Stony Brook University Hospital (PPS ID:16)

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	Develop a robust data infrastructure and advanced analytical capabilities.	A health information exchange (HIE) across PPS partners is essential for effective care coordination and management. A key objective will be to assure that all PPS partners have electronic medical records (EMR) that feed disease registries, clinical decision support systems, predictive models, and other analytic software. This includes assuring that providers have timely access to claims-based data (particularly for ED visits), and the ability to translate information into care management activities. We will manage subsets of high need, high cost patients with personalized approaches and will use predictive modeling to identify patients at risk for decompensation so that we can address their needs proactively and monitor population-based parameters.
2	Improve access to care, particularly for Medicaid members and uninsured populations.	Access to comprehensive, quality healthcare services is important for achieving health equity and for promoting better overall quality of life. Healthcare access impacts overall physical, social and mental health status; prevention of disease and disability; detection and treatment of health conditions; preventable death; and life expectancy. Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires gaining entry into the healthcare system; accessing a healthcare location where needed services are provided; and finding a healthcare provider that the patient can trust and with whom the patient can communicate.
3	Improve disease management, particularly for those with chronic disease.	Chronic disease is highly prevalent in Suffolk County and costly to manage. Deficiencies in disease management include: rushed practitioners not following established practice guidelines; lack of care coordination; lack of active follow-up to ensure the best outcomes; and the fact that patients are often inadequately trained to manage their illnesses. Preventing chronic disease and impacting morbidity and mortality from chronic conditions can be enhanced by adopting strategies that integrate population health and the social determinants of health into chronic care models, along with realigning the patient-physician relationship and effectively engaging providers across the continuum within the communities they serve.
4	Move providers away from the traditional fee-for-service payment and toward value based payment.	This goal will include cooperating with payers in developing a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures. This will not only improve the quality of care, but also it will lead to better value by driving improvements in quality and slowing the growth in health care spending.
5	Eliminate health disparities in Suffolk County.	This goal is based on the belief that all people should have the opportunity

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#	Goal	Reason For Goal
		to reach their full potential for health. Yet, those at the lower ends of the socioeconomic spectrum (which disproportionately includes racial and ethnic minorities) often have lower access to care and fewer healthy lifestyle options. They often have higher rates of morbidity and mortality as compared to more socioeconomically advantaged populations. While movement toward this goal will require a multipronged strategy, PPS activities will include: Identifying and mapping high-need areas that experience health disparities and aligning existing resources to meet specific needs; developing and evaluating community-based interventions; supporting and expanding training programs that bring diverse workers (racial and ethnic balance) into the healthcare and public health workforce; and increasing the dissemination and use of evidence-based cultural competency and health literacy practices and interventions.
6	Transform the PPS into a highly efficient integrated delivery system.	The current healthcare delivery environment (structure and processes) that defines the context for the Suffolk PPS is too costly and often yields suboptimal patient outcomes. We aim to develop a system in which: patients' clinical information is available to providers at the point-of-care and to patients through electronic health record systems; patient care is coordinated across providers and transitions to different care settings are actively managed; providers are accountable to each other, review each other's work, and collaborate reliably to deliver care that is of high quality and value; patients have easy access to appropriate and culturally competent care and information, including after hours; there is clear accountability for the total care of patients; and the system is continuously innovating and learning how to improve quality, value, and the patients' experience.
7	Assure that all PPS operations integrate concepts of cultural competence and health literacy.	Cultural competency and health literacy are critical to reducing health disparities and improving access to high-quality health care--health care that is respectful of and responsive to the needs of diverse patients. This is essential if healthcare resources are to be used wisely to produce optimal patient outcomes.
8	Establish a solid foundation of team-based care across medical, behavioral, and social services.	This goal is fundamental to improving care coordination. As such, it will lead to the creation of processes and protocols for robust care coordination and transitional care. Care will be collaborative and coordinated for patients within medical homes and Health Homes. We will use cross-functional care teams that span the continuum of physical health, behavioral health, and social services, including long-term supports and services. Such teams will have well-defined roles and responsibilities and will work closely with primary care providers. We will transition to advanced primary care models consistent with the State Health Innovation Plan that support the integration of physical and behavioral health and that provide robust care coordination to engage patients in the self-management activities that will keep them from presenting to the ED and reduce unnecessary hospitalizations.
9	Assure that patients get the right care at the right time, while avoiding unnecessary services.	This goal reflects tenets of the Triple Aim which will make care safer and reduce costs. It includes a specific focus on reducing unnecessary admissions and ED visits. It is intended to encourage physicians and other providers to change their practice patterns (where needed) to reflect professional medical guidelines. Care will be evaluated using PPS-wide shared metrics. This will entail the design of standard operating procedures, a workforce with diverse yet complementary skills, workloads that allow enough time for errors to be corrected or mitigated, and leadership that promotes continuous improvement. This will lead to better, safer care by preventing serious medication errors, healthcare associated infections and other preventable events.

***Formulation:**

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

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We have designed a governance model that will assure that the PPS continues to meet the needs of the community. The organizational structure of the PPS is a variant of the Delegated Model described in the "Governance How to Guide" prepared by the DSRIP Support Team. A Board of Directors will serve as the principal mechanism for implementing an effective, shared governance structure for the PPS. The Board will have representatives from critical stakeholder groups, with nearly half of the members consisting of such individuals. The Board will also maintain a Community Needs Assessment and Outreach Committee, whose charge is to provide guidance in identifying community health needs and ensuring that the PPS's projects and other initiatives are effective in addressing such needs on an ongoing basis. The PPS will incorporate robust cultural competency and health literacy program as well as ongoing analysis of trends in health disparities and the needs of vulnerable populations.

***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.

We envision a permanently transformed system in which all Medicaid members will receive coordinated, patient-centered primary and specialty care; providers will be accountable for quality, patient experience, and cost; financial incentives will be aligned to reward providers for keeping patients healthy; and providers will effectively and sustainably partner with community organizations and consumers. MCOs, providers, and Health Homes will come together with CBOs to break down silos between acute care, behavioral health, and care for those with developmental disabilities. PPS members will work in common cause toward improved health outcomes. Medicaid FFS will be replaced by MCO-based payment and MCO benefit requirements will be largely (if not entirely) met by PPS members. CBOs will be integral partners in addressing the social determinants of health.

***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.

#	Regulatory Relief(RR)	RR Response
1	10 NYCRR 34-1.3; 10 NYCRR 34-2.3; 10 NYCRR 34-2.4 Currently Prohibited Business Practices	Regulations: • 10 NYCRR 34-1.3 prohibits practitioners from making referrals to a healthcare provider authorized to provide such services where such practitioner has a financial relationship with such health care provider. • 10 NYCRR 34-2.3 prohibits health services purveyors from accepting payment/consideration from a clinical laboratory (CL) for the referral for the performance of CL services. • 10 NYCRR 34-2.4 prohibits a CL from giving payment/consideration to a health services purveyor for the performance of CL services. Projects Implicated: 2ai, 2biv