reporting and monitoring process. The SCC has designed and deployed a formal governance reporting and monitoring process to ensure transparency and ongoing monitoring of the SCC's participation in the DSRIP Program.

Consumer Advisory Council Design
The SCC is beginning to engage our Community Engagement Workgroup to design a consumer advisory council to engage through governance, the SCC's targeted beneficiaries. This work is also part of Milestone 11 of DSRIP Project 2ai, which we have scheduled CY 2017 to complete.

Community Engagement
This section highlights the community-engagement milestones under the Governance organizational work stream. Community Engagement is led by Althea Williams, MBA, CPC, PCMH-CCE, Director of Community and Practice Innovation.

The purpose of Community Engagement is to collaborate and engage community partners throughout Suffolk County to address health disparities, build strong relationships with stakeholders to communicate and participate in community engagement activities and events, and encourage patient engagement. The objectives of the community engagement plan is to build trust through participation, establish methods of communication with community partners and develop innovative engagement approaches. The plan reinforces SCC's commitment to assuring information is communicated through a bi-directional flow of information and was approved by the Community Needs Assessment, Outreach and Cultural Competency and Health Literacy Committee on February 22nd, 2016.

The community engagement workgroup meets on a monthly basis for sharing thoughts, ideas, and strategies to further continue the ongoing process of meeting project specific deliverables, developing relationships with CBOs, promoting input from community partners across the PPS, and empowering both SCC and the community to address opportunities for improvement. Some key stakeholder representation on the Community Engagement Workgroup are all three hubs, hospitals, different community based organizations, and federally qualified health centers in Suffolk County. There is also representatives from the community all throughout the projects (workgroups, committees) and organizational work streams. Currently the community engagement workgroup has engaged in discussions about a front-facing community engagement visual, addressing social determinants of health, a renewed community facing webpage, new expanding partnerships and collaborations, and the promotion of community based events and activities.

To date, SCC has completed and submitted two Community Engagement milestones: #5 and #6.

For Milestone 5, the finalized community engagement plan included communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement, etc.), In addition, SCC created a tracking system that details all of the community based organization relationships, engagement activities and communication for quarterly reporting. Subsequently, while implementing this plan SCC continues to have one-on-one meetings with law enforcement representatives, legislators, faith-based organizations, and community based organizations. Specifically, SCC's collaboration with the Long Island Population Health Improvement Program (LIPHIP) has been critical. During LIPHIP's monthly Collaborative meetings SCC has networked and developed relationships that has fostered into future collaborations. SCC continues to work with hospitals, the Nassau Queens PPS, local department of health/public sector agencies, municipalities and other Community Based organizations that are present at the LIPHIP collaborative meetings focusing on community engagement workgroup efforts as well as other project workgroups. Additionally, SCC in conjunction with LIPHIP and Nassau Queens PPS, are in the beginning stages of developing a community networking event in which the primary focus will be identifying and addressing the social determinants of health and the progression towards preventing working silos within the community. We aim to collaborate with faith based organizations, care management organizations, and several community based organizations. This networking event truly speaks to the community engagement plan and plans to foster connections within Suffolk County.

For Milestone #6, SCC finalized 5 partnership agreements with CBOs. Early on SCC partnered with the Association for Mental Health and Wellness, Economic Opportunity Council of Suffolk County, and Hudson River Health Care. More recently, formal partnership agreements have been completed with Planned Parenthood and Family Service League. The SCC under the direction of the Project Management Office and Care Management Organization is on target with their plans and have initiated many engagements with CBO's for which we will look to continue forming partnerships throughout the DSRIP program lifecycle.

Additional community engagement success include the active increase of access to high quality chronic disease preventative care and management services. SCC includes Suffolk County community health and wellness events and affairs in our e-newsletters (DSRIP-In-Action) on a bi-weekly basis. SCC has also developed a CBO resource directory that enables both providers and patients to have increased access to preventative health and disease management resources. This document is also available on the website. SCC had executed a formal sharing agreement with Greater New York Hospital

Association which will embed and integrate the Health Information Tool for Empowerment (HITE). Providing access to this tool in the community area of the website will allow for ease of access to Suffolk County residents to search for health and wellness services in local communities and further address the social determinants of health. In addition to HITE, the LIPHIP is supporting the SCC with enhancing stakeholder collaborations, providing access to data-driven analytics and developing local strategies for addressing health disparities.

The key to implementing the community engagement framework has been collaboration and communication. Collaborating with not only community partners and stakeholders but community leaders, in both the public and non-public sectors. Effectively communicating with different organizations through face-to-face meetings, email, and networking events and affairs has been a critical component of the execution of the community engagement model.

The SCC continues to demonstrate successful completion of all Governance Milestones by the ongoing submission of the required governance templates quarterly to the NYS DOH.

Additional References:

- *Please see "SCC Midpoint Assessment Narrative: Workforce" for updates regarding Governance Milestone #8 Workforce.*
- *Please see SCC Midpoint Assessment Narrative: Project 2di" for updates regarding CBO engagement in leading our DSRIP Project 2di.*
- *Navigate to our Project Advisory Committee (PAC) webpage to visit our June 2015 PAC Meeting Agenda & presentation recordings, which covered CBO engagement highlights and a CBO Panel discussion.*

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Highlights and successes of the efforts:

Organizational Work Stream: IT Systems and Processes

SCC is pleased to announce the successful completion of four organizational milestones within the IT Systems and Processes work stream. Each milestone has been completed in accordance with the delivery dates set forth by the Department of Health and outlined within the SCC Implementation plan. Where applicable work continues on those milestones that require ongoing quarterly reporting, training and validation by the Independent Assessor (IA).

Work has commenced on the fifth and final IT Systems and Processes Milestone #4 "Engaging Attributed Members of Qualifying Entities" and is scheduled to be completed September 30th 2016, again in accordance with the scheduled DOH delivery dates.

Summary of Completed Milestone Successes and Challenges:

MS #1: IT Current State Assessment - 6/30/2016
IT Surveys were conducted by both SCC IT staff and KPMG across prioritized provider types such as Hospitals, PCPs and SNFs. The results of the surveys revealed that a majority of respondents have an EHR of some type. There were 15 established EHR vendor products that account for the majority of responses received to date of which a good portion were already Meaningful Use certified. A majority of respondents noted that they are currently connected to a RHIO, with a plurality connected to Healthix. While the results received to date have been positive there were many survey recipients that did not respond. In an effort to mitigate this risk the SCC Business and Technical On-Boarding teams will continue to conduct and document IT Surveys throughout the partner on-boarding process.

MS #2: Change Management Strategy – 6/30/2016
The SCC IT Change Management Strategy document and IT Change Request form has been completed and approved by both the IT Task Force and the IT Governance Committee. The strategy document outlines key change management requirements such as the change request process, governance of the change process, change management communication, centralized distribution and publication of the change management documentation. Training has been completed across key stakeholders within the each of the Hubs that are part of the SCC PPS. The Change Management document itself serves as the training material. There were no significant challenges associated with the completion of this milestone other than assuring that a Train the Trainer model can be adopted across each Hub's organization.

MS #3: Data Sharing and Clinical Interoperability Roadmap – 3/31/2016
Milestone #3 can arguably be considered the one of the most important IT Milestones within the DSRIP program as it provides the foundation for the SCC Integrated Delivery System and the required data sets used to support each of the clinical projects.

In the context of the SCC PPS we have agreed on the following definition:

Clinical data sharing and interoperability describes the extent that the SCC Population Health Platform can receive and interpret shared patient data across the PPS. For the SCC Population Health Platform to be interoperable it must be capable of receiving clinical data from disparate EMR systems and subsequently display and report on that data in a consistent manner.

The ability to accurately and consistently display patient data within Regional Health Information Organizations (RHIO) provides the final link towards achieving interoperability across the PPS.

The following represents a set of IT assets (related to this Milestone) that have been successfully deployed into our production environment to date:

Specific to the SBM Hub:

- HealtheIntent - Foundation platform that receives all data from PPS Coalition partners and the DOH.
- HealtheRegistries – Chronic condition and wellness registry solution, which leverages clinical, financial and operational data across disparate sources and normalizes the data into meaningful information.
- HealtheCare - Care Management tool linked with HealtheIntent for DSRIP care managers and care management services.
- HealtheAnalytics- Reporting tool that supports Business Objects and Tableau

Hub Neutral PPS Wide:

- HealtheEDW - Powered by the HealtheIntent platform, which aggregates data (clinical, financial and operational) across multiple disparate sources and normalizes the data. HealtheEDW allows organizations to review current performance, historical trends, benchmarks and other analytics capabilities that provide input into continual process improvement initiatives

Note: The current strategy is to deploy HealtheEDW across all 3 Hubs, however both the CHS and Northwell Health systems are still in the process of finalizing their contracts with the vendor. The SCC and the Stony Brook Hub have committed to using HealtheEDW as their central data repository for clinical integration.

Completion of this milestone has also allowed the SCC to confidently jettison our Technical On-Boarding process with over 35 providers actively being on-boarded.

That being said, there have been challenges and our technical integration work is still under way with the following items under some form of design, development, implementation or deployment:

- Population Identification
- Ingestion of DOH roster and claims
- SCC's hard and soft attribution algorithms
- Splitting the DOH Roster and deriving provider affiliation across SCC's 3 Hubs
- Clinical data sharing across the Enterprise Data Warehouses (EDWs) used by each Hub
- Proactive Performance Monitoring and Reporting
- Finalizing RHIO Integration and Care Plan sharing
- PPS wide alerting between Hubs

Finally, achieving true clinical interoperability across the SCC PPS is particularly challenging since the PPS is based on a 3 hub model (consisting of Northwell Health, Catholic Health System and Stony Brook Medicine) each of which have their own proprietary technical infrastructure and business requirements. This constraint is being mitigated by achieving interoperability with the RHIO's, HIE under the larger umbrella of SHIN-NY.

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MS #5: Data Security and Confidentiality – 6/30/2016

The SCC current state System Security Plans (SSPs), will have been submitted (7/29/16) to the DOH as a means of completing Milestone #5 within the IT Systems and Processes organizational work stream.

The SCC Information Security Plan (ISP) is an integral part of the SSP documentation and addresses the SCC Data Security and Confidentiality requirements. In preparation for the on-going monthly receipt of DOH claims data, both the SSPs and the ISP will be updated to reflect "future state" requirements. Our Cloud Service Provider (CSP) downstream partner is also in the process of completing a full set of SSPs to address "future state" processes.

The current state ISP has been shared with both the IT Governance Committee and the IT Task Force and comments have been incorporated were applicable. When completed the updated future state ISP will be published to the same parties for review, comment and sign off.

Additional work related to this milestone completed to date is as follows:

- Security Assessment Affidavit – complete and submit updated version of this document as well as update and submit the SSP overview document to reflect "future state".
- Identity Assessment Level (IAL) document – required by the DOH for the receipt of claims data, outlines the roles and risk levels of all users accessing DOH Claims data.
- Initial development, implementation and deployment of SCC's Two Factor Authentication (2FA) with testing currently underway.
- Completion of Data Exchange & Application Agreements (DEAA) Attachment D for our subcontractors.
- Consumption of DOH Claims and Roster within a highly secured restricted current state environment

Challenges associated with this milestone span both the business and technical arenas.
From a business perspective the PPS lead is required to assure that Claims and Roster data is not shared with any downstream partner (Hub) until they have completed their required documentation and technical implementation of two factor authentication. However each Hub will minimally require the Roster to identify their providers and associated patient population. Discussions on this topic are still underway with both the DOH and our Hub partners. On-Going requirement changes instituted by the DOH with respect to policies around safeguarding claims data is viewed as a risk.

From the technical perspective the implementation of the two factor authentication across the all applicable downstream partners will also be an operational challenge.

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DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting the overall organizational efforts to date.

PPS Name: State University of New York at Stony Brook University Hospital

Highlights and successes of the efforts:

Organizational Work Stream: Performance Reporting

The Performance Reporting Organizational Work Stream is led by Kevin Bozza, MPA, FACHE, CPHQ, RHIT, Senior Director for Network Development and Performance. Mr. Bozza has over 18 years of experience in healthcare administration both in hospitals and health systems focusing on quality improvement, clinical decision support, education and training, project management and facilitation of pay-for-performance programs. Mr. Bozza has worked extensively with physician leaders and executive staff over the years to implement quality initiatives. He holds a Master's Degree in Public Administration from New York University in Health Policy and Management and is a fellow in the American College of Healthcare Executives (FACHE), and credentialed in healthcare quality (CPHQ) and health information management (RHIT).

In June of 2015, the Performance Evaluation and Management Workgroup was established which serves as the advisory group to the Clinical Governance Committee on matters related to the DSRIP metrics, performance reporting and quality improvement activities. Membership includes representation from all three hubs i.e. clinicians and professionals with experience in data informatics, quality improvement, care management, project management and information technology. The workgroup is supported by staff from Stony Brook University Hospital's Information Technology and Biomedical Informatics departments who are responsible for the retrieval and analysis of data across the PPS as well as safeguarding protected health information (PHI). The committee meets monthly to address identified needs and to operationalize deliverables.

The initial charter for the workgroup was to develop a plan that would establish an organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided by the SCC. The "Plan" now referred to as the SCC Performance Reporting and Improvement Plan does just that by identifying the reporting structure and responsibilities, gap-to-goal performance goals, the intended decision support tools, the action planning process to address performance gaps and the approach to training. The Plan was finalized by the workgroup, endorsed by the Clinical Governance Committee and approved by the SCC Board of Directors in DY1 Q3. The plan was submitted to the Department of Health and both Milestone one and two are now complete.

In addition to developing the Plan, the workgroup was involved early on in supporting the SCC PMO and Project Workgroups/Committees with defining patient engagement metrics and identifying a secure protocol to transfer patient engagement data from partners to the SCC. To meet the DY1 Q2 patient engagement reporting requirement, business associate agreements were executed with targeted partners so that PHI data could be shared with the SCC through Box.

Eight of the eleven SCC DSRIP projects require demonstration of active engagement of patients and those metrics have been clearly defined by the SCC. The patient engagement definitions and data specs are located in the "For Partners" section of the SCC website for reference https://suffolkcare.org/forpartners/datarequest. Recognizing the importance of ongoing education for the partners regarding this request, the SCC continues to host a quarterly patient engagement webinar to re-review the definitions as well as the secure file transfer process. The webinars are recorded and posted on the SCC website following each live meeting.

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In addition to training partners regarding the patient engagement reporting requirements, the SCC developed a Learning Center in early June on the SCC website and included four e-learning modules focused on performance. The modules are intended to supplement the in-person learning opportunities provided to partners during onboarding and to add to existing training programs across partner organizations https://suffolkcare.org/forpartners/learning-center. One module focuses on the SCC Performance Reporting and Improvement Program and the three additional modules focus on curriculum made available through the Institute for Healthcare Improvement (IHI). One module in particular focuses on the IHI Improvement model which is the model the SCC endorsed in the Performance Reporting and Improvement Plan. End-users of the Learning Center are required to complete a brief registration and post survey so that training can be tracked and monitored.

The SCC continues to orient partners to the SCC Performance Reporting and Improvement Plan through the partner onboarding process as well as through presentations that have been made to the SCC Board of Directors, PAC and Project Committees. Recognizing the importance of improving the performance measures the SCC has also incorporated performance measurement as one of the performance factors partners will be held accountable for in order to be paid. In addition, Measurement Year 1 results have been shared with the SCC Board of Directors and Project Committees and efforts are currently underway to address identified gaps.

The SCC has utilized the MAPP data to identify trends by MCO assigned physician but is currently reviewing a broader scope of work thinking through an attribution methodology to identify the "established physician" through claims information. Two subgroups of the Performance Evaluation and Management Workgroup have been established one is focused on developing a PCP attribution methodology and the other is working on designing performance dashboards for various levels of the organization including individual providers, project committees, hubs and the SCC Board. The dashboards will be generated from data that the SCC is ingesting from its partners during the onboarding process. The goal is to operationalize a concurrent action planning process so that interventions can be implemented and then monitored to evaluate the impact, instead of waiting for the final MY results to be published through the MAPP tool. In addition, the SCC is working through developing business rules for paying partners for performance. The SCC continues to collaborate with the Nassau Queens PPS on both the business rules for paying partners for performance as well as the overall approach to performance improvement.

Following SCC's All-PPS listening tour presentation the Salient team requested additional time with the SCC team to solicit feedback on future developments in the MAPP tool and SIMS. The SCC is looking forward to having this opportunity to further discuss reporting needs as well as to provide feedback on upcoming reports to support the SCC performance improvement program.

All of this work will continue throughout the remainder of the calendar year.

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DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting the overall organizational efforts to date.

PPS Name: State University of New York at Stony Brook University Hospital

Highlights and successes of the efforts:

Organizational Work Stream: Population Health Management

The Population Health Management Organizational Work stream consists of two milestones to be completed by March 31, 2017. Milestone 1 in this work stream called for developing a Population Health Management Roadmap and Milestone 2 is the finalization of a bed reduction plan. Population Health Management is a topic covered in the Population Health Management Operating Workgroup (now the Population Health Management/Integrated Delivery System Workgroup (PHM/IDS)).

Kelli Vasquez, LCSW, Senior Director of Care Management and Care Coordination, leads the Population Health Management Organizational Work Stream tasks and approach, in collaboration with Linda Efferen, MD, MBA, SCC Medical Director, and the Project Manager for 2ai, Alyeah Ramjit, MS, MHA to develop agendas, workplans and facilitation of the above described workgroup.

Kelli Vasquez, LCSW had prior leadership experience as the Assistant Director of Care Coordination for an Independent Physician Association and Accountable Care Organization. Prior to these roles, Ms. Vasquez held clinical positions in various healthcare fields including outpatient hemodialysis, medical-surgical discharge planning, adult and pediatric inpatient psychiatric care, and outpatient mental health counseling. Currently, she is charged with leading the Suffolk Care Collaborative Care Management Organization and all Care Coordination projects and programs for the PPS.

Linda Efferen, MD, MBA is the Medical Director for the Suffolk Care Collaborative, Office of Population Health, Stony Brook Medicine. She came to Stony Brook from South Nassau Communities Hospital, where she served as Senior Vice President & Chief Medical Officer and Clinical Professor of Medicine at Hofstra North Shore-LIJ School of Medicine. Prior to that, she was affiliated with the NSLIJ Health System as Associate Chair in the Department of Medicine at Long Island Jewish Medical Center after serving as Division Chief for Pulmonary and Critical Care Medicine at SUNY Downstate. A member of many professional organizations, she has held leadership positions at the local, state and national levels. A graduate of Fordham University and the Sackler School of Medicine in Tel Aviv, Israel, Dr. Efferen is board-certified in internal medicine, pulmonary disease, critical care medicine and palliative care.

Alyeah E. Ramjit, MS, MHA holds the position of Project Manager, Integrated Care. Prior to her work at SCC, Ms. Ramjit was employed by AgeWell New York as a business liaison for Medicare Part D operationsand has over 5 years of clinical healthcare experience as an Emergency Medical Technician. She holds a Master's Degree in Clinical Nutrition from the New York Institute of Technology as well as a Master's Degree in Health Administration from Hofstra University.

The Workgroup responsible for Clinical Integration, PHM/IDS, includes stakeholders from all 3 HUBs: Catholic Health System, Northwell Health, and Stony Brook University Hospital. Clinical leads, project managers and IT personnel are all represented in this group for each HUB. The workgroup also consists of members of the Population Health

Management Software tool and consultants for Care Management who have attended and added meaningfully to the group and its work.

There have not been any Subject Matter Experts consulted for work in Population Health Management specifically, however the work done in the some of the Projects, such as the Transitions of Care Model, have utilized SMEs and their work has been highlighted in the Population Health Management Roadmap.

Project development strategy

To begin work in Population Health Management, the workgroup was formed and definitions and requirements were discussed. Defining Population Health Management required input from all members of the workgroup including representatives from the CHS, Northwell Health, and Stony Brook University Hospital HUBs. The agreed upon definition is:

"Population Health Management is the aggregation of patient data across multiple health information technology resources, the analysis of that date in a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes. It is the technical field of endeavor which utilizes a variety of individual, organizational and cultural interventions to help improve patient self-care, morbidity patterns (i.e. the illness and injury burden) and the health care use behavior of defined populations."

This definition then allowed for the Workgroup to create a timeline, sub-steps, dependencies, risks and contingencies for completing a Population Health Management Roadmap. Essentially, a "roadmap to the Roadmap" was developed and this identified key areas for necessary input. The Workgroup meets monthly and receives report outs from the PCMH Certification Workgroup, the Information Technology Task Force, the Value Based Payment Workgroup, the Transitions of Care Workgroup, the Community Health Activation Program Workgroup, the Performance Management Workgroup and the Care Management and Care Coordination Workgroup. Work being done in each of these areas helped to inform the ultimate Roadmap and identify further areas for exploration and development.

In consideration of the elements of Population Health Management, the PHM/IDS Workgroup completed a scoping exercise to ensure that key areas were considered and a plan to implement was developed. This exercise informed development of the framework of the Roadmap.

The 'hot spot' analysis conducted in the SCC was an integral piece to the development of the Roadmap. The ability to identify and prioritize target populations and then create plans for addressing health disparities is a key function of Population Health Management. This analysis will provide actionable intelligence in the development of strategies for improving health outcomes. Work in this area will remain ongoing and will include details from the Suffolk County Community Needs Assessment as well as input from the key stakeholders involved in the Project Management Organization, Cultural Competency and Health Literacy Workgroup, Care Management Organizations, Community Engagement Workgroup as well as the Long Island Health Collaborative and Stony Brook Medicine's Biomedical Informatics department.

The ability to collect and analyze data is a requirement for successful Population Health Management. Data collection in this area is just beginning and the details of how this data is collected and managed is outlined in the Population Health Management Roadmap.

Population Health Management and the development of the Roadmap are HUB neutral. Activities and strategies will be deployed across the entire PPS and representatives from all 3 HUBs have contributed and agreed upon the elements of this Roadmap. Populations of patients will be identified and will be managed in ways that are efficient and efficacious for the patient which may mean management within a HUB system as well as across various HUB providers.

Project implementation/execution

Many of the elements of the Population Health Management Roadmap are currently being implemented which include: data collection through HUB IT technologies as well as into the SCC Enterprise Data Warehouse; training and roll out of SBIRT in the PPS hospitals; the deployment of Care Management in all 3 HUBs; the creation of Clinical Guideline Summaries for all clinical projects including management of Diabetes, Hypertension, Asthma and Behavioral Health and Primary Care Integration; and the training and initiation of INTERACT in Skilled Nursing Facilities. The Transitions of Care Model is in the first phases of implementation through the use of Implementation Teams, as is the certification of practice sites for Patient Centered Medical Home recognition. The Roadmap has essentially outlined the key areas needed to successfully manage populations of patients. SCC is now at the point of operationalizing these programs through various provider and project level implementation plans. Additionally, cohorts of patients are being identified for engagement and strategies to engage are being aligned with Program Implementation and Care Management capabilities.

Challenges to implementation of the Population Health Management Roadmap lie in the contracting of PCP partners and the successful completion of onboarding for these partners. When a provider site is contracted, work begins in the areas of IT technical onboarding, PCMH baseline assessments, PC/BH integrated care readiness and the need for Care Management support. Efforts around Population Health Management have already begun networks and will continue to encompass more and more patients and providers as contracts continue to be executed throughout the PPS. Additional challenges are faced in terms of IT connectivity and the ability to ingest data into the SCC Enterprise Data Warehouse (EDW). It is here that we identified the need to have all 3 HUBs roll their data into one EDW which will then be capable of generating reports and registries used to monitor performance and highlight populations in need.

Milestone #1 in Population Health Management “Develop a population health management roadmap” was completed on June 30, 2016. Approximately, 860 providers within 281 sites will be targeted for population health management. The Population Health Management Roadmap is shared throughout the PPS and has been approved by the Board of Directors with representations from all 3 HUBs.

As next steps to the development of this Roadmap, efforts have begun to identify cohorts of patients that will require navigation to health care services, improvement in the closure of gaps in care, and those patients frequently utilizing ED and hospital services that could otherwise be avoided. Through the efforts of Care Management Organizations, the CHAP program, TOC Model role out, and navigation to Health Homes, the SCC will work to successfully manage the care of these targeted populations and begin analyzing outcomes for areas of further need. Both concurrent review of data received from the SCC partners, as well as a Department of Health data through MAPP will be used to understand patients that require further management and resources will be deployed to assist these populations. The PHM/IDS Workgroup will lead these efforts and work to develop strategies as additional patient cohorts are identified.

Throughout the development of the Population Health Management Roadmap, it was important for the Workgroup as well as the PPS Stakeholders to have a clear understanding and agreement on the concepts of how Population Health Management differs and aligns with Clinical Integration. SCC recognizes the need to have a Clinically Integrated Network that provides the foundation for being able to successfully manage target populations through Population Health Management. Additionally, we understood that the pillars of Population Health Management are data collection, storage and management, use of technology to monitor and stratify populations, identification of patient populations, team based interventions and care team coordination and measuring outcomes.

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DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting the overall organizational efforts to date.

PPS Name: State University of New York at Stony Brook University Hospital

Highlights and successes of the efforts:

Organizational Work Stream: Practitioner Engagement

The Practitioner Engagement Organizational Work Stream is led by Kevin Bozza, MPA, FACHE, CPHQ, RHIT, Senior Director for Network Development and Performance with support from the SCC Provider Relations Team. Mr. Bozza has over 18 years of experience in healthcare administration both in hospitals and health systems focusing on quality improvement, clinical decision support, education and training, project management and facilitation of pay-for-performance programs. Mr. Bozza has worked extensively with physician leaders and executive staff over the years to implement quality initiatives. He holds a Master's Degree in Public Administration from New York University in Health Policy and Management and is a fellow in the American College of Healthcare Executives (FACHE), and credentialed in healthcare quality (CPHQ) and health information management (RHIT).

The Practitioner Engagement Workgroup was formally organized in the Fall of 2015. The Workgroup is chaired by Dr. Maria Basile, Assistant Vice President for Medical Staff Affairs at John T. Mather Memorial Hospital and Executive Committee member of the Suffolk County Medical Society, and includes representation from all three Hubs. The workgroup was initially charged with developing the Practitioner Communication and Engagement Plan as well as the training strategy for practitioners and other professional groups to fulfill milestones 1 & 2 for this organizational work stream. The plan was finalized by the workgroup, endorsed by the Clinical Governance Committee and approved by the SCC Board in DY1 Q4. The plan was submitted to the Department of Health and both milestones are now complete.

The plan provides a foundation for practitioner engagement efforts and a framework to guide future engagement activities across the SCC. The Practitioner Engagement and Communication plan also addresses the initial training plan for practitioners related to DSRIP 101 education as well as provides an overall approach to orienting partners to the SCC DSRIP Projects and quality improvement agenda. To support practitioner education, the SCC launched a Learning Center in early June on the SCC website that includes e-learning modules focused on DSRIP 101 as well as Performance Reporting and Improvement. Future modules are underway to provide practitioners with additional access to training programs that can be completed at their own pace.

Early on the SCC recognized the importance of properly engaging its partners by establishing a comprehensive partner onboarding program. For contracted partners, the onboarding program provides education regarding the DSRIP projects, performance reporting requirements and other essential need-to-know topics. The onboarding program and all associated reference materials are available on the SCC website located at https://suffolkcare.org/forpartners/onboarding. Although there is some degree of variability as to how each Hub completes the activities, each Hub generally follows a three-step process to onboarding partners which includes an introductory meeting to discuss the contract, a follow-up meeting with contracted partners to provide general orientation to the SCC, and finally, education and training to the DSRIP project requirements.

Some of the challenges for the SCC involved finalizing the funds flow model which added some delays to the contracting process. That being said, the SCC has been expediting the contracting process as much as possible to shift the focus to project implementation across the SCC partners.

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To date, 50% of PCPs, 40% of Hospitals and 48% of SNFs targeted for contracting are now complete. SCC also executed 3 partnership agreements with Community Based Organizations including the Association for Mental Health and Wellness, Economic Opportunity Council of Suffolk County and Hudson River Health Care. There are two pending contracts for Planned Parenthood and Family Service League.

As for lessons learned, the SCC continues to share best practices across the Hubs for engaging practitioners through the Practitioner Engagement Workgroup. One opportunity for improvement identified is to better facilitate the volume of staff reaching out to the community practices to support implementation efforts. A more formal phased approach to project implementation is being considered to reduce any potential concerns.

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DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting the overall organizational efforts to date.

PPS Name: State University of New York at Stony Brook University Hospital

Highlights and successes of the efforts:

Organizational Work Stream: Workforce

The Workforce Organizational Work Stream is led by Kevin Bozza, MPA, FACHE, CPHQ, RHIT, Senior Director for Network Development and Performance. The SCC Workforce Strategy is supported by KPMG, the workforce consultant. Mr. Bozza has over 18 years of experience in healthcare administration both in hospitals and health systems focusing on quality improvement, clinical decision support, education and training, project management and facilitation of pay-for-performance programs. Mr. Bozza has worked extensively with physician leaders and executive staff over the years to implement quality initiatives. He holds a Master's Degree in Public Administration from New York University in Health Policy and Management and is a fellow in the American College of Healthcare Executives (FACHE), and credentialed in healthcare quality (CPHQ) and health information management (RHIT).

The plan for addressing the workforce strategy began with establishing two workforce committees the Workforce Governance Committee and the Workforce Advisory Committee. Members of the Workforce Governance Committee are appointed by the SCC Board and represent key stakeholders from across the PPS. The primary focus areas for this committee include setting the workforce vision and strategy, approving the workforce milestones, identifying risks and troubleshooting challenges, monitoring results and key metrics and providing oversight of the selection of the workforce consultant. The Workforce Advisory Committee includes representatives from Human Resources, various labor unions, Hub representation, Nursing, CBOs and Physician Groups. The focus areas for this committee include providing feedback on operational implementation of the workforce initiatives, collaborating in the development of operational policies and procedures to meet DSRIP project requirements, informing the workforce plans and strategy and serves as the "voice of the healthcare workforce" in the context of the DSRIP program. The Workforce Governance Committee meets monthly and the Workforce Advisory Committee meets quarterly.

The formal engagement with KPMG initiated in the Fall of 2015 with the first priority to deploy a comprehensive current state assessment survey to understand the partner's readiness for implementing DSRIP projects. The survey was designed to collect information regarding the partner's information technology infrastructure, training needs and the current workforce in select job family categories such as physician, nursing, social work, care management and behavioral health. The SCC had a 50% response rate which provided a good baseline of information to help inform the Target State and Current State Model.

In early 2016, a series of Target State meetings were held with the Project Leads, Project Managers, Hubs and other key stakeholders for each project to identify the types of positions needed to implement each DSRIP project. In addition, the skills, competencies licenses and/or certifications required were identified as well as the number of positions needed to manage the targeted population for each project. Leveraging national benchmarks and statistical models KPMG provided guidance to each project committee to help project both the type and number of positions needed. In the Spring of 2016, KPMG facilitated meetings with key contracted partners to identify their staffing allocation for each DSRIP project. One of the challenges for the SCC with completing the target state as well as the detailed gap analysis has been getting partners who have not yet executed a participation agreement with the SCC to the table to complete this exercise. The unintended delays forced the SCC to push out both Milestone 1: Define Target State and Milestone 3: Perform detailed gap analysis to DY2 Q1 and Milestone 2: Create a workforce transition roadmap to DY2 Q2. All three milestones are now on target for

completion but will require future updating as we continue to execute contracts with the partners. Milestones 1 and 3 were approved by the SCC Workforce Governance Committee at the June 20th meeting and were advanced to the Department of Health for review as part of the DY2 Q1 report submission. Several "emerging titles" positions have been identified as a needed resource to support the SCC DSRIP program. Hiring for these positions has initiated through executed contracts with Community Based Organizations as well as expanding care management programs across the Hubs.

Concurrent with the Target State/Current State meetings, the SCC organized an excel workbook which was distributed to the Hubs to establish a Workforce Budget across all 5 years of DSRIP and to facilitate a reporting process from the Hubs regarding workforce spend. Each Hub is responsible for tracking individual expenses by reporting category i.e. New Hire/Recruitment, Redeployed, Retrained/Trained for the partners aligned with their Hub. Bi-annually, each Hub will report the aggregate expenses to the SCC which then will be aggregated at the PPS level for reporting to the DOH. The SCC fulfilled the Workforce Spend reporting requirements for the DY1 Q4 quarterly report. Recently, the SCC aligned the workforce reporting requirements with the pre-existing patient engagement reporting schedule so that the partners can plan well in advance for all SCC reporting needs.

In order to manage the influx of surveys or requests to our partners to meet the Workforce milestones, the SCC sequenced the "asks" as much as possible to reduce any concerns regarding the additional workload. Following the completion of the Target State/Current State data requests, the SCC focused on facilitating the Compensation and Benefits survey. The compensation and benefits survey was distributed on May 6, 2016 to 81 partners with a deadline to return the survey by June 10, 2016. KPMG distributed the survey and prepared the final report. Thirty nine surveys were returned for a response rate of 48%. The final report was approved by the SCC Workforce Governance Committee at the June 20th meeting and was advanced to the Department of Health for review as part of the DY2 Q1 report submission.

To address the Impact Report, the SCC worked with KPMG to develop a survey tool so that contracted partners could report their DY1 actuals. The deployment of this survey followed the Compensation and Benefits Survey with a scheduled completion date of July 22nd. Since the DOH extended the due date for this deliverable the SCC will prepare the final report for submission with the DY2 Q2 report.

Developing the SCC Training Strategy and Plan was a priority for the SCC with work initiating on the plan in the Fall of 2015. The SCC facilitated a needs assessment across all DSRIP projects and Organizational Work Streams to inform the final plan. In addition to the information gleaned from the current state assessment survey, meetings were held with the Project Managers and Project Leads to identify the training needs. The needs assessment helped to identify the courses, skills and processes that would need to be acquired in order to successfully participate in the DSRIP projects. The training needs assessment also identified the impacted staff. Hub Project Managers vetted the assessment, the plan and modified the plan to suit Hub-specific requirements and incorporated Hub-specific delivery modes. The SCC Training Strategy and Plan was approved by the Workforce Governance Committee at the March 30, 2016 meeting and was advanced to the Department of Health for approval in the DY1 Q4 report.

The SCC has facilitated several training sessions for partners to-date focused on specific skills in SBIRT, Interact, PAM as well as general orientation to the SCC DSRIP program. The SCC is utilizing a blended learning approach for training and has built a forward facing Learning Center on the SCC website for partners to supplement in person training. The E-learning modules currently on the SCC website focus on DSRIP 101, Performance Improvement and Reporting as well as Cultural Competency and Health Literacy. Future E-learning modules are in the work que which will help the SCC educate and outreach to more of the workforce across the PPS. The SCC is currently finalizing the core curriculum for the primary care practices which will orient partners to the DSRIP project requirements. The SCC will be relying on a train-the-trainer approach to orient the primary care practices to the DSRIP project requirements by training the assigned DSRIP champion at each practice site who will in turn orient the practice staff. Looking ahead, the SCC will continue to finalize the DSRIP course content where there are gaps. The SCC Central Services Organization will review training evaluations and results and if necessary, changes will be made to the course content or new course content will be developed based on the identified need.

The final Workforce milestone the SCC focused on throughout the first quarter of DY2 was finalizing the Workforce Communication and Engagement Plan. In collaboration with KPMG, the SCC developed a framework to conduct a

stakeholder engagement and communication assessment to identify readiness and resistance to DSRIP changes as well as partner communication needs. Interviews were held with key leadership groups across the SCC partners. KPMG met with 52 stakeholders via 28 interview sessions and facilitated sessions with the Workforce Advisory Committee, Practitioner Engagement Workgroup and toured the Stony Brook School of Nursing and the Northwell Health Center for Learning and Innovation. The findings from the Organizational Change Risk and Readiness Analysis informed the final Workforce Communication and Engagement Plan. The plan was approved by the Workforce Governance Committee at the June 29th meeting and was advanced to the Department of Health for review as part of the DY2 Q1 report submission.

The SCC continues to utilize multiple modes of communication to keep the workforce abreast of the DSRIP program and SCC initiatives. These include eNewsletters such as DSRIP in Action which is a bi-weekly DSRIP update to all SCC partners highlighting notable achievements, announcements, programmatic updates and special meeting reminders; Synergy newsletter which features important articles, notable highlights as well as answers to questions about the DSRIP initiative; the SCC website; standing project workgroup and committee meetings and SCC hosted webinars just to name a few. The SCC expects to continue to identify communication and engagement opportunities as the workforce plan is implemented and contracts are finalized with the partners.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 2.a.i

Building a Suffolk County Integrated Delivery System (IDS) (DSRIP Project 2ai)

Challenges the PPS has encountered in project implementation:
Throughout the implementation of the Integrated Delivery System project the SCC has faced many challenges across the 11 milestones. these challenges are described below: **Network Development:** Primary care providers (PCP) and non-primary care providers (Non-PCP) have proved to be a challenge when initiating contracting due to their hesitation in taking on a role in DSRIP as well as understanding their required performance reporting across the Domain 2, 3 & 4 measures. In addition, there are challenges in meeting provider engagement targets within the non-PCP category. **Information Systems & Clinical Interoperability:** PPS wide alerting between Hubs has proved as another challenge due there being three RHIOs, Healthix, HealthLinkNY and New York Care Information Gateway (NYCIG) having partners within the Suffolk PPS. These RHIOs are solely interfacing at the level of the SHIN-NY and therefore is it very hard for an exchange of information between the Hubs. **RHIO Connectivity:** One of the biggest challenges faced by the PPS is connecting SNFs and PCPs to a RHIO as per the DSRIP requirements due to some of these provider types not having an EMR or having an EMR that is unable to fully connect to a RHIO. **Care Coordination & Care Management** The Care Management Organization (CMO) is rapidly growing and increasing patient service. While taking on many patients quickly, the CMO lacked a care management tool in which care managers could easily access patient information.
Efforts to mitigate challenges identified above:
In an effort to mitigate the challenges discussed above the SCC combined existing workgroup efforts between the Population Health Management Workgroup (PHM) and the Integrated Delivery System (IDS) Workgroup to build a program design/framework, create unified definitions, initiate and monitor programs. Additional responsibilities to include, review progress against the IDS project requirements and organizational work stream plans and deliverables. This approach received monthly reports from an existing set of workgroups and will assure that the workgroups are working towards the development of an IDS. Specific mitigating to the challenges listed above are expanded on below: **Network Development:** The SCC has recently hired a Director of Behavioral Health and is actively seeking a Director of Clinical Improvements Programs to help bridge the communication gap with the primary care and non-primary care providers. These Directors also take on the role of increased engagement and education of PCPs and Non-PCPs role in Domain 2, 3 & 4 measures. The SCC is also currently designing multiple toolkits geared towards the PCPs, Non-PCPs and behavioral health (BH) provider types. These toolkits are specific to each provider type's engagement across the DSRIP projects and will help the provider understand their role in DSRIP.

The SCC's also has staffed a Provider Relations Team, staffed with full-time Provider Relations Managers who act as a singular point of contact during the contract and on-boarding program. The Provider Relations Manager navigates the contracted entity throughout the various team engagements, such as PCMH transformation for PCPs.

PCMH:

The SCC has deployed provider practice support teams to engage PPS primary care practices to redesign their care delivery processes to move to Level 3 and/or Advanced Medical Home model. The PPS primary care practices will receive support in the redesign of their care delivery model to a PCMH Level 3. The SCC has entered into formal agreements with two PCMH transformation vendors to support the PCP practices, Healthcare Association of New York State (HANYS) Solutions and Primary Care Development Corporation (PCDC). PCMH transformation support was initiated in the first practices in November of 2015. In addition, the PPS has developed a PCMH Certification Workgroup comprised of clinical and non-clinical representatives from PCP practices engaged in transformation activities, subject matter experts (i.e., vendors, PCMH-CCEs), IT, care management, performance improvement, and representation across all three Hubs. This workgroup has developed a PCMH strategy plan to ensure PPS practices achieve PCMH level 3. The strategy, approved by all three Hubs, includes the scope and plan for transformation; tracking and monitoring engagement/progress; validation of PCMH achievement; and building compliance as well as sustainability of current and future PCMH standard iterations.

Information Systems & Clinical Interoperability:

The PPS strategy to mitigate alerting to is utilize the RHIO for patients who are inside of the Hub. For example, if a patient had a visit in the CHS Hub, the alert would be sent through Healthix to NYCIG and then to a subscribed patient provider. The goal of the SBM Hub is to utilize HealtheIntent, the Population Health Platform, for alerting messages to be sent to the care managers. The PPS wide goal is to utilize the HealtheEDW platform. HealtheEDW is powered by the HealtheIntent platform, which aggregates data (clinical, financial and operational) across multiple disparate sources and normalizes the data. The SCC has developed a strategy which allows for each Hub to manage data independently and then have this data ingested into HealtheEDW. HealtheEDW allows organizations to review current performance, historical trends, benchmarks and other analytics capabilities that provide input into continual process improvement initiatives. HealtheEDW will allow data aggregation from all three Hubs for complete clinical integration thereby being able to have alerts generated through Healthix and NYCIG. This connectivity plan is also referenced in the SCC Population Health Management Roadmap.

RHIO Connectivity:

To mitigate providers' inability to connect to a RHIO, we have created a RHIO Workgroup (see below) whose purpose is to work towards PPS RHIO Connectivity. We have engaged two RHIOs in the PPS, Healthix and NYCIG, whose function is to on-board, train and verify RHIO connectivity. These RHIOs also train on the use of secure messaging and alerts. Healthix has begun engagement with EMR vendors that need to build out for the purposes of DSRIP. Healthix also participates GNYHA DSRIP Care Plan and QE Collaboration Workgroup's Care Plan Pilot Program. The PPS participates in this GNYHA Workgroup as well with NWH participating in the Care Plan Pilot.

Care Coordination & Care Management:

The SCC has provisioned the creation of a Care Management Office with RN care managers, social workers and community health workers that interface with the patient. With the increasing patient population in the CMO, HealtheCare was provisioned as a community based care management tool. HealtheCare is a person-centric approach of proactive surveillance, coordination and facilitation of health services across the care continuum to achieve optimal health status, quality and costs. The SCC HealtheCare program provides MARA (Milliman Advanced Risk Adjusters) risk scores for all patients in the population and allows you to sort by score in order to target patients with the highest score first. Each individual risk score is comprised of data from four categories: inpatient, outpatient, physicians and pharmacy.

Implementation approaches that the PPS considers a best practice:

Care Coordination & Care Management Workgroup:
Through the need of healthcare management for the patient population and the coordination of care throughout the continuum the Care Coordination & Care Management Workgroup was born. The workgroup is led by the Senior Director of Care Management and Care Coordination at the SCC. Most recently the workgroup participated in a topic focused on navigating care throughout the continuum. Approximately 50 partners attended with representatives from Health Homes, Home Care, Behavioral Health, Skilled Nursing Facilities and government agencies. The focus of this group to collaborate on ways in which all organization in the Suffolk County can communicate effectively for coordination of patient care. The workgroup has also been successful in creating a Suffolk County manual of Care Management & Care Coordination Services with descriptions of each participating organization. The future progress of the workgroup will be working on creating access to nutritious food for patients, especially those that may have a prescribed diet, availability of housing, access to non-emergent transportation and availability of psychiatric medication management appointments.

Project Leads:
In addition to having a project manager for 2ai, we have engaged the time, commitment and expertise of two Project Leads. The role of the Project Leads is to work with the project manager and key stakeholders to set the key goals and objectives. The Project Lead also acts as the champion of the project and manages progress data. In Project 2ai, we have two Project Leads, Joseph Lamantia and Jim Murry. Joseph Lamantia is the current Chief of Operations for Population Health at Stony Brook Medicine and Jim Murry is the current Chief Information Officer at Stony Brook Medicine. Both Mr. Lamantia and Mr. Murry have a background in hospital operations/hospital information technology.

Tracking Completion of Milestones and Provider Level Engagement:
Within the PPS we use a Performance Logic as a tracking tool. Performance Logic (PL) is a sophisticated project management software tool utilized to manage DSRIP projects. PL is used to monitor progress, share information and communicate project status updates to project leads and Suffolk County providers. Project leads can more effectively communicate real-time information to Suffolk County providers by using PL tools such as web forms, project templates and status dashboard. Internally, risks and issues are recorded in PL and a document repository allows for storing and sharing project-related documents. With its standardized, results-oriented project management tool and features, PL helps the PPS reach its goals and document achievement throughout DSRIP engagement. PL is also used to monitor provider level engagement via the Primary Care Provider (PCP) Implementation Plan. This plan speaks to involvement of the PCPs and Non-PCPs across the DSRIP Domain 2 & 3 projects. The 2ai project manager frequently checks this implementation plan in the PL tool to assess engaged versus disengaged providers.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Network Development:
The SCC has formally initiated engagement with our Coalition Partners through the SCC Coalition Partner On-Boarding Program. Coalition Partners are defined as health care delivery providers in Suffolk County who have attested to be a member of the Suffolk PPS. The on-boarding program has been designed to properly enroll Coalition Partners into the DSRIP program, establish payment procedures and define roles and responsibilities for participation. Each Hub in the PPS has a respective on-boarding team who engages with identified providers within their Hub in Suffolk County. The SCC has been diligently working to on-board primary care providers and skilled nursing facilities to meet the 3/31/2017 deadline under Project 2bvii.

Information Systems & Clinical Interoperability:
The SCC IT Team has created an IT On-Boarding Process for all new providers which occur in 4 phases. In the initial phase the IT team holds a kick-off meeting with the provider where they review high level methods of work, such as EMR vendor type and vendor contacts. They also discuss the appropriate IT contacts, on-boarding timeline and interface specifications. Phase two occurs over the duration of 2-5 meetings which a technical deep dive meeting occurs with the identified IT contact(s). This meeting addresses any concerns the IT contact may have and also addresses questions surrounding technical data analysis and data mapping. At the end of phase 2, the provider is ready to being sending test data. During Phase 3 provider interface testing begins. The network connectivity is established and supported data messages, such as Flat Files, HL7, C-CDA and Claims data are validated, as applicable. Multiple meetings also occur in Phase 3 with the overall

goal of Phase 3 to make the provider ready to go live into sending data to the population health platform and the RHIO. The SCC IT Team completes the On-Boarding process during Phase 4 where they coordinate and schedule weekly calls with the IT contacts, go through another data validation process, ensure Quality Assurance is completed and assure providers data is successfully filing into the SCC Population Health Platform. At the completion of Phase 4, the provider is expected to submit live transaction to the Platform. The overall IT On-Boarding process beginning with Phase 1 and ending with Phase 4 is expected to be completed within 9-10 weeks.

RHIO:

The SCC has created a RHIO Sub-Workgroup under project 2ai. The purpose of this workgroup is to represent and work towards a PPS effort for overall RHIO connectivity. RHIO project managers from all three Hubs are represented as well as representatives from the Healthix RHIO and NYCIG RHIO. To date the workgroup has made two decisions regarding data source selection for Metrics 1 & 2 under Project 2ai as well as defined what RHIO connectivity should be for all provider types. The RHIO Workgroup has also been successful in working towards our safety net provider type commitments. The PPS has connected 9 out of 33 safety net Skilled Nursing Facilities (SNF) with 12 SNFs (a combination of safety net and non-safety net) currently in progress. Future steps for the RHIO Workgroup include working with EMR vendors to help build out as per DSRIP RHIO requirements.

VBP/MCO

The PPS has engaged with 5 MCOs, Healthfirst, Affinity, Emblem, Fidelis and UnitedHealthcare, to develop value-based payment strategies. To date, the PPS has been meeting monthly with the MCOs to discuss utilization trends, payment issues and payment reform. Through August and September the VBP Workgroup will be involved in the creation of the PPS VBP Plan. This plan will consist of sections speaking to measuring performance, reporting based on analytics and payment reform. The PPS will then begin working collaboratively with the MCOs to operationalize the VBP Plan in 2017.

The VBP Plan will outline the transformation towards payment reform which includes:

- Reducing the overall Medicaid dollars spent on administrative costs
- The advantages of value over volume
- Ensuring reinvestment of prospective savings within the delivery system
- Aligning payment incentives to achieve the aims and goals of DSRIP and population health management

The PPS goal is that by the end of DY 3 at least 10% of total MCO expenditure are captured in VBP Level 1 or above. By the end of DY 4, at least 50% of total MCO expenditure will be contracted by VBP Level 1 or above and at least 50% of total payments contracted through Level 2 VBP or higher (full capitation plans only). By the end of DY 5, 80-90% of total MCO expenditure will have to be captured in at least Level 1 VBP and at least 35% of total payments contracted through Level 2 or higher for fully capitated plans and 15% contracted in Level 2 or higher for not fully capitated plans.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There has not been a change to the population proposed to be served.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 2.b.iv

Transition of Care Program for Inpatient & Observation Units (TOC) (DSRIP Project 2biv)

Challenges the PPS has encountered in project implementation:
Throughout the implementation of Transitions of Care program the SCC has faced many challenges which can be spoken to in the categories below: **Information Technology Challenge:** While using existing EHR systems that do not yet have the ability to capture critical information, such as social determinants of health. **Behavioral Health Challenge:** The pool of high risk patients has increased due to a criteria of 'any behavioral health comorbidity' in the SCC TOC Model. **Health Home Challenge:** Navigating and connecting patients back to their respective Health Homes (HH) has also been a challenge. **TOC Provider & Awareness Challenge:** While meeting with our hospital partners, the SCC learned that the transition of care provider did not have adequate permission to visit their patients prior to discharge. During past meetings, the SCC also learned that staff at partnered hospitals were unaware of efforts surrounding the SCC TOC program and providing 30-day TOC services to the identified patients.
Efforts to mitigate challenges identified above:
The SCC approach to overcome the challenges identified above can be spoken to in the respective categories below: **Information Technology Challenge Approach:** The SCC is avidly working with the Stony Brook Hub Information Technology team and hospital partners are working with their respective EHR vendors and information technology teams to build out and enhance current EHRs to include a social needs screen that will help to further identify the social determinants of health. Thus far, Stony Brook Medicine and John T. Mather have been successful in integrating a social needs screen into their EHR platform. **Behavioral Health Challenge Approach:** Utilizing 30-day services to connect patients with behavioral health providers and also utilizing providers participating in the 3ai project. In an April 2016 Learning Collaborative, Brookhaven Hospital, Stony Brook Medicine, Northwell Health and John T. Mather Hospital participated in an interactive panel discussion with the SBIRT program. This Learning Collaborative was effective in bringing together hospital leadership and behavioral health providers. As spoken to the TOC Model, a patient that presents with a behavioral health co-morbidity is a high-risk for needing 30-day TOC services. This August, the SCC will be holding another Learning Collaborative with the Suffolk County OASAS, behavioral health facilities, community based organization and hospital leadership to discuss access to treatment and issues in Suffolk County. In addition to connecting patients to behavioral health services, the SCC has emphasized scheduling appointments for follow-up prior to patient discharge to our hospital partners.

Health Home Challenge Approach:
To address Health Home patients identification challenge the PPS is working with Health Homes to further identify which patients belong to the PPS for navigation purposes. The PPS has also requested that the NYS DOH grant access to the *Health Home Tracking System (HHTS) Portal* to all Hospitals in Suffolk County, to ensure HH patients can be easily identified and navigated back to the Care Management Agency to which they are assigned.

TOC Provider & Awareness Challenge Approach:
As a way to create supporting documentation for Milestone 4, Metric 1, the SCC hospital partners will be creating and or adopting a procedure that speaks to the TOC provider having access to visit their patients in the hospital prior to discharge and PPS hospital partners internal TOC implementation team will be promoting the TOC program within their respective facility via informational sessions, e-blasts or newsletters.

Implementation approaches that the PPS considers a best practice:

Implementation for this program is HUB-neutral, each provider participating regardless of HUBs has taken the same approach towards implementation and reporting requirements to demonstrate successful completion of the program. Workgroup, committee and stakeholder groups, across this program have appropriate HUB representation.

Throughout the implementation of the Transition of Care program the SCC has been actively engaged in providing resources for hospital partners during the implementation phase.

- The SCC engaged Dr. Amy Boutwell, MD, MPP, a content expert in care transitions. Dr. Boutwell is the co-founder of the STARR (State Action on Avoidable Re-hospitalizations) Initiative for Healthcare Improvement (IHI). Since 2008, Dr. Boutwell has been deeply immersed in the clinical, operational, policy, payment and political aspects of approaches to reduce avoidable re-hospitalizations and improve care transitions. The STARR initiative currently engages over 150 hospitals in four states, over 500 community providers through “cross-continuum teams” and over 75 state-level public and private-sector leadership entities through state steering committee. Dr. Boutwell serves as a senior physician consultant to the National Coordinating Center for the CMS QIO Care Transitions theme and is thus engaged in community-based care transitions mobilization efforts in all 50 states. Additionally, Dr. Boutwell is co-leading an AHRQ-funded effort to test and adapt best practices to improve transition to ensure applicability to the Medicaid/safety-net population. Dr. Boutwell was engaged by the SCC in October 2015 to work with the TOC/OBS Committee beginning December 2015 through March of 2016 to create the SCC Transition of Care (TOC) Model. The TOC/OBS Committee is composed of stakeholders not only from the SCC partnering hospitals across the three HUBs but stakeholders from Skilled Nursing Facilities, pharmacies, health homes, community-based organizations and social service organizations. Dr. Boutwell was successful in her engagement with the TOC/OBS Committee as the TOC Model was approved by the TOC/OBS Committee, reviewed by the Project 2ai Workgroup and approved by the SCC Board of Directors in March of 2016.

- The SCC has created an implementation plan which speaks to the necessary tasks that should be fulfilled for the completion of this project.
    - The implementation plan consists of 6 work breakdown structure (WBS) sections. Each section is a focus point during monthly meetings with the Facility Champions (see below) and speaks to documentation that needs to be provided prior to completion of the TOC project in 3/31/2017. Some elements of the WBS include creating an internal TOC Implementation Team (see below), training hospital involved staff on the Transition of Care Model, enhancing current IT/EMR requirements to meet the NYS DOH project requirements and creating partnerships with social services, health homes and home care agencies.
    - The SCC has provisioned the creation of hospital led implementation teams, composed of hospital leadership, emergency administration personnel, information technology personnel, care management personnel, social work personnel and behavioral health personnel. The purpose of this hospital-driven implementation team is to oversee and champion the implementation of the Transitions of Care program. They will also hold other responsibilities associated with monitoring performance, gather data for patient engagement reporting, identifying risks and evaluating lessons learned for their facility.

- SCC has also participates in GNYHA's Post-Acute Care Workgroup where PPSs participating in Project 2biv share lessons learned. Most recently, the SCC attended GNYHA's workgroup on Improving Care Transitions and Reducing Inappropriate Readmissions we participated in brainstorming a communication method between Skilled Nursing Facilities and Hospitals, creating collaboration between Project 2biv and 2bvii. The SCC's approach to increasing communication between these facilities is described below in an upcoming Learning Collaborative that will be held in September.

- SCC has continued to build and strengthen our relationships with hospital Facility Champions. The Project Manager of Integrated Care has monthly one-on-one calls with each Facility Champion prior to the monthly Workgroup or Committee meetings to keep them engaged and encourage continued collaboration. The SCC has also been visiting our hospital partners on site to further engage with the Facility Champion and their care coordination team.

- The SCC is also looking to bridge the gap between hospitals and skilled nursing facilities by holding a Learning Collaborative to increase communication between these stakeholders in September 2016. The Learning Collaborative approach focuses on spreading, adopting and adapting best practices across multiple settings and introducing opportunities in organizations that promote the delivery and implementation of effective programs. The SCC Learning Collaboratives are shared-learning sessions with topics designed specifically for organizations participating directly or indirectly in the DSRIP programs. The goal of the learning collaborative is to create a community of knowledge that can help participants accelerate program implementation, systematic change and make lasting breakthroughs that meets or exceeds program expectations. The Learning Collaborative is just an example of one approach the SCC is taking on to foster a shared-learning environment.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The SCC has recently welcomed Jennifer Kennedy, RN, BSN, MS as the Director of Care Transitions Innovation. Jennifer brings years of experience in healthcare as a clinician and previous experience as the Director of Integrated Care & Clinical Operations. Jennifer joins the SCC from National Healthcare Associates, Inc. where she led clinical care redesign strategy to move her organization towards value-based payment reform, participation in bundle payment initiatives and created ACO partnerships. She also led and motivated a clinical integration team to facilitate an integrated approach to care delivery with acute care providers. Jennifer's role with the SCC includes supporting and helping grow the TOC and INTERACT projects into sustainable programs and working with the Facility Champions as a "coach"/support system.

The SCC has recently engaged with the American Academy of Ambulatory Care Nursing regarding their Care Coordination & Transition Management-RN (CCTM-RN) certification program. This certification was developed in conjunction with the Medical-Surgical Nursing Certification Board (MSNCB) and the exam is also administered by the (MSNCB). This program will be kicked off in August 2016 as a train the trainer approach to all hospital partners. The CCTM-RN certification consists of 13 modules across varying domains, such as Communication and Transition Throughout the Care Continuum through Utilizing Informatics and Telehealth to create best practices. The SCC will be providing 25 RNs across the 11 hospital partners with opportunities in obtaining their CCTM-RN. Jennifer Kennedy, Director of Care Transitions Innovation, will be facilitating the module trainings and holding review sessions prior to the examination. The CCTM-RN modules and certification will help in understanding the fragmented health care system through individualized patient-centered assessment and care planning across setting, providers and levels of care. The CCTM certification validates the unique knowledge, skills, and abilities of the RN in care coordination in ambulatory, acute, community and other care settings.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There has not been a change to the population proposed to be served.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 2.b.vii

Interventions to Reduce Acute Care Transfer Program (DSRIP Project 2bvii)

Challenges the PPS has encountered in project implementation:

- **Information Technology Challenge:** Some SNFs do not have an EHR, while others are using existing EHR systems that do not yet have the ability to capture critical information, or connect meaningfully with the RHIO.
- **Meaningful Use Stage 2 EHR:** None of the 44 SNFs have an EHR vendor that is meaningfully use certified.
- **Turn-over Rate:** We're finding a higher than average turn-over rate of key clinical nurse leadership roles at participating SNFs
- **SNF Resources:** Due to challenges of the current health care reimbursement system, SNFs are lean and many staff have multiple hats. With the addition of many of the DSRIP requirements and timelines, SNFs who are on the smaller size do have a hard time keeping up with reporting requirements, such as the Patient Engagement quarterly report.

Efforts to mitigate challenges identified above:

The SCC approach to overcome the challenges identified above can be spoken to in the respective categories below:

Information Technology Challenge Approach:
The SCC is avidly working with the Stony Brook Hub Information Technology team and the SCC RHIO workgroup to define the specifications for RHIO connectivity for SNFs data. In addition, we've defined meaningful bi-directional secure messaging through the RHIO portal for clinical users, which we intend on providing SNFs during RHIO on-boarding accesses to the RHIO's portal. In addition, with the promotion of the use of the CCDA, we envision this as an effective tool to support transitions of care and communication from the acute to post-acute provider network.

Meaningful Use Stage 2 EHR: This requirement has been removed by the NYS DOH and has been removed from the scope of work of the Program at the SCC.

Turn-over Rate: We're brainstorming with our new Director for Care Transition Innovation, who will also be acting as the programs "coach" to build new and exciting opportunities to engage staff in the program. One example our new Director has used in the past was a "INTERACT Jeopardy" for clinical staff engagement.

SNF Resources: Once the SNF completes technical on-boarding and their data is ingested as part of our Clinical Data Sharing Roadmap, we envision being able to relive SNFs from manually reporting Patient Engagement data quarterly, the PPS should be able to run the report through the new enterprise data warehouse.

Implementation approaches that the PPS considers a best practice:

Implementation for this program is HUB-neutral, each provider participating regardless of HUBs has taken the same approach towards implementation and reporting requirements to demonstrate successful completion of the program. Workgroup, committee and stakeholder groups, across this program have appropriate HUB representation.

Alignment to NY-RAH Program

During the DSRIP Application, Planning and now into Program Implementation the SCC has continued to engage and align with New York Reducing Avoidable Hospitalizations (NY-RAH) Program, an INTERACT-based program which has been deployed in 30 skilled nursing facilities in New York City and Long Island. Ten of the 40+ SNFs participating in the DSRIP Project 2bvii – INTERACT had been participants of the NY-RAH program since 2013. The Registered Nurse Care Coordinators (RNCCs), acting as coaches and quality improvement consultants, focusing on increasing the capacity of each facility to review its processes, identify root causes for preventable hospitalizations, and modify protocols as necessary by engaging staff at all levels. Tools from Interventions to Reduce Acute Care Transfers (INTERACT) are implemented along with a high priority on implementing advance care planning and palliative care resources available from INTERACT and other sources. The RNCCs will also help facilitate implementation of electronic solutions to improve transitions. We've continued to learn and engage the NY-RAH team, including Tim Johnson, Executive Director at GNYHA Foundation and administrator of the program to share best practices and learn from one-another.

Project Leadership

Project Leads, Dianne Zambori, Associate Executive Director for Eastern Region, Quality Initiatives, Northwell Health and Bob Heppenheimer, Executive Director for Nesconset Center for Nursing and Rehabilitation and Hilaire Rehabilitation & Nursing, are the two project leads for the Suffolk County INTERACT implementation program. Both leads have been engaged since the DSRIP application phase and are instrumental in bridging relationships with our post-acute care partners' across the PPS-network.

Train the Trainer Model Quick Start – November 2015

The SCC started planning for an INTERACT™ Champion Certification Program when the program commenced on April 1 of 2015, keeping in mind the program is due 3/31/2017. Once all SNFs were engaged and had identified their facility champion and optional co-champion, by early November, the SCC's Clinical Project Manager, managing SCC's INTERACT™ Program, held the first **Certified INTERACT™ Champion (CIC) Training** Program on-site at Stony Brook Medicine. There were 40 Skilled Nursing Facilities (SNFs) that participated. Participation provided trainees with new or improved competencies in the INTERACT™ principals as well as prepared the participants for the INTERACT™ certification exam; established by INTERACT T.E.A.M. Strategies, LLC. By December of 2016, we congratulated eighty staff members, who had passed the exam and are now certified. All trainees are now leading INTERACT™ implementation at their SNFs as "Facility Champions." Here is the list of SNFs with CIC's to date:

1. *Affinity Skilled Living*
2. *Apex Rehabilitation and Care*
3. *Bellhaven Center for Nursing and Rehabilitation*
4. *Berkshire Nursing Center*
5. *Vincent Bove Health Center at Jefferson's Ferry*
6. *Broadlawn Manor Nursing and Rehabilitation Center*
7. *Brookhaven Rehabilitation & Health Care Center*
8. *Carillon Nursing and Rehabilitation Center LLC*
9. *Daleview Care Center*
10. *East Neck Nursing and Rehabilitation Center*
11. *Good Samaritan Nursing Home*
12. *Gurwin Jewish Nursing & Rehabilitation Center*
13. *Hilaire Rehabilitation and Nursing*
14. *Huntington Hills Center for Health and Rehabilitation*
15. *Island Nursing and Rehabilitation Center*
16. *Lakeview Rehabilitation and Care Center*
17. *Long Island State Veterans Home*
18. *Maria Regina Residence*
19. *Mills Pond Nursing and Rehabilitation Center*
20. *Momentum at South Bay for Rehabilitation and Nursing*
21. *Nesconset Center for Nursing and Rehabilitation*
22. *Oak Hollow Nursing Center*
23. *Our Lady of Consolation Nursing & Rehabilitative Care Center*
24. *Peconic Bay Skilled Nursing and Rehabilitation Center*
25. *Peconic Landing at Southhold*
26. *Riverhead Care Center*
27. *Ross Center for Health and Rehabilitation*
28. *San Simeon by the Sound Center for Nursing and Rehabilitation*
29. *Sayville Nursing and Rehabilitation Center*
30. *Smithtown Center for Rehabilitation and Nursing*
31. *St. Catherine of Siena Nursing and Rehabilitation Care Center*
32. *St. Johnland Nursing Center*
33. *St. James Rehabilitation and Health Care Center*
34. *Suffolk Center for Rehabilitation and Nursing*
35. *Sunrise Manor Center for Nursing*
36. *The Hamptons Center for Rehabilitation and Nursing*
37. *Water's Edge at Port Jefferson for Rehabilitation and Nursing*
38. *Westhampton Care Center*
39. *White Oaks Nursing Home*
40. *Woodhaven Center of Care*

Facility Champion & Qualifications Recommendations

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 2.b.ix

Transition of Care Program for Inpatient & Observation Units (TOC) (DSRIP Project 2bix)

Challenges the PPS has encountered in project implementation:

Throughout the implementation of the Observation Unit program the SCC has faced many challenges such as hospital partners underutilizing their observation units, understaffing of the observation unit, patients being admitted into inpatient status after a few hours in the observation unit and continuity of care post discharge from the observation unit.

We've also realized though forecasting activities the challenges in meeting future years DSRIP Project 2bix Domain 1 Patient Engagement commitments. Based on current OBS unit utilization trends, including an improvement factor though the implementation of this program, the current patient engagement targets may be unattainable and were mistakenly over-forecasted when the DSRIP application was written.

Efforts to mitigate challenges identified above:

The SCC approach to overcome the challenges identified above are working with hospital partners in providing resources that will help them better utilize their observation unit. SCC hospital partners have been advised to refer to **Chapter 6 of the Medicare Benefit Policy Manual** for guidance on when observation services should be ordered for patients. Through an exercise being facilitated by the SCC entitled the ***SCC OBS Opportunity Assessment with Clinical & Financial Model*****,** hospital partners will identify their current baseline as it pertains to staff and a narrative that speaks to closing the staffing gap. This document will be completed on an annual basis.

The SCC will address continuity of care via the Transitions of Care Model under Project 2biv, which speaks to identified high risk patients upon admission into an observation unit or an inpatient floor receiving 30-day TOC services upon discharge. A patient that is admitted to an inpatient floor or observation unit will be identified for transition of care services via any or all of the following high-risk criteria:

- Readmitted within 30-days of a previous hospitalization;
- History of 3 or more hospitalizations (inpatient or observation) in the past 12 months;
- Any behavioral health comorbidity;
- Unmet social needs, as identified via a social needs screen at or within 24 hours of admission

Care coordination services post-discharge from the observation unit is clearly defined in the Transition of Care Model for patients that are identified as high risk utilizing the above criteria. The 30-day transition of care service will commence on the day of discharge and the transition of care provider will follow the patient for the 30-day time period while providing timely updates to the patient's primary care provider.

Implementation approaches that the PPS considers a best practice:

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Implementation for this program is HUB-neutral, each provider participating regardless of HUBs has taken the same approach towards implementation and reporting requirements to demonstrate successful completion of the program. Workgroup, committee and stakeholder groups, across this program have appropriate HUB representation.

The SCC has focused on continuing to build and strengthen relationships with our hospital Facility Champions. The SCC has increased engagement and buy-in via monthly implementation meetings with all hospital partners'. These meetings focus on best utilization of the observation room, how to best identify patients that would benefit from observation room admission, the CMS guidelines that surround usage of the observation unit, how data gathering from the observation unit can help improve overall emergency department use and flow and the benefit of streamlining services. The overall goal of engaging with our hospital partners' through monthly implementation meetings is to help them identify risks and gaps in current care coordination and post-discharge care coordination. The SCC has also found that helping our hospital partners' work through their issue/risk log together has improved the communication lines.

In addition, the SCC has created an *OBS Opportunity Assessment with Clinical & Financial Model*, which was distributed to all Facility Champions in the TOC/OBS June Workgroup meeting. The Facility Champions have been tasked with engaging their Emergency Department leadership, who are also on the implementation team, in filling out this document. In this document the hospitals will identify the targeted population and challenges this population faced prior to the implementation of observation units as well as three goals they wish to accomplish throughout the lifetime of the project. This document will help the hospitals understand their current resources, such as the number of beds needed in the observation unit, the type of observation unit that will be used (scattered or dedicated), staffing, funding, care coordination protocols between multiple services and how they will effectively use and measure their outcomes. Hospital partners will reassess their observation units during an annual review period with the SCC. The annual review period will help hospitals understand the benefit of having and properly utilizing the OBS unit as well as empower the implementation team to further understand their gaps and form processes for gap to goal.

Within the past year, the OBS project has grown from a project that was engaging stakeholders to learn about current practices into a sustainable program that will be built upon in the years to become specific to each hospital partner and their oversight of the program implementation.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The SCC has provisioned the creation of hospital led implementation teams, composed of hospital leadership, emergency administration personnel, information technology personnel, care management personnel, social work personnel and behavioral health personnel. The purpose of this hospital-driven implementation team is to oversee and champion the implementation of the Observation Unit program. The implementation team will thus further be in charge of choosing a scattered or dedicated bed approach within close proximity to the Emergency Dept., assessing the number of beds that are needed for the observation unit, making available the appropriate number of staff is trained to work in the observation unit and creating care coordination protocols dependent of patient status. They will also hold other responsibilities associated with monitoring performance, gather data for patient engagement reporting, identifying risks and evaluating lessons learned for their facility.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There has not been a change to the population proposed to be served.

The Project Workgroup, representative of all facility champions early on made the decision to recommend and do their best to enforce that each Facility Champion at each SNF should be whomever is filling the role of Director of Nursing (DON). To date almost 100% of the SNFs have followed this recommendation. In addition, the group decided to also recommend each SNF name a co-Facility Champion in addition to the Facility Champion to ensure that there is continuous coverage for this role.

"Learning Collaboratives"
The INTERACT stakeholders are engaged at a minimum quarterly in the form of Learning Collaboratives. The Learning Collaborative approach focuses on spreading, adopting and adapting best practices across multiple settings and introducing opportunities in organizations that promote the delivery and implementation of effective programs. The SCC Learning Collaboratives are shared-learning sessions with topics designed specifically for organizations participating directly or indirectly in the DSRIP programs. The goal of the learning collaborative is to create a community of knowledge that can help participants accelerate program implementation, systematic change and make lasting breakthroughs that meets or exceeds program expectations. The Learning Collaborative is just an example of one approach the SCC is taking on to foster a shared-learning environment. Beginning September, the SCC is looking to bridge the gap between hospitals and skilled nursing facilities by holding a Learning Collaborative to increase communication between these stakeholders participating in the Hospital DSRIP 2biv Project and SNFs participating in the DSRIP 2bvii Project.

Coaching Model – Director, Care Transition Innovations
The SCC has recently welcomed Jennifer Kennedy, RN, BSN, MS as the Director of Care Transitions Innovation. Jennifer brings years of experience in healthcare as a clinician and previous experience as the Director of Integrated Care & Clinical Operations. Jennifer joins the SCC from National Healthcare Associates, Inc. where she led clinical care redesign strategy to move her organization towards value-based payment reform, participation in bundle payment initiatives and created ACO partnerships. She has also implemented INTERACT practices in over 30 facilities. Further, Jennifer has led and motivated a clinical integration team to facilitate an integrated approach to care delivery with acute care providers. Jennifer's role with the SCC includes supporting and helping grow the TOC and INTERACT projects into sustainable programs and working with the Facility Champions as a "coach"/support system.

INTERACT Implementation Plan & Supporting Implementation Toolkit
The SCC has created an implementation plan which speaks to the necessary tasks that should be fulfilled for the completion of this project. The implementation plan consists of steps for the SNF to "check off" as they move through design, training, planning, implementation and monitoring of the INTERACT 4.0 Toolkit. In addition, sections of the plan are focus points during monthly Project Workgroup meetings with the Facility Champions. Some elements of the WBS include creating an internal INTERACT Implementation Team (see below), training requirements, quality assurance requirements, advanced care planning elements. A supporting toolkit has been written to include all reference documents and forms that the SNF must complete and return to the SCC to demonstrate successful completion of the INTERACT program.

SNF-Based Implementation Teams
The SCC has provisioned the creation of SNF-based INTERACT implementation teams, recommended composition includes leadership, medal staff, community-based physicians, nursing, nurse educators, quality improvement staff, information technology personnel, case management personnel, social work personnel and behavioral health personnel. The purpose of this implementation team is to oversee and champion the implementation of the INTERACT program. They will also hold other responsibilities associated with monitoring performance, gather data for patient engagement reporting, identifying risks and evaluating lessons learned for their facility.

Participation in the GNYHA's Post-Acute Care Workgroup
SCC has also participates in GNYHA's Post-Acute Care Workgroup where PPSs participating in Project 2bvii share lessons learned. Most recently, the SCC attended GNYHA's workgroup on Improving Care Transitions and Reducing Inappropriate Readmissions we participated in brainstorming a communication method between Skilled Nursing Facilities and Hospitals, creating collaboration between Project 2biv and 2bvii.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

- On October 15th, the Suffolk Care Collaborative co-hosted a meeting alongside the Nassau Queens PPS at an Intercounty Health Facilities Association, Inc meeting, the Long Island Intercounty Health Facilities Association is a collection of over 60 long term nursing care or short term rehabilitation facilities in Nassau and Suffolk County and care for over 15,000 residents and patients. About 60 Skilled Nursing Facilities (SNFs) were represented at our presentation. The SCC presentation objectives included the following: reviewing the INTERACT ™ 4.0 Toolkit, provided a project 2bvii overview, shared our data collection strategies & instructions, announced our Certified INTERACT ™ Training Program, and answered questions from SNF PPS partners.
- Late-2015, National Health Care Associates hosted an event entitled Improving Long-Term and Post-Acute Care By Reducing Unnecessary Hospitalizations where **Dr. Joseph G. Ouslander M.D., Project Director for INTERACT ™** QIP and Professor and Associate Dean of Florida Atlantic University in Boca Raton Florida, was the key note speaker on Long Island, NY. Dr. Ouslander presented the INTERACT™ Quality Improvement Program to reduce unnecessary hospitalizations as well as strategies for efficient and effective implementation. Many of our partner SNFs were in attendance and as well as some of our project team members. This provided our project team an exciting opportunity to learn more about the INTERACT ™ QIP first-hand from Dr. Ouslander, the creator of the intervention program.
- Late-2015, the SCC's Clinical Governance Committee reviewed and recommended the INTERACT ™ Program Clinical Guidelines Summary to the PPS Board of Directors, scheduled for December 21, 2015, which was thereafter approved.
- In January of 2016, **Dr. Joseph G. Ouslander, M.D., Project Director for INTERACT ™** QIP and Professor and Associate Dean of Florida Atlantic University in Boca Raton Florida, presented as the key note speaker at an event titled "Successfully Implementing the INTERACT DSRIP Projects," at the NYU Kimmel Center. The SCC was invited/selected by Dr. Joseph G. Ouslander to speak during this program on strategies for implementation, the SCC's approach for designing implementation, defining roles and responsibilities of key project stakeholders while following the DSRIP requirements. The SCC's Project Manager for the program also included our experience and approach towards facilitating the Certified INTERACT Champion Training Program for the PPS.
- Just recently, the SCC initiated a training effort for members of all Project Committees across the portfolio of DSRIP programs; the topic is *Performance Reporting & Improvement Plan*, where Kevin Bozza, Sr. Director for Network Development & Performance Trained our SNFs on the SCC's PI Plan, Reporting and Monitoring Structure and shared our DSRIP Project 2bvii Measurement Year 1 Scorecard. This presentation is also available on our Learning Center.
- The SCC has aligned our Advance Care Planning goals with that of IPRO, the Medicare Quality Improvement Organization for NYS who has launched a CMS Special Innovation Project focusing on adoption of a community based approach to Advance Care Planning in the Nassau and Suffolk county region. The INTERACT Project Committee and DNS Workgroup has recommended that SNFs participating in the DSRIP INTERACT Program implement MOLST or eMOLST as part of the Advance Care Planning scope of work of the project. IPRO has been engaged to build strategies on implementation assistance and support in the implementation of MOLST or eMOLST. They also provide resources and updates from the State-wide MOLST Implementation Team, currently designing an open online course for MOLST Basics and MOLST Toolkits. To date, we've engaged Carolyn Kazdan, Quality Improvement Specialist at IPRO, Medicare Quality Improvement Organization for NYS to roll-out a SCC SNF Training/Learning Experience that was held earlier this year, our participating SNFs attended to learn about MOLST and implementation strategies. Next up, we're planning for IPRO to return in October of 2016 to provide another learning experience targeting our INTERACT Facility Champions as well as SNF Medical Directors in Advance Care Planning strategies of eMOLST implementation. Patricia Bomba, MD, FACP, Vice President & Medical Director, Geriatrics, Excellus BlueCross BlueShield & MedAmerica Insurance Company, Chair, MOLST Statewide Implementation Team & eMOLST Program Director and Chair, National Healthcare Decisions Day NYS Coalition is engaged in all activities, Dr. Bomba brings a wealth of resources and subject-matter expertise to our Suffolk County-based efforts.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

N/A

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each
section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 2.d.i

Community Health Activation Program (CHAP) (DSRIP Project 2di)

Challenges the PPS has encountered in project implementation:
1) The difficulty of activating and engaging the UI, LU and NU populations cannot be understated. It requires extensive coordination and communication across the system, and dedication to all aspects of Outreach & Assessment, Community Navigation, and Wellness Coaching (when applicable) designed to meet DSRIP requirements. 2) Inadequacy of existing digital tools designed for documenting and reporting program activities, including Community Navigation and Wellness Coaching 3) MCO responsiveness to project engagement is in its early stages and has been limited to date. 4) As a consequence of the lack of data available currently for the LU/NU populations, the PPS has limited outreach efforts exclusively to the UI population, which affords its own set of challenges and barriers, including the difficulty of locating the UI population to resurvey for consecutive DYs after the initial baseline year. 5) The SCC had originally faced the challenge of increasing a patient's activation level in order to meet Domain 2 Performance metrics.
Efforts to mitigate challenges identified above:
1) The **Community Health Activation Program** has been created to address all aspects of the 2di project, including: a. **Outreach & Assessment**: The PPS has engaged key project stakeholders to initiate "hot spot" analysis and determine data sources available to support Community Outreach/Navigation Program Development. In conjunction with the Stony Brook University Hospital Biomedical Informatics team, the PPS has developed hot-spot maps to support the strategy for contracted/engaged CBOs and their respective trained Community Health Workers (CHWs) for fieldwork. These maps have been shared with the CBOs to identify specific locations where the program can be delivered within these "hot spot" areas (e.g. food pantries, shelters, etc.) CHWs, are trained in the use of PAM and the appropriate follow-up for individuals based on their PAM score. b. **Community Navigation**: The PPS has built, and continues to develop, community navigation resources and partnerships to connect individuals to primary care, BH, access to health care/enrollment, health home or social service agencies resources. Additional information on Community Navigation is provided in the next section. c. **Wellness Coaching**: Wellness Coaching, defined as a function of the Community Navigation Program, integrates the use of the Insignia Health® Coaching for Activation® (CFA) platform, as well as the inclusion of soft skills such as motivational interviewing. 2) The PPS has been working with the healthcare technology company CipherHealth to develop an online platform for documenting and reporting Navigation and Wellness Coaching activities. The platform includes: a. Patient Info Page: Patient demographic and contact information b. User Status: i. PAM only – "Outreach" 1. A CHW working in the field determines the status of the user based on three categories. The first category, "PAM only", indicates that the individual is either not appropriate for, or interested in, further engagement in the program. This is considered the "Outreach Level", and the user does not have to continue to the consent form.

ii. Navigate – "Enrolled"
    1. If the CHW selects "Navigate" the user has been identified as appropriate to receive Navigation services, in addition to the PAM survey, which will 'enroll' the user in the program and the CHW will proceed to the consent page.
iii. Coaching – "Enrolled"
    1. If the CHW selects "Coaching" the user has been identified to receive Coaching, Navigation and the PAM survey, and will also be formally enrolled. By selecting coaching, the program will automatically generate an email to the CHW's supervisor within their Community Based Organization to assign a coach to that user. The CHW proceeds to the Consent page.

c. Patient Consent Form: A statement of privacy protection and consent to participate in the CHAP program via an online consent/e-signature application
d. Patient Panel: Documentation of Wellness Coaching Activities, as appropriate
e. Navigation Referral Form: The Navigation Form may be used by the CHW following the completion of a PAM survey, or by a Wellness Coach following a coaching session
    i. The purpose of the Navigation Form is to document and track navigation of users to health and/or social services within the PPS, in accordance with DOH Domain 1 DSRIP project requirements.
    ii. A CHW/Coach may select from the following drop down menu, may select multiple, but must select at least one:
        1. Connect to PCP
        2. Connect to Health Insurance
        3. Connect to Behavioral Health Provider
        4. Connect to Coach (internal referral)
        5. Connect to Social Services
        6. Connect to Other SCC DSRIP Programs
        7. Diabetes Wellness & Self-Management Program (DWSP)
        8. Promoting Asthma Self-Management Program (PASP)
        9. Cardiovascular Wellness & Self-Management Program (CDWSP)
        10. Connect to Health Home
        11. Selecting any field will auto prompt email/assign task to CHW/Coach to do follow-up
    iii. Reports can be generated to track all Navigation activities by Individual, Type (ex PCP, BH...), Dates, etc.
    iv. Additionally, the Navigation Referral Form has a space for notes where a Navigator or Coach may enter information pertaining to the nature of the referral (how it was done, who referred to, for what purpose, etc.)

3) Efforts to address MCO participation has been a high priority during implementation planning. To date, we have received Low-Utilizer data from Healthfirst through Stony Brook Medicine's provider organization. Next we're drafting an information exchange agreement we'll plan to extend to all MCOs to formalize this relationship.
4) The project Workgroup has made efforts to strategize best practices for locating individuals to resurvey after the initial baseline year, including taking extensive records of contact information. However, this still remains a challenge.
5) The SCC has learned that there has been a consideration at the Federal and State levels to change the Performance metric from an increase in PAM Level to an increase in a PAM score for an individual. This would seem to fit with the expectations of Insignia to increase a patient's activation measure.

Implementation approaches that the PPS considers a best practice:

Our multi-disciplinary teams for this project, rebranded the **Community Health Activation Program (CHAP)** by the SCC, are working to a comprehensive activation program within the PPS and tailor navigation and coaching efforts to address the unique challenges faced by each patient. The program is a CBO-led effort, all project requirements are being implemented by the PPS lead with contributions being made in program design, implementation and monitoring across all 3 HUBs. In addition:

- Internal stakeholders, including the Project Lead, Gwen O'Shea, President and CEO of the Health and Welfare Council of Long Island, and Board member that represents patient advocacy on our PPS Board of Directors were engaged to determine program protocols, policies and procedures to develop the CHAP Training Curriculum.

- A CHAP Project Workgroup has been formed composed of subject matter experts engaged to support the development, execution and monitoring of project milestones. The Workgroup is involved in the development of the CHAP program, and has met on a biweekly basis since August 2015.
- The PASP Project Committee is composed of key internal and external project stakeholders, including representation from MCOs, key community and public service and governmental agencies engaged to support the conclusions, deliverables and monitor system impacts of the DSRIP Program, as they relate to Project 3dii.

The CHAP Workgroup has developed the Community Health Activation Program (CHAP) designed to integrate the community navigation program requirements across the DSRIP portfolio into the CHAP. At any point of an interaction with our attributed population, a need may be identified based on the following categories: access to health insurance, socioeconomic needs, behavioral health, substance abuse, medical services, health home or HARP eligibility, PCP navigation for existing Medicaid patients. The Community Navigation training program and directory provides an avenue to facilitate a referral based on an identified need. Requirements of community navigation services for our attributed population includes all DSRIP projects. Referrals can be made to the Community Navigation Program OR workflow can include the individual engaged with patient can be trained to use the Community Navigation Program Directory to facilitate navigation.

The CHAP model design includes centralized functions/procedures such as:

- Financing & Administration
- Promotional/Communication Tools
- Training Materials
- Program Development Opportunities
- Community Navigation Network Tool (SCC webpage)
- Information Technology Documentation Tools for Wellness Coaching & Surveying
- Reporting Procedure

And decentralized functions/procedures, including:

- Staffing/Training/On-boarding
- Wellness Coaches
- Community Health Workers (Surveys)
- Operational procedures/handoffs

Additionally, CBO's contracted for CHAP may be engaged for all or any one of the following CHAP functions:

1. PAM Surveying (In-reach or Outreach model)
2. Community Navigation
3. Wellness Coaching
4. Training

The PPS is supporting a CBO-led in-reach and outreach program to identify, engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care. Participating in this project are 4 PPS CBO partners. The CBOs have demonstrated experience in successful outreach to the target population by identifying hot-spot locations and establishing partnerships with local Departments of Social Services, libraries, food pantries, etc., across the County to identify individuals, and provide their services in a culturally competent manner. Building upon these resources, the PPS has expanded and enhanced the CHW, Community Navigator, and Wellness Coaching staff, building on the current capacity of CBOs to reach more deeply into the target population.

As navigators identify and assess UI, LU and NU individuals on the PAM scale, the approach and appropriate level of follow-up is determined. Navigators ensure that those individuals who score at the higher levels of activation (3 or 4) are linked to a PCP or appropriate healthcare resource. Additionally, uninsured individuals will be connected to appropriate insurance products to improve the financial accessibility of care. Those who score at 1 or 2 continue with wellness coaching and may be linked to care management and primary care. For individuals without PCPs, they are linked with primary care resources based on geography, cultural match, and financial accessibility. CHWs and Navigators reassess individuals using PAM on a semi- annual basis to determine changes in activation and engagement.

Wellness Coaches, trained in the Coaching for Activation method, work with individuals to build awareness of the importance of prevention and early intervention among uninsured and LU/NU Medicaid recipients, and increase their confidence in using and managing their care.

Beneficiaries Join CHAP Discussions

In March 2016, the CHAP Workgroup was pleased to welcome three CHAP participants from the community to join a discussion about program development. Brian Cintron, and his care-taker Daniel Espinal, and Wendy Caruana, are currently involved in the CHAP program. They have had first-hand experience with the services we offer, including the PAM survey as well as Community Navigation. The Workgroup asked them to join the meeting to learn more about the specific challenges they face in obtaining health and/or social services, how they came to be involved in our program, and learn how we may continue to evolve our program to better meet the needs of the community.

At the meeting, our discussion centered on the challenges our guests face when seeking health or social services in the local community. The issue of locating services in the area, and who to contact for information was identified as a major challenge. Eligibility and the question of health care costs was also a concern. Additionally, long wait times and not always knowing what questions to ask were brought up as barriers to access.

While there are clearly many obstacles still left to overcome, all three of our guests noted that their situation was improved through their involvement in CHAP. Wendy, who was previously uninsured before participating in the program, is now a Medicaid beneficiary, and has been navigated to providers and services by Community Health Workers in her area. Danny, who oversees care for his friend Brian, said he has a much clearer picture now of the services Brian is eligible for and how to attain those services. In the brief two months that he has been engaging in CHAP with Brian, he feels his friend's situation has improved and that he is better able to help Brian manage his care.

The SCC thanks our CBO partners, the Economic Opportunity Council, Hudson River Healthcare and the Mental Health and Wellness Association, for leading and facilitating these discussions. The SCC plans to continue to engage Wendy, Brian and Daniel, and others, as we look for new and additional ways to improve the program, and to receive feedback from people that CHAP is serving throughout Suffolk County.

Community Health Assessment Survey

The SCC has partnered with the Long Island Health Collaborative (LIHC) to conduct a health assessment survey for Medicaid recipients and Uninsured residents of Suffolk County. Survey results will be used to help target health needs of individual communities and develop a plan for designing programs to address these needs. The SCC is conducting the survey in collaboration with our partner organizations, including Nassau Suffolk Hospital Council (NSHC) open enrollment HUBs across the county to locate our target population.

Identifying and navigating non-utilizing Medicaid members with an unassigned MCO PCP

The SCC created a workgroup to analyze various Medicaid member data sets and develop strategies for targeted outreach that will yield meaningful impact in improving the health of the population. An initial analysis has identified a cohort of 22,329 Medicaid members with no claims and are not assigned to an MCO PCP. This cohort of Medicaid beneficiaries are not benefiting from the utilization of primary care services. The CHAP program is working closely with this workgroup to engage and navigate the identified Medicaid cohort to a PCP for a primary care wellness visit.

Participation in Greater New York Hospital Association (GNYHA) Project 2di Workgroup

GNYHA has organized a quarterly Workgroup of all PPS' that have selected Project 2di. Amy Solar-Greco, 2di Project Manager, presented the SCC CHAP model at the first meeting of the Workgroup, and has attended each subsequent meeting to learn program updates and communicate with contacts and project stakeholders from around New York State.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

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Project Implementation Accomplishments to Date

- Identified beneficiaries to attend Project Workgroup discussions to support strategies to further enhance program operations.
- SCC has met and exceeded patient engagement targets each quarter
- The PPS has developed a Grievance Procedure for Medicaid recipients and project participants to report complaints and receive customer service. The SCC anticipates meeting the needs of its coalition partners, employees and patients in a timely, reasonable and consistent manner. In any instance where there is a concern coalition partners, employees or patients (and/or their immediate family or personal representatives) have the right to submit a complaint, verbally or in writing, 24 hours per day. SCC has adopted the process to help with any complaints or grievances related to experience with the SCC.
- The PPS has developed standard procedures to support the CHAP program, including:
    - SCC CHAP Training Procedure
    - SCC CHAP Reporting Procedure
    - SCC CHAP General Operations Procedure

  These procedures outline the specific requirements for partners engaged in the CHAP programs, and defines any documents or data sources that are expected for submission.

Next Steps in Project Implementation

- We plan to continue working with partner CBO's and identifying new CBO partnerships for program.
- Continue to baseline and evaluate survey data to support strategies for performance improvement.
- Implementing a training strategy to reach 350 PAM Providers by 3/31/2017

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

N/A

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 3.a.i

Integration of Primary Care and Behavioral Health Services (DSRIP Project 3ai)

Challenges the PPS has encountered in project implementation:
There are infrastructure, provider, patient, and regulatory challenges with the 3ai project. The infrastructure challenges include: • Hire more BH staff, existing staff must adjust to the new model • Limited behavioral health workforce in Suffolk County • Agencies may not be able to meet the demand as additional people in need are identified • The demand for care management outstrips the supply Provider challenges include: • Struggling with PCMH standards • PCPs lack understanding of antidepressant medication management, documentation, and treatment of behavioral health conditions Patient challenges include • Language, health literacy, and cultural competency barriers • Food/ housing issues for the target population • Transportation and health care access challenges Regulatory Challenges • OMH, DOH, OASAS policy and licensure restrictions
Efforts to mitigate challenges identified above:
The benefits of integrating behavioral health and primary care services are great. In doing so we are better positioned to identify behavioral health diagnoses early, ensuring rapid treatment, are able to ensure that treatment for medical and behavioral health conditions are aligned with one another, and will help to destigmatize behavioral health treatment for those we serve. While we are aware that there are hurdles to implementing this project, such as a limited behavioral health workforce in Suffolk County, restrictions in current OMH/DOH policies and licensures, limitations in reimbursement and the need for a great deal of time and technical assistance to roll this out, we also know that the benefits outweigh these constraints. • By working with the Stony Brook University's academic programs we will be able to train our future workforce to be prepared to practice in a manner that best cares for our patients. We are engaging with the University Deans to begin to introduce the SCC's Integrated Care curriculum that will help to educate on the practice and benefit of integrated care. • We have also been a part of many subgroups and workgroups that are bridging the gaps between regulations, reimbursement and best practice. The GNYHA 3ai workgroup has enabled our PPS to connect with others across the state in order to share ideas, lessons learned, and help create a truly integrated system of care throughout the

state. Additionally, as active members of the NYC DOHMH PPS/MCO RPC we are working collaboratively with other stakeholders in this project to begin to find creative ways to implement these programs in a sustainable and effective fashion. By working closely with regulatory bodies, payers, and clinicians the Suffolk Care Collaborative has established itself as an innovator in putting new programs in place across the county.

- SCC has committed a great deal of resources to assisting our partners as they work to alter workflows, provide evidence based care and reduce unnecessary hospital use. For example, the SCC has engaged two PCMH Certification vendors to work directly with participating primary care sites. The SCC is also engaging with Family Service League to provide behavioral health services to primary care providers, as detailed further below.
- Care Managers, staffed by the SCC new Care Management Organization, will be deployed in a number of primary care sites to help navigate patients to vital services they may need.
- Project Committee for the 3ai program is charged with monitoring access of BH workforce in support of filling or finding solutions for future identified gaps in BH workforce.

Together we use lessons learned and successful processes to move into the future of healthcare.

Implementation approaches that the PPS considers a best practice:

While there is collaboration, especially during the workgroup and committee meetings, the three HUBs, Northwell Health, Catholic Health Systems, and Stony Brook Medicine, are taking unique approaches to the 3ai project. This HUB-specific approach will allow us to use strong existing relationships to engage with more behavioral health and primary care providers, and do so more effectively.

Stony Brook Medicine HUB

Stony Brook Medicine is taking a phasic approach to engaging sites to participate in the project. In the Stony Brook HUB, 68 sites, across three phases, have been identified and engaged for participation in 3ai. To begin each phase, a batch of sites is identified by the Stony Brook HUB, and a site assessment is completed. To aid in the evaluation of behavioral health and primary care site's current level of integration, and readiness for integration, the Stony Brook Medicine HUB has partnered with the North Carolina Center of Excellence for Integrated Care (COE), which is a division of The Foundation for Health Leadership & Innovation. The Foundation is headquartered in Cary, North Carolina, and works to develop and support innovative programs that advance affordable and sustainable quality health services to improve the overall health of communities in North Carolina and beyond. The COE is a program of the Foundation that offer training and support to implement integrated care across multiple settings. The COE extends their expertise in integrating care to healthcare professionals and organizations

For these assessments Stony Brook Hub representative (Susan Jayson, Alyse Marotta, or Kristie Golden), traveled with a COE representative to each identified site to conduct the Maine Health Access Foundation (MeHAF) Site Self-Assessment (SSA) Survey. The purpose of the survey is to assess the current status of a site along several dimensions of integrated care, and to stimulate conversation among integrated care team members at the site about where they want to be along the continuum of integrated care. The information collected in these sessions was then analyzed by the COE, and returned to the site for their review in the form of a dashboard. The COE review the dashboard in detail, via phone conference, with the assessed site. Personnel from the site, ranging from clinical to administrative staff, were asked to participate in this 21 question assessment, proctored by a COE representative. This assessment serves as the "kick-off" event for the sites, and moves them towards implementation. Thus far, the HUB has completed two phases, engaging 46 behavioral health and primary care sites. The sites that are to be in phase 3 have been identified, and will be assessed in October.

In addition to the COE, the Stony Brook Hub has also contracted with Family Service League (FSL) for Integrated Care Services. FSL manages one of the largest and most comprehensive networks of care across Long Island, serving infants to elders through Children and Youth Programs, Senior Services, Vocational Programs, Family Support Programs, Mental Health and Substance Abuse Programs, and Housing and Homeless Services. FSL's program model includes strategically placed family centers that provide a continuum of care to address the multitude of challenges faced by children, families and individuals in the various aspects of their lives. FSL is governed by an active 36 member Board of Directors and staffed by 700 (full and part time) skilled professionals, paraprofessionals and support personnel. More than 400 volunteers support the work of the agency as program volunteers, fund raisers, professional and community advisors. The Stony Brook HUB will use Community Based Organizations, such as Family Service League, as a resource to help identify behavioral

health professionals to embed in primary care practices. In the current state, the CBO will be able to enter into an agreement with the practice so that they can continue to bill for and clinically support the BH provider. As we move from a fee-for-service world to one of Value Based Payments this model will become financially sustainable for practices as they will be improving outcomes for their patients and will, therefore, begin to pay for these resources themselves.

Northwell Health HUB

The Northwell HUB has taken a similar approach to the 3ai project as the Stony Brook HUB. In the effort to successfully integrate behavioral health and primary care, Northwell Health has an ambulatory behavioral health team with a Medical Director, Behavioral Health Educator, and Project Manager. In DY1, this team engaged primary care practices (both employed and non-employed), assessed practice readiness for integrated care, and educated practice staff on how to appropriately administer and score PHQ screenings. In DY2, the team will hire licensed behavioral health practitioners, or partner with mental health providers to embed licensed behavioral health practitioners in these practices to accept warm hand-offs from the PCPs. Northwell notes that their accomplishments include:

- 11 voluntary practices in Suffolk County have completed or are in the process of completing the on-boarding materials to contract with Northwell Health for the DSRIP program.
- The Northwell HUB has regular meetings and effective partnerships with the Behavioral Health and PCMH Leadership teams
- The Northwell HUB, much like the Stony Brook HUB, is pursuing a contract with the Family Service League to embed licensed social workers at multiple primary care practices. The Family Service League currently has a LCSW at Northwell Health's Dolan Family Health Center two days per week.
- The Behavioral Health team conducted education sessions with the employed primary care physicians on the DSRIP program, Behavioral Health Integration, and the PHQ survey.

The challenges that Northwell perceives is as follows:

- Primary Care Physicians and their staff are incredibly busy, and we have challenges getting enough time with them to discuss both PCMH transformation and Behavioral Health screening and integration. We are overcoming this issue by identifying a practice administration champion to coordinate the DSRIP projects.
- EHRs require modifications to report PHQ screening
- Some Physicians are resistant to prescribe psychotropic medications.

Catholic Health System HUB

The Catholic Health System (CHS) HUB has taken a similar to the project as well. At the individual practice level, once contracting is completed by CHS PMO staff, the on-boarding process begins with a kickoff meeting between the CHS project staff and the physician or facility and its key staff in order to provide orientation materials and review project expectations. A timeframe should be established for completing the Integrated Care Assessment. A follow-up meeting will then be held with the Practice or Facility to discuss the assessment, establishing goals for the practice, determining who will be key participants in the DSRIP project transformation, and the timeline which is synchronized with the SCC milestones and tasks. Within each facility or practice, there will be regularly scheduled internal workgroup meetings held to monitor progress towards goals. The CHS Project Manager will attend these as needed to facilitate implementation and trouble shoot issues. A CHS led external workgroup will be established for the Model 1, Model 2 and IMPACT model facilities to offer a forum for shared learning and support. Practices or facilities will be encouraged to participate in the SCC Learning Collaborative pertinent to their project model. The CHS Hub IT staff will provide the practices and facilities with data on metrics which should be used to inform systems as a Plan-Do-Study-Act process. Throughout this implementation process, the CHS Hub will provide the SCC PMO with all required documentation through the Performance Logic system or other means as required) to ensure PPS meets or exceeds state reporting timeframes.

CHS recruited a Project Manager and this staff person is being oriented to the project deliverables and the SCC PPS system. The SCC has provided a training session on the Performance Logic system as well as several meetings to discuss the PPS Project Management office structure and operations. The Project Manager is participating in the weekly SCC HUB PMO Meeting Conference calls as well as the project work group for 3.a.i. Preliminary meetings and discussions have been held

with the facilities listed on the spreadsheet submitted to the SCC PMO. Next steps are pending finalized contracts with those contacts. Contracting is in process with a number of practices and facilities.

HUB Neutral

Though project implementation is transpiring in a HUB-specific fashion, there is also a strong HUB-neutral effort that allows for collaboration across all three HUBs. These open lines of communication allow for the free flow of ideas and exchange of information across Hospitals and HUBs. The Project Managers from these HUBs have been meeting regularly to share best practices, and the SCC Director of Behavioral Health has been providing guidance and insight to each group. During the Project Workgroup meetings, the Project Manager of each HUB reports out on the status of their respective group, and what their efforts have been since the last meeting. The Project Managers additionally populate a shared spreadsheet on which they list the sites that have been engaged, and pertinent information about that site. To also maintain organization across the HUBs, each project manager

Another opportunity for collaboration in a HUB-neutral format are the Learning Collaboratives. The Learning Collaborative approach focuses on spreading, adopting and adapting best practices across multiple settings and introducing opportunities in organizations that promote the delivery and implementation of effective programs. SCC Learning Collaboratives are shared-learning sessions with topics designed specifically for organizations participating directly or indirectly in the DSRIP programs. The goal of the collaboratives is to create a community of knowledge that can help participants accelerate program implementation, systematic change and make lasting breakthroughs that meets or exceeds program expectations. For a portion of these Learning Collaboratives, the COE has been facilitating web conferencing sessions for providers in each Model. Although led by the COE, the participants in the conference sessions direct the topics that they would like to discuss, creating a greater degree of utility and provider buy-in for these Collaboratives.

The SCC has also created 3 Integrated Care Implementation Toolkits (1 for each model). The toolkits have come to fruition through the effort of the 3ai workgroup members, and they have been approved by the project committee, Clinical Governance Committee, and Board of Directors in July of 2016. The purpose of these toolkits is to assist our participating Primary Care and Behavioral Health partners during the implementation phase and during the life cycle of the 3.a.i project, throughout the DSRIP years. It is meant to act as a guide and information source to which our partners can refer to for all of their 3.a.i. DSRIP project needs. The general content in each toolkit includes overview of the DSRIP project requirements for implementation, overview of the Primary & Behavioral Health (PCBH) Integrated Program, and instructions regarding how to submit documents and maintain binder. While some of the content in each toolkit is specific to the Model that will be adopted in each location, the aforementioned general format still applies. These toolkits are designed to be amendable documents, therefore we expect the toolkits to undergo several iterations as the project progresses. This design allows for the accuracy and relevancy of the content to be maintained. Future versions of the toolkits will be made available to our partners electronically through the SCC Partner Portal. These toolkits have been distributed to our partners at an "Implementation Kick-off Breakfast" that we hosted for the engaged sites.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The DSRIP Project 3.a.i, Integration of Primary Care and Behavioral Health Services, is aimed at developing collaborative care models between primary care providers and behavioral health organizations, which 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, and the like. The efforts in the 3.a.i project have been parsed out into three components, relating to the model type: Model 1, Model 2, and Model 3. The immediate goal of Model 1 is to integrate behavioral health services into primary care practices, and the long term goal is to improve identification and access to behavioral health services in Suffolk County. The immediate goal of Model 2 is to integrate primary care services into Suffolk County OMH and OASAS licensed facilities, and the long term goal is to improve screening rates and access to chronic disease management/primary care services among residents enrolled in Suffolk County OMH and OASAS licensed facilities. The immediate goal of Model 3 is to implement the IMPACT model at primary care sites, and, like Model 1, the long term goal is to improve identification and access to behavioral health services in Suffolk County.

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The work that is being done through the 3ai Project is facilitated by the Suffolk Care Collaborative, and our DSRIP partners. At the SCC project level, the project is spearheaded by Project Manager, Behavioral Health, Alyse Marotta, Suffolk Care Collaborative, Director of Behavioral Health Integration, Susan Jayson, Suffolk Care Collaborative, and Project Lead, Kristie Golden, PhD, Associate Director of Operations, Neurosciences, Nephrology, Neurosurgery and Psychiatry for Stony Brook Medicine.

The development and implementation of the **SBIRT Initiative** is furthered through the work of the 3ai Project Workgroup and 3ai Project Committee. The charge of the Project workgroup is to support the development, execution, and monitoring of project milestones. The charge of the Project Committee is to support the conclusions, deliverables, and monitor system impacts of the DSRIP program. Both the Project Workgroup and the Project Committee is comprised of key internal and external project stakeholders, including members of primary care and behavioral health facilities, and OMH and OASAS personnel. The Project Workgroup meets on a bi-monthly basis, and the Project Committee meets on a quarterly basis, and meetings have been scheduled through the end of 2016.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

N/A

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 3.b.i

Cardiovascular Health Wellness & Self-Management Program (CWSP) (DSRIP Project 3bi)

Challenges the PPS has encountered in project implementation:

Very similarly across all Domain 3 clinical improvement program efforts, our challenges encountered include:

1) Ability to achieve PMCH Level 3 recognition by DY 03.
2) Domain 1 Patient Engagement Definition & Project Requirement 12: To document in a discrete field the cardiology self-management goal to that it may be a reportable data-element for patient engagement reporting requirements quarterly. Providers are not documenting this in a discrete field, it is in the form of a note, so it is becoming a manual process to log every instance of this in a busy office setting.
3) Project requirement 7 – awaiting IA guidance on if the care coordination teams is at the "PPS" or "Provider office" level?
4) Availability of resources to offer Home Blood Pressure services that are reimbursable to PCP offices should they wish to partner to offer services rather than purchase or license and administer their own equipment.
5) Engagement of Non-PCP provider group in strategies of the Million Hearts Campaign
6) Project requirement 10, metric 2: PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients – challenged with understanding State expectations of an "automated scheduling system" for the PPS. In addition, if this a PPS or provider level requirement?

Efforts to mitigate challenges identified above:

1. The SCC has rebranded this project the **Cardiovascular Health Wellness and Self-Management Program** (CWSP) by the SCC. The SCC continues to show value to PCPs by improving access to comprehensive cardiovascular disease education and materials. Our multi-disciplinary teams for this project are working to provide consistent cardiovascular health education at each encounter within the PPS (i.e. hospital/ED, office, home visit) and tailor interventions to address the unique challenges faced by each patient:
   - Internal stakeholders, including the SCC Director of the Care Management Organization, were engaged to determine treatment protocols, policies and procedures to develop the CWSP care coordination model for the management and control of cardiovascular disease many as defined through the Million Hearts Campaign. Clear work flow processes for the care management/care coordination function were developed that will support the CWSP program. Written training materials were also developed for care management/care coordination staff to improve health literacy, patient self-efficacy, and patient self-management.
   - A CWSP Project Workgroup has been formed composed of subject matter experts engaged to support the development, execution and monitoring of project milestones. The Workgroup is involved in operationalizing the clinical improvement program in provider locations, standing up our Stanford Model Diabetes Self-Management Training programs, and building strategies from evidence-based clinical guidelines as described by the Million Hearts Campaign. This workgroup has been combined with the efforts of our Diabetes Wellness & Self-Management Program (DSRIP Project 3ci) as well due to their similarities.
   - The CWSP Project Committee is composed of key internal and external project stakeholders, including representation from key community and public service and governmental agencies engaged to support the conclusions, deliverables and monitor system impacts of the DSRIP Program, as they relate to Project 3bi.

2. The SCC has deployed provider practice support teams to engage PPS primary care practices to redesign their care delivery processes to move to Level 3 and/or Advanced Medical Home model. The PPS primary care practices will receive support in the redesign of their care delivery model to a PCMH Level 3. The SCC has entered into formal agreements with two PCMH transformation vendors to support the PCP practices, Healthcare Association of New York State (HANYS) Solutions and Primary Care Development Corporation (PCDC). PCMH transformation support was initiated in the first practices in November of 2015. In addition, the PPS has developed a PCMH Certification Workgroup comprised of clinical and non-clinical representatives from PCP practices engaged in transformation activities, subject matter experts (i.e., vendors, PCMH-CCEs), IT, care management, performance improvement, and representation across all three Hubs. This workgroup has developed a PCMH strategy plan to ensure PPS practices achieve PCMH level 3. The strategy, approved by all three Hubs, includes the scope and plan for transformation; tracking and monitoring engagement/progress; validation of PCMH achievement; and building compliance as well as sustainability of current and future PCMH standard iterations.

   The PPS has initiated efforts to increase patient self-management education resources, such as the Stanford education program in Suffolk County. The PPS has engaged the Bio-Medical Informatics (BMI) department at Stony Brook University Hospital (SBUH) to implement the collection of valid and reliable REAL (Race, Ethnicity and Language) data. The data will be used to develop Hot Spotting strategy to implement Stanford Model programs in high risk neighborhoods.

3. To mitigate the challenges of the Domain 1 Patient Engagement Definition & Project Requirement 12, which requires documentation in a discrete field the cardiology self-management goal so it may be a reportable data-element for patient engagement reporting requirements quarterly. We've learned that Providers are not documenting this in a discrete field, it is in the form of a note, so it is becoming a manual process to log every instance of this in a busy office setting. In June of 2016, the SCC approved a new protocol for documenting self-management goals which will be used to support implementation of the CWSP program at participating practice sites. The new protocol includes the recommendation and instructions on how to build this into an EHR in a discrete field so that it may be reported automatically. We still envision challenges during implementation and will continue to offer technical assistance to reduce the barriers.

4. Project requirement 7 – awaiting IA guidance on if the care coordination teams is at the "PPS" or "Provider office" level. The SCC PMO has create an "IA Question Memo" that is emailed to the IA on a continuous basis to ensure a direct communication line.

5. Availability of resources to offer Home Blood Pressure services that are reimbursable to PCP offices should they wish to partner to offer services rather than purchase or license and administer their own equipment. We're currently drafting a Home Blood Pressure Services plan which will define available resources and reimbursement details for our participating PCPs.

6. We plan to engage our Non-PCPs in the tobacco cessation protocols (5 A's and/or NYS Quitline Referrals) to meet provider engagement commitments in program for Non-PCPs to adopt strategies of the million hearts campaign. Program protocols have been written for these tobacco cessation practices and we look forward to rolling them out with our contracted Non-PCPs.

7. Project requirement 10, metric 2: PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients – challenged with understanding State expectations of an "automated scheduling system" for the PPS. In addition, if this a PPS or provider level requirement? These questions remain with the IA and we look forward to hearing back guidance. The SCC PMO has create an "IA Question Memo" that is emailed to the IA on a continuous basis to ensure a direct communication line.

Implementation approaches that the PPS considers a best practice:

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General Program Highlights ("HUB Neutral")

Stanford Chronic Disease Self-Management Program
We're looking to partner with local CBOs who offer Chronic Disease Self-Management Programs. This strategy will build upon existing targeted populations of the CBO to support scaling and funding/resourcing efforts. Example, through a new partnership we're exploring with RSVP Suffolk for Chronic Disease Self-Management services, their existing program has grass roots community connections who have experience with individuals 55+ with an existing chronic condition, although this is not any change to whom we had planned to target, we're excited about a CBO partnership that has this foundation. Another example is the Northwell Health program that targets any age in areas of high need for self-management program enrollment and education. We're also exploring the need for Spanish speaking peer leaders trained.

Suffolk County Tobacco Cessation Coalition
As part of this effort, providers and community members will be educated about smoking cessation resources in Suffolk County, through engagement of the project and the SCC promotion of such resources. Through these efforts, providers will be knowledgeable regarding their prescriptive abilities in terms of smoking cessation aids, and better able to refer patients to community resources and the NYS Quitline. The SCC has also worked to engage key stakeholders and groups that have been leaders in tobacco cessation and prevention. Recognizing the opportunity to bring these stakeholders together to work collaboratively, the SCC created the **Suffolk County Tobacco Cessation Coalition**. Members of this group include: **Patricia Folan, RN, DNP, CTTS**, Director, Center for Tobacco Control, Northwell Health, **Patricia Bax, RN, MS,** Marketing Director, NYS Smokers' Quitline, **PJ Tedeschi,** Coordinator, Tobacco Action Coalition of Long Island at the American Lung Association of the Northeast, **Marcy Hager, MA,** Project Director of the Center of Excellence for Health Systems Improvement for a Tobacco-Free New York at CAI Global, and **Rachel Boykan, MD,** Pediatrician, Stony Brook Medicine, Stony Brook Children's and has received recognition state-wide for best practices in implementing tobacco cessation practices.

Clinical Guideline Summary
The Clinical Guidelines Summary were developed by the SCC PMO and Internal Stakeholders, reviewed and approved by the 3bi Project Workgroup, the DWSP Project Committee, and the Clinical Governance Committee, and reviewed by the SCC Board of Directors.

While there is collaboration, especially at the Project Workgroup and Project Committee levels, the three HUBs: Northwell Health, Catholic Health Systems, and Stony Brook Medicine, are taking unique approaches to the 3bi project. This HUB-specific approach will allow us to use strong existing relationships to engage with more primary care providers as well as specialists in endocrinology, and do so more effectively.

Stony Brook HUB Program Highlights

In the Stony Brook Hub, this project is closing identified gaps in coverage by engaging primary care practices to focus on the development of a care management (CM) approach for patients with cardiovascular disease and hypertension utilizing designated Health Managers, lay care associates, and existing self-management care/education resources in the county who will focus on providing culturally competent service support. These resources, with the embedded or regional CM resources developed as a component of the PPS care management structure to support all projects, are creating a comprehensive strategy that incorporates Identification, Management, Education and Empowerment of target population's "high risk" patients with cardiovascular disease, as well as meet the needs of those at medium or low risk; consistent with DSRIP 3.b.i requirements.

The project leverages population management registries and care management tools as well as expands on current under-resourced educational initiatives and community resources. Primary care practices in the PPS are engaged to redesign care delivery processes in the context of moving toward Level 3 NCQA PCMH recognition or the Advanced Medical Home model. Redesign regarding cardiovascular disease care includes the integration of best practice clinical guidelines from the Million Hearts Campaign and leveraging the EHR to effectively identify and close care gaps in the patient population with cardiac disease.

The SCC has developed a Care Management Organization (CMO) which is designed to fill the current gaps in care management across Suffolk County. The SCC CMO takes an "embedded model" approach which allows for a care manager to be placed at a Primary Care Providers office and become part of the care team. Here, the care manager is better equipped to help manage a patient's care in conjunction with the PCP. Patients are identified as high risk using a risk stratification process which includes patients with comorbid conditions and frequent hospital utilization. Patients with Chronic disease are managed through a one to one relationship with the care manager and are provided with social work and community health associate levels of care as needed to address behavioral health and social determinants of health that may be impacting their wellness. Through this relationship care is coordinated between the patient, their PCP and any specialists that may be involved. Additionally, patients that are missing chronic disease related care measures such as blood pressure or a hypertensive visit, are navigated to the appropriate resource to ensure preventive and chronic care needs are met.

Immediate goals include:

- Identification of eligible individuals with cardiovascular disease
- Risk-stratification based on high-risk comorbidities/conditions (e.g. hypertension, lung disease, polypharmacy, etc.).
- Verify medical home/PMD for each enrollee;
- Assign high-risk patients to care coordinator.
- Interact with SCC clinicians to obtain cardiac-specific clinical data based on the Million Hearts Campaign including the approved Standards of Medical Care in Cardiovascular Disease or Hypertension.
- Inform SCC clinicians of the most recent standards as well as tools from the Million Hearts Campaign to assist their practices in meeting clinical benchmarks for the disease.

Long term goals include:

- Improve utilization of home blood pressure services with eligible patients;
- Increase rates of screening for hypertension and related-complications and secondary prevention;
- Empower patients with hypertension or cardiovascular disease to achieve successful self-management practices;
- Decrease rates of cardiac-related complications in those with the chronic condition;

Provider Relations Team

SCC has staffed a set of Provider Relations Managers to oversee program implementation for Primary Care, Non-Primary Care and Behavioral Health practice sites. A project plan has been written, which is housed in Performance Logic, the PMO project management software tool to monitor program implementation across the following elements for these engaged practice sites: on-boarding/contracting, site champion orientation, patient engagement reporting education, train the trainer program, online LMS, care management services implementation (including transitional care management services for high risk populations discharged from hospitals), PCMH certification program implementation, technical on-boarding (information technology EHR interface and integration, RHIO connectivity, behavioral health services integration, cardiology and diabetes clinical improvement program elements, population-wide campaigns, distribution/orientation of patient education materials, asthma home environmental trigger assessment services, CHAP community navigation program, population health manager software/registries training, and more as identified through continuous program design work.

Northwell HUB Program Highlights

The Northwell Health program includes: (1) Evidence-based Cardiovascular care; (2) Coordination with PCMH Teams; (3) Staff development and education; (4) Tobacco Cessation

1. **Evidence-Based Cardiovascular Care**

- Northwell Health has implemented evidence based guideline in the management and education of the patients with cardiovascular disease.
- The electronic medical record has standardized templates to support capturing and tracking preventive and chronic disease management services

- Northwell Health has hired a Disease Management educator (RN) who started DY2 Q1 who will be responsible for educating practices on evidence-based protocols and practices.
- Northwell Health is in the process of creating and implementing a comprehensive cardiovascular curriculum which includes remote access education modules, train the train site champions, toolkits and resource documents as well as face to face interaction sessions to support the 3.b.i. deliverables.

2. Stanford Chronic Disease Self-Management Program

- Northwell Health is working with community-based organizations to offer the Stanford Chronic Disease Self-Management Program (CDSMP) in hot-spot neighborhoods
- The education team is certified as Program Leaders, and two educators are certified as Master Trainers
- To date, Northwell Health has offered two patient CDSMP classes.

3. Coordination with PCMH Teams

- The Disease Management leadership is working closely with the team leading the PCMH Transformation Team in the employed Northwell Health practices (Pediatrics, Family Medicine, and Internal Medicine). The PCMH Transformation Team is submitting a multi-site applications for all practices on the TouchStone EHR (42 practices).
- The Disease Management leadership is working closely with the team leading the PCMH transformation with the voluntary practices. The majority of practices were on-boarded in DY2Q1 and three consultants have been engaged (HANYS, PCDC, NYC Reach). Evidence-based practices for disease management have been shared with the consultants.

4. Tobacco Cessation

- Northwell Health participates in the Allscripts Super User Workgroup in collaboration with The Center of Excellence for Health Systems Improvement (COE for HSI) for a Tobacco-Free New York, The goal of this workgroup is to bring together stakeholders from partnering federally qualified health centers (FQHC) and community health centers (CHC) across New York State to build and test a new, high-functioning and efficient tobacco dependence screening and treatment blueprint within Allscripts Electronic Health Record (EHR).
- All educators from the Diabetes Wellness and Disease Management Education Program will be participating in a special smoking cessation training initiative in collaboration with The Center for Tobacco Control as well as having one of our educators attend the Tobacco Treatment Specialist Core Training September 20-23, 2016. This enhanced training will better align our education staff to counsel and refer patients to smoking cessation programs.

Northwell Health Key Accomplishments

- 5 voluntary practices in Suffolk County have completed or are in the process of completing the on-boarding materials to contract with Northwell Health.
- Regular meetings and effective partnerships with the PCMH Leadership teams

CHS HUB Program Highlights

Challenges CHS has encountered in project implementation:

- Project requirement to that all PPS safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of engagement DY 3. This is a challenge as many of the partners or potential partners are at different stages of engagement and EHR connectivity. Additionally, an EHR platform must be used to prompt providers to complete the 5A's of tobacco control. For those practices who have not yet connected to an EHR, this is an expensive and time-consuming process, and is not a priority to all providers.
- Patient engagement is a high priority for this project as it is key in maintaining patient health status.

Efforts to mitigate challenges identified above:

- CHS hub is working to engage all PCPs in the process and is providing transformation support. CHS is using outside vendors whose expertise is achieving PCMH Level 3 standards.
- CHS is working to determine the IT connectivity status of each individual practice such that they can be appropriately engaged and assisted in becoming connected to the most appropriate IT platform to enable communication and data sharing.
- CHS and the PPS are looking into data solutions that will enable connectivity across the PPS. A data warehouse may be used to consolidate and risk stratify the relevant patient information.
- Use of home blood pressure monitoring and support as appropriate and facilitating access to blood pressure checks without copayment or advanced appointment in the office. Patients who have repeated elevated blood pressure readings but no diagnosis of hypertension should be identified and scheduled for a hypertension visit. At least one self- management goal identified by the patient must be documented in the medical record and reviewed at each visit.

Implementation approaches considered a best practice:

- CHS promotes the use of evidence based care in the education and management of cardiovascular diseases. The Stanford Chronic Disease Self-Management Program is utilized, which is an educational program aimed at empowering patients with cardiovascular disease to achieve self-management practices and lifestyle change.
- The PPS has additionally streamlined implementation with the other disease management project requirements (3.c.i), which has effectively engaged more resources towards project efforts.

Additional details on CHS project implementation efforts:

- The St Francis Open Heart Surgery program at Good Samaritan was developed using clinical and operational standards and protocols from CHS' St Francis Hospital. (CHS's St. Francis Hospital is New York State's only specialty designed cardiac center which offers a Community Health and Education program and the largest Cardiac Fitness and Rehabilitation program on Long Island, based on the DeMatteis Center for Cardiac Research and Education.)

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Project Implementation Accomplishments to Date across all HUBs

- Evidence-based guideline summaries are complete.
- PCP and Non-PCP practice site implementation plan written
- Clinical improvement program materials are in development for the project in concert with program Subject Matter Experts.
- Clinical Improvement Program Implementation Toolkit drafted, which will include both the Cardiology and Diabetes program
- Received proposals from 2 CBO partners to explore formalizing the Stanford Diabetes and Chronic Disease program
- SCC has met and exceeded patient engagement targets each quarter
- **Sharing Best Practice:** The SCC participates on an all PPS Cardiology program implementation call. Just about 10 other Project Managers of the 3bi program participate and PMs discuss implementation strategies, challenges, lessons learned, etc.
- The planned initiation of Suffolk County Tobacco Cessation Coalition to engage key stakeholders (described above)
- Participation from our HUB partner Northwell in the Allscripts Super User Workgroup in collaboration with The Center of Excellence for Health Systems Improvement (COE for HSI) for a Tobacco-Free New York, The goal of this workgroup is to bring together stakeholders from partnering federally qualified health centers (FQHC) and community health centers (CHC) across New York State to build and test a new, high-functioning and efficient tobacco dependence screening and treatment blueprint within Allscripts Electronic Health Record (EHR).

Next Steps in Project Implementation

- Continue initiating practice site implementation plan with every newly contracted/engaged practice site

- Continue to develop Training Curriculum and program materials to support implementation.
- Present Hot-spotting strategies to support implementation in development to project committee

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

N/A

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 3.c.i

Diabetes Wellness and Self-Management Program (DWSP) (DSRIP Project 3ci)

Challenges the PPS has encountered in project implementation:

Challenges the SCC has encountered in project implementation include:

1) Ability to achieve PMCH Level 3 recognition by DY 03.
2) Address growing epidemic of Diabetes and Obesity.
3) Lack of available public transportation in the county

Efforts to mitigate challenges identified above:

1) The SCC has rebranded this project the **Diabetes Wellness and Self-Management Program** by the SCC. The SCC continues to show value to PCPs by improving access to comprehensive diabetes education and materials. Our multi-disciplinary teams for this project are working to provide consistent diabetes education at each encounter within the PPS (i.e. hospital/ED, office, home visit) and tailor interventions to address the unique challenges faced by each patient:
   - Internal stakeholders, including the SCC Director of the Care Management Organization, were engaged to determine treatment protocols, policies and procedures to develop the DWSP care coordination model for the management and control of diabetes. Clear work flow processes for the care management/care coordination function were developed that will support the DWSP program. Written training materials were also developed for care management/care coordination staff to improve health literacy, patient self-efficacy, and patient self-management.
   - A DWSP Project Workgroup has been formed composed of subject matter experts engaged to support the development, execution and monitoring of project milestones. The Workgroup is involved in operationalizing the clinical improvement program in provider locations, standing up our Stanford Model Diabetes Self-Management Training programs, and monitoring and evaluating diabetes patient education materials endorsed by the SCC.
   - The DWSP Project Committee is composed of key internal and external project stakeholders, including representation from key community and public service and governmental agencies engaged to support the conclusions, deliverables and monitor system impacts of the DSRIP Program, as they relate to Project 3ci.

2) Provide practice support teams to engage PPS primary care practices to redesign their care delivery processes to move to Level 3 and/or Advanced Medical Home model. The PPS primary care practices will receive support in the redesign of their care delivery model to a PCMH Level 3. The SCC has entered into formal agreements with two PCMH transformation vendors to support the PCP practices, Healthcare Association of New York State (HANYS) Solutions and Primary Care Development Corporation (PCDC). PCMH transformation support was initiated in the first practices in November of 2015. In addition, the PPS has developed a PCMH Certification Workgroup comprised of clinical and non-clinical representatives from PCP practices engaged in transformation activities, subject matter experts (i.e., vendors, PCMH-CCEs), IT, care management, performance improvement, and representation across all three Hubs. This workgroup has developed a PCMH strategy plan to ensure PPS practices achieve PCMH level 3. The strategy, approved by all three Hubs, includes the scope and plan for transformation; tracking and monitoring engagement/progress; validation of PCMH achievement; and building compliance as well as sustainability of current and future PCMH standard iterations.

3) The PPS has initiated efforts to increase patient self-management education resources, such as the Stanford education program and also promote CDE resources in Suffolk County. The PPS has engaged the Bio-Medical Informatics (BMI) department at Stony Brook University Hospital (SBUH) to implement the collection of valid and reliable REAL (Race, Ethnicity and Language) data. The data will be used to develop Hot Spotting strategy to implement Stanford Model programs in high risk neighborhoods.

4) SCC is working in conjunction with the Suffolk Independent Living Organization (SILO) to increase the availability of public transportation in the county for individuals with disabilities. SILO helps consumers to obtain needed services, such as bus stop announcements for the visually impaired, removal of erroneous no-show records for para transit service, and door to door service for para transit consumers requiring additional assistance.

   In addition to this collaboration, SCC has begun to strategize other ways in which transportation access can be improved in Suffolk County. Considerations for partnerships with companies like National Med Trans and Lyft are underway. The goal of these discussions is to improve patients' access to needs related to Social Determinants of Health and to bridge the gap between what is considered medically necessary and what is a currently non-covered necessary trip that allows patients to more successfully manage their health.

Implementation approaches that the PPS considers a best practice:

While there is collaboration, especially at the Project Workgroup and Project Committee levels, the three HUBs: Northwell Health, Catholic Health Systems, and Stony Brook Medicine, are taking unique approaches to the 3ci project. This HUB-specific approach will allow us to use strong existing relationships to engage with more primary care providers as well as specialists in endocrinology, and do so more effectively.

Stony Brook HUB Program Highlights

In the Stony Brook Hub, this project is closing identified gaps in coverage by engaging primary care practices to focus on the development of a care management (CM) approach for patients with diabetes utilizing designated Health Managers, lay care associates, and existing diabetes care/education resources in the county who will focus on providing culturally competent service support. These resources, with the embedded or regional CM resources developed as a component of the PPS care management structure to support all projects, are creating a comprehensive strategy that incorporates Identification, Management, Education and Empowerment of target population's "high risk" patients with diabetes, as well as meet the needs of those at medium or low risk; consistent with DSRIP 3.c.i requirements.

The project leverages population management registries and care management tools as well as expands on current under-resourced educational initiatives and community resources. Primary care practices in the PPS are engaged to redesign care delivery processes in the context of moving toward Level 3 NCQA PCMH recognition or the Advanced Medical Home model. Redesign regarding diabetes care includes the integration of best practice clinical guidelines and leveraging the EHR to effectively identify and close care gaps in the patient population with diabetes.

The SCC has developed a Care Management Organization (CMO) which is designed to fill the current gaps in care management across Suffolk County. The SCC CMO takes an "embedded model" approach which allows for a care manager to be placed at a Primary Care Providers office and become part of the care team. Here, the care manager is better equipped to help manage a patient's care in conjunction with the PCP. Patients are identified as high risk using a risk stratification process which includes patients with comorbid conditions and frequent hospital utilization. Patients with Diabetes are managed through a one to one relationship with the care manager and are provided with social work and community health associate levels of care as needed to address behavioral health and social determinants of health that may be impacting their wellness. Through this relationship care is coordinated between the patient, their PCP and any specialists that may be involved. Additionally, patients that are missing Diabetes related care measures such as lab tests or eye exams, are navigated to the appropriate resource to ensure preventive and chronic care needs are met.

The Clinical Guidelines selected for this program are the American Diabetes Association Standards of Medical Care in Diabetes – 2016. Clinicians are expected to adhere to the ADA Standards of Medical Care in Diabetes and obtain diabetes specific clinical data and outcomes as noted in the Immediate and Long-term Goals.

Immediate goals include:

- Identification of eligible individuals with diabetes
- Risk-stratification based on high-risk comorbidities/conditions (e.g. chronic kidney disease, coronary disease, insulin use, polypharmacy, etc.).
- Verify medical home/PMD for each enrollee;
- Assign high-risk patients to care coordinator.
- Interact with SCC clinicians to obtain diabetes-specific clinical data based on the American Diabetes Association (ADA) Standards of Medical Care in Diabetes (e.g. hemoglobin A1c (HbA1c), lipids, urine micro albumin, rates of secondary prevention screening, etc.).
- Inform SCC clinicians of the most recent ADA standards as well as tools from the National Diabetes Education Program to assist their practices in meeting clinical benchmarks for the disease:

Long term goals include:

- 'Improve utilization of HbA1c testing in patients with diabetes;
- Increase rates of screening for diabetes related-complications and secondary prevention;
- Empower patients with diabetes to achieve successful self-management practices;
- Decrease rates of diabetes-related complications in those with the disease;
- Improve HbA1c and LDL-c measures.

The Clinical Guidelines Summary were developed by the SCC PMO and Internal Stakeholders, reviewed and approved by the 3ci Project Workgroup, the DWSP Project Committee, and the Clinical Governance Committee, and reviewed by the SCC Board of Directors.

SCC has staffed a set of Provider Relations Managers to oversee program implementation for Primary Care, Non-Primary Care and Behavioral Health practice sites. A project plan has been written, which is housed in Performance Logic, the PMO project management software tool to monitor program implementation across the following elements for these engaged practice sites: on-boarding/contracting, site champion orientation, patient engagement reporting education, train the trainer program, online LMS, care management services implementation (including transitional care management services for high risk populations discharged from hospitals), PCMH certification program implementation, technical on-boarding (information technology EHR interface and integration, RHIO connectivity, behavioral health services integration, cardiology and diabetes clinical improvement program elements, population-wide campaigns, distribution/orientation of patient education materials, asthma home environmental trigger assessment services, CHAP community navigation program, population health manager software/registries training, and more as identified through continuous program design work.

CHS HUB Program Highlights

Catholic Health Services (CHS) has been working within the Suffolk Care Collaborative (SCC) in a combined effort to effectively manage the needs of diabetic adults across the care continuum to promote favorable patient outcomes within Suffolk County.

CHS promotes the use of evidence based care in the education and management of diabetes. Standardized diabetes teaching guides produced by the Long Island Health Network (LIHN) are utilized across the care continuum. This instructional guide is initiated in the hospital setting and carried over into the home utilizing the same tools to enhance the patient experience. Clinicians within CHS entities as well as LIHN affiliates have been educated in the use of the materials in a collective effort to support a smooth transition from the hospital into the home environment.

Newly diagnosed or difficult to manage diabetics may be referred to the Agency's Telehealth program for close monitoring of vital signs and potentially blood sugar levels between skilled home and physician visits. This instills a greater level of patient engagement and accountability in the management of this chronic disease process.

Baseline HgA1c results are documented in the clinical record. A referral to, and follow up with a community endocrinologist supports continued monitoring of this diagnostic measure.

A diabetic monitoring, assessment, and instructional component is embedded into the Electronic Medical Record (EMR) for the Home Health clinicians to access during skilled visits. This affords the clinician the ability to easily retrieve patient data to identify, support, and document patient progress and additional educational opportunities. It also promotes instantaneous medication reconciliation to reflect any newly implemented regimen changes.

Northwell HUB Program Highlights

The Northwell Health program has three components: (1) Evidence-based care; (2) Diabetes Wellness Program; (3) Stanford Chronic Disease Self-Management Program; (4) Coordination with PCMH Teams

(A) Evidence-Based Care

- Northwell Health has implemented evidence based guideline in the management and education of the patients we care for.
- System wide diabetes protocols define best practice and promote quality metrics including HbA1c, retinal dilated eye exams, nephropathy screening and foot exams.
- The electronic medical record has standardized templates to support capturing and tracking preventive and chronic disease management services
- Northwell Health has hired a Disease Management educator (RN) who started DY2 Q1 who will be responsible for educating practices on evidence-based protocols and practices.

(B) Diabetes Wellness Program

- The program provides self-management education to patients and their support system
- Education classes are offered in both English and Spanish
- The program follows the philosophy that health education, individual motivation, and support systems are crucial in allowing people with diabetes to improve lifestyle behaviors.
- The program's staff is trained in motivational interviewing to assist the individual participants to set self-management behavioral goals.
- The Diabetes Wellness Program is accredited by the American Association of Diabetes Educators (AADE) since 2001

(C) Stanford Chronic Disease Self-Management Program

- Northwell Health is working with community-based organizations to offer the Stanford Chronic Disease Self-Management Program (CDSMP) in hot-spot neighborhoods
- The education team is certified as Program Leaders, and two educators are certified as Master Trainers
- To date, Northwell Health has offered two patient CDSMP classes.

(D) Coordination with PCMH Teams

- The Disease Management leadership is working closely with the team leading the PCMH Transformation Team in the employed Northwell Health practices (Pediatrics, Family Medicine, and Internal Medicine). The PCMH Transformation Team is submitting a multi-site applications for all practices on the TouchStone EHR (42 practices).
- The Disease Management leadership is working closely with the team leading the PCMH transformation with the voluntary practices. The majority of practices were on-boarded in DY2Q1 and three consultants have been engaged (HANYS, PCDC, NYC Reach). Evidence-based practices for disease management have been shared with the consultants.

Northwell Health Key Accomplishments

- 5 voluntary practices in Suffolk County have completed or are in the process of completing the on-boarding materials to contract with Northwell Health.
- Regular meetings and effective partnerships with the PCMH Leadership teams

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Project Implementation Accomplishments to Date

- Evidence-based guideline summaries are complete.
- PCP and Non-PCP practice site implementation plan written
- Clinical improvement program materials are in development for the project in concert with program Subject Matter Experts.
- Clinical Improvement Program Implementation Toolkit drafted, which will include both the Cardiology and Diabetes program
- Received proposals from 2 CBO partners to explore formalizing the Stanford Diabetes and Chronic Disease program
- SCC has met and exceeded patient engagement targets each quarter
- Key project stakeholders are participating in the New York Diabetes Coalition, charged with updating the Diabetes Prevention and Management Toolkit for Providers focusing on the Guidelines for Adult Diabetes Management. This guideline, which is a summary of guidelines for diabetes management based on the American Diabetes Association's Clinical Practice Recommendations and a health care provider chart tool for recording dates of diabetes examinations and tests, can serve as a standardized tool for supporting the implementation of project 3.c.i High-Risk Disease Management across participating PPS practices.

Next Steps in Project Implementation

- Continue initiating practice site implementation plan with every newly contracted/engaged practice site
- Continue to develop Training Curriculum and program materials to support implementation.
- Present Hot-spotting strategies to support implementation in development to project committee

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

In the Project Plan Application, there were additions to the project that were contingent upon Capital Funding. Specifically, Stony Brook did not receive capital funding requested for a CDE Education Center, thus the additions to increase CDE resources in the county will not be carried out through this project. The SCC will continue to promote existing CDE resources that are currently available and navigate eligible and appropriate patients to these services.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 3.d.ii

Promoting Asthma Self-Management Program (PASP) (DSRIP Project 3dii)

Challenges the PPS has encountered in project implementation:

1) Families eligible for Medicaid/uninsured are more likely to have challenges (e.g., low health literacy, difficulty obtaining medications, transportation problems, home environmental triggers etc.) that contribute to increased risk for poor asthma-related health outcomes.
2) Some PPS providers will experience barriers in implementing National Heart, Lung, and Blood Institute (NHLBI) asthma guidelines.
3) Consistency in hiring, training, and supervision of CHWs.

Efforts to mitigate challenges identified above:

1) Our multi-disciplinary teams for this project, rebranded the **Promoting Asthma Self-Management Program (PASP)** by the SCC, are working to provide consistent asthma education at each encounter within the PPS (i.e. hospital/ED, office, home visit) and tailor interventions to address the unique challenges faced by each patient.
    - Internal stakeholders, including the SCC Director of the Care Management Organization, were engaged to determine treatment protocols, policies and procedures to develop the PASP care coordination model for the management and control of asthma. Clear work flow processes for the care management/care coordination function were developed that will support the PASP program. Written training materials were also developed for care management/care coordination staff to improve health literacy, patient self-efficacy, and patient self-management.
    - A PASP Project Workgroup has been formed composed of subject matter experts engaged to support the development, execution and monitoring of project milestones. The Workgroup is involved in the development of the Asthma Home Environmental Assessment Trigger Program.
    - The PASP Project Committee is composed of key internal and external project stakeholders, including representation from key community and public service and governmental agencies engaged to support the conclusions, deliverables and monitor system impacts of the DSRIP Program, as they relate to Project 3dii.
2) The SCC will offer all PPS providers education and care redesign support required to meet project goals. The PPS is promoting the PASP Program to PPS medical practice sites and promoting the use of the New York State standardized Asthma Action Plan for high risk patients at medical practices, in the context of moving toward Level 3 NCQA PCMH recognition and the Advanced Medical Home model
3) Building upon the existing program, the PPS through the PASP program will hire and train additional management personnel to provide consistent workforce training and supervision.

Implementation approaches that the PPS considers a best practice:

While there is collaboration, especially at the Project Workgroup and Project Committee levels, the three HUBs: Northwell Health, Catholic Health Systems, and Stony Brook Medicine, are taking unique approaches to the 3dii project. This HUB-specific approach will allow us to use strong existing relationships to engage with more primary care providers as well as specialists in pulmonology, and do so more effectively.

Stony Brook HUB Program Model

The PPS Stony Brook Hub has built a medical home program specific to asthma chronic disease management support enriched with home visits by trained community health workers (CHWs) leveraging the strengths of the existing Stony Brook Pediatrics Keeping Family Healthy (KFH) program at a current Level 3 PCMH site. Patients are stratified into three risk categories: high, moderate and low. All high-risk patients are referred for home visits. Families receive ~4-5 CHW home visits over 6 months, with calls/text reminders as needed between visits, especially after ED/hospital visits, to provide patients with root cause analysis and avoid future incidents.

CHWs follow a protocol to guide visit content focused on home environmental trigger reduction, self-monitoring and self-management of asthma symptoms, asthma medication use, and medical follow-up. CHWs link patients to resources for trigger reduction interventions, especially to change the indoor environment. Plans are in development for a visit summary to be sent to all care team members (e.g., clinicians, Medicaid Managed Care plans, Health Home care managers, school nurses, etc.) via interoperable EHR and PPS-wide care management platforms created to support integrated care delivery.

Low/medium-risk patients receive education and support from case managers at the medical home and benefit from PPS-wide care management platforms whereby pertinent disease- management information, such as Asthma Action Plan, is accessible to all care team members. Initial implementation will occur in known asthma "hot-spots" (i.e. Islip, Patchogue, Brentwood, Bayshore, and Mastic). The Suffolk Care Collaborative's Care Management Organization provides embedded care management resources at the PCP office to target high risk patients in need of one on one care management. Asthma action plans, medication adherence, as well as management of comorbid conditions are addressed in this care management model. Additionally, should a patient access hospital care, the SCC CMO provides Transition of Care services to assist the patient in the 30 day post-acute transition and work with the patient and their providers to ensure appropriate follow up and reduction in the need for readmission.

CHS HUB Program Model

Catholic Health Services (CHS) has been working within the Suffolk Care Collaborative (SCC) in a combined effort to effectively manage the needs of asthmatic children across the care continuum to promote favorable patient outcomes and reduce the asthma burden within Suffolk County.

CHS promotes the use of evidence-based care in the education and management of asthma through the incorporation of best practices into the care planning for this population. Such practices include: the utilization of the New York State standardized Asthma Action Plan, referral to a pulmonologist for continued follow up in the community, and the use of a spacer to enhance the efficacy of inhaler medications.

Through a partnership with the Asthma Coalition of Long Island (ACLI), standardized educational materials are being developed by the Education Committee, of which CHS is an active member; through project **BREATHE** (**B**ringing **R**esources for **E**ffective **A**sthma **T**reatment through **H**ealth **E**ducation) for asthmatic children and their families. *Let's Take Control of Asthma!* is a teaching instrument intended to be utilized by clinicians across the continuum of care. Environmental History and Resource materials have been developed in an age, cultural, and educationally sensitive format. Clinicians within CHS entities have been educated on the use of the materials in a collective effort to facilitate a seamless transition from the hospital into the home.

A home and environmental assessment have been incorporated into the Electronic Medical Record (EMR) for the Home Health clinician to apply during each skilled nursing visit. The clinician has the capability to easily identify, support, and document areas of concern, progress, and patient/caregiver educational opportunities.

Northwell HUB Program Model

Northwell Health is working with pediatricians, hospitals, home care, and community organizations to improve asthma care in Suffolk County. The program has three components: (1) Evidence-based care for all children with an asthma-related visit; (2) Referrals to Northwell Health Pediatric Nurse Home Visit Program; (3) Performance Measurement

(A) Evidence-Based Care

- Pediatricians are trained on the NHLBI National Asthma Education and Prevention Program guidelines and the Asthma Care Quick Reference: Diagnosing and Managing asthma.

- For every asthma related visit, providers are expected to classify the severity of asthma, assess risk and symptom control, prescribe appropriate asthma control medications and complete an Asthma Action Plan in partnership with the patient and family.
- Guided by cultural and health literacy principles, providers educate patients and their families on asthma triggers, environmental control, self-monitoring to assess level of asthma control, and early identification and treatment of symptoms.
- Where appropriate, referrals to specialists are performed based on NHLBI guidelines.

(B) Referrals to Pediatric Nurse Home Visit Program

- For patients defined as high risk (any patient with an asthma-related ED or hospital visit, change in medications, or recent diagnosis), a pediatrician, emergency department physician, or hospital attending can refer the patient to the Northwell Pediatric Nurse Home Visit Program
- The Nurse visits the patient's home, examines the home environment for possible asthma triggers, reviews the Asthma Action Plan completed by the provider, reviews medications, and provides education to the child and family.
- The nurse communicates with the referring provider to inform them of their findings and recommendations and provides a warm handoff back to the referring provider.

(C) Performance Measurement

- Northwell Health is monitoring the number of referrals from pediatricians in the community to the Home Visiting Program
- Northwell Health is tracking the number of asthma-related visits to the hospital Emergency Departments. Additional provider education will be provided as needed to ensure pediatricians make timely referrals for home visits

Northwell Health Key Accomplishments

Provider flyer

- Utilizing the expertise of our Director of Communications, provider facing flyers have been created to provide information about the Home Visiting Program, including description of services provided and the process of referring a patient to the program
- Patient facing flyers were also created to inform patients and families about the Home Visiting Program and what they can expect during an asthma-related home visit. We are in the process of printing the patient facing flyers in Spanish to better communicate with our Spanish speaking population.

Grand Rounds training

- On May 13th, 2016, representatives from the DSRIP PMO and our Home Visiting Program provided an overview of the burden of asthma in Suffolk County and informed both hospital-based providers and ambulatory providers of the availability and benefits of the home visiting program. Providers were given an opportunity to ask questions and were trained on how to refer patients to the program. Flyers about the program were also distributed.

Education during provider on-boarding

- As we move from project planning to project implementation, partnering with our primary care providers, there needs to be an emphasis on training. We've retained a chronic disease educator, whose responsibilities include training providers and their staff on the following:
- Intro and requirements for project 3dii
- NHLBI guidelines
- Asthma Action Plan
- Information about Home Health Visiting Program and process for referring patients
- Warm handoff
- RCA after known asthma patient visits ED/is hospitalized secondary to asthma

NYS Summit Asthma Conference

- On June 24th, representatives from the DSRIP PMO and our Home Visiting Program attended the NYS Summit Asthma Conference in Albany to participate in workshops, presentations and panel discussions on the latest evidence, resources and guidelines in asthma control and home-based interventions and services.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Project Implementation Accomplishments to Date

- Evidence-based guideline summaries are complete, including the following goals and interventions:
  - Immediate goals include:
    - Identify eligible individuals, stratify risk level for each patient, verify medical home/PMD for each enrollee, and enter patients' information to registry;
    - Assign patients to care coordinator and high risk patients to Community Health Workers (CHW).
  - Long term goals include:
    - Provide patients with asthma care consistent with NHLBI guidelines including:
      - regular asthma visits;
      - classification of severity, risk and control of asthma at each visit;
      - appropriate Rx of asthma control meds;
    - Provide an Asthma Action Plan (AAP) at each visit carrying a primary diagnosis of asthma.
    - Sustain home-based services to address asthma triggers and reduce avoidable asthma related ED and hospital visits.
  - Providers will be responsible for:
    - determining if patients have the diagnosis of asthma;
    - treating asthma per NHLBI guidelines, including classifying severity, risk and control, and dispensing an Asthma Action Plan for each visit with a primary diagnosis of asthma;
    - referring patients diagnosed with asthma to an asthma specialist if the diagnosis is not straightforward or if referral is merited per the NHLBI guidelines;
    - screening asthma patients in the practice to identify those at high-risk and refer them to the designated care coordinator;
    - Review information provided by care coordinators and CHWs regarding individual patients.
- PCP and Non-PCP practice site implementation plan complete.
- SCC has met and exceeded patient engagement targets each quarter
- Program materials, training materials, procedures and workflow documents to support the Home Environmental Trigger Assessment Program have been created, including:
  - Work flow diagram for Program Model
  - Roles and Responsibilities Documents for each Key Program Representative
  - Community Health Worker On-boarding & Training Material
  - PASP Reporting Procedure
  - PASP Evidence-based trigger reduction interventions
  - PASP procedures to provide and navigate clients to resources for evidence-based trigger reduction interventions
  - PASP Patient educational materials for the PASP Evidence-based trigger reduction interventions
  - PASP Patient education materials for self-management education services

Next Steps in Project Implementation

- Next we're looking to formalize partnerships to operationalize the Home Assessment Program to launch in September 2016
- The Workgroup will continue to be engaged to create program communication materials and pamphlets for our network of providers.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

N/A

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 4.a.ii

Substance Abuse Prevention & Identification Initiatives (DSRIP Project 4aii)

Challenges the PPS has encountered in project implementation:

There are several potential challenges that exist within the 4aii project, which can be categorized as infrastructure challenges, provider challenges, and patient challenges.

Infrastructure Challenges:

- Additional ED staffing may need to be recruited in order to accommodate the addition of the SBIRT service and identification of more patients in need of SUD or tobacco services. This is a process that will incur additional cost and the hospitals need time to recruit for this additional staffing.
- Workflow issues in the ED where time is a significant factor
- The role of individuals outside the hospital must be considered when working with substance issues: parents, caregivers, community coalitions, teachers, lawmakers, law enforcement, peers, etc.

Provider Challenges:

- Training on documentation will need to take place for providers
- Engagement of teens in SUD programming
- Overcoming attitudes towards smoking
- Provider education about smoking cessation medications/ prescriptions

Patient Challenges:

- Encouraging acceptance of help for a SUD
- Social determinants of health

Efforts to mitigate challenges identified above:

All initiatives are further expanded upon in the "best practices" section of this narrative.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Initiative

This initiative partners with Hospitals in Suffolk County to implement SBIRT in Hospital Emergency Departments. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. The SBIRT Project Workgroup meets on a quarterly basis, and meetings have been scheduled through the end of 2016. During each of these meetings, a specific topic is discussed, and aims to clarify the project approach and requirements. Quarterly, Project Workgroup and Project Committee meet together under the title of "Learning Collaborative". These in-person meetings are a unique opportunity for the Hospitals to share their experiences with one another, troubleshoot issues, and learn from subject matter experts. Our first Learning Collaborative, convened on April 25th, was themed "Roundtable Discussion: Implementation Lessons Learned". Representatives from the four Partner Hospitals that went live with the SBIRT program in their respective EDs sat on a moderated, interactive panel for this meeting. These individuals included Jennifer P, Project Manager, PCMH, Brookhaven Memorial hospital; Kristie golden, Associate Director of Operations, Neurosciences,

Neurology, Neurosurgury & Psychiatry, Stony Brook Medicine; Sandeep Kapoor, Director, SBIRT, Northwell Health; and Denise Driscoll, AVP Behavioral Health, John T. Mather Memorial Hospital.

Before the meeting, partners were encouraged to submit questions for the panel discussion, and topics which arose included workflow, EHR/IT concerns, referrals, and billing. This session provided an opportunity for the Hospital personnel to meet, collaborate, and exchange information, which aids in collectively moving the project forward. We are particularly excited for the our August meeting, as we will be inviting Suffolk County OASAS behavioral health facilities community based organizations to join the Hospitals to discuss access to treatment issues in the County, and troubleshoot solutions. This will aid in breaking down barriers to care, and pave an avenue of communication between these sectors of care.

Additionally, by screening everyone (ages 13 and up) that comes into the ED, it normalizes the screening process for substance use, and opens a line of communication between the provider and the patient. This line of communication works to reduce the stigma and taboo attached to this topic, and may make patients more forthcoming with their behaviors, and more receptive to treatment.

To aid in overcoming staffing and financial challenges, the SCC is offering to fund a Health Coach for each Hospital. This position is dedicated to SBIRT, and will work in the emergency department. This position will be funded by the SCC for two years, during which the Hospital will create a sustainability plan, which they will submit to the SCC. By the end of the two years, the position should be fully sustainable and integrated into the ED.

Suffolk County Tobacco Cessation & Prevention Initiative
As part of this effort, providers and community members will be educated about smoking cessation resources in Suffolk County, through engagement of the project and the SCC promotion of such resources. Through these efforts, providers will be knowledgeable regarding their prescriptive abilities in terms of smoking cessation aids, and better able to refer patients to community resources and the NYS Quitline. The SCC has also worked to engage key stakeholders and groups that have been leaders in tobacco cessation and prevention. Recognizing the opportunity to bring these stakeholders together to work collaboratively, the SCC created the **Suffolk County Tobacco Cessation Coalition**. Members of this group include: **Patricia Folan, RN, DNP, CTTS**, Director, Center for Tobacco Control, Northwell Health, **Patricia Bax, RN, MS,** Marketing Director, NYS Smokers' Quitline, **PJ Tedeschi,** Coordinator, Tobacco Action Coalition of Long Island at the American Lung Association of the Northeast, **Marcy Hager, MA,** Project Director of the Center of Excellence for Health Systems Improvement for a Tobacco-Free New York at CAI Global, and **Rachel Boykan, MD,** Pediatrician, Stony Brook Medicine, Stony Brook Children's and has received recognition state-wide for best practices in implementing tobacco cessation practices.

Underage Drinking Prevention Initiative
This initiative will reach a youth contingency of the population and engage them where they are a captive audience; in the school system. By partnering with community agencies, the SCC is able to gain access to vulnerable communities, and leverage the partner relationships to bring in key community stakeholders mentioned above.

Implementation approaches that the PPS considers a best practice:

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Initiative
The first arm of this program is the Screening, Brief Intervention, and Referral to Treatment Initiative, or SBIRT. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. The Suffolk Care Collaborative is partnering with 11 hospitals in Suffolk County to train their Emergency Department staff in SBIRT, and fully incorporate the screenings into their daily operations. The immediate goal of this program is to implement the program at the hospitals for patients 13 years of age or older, and the long term goal is to connect patients with treatment for substance use/ abuse and reduce the incidence of substance misuse in the County.

The work that is being done through the SBIRT Initiative facilitated by the Suffolk Care Collaborative, Hospital personnel, and State and community based organizations. At the SCC level, the SBIT Initiative is spearheaded by Behavioral Project Manager, Alyse Marotta, Suffolk Care Collaborative, and Project Lead, Kristie Golden, PhD, Associate Director of

Operations, Neurosciences, Nephrology, Neurosurgery and Psychiatry for Stony Brook medicine. The development and implementation of the SBIRT Initiative is furthered through the work of the SBIRT Project Workgroup and SBIRT Project Committee. The charge of the Project workgroup is to support the development, execution, and monitoring of project milestones. The Project Workgroup is comprised of subject matter experts, specifically representatives from the Office of Alcoholism and Substance Abuse Services (OASAS), and individuals across all three HUBs, including senior leadership and Hospital Facility Champions and Performance Logic End Users. The SBIRT Program Facility Champions are key external stakeholder for the Hospital-partner to lead implementation of the Initiative in their respective Hospital Emergency Departments. This role provides leadership support and assumes continuing responsibility for the development, implementation, training, compliance, coordination, maintenance, and evaluation of the DSRIP project. The Performance Logic End Users are SCC Coalition Partners who are assigned a project implementation plan to track their organization's participation in the SBIRT Initiative within the Performance Logic project management tool. Each of the 11 Suffolk County Partner Hospitals have identified their site Facility Champion and Performance Logic End User, who are currently engaged in the Project. In addition to these two roles, each of the Hospitals have assembled a Hospital-based Implementation Team, which is a core team of staff members focused on the implementation and sustainability of the SBIRT Initiative. The charge of the Project Committee is to support the conclusions, deliverables, and monitor system impacts of the DSRIP program. The Project Committee is comprised of key internal and external project stakeholders, including representation from OASAS, SUD clinics, behavioral health sites, hospitals (including the Hospital Based Implementation Teams), and community advocacy agencies.

In alignment with the NYS DOH DSRIP Project Implementation Project Plan, the SCC developed a comprehensive SBIRT in the ED Implementation Plan. This plan details the steps that Hospitals will need to take to carry this project through to fruition. These steps include building hospital internal capacity, equipping the Hospital EMR to document the screenings, ensuring that finance/ billing is in place at the Hospital, conducting initial SBIRT trainings for the ED staff, developing a workflow strategy, establishing a referral process to connect patients with external resources, implementing the SBIRT protocol, and reporting implementation lessons learned to the SCC during Project Workgroup meetings. This implementation plan was approved by the Project Workgroup, and has been loaded into Performance Logic. The Performance Logic End Use at each Hospital has been formally trained to use the program, and will use the program to report their progress to the SCC, and return all required project documents.

All of these involved stakeholders have collaborated to identify a comprehensive approach for implementing SBIRT in the ED. As described above, the Hospitals have identified three distinct roles: SBIRT Facility Champion, Performance Logic End User, and Hospital-based Implementation Team member. The Facility Champions acts as the primary point of contact for the SCC, and the SCC will be coordinating 4-hour SBIRT trainings at each of the 11 partner hospitals for emergency staff to be trained and become SBIRT certified. The Performance Logic End User is the designated individual at the Hospital who is charged with updating the project management tool, Performance Logic, in order to submit data to the SCC and track Hospital progress. The Facility Champion and Performance Logic user make up 2 members of the Hospital-Based Implementation Team, which drives the project at the Hospital. The Team members follow the sequence listed on the implementation plan to work through the project requirements and implement the program. This work includes working with internal IT and billing services ensure that the services are properly documented in the HER, and the services are billed for appropriately. Also included in this work is educating and certifying pertinent ED staff members in SBIRT, and formulating a workflow plan to accommodate this new service.

To assist the Hospitals in planning and implementing SBIRT in the ED, the SCC is creating an SBIRT toolkit, which will serve as comprehensive guide for navigating this DSRIP program. The information in this toolkit includes the DSRIP Project 4aii charter and clinical summary documents, Facility Champion roster and Project Contacts, documentation forms to be returned to the SCC, SAMSHA billing guidelines, and an extensive list of SBIRT resources.

The 4-hour OASAS SBIRT trainings, organized by the SCC, began in December, 2015 and have continued at a rate of approximately one per month. Thus far, five Hospitals have hosted trainings, and four Hospitals have gone live with SBIRT in the ED; Southside Hospital, Brookhaven Memorial Hospital Medical Center, Stony Brook Medicine, John T. Mather Memorial Hospital, and Eastern Long Island Hospital. The remainder of the trainings have been scheduled with each hospital, and the OASAS Certified Training Program will continue through the remainder of the summer and fall. Thus far, 97 individuals across these Hospitals have been trained in SBIRT. These individuals have received a 4-HOUR SBIRT

Certification certificate, which allows for the billing of SBIRT services as per OASAS and Medicaid guidelines. The training serves as the kick-off to program implementation, and should mark one of the last steps before the hospital "goes live" with the program. The Hospitals that have gone live with the program include Southside Hospital, Brookhaven Memorial Hospital Medical Center, Stony Brook Medicine, and John T. Mather Memorial Hospital. As mentioned above, the SCC is creating a collaborative environment in which the Hospitals that are more advanced in the implementation process share their experiences with the Hospitals that are not as advanced.

Suffolk County Tobacco Cessation Initiative

The second arm of the 4aii program is the Suffolk County Tobacco Cessation Initiative. This initiative partners with the Office of Mental Health (OMH) and community-based cessation programs in Suffolk County to implement a tobacco cessation patient and provider education initiative. This tobacco team, formed under the SCC, is called the Suffolk County Tobacco Cessation Coalition The primary goal of this project is to reduce tobacco use among adults who report poor mental health. This goal will be moved forward through implementing tobacco-free regulations at participating OHM facilities, and implementing evidenced based smoking cessation practices at participating OMH facilities.

Tobacco use prevention, tobacco cessation and smoke-free environmental strategies reside several of 11 DSRIP programs. In an effort to design one comprehensive "SCC Tobacco Cessation Program" we have consolidated our efforts; the tobacco components of each project have been synthesized into this mini-project, and once ready for implementation, re-introduced back into the DSRIP programs. During the implementation phase of this new tobacco project within the 4 DSRIP programs, the Suffolk County Tobacco Cessation Coalition will continue to work closely with the Project Managers to ensure the tobacco cessation scope of work detailed in these project requirements are fulfilled.

Underage Drinking Prevention Initiative

The third arm of this project is the Underage Drinking Prevention Initiative. The goal of this initiative is to support, leverage and supplement existing resources to increase the capacity of the community to address and ameliorate the negative social and environmental conditions which expose the youth to risk related to widespread and accepted drug use patterns. This initiative will address behaviors that drive alcohol and drug abuse, and will promote positive changes in community attitudes and behaviors. Community Based Organizations will be engaged to operationalize drinking prevention services in the Bellport, NY community.

The SCC is partnering with the Prevention Resource Center (a division of Family Service League) to design and implement an underage drinking prevention program in the South Country School District. An agreement has been rendered that details the involved partners, the target population, the prevention initiative scope of work, the coalition prevention initiatives, administrating and reporting responsibilities, and payment distribution plan. This agreement will be signed in July 2016, and will be in effect through July 2019, which is the remaining duration of DSRIP. As the LIPRC has been working on population health efforts in this region, we are able to leverage their reputation in the community, acknowledge the efforts of existing community coalitions, and work to support their longstanding efforts. This level of community buy in will likely result in a more successful implementation of these programs, and provide for their sustainability.

The target population of this initiative is South Country community residents under the age of 21 who live in the greater Bellport region which includes Bellport, North Bellport, parts of East Patchogue, Medford and Yaphank, along with the Native Americans from the Shinnecock Nation. The area is known to the Suffolk Youth Bureau as 'high need'. To reach these individuals, the LIPRC will leverage the existing community coalition in the region: South County/ Compass Unity Through Strength & Diversity Coalition, or COMPASS: Unity. COMPASS: Unity acts as a community coalition poised to connect multiple sectors, including business parents, media, law enforcement, schools, faith organizations, health providers, prevention providers, addiction treatment, mental health, social service agencies and government. Coalition partners gain a more complete understanding of the community's problems and together the partners engage in efforts to identify problems, implement evidence based solutions, which allows for greater community access than if the SCC were to act without this group. To provide guided leadership and to supplement the work done by COMPASS: Unity, the LIPRC will hire a Substance Abuse Prevention Specialist. This Specialist will operate out of the Boys and Girls Club of Bellport, and will spearhead the community activities that have been drafted by the LIPRC.

In this project, the LIPRC will be utilizing evidence-based prevention strategies and guiding principles. The first evidence based prevention strategy that the LIPRC uses is the SAMHSA National Strategic Prevention Framework (SPF), which is used by prevention professionals to plan, implement, and evaluate prevention efforts. The LIPRC will also be utilizing the CADCA National Coalition Academy's "Seven Strategies of Community Change", which is are strategies used by coalitions to change individual behaviors and group conditions.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Initiative

The SCC is looking beyond the scope of DSRIP in order to further substance abuse prevention and identification initiatives in Suffolk County. The SCC has identified **Communities of Solution** (COS) as a large, collaborative network in the County that focuses on this issue. The COS was established in Suffolk County in 2008, and focuses on improving outcomes through education, information dissemination, and cross-system activities pertaining to improving access to and quality of prevention and certified treatment services for substance use disorders. The COS organizational structure includes various Task Committees designed to carry out activities and report accomplishments regularly to COS and to the community, and may convene on an ad-hoc basis. These Task Committees include the Data committee, Community Resource List (CRL) Committee, Advocacy, Parent Forum Committee, School Outreach Committee, SBIRT Committee, Public Health Education Committee, Marketing Committee, and Access to Care Committee. The membership of COS is comprised of a host of Suffolk County stakeholders including OASAS certified clinics, Suffolk County public schools, Suffolk County governmental officials, Suffolk County law enforcement, Hospitals, and healthcare workers. DSRIP Project 4aii Project Manager, Alyse Marotta, attends the monthly full body meeting of Communities of Solutions to stay apprised of substance use efforts in Suffolk County, and to report on DSRIP activities.

Access to care has been a longstanding issue in Suffolk County, as there is a documented shortage of behavioral health workers. The SCC is initiating a reporting procedure to quantify the SBIRT screenings that are being done/ will be done in the ED setting. This data will include the number of screening that are completed, and the number of those screening that resulted in a referral to treatment. By examining this data from the Hospital level, the access to behavioral healthcare issue can be analyzed from another lense, and may bolster support for increased funding for behavioral health expansion in the County.

In a show of collaboration, the hospitals have adopted an unofficial "open" training policy, wherein ED staff members from Suffolk County Hospital are invited to attend SBIRT training offered at any of the other Suffolk County Hospitals. In addition to the trainings hosted for emergency department staff, the SCC OASIS Certified SBIRT Training Program has been expanded to include our primary care practice site partners, and dental provider partners.

Suffolk County Tobacco Cessation Initiative

The OMH facilities that have partnered with the Suffolk Care Collaborative and have signed our SCC Participation Agreement, a performance based contract with the SCC, includes the implementation requirement of environmental smoke free regulations.

Underage Drinking Prevention Initiative

The Long Island Prevention Resource Center (LIPRC) is utilizing two evidence based, population-wide strategies: SAMHSA - National Strategic Prevention Framework and CADCA National Coalition Academy – Seven Strategies for Community Change. The LIPRC will also be documenting their progress in our SCC PPS-wide eNewsletter publications, which are distributed to our PPS partners. This will allow the SCC to share the work that the coalition is completing, which allows their best practices to be widely disseminated.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

N/A

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: State University of New York at Stony Brook University Hospital

Project: 4.b.ii

Access to Chronic Disease Preventive Care Initiatives (DSRIP Project 4bii)

Challenges the PPS has encountered in project implementation:

There are several potential project challenges in the 4bii project, and can be categorized into patient/ socioeconomic issues, practice effectiveness, and care management.

Socioeconomic Issues:

- Limited public transportation
- Large disparities in race/ ethnicity/ language and other cultural factors

Practice Effectiveness:

- Lack of provider awareness regarding current best practice prevention recommendations and community resources

Care Management:

- Few warm handoffs or standard routes of communication or registries regarding patients who may need screenings

Efforts to mitigate challenges identified above:

All DSRIP Programs were re-branded and given program names that is used in public program administration. The DSRIP Program 4bii, is entitled the Chronic Disease Preventive Care Initiatives. These population wide initiatives focus on access to high quality chronic disease preventative care and management in both clinical and community settings. Initiatives include the following: Lung Cancer Screening Initiative, Breast Cancer Screening Initiative, Colorectal Cancer Screening Education Initiative, Obesity Prevention Initiative, Tobacco Cessation Initiative. The areas of chronic disease focuses were derived from the Suffolk County Community Needs Assessment. In addition, Suffolk County has selected the Preventing Chronic Disease Prevention Agenda Priority, under the county-wide NYS Prevention Agenda Efforts.

The programs population-wide initiatives are met with strong program leadership, Janine Logan, Senior Director, Communications and Population Health at the Nassau-Suffolk Hospital Council (NSHC) and Director of the Long Island Population Health Improvement Program and the Long Island Health Collaborative. Each DSRIP program is staffed by a manager at the SCC, Afrin Howlader, MPH, CHES, Community Engagement Liaison, manages all initiatives under the program. The program has a *Project 4bii Committee* representative of subject matter experts across the chronic disease initiatives and county, as well as one workgroup, entitled the *Community Engagement Workgroup* that will collaboratively work on meeting all program objectives. A few highlights of program stakeholders engaged in our efforts include: Linda Bily, Director of Cancer Patient Advocacy at Stony Brook University Hospital, Alison Abrams, Director of Public Health Nursing at the Suffolk County Department of Health, Dr. Zahrine Bajwa, CPH, PhD at the Cornell Cooperative Extension, Sarah Ravenhall, Program Manager of the Long Island Population Health Improvement Program and Dr. James Tomarken, Commissioner of the Suffolk County Department of Health.

The SCC and project workgroups/committees are working towards identifying culturally competent patient and provider educational materials regarding specific chronic diseases and screenings (lung cancer, breast cancer, colorectal, obesity, tobacco cessation). These materials will serve as educational opportunities for providers to become apprised of current best practices, and for patients to learn more about these topics in a format which is at the appropriate health literacy level, and are relatable for persons from a variety of racial, ethnic, and language diversities. These educational materials will be utilized for provider office distribution, the future SCC Community web-page (go-live scheduled for Fall 2016), and community forums where beneficiaries and community-members are present. To date, patient education materials for tobacco cessation, lung cancer, colorectal cancer and obesity have been approved by the cultural competency and health literacy workgroup.

The SCC has developed a Care Management Organization (CMO) which is designed to fill the current gaps in care management across Suffolk County. The SCC CMO takes an "embedded model" approach which allows for a care manager to be placed at a Primary Care Providers office and become part of the care team. Here, the care manager is better equipped to help manage a patient's care in conjunction with the PCP. Patients are identified as high risk using a risk stratification process which includes patients with comorbid conditions and frequent hospital utilization. Patients with chronic diseases are managed through a one to one relationship with the care manager and are provided with social work and community health associate levels of care as needed to address behavioral health and social determinants of health that may be impacting their wellness. Through this relationship care is coordinated between the patient, their PCP and any specialists that may be involved. Additionally, patients that are missing core measures such as lab tests or screenings, are navigated to the appropriate resource to ensure preventive and chronic care needs are met. To date, the SCC CMO has 18 staff members working with patients and providers as well as supporting hospitals in implementing their transitions of care model. SCC will work with all Stony Brook Hub contracted providers to assess their care management needs and appropriately resource those sites based on patient volume. In addition our HUBs have also initiated CMO services.

Implementation approaches that the PPS considers a best practice:

Population-wide Communication Plan & Program Integration

To date, SCC has been actively increasing access to high quality chronic disease preventative care and management through several activities. SCC has posted community health and wellness events and affairs within the Suffolk County community in e-newsletters (DSRIP-In-Action) on a bi-weekly basis. SCC has also developed a CBO resource directory that enables both providers and patients to have increased access to preventative health and disease management resource, this document is also available on the website. The SCC's Community Web-page targeted to go-live in Fall of 2016 is planned to offer in both Spanish and English many community-based resources to support our targeted populations. This webpage will include population-wide campaigns on specific chronic diseases, which are all being designed and developed by the SCC and our participating stakeholders throughout the county and state.

Our population-wide communication strategies extends through the implementation of all other DSRIP programs. A few examples include the Building a Suffolk County Integrated Delivery System Program which has a priority-focus on care coordination and the connectivity of beneficiaries to social services to address social needs. Availability and navigation connections are being convened through SCC CBO and Social Service partnerships being made throughout the network. Another example is our Transition of Care Program for Inpatient and Observation Units includes the requirement of a social needs screen for all high risk identified inpatients or observation unit patients to ensure social needs are met during discharge planning or the 30-day transition of care period. Lastly, our Community Health Activation Program (CHAP), which is celebrating it's one year Anniversary from implementation this upcoming August 2016, is a CBO led program by the SCC, which focuses on engaging persons not utilizing the health care system and works to engage and activate those individuals to utilize primary and preventive care services. The population-wide engagement strategy for this program is primarily an outreach model very similar to the Health Home Care Management Agency model, as well as includes an in-reach model for Hudson River Healthcare (7 health home clinics throughout Suffolk County all located in areas of high need). The CHAP program utilize the PAM® survey tool and a wellness coaching model CFA to community and engage our targeted beneficiaries. To date, the CHAP program has engaged primarily in-person over 12,000 individuals also of whom are primarily uninsured.

Health Information Tool for Empowerment (HITE)

The SCC has recently signed a Data Sharing Agreement with Greater New York Hospital Association which explores the options to embed and integrate the Health Information Tool for Empowerment (HITE) into the SCC's website. Providing access to this tool in the future-state Community Webpage will allow for ease of access to Suffolk County residents to search for health and wellness services in local communities. This will also be used by care managers and care coordinators throughout the Suffolk County Integrated Care Network.

Long Island Population Health Improvement Program (LIPHIP) Engagement

SCC's collaboration with LIPHIP has been invaluable as LIPHIP is assisting to further our stakeholder collaboration efforts, data-driven analytics, and local strategies for addressing health disparities. During LIPHIP's monthly Collaborative meetings SCC has networked and developed relationships that has fostered into future collaborations that allow to raise awareness and access for chronic disease prevention. For example, community partners extend information for health events and affairs within the community and these events are posted in DSRIP-In-Action on a bi-weekly basis.

Clinical Guideline Summaries

To help promote practice and provider effectiveness and promotion of evidence-based best practice guidelines for chronic disease management and preventive care practices; the SCC has developed Clinical Guidelines Summary documents which serve as an educational tool for SCC provider partners. These clinical guidelines were recommended by each respective Project Committee and then moved to the Clinical Governance Committee for approval before publishing. Stakeholders across the county and state who participated in the selection of these clinical guidelines are subject matter experts in the fields. Further, these documents are posted on the SCC website for provider and public access.

Prevention Agenda Integration & Alignment

The New York State Prevention Agenda 2013-2018 is call to action for state and local agencies to improve the health on New Yorkers in five priority areas, and to reduce health disparities amongst all populations who experience them, including racial, ethnic, disability, and low socioeconomic groups (NYSDOH, 2016b). The overarching vision of the Prevention agenda is to mold New York into the healthiest state in the Nation through the focus on these five priority areas: prevent chronic disease; promote healthy and safe environments; promote healthy women, infants, and children; promote mental health and prevent substance abuse; and prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare associated infections. The Agenda outlines goals for each priority area, defines indicators to measure progress towards these goals, and identifies interventions that have been demonstrated effective in reaching these goals.

In Suffolk County, there is a specific prevention agenda that is being implemented county-wide by the local county health department, and Suffolk County Hospitals, including Brookhaven Memorial Hospital Center, Good Samaritan Hospital Medical Center, St. Catherine of Siena Medical Center, St. Charles Hospital, Eastern Long Island Hospital, Peconic Bay Medical Center, Southampton Hospital, John T. Mather Memorial Hospital, Huntington Hospital, Southside Hospital, and South Oaks Hospital. The two Prevention Agenda Priority Areas that are being addressed in Suffolk County are Preventing Chronic Diseases and Promoting Mental Health and Preventing Substance Abuse. For both Prevention Agenda Priorities, there is a specific State Action Plan which outlines the intervention. For the **Preventing Chronic Disease Prevention Agenda Priority,** the specific action plan introduces the focus areas, interventions by levels of Health Impact Pyramid, and interventions and activities by sector. This action plan has three focus areas: reduce obesity in children and adults; reduce illness, disability and death related to tobacco use and secondhand smoke exposure; increase access to high quality chronic disease prevention care management in both clinical and community settings. (NYSDOH, 2016c). The Promote Mental Health and Prevent Substance Abuse Agenda Priority specific action plan likewise introduces goals and objectives, and interventions by sector (NYSDOH, 2016e). This action plan has three focus areas: promote mental, emotional, and behavioral well-being in communities; prevent substance abuse and other mental emotional behavioral disorders; and strengthen infrastructure across systems (NYSDOH, 2016e).

Many of the efforts put forth through the Delivery System Reform Incentive Payment (DSRIP) Program mirror those of the Suffolk County Prevention Initiative. Specifically, they most closely align with the objectives of Project 4aii, Substance Abuse Prevention and Identification Initiatives, and 4bii, Access to Chronic Disease Preventive Care Initiatives. The Suffolk Care collaborative is working to align the DSRIP project activities and goals with those of the Prevention Agenda in order to provide for greater support of these public health initiatives.

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DSRIP Project 4bii, Access to Chronic Disease Preventive Care Initiatives, aligns with the Suffolk County Prevention Agenda Priority area of Preventing Chronic Disease. The project objective of 4bii is to focus on access to high quality chronic disease preventive care and management in both clinical and community settings. There are 4 initiatives that comprise this project: Lung Cancer Screening Initiative; Breast Cancer Screening Initiative; Colorectal Screening Initiative; Obesity Prevention Initiative; and Tobacco Screening Initiative.

The Lung Cancer Screening Initiative is one of three focus areas involving cancer screenings. The first goal of this project is to identify Suffolk County residents who are at risk for lung cancer through pre-screening initiatives in an effort to connect patients who meet screening criteria to available services. The second goal of this project is to promote early detection of lung cancer through current screening programs in an effort to increase the percentage of patients (who meet criteria for screening) who complete the screening process, and decrease time from identification of need to completion of the lung cancer screening.

The Breast Cancer Screening Initiative is the second focus area involving cancer screenings. Much like the Lung Cancer Screening Initiative, the breast cancer project goals are to identify Suffolk County residents who are at risk for breast cancer through pre-screening initiatives in an effort to connect more patients who meet screening criteria to available services, and to use evidence-based recommendations to identify those who are at risk and eligible for breast cancer screening. To identify eligible persons in need of breast cancer screening, the SCC will collaborate with community health centers, the Suffolk County Cancer Services Program, and other community groups. For those who are identified as clinically eligible, they will be referred to local breast cancer screening resources. Additionally, providers will be educated to increase awareness of screening guidelines.

The Colorectal Cancer screening Initiative is the third and final focus area involving cancer screenings. The immediate goal of this project is to increase knowledge among patients 50 years of age and above on colon cancer screenings in participating primary care settings. The long term goal of this project is to increase colon cancer screening rates among adults 50 years of age and older. To increase patient knowledge and increase screening rates, providers who are part of the patient care team will educate patients 50 years of age and older on colon cancer screenings, using the USPTF guidelines.

In addition to cancer screenings, the Obesity Project is another primary thrust of the 4bii project. The immediate goal of the Obesity Project is to develop a resource guide to support facilitation of access to programs which support Suffolk County residents' adoption of health eating and physical activity habits and maintain a healthy weight. The long term goal of this project is to create community environments that promote and support health food access, food and beverage choices and physical activity (in locations including worksites, corner stores, schools, and parks/ recreational facilities) by supporting agencies in Suffolk County working towards these goals with other funds. Such support includes facilitating promotion of events and increased awareness of positive changes in the built environment or in policies.

The third and final focus of the 4bii project is the Tobacco Cessation Initiative. The immediate goal of this project is to screen patients 18 years of age and older in participating primary care settings and participating OMH licensed facilities for tobacco use and provide for connect to assistance for smoking dependence. The long term goal of the project is to reduce the prevalence of tobacco use in the County. The interventions for this project include implementing the 5A's of tobacco dependence intervention among providers, and connecting patients who express an interest in quitting with the NYS Quitline and patient care team, including care management, to ensure adequate follow up and patient navigation.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The development strategies of the program include the collaboration of the workgroups and key stakeholders to brainstorm strategies to involve PCP engagement, identify community-based programs, resources and health fairs/events in the community which share the common objectives of the project, develop a resource guide, have key stakeholders create educational materials and educate providers, and involve care managers to provide support in connecting patients to resources.

SCC is currently working on hot-spotting strategies and using county health assessment data to identify and determine priority areas of particular need for the project. As described above, the program also aims to work closely with the Community Health Activation Program (CHAP) and other community initiatives related to DSRIP and in the Suffolk County community.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

In the Project Plan Application, there were several additions to the project that were contingent upon Capital Funding. As Stony Brook did not receive this capital funding, several of these additions will not be carried out through this project. These components include:

- Tele-health tablets for care managers and community health resources to undertake remote screening on a mass scale. Additionally, our CHAP program is providing partnered CBO's tablets for Community Health Workers to administer PAM surveys under project 2di.
- Space rentals in community centers and other venues to outreach to general population with key messages (obesity, smoking, etc.). As well as various partnerships in the community that allow the PPS to be invited to these spaces at no cost (i.e., Health and Welfare Council of Long Island).
- Purchase of a mobile van to conduct mammography screening (requiring necessary equipment for screening)
- Purchase of mobile can to conduct lung cancer screenings (requiring necessary equipment for screening)