Nassau University Medical Center (PPS ID:14)

SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

Description:
The DSRIP PPS Organizational Application must include an executive summary clearly articulating how the PPS will evolve into a highly effective integrated delivery system. This section will also include questions about any application(s) for regulatory relief the PPS is pursuing.

Scoring Process:

This section is not factored into the scoring of the PPS application. This response will be reviewed for completeness and a pass/fail determination will be made.

Section 1.1 - Executive Summary:

***Goals:**
Succinctly explain the identified goals and objectives of the PPS. Goals and objectives should match the overall goals of the NY DSRIP waiver and should be measurable.

#	Goal	Reason For Goal
1	To create an integrated delivery system. Start DY1 through DY5	The existing fragmented system has led to poor value as measured by cost/outcomes. The Nassau Queens PPS (NQP) expects to: - Have an integrated network of providers across the care continuum committed to risk sharing, care coordination and evidenced based medicine - Establish a Program Management Office to align the PPS and partners -Monitor financial stability of partners - Reduce avoidable hospitalizations (readmissions, admissions, and emergency department visits) by 25% - Incentivize providers to meet DSRIP goals/metrics - Develop a coordinated system of providers linked by Health Information Technology; current review indicates many partners may not be connected to the RHIO - Establish care management protocols and process for patients with chronic conditions - Partner with Community Based Organizations (CBO) to address the basic needs of the population - Educate providers in cultural competent care (race and ethnicity, faith, gender, sexual orientation) and health literacy
2	To create PCMH Level 3 safety-net providers and link patients to them: Start DY1 through DY3	PCMHs organize primary care emphasizing care coordination, communication and minimize use of unnecessary specialty and ancillary services. The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be". Medical homes can lead to higher quality and lower costs and can improve patients' and providers' experience of care. - Expand PCMH designation to safety-net primary care practices - Enhance availability and access to care through systems such as open scheduling, expanded hours and use of technology - Decrease no-show rate by 15% - Ensure all primary care practices are connected to the Regional Health Information Organization (RHIO) - Use Electronic Health Record (EHR) registries to identify at-risk patients and make appropriate care coordination referrals
3	Co-locate primary care in hospital EDs with high	Use of the Emergency Department (ED) for preventable and avoidable

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#	Goal	Reason For Goal
	volume of preventable and avoidable visits	visits is the most expensive type of care and reinforces the fragmentation of the delivery system - Regularly track ED visits (i.e., quarterly or more frequently, if necessary) for preventable and avoidable visits, report same to hospitals and PPS - Refer patients with multiple preventable and/or avoidable ED visits to PCMH and assign care coordinator - Develop hospital billing and ED policies and procedures for triage and referral of ED patients to co-located PCMH level 3 primary care practice - Link hospital EMR system with real time notification system, preferably through the RHIO - Establish community awareness program for PPS partners and ED signage to raise awareness of primary care alternatives to the ED
4	Coordinate the expansion of community-based behavioral health services in an organized way	Address how access barriers in the community for substance abuse and psychiatric services contribute to avoidable hospital use. Start DY1 through DY5 - Expanding primary care in behavioral health centers and behavioral health care in primary care practices - Expand crisis stabilization services that are available 24 hours, 7 days a week, 365 day per year - Annually evaluate the need for crisis stabilization services in the PPS community needs assessment - Educate providers in culturally appropriate patient interaction - Educate and ensure that hospital and behavioral health centers develop policies and procedures for referral to crisis stabilization services - Develop a centralized triage service among providers
5	Integrate the provision of physical and behavioral health services	Physical and behavioral health problems are frequently co-occurring, yet the delivery system is not organized to provide care for the multi-faceted needs of patients in one setting. Long Island FQHC ran a one-month study by conducting PHQ4s on all patients and determined that 27% had a score that would warrant behavioral health referral. - Expanding primary care in behavioral health centers and behavioral health care in primary care practices - Hold regularly scheduled meetings to develop collaborative practices and share evidence based care protocols - Ensure screenings (such as PHQ-9, SBIRT) are conducted for all patients and that they are documented in the patient electronic health record
6	Improve care transitions to reduce 30 day re-admissions for chronic health conditions	Inadequate communication between providers in patient transfers and unclear patient care plans can lead to errors in care resulting in hospital re-admissions - Provide the Medicaid and uninsured the ability to sign up for the RHIO - Develop and implement policies and procedures of hospital transition care plans with transition care plans to SNF or Home Care or PCP - Identify patients with chronic health conditions and link care coordinators, as necessary - Link providers electronically to share patient records and transition care plans - Train providers on using transition care plans - Incentivize providers to actively participate in transition care plan reporting and performance
7	Implement the INTERACT project with SNF partners	The use of the INTERACT program principles and program have been shown to reduce patient transfers from SNFs to hospitals - Use INTERACT training program for the staff of SNF participating partners encompassing care pathways and INTERACT principles - Ensure that all participating SNFs establish an INTERACT coaching

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		program - Ensure that the INTERACT project committee uses quality improvement and rapid cycle improvement methodologies
8	Implement patient activation activities to engage the uninsured and Medicaid's low/non-utilizers.	NQP wants to engage fully the Medicaid and uninsured populations of Nassau and Queens, even hard-to-reach populations like low- and non-utilizers of health care and the uninsured. To achieve this, it plans to: -Partner with CBOs to assist in patient "hot spotting" -Undertake Patient Activation Measure (PAM) training for PPS partners -Set goals per each PAM activation level for improvement - Utilize beneficiaries as a resource to promote preventive care -Establish performance measurement reports on the number of patients screened; number of clinicians trained, number of patient:PCP bridges established, number of patients identified, linked by MCOs -Share member engagement lists with insurance companies on a monthly basis - Measure and improve volume of non-emergent visits for uninsured, non-utilizers, and low-utilizers -Community navigators prominently placed in "hot spot" areas -Timely access for navigator when connecting individuals to services
9	Implement evidence-based strategies for disease management for high-risk adult populations	Monitoring and early intervention of cardiovascular disease and diabetes can attenuate chronicity - Registries are used to identify patient with chronic conditions like cardiovascular disease (CVD) and/or diabetes - Participating primary care practices meet connectivity to the RHIO HIE - Identify and track actively engaged cardiovascular and/or diabetes patients for metrics and milestone reporting - Educate and implement tobacco control protocols for participating primary care practices - Assist patients presenting with early CVD and/or diabetes in self-management - Track participating primary care provider clinical record documentation of self-management goals. - Track implementation of policies and procedures which reflect initiatives of Million Lives Campaign
10	Partner with CBOs for outreach, patient engagement and meeting the non-health needs of patients	NQP is committed to a true partnership with CBOs to reach the Nassau and eastern Queens communities and to address non-health needs. -Utilize Community Based Organizations to reach into the community, increase the number of referrals both to and from CBOs. -Have CBOs provide outreach and engagement with the diverse populations, utilize them to help disseminate PAM. Number of PAM trainings among CBOs. -Measure the number of referrals to CBOs for non-health needs and identify gaps in services, working to address those gaps
11	Become a culturally competent network and address the health literacy needs of our patients	- Engage CBOs in development of culturally competent training and performance and addressing the health literacy of the population -have cultural competence training and health literacy as part of its workforce strategy -undertake training for all staff in both cultural competence and health literacy for providers, train patients in health literacy on a regular basis -Commit to Improving diversity in hiring
12	To build on care redesign experience of partners to move to payment reform by the end of DY 5	By the end of the DSRIP period, we expect many providers to be participating in pay-for-performance, risk based models for Medicaid patients. The hubs have experience with running insurance companies, participating in the Medicare shared savings program, and partnering with MCOs, such as Healthfirst on a risk and other value payment basis. This experience will give us a starting point for the transition from fee-for-service

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#	Goal	Reason For Goal
		reimbursement to value-based payment. -Increase the number of risk-based contracts with MCOs during the DSRIP period -Increase the number of capitation contracts by the end of the DSRIP period -Measure for baseline and increase number of contracts with CBOs that are on a risk basis, assuming that payers will cooperate

***Formulation:**

Explain how the PPS has been formulated to meet the needs of the community and address identified healthcare disparities.

Catholic Health Services of Long Island (CHS), Long Island Jewish Medical Center (LIJ) and Nassau University Medical Center/NuHealth created the NQP, serving the communities of Nassau and eastern Queens. The Project Advisory Committee or PAC was created to involve community stakeholders in the PPS. Our PAC contains over 180 members representing hospitals, physician groups, nursing homes, FQHCs, home care agencies, behavioral health treatment programs, health homes, hospices, developmental disability providers, community agencies, unions, Medicaid managed care plans, food banks, housing organizations, OMH, OASAS and other governmental agencies. Many of these groups also participate as active partners in DSRIP projects. PAC members were involved in the CNA and selection of projects. Their on-going involvement assures that NQP will be able to identify and address health disparities. In addition, NQP will continue to hold stakeholder meetings and to publish our findings on the website. We will encourage community members to provide ongoing feedback on our DSRIP projects throughout the term of the DSRIP program.

***Steps:**

Provide the vision of what the delivery system will look like after 5 years and how the full PPS system will be sustainable into future.

The vision for the PPS is to ensure the health and well-being of community members via a delivery system that focuses on community-based ambulatory care rather than inpatient care. The vision is to be achieved by connecting individuals to comprehensive, culturally sensitive primary care and assuring that care is provided in the most appropriate settings, avoiding unnecessary care, and sharing information among providers in real time. The PPS will accomplish this vision and be able to manage (and be paid for) the population on a risk basis by the end of the DSRIP period. The system will be sustainable because payment will be based on per capita amounts reflecting current care patterns. Value based payments will provide an incentive to treat patients in the most appropriate, community-based settings, instead of relying on inpatient settings.

***Regulatory Relief:**

Is the PPS applying for regulatory relief as part of this application? Yes

For each regulation for which a waiver is sought, identify in the response below the following information regarding regulatory relief:

- Identify the regulation that the PPS would like waived (please include specific citation);
- Identify the project or projects in the Project Plan for which a regulatory waiver is being requested and outline the components of the various project(s) that are impacted;
- Set forth the reasons for the waiver request, including a description of how the waiver would facilitate implementation of the identified project and why the regulation might otherwise impede the ability of the PPS to implement such project;
- Identify what, if any, alternatives the PPS considered prior to requesting regulatory relief; and
- Provide information to support why the cited regulatory provision does not pertain to patient safety and why a waiver of the regulation(s) would not risk patient safety. Include any conditions that could be imposed to ensure that no such risk exists, which may include submission of policies and procedures designed to mitigate the risk to persons or providers affected by the waiver, training of appropriate staff on the policies and procedures, monitoring of implementation to ensure adherence to the policies and procedures, and evaluation of the effectiveness of the policies and procedures in mitigating risk.

PPS' should be aware that the relevant NYS agencies may, at their discretion, determine to impose conditions upon the granting of waivers. If these conditions are not satisfied, the State may decline to approve the waiver or, if it has already approved the waiver, may withdraw its approval and require the applicant to maintain compliance with the regulations.