Staten Island
Performing Provider System, LLC

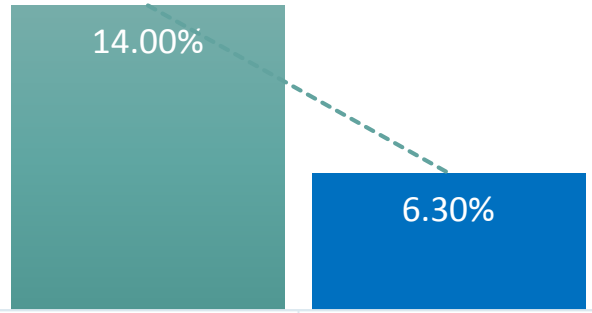
Staten Island Performing Provider System

PRESENTATION TO THE PUBLIC HEALTH & HEALTH PLANNING COUNCIL

SEPTEMBER 23, 2016

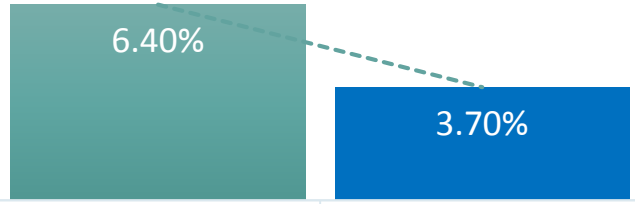
Current Progress - Improving Care Outcomes

2.A.III : HH at Risk



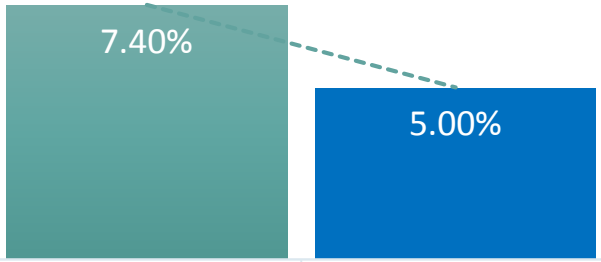
	DY1	DY2Q1
30-Day ER Util. Rate	14.00%	6.30%
Total AE Patients	607	1,064

3.C.I : Diabetes Management



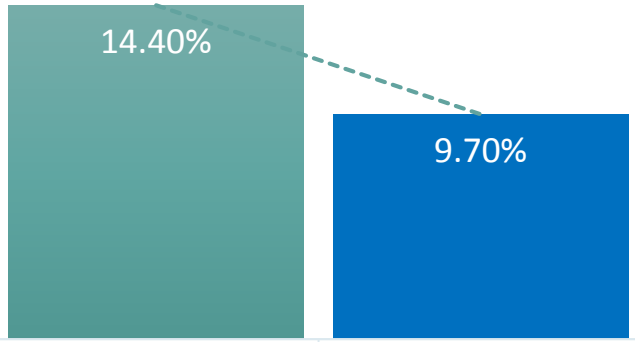
	DY1	DY2Q1
30-Day ER Util. Rate	6.40%	3.70%
Total AE Patients	2,944	3,443

3.A.I



	DY1	DY2Q1
30-Day ER Util. Rate	7.40%	5.00%
Total AE Patients	9,922	6,851

3.A.IV



	DY1	DY2Q1
30-Day ER Util. Rate	14.40%	9.70%
Total AE Patients	327	269

Key Findings:

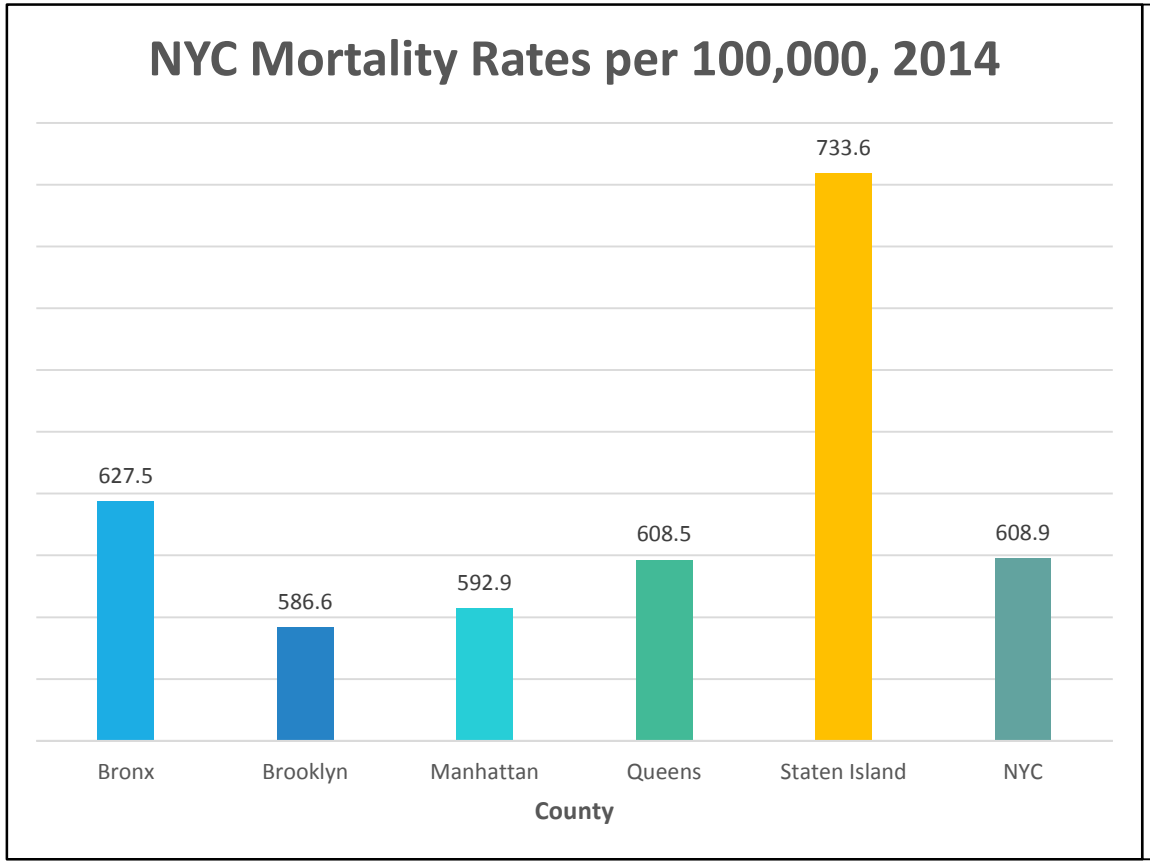
Significant improvement in 30-day ER Utilization Rate *(DY1 vs. DY2Q1)*

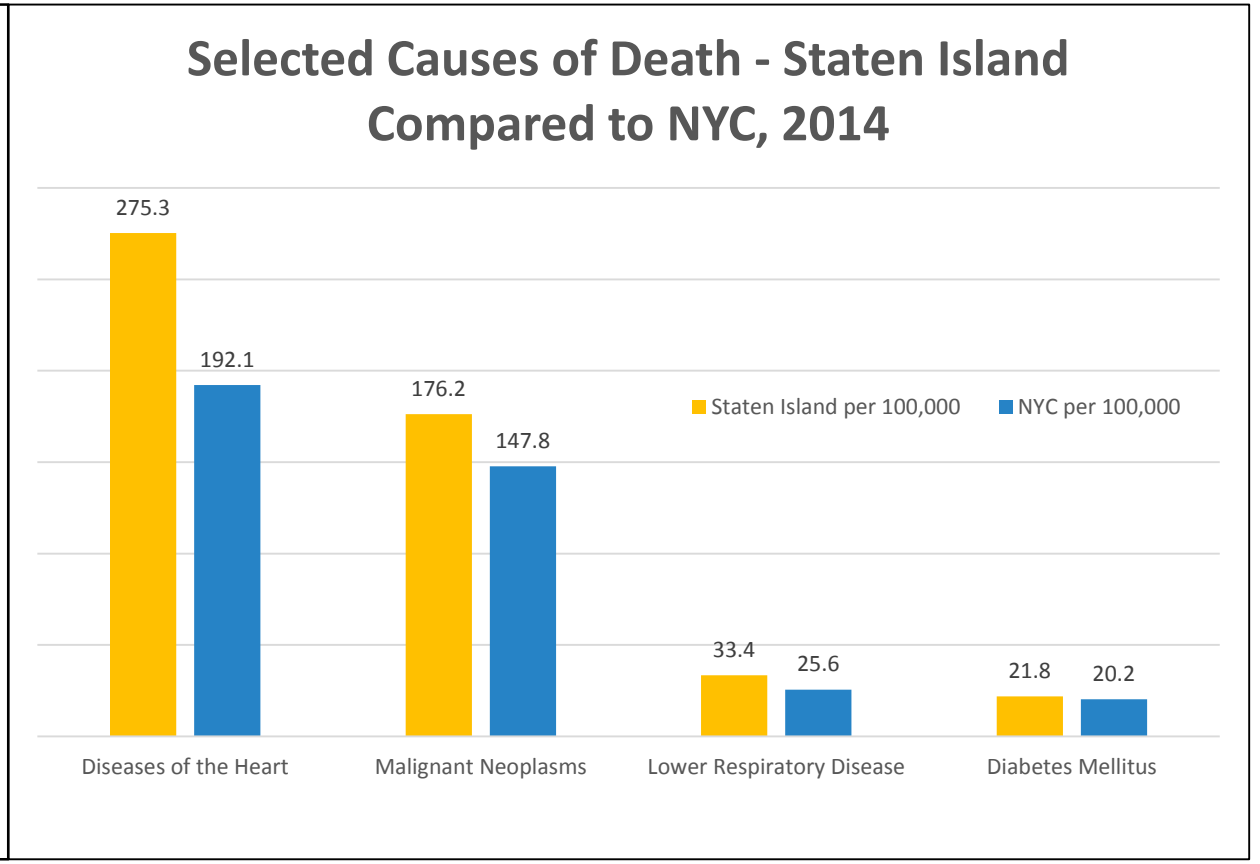
- 2.A.III: **55%** improvement, decreased from 14% to 6.3%.
- 3.C.I: **42%** improvement, decreased from 6.4% to 3.7%.
- 3.A.I: **32%** improvement, decreased from 7.4% to 5.0%.
- 3.A.IV: **33%** improvement, decreased from 14.4% to 9.7%.

Public Health Data Defines Targeted DSRIP Programs

- Identification of health disparities on Staten Island driven by community needs assessment and public health data
- CBO and partner engagement critical for engaging underserved populations affected by social determinants of health
- Use of MAPP and comprehensive data sources enhances PPS analytics
- Data drives DSRIP projects, Population Health Improvement Projects and informs Cultural Competency and Health Literacy strategy
- New York State Prevention Agenda informs DSRIP goals and initiatives
- Innovative program development on Staten Island includes multi-disciplinary pilots
- DSRIP Year 2 data suggests outcome improvements
- Recommendations to facilitate further project implementation

Health Disparities on Staten Island





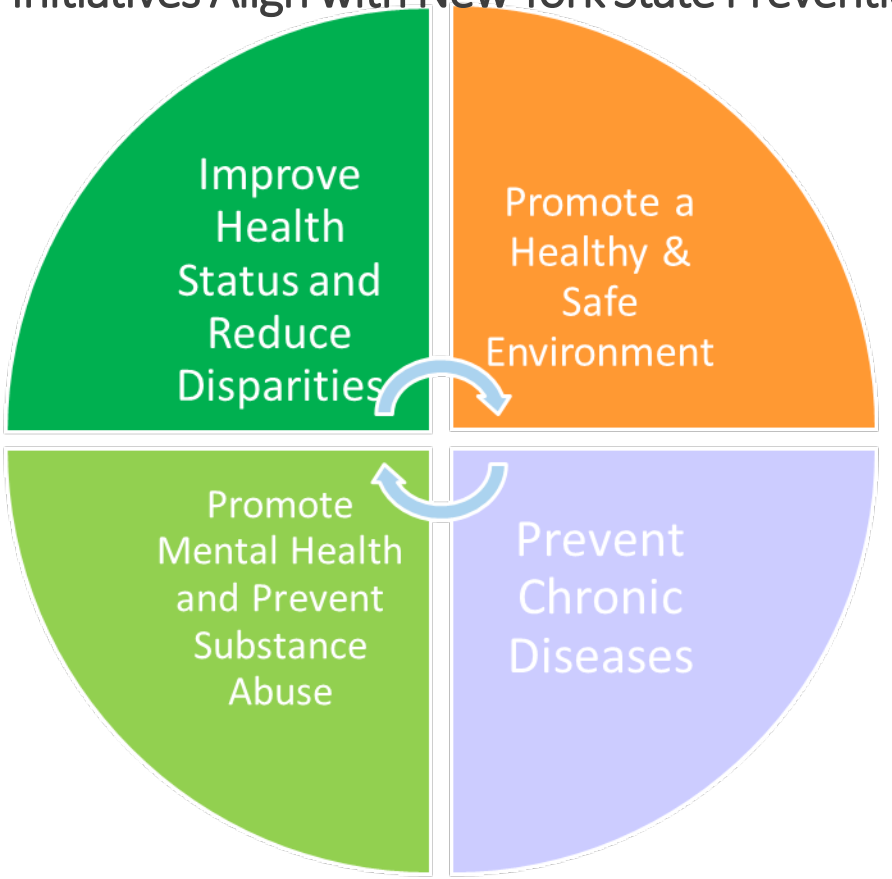
Source: New York State Department of Health Vital Statistics, 2014. Table 39: Death Rates For Selected Causes of Death by Resident County, Updated May 2016. Accessed 9/15/2016.

New York State Prevention Agenda Informs DSRIP Goals & Initiatives

Prevention Agenda

- Improve the health status of New Yorkers
- Reduce exposure to outdoor air pollutants
- Improve the built environment to promote healthy lifestyles
- Reduce obesity
- Increase access to chronic disease preventive care
- Reduce dental caries
- Strengthen infrastructure for behavioral health

DSRIP Initiatives Align with New York State Prevention Agenda



DSRIP

Prevent hospitalizations, reduce disparities and increase the number of adults who have a regular health care provider

- Asthma project
- Healthy Communities initiative
- Population Health Improvement Program & partnerships with school health
- Pilot for CKD risk with CHASI
- Oral health promotion program
- Behavioral Health Improvement Program Pilots

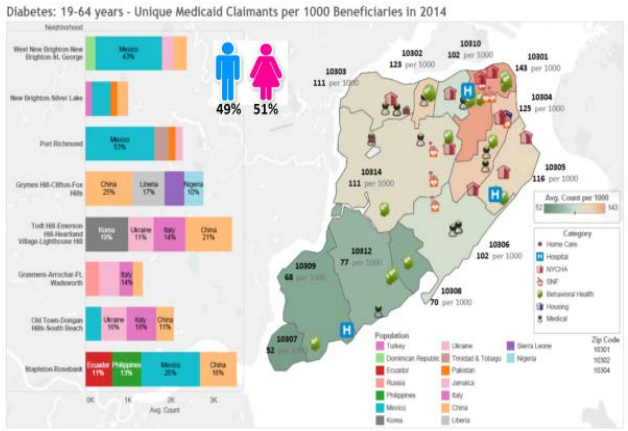
Engagement and Collaboration with CBOs Informs Program Development

Clinical Partners

CBOs

Health Literacy Workgroup

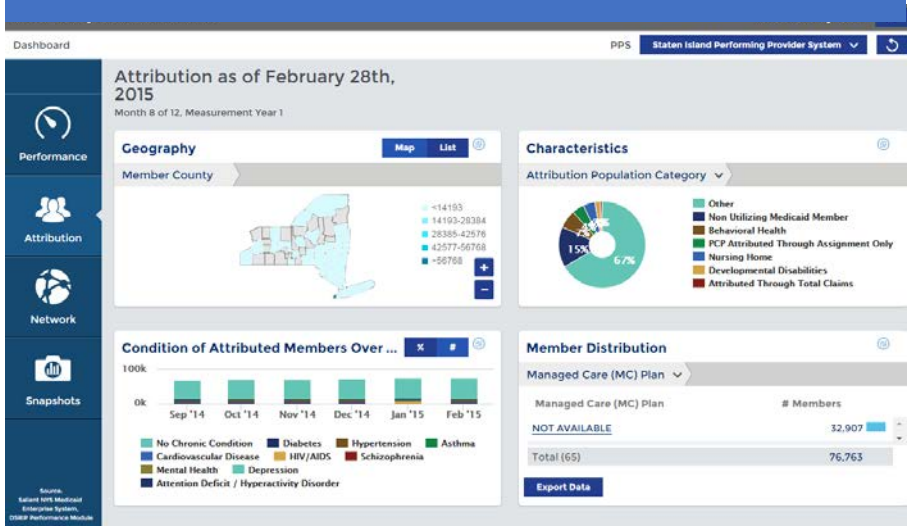
CCHL Site Champion Workgroup



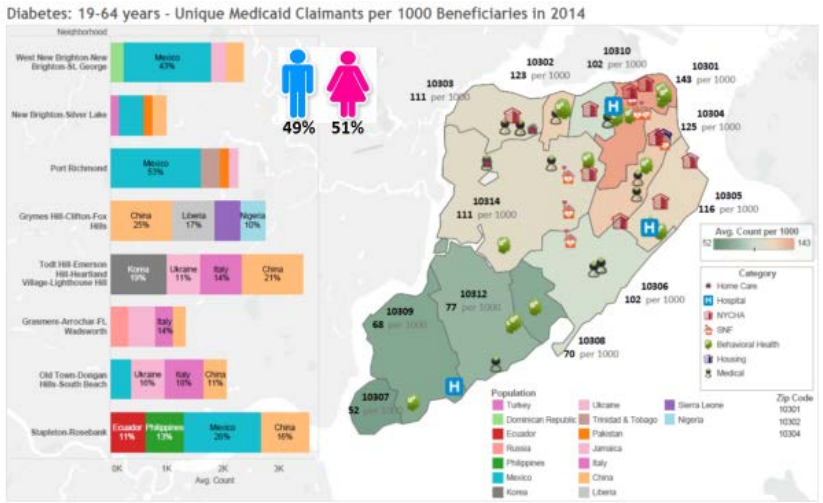
- Cultural Competency training partnerships for partner staff
- Diversity and inclusion for all Staten Islanders via language access services, Health Literacy campaigns and health education
- Patient Administering Patient Activation Measure® surveys
- Addressing social determinants by partnering with food banks, DOE, housing and immigrant agencies
- Promote Healthy Neighborhoods Initiatives
- Population Health Improvement Program Small Physician practices

Using Public Health Data to Develop DSRIP Programs

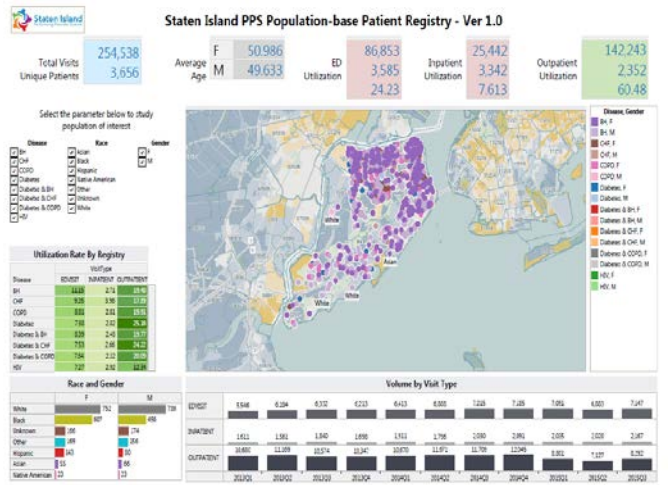
MAPP Dashboard



Healthcare Hotspotting

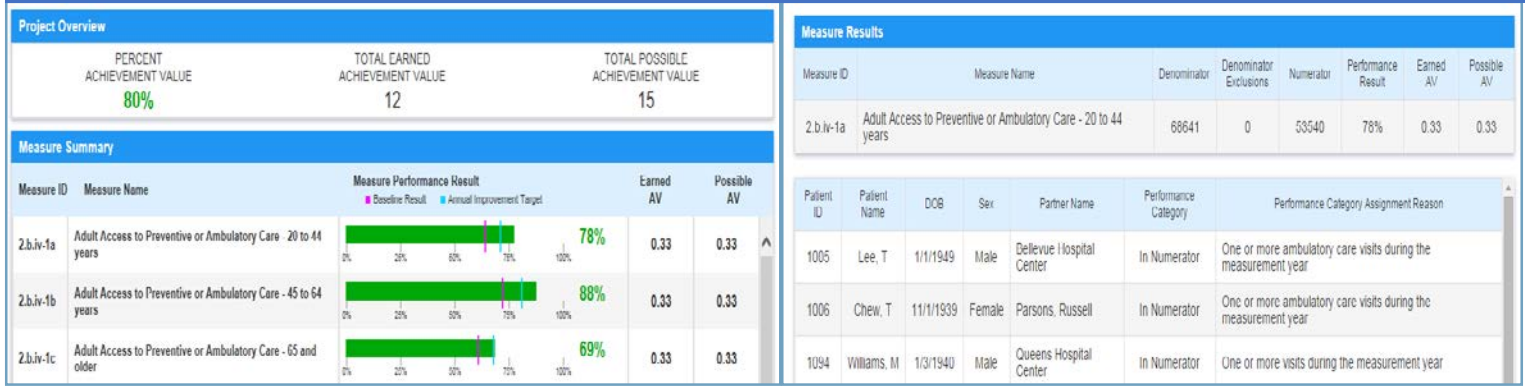


Population-based Registry 1.0



Strategic Planning ▷ Performance Improvement ▷ Population Health Management

Performance Management Dashboard



Comprehensive Data Sources

1 Direct Data Feed from Partners

- Lead Providers Clinical Data
- Other Partners Clinical/Billing Data
- Care Management Partners (GSI)
- Actively Engaged roster

2 Public Data

- Uninsured population
- Planning Dept. Data
- ACS Data: Education & Housing Status
- NYC FITNESS-GRAM

3 DOH Data Sources

- Medicaid Member Roster v3
- Claims Data v1
- Medicaid Data Warehouse / SIM
- IPA File
- CPA File

4 Other Feeds

- Patient Activation Measures (PAM)
- Local RHIO Data Sources
- MCO's
- Board of Education
- Emergency Medical Service (EMS) Dataset

Population Health View

1 Key Statistics

Total Visits	139,488	Average Age	F	42.74751	ED Visits	49,308	Inpatient Visit	12,356	Outpatient Visits	77,824
Unique Patients	2,609		M	42.80918	Unique Patients	2,544	Unique Patients	2,150	Unique Patients	1,695

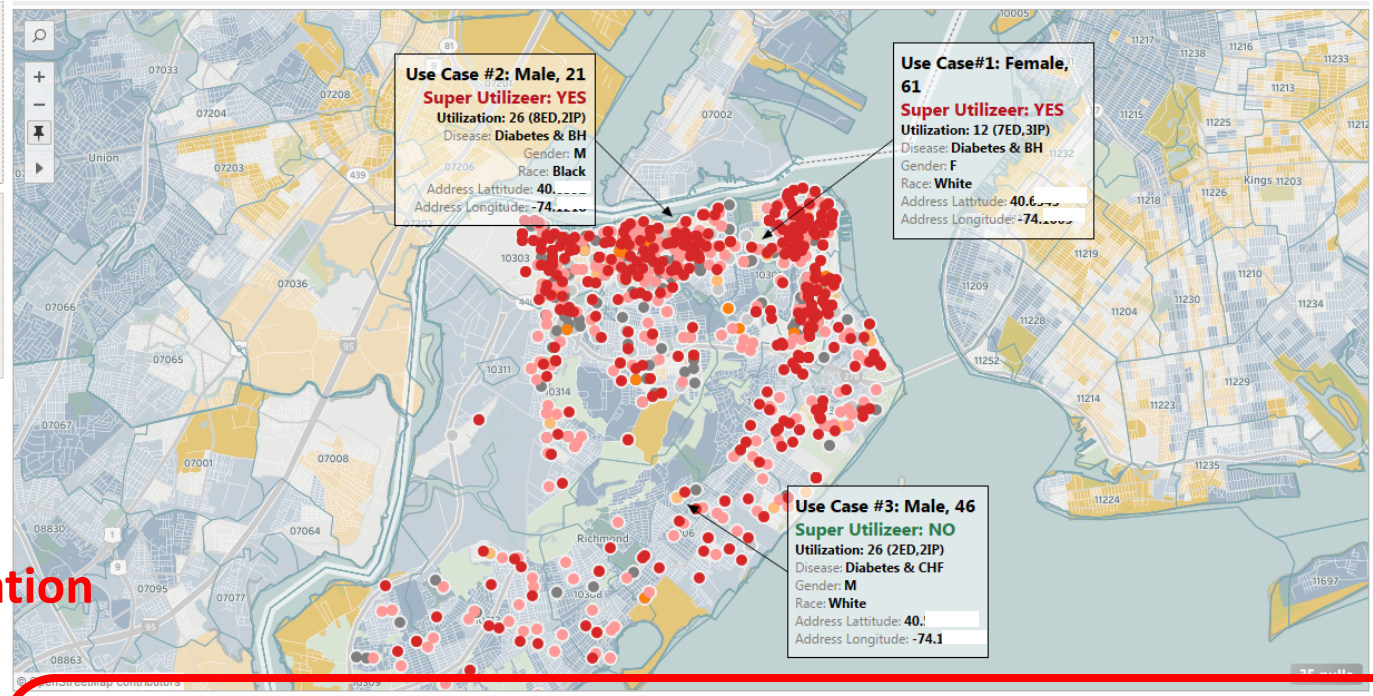
Disease
- (All)
- Asthma
- BH
- CHF
- COPD
- Diabetes
- Diabetes & BH
- Diabetes & CHF
- Diabetes & COPD
- HIV
- NULL

Race
- (All)
- Asian
- Black
- Hispanic
- Native American
- NULL
- Other
- Unknown
- White

Age_Group
- (All)
- 0-18
- 19-64
- 65+

Year
- (All)
- 2012
- 2013
- 2014
- 2015
- 2016

Gender
- (All)
- F
- M



Disease, Gender
- Diabetes & BH, F
- Diabetes & BH, M
- Diabetes & CHF, F
- Diabetes & CHF, M
- Diabetes & COPD, F
- Diabetes & COPD, M

Utilization Rate (Per 100 Patient) By Disease Area

Disease	VisitType		
	EDVISIT	INPATIENT	OUTPATIENT
Diabetes & BH	214.0	123.9	329.2
Diabetes & CHF	190.5	125.1	388.2
Diabetes & COPD	185.2	125.1	341.4

2 Utilization by Population

Race and Gender

	F	M
White	528	597
Black	532	403
Other	105	117
Hispanic	142	74
Asian	35	42

3 Patient Demographics

Utilization Trend by Visit Type (Visits Per 100 Patients)

	2013Q1	2013Q2	2013Q3	2013Q4	2014Q1	2014Q2	2014Q3	2014Q4	2015Q1	2015Q2	2015Q3	2015Q4
EDVISIT	190.6	199.5	203.0	194.3	203.6	207.3	205.8	199.4	187.8	193.6	200.9	172.5
INPATIENT	122.6	128.7	121.1	121.5	121.8	129.2	125.9	119.1	120.3	129.2	134.5	119.8

4 Hospital Utilization Trend

Population Health Management

Tool:
Population-based Patient Registry Ver. 1.0

Use Case:
Diabetes w/chronic Comorbid Conditions

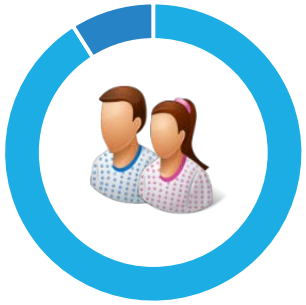
Population:
Attributed Members with at least one of the chronic comorbid conditions:

Diabetes, BH, COPD and CHF

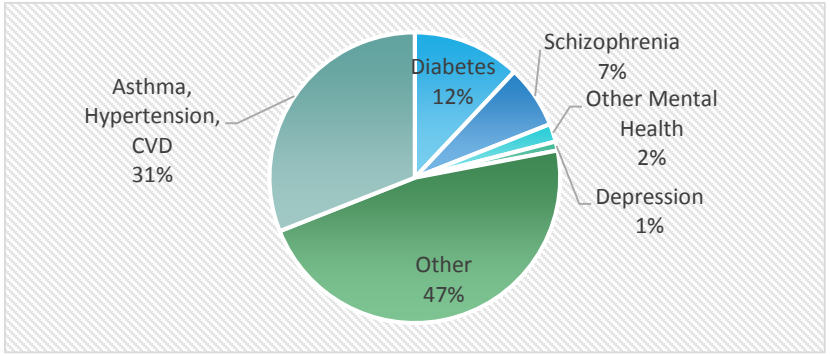
The Impact of Top 500 High Risk Patients (HRP)

Staten Island PPS Risk profile algorithm identified the top 500 High Risk Patients (HRP) from 63,605 Staten Island PPS Medicaid Enrollees

<1% of Staten Island PPS Medicaid Enrollees are defined as High Risk Patients (HRP)



100% HRP had one or more Chronic conditions



That population drives **20%** of preventable ED Visits (PPV) of Staten Island PPS Medicaid enrollees

Avg. PPV /HRP: **8.29**

Min PPV /HRP: **4** Max PPV /HRP: **140**

… and **20%** of preventable readmissions

Avg. PPR/HRP: **1.54**

Min PPR /HRP: **1** Max PPR /HRP: **6**

Percentage of Top 500 High Risk Patients (HRP) engaged in DSRIP projects

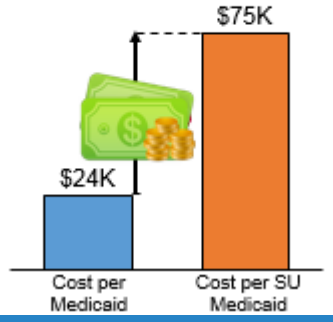
44%
2.a: Integrated Delivery
(Health Home or HHR)

12%
2.b: Care Coordination (2.b.iv, 2.b.vii, 2.b.viii)

47%
3.a: Behavioral Health
(3.a.i, 3.a.iv)

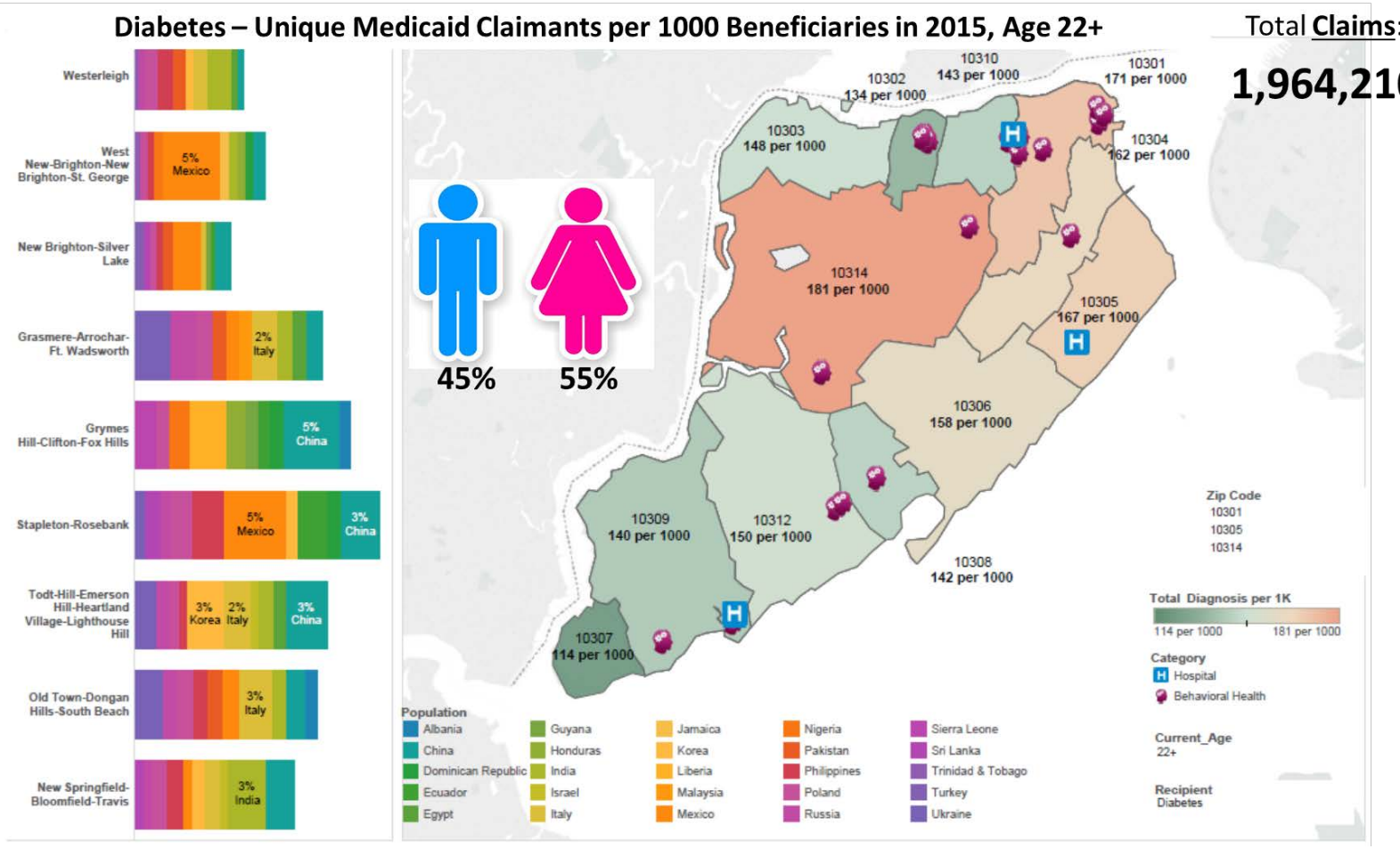
22%
Took PAM survey as of 09-09-2016

Average spending per Super Utilizer recipient is 3.1X greater



Use Case: Diabetes Management

Overlaying data to target key hot spots and develop programs

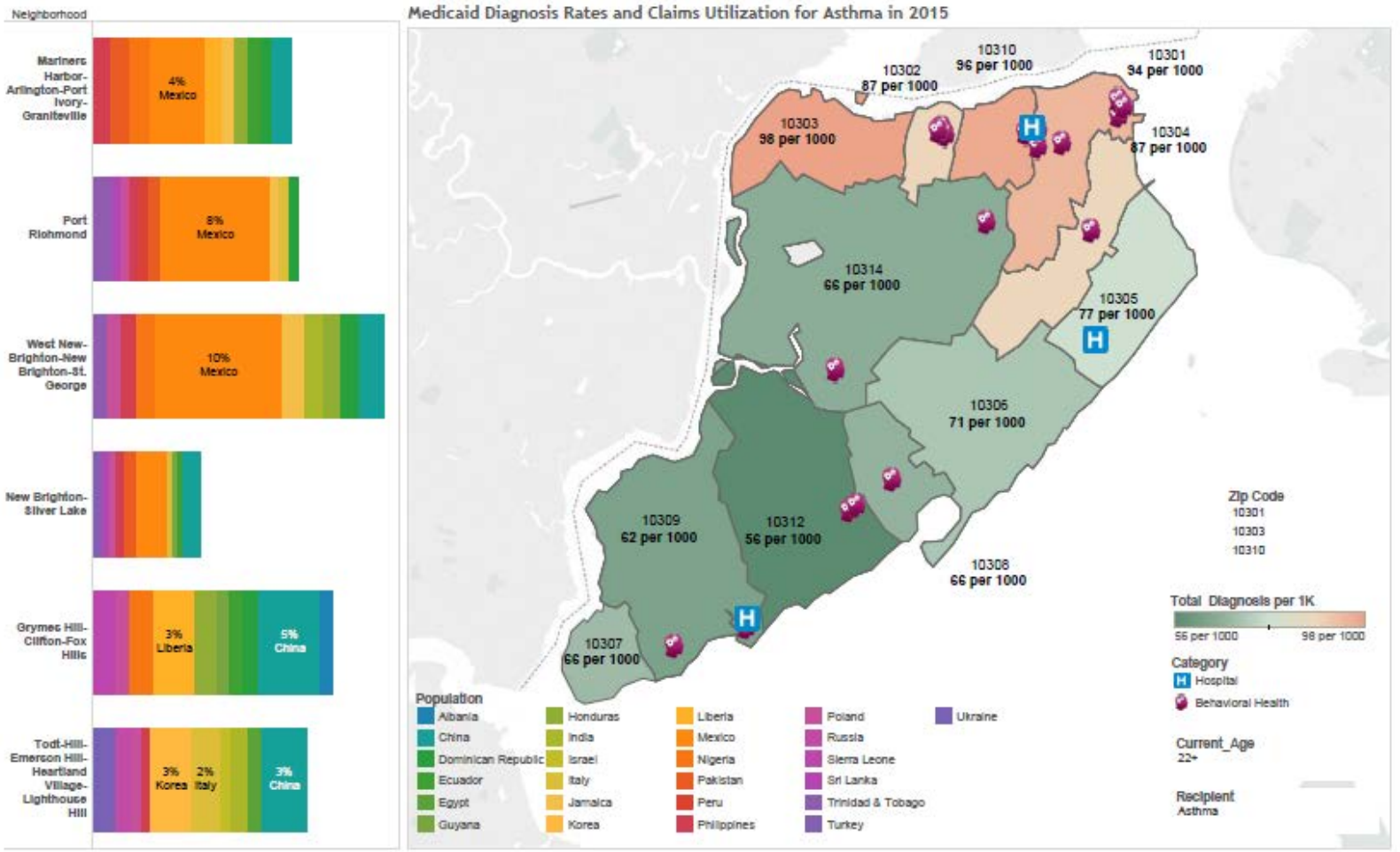


Improving Diabetes Management

- PPS gathers and evaluates baseline data for this population
- Population Health Improvement Program (PHIP) target Small Practices
- City Harvest Program w PHIP to give a “Healthy Food Prescription” & nutrition/cooking classes
- Fund Stanford Model – Chronic Disease Self-Management Program and Diabetes Self-Management Program
- Expansion to other healthcare providers and community groups

Source: (1) Salient Interactive Miner (2) DOH Member roster *Data Period: FY2015*

Use Case: Asthma Analytics and Program Development

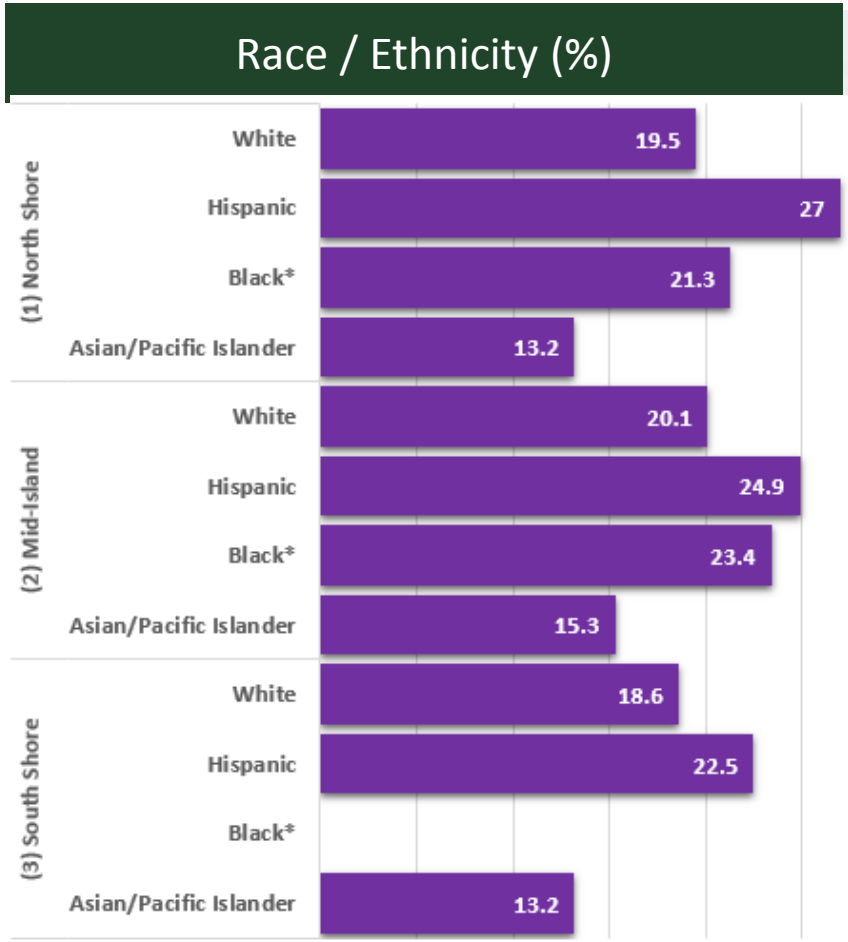


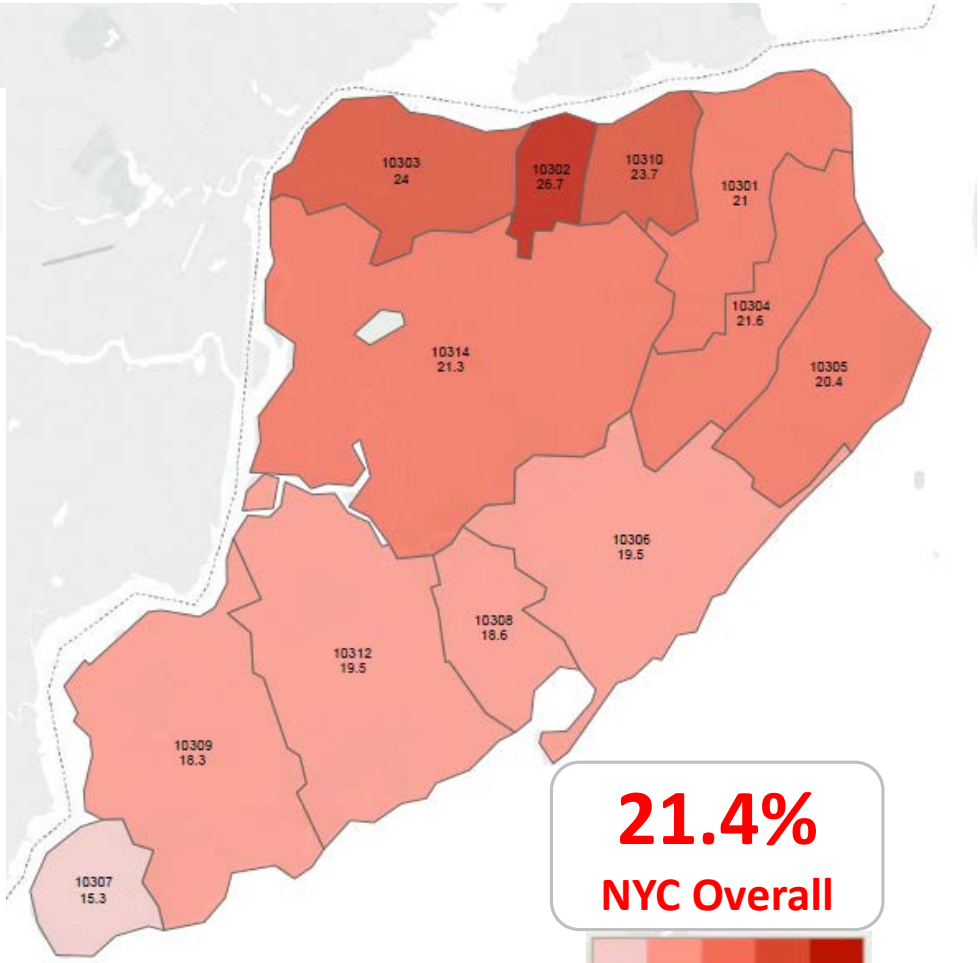
Improving Asthma Management

- PPS gathers and evaluates baseline data for this population
- Incorporated Asthma as a VBP component of our PHIP Program
- Introduced Asthma Home Visits by CBO Partner for at risk patients
- Utilize School Health data to hotspot lost days and monitor progress
- PPS shares analysis with clinical partners to improve follow-up and outcomes for asthma patients

Source: (1) Salient Interactive Miner (2) DOH Member roster *Data Period: FY2015*

Obesity Prevalence among NYC public school students by zip code, grades K-8, during the 2012-13 school year





** Indicates that N<100. This estimate is unstable and has been suppressed.*

Grade K-8

%
12.90 — 26.70

	0K	01	02	03	04	05	06	07	08
North Shore	16.20	19.50	22.80	24.60	25.20	26.70	24.90	22.80	20.10
Mid-Island	18.60	16.50	21.90	21.90	24.90	21.30	19.50	21.60	19.50
South Shore	12.90	13.80	17.70	20.10	20.40	20.40	20.10	20.70	20.40

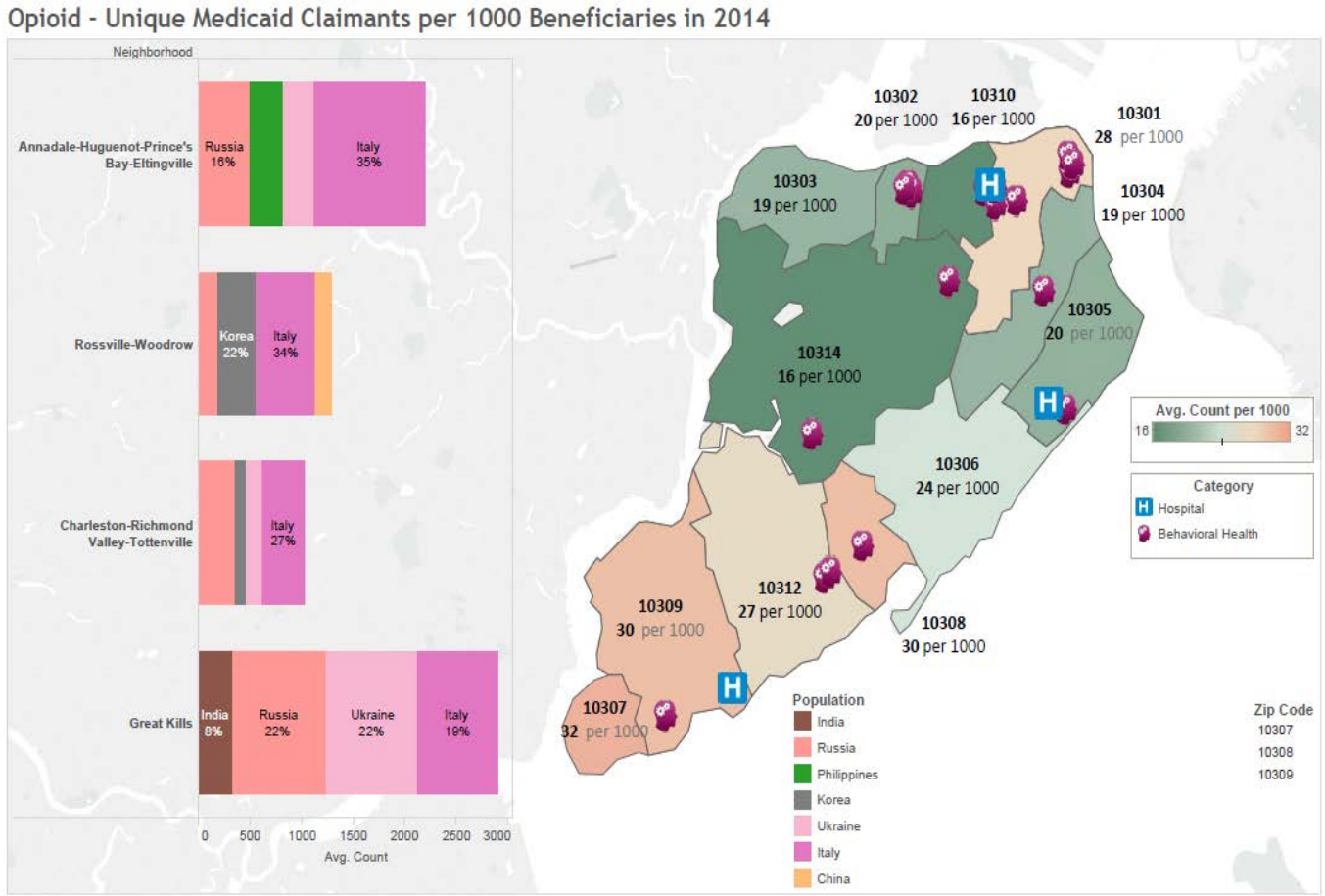
Program Development

- Incorporated Childhood Obesity as a VBP component of our PHIP Program
- Introduced Nutrition education/cooking classes, Food Prescription program by City Harvest for at risk patients
- Utilize School Health data to hotspot and monitor progress
- PPS shares analysis with clinical partners to improve follow-up and outcomes for at-risk patients

Data Source: NYC FITNESSGRAM

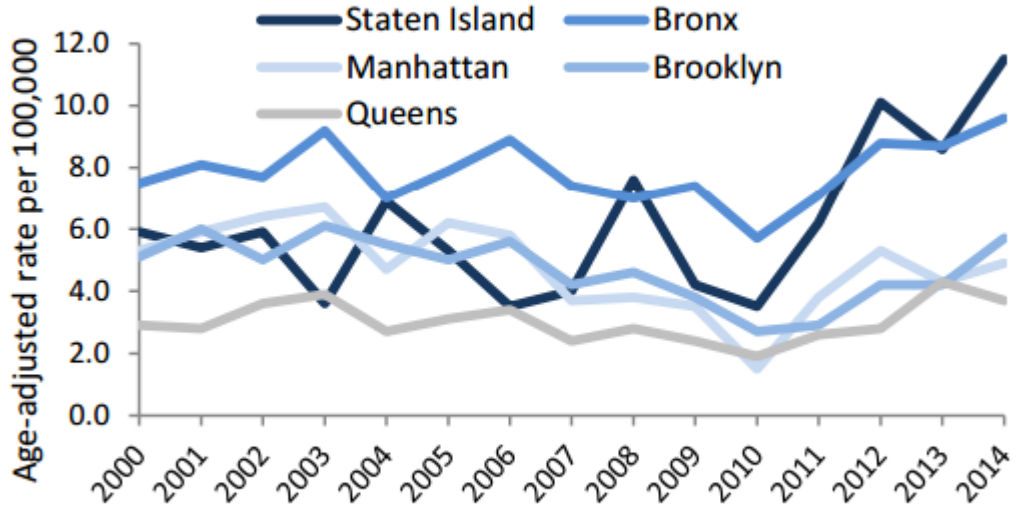
Use Case: Substance Abuse Epidemic

Geomapping: Nation of Origin Overlay



Staten Island ↑ Overdose Deaths in NYC ⇄ Heroin / Opioids

Unintentional overdose deaths involving heroin by borough of residence, New York City, 2000–2014*



* Data for 2014 are preliminary and subject to change

Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics

Source: (1) Salient Interactive Miner (2) DOH Member roster Data Period: FY2015

Innovative Programs: Behavioral Health Pilots

ED Warm Handoff Pilot

Reduce avoidable SUD-related ED visits by connecting ED patients with substance use disorder needs to timely and appropriate treatment and services

- BH Specialists in ED
- Peer Counselors in ED
- 24/7 call center
- Provider Directory
- SUD Treatment Providers
- 24/7 Crisis Stabilization Centers

EMS HealthLink Pilot

Reduce inappropriate ED and EMS utilization by engaging Staten Islanders in longitudinal relationships with multi-disciplinary care teams that address their comprehensive healthcare needs

- Mobile crisis / Outreach Team
- EMS NYC Support
- 24/7 call center
- Provider Directory
- SUD & MH Treatment Providers
- 24/7 Crisis Stabilization Centers

RCDA Pre-Arraignment Diversion Program (PDP)

Reduce overdose deaths, non-fatal ODs, and improve health outcomes by diverting individuals to treatment/service providers post-arrest and pre-arraignment

- RCDA Coordinator
- Peer Counselor
- 24/7 call center
- Provider Directory
- Treatment / Service Providers
- 24/7 Resource / Stabilization Centers

SI PPS EMS Super Utilizer (SU) Dashboard : FY2014-15

Chief Complaint: (All)

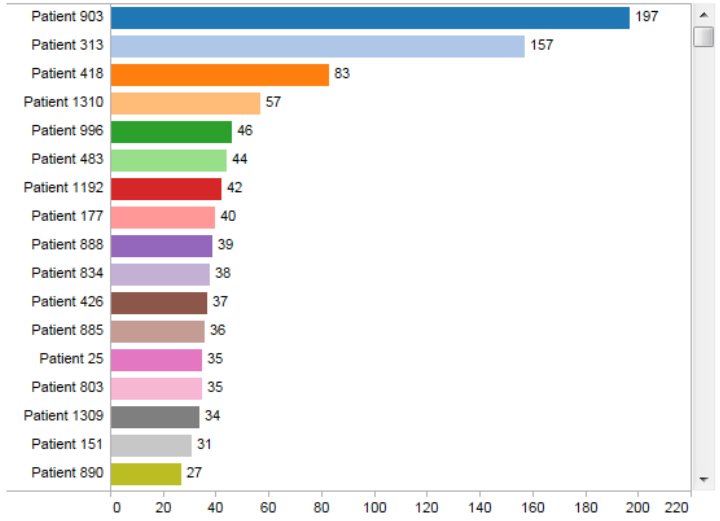
Dispatch Code: (All)

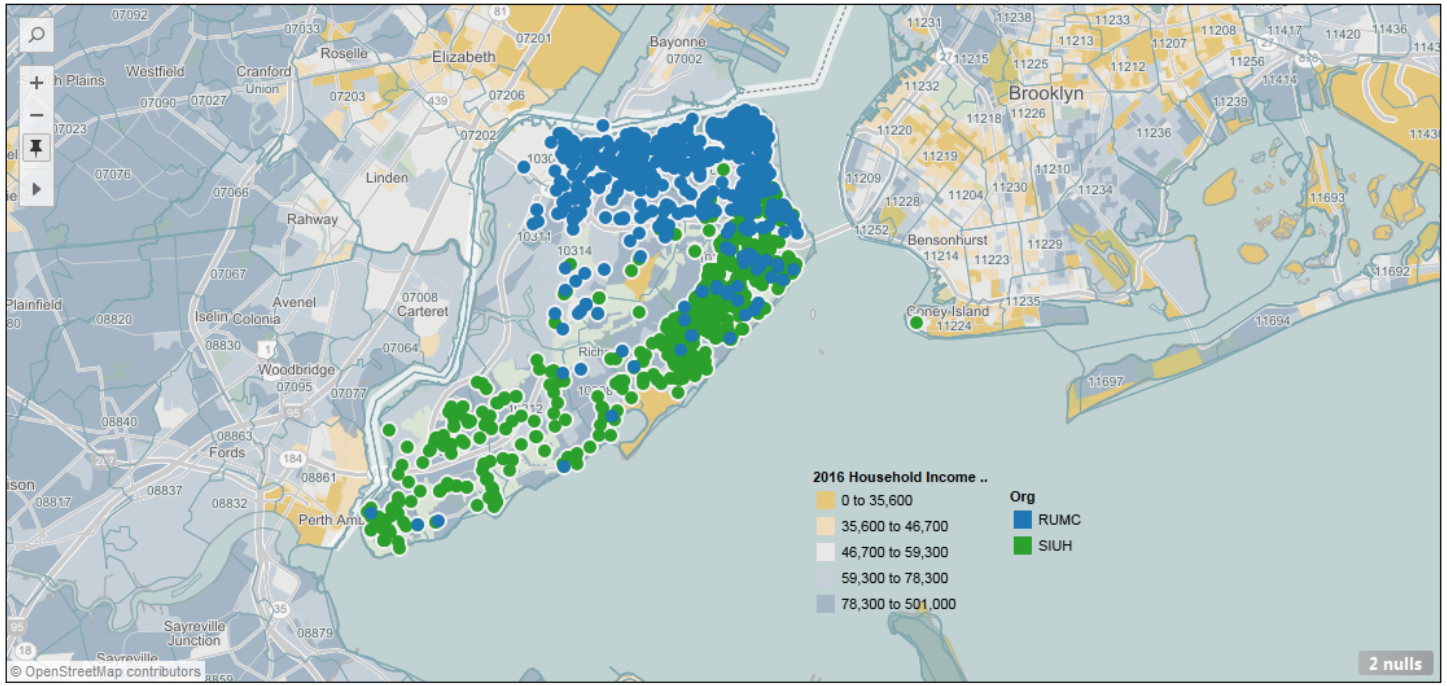
Org: (All), RUMC, SIUH

# Unique SU	TOTAL # CALLS	# RUMC CALLS	# SIUH CALLS	Estimated TOTAL COST
1,441	6,605	4,510	2,095	$9,907,500

Super Utilizers (Rank by # of Calls):

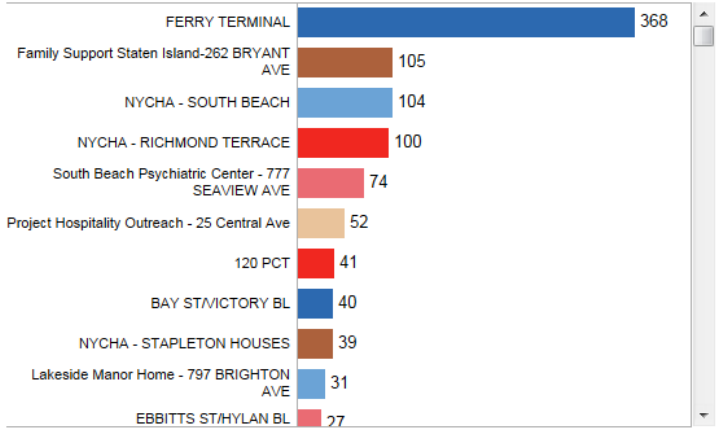
(All)



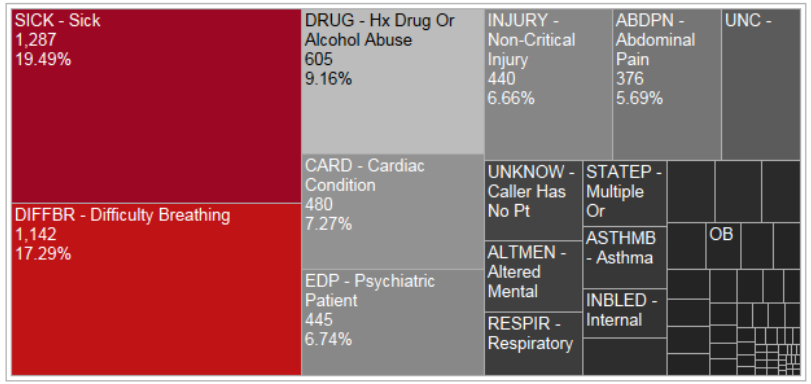


Incidence Locations (Rank by # of Calls):

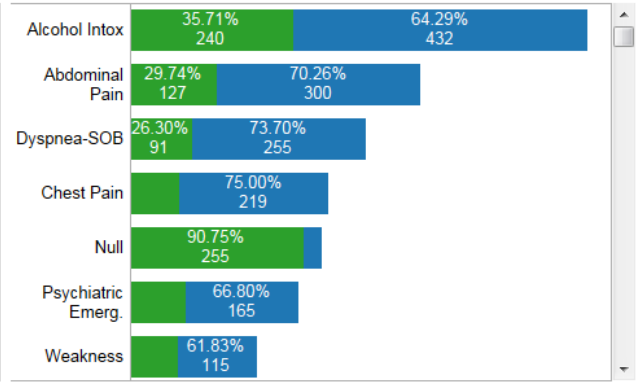
(All)



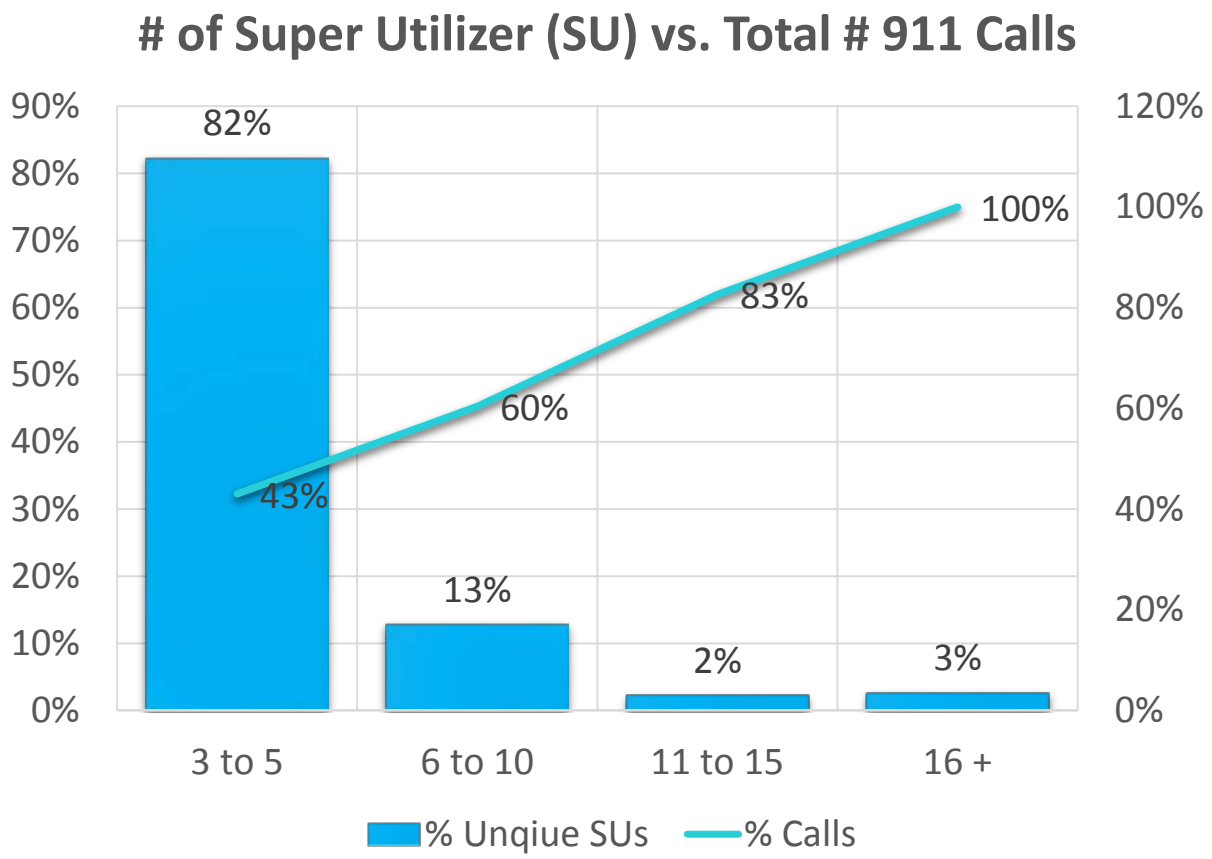
Dispatch Codes



Top Chief Complain



Staten Island PPS Super Utilizer EMS Call Analysis



EMS Super Utilizers (SU)	Description
SU Definition	Patients made 3 or more 911 calls to RUMC or SIUH EMS in 24 months
Data Period	1/1/2014 – 12/31/2015
Data Source	RUMC and SIUH EMS tracking systems
Results Set	1441 unique patients ; 6605 calls identified.
Descriptive Statistics	• Average 911 calls per patient : 4.6 • Max Calls per Patient: 197

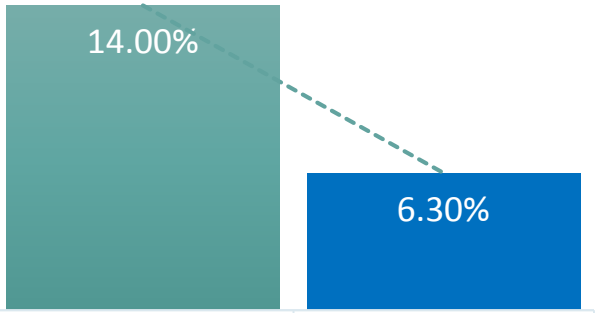
- 82% SUs made 3 to 5 calls
- 13% SUs made 6 to 10 calls
- 5% SUs made 11 or more calls, and contribute 40% of the total call volume

EMS Diversion Program with NYC Support

- Promote alternate 911 call model in collaboration with PPS partners, law enforcement, and other public agencies utilizing NYC Support and 24/7 Call Center to link individuals to community services in Staten Island
- Utilize SUD Warm Hand-Off and RCDA Pre-Arraignment Diversion programs for at-risk population management
- Identify frequent callers and engage them proactively for care management and outreach via Health Home teams
- Identify locations with high volumes of calls and integrate outreach teams to actively engage people with unmet, emerging needs
- Dispatch mobile outreach teams to high demand locations at key times

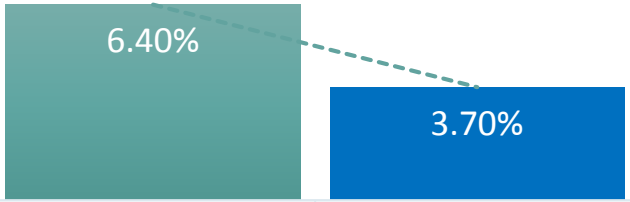
Current Progress - Improving Care Outcomes

2.A.III : HH at Risk



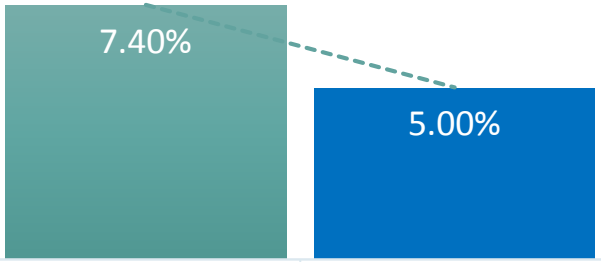
	DY1	DY2Q1
30-Day ER Util. Rate	14.00%	6.30%
Total AE Patients	607	1,064

3.C.I : Diabetes Management



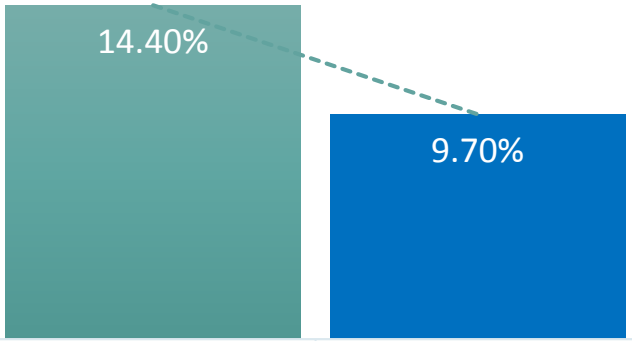
	DY1	DY2Q1
30-Day ER Util. Rate	6.40%	3.70%
Total AE Patients	2,944	3,443

3.A.I



	DY1	DY2Q1
30-Day ER Util. Rate	7.40%	5.00%
Total AE Patients	9,922	6,851

3.A.IV



	DY1	DY2Q1
30-Day ER Util. Rate	14.40%	9.70%
Total AE Patients	327	269

Key Findings:

Significant improvement in 30-day ER Utilization Rate *(DY1 vs. DY2Q1)*

- 2.A.III: **55%** improvement, decreased from 14% to 6.3%.
- 3.C.I: **42%** improvement, decreased from 6.4% to 3.7%.
- 3.A.I: **32%** improvement, decreased from 7.4% to 5.0%.
- 3.A.IV: **33%** improvement, decreased from 14.4% to 9.7%.

Recommendations

- Greater RHIO/SHIN-NY functionality to enhance practitioner use
- Support from major EHR vendors on addressing Population Health metrics
- Encourage relationships with MCOs to focus on Population Health initiatives
- More favorable regulatory and reimbursement process, support co-location, integrated care and SUD practices
- Expand telemedicine capacity in multiple settings
- Create a state-wide program that permits local EMS to redirect non-emergency care to alternate service locations (i.e. for individuals experiencing Behavioral Health crises, ETOH, SUD, minor medical complaints)