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DSRIP PROJECT APPROVAL AND OVERSIGHT PANEL PRESENTATION

Thursday, February 2, 2017
12:10-12:50pm

Presented by

Joseph Lamantia

Chief of Operations for Population Health

Stony Brook Medicine

Suffolk Care Collaborative

PRESENTATION OBJECTIVES

Program Achievements	• Share Achievements of Program & Initiatives' Implementation • Community Based Organization Partnerships • Workforce Transformation & Development Opportunities • Performance Management & Improvement Initiatives
Provider Engagement	• Respond to Midpoint Assessment Partner Engagement IA Recommendation • PPS Network Development & Contracting Plan Progress
Trajectory 2017 - Onward	• How the SCC is addressing its own sustainability and support of partnering providers in value based payment.
Funds Flow	• Describe Provider Performance Funds Flow Distribution • Describe PMO funds flow detail

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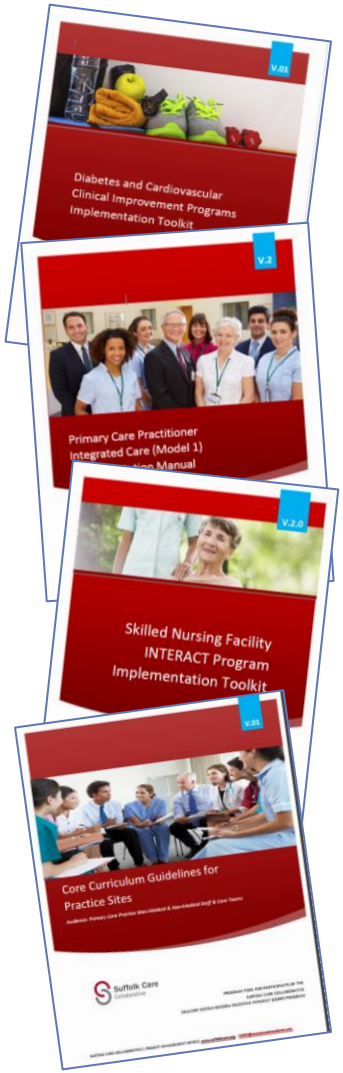
REFLECTING ON 2016
PROGRAM IMPLEMENTATION ACHIEVEMENTS

- In 2016 the SCC contracted with over **100** organizations.
- Actively engaged roughly **60,000** patients through our DSRIP projects.
- **117** Primary Care Providers within their associated practices have transitioned to PCMH Level 3 ahead of schedule.
- **22 (57%)** Skilled Nursing Facilities have implemented INTERACT ahead of schedule.
- SCC Care Management Organization has touched over **1,700** patients.
- Trained over **300** Community Health Workers and Associates in Patient Activation Measurement, Coaching for Activation and Community Navigation.
- Engaged over **29,000** uninsured individuals through CBO partnerships to engage, activate and navigate individuals to community-based and preventive care services under DSRIP Project 2di.
- **Patient Advisory Consumer Group** Meetings foster collaborative and meaningful discussions about program development, key trends and solutions with Medicaid Beneficiaries.
- **OASAS Certified SBIRT Training Program** initiated January 2016 for Hospitals has expanded to Primary Care Practices staff.
- **7** Hospitals have implemented SBIRT screenings in Emergency Departments ahead of schedule.
- Published **Implementation Toolkits** and Plans for all DSRIP projects which includes nationally-recognized evidence based clinical standards, guidelines, workflows and patient/provider education.
- Hosted **31 Learning Collaboratives** creating new communication lines and relationships regionally throughout the Suffolk County health-care delivery network.



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NEW MODELS OF HEALTH CARE DELIVERY
INTEGRATING PRIMARY CARE & BEHAVIORAL HEALTH SERVICES

What we know today?

- Approximately **23%** of our PPS Medicaid members are defined as behavioral health recipients.
- Behavioral health recipients cost, on average, **4.65 times more** per recipient and represent **58%** of total Medicaid spending
- Behavioral health recipients drive **48% of all ED visits**
- Behavioral health recipients represent **58%** of admissions to hospital and on average have a **1.65X** longer length of stay in hospital than non-behavioral health recipients
- ***32%* of all Primary Care visits are attributed to behavioral health recipients**

How we're making a change?

- **401 PCP** and **347 BH Providers** are Participating in the SCC's PCBH Integrated Care Program - **Exceeding** our Provider Engagement Commitments

	Target Number of Practice Sites	Engagement Complete (Educated and/or Evaluated)	Integrated Care Complete
Grand Total	**144**	**144 (100%)**	**39 (27%)**

*Source: CY 2013-2014 Medicaid claims data is the data source

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ENHANCEMENTS OF HEALTH CARE DELIVERY
CARE MANAGEMENT AND CARE COORDINATION SERVICES

SCC Care Management Organization

- Currently supporting **13** PCP Practice Sites
  - Representing **67** Primary Care Providers receiving support for their High Risk Medicaid patients.
- Providing Transitional Care Management for **3** Hospitals.
- Over **1700** patients have been engaged by the SCC CMO for Complex Care Management services.
  - All patients engaged in services receive a biopsychosocial assessment in order to address medical concerns, behavioral health needs, and to mitigate barriers related to the social determinants of health.
- All eligible patients are **navigated to Health Homes** with SCC staff ensuring warm hand offs and proper linkages.

PPS Wide Efforts

- Bi-Monthly Meetings between Care Management leadership of all 3 Hubs.
- Quarterly Care Management and Care Coordination Workgroup Meeting.
- Home Care Initiative underway to engage Home Care Agencies in care delivery for patient output of project implementation.
- SCC has partnered with NQP and our two assigned Health Homes (Northwell Health and HRHCare) in the development of a centralized mechanism to refer patients to Health Homes through Nassau and Suffolk County. (Timing TBD and contingent upon PPS leadership approval).
- Collaboration with Community Engagement efforts to ensure CBO partners are interacting with Care Management and Care Coordination across the continuum.

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ACHIEVEMENTS: CBO PARTNERSHIPS & COMMUNITY ENGAGEMENTS

6 of the **11** SCC DSRIP Programs have identified CBO partnerships and the SCC plans to continue to identify additional and new opportunities in 2017!

PMO Program Partnerships

- 2di: Community Health Activation Program community-health worker outreach model to engage and activate uninsured, non and low utilizing Medicaid Populations.
- 3ai: Providing licensed Behavioral Health workers to participate in Integrated Care Models within primary care practices.
- 3dii: Providing Asthma Home Environmental Trigger Assessment services for at risk asthmatic pediatric populations.
- 3ci & 3bi: Operationalizing Stanford Chronic Disease and Diabetes Self-Management Program workshops for populations with chronic conditions.
- 4aii: Initiated an underage drinking prevention program for youth in areas of high need. This initiative will address behaviors that drive alcohol and drug abuse, and will promote positive changes in community attitudes and behaviors.

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ACHIEVEMENTS: CBO PARTNERSHIPS & COMMUNITY ENGAGEMENTS

Care Management Organization Referrals & Integration

- We recognize many of the concerns that our patient populations face are around psychosocial risk factors such as the **social determinants of health**.
- The SCC CMO has interacted with over **1700 patients** to date and has made approximately **1200 referrals** to Community Based Organizations, representing **over 100 different organizations**.
- The **areas of need** we have found most prevalent:
  - Housing
  - Food Instability
  - Transportation
  - Legal Services & Immigration Needs
  - Clothing & Other Supply Needs
  - Home Modifications & Renovations
  - Financial Instability
  - Healthy Activity Needs
- The CMO has engaged CBO Partners to **conduct in-services and trainings** with the Care Management staff. To date, six different organizations have presented.
- The SCC understands that **increased referral volumes** may compromise a Tier-1 CBO's ability to continue to meet the requested need as scaling their operations to meet additional need may become problematic. Early planning is underway for the **sustainability** of high need (based on PPS referrals) Tier-1 CBO's.

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ACHIEVEMENTS: CBO PARTNERSHIPS & COMMUNITY ENGAGEMENTS

Community Collaborations

- Established committees, workgroups, projects and programs that **have engaged CBOs**, and community organization partners across our PPS.
- A "CBO Summit" was held in February at St. Joseph's College where 60 community organizations participated in facilitated **roundtable discussions** to determine **prevention agenda prioritization** and drive plans for community improvement.
- A "Building Bridges: Communications, Data & Networking," this cross regional/county communication collaborative effort to **reduce the silos that exist** within our surrounding communities in Suffolk County had over 100 participants representing some 60 community organizations.
- Created a **Community Resource Directory** partnership with Greater New York Hospital Association's Health Information Tool for Empowerment (HITE) database.
- **Collaborative partnerships** with the Long Island Population Health Improvement Program (LIPHIP) and NQP PPS continues to strengthen our approach to regionally enhancing community engagement across Long Island and developing a neighborhood that is integrated.
- SCC DSRIP IN ACTION bi-weekly eNewsletter publication distributes local Community Forums and Events to a distribution list of roughly **2,000** health care delivery partners.
- The SCC will be launching a community-facing public **webpage** in 2017.

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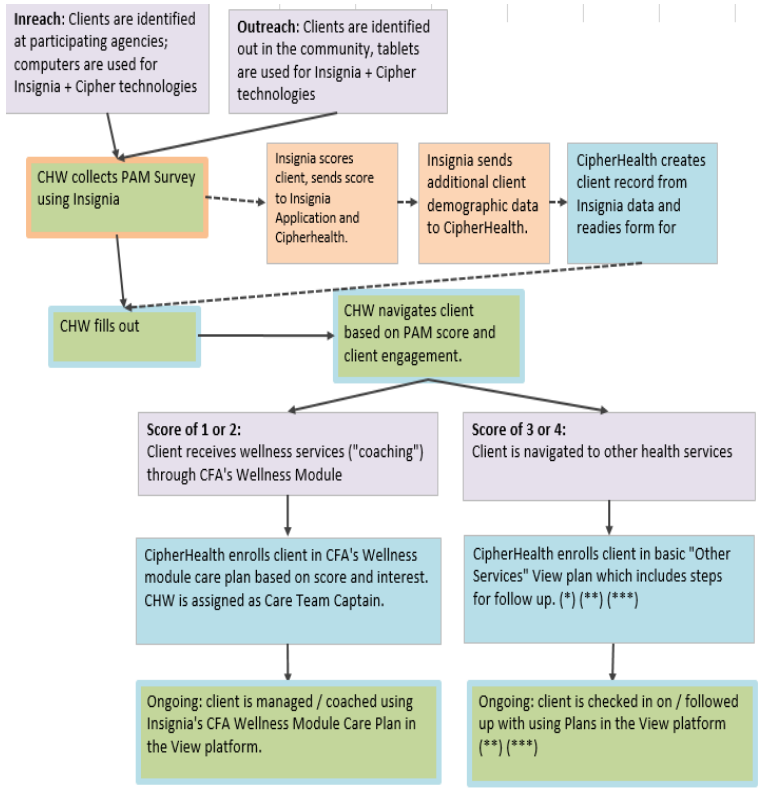
ACHIEVEMENTS: CBO COMMUNITY NAVIGATION INTEGRATION EFFORTS

The SCC has partnered with CipherHealth, a healthcare technology company committed to improving patient outcomes and experiences through enhanced documentation of community health worker outreach and community coordination.

- **Goals include:**
  - Work with CBO's to quantify community navigation, wellness coaching activities and determine impact/value county-wide.
  - Use analytics to drive ongoing partnerships with new CBO's (referring agencies) and quantify/identify gaps and issues in community navigation (transportation).
  - Use this software product to help CBOs develop and further competencies in analytics and reporting.
- **Examples of information to be collected:**
  - Number of referrals to Primary Care
  - Number of referrals to Social Services
  - Number of individuals enrolled into insurance
  - Wellness Coaching documentation

New Outreach Workflow Diagram Designed



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ACHIEVEMENTS: WORKFORCE DEVELOPMENT & TRAINING

- Partnered with Nassau Queens PPS, the Long Island Health Collaborative and the Center for Suburban Studies at Hofstra University to deliver a **Cultural Competency and Health Literacy (CC&HL) Training** program. **60** Master Trainers and **122** workforce staff have been trained as of January 2017.
- SCC Facilitated **17** OASAS Certified SBIRT Training Sessions across **9** Suffolk County Hospitals, resulting in **238** staff across hospitals and PCP sites, completed training and received OASAS SBIRT Certifications.
- Community Health Worker Training for staff engaged in our Asthma Home Environmental Trigger Assessment Program curricula provided by the Association for Asthma Educators, developed by **Certified Asthma Educators**.
- Partnership with North Carolina Center for Excellence in **Integrated Care** in design of Primary Care & Behavioral Health Integrated Care Education Series and Implementation for participating provider practices.
- Care Coordination & Transition Management (**CCTM**) from the American Academy of Ambulatory Care Nursing certification effort initiated September 2016 for roughly **25** Nurses across all **11** Hospitals participating in TOC Project.
- Over **80** Directors of Nursing across **44** Skilled Nursing Facility partners received an INTERACT Champion Certification in November of 2015 which kicked-off our program implementation efforts.
- **30** Care Management Organization staff training immersion at **Geisinger Health System**.
- **MAX** Series Participation in the Train-the-Trainer Program.

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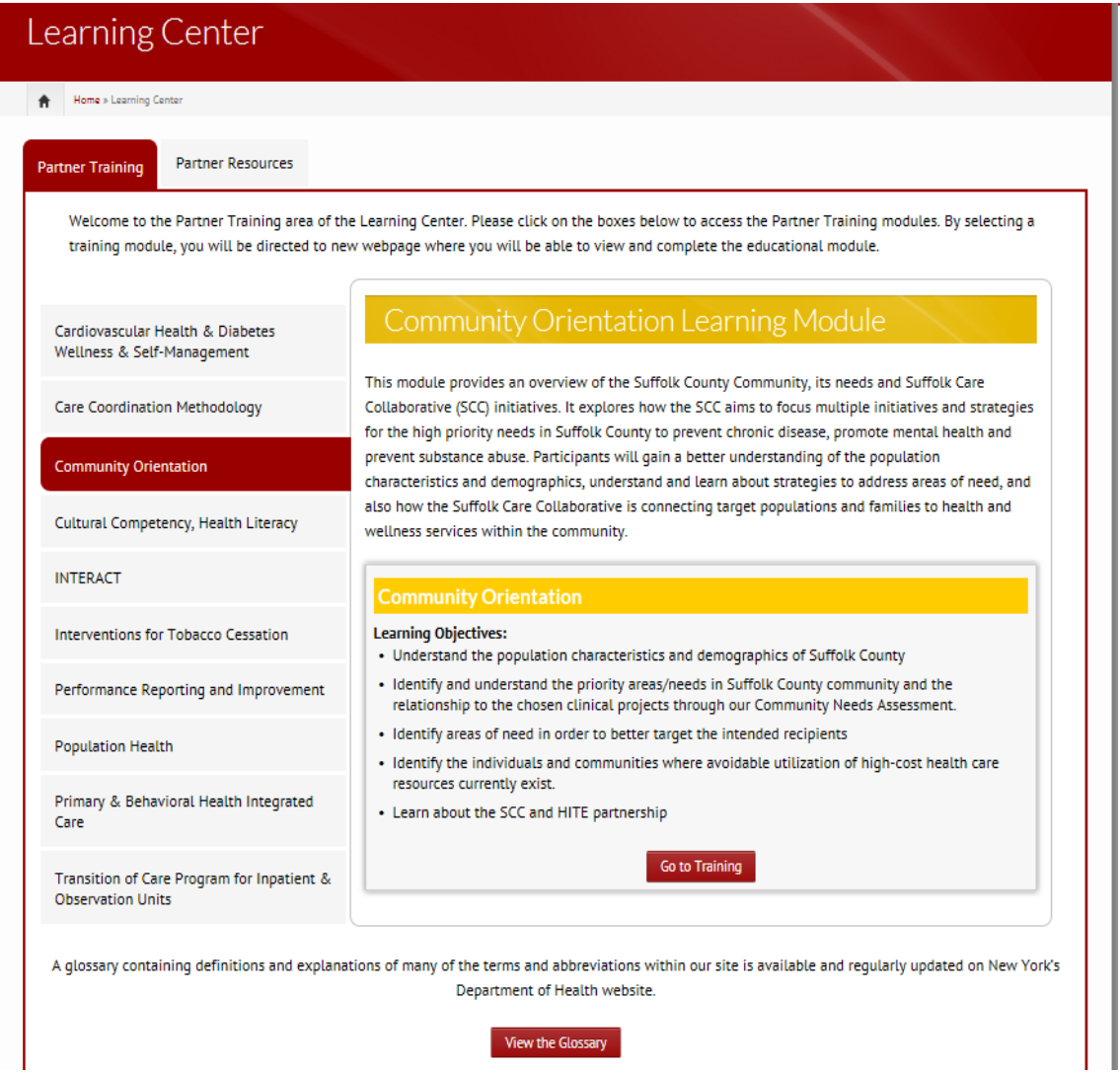
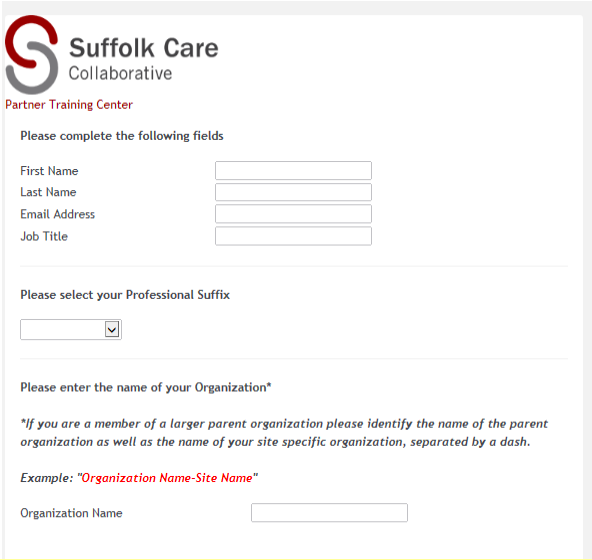
ONLINE LEARNING CENTER FEATURES PARTNER TRAINING



- 10 Learning Modules are live!
- 15-30 Minutes in length; completed at your own pace
- Participants complete a brief registration form and post evaluation
- Participation is tracked for DOH reporting purposes
- **Additional modules in development**



254 Staff Trained to Date!

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ACHIEVEMENTS: ACADEMIC PARTNERSHIPS

- Stony Brook University School of Social Welfare collaboration on addressing **social determinants of health** and field placement for internships.
- Stony Brook University School of Social Welfare development of a **Primary Care & Behavioral Health Integrated Care** Course Curricula and Care Coordination Curricula
- Stony Brook University School of Health Technology & Management partnership for graduate student fieldwork placement in PPS **Performance Reporting & Improvement Program**.
- Hofstra University School of Health & Human Services partnership for graduate student fieldwork placement in the SCC **Project Management Office**.
- St. Joseph's College engagement with SCC employees acting as subject matter experts for **student enrichment** via guest speaker positions.
- Under development the SCC partnership with Suffolk Community College to operationalize a **Community Health Worker** Certification Program.

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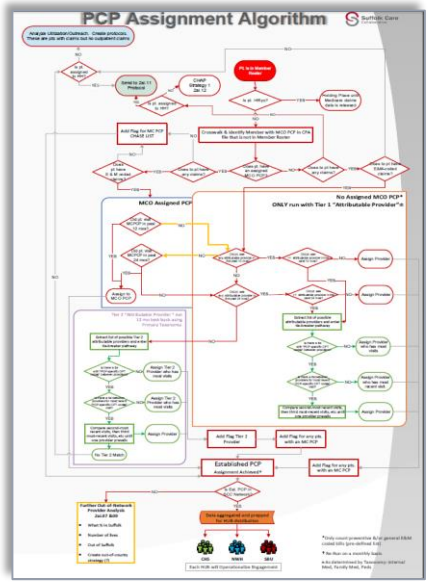
PERFORMANCE MEASUREMENT & IMPROVEMENT PLANS UNDERWAY

Data Analysis & Management

- Formalized SCC Domain 2 & 3 Performance Measurement Report to inform key stakeholders of performance trends, opportunities for improvement and the associated financial impact.
- Finalized SCC PCP Attribution Algorithm to address the issues with sole attribution based on MCO PCP assignment.
- Published actionable performance workbooks by HUB, Provider and Patient to close performance gaps utilizing DOH MAPP data.
- Leveraging current payor performance data to identify and address performance Gaps.
- Replicated DOH DSRIP measures in the SCC population health platform and developed performance dashboards to evaluate measures concurrently.



Process Improvement

- Developed member engagement strategies to address performance Gaps.
- Developed PI Toolkit to facilitate a pro-active action planning process.
- Quality Improvement Program operationalized for the INTERACT Project (2bvii).
- Finalizing Clinical Documentation Improvement Guide to educate providers.

Response to IA Recommendation Regarding Provider Engagement

- The SCC was evaluated on Provider Engagement based on PIT reporting through DY2 Q2, relative to our SCC Contracting Plan & Schedule, there has been much progress in partner contracting since DY2Q2.
- Misclassifications of provider types causes misinterpretation of distribution of engagement efforts.
- The SCC has met or exceeded all provider-level project requirements with speed and scale commitments ahead of schedule.

Provider Type	NYS DOH PIT Submission DY2Q2	SCC Actual Contracted YTD (December)	Progress
PCP	112	418	+286
Hospitals	7	10	+3
SNF	34	38	+4
BH	43	347	+304
Non-PCPs	229	1184	+955

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PARTNER ENGAGEMENT
BUILDING A PROVIDER NETWORK

PPS-wide Provider Contracting Progress Report

	# of Contracted Entities	# of PCP providers	# of Hospitals	# of SNF	# of BH Providers	# of Non-PCP Providers
Count Targeted for Contracting	162	635	11	43	347	1615
Actual Count Contracted	**104**	**418**	**10**	**38**	**347**	**1184**
% Complete	**64%**	**66%**	**91%**	**88%**	**100%**	**73%**
Engagement Commitments	-	511	8	38	145	1615
% Complete towards Commitments	**-**	**82%**	**125%**	**100%**	**239%**	**73%**

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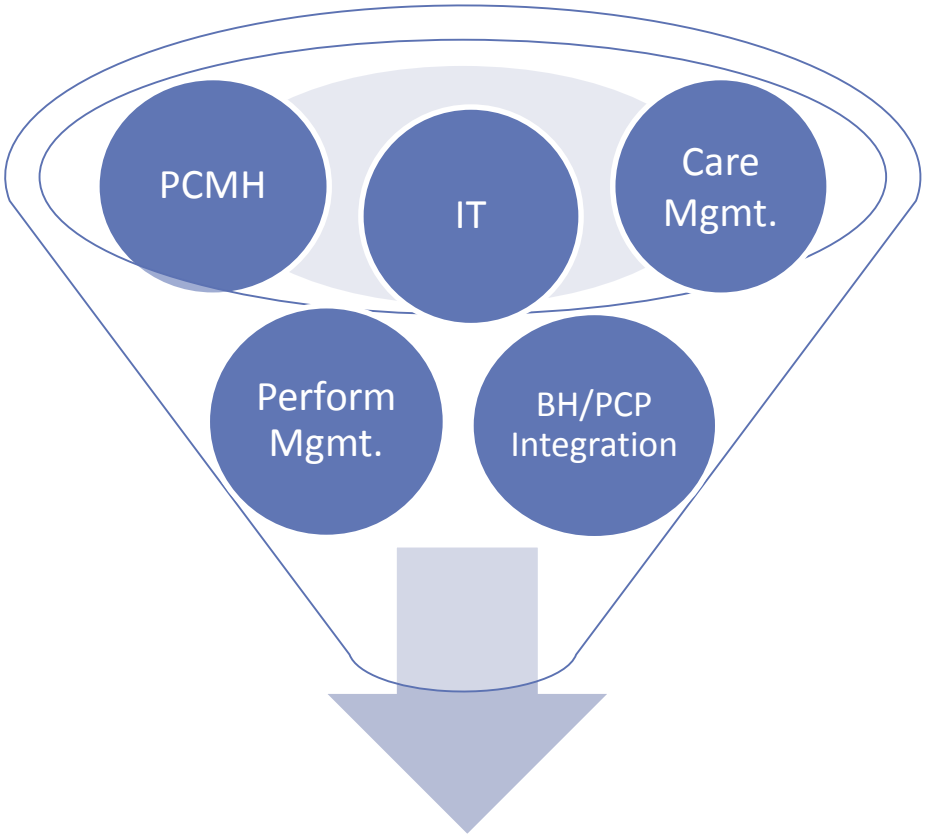
TRAJECTORY 2017 – ONWARD
POPULATION HEALTH MANAGEMENT SERVICES ORGANIZATION



SUPPORTING THE TRANSITION FROM FFS TO VALUE

UNDERSTANDING VALUE

- We believe that a Primary Care driven, patient centered model is the core of a successful VBP Model
- More than just changing provider contracts and compensation. Real change must occur
- Requires a proactive clinical focus, in which patients at high risk for disease progression are identified for early intervention
- Requires ongoing patient engagement and education
- Coordination with CBO's to address Social Determinants is a must

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LEVERAGING DSRIP AS A CATALYST FOR CHANGE

DSRIP has created capabilities for Medicaid, most of which can be leveraged across multiple Populations.

Population Health Service Organization *(Foundation)*

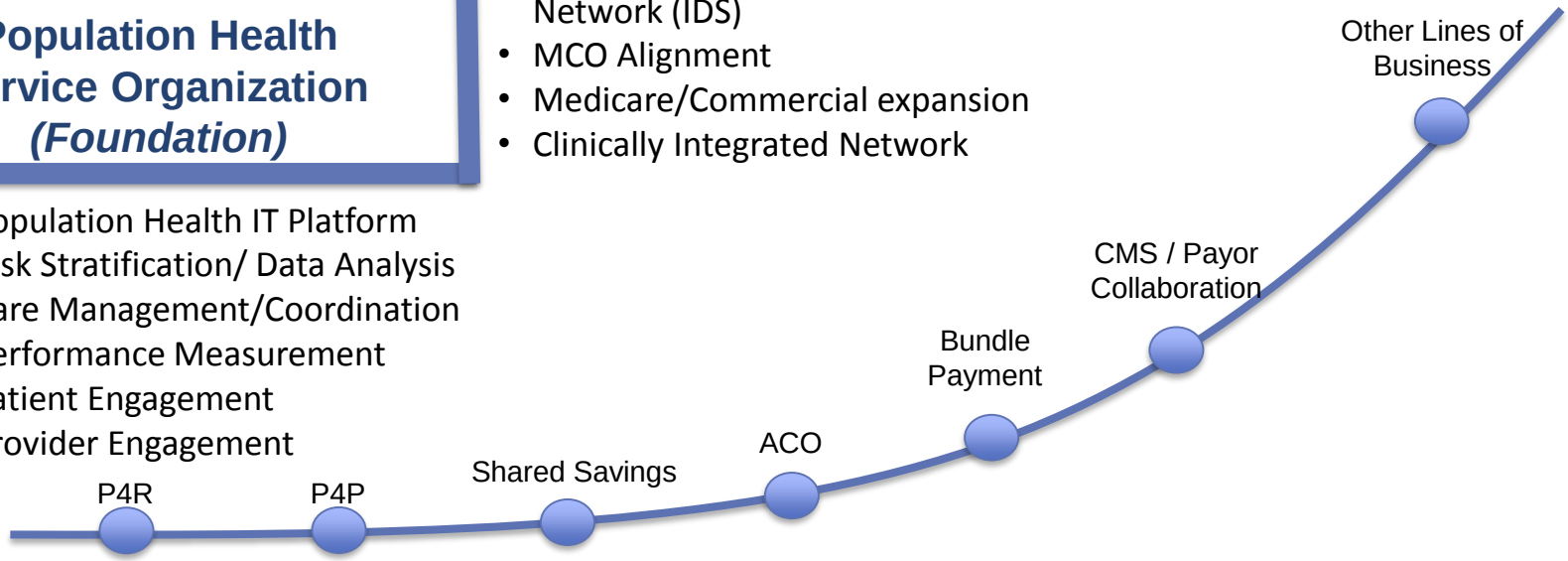
- Population Health IT Platform
- Risk Stratification/ Data Analysis
- Care Management/Coordination
- Performance Measurement
- Patient Engagement
- Provider Engagement

Clinical and Financial Model (re)Design

- Aligned, High Performing Network (IDS)
- MCO Alignment
- Medicare/Commercial expansion
- Clinically Integrated Network

Provider Sponsored Health Plan

- Patient Enrollment
- Utilization Management
- Claims Payment



Represented as performance payment distributions to specific providers contracted

Provider Performance-based Funds Flow Agreement Payments

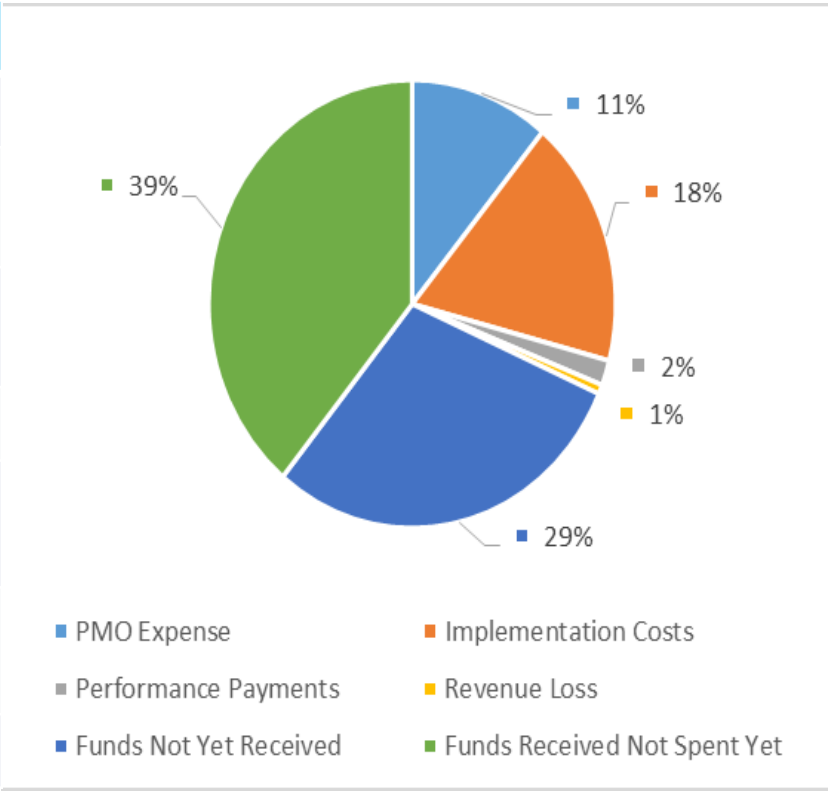
Provider Type	Performance Payments	% Total
PCP	$1,898,169	53%
Hospital	$1,047,351	29%
Behavioral Health	$482,928	14%
Skilled Nursing Facilities	$139,270	4%
Total	$3,567,718	100%

CBO Agreement Funds Flow Payments

Provider Type	Payments
CBO	$771,049.60

PPS Expense Breakdown

Category	Amount	% Total
PMO Expense	$7,266,478	11%
Implementation Costs	$11,835,948	18%
Performance Payments	$1,191,847	2%
Revenue Loss	$446,213	1%
Funds Received Not Yet Spent	$25,630,012	39%
Funds Not Yet Received	$19,319,981	29%
TOTAL	**$65,690,480**	**100%**



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QUESTION & ANSWERS

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