# DSRIP Stories of Meaningful Change in Patient Health

NEW YORK STATE | Department of Health | Medicaid Redesign Team

# Introduction

In April 2014, New York finalized an agreement with the federal government for a groundbreaking Delivery System Reform Incentive Payment (DSRIP) waiver which allowed New York to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms.

DSRIP promotes community-level collaborations and focuses on system reform, with a specific goal of achieving a 25 percent reduction in avoidable hospital use over five years. A cornerstone of DSRIP, health and social care providers across the State formed collaborative networks called Performing Provider Systems (PPS) to implement innovative projects focused on system transformation, clinical improvement and population health improvement.

*DSRIP: Stories of Meaningful Change in Patient Health* highlights but a handful of real-life successes in improving outcomes by putting the needs of the patient front and center. From culturally competent care coordination, to healthy food, to convenient locations for health care screenings and patient education, these are the stories of DSRIP.

The Department of Health extends its thanks to the PPS' and the organizations and individuals who shared these stories. In some cases, names have been changed to ensure confidentiality.

# The Importance of Care Management

Orlando was admitted to the hospital ten times in a five-month period. He had end stage renal disease and open wounds on both of his legs due to poor circulation. With each hospital admission, Orlando's condition deteriorated. He was often confused when he was in the hospital and he wanted to go home where he lived alone. But when health care providers arrived at his home, he would often not let them in. After neighbors heard him calling for help, Orlando was again sent back to the hospital. That's when he met the Transitional Care Team at Wycoff Heights Medical Center.

Knowing that Orlando wanted to remain independent at home, the Transitional Care Team designed a care plan to help improve his health and overall adherence to care. The team called Orlando daily reminding him to let the registered nurse in his home, attend hemodialysis, and remember his follow-up appointments. They also referred Orlando to the Brooklyn Health Home, which was able to connect him to financial assistance services to help pay overdue rent and utility bills.

**Almost immediately, Orlando improved. He now visits the wound care clinic every week and he has not missed a dialysis session in the year since the intervention. He has had only one hospital admission in a nineteen-month period. In partnership with the Community Care of Brooklyn PPS, Transitional Care Teams like Wyckoff's have referred over 3,000 Brooklyn patients to Health Home care management services to help them maintain their independence and improve their health.**

# Culturally Competent Care

Mrs. Y and her son were at the emergency department for the eighth time in twelve months when they met their NYU Langone Community Health Worker (CHW) who was able to engage Mrs. Y in her native language, Spanish, and offer her support.

Mrs. Y confided in her CHW that she had a challenging time managing her son's medical condition. Her own medical conditions often impacted her ability to remember medical appointments and adhere to her son's asthma medications.

The CHW contacted the team's Certified Asthma Educator (CAE) and they scheduled a joint home visit. The CAE educated Mrs. Y about the difference between controller and rescue medication and showed her the proper use of an inhaler. While developing a trusted relationship with the CHW, Mrs. Y shared her concerns about her son's care at school, and felt unheard because of a language barrier. The CHW coordinated and attended a meeting with Mrs. Y, the school psychologist, and school counselor. As a result, Mrs. Y was able to obtain documents that were needed for her son's doctor, received access to nutritional services to address his morbid obesity, and got a Medicaid Service Coordinator assigned to her for ongoing support. The CHW also referred the family to the New York State Children's Health Home program for care coordination services.

**Before working with the CHW, Mrs. Y's son had missed 10 outpatient medical appointments over the prior year. During the first month and a half of the CHW intervention, her son kept all of his appointments at the Family Health Centers at NYU Langone and his overall health improved. The CHW called the family before appointments to remind them of the date and time, and offered escort services, if needed.**

# When the Student Becomes the Teacher

Zoe, 38, was hospitalized three times in 2017. Each time she was discharged, she struggled with medication management, missed follow up doctor appointments and had trouble connecting to social supports. She reported suffering from boredom and did not follow hospital discharge plans.

That is when staff from Westchester PPS' Transition of Care Wellness (TOCW) program stepped in. The program aims to address gaps in the transition of care experienced by patients with behavioral health diagnoses who have had multiple inpatient hospitalizations and are at high risk for readmission. This program connects patients, who meet the program criteria, with peer support services offered through Independent Living Systems and a partnership with PEOPLe Inc. In addition, participating patients in the TOCW program receive a clinical assessment within 48 hours of hospital discharge by a behavioral health clinician, offered through two of the member agencies of Coordinated Behavioral Health Services (CBHS).

The CBHS and Peer support service agencies work closely together on a daily basis, along with hospital staff at the inpatient behavior health units, to coordinate care and ensure that the patient's first follow-up appointment is scheduled prior to discharge as well as confirming that the patient completes the appointment.

Since the TOCW team has been working with Zoe, she was connected to a PEOPLe Inc. Housing Coordinator. Although she does not participate in the PEOPLe housing program, staff helped her resolve issues she was having at her residence to avoid being evicted. She was also connected with crisis respite services to avoid future hospitalizations and a recovery specialist to work on goal-setting.

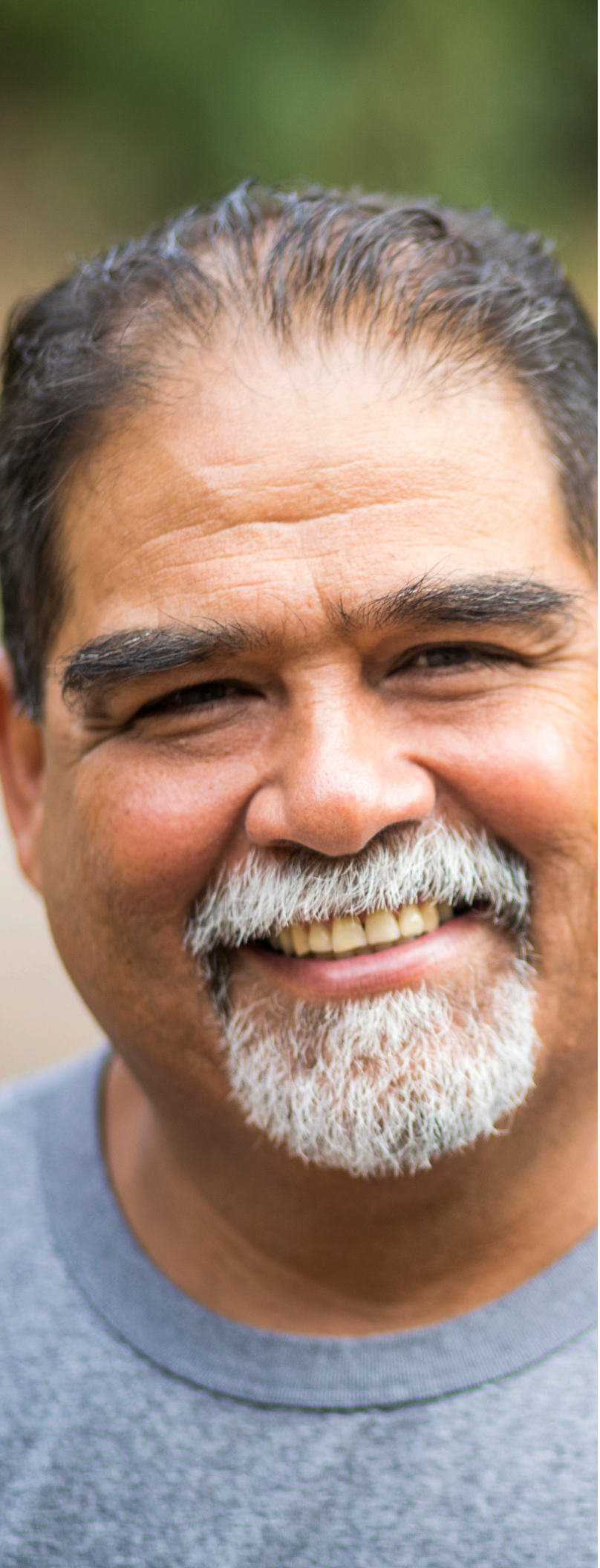
**Zoe, who has not been back to the hospital since engaging with the TOCW team, has expressed interest in becoming a certified peer advocate. She is currently working with the TOCW team to reach that goal.**

# Breathe Better Bronx

Breathe Better Bronx helps people like Isabelle, living in the South Bronx control their asthma through asthma treatments, home-based services, medication management, and education. In January 2017, a Breathe Better Bronx Community Health Worker (CHW) team was alerted that Isabelle had been admitted to the inpatient pediatric floor for asthma.  A nurse recommended to Isabelle's family that they meet with the Breathe Better Bronx team to discuss her asthma needs. Mike, a CHW, told them about the services offered by Breathe Better Bronx, such as an in home assessment.

In partnership with the Bronx Health Access PPS, Bronx Lebanon Hospital Center, BronxWorks, Urban Health Plan, and Boom! Pharmacy, the Breathe Better Bronx team has counseled over 400 adult and pediatric patients to help reduce asthma attacks, visits to the Emergency Department, and hospital inpatient stays.

**The family identified that the home could be trigger for Isabelle’s asthma because of roaches and chipping paint. Through advocacy efforts with the landlord, education about asthma and the home environment, and tangible remediation such as mattress protectors, green cleaning supplies and a Swiffer duster, Isabelle’s family reported that her asthma is now well managed.**



# The Power of Care Navigation

Matthew, 55, arrived at the emergency department with shortness of breath, chest pain, and an intense four-day headache. He suffered from asthma, congestive heart failure, diabetes, and several other conditions. Prior to his emergency department visit, Matthew missed eight out of ten scheduled medical appointments.

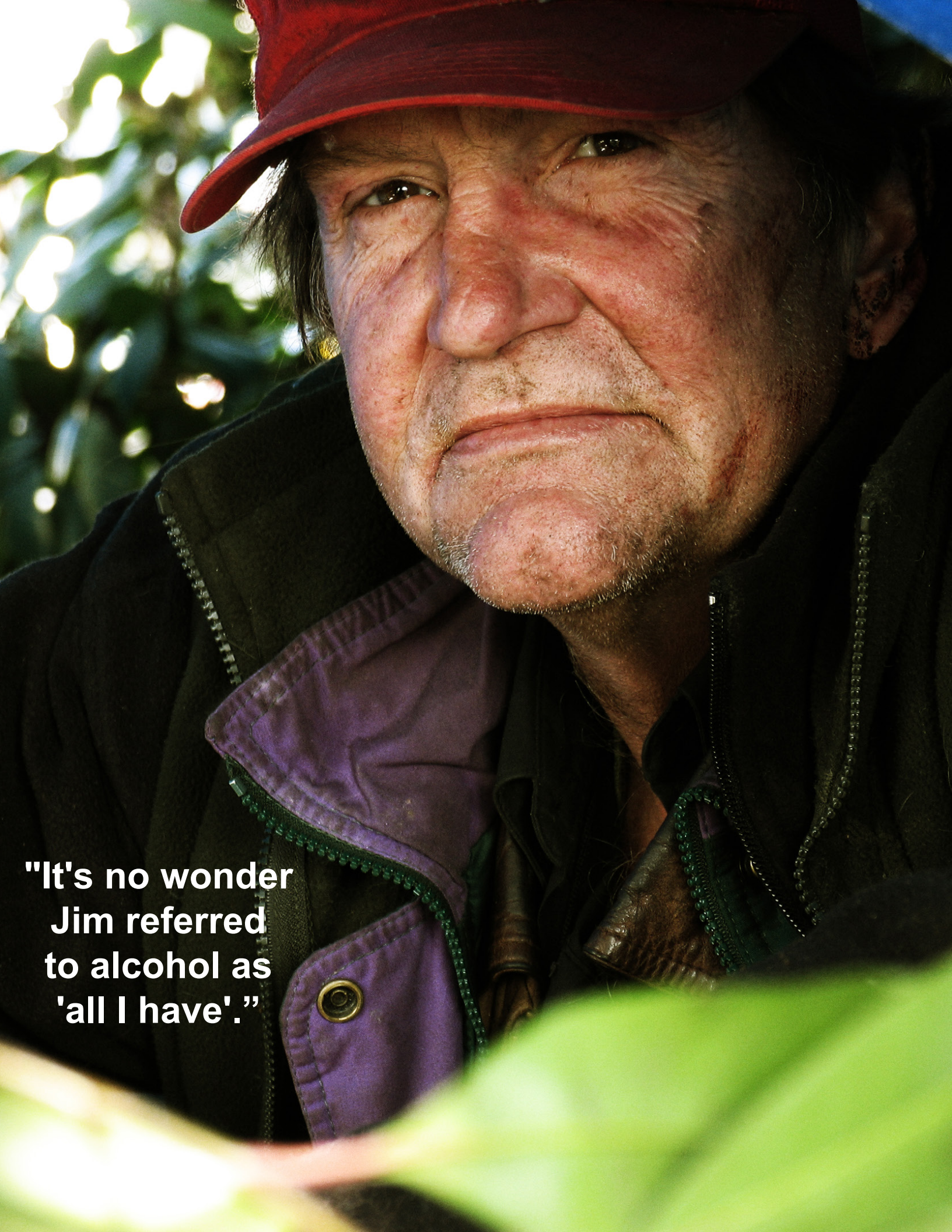
During his visit to the emergency department, Jennifer, a NYU Langone PPS Community Health Worker (CHW), met with Matthew and enrolled him in a transitional support program. Matthew acknowledged that he lacked stable housing, which not only worried him, but also made it difficult to focus on his medical needs.

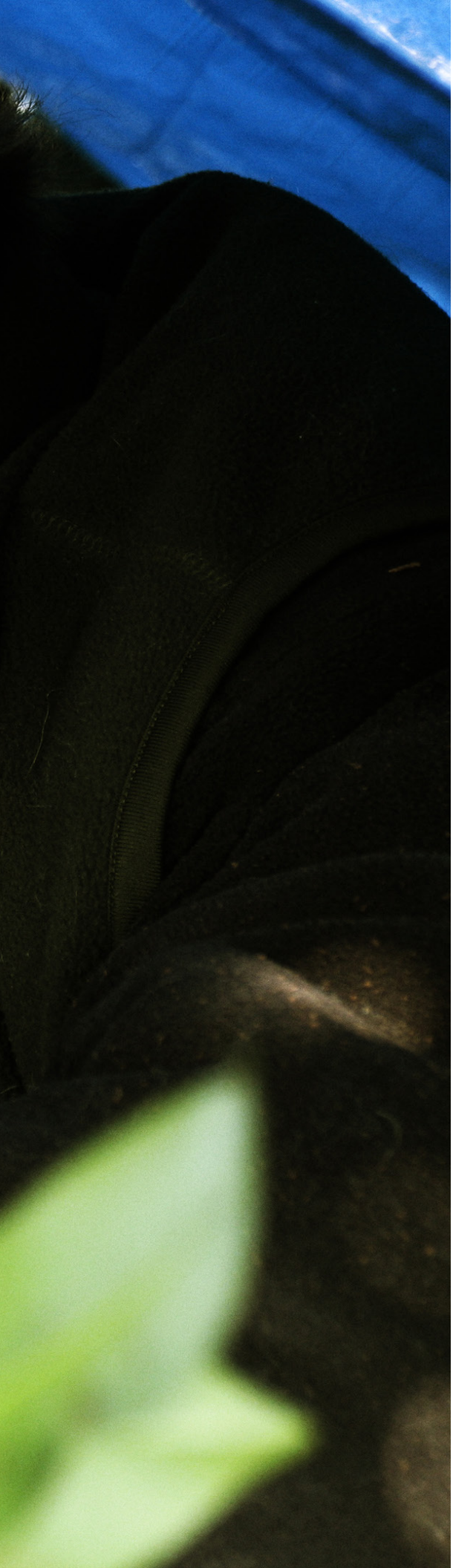
Over the next 30 days, Jennifer helped Matthew complete housing applications and referred him to a housing specialist to explore a more immediate solution. Jennifer worked to re-schedule his missed medical appointments and arranged medical transportation to bring him to and from his doctor's visits.

Before finishing the CHW program, Matthew was referred to NYU Langones' Health Home program for on-going care management support. Over the next month, Matthew continued to reside with relatives while working with his Health Home Care Manager and a housing specialist. After being educated on special options within the shelter system for individuals with complex medical needs, Matthew agreed to be placed.

The housing specialist accompanied Matthew to his assessment appointment and helped him settle into his new home. The placement was successful, and Matthew is now receiving routine medical care as well as assistance that will help him find and finance a longer-term housing solution.

**In six months after meeting Jennifer, Matthew was compliant with all of his medical appointments and returned to the emergency department only once.**


"It's no wonder
Jim referred
to alcohol as
'all I have'."



# Meeting a Patient Where They're At

“Meeting a patient where they’re at.” It means understanding the patient, and trying to incorporate means to improve their health into their way of life, culture and home. For Sarah, a care manager at Alliance for Better Health PPS, it meant meeting Jim on the dirt floor of the tent where he had been living for four years.

Jim had long-term chronic mental illness, alcoholism, and frequently found himself in the local emergency department. Because of Jim’s frequent ED visits, he was referred to Sarah. After several attempts to reach Jim by phone, the care management team decided a home visit was necessary. When the team arrived at Jim’s home, it was a dirt and tarp shelter in what is known as “tent city.”

Sitting on the floor of Jim’s tent, the care management team asked him questions about his health and worked to identify social and behavioral health needs.

It was clear to Sarah that Jim had many needs, both medical and non-medical, but the priority was finding him a place to live – a building, with a door, and running water. Sarah reached out to housing resources in the area and found Jim a place at a Catholic Charities residential program. After addressing Jim’s greatest need, they could then begin to work at  improving his overall health.

**Jim is now connected with a primary care physician and a mental health counselor and has been keeping his appointments with his physicians. “Does Jim still face challenges?” Sarah asks. “Of course, we did not go from 0 to 60. He is, however, making progress.”**

# The 100 Schools Project

Meeting the needs of students with emotional, behavioral and substance-abuse issues presents challenges for schools. Through the partnership of four DSRIP PPS (OneCity Health, Bronx Partners for Healthy Communities, Bronx Health Access, and Community Care of Brooklyn), the NYC Department of Education, the NYC Department of Health and Mental Hygiene, and the Jewish Board of Family and Children's Services, staff trainings and student workshops are changing the way behavioral health is addressed in schools throughout New York City.

Developing tailored trainings for school staff, as well as workshops for students and in many cases, parents, is leading to a positive impact on schools' climate and reducing the stigma of mental health. Participating schools also learn how to connect students who have emotional, behavioral, or substance-use challenges with top-tier local mental health providers while enabling the students to remain in school. Here are just two examples:

In Manhattan, following an incident involving underage drinking in a school, a Behavioral Health Coach organized a workshop with the NY Counter Drug Task Force and hosted a speaker from a local residential adolescent drug/alcohol treatment center. The speaker detailed her story of drinking, which started at the same age as the middle schoolers. Students participated in peer pressure navigation and refusal skills development training.

When a student disclosed her transgender identification at another school, a Behavioral Health Coach prepared a LBGTQ training. Staff had previously noted the student had withdrawn from peers, presented oppositional behavior and received interventions for suicidal ideations. The training was an opportunity to answer staff questions and implement new protocols, such as the school honoring the student's request to refer to her using female pronouns and her chosen female name. The school's response and accommodation were very helpful to the student, reported the Behavioral Health Coach, as the student's peers were supportive and the teachers noticed improved academic engagement.

**The 100 Schools Project will expand to colleges throughout New York City. Four community colleges in the CUNY System – Bronx Community College, Guttman Community College, Hostos Community College and LaGuardia Community College – will begin to host workshops for staff, student leaders and families, conduct crisis trainings and mentor students interested in behavioral health careers.**

## 100 Schools Project:
### Snapshot

As of June, 2018,
The 100 Schools Project
is in **95 schools**


| Borough | Crisis/Post Intervention | Trainings | Staff trained | Coaching sessions | Referrals | Case conferences | Linkages | Classroom observations | Parent Meetings |
|---|---|---|---|---|---|---|---|---|---|
| Brooklyn | 42 | 183 | 2750 | 616 | 89 | 211 | 48 | 486 | 20 |
| Manhattan | 47 | 71 | 867 | 187 | 42 | 52 | 80 | 178 | 25 |
| Queens | 24 | 104 | 2186 | 289 | 211 | 219 | 329 | 203 | 61 |
| The Bronx | 23 | 153 | 1508 | 442 | 76 | 253 | 138 | 164 | 10 |

# Battling an Epidemic: Addressing the Opioid Crisis

In rural, central New York, Bassett Healthcare Network, in partnership with Leatherstocking Healthcare Collaborative PPS, are using medication-assisted treatment (MAT) in primary care offices to battle opioid dependence.

Bassett's opioid addiction program is helping more than 200 patients from around central New York address their addiction through a combination of MAT, counseling, and comprehensive primary care to address other health issues. By weaving treatment into primary care services and conceptualizing it as management of a chronic health condition, MAT fits into the purview of whole-person primary care to which primary care clinicians are accustomed.

Dr. Jennifer O'Reilly, a primary care physician and medical director in Bassett's Norwich health center, is working with family nurse practitioner, Pam Gilbert, to help addicted patients. They currently have 58 patients in treatment.

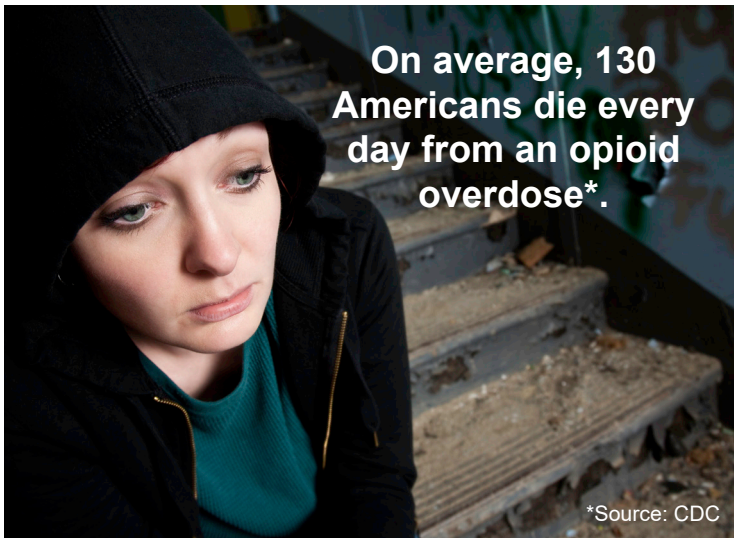
"The work has been incredibly rewarding," said O'Reilly. "We are able to offer prenatal care in conjunction with MAT to our pregnant patients. We have a number of patients who have been able to find stable housing, successfully start a job, and regain custody of their children since starting treatment. We have been able to address multiple chronic illnesses, including hepatitis C, that otherwise would have gone untreated. We are also providing contraceptive care, preventative screenings, and mental health care for these marginalized patients. The patients have been so grateful for help, and having them receive their treatment in primary care has normalized their condition and helped them to feel less persecuted and judged for their mental health and substance use issues."

At the Middleburgh, Schoharie and Cobleskill health centers, Bassett's Schoharie County clinics are helping 48 patients through addiction treatment and recovery.

"In the primary care setting, there's no stigma," said Sandra Falco, nurse manager for the Cobleskill Health Center. "Our addicted patients are here for treatment of a chronic illness and they're grateful to have help managing other medical conditions as part of their overall health. It's exciting to be able to effect such positive change on our patients' lives."

"We've had people who've gotten their lives back together; I've had a patient graduate from college, get a job and move on with his life. It is tremendously rewarding," said Dr. Joseph Sellers, regional medical director and a primary care practitioner for the Cobleskill Heath Center.

**The network current has 27 primary care practitioners, both physicians and advanced practice clinicians, who have obtained Drug Addiction Treatment (DATA) waivers which allow them to prescribe buprenorphine for the treatment of opioid addiction. Bassett's goal is to have 90 percent of the network's primary care clinics offering addiction treatment as part of comprehensive primary care within the next three years.**






# Just Tell One

JustTellOne is a public awareness campaign that focuses on four key areas: mental health-depression, suicide, alcohol abuse, and substance abuse. The program is a collaboration between the Mental Health Association of Erie County and the Erie County Council for the Prevention of Alcohol and Substance Abuse, in association with Millennium Collaborative Care PPS and Community Partners of WNY PPS, and with support from organizations representing Niagara, Orleans, Erie, Genesee, Wyoming, Chautauqua, Cattaraugus, and Allegany Counties.

JustTellOne.org's mission is to give Western New York youth and young adults, ages 14-26, the tools and confidence to start the conversation about their behavioral health and/or substance abuse issues. By helping a young person reach out for help as early as possible, they can increase the use of intervention services and decrease the likelihood of the issue turning into an emergency.

Research shows that needing someone to talk to is a common sentiment among youth who suffered from mental health or behavioral issues. The name of the campaign and website, Just Tell One, draws on that central thought. Because starting a conversation is so important, the site provides tools and language to those who are struggling with mental health or addiction and to those who are approached by someone needing help.

"One of the most gratifying stories we heard was from a school in the Sweet Home district of Amherst where they started a 'Trusted One' post-it wall," said Carol, campaign director and Director of Community Awareness for the Mental Health Association of Erie County.

**"Students were asked to post the name of the adult they would trust with their story. The best part was the email they sent out to the staff informing them of the wall, and suggesting they go to JustTellOne.org and click on the 'Give Help' section to learn how to respond if a young person has chosen them as their trusted adult." Carol adds, "Giving people the tools to start that first conversation will help save lives."**

# Blood Pressure Screening and a Haircut

Master Barber Howard Ivey learned he had high blood pressure even though he was only in his mid-30s. Now Howard is helping others monitor their blood pressure.

He became one of the first to join an innovative partnership with Millennium Collaborative Care PPS, community-based organizations and other local barber shops and salons to offer blood pressure screenings in addition to grooming and beauty care services to patrons in Buffalo and Niagara Falls, NY.

The mission of the “Barber & Beauty Shop Initiative” is to bring cardiovascular health awareness to members of the community at locations that are most comfortable and convenient. The ultimate goal is for clients to become advocates for their own health.

“I was one of the non-believers in the beginning," he said. "I thought I felt fine, but I wasn’t fine.”

Howard estimates over 60 customers have taken advantage of the blood pressure self-screening service he has been offering at “Howard’s Hair Studio For Men” in Niagara Falls, NY.

“We have always talked about health issues with customers in my shop,” said Howard. "I would take their blood pressure and a lot of them were surprised that their blood pressure was high. I told them, we might feel fine, but eventually high blood pressure will take a toll on your health."

**Working in partnership with the Community Health Center of Niagara, a Federally Qualified Health Center (FQHC), Millennium PPS has been able to equip five Niagara Falls locations with easy-to-use self-monitoring blood pressure screening cuffs that patrons can place around their wrist to read and record their own blood pressure. ‘Barber & Beauty Shop Health Stop’ signage has been provided to barber and beauty shops to aid in the process and an information box located in the shop allows clients to submit their name and phone number for follow up information about a provider.**

Janice Cornell, a participant in the program, tends to her plot in the vegetable garden at Comfort Food Commnunity.

# Food Friends: A Comfort Food Community

The mission of Comfort Food Community of Greenwich, New York is to contribute to the health of their community through the inspirational power of food. Comfort Food Community is leveraging the community's physical and social resources to eliminate food insecurity in their region. The community based organizations (CBO) developed a space where individuals, families, farms, schools, social agencies, and local businesses can come together to share knowledge, build relationships and enjoy healthy food. They strive to cross socio-economic boundaries by welcoming all members of their community to participate as their needs and interests warrant.

Through a partnership with Adirondack Health Institute (AHI) PPS, Comfort Food Community's emergency food relief service has transformed into a holistic intervention center to focus on improving individual well-being through resource connection, health coaching and education, and implementing strategies to increase consumption of locally-sourced produce.

Guests attend cooking demonstrations with appetizing samples of easy to make recipies using nutrient-dense foods and guest's pantry selections are tailored to their their specific conditions. They also provide preventative support and management of chronic illnesses such as diabetes, hypertension, depression, autoimmune disorders, and other ailments. The CBO also offers psychosocial classes explaining trauma's effects on the mind and body and teach positive coping strategies for stress such as meditation, horticultural therapy, and yoga.

**Comfort Food Community plans to launch a vegetable prescription program within the year and are also developing a medically tailored meals program.**

**My kids call Comfort Food, 'Food Friends,' because that's what the people here have become to us. The staff treat me with such dignity and respect. It's easy to keep hope that I'll be able to improve my situation."**

# A Prescription for Fresh Fruits and Vegtables

Patients who visit a primary care provider in central New York might just leave with a prescription for fruits and vegetables. That's exactly what is happening under a program called FVRx launched by the Rural Health Network for Central New York. Prescriptions turn into food vouchers for patients to spend at local farmers' markets, farm stands and other retailers.

The FVRx Program was developed to prevent and manage chronic diet-related diseases in the adult Medicaid population, with a focus on improving cardiovascular disease, diabetes, and associated risk factors. The program also works to increase the knowledge, skills and behaviors around the consumption of nutritious food by improving financial and physical access to healthy options, along with education, peer support and referrals to other services in the community. Along with food vouchers, participants in the program receive nutrition counseling, and community-based cooking education sessions, chronic disease self-management classes, transportation vouchers, and other supportive services.

A win-win-win. Clinical staff see improved results for the patients they serve including reported weight loss, reduced blood pressure, improved blood sugar numbers and reduced stress. Participants reported they are making healthier food choices for themselves and their families. Farmers markets and food retailers report that the FVRx program brought in new customers who now shop at the sites regularly.

**In the first year of the FVRx program reached 213 Medicaid members. In the second year, the FVRx program expanded to 12 primary care offices in Broome, Tioga, and Delaware Counties with an additional 200 participants. There are now 25 locations where participants can shop with their vouchers for fresh fruits and vegetables, including farmers' markets, farm stands, mobile produce markets, Community Supported Agriculture locations, and local grocery stores.**


FVRx®
FRUIT & VEGETABLE
Prescription Program
Vouchers

## Bringing Dental Services to an Underserved Area

With a dental shortage in the North Country region of New York State, emergency departments in Watertown and its surrounding areas have seen an increased number of visits for dental issues.

In 2015, the North Country Initiative PPS assisted the North Country Family Health Center (NCFHC) with the recruitment of a dentist, allowing access to dental services for individuals and families covered by Medicaid and Medicare. Prior to the dentist's arrival in the North Country, it had been five years since Medicaid members had access to dental services in Lewis County.

"I am very pleased to be returning to family practice dentistry at the NCFHC," said Dr. Chang. "The agency's mission of providing dental care to patients who need it, regardless of income or insurance status, is a great benefit to our community."

**The North Country Initiative PPS Provider Incentive Program has provided nearly $4 million to partners for the recruitment and retention of nearly 50 healthcare providers in the region since 2015.**

## Addressing a Workforce Shortage

In a rural area of New York State, an innovative partnership has been established between SUNY Adirondack and the Adirondack Health Institute PPS to support training and education in health care occupations identified as high-priority in the region.

By leveraging DSRIP workforce funds, assistance is available for income-eligible individuals who have expressed interest in healthcare professions targeting populations DSRIP is intended to serve.

Kayla Duers of Queensbury received support and wrap-around services to participate in a Certified Nurses Assistant course. She has been hired by a nursing home in Warren County and plans to work while continuing her education.

"Every day I get a little closer to my dream of becoming a midwife and this funding is helping to make that dream a reality," said Kayla.

**"I have had the distinct privilege of witnessing people grow personally and professionally through this partnership," said Tara Booth, Healthcare Program Assistant at SUNY Adirondack. "I have watched people delight in the accomplishment of graduating from a program and experienced the intense gratitude felt by participants who have finally been given the tools they need to succeed."**

# The Scrubs Club

Training the future healthcare workforce can start prior to college, and that is exactly what the Scrubs Club, Bassett Medical Center, and Bassett PPS intend to do.

As members of the Scrubs Club, 70 students from five high schools visit Bassett Medical Center once a month during the school year, to investigate and explore a variety of healthcare occupations. Students are not only exposed to front line clinicians such as nurses and doctors, but are introduced to other careers in a hospital setting such as finance, billing, human resources, carpentry, maintenance, security services and information technology.

“One of the major things Scrubs Club has helped me with is my plan for my future,” said Olivia, a tenth-grade student at a local high school. “Before coming to Scrubs Club, I was sure I wanted to be a physical therapist. I have now decided I am interested in endocrinology or pediatric endocrinology. I am so grateful to have been a part of this amazing club and all the opportunities it has provided me.”

Angelica, a high school sophomore, said her favorite part of Scrubs Club was going to the helipad, seeing the helicopter land and meeting the flight paramedics. She met one of the flight paramedics and now says that is what she wants to do.

“My take-away from this experience was how much I enjoyed working with the high schoolers,” said Ghafar Kurdieh, RN, Bassett nurse educator and Scrubs Club instructor. "To see their excitement and energy gives me hope for the next generation.”

**Each new school year, the Scrubs Club will welcome a new group of students and the future of the healthcare workforce.**



Department of Health

Medicaid Redesign Team