

CBO/Health System Partnership Impact on Avoidable Hospitalizations and Readmissions



DePaul Community Services dedicates psychiatric and medical step-down beds for Rochester Regional Health and UR Medicine.



An innovative partnership to address social determinants of health by providing a transitional housing solution.



80% Psychiatric Patients Transition to Permanent Housing

61% Medical Patients Transition to Permanent Housing

30x Cost Savings to Medicaid

Improved Quality of Life and Health Outcomes



FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

Cross-PPS Collaboration in the Hudson Valley



Performing Provider System (PPS)

Westchester Medical Center Health Network



Montefiore
HUDSON VALLEY
COLLABORATIVE

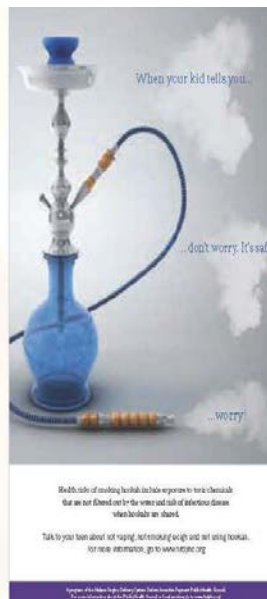
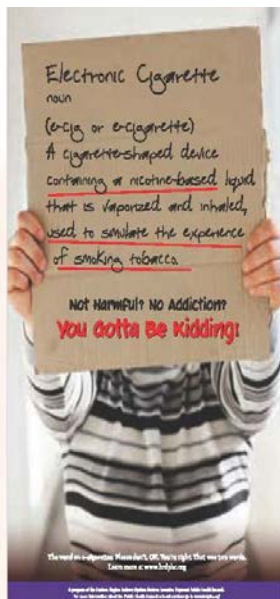
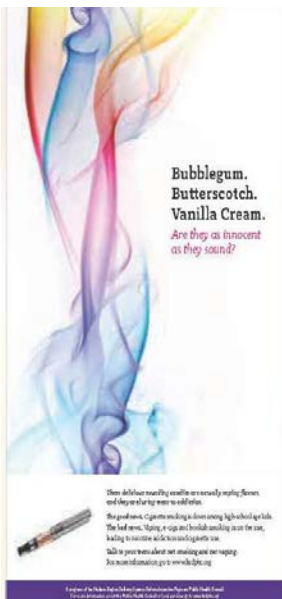


RCHC
REFUGEE COMMUNITY HEALTH COLLABORATIVE

The Hudson River DSRIP Public Health Council (HRD PHC), comprised of the three lower Hudson Valley PPS and a combination of over 45 government agencies and community organizations collaborating on Tobacco Cessation (4.b.i) and Cancer Screening (4.b.ii) public health projects.

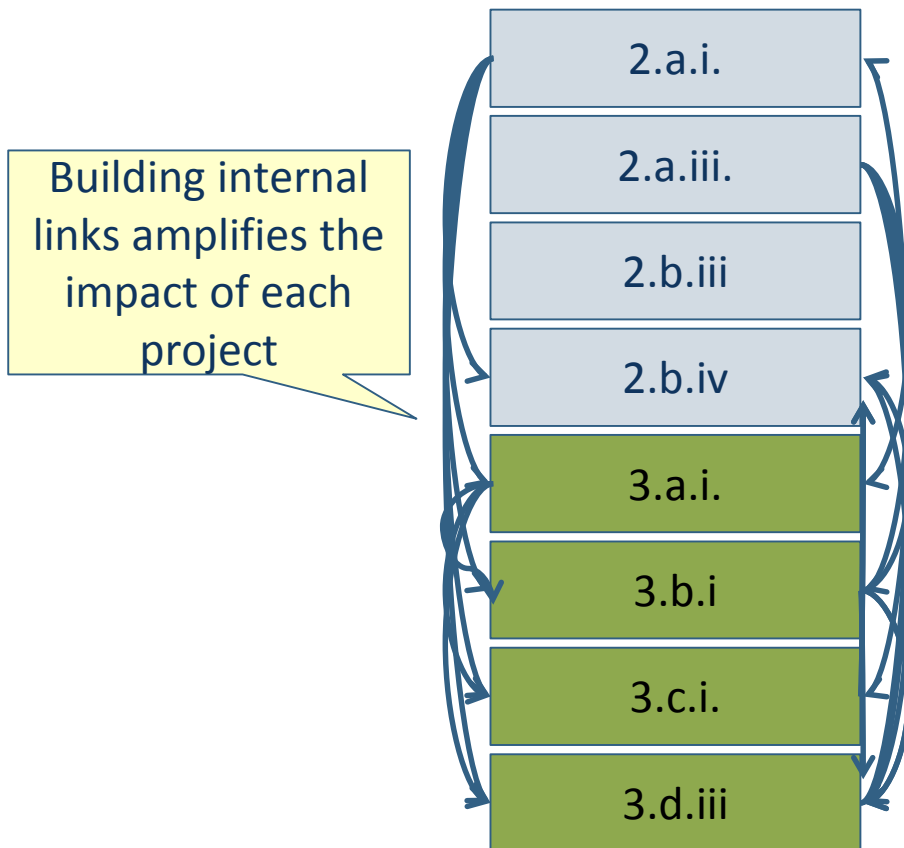
Achievements:

- ✓ **Adopted NYS Prevention Agenda's cancer screen rates as benchmark and using the PDSA implementation process.**
- ✓ **Launched (timely) anti-vaping campaign aimed at high school students—way ahead of new FDA ban (8/8/2016) on e-cigarette and vaping sales to those under 18.**
- ✓ **Distributed over 5,000 posters in high schools throughout the Hudson Valley. Visit www.hrdphc.org to learn more.**



BPHC - “One DSRIP” Approach

Integration across projects prevents duplication of labor and supports sustainability.



- Crosswalk of DSRIP requirements and measures to PCMH requirements
- Health Home engagement
- Behavioral health resource guide
- Domain 3 measures to pilot RHIO alerts
- CVD and Diabetes partners identify patients for asthma services
- IDS required training to improve Domain 3 measures

The SCC Care Management Organization is operational

Nov. 2015 - Today



Embedded in 4
PCP Practices



Providing TOC
services to 1
hospital

Current Staffing Model:
10 RN Care Managers
8 Social Workers
5 Community Health
Associates

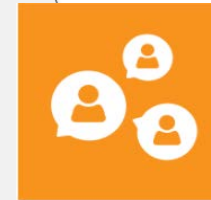


Our Vision:
To build a patient-
centered, coordinated,
integrated delivery
system.
The PPS sponsored CMO
will serve those patients
currently not aligned to
an existing CMO.

6 Month Look Out



Support 40 PCP
Practice Sites with
Embedded/
Community Resources

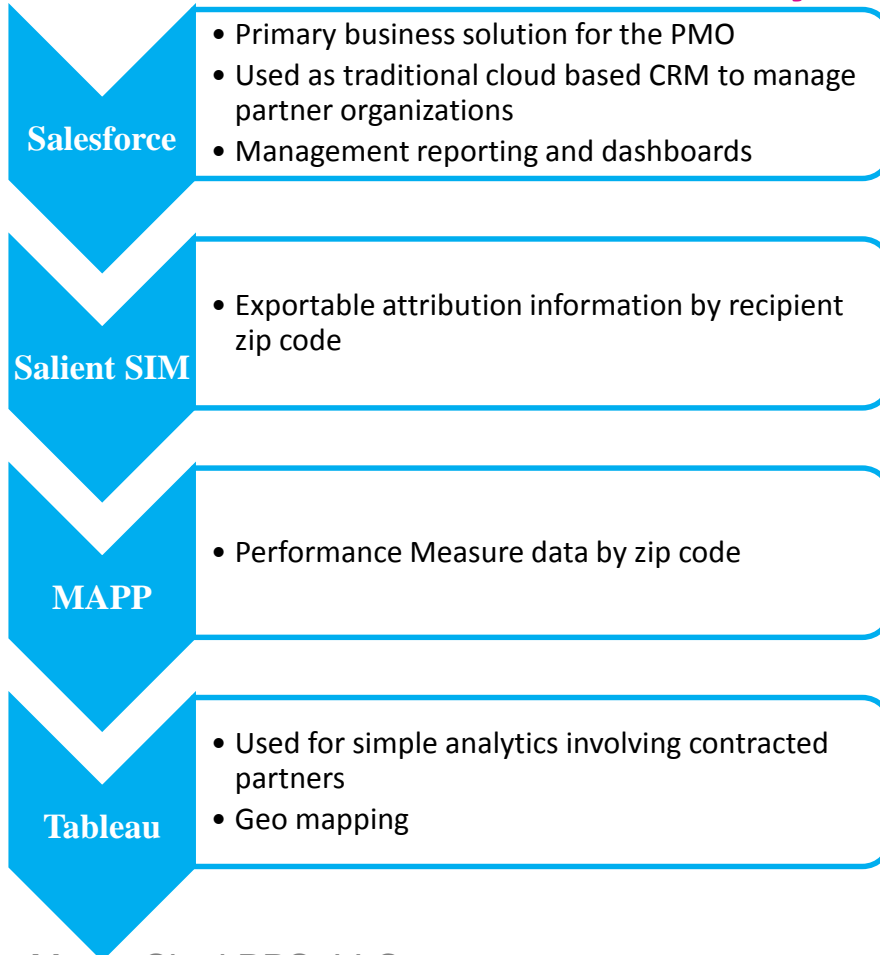


Provide TOC
services to 5
hospitals

Our Goal: Enhance patients' self-
care abilities, improve access to
community-based resources, break
down care silos and reduce
avoidable hospital admissions and
emergency room visits through
Population Health Management.

Mount Sinai PPS

Combined Multiple DSRIP Data Sources to operationalize care delivery to patients

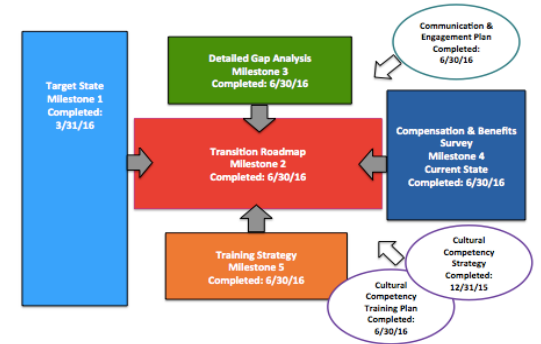


By filtering to zip codes with $\geq 5,000$ lives some clear clusters appear



Mount Sinai focused on high density attribution clusters

MHVC Launched Workforce Transition Roadmap



Transition Roadmap Implementation Guide

Training & Education Strategies

Blended Learning Methods

Train-the-Trainer Process

Quality Improvement

On-going Training Needs Assessment

Recruitment & Retention Strategies

Job Board / Clearinghouse

Career Ladders & Succession Planning

Workforce Diversity Initiatives

Recruitment & Selection Process

Retraining & Redeployment Strategies

Structural Mapping

Analysis & Review of Alternative Roles

Forecasting & Phased Reductions

Support Processes for Impacted Staff

Organizational Development Strategies

Organizational Culture

Change Risk & Readiness

Communication & Engagement

Cultural Competency & Health Literacy

Community Partners of Western NY

Telemedicine:

- Community Partners of Western New York (CPWNY) and partner Women and Children (WCA) Hospital have contracted with a third party vendor Specialist on Call (SOC).
- Clinical areas of focus have been inpatient neurology, outpatient neurology, and acute critical care.
- Additional pilot programs under development for additional use of telemedicine component.



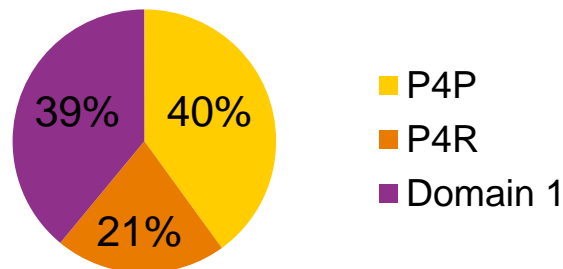
COMMUNITY PARTNERS OF WNY

Performing Provider System

Accomplishments:

- ❑ Assigned metric “ownership” to individual leaders.
- ❑ Educated partners on P4P impacts and the potential to lose AVs if performance goals are missed
- ❑ Development of multiple P4P summaries and education tools
- ❑ Business Intelligence dashboard development based on EMR data for real-time performance.

Payment Categories



YEAR 2 DSRIP Performance Measures (Domains 2-4) - Grouped by Measure (Score as of June)

State Perf Goal	Num	Den	Result:	Annual Impvt Target	High Perf elig/ Goal?	Most Recent Score *	On Target to meet goal	Lower Better ?	Achmnt Value if goal met	P4P MY 2?	
76.5	Base	50	66	75.8	75.8	No	63.16	No	No	1	Yes
	MY1	48	76	63.2	64.5	No					

Adherence to Antipsychotic Medications for People with Schizophrenia (\$722,298.04)

(# of people who remained on an antipsychotic medication for at least 80% of their treatment period/# of people, ages 19 to 64 years, least 2 antipsychotic medications during the measurement year)

LCHP Pay for Performance Measure Specification Manual

Compiled by A. Van Kampen (Updated 8/11/16)

INTEGRATION OF PRIMARY AND BEHAVIORAL HEALTH

- 899/1019 PHQ-9 screenings completed of 1019 offered over 5 months (88%)
- 67 of 134 PHQ-9 screens scoring >15 referred to on-site BHC (50%)
- 78 patients with a PHQ-9 score of 15 higher received follow-up with BHC on-site
- Expanding program to include SBIRT in July 2016.

Description	Before (Mar'16 – Apr '16)	After (May '16 – Jun '16)	% Change (From Baseline)
Total Screening Rates	66.5 average / month	310 average / month	366%
Warm Handoffs	4.5 average / month	15 average / month	233%
Follow-up (for PHQ-9 score 15-27)	8 average / month	32.3 average / month	303%

Maimonides PPS

Systems supporting contracting and payment across large network of diverse partners:

- Master Services Agreements in place with more than two-thirds of network Participants
- MSA Schedules specify requirements, deliverables, budget and monthly reporting obligations
- Budgets modeled on program requirements/performance targets vs. Participants' budget proposals
- Participant reporting portal
- Electronic payments, contingent upon:
 - ✓ Signed MSA, BAA and Schedule
 - ✓ Satisfactory Compliance Check
 - ✓ Completed Participant Survey
 - ✓ Approved Monthly Report

To date, 99 Schedules with a total budget of more than \$17.4M

Nassau Queens PPS

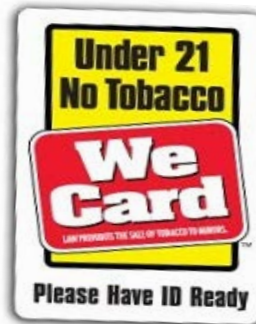
Opening of new Primary Care Practice, Co-Located with Emergency Department (ED)

- Nassau University Medical Center opened a new Primary Care Practice in April 2016 adjacent to the ED to create an easily accessible alternative to the ED.
- From April – July 2016, there were **11,941** visits. Of those, **31% (or 3,656)** were **new patients**.



Tobacco Cessation (4.b.i)

Two of the six counties within our PPS have raised the minimum legal sales age for tobacco products (including e-cigarettes) to 21 years of age!



Congratulations to Albany and Schenectady Counties and many thanks to the Tobacco Cessation Workgroup, the Capital District Tobacco Free Coalition and the support of our partners.

Albany Medical Center PPS Clinical Achievements

PPS-wide comprehensive Clinical Integration Care Coordination Model:

- collaborative effort by PPS stakeholders
- standardized, timely and effective processes and guidelines to drive enhanced care coordination
- emphasizes care being delivered in a continuous cycle across care delivery settings, with the majority of services and care being provided in the community
- Process flows, Visio diagrams to illustrate technology alignment to processes, and tools/templates support the implementation

Adoption of evidence-based guidelines for managing: Asthma, Hypertension, Opiate prescribing in ED settings, and screening for Depression



ADVOCATE COMMUNITY PROVIDERS PPS

Organizing Community-based Primary Care

- Convened 7 partners in “fishbowl” focus group, observed by ~50 network members, to discuss DSRIP impact on **neighborhood medical practices**
- Conducted online survey to collect point-in-time **workforce** data from network providers via Center for Health Workforce Studies
- Held in-person introductory **physician engagement** meetings attended by 170 physicians and medical practice staff
- **Trained** 197 office managers and office administrators
- Delivered Project 3.a.i medical assistant/in-practice **behavioral health** care manager training to 133 medical practice staff as part of IMPACT model.
- Retained 1199TEF as Primary Workforce/Training consultant and developed a **workforce training and communication** portal – HWApps



Workforce Development

DSRIP 101 e-course developed and rolled out to all partners.

Over 300 physicians, nurses, and medical assistants completed face-to-face training around care transition protocols, customer service, and chronic disease management



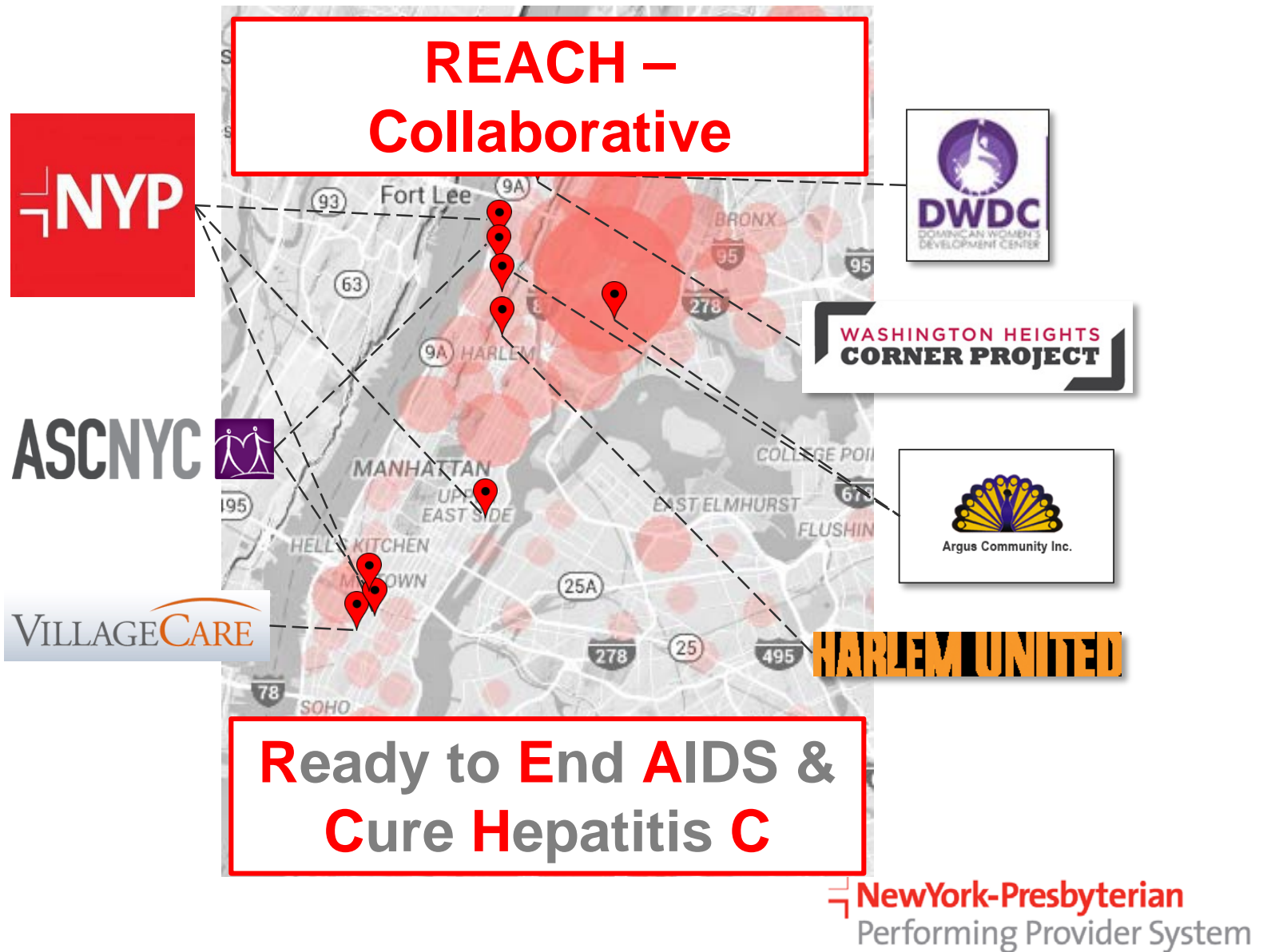
65% of key network partners are linked to RHIO

Resources allocated to develop system-wide reports to identify and link eligible patients with Health Homes and improve communication with PCPs around ED/IP admissions and missing services



Connected with **75%** of network PCPs to assess transformation efforts and offer vendor support for PCMH Level 3 accreditation

NYP PPS: HIV Projects - CBO Engagement



Adirondack Health Institute PPS

Progress toward advancing primary care:

- All primary care practices are utilizing certified EHR technology, are connected with local health information exchange and actively sharing health information among clinical partners
- 21 practices (24% of practices) will be submitting PCMH 2014 applications to NCQA by the end of DY2 Q2
- Technical assistance deployed to assist remaining practices achieve PCMH 2014 Level 3 no later than the end of DY3



○ Collaboration ○ Catalyst ○ Community

Refuah CHC Expansion of Mobile Crisis Program

Supporting the promotion and expansion Rockland's Behavioral Health Crisis Response Team (BHRT) via:

- Marketing campaign: Billboard posted in high-traffic area and targeted in-person outreach to PCPs and BH providers
- Sponsoring a 2nd BHRT clinical team to meet increased demand
- Partnering with local volunteer EMTs from the community to leverage their trusted position and cultural/linguistic competence

86.5% of BH crisis calls are de-escalated by BHRT and AVOID ER

FREE, CONFIDENTIAL, CRISIS CARE

GIN ESPWA JEST NADZIEJA דוועט זיין גוט **THERE'S HOPE** 有希望 ЕСТЬ НАДЕЖДА HAY ESPERANZA

DON'T WAIT, GET HELP!

ROCKLANDHELP.ORG • 845.517.0400

A JOINT PROJECT OF

Rockland County

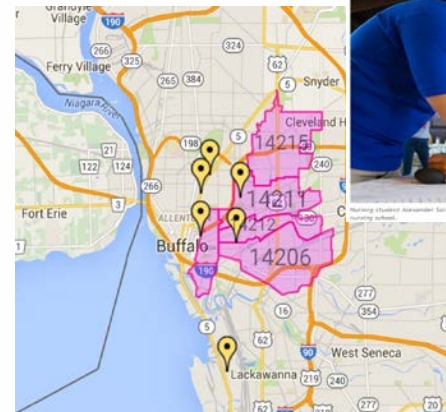
Millennium Collaborative Care Million Hearts® Program Data



- 78 University of Buffalo School of Nursing students trained in Million Hearts® using Ohio State University course (<https://millionhearts.osu.edu>)
- Events at 7 Churches serving predominantly African American parishioners
- Community Event at University of Buffalo –South campus
- 222 community members screened overall
 - 70% female
 - 78% African American race
 - 60% ages 51-80 years
 - 23% smokers
 - 20% normal BMI, 35% overweight, 44% obese
 - 50% taking Blood Pressure Medication
- Blood Pressure, BMI, Patient Activation Survey, Stress Scale
- Health Education provided (Physical activity and Nutrition)



UB Reporter
News and views for UB faculty and staff
Campus News | Research News | Your Colleagues | Working at UB | UB Seen



Central New York Care Collaborative, Inc. (CNYCC)

Project Spotlight – Primary Care/Behavioral Health Integration (3ai)

Incorporation of Behavioral Health Services in to the Primary Care Setting:

- Over 40 contracted partner organizations participating in project
- Development of framework to establish workflows and support integration efforts
- Relationship facilitation between PCPs and BH providers
 - “Meet & Greet” Events for participating partner organizations
 - One-on-One Meetings to outline potential partnerships
- Development of Standards of Care protocol for participating partner organizations
 - Phased Implementation to Ensure Process Adoption
 - Screenings for Substance Abuse and Depression (model 1)
 - Focus on obesity, diabetes, cardiovascular disease (model 2)
- **Approximately 14,000 actively engaged patients to-date**
 - Consistently meets/exceeds quarterly **actively engaged patient** targets



New York-Presbyterian Queens Pediatric Asthma Project- School Based Clinic Education Program



- Education program developed for school based clinic staff focused on:
 - Asthma basics
 - Environmental triggers
 - Home-based care opportunities, referrals and clinical providers
- Goals of the program:
 - Decrease school absenteeism
 - Reduce emergency department utilization & hospital admissions
 - Increase awareness & education
 - Link patients to programs for ongoing education or treatment
- CBO contract with the Asthma Coalition of Queens to build on existing programs



NYU Lutheran PPS

Progress on Value Based Roadmap

- A new legal entity, NYU Langone IPA, Inc, created to perform risk-contracting on behalf of the Medicaid population
- Currently enrolling providers and key DSRIP partners in the IPA and working to gather payor data to assess overall readiness
- Performing sophisticated analytics to identify opportunities to improve population health and manage high-risk patients
- Actively engaging with payers to enter into VBP arrangements:
 - Pursuing a pilot arrangement through KPMG that covers almost 30,000 United Medicaid members
 - Full-Risk contract in place with HealthFirst
 - Shared Savings contract with Empire BlueCross BlueShield





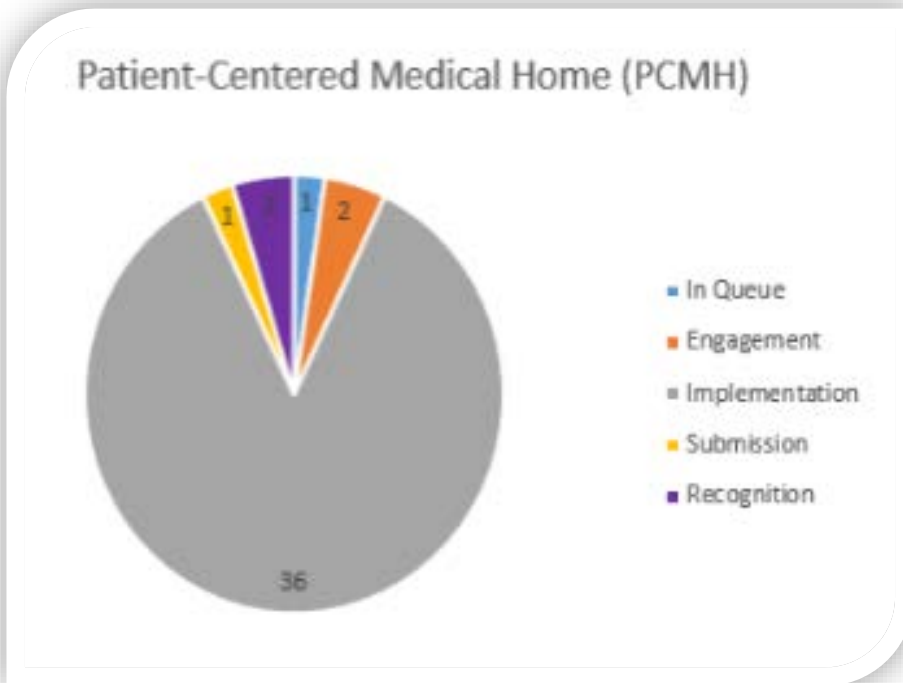
Palliative Care Symposium Brings National Leader and Best Practices to Local Practitioners



While most practitioners recognize that palliative care is proven to extend and improve the quality of life, they often don't know a great deal about what specific palliative care works and how to provide it.

Alliance for Better Health Care's sponsored Regional Palliative Care Symposium, "*Palliative Care: Defining and Applying Best Practices*," brought the passion and nationally renowned expertise of Patricia A. Bomba, MD, FACP to a group of more than 150 clinicians, administrators and allied health professionals who represented diverse practices across the region.

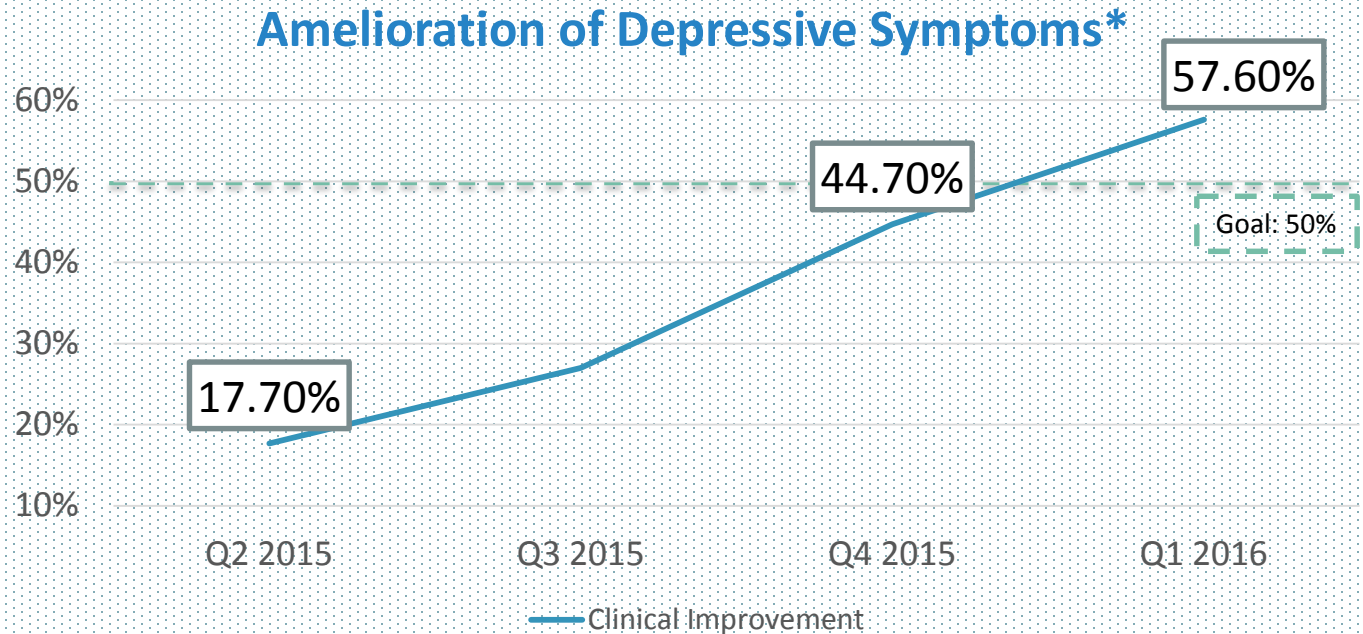
North Country Initiative - PCMH Progress



- ▶ Created plan, timeline & gap analysis for **42 primary care sites**
- ▶ Successfully phased & assigned **42 Primary Care** sites to PCMH team, which includes four NCQA PCMH Certified Content Experts
- ▶ Created in depth tracking system to manage all 42 PCMH implementations across the Tri-County Region
- ▶ **Three practices have submitted, two recognized 2014 Level III PCMH.** Others are on schedule to meet the DSRIP timeline



40,000+ screenings completed



*<http://catalyst.nejm.org/collaborative-care-depression-safety-net-health-system/>

PCMH Transformation Progress

Establishing one standard of care and the skills to succeed and sustain DSRIP.

Challenges

- PCMH 2014 Level 3 by March 2018
- Varied settings, preparation, experience
- SDOH PCP target for BPHC: 889
- Eligible PCPs: 467

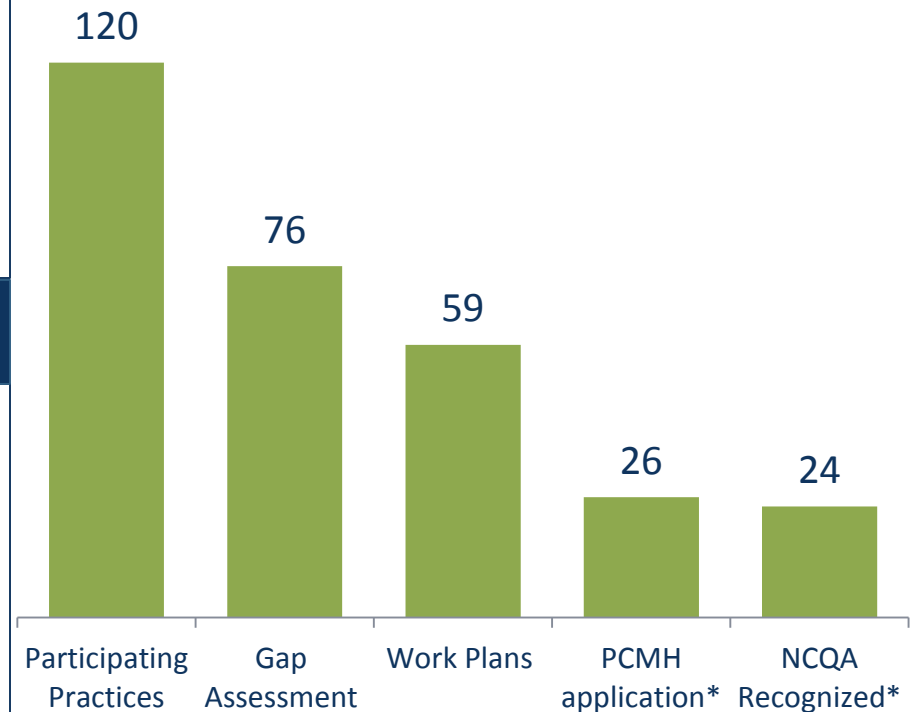
Best Practices

Funding for PCMH Coaches: CSO recruited pool of coaches, Practices selected coaches

Funding for PCMH Startup Infrastructure Coaches Community of Practice: meets to exchange

learnings

PCMH Achievement (by Sites)



* current as of 8/15/2016

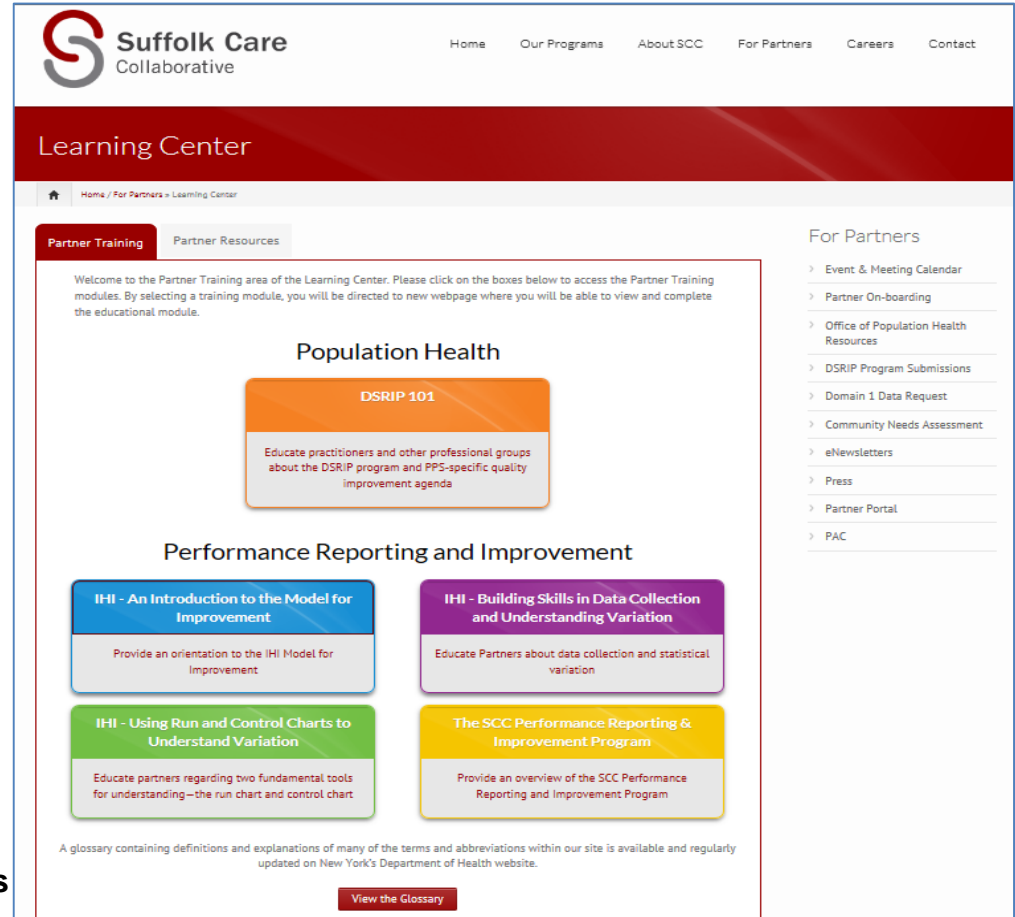
Online Learning Center for Providers & Partners Live!

Current Modules include:

- ✓ Population Health
- ✓ DSRIP 101
- ✓ Performance Reporting & Improvement Education
- ✓ Cultural Competency & Health Literacy 101

Coming Soon!

- New Models of Care & Healthcare Trends
 - Motivational Interviewing & Health Coaching
 - Care Coordination Methodology
 - Behavioral Health Integrated Care
 - Cardiovascular Health Wellness
 - Diabetes Wellness
 - Transitions of Care
- ✓ Learning Modules are 15-30 Minutes in length
 - ✓ Participants complete a brief registration form and post evaluation
 - ✓ Participation is tracked for DOH reporting purposes




The screenshot shows the Suffolk Care Collaborative Learning Center website. The header includes the logo and navigation links: Home, Our Programs, About SCC, For Partners, Careers, and Contact. The main heading is "Learning Center". Below this, there are tabs for "Partner Training" and "Partner Resources". A welcome message states: "Welcome to the Partner Training area of the Learning Center. Please click on the boxes below to access the Partner Training modules. By selecting a training module, you will be directed to new webpage where you will be able to view and complete the educational module." The main content area features several modules:

- Population Health**
 - DSRIP 101**: Educate practitioners and other professional groups about the DSRIP program and PPS-specific quality improvement agenda.
- Performance Reporting and Improvement**
 - IHI - An Introduction to the Model for Improvement**: Provide an orientation to the IHI Model for Improvement.
 - IHI - Building Skills in Data Collection and Understanding Variation**: Educate Partners about data collection and statistical variation.
 - IHI - Using Run and Control Charts to Understand Variation**: Educate partners regarding two fundamental tools for understanding—the run chart and control chart.
 - The SCC Performance Reporting & Improvement Program**: Provide an overview of the SCC Performance Reporting and Improvement Program.

A footer note mentions a glossary available on New York's Department of Health website, with a "View the Glossary" button.

RHIO Connectivity Incentives to Partners

RHIO Pilot

- Incentivize Partners with Funds Flow to Increase Connectivity 
 - 10 Partners Connected & Received Funds Flow in Round 1, including:
 - Pediatric & Primary Care, Skilled Nursing Facilities, Home Care, Health Home, Behavioral Health, CBO – Youth & Adult Centers
 - 10 Additional Partners Engaged, Round 2 (underway)
- Align Incentives to Maximize Return of Clinical Integration
 - Ensure Partner Connectivity to Improve Quality
 - Align Project & EIP Commitments
 - Increase Communication & Awareness of Quality Indicators (DSRIP & EPP)



INNOVATION FUND PROGRAM

Goal: Promote grass roots innovation to impact Access to Care, Quality of Care, and Disparities of Health based on programs designed by PPS organizations with longstanding community service

- 3.5% of Overall DSRIP Award allotted to fund
- DY2-DY4 for new innovation, DY 5 for sustainability programs
- ***Strong Response!*** 23 Proposals received, totaling \$7.1M for: Behavioral Health, Tele-Medicine, Palliative Care, Disease Management, Navigation, Transportation, VBP, & Nutrition
- Evaluations currently underway by independent review committee

Community Partners of Western NY

TigerText Implementation:

- Secure messaging solution allowing for HIPPA-compliant clinician communication
- Pilot programs implemented in Women's Christian Association Hospital and Hospice Buffalo, Hospice Buffalo partnered with Catholic Health to implement in the Palliative Care initiative
- User benefits: communicating via preferred channel, enhancing the workflow, messaging PHI, and improving patient and employee satisfaction



COMMUNITY PARTNERS OF WNY

Performing Provider System

WMCH: Rapid Improvement Cycles Significantly Reduce ED Visits and Opioid Use



Interdisciplinary and multi-provider teams from WMCH Health PPS, Ellenville Regional Hospital and Institute for Family Health participated in the Medicaid Accelerated eXchange (MAX) Series Program, from May 2015 – October 2015.

Key program components include redesign and improvement of primary care processes aimed at preventing unnecessary ED use among high-risk patients.

Achievements:

- ✓ **Reduced ED visits by 34%**
- ✓ **Reduced opioid prescription orders by 73%**

This program had a cohort of 64 patients.



**Performing Provider
System (PPS)**

Westchester Medical Center Health Network

Albany Medical Center PPS Community Achievement

- Law Enforcement Assisted Diversion (**LEAD**)
 - AMCH PPS and Albany City Police initiative
 - Reduce low level arrests and recidivism
 - Aimed to divert individuals with mental illness, drug dependence, homelessness, etc.
 - Officers are given discretion to refer individuals to a case manager rather than sending them to jail
 - Case managers assist individuals in accessing a comprehensive network of needed services
 - Anticipated that healthcare costs will be reduced and/ or patient engagement will be increased through the intervention
 - Pilot program currently underway through the Katal Center for Health, Equity, and Justice, with case management provided by Catholic Charities



To address workforce needs of Project 3.d.ii, the Alliance for Better Health Care has contracted with Kettering National Seminars to conduct an Asthma Educator Examination Prep Course



A total of 33 licensed professionals representing our partners, aligned CBO's and adjoining PPS are registered for the course on August 18-19

Central New York Care Collaborative, Inc. (CNYCC)

Population Health Management (PHM)

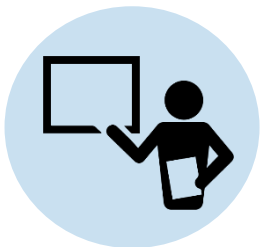
Development of a PHM approach to support a new model of patient care:

- Integrated infrastructure to support, **People** (CNYCC Partner Organizations); **Process** (Project Implementation); and **Technology** (Integrated PHM Platform)
- Comprehensive partner engagement in development : Benefits realization approach, Partner feedback through workshops, interviews, presentations, PHM “Vision” development based on partner feedback
- Focus on impact of Value Based Payment (VBP) approach to PHM Strategy including: Economies of Scale; Care Coordination; and Reporting/Analytics
- Exploring regional collaboration with other payees & VBP initiatives





17 primary care sites engaged



130 partners trained in delivering healthcare proxies



2,640 healthcare proxies obtained



Created and shared a **'best practices'** summary document

Millennium Collaborative Care Maternal and Child Health

- Community Health Workers outreaching to, knocking on doors, and connecting with our community around health screening and preventive care
- Paraprofessional within the healthcare team with standardized screening tools and the ability to assist in the community addressing social determinants of health.
- **More than 600 mothers and mothers to be engaged and being following through pregnancy and the first 2 years of child's life**



MAX Series: St. Joseph's Hospital

Multidisciplinary "Action" Team

Target Population



Patients with **4 or more** inpatient admissions

125 Inpatient Super Utilizers (Many on Dialysis)

2015 Baseline Data



Hospital
909 ED Visits
637 IP Admissions
11.2% Referred to CM

2016



Health Home and Case Management Team
Intervention
6 months (2016)

OUTCOME DATA

125

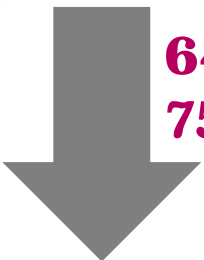
Cohort of High Utilizers

62 pts
50%
Presented to ED

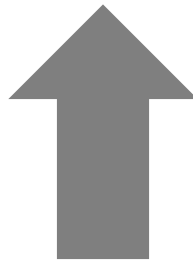
48 pts
77%
Engaged by Care Manager

34 pts
55%
Connected to Social Services
Connected Back to Dialysis Center

- Housing
- Drug Rehab
- Immigration
- Assisted Living



64% ED Visits
75% Admissions



136%
Engagement with Care Coordination Team

Accomplishments:

- ❑ Put funds in the hands of partners to begin affecting change in their organizations
- ❑ Published Funds Flow process and payment amounts on website for all partners to view
- ❑ Collaboration with neighboring PPSs to share best practices



Jason Helgerson. | AP Photo/Mike Groll

Spending off to slow start under Medicaid waiver project

By DAN GOLDBERG | 05/17/16 05:16 AM EDT

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[Share on Twitter](#)

The state's Delivery System Reform Incentive Payment program, the most ambitious Medicaid reform effort in New York history, is behind schedule in spending the money that has been allocated for the program.

Of the 25 Performing Provider Systems, only Bassett Medical Center spent more than half of what it was allotted through the first nine months of the program's first year. Six of the 25 systems spent less than 10 percent, according to the most recent reports.

“Of the 25 Performing Provider Systems, only Bassett Medical Center spent more than half of what it was allotted through the first nine months of the program's first year.”

- POLITICO

Mount Sinai PPS

Valuing CBO Partners to create a cohesive Delivery System

The **Clinical Value Scorecard** – developed to identify potential contributions of organizations using industry benchmarks for their provider type.

- Using partner subject matter experts, developed survey questions under five key categories to help assess partners using industry specific benchmarks for their provider type (CBOs)
- The five “performance sections”: business model, patient perspective, efficiency measures, accreditations and designations and quality measures.
- Responses in the sections will help us objectively identify a partner’s potential contributions to the PPS

CBO Pilot Project

- CBOs will engage in pilot projects to demonstrate the impact their services can make on DSRIP outcomes.
- This will lead to innovated means by which to contract with CBOs
- Innovative ways to integrate CBO's services into value-based payment arrangements

Maimonides PPS

Engagement of Health Homes and Care Management Agencies in key DSRIP initiatives:

- Active participation by Brooklyn Health Home and CBC Health Home in CCB governance committees and key workgroups
- Agreements with 5 Care Management Agencies providing on-site support
 - Currently: Care Coordinators on site at 5 hospitals
 - Soon: Care Coordinators on site at 2 FQHCs
- Expanded use of Health Home care management / care coordination systems and processes to support care transitions, Health Home at Risk and PCMH+ initiatives
 - 396 patients reconnected to assigned Care Managers
 - 541 patients newly enrolled
 - Achieved conversion rate of 25-30% (vs. statewide average of 15%)

ADVOCATE COMMUNITY PROVIDERS PPS

Strong Community Engagement to Promote Primary Care and Health Literacy

- Trained and deployed “boots on the ground”: 21 **Community Health Workers (CHWs)** and 2 CHW Supervisors across Bronx, Brooklyn, Manhattan, Queens
- Conducted “**Hotspot**” analysis to inform community outreach and resource deployment
- Executed contracts with **CBOs** for a total of \$250,000
- Conducted **Health Week**: 12 community events, ~1,000 participants in Morrisania in the Bronx, the state’s “sickest” community district
- Partnership agreements with 9 **schools**:
 - 12 health, fitness and reading events at 11 schools
 - 1,385 children and families engaged

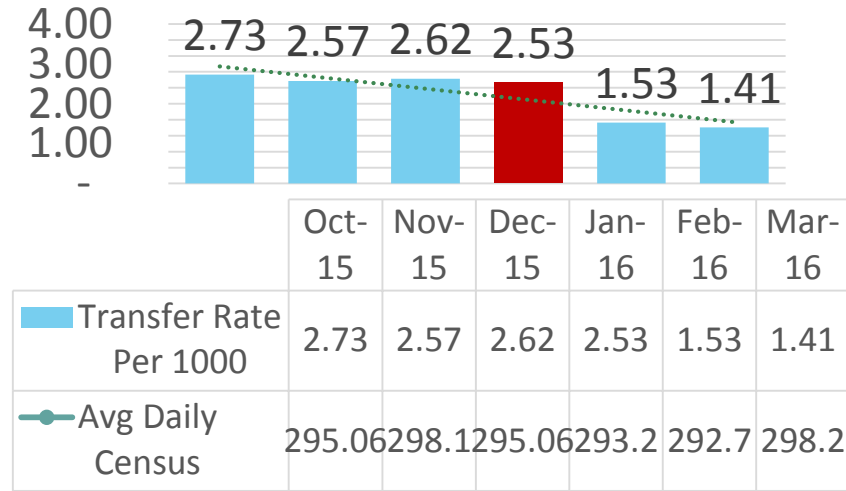




Meeting Readmission Goals – Telemedicine Pilot

- Working with a New York and New Jersey telemedicine company focused on nursing home and aging-in-place populations
- Physicians are:
 - Board certified in emergency medicine at major NYC hospitals
 - Credentialed at the skilled nursing facility
 - Able to make medical orders in the medical record
- Perform medical evaluations via videoconferencing for patients including:
 - Evaluation
 - Video-assisted examination
 - Treatment plan
 - Discussion with the patient, nurse and/or caregiver
- Weekend Coverage
 - 5pm on Friday through 7am on Monday

Transfer Rate Per 1000 Patient Days Oct, 2015 – Mar, 2016



*Metric: Transfer rate per 1000 Patient Days.
Telemedicine pilot started in Jan, 2016.*

65% improvement in 2nd month of pilot

Transfer rate per 1000 decreased from 2.53 to 1.53 and continued to 1.41 in the 3rd month





Care Transitions Operations Manual approved using Coleman Model for Care Transitions



Recruitment and training of 16 peer educators to conduct Stanford Diabetes Self-Management Program (DSMP)



Criteria and referral protocols piloted for Health Home at-Risk patient enrollment



Depression screening in primary care added as a mandatory field in EMR

Accomplishments

- ❑ Multiple success stories for addressing ED super utilizers with a behavioral health diagnoses.
- ❑ Identification of gaps, such as the need to include community-based navigation resources in the ED.
- ❑ Relationship (re)establishment with local primary care providers.



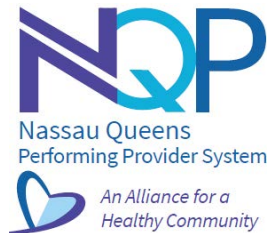
Next Steps

- ❑ Obtain funding from PPS to establish community-based navigator resource to help patients with significant social determinants.
- ❑ Collaborate with other hospitals to begin addressing ED super utilizer populations.
- ❑ Two other hospitals initiating MAX Series-like programs in ED focused on asthma patients.

COMMUNITY BASED COLLABORATION

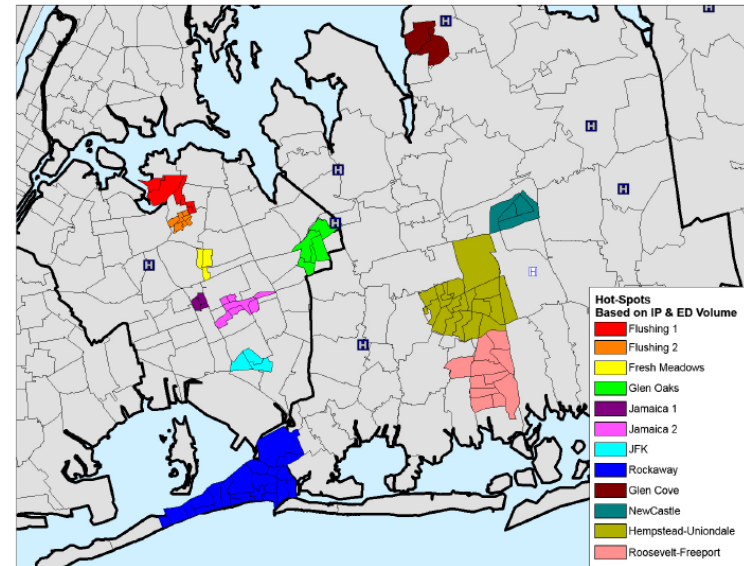
- Adoption of direct contracting model –47 non-hospital community organizations, totaling more than \$2M in commitments through March 2017 for DSRIP projects.
- Trained 26 staff members as Community Health Advocates as part of Health Navigation Services (2.c.i) program
- CBO recruitment of positions, such as LCSW, to address workforce needs
- Training 17 CBO PAM Survey Master Trainers

Nassau Queens PPS



Hot-Spotting Analysis Drives Strategy for CBO-Delivered Community Member CCHL Education

- CBO Train the Trainer Model
- Training delivery embedded in CBO agreements
- Patients empowered to be active partners in their healthcare through education:
 - Impact of social, cultural factors, health beliefs and behaviors on health outcomes
 - Ask Me3 Translation services and iSpeak Cards
 - Importance of accurate REL data capture
- Trained over **940** persons on diverse CCHL topics



New York-Presbyterian PPS

Care Transitions (Project 2.b.iv) Progress:

- Hired 8 RN Transitional Care Managers and developed an evidenced based protocol to standardize the level of care for over 500 patients touched by the project
- Continued collaboration with internal and external partners to maximize care transitions resources.
- Established contracts with 3 CBOs and on-boarded 6 Community Health Workers - program implemented in August 2016 to include home and follow-up appointment visit accompaniment

Integration of Palliative Care into the PCMH (3.g.i)



Enhance Primary Care Physicians' knowledge of palliative care for further incorporation into practice through integrated educational interventions

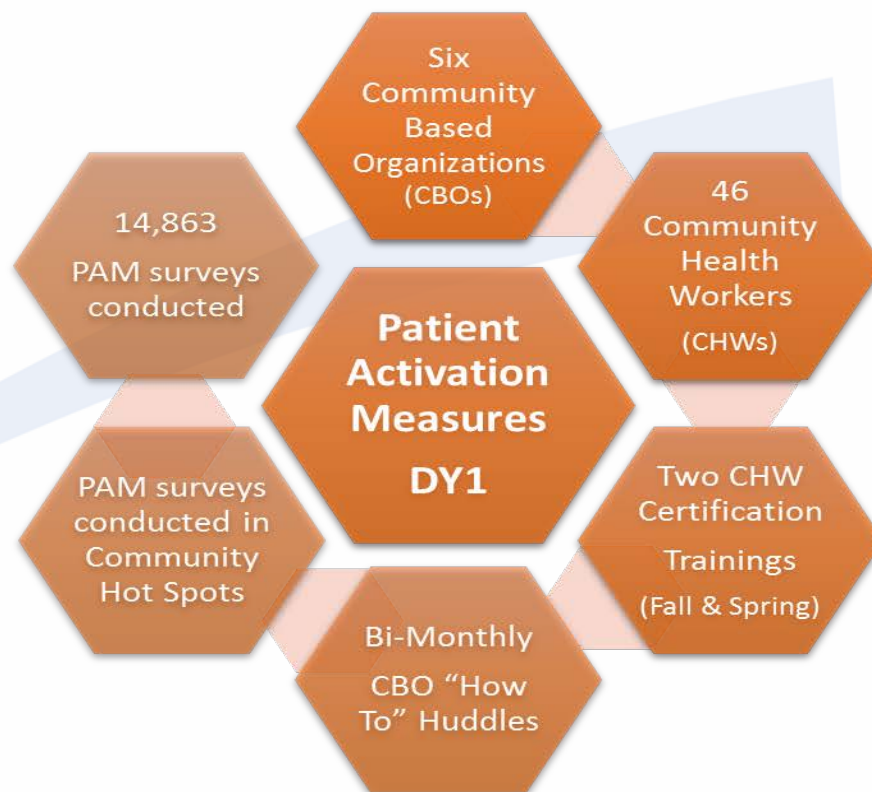


200 providers granted PPS sponsored membership and access to the Center to Advance Palliative Care (CAPC) website to obtain training materials and courses for providers and clinical champions



Establishment of clinical guidelines, standardization of referral process, and ensure pathways encompass cultural competency and health literacy

Millennium Collaborative Care Project 11





Use of Data to Inform Cultural Competency and Health Literacy Plan

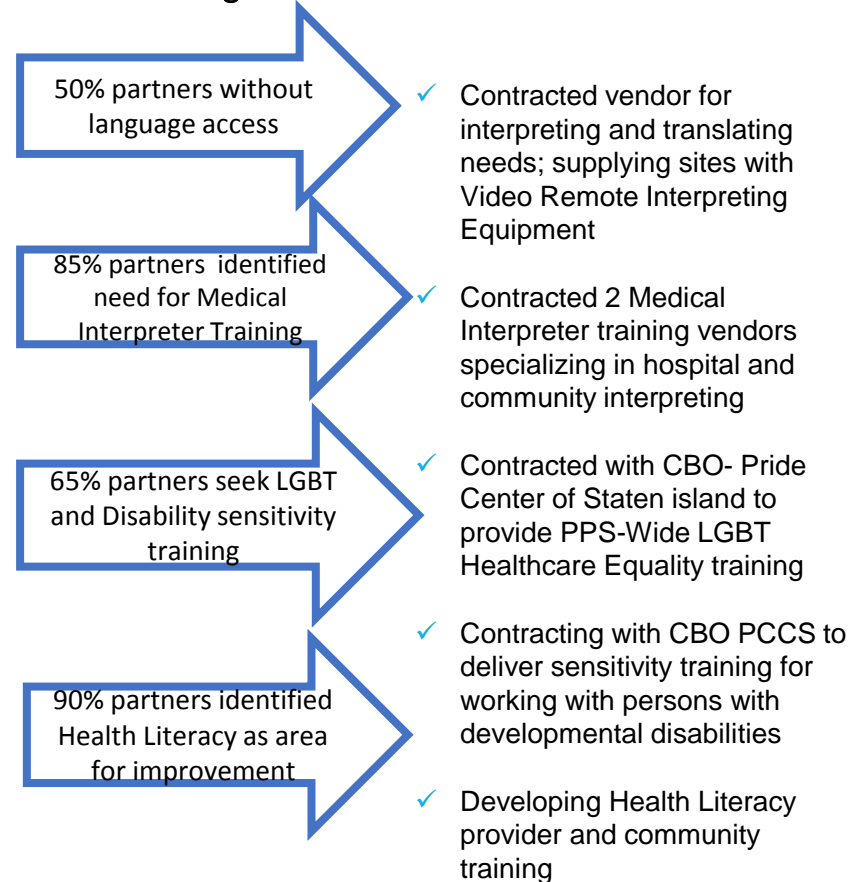
Diversity and Inclusion:
Language Access, Health Literacy, Cultural Competence, Healthcare Equality



- Plans, policies, procedures
- D&I initiatives
- Staff development and training
- Monthly meetings
- Develop programs, share best practice
- Report all information to site leadership
- Organizational capacity
- Training: status, ability and needs
- Service improvement

Findings:

Action:



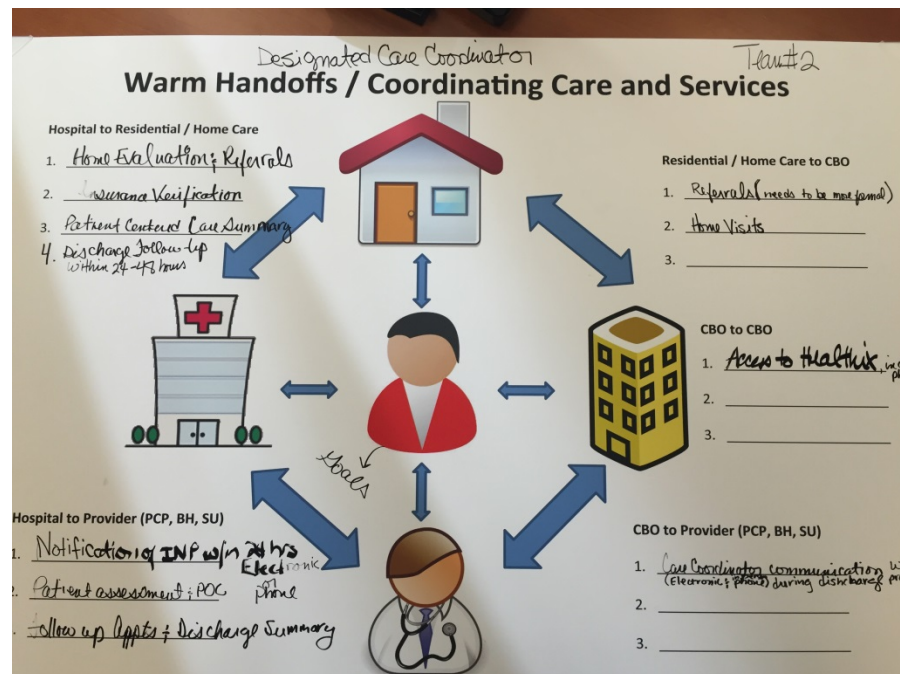
New York-Presbyterian PPS



- Biannual Learning Symposium
- Brings NYP PPS collaborators together
- Solutions and action-oriented

January 2016 Symposium

- Focused on improving connections between care team members across the PPS
- 5 most common handoff scenarios impacting patient care (i.e. hospital discharge to post-acute provider) addressed
- 3 processes/strategies to improve handoff developed for each scenario (i.e. educate patients and care team on use of RHIO)
- A single strategy the PPS could implement over the next 6 months prioritized by each group



NYU Lutheran PPS

MAXX Series– Integration of Behavioral Health and Primary Care

- Initial pilot successful in:
 - Increasing screening rates by 61%
 - Decreasing no show rates by 6.4%
 - Increasing the average number of warm handoffs to 11 per month
 - Increasing the average number of coordination between PCP and Social Worker upon discharge from treatment to 2.5 per month
- Pilot will be expanded to other sites



BPHC PPS - CBO Engagement

request
for
proposal

air.nyc

Asthma home-based services

- 15 years experience
- Community health workers
- Know the Bronx
- Speak the languages
- Strong track record



- Diabetes Self-Management Program (Stanford model)
- Lower Extremity Amputation Prevention Program (LEAP)
- Paid training for 20 coaches = individuals recruited from community
- Classes for 600-800 students from community **hot spots**

CBO-driven

- Process & Criteria
- Content & Curriculum

Community-based BH and social services targeted for funding in DY2:

- **Cultural Competency Training**
- **Critical Time Intervention**
- **Behavioral Health “Call to Action”**
- **Community Health Literacy**

North Country Initiative - Workforce

- ▶ **Leveraging Long-term Pipeline**
 - ▶ *Career exploration programs*
- ▶ **Collaborating with Institutions of Higher Education**
 - ▶ *Bachelors & Masters Programs at community college (i.e. Nurse Practitioner & Social Worker)*
 - ▶ *Development of North Country Care Coordination Certificate Program with SUNY Jefferson & SUNY Canton*
- ▶ **Customized Training Videos (DSRIP 101, Blood Pressure Measurement, Health Literacy & MEB)**
- ▶ **Provider Incentive Programs**
 - ▶ ***Approximately \$3 million for recruitment of 11 Primary Care Physicians, 3 Nurse Practitioners, 2 Physician Assistants, 2 Psychologists, 2 Psychiatrists & 2 Dentists***
 - ▶ ***Licensed Clinical Social Worker & Certified Diabetes Educator***
- ▶ **Regional Expansion of Graduate Medical Education**
 - ▶ *Providing financial support of residency spots at local GME Program, rotations at regional sites, minimum 3 year commitment to work in region*

Mount Sinai PPS

Building IT infrastructure for data sharing among all partners to create an Integrated Delivery System

Health Information Exchange

- Collaborating with Healthix for HIE services
- **23** of top 30 partners are now connected to Healthix

Data Warehouse and Analytics

- Developed in June 2016
- Developing and Tracking **13 Performance Measures** using performance management portal
- Effort to extract data from internal HIE and load in data warehouse for analysis; internal HIE to be receiving information from Healthix/RHIO

Call Center

- Functionality to include but are no limited to:
 - **Referrals/Scheduling**
 - **Patient Navigation**
 - **Care Coordination**

Community Gateway

- A **ONE-STOP** shop web-based Partner Portal, will allow all partners access centralized IT solutions
- Is now live with a subset of pilot partners

NYU Lutheran PPS

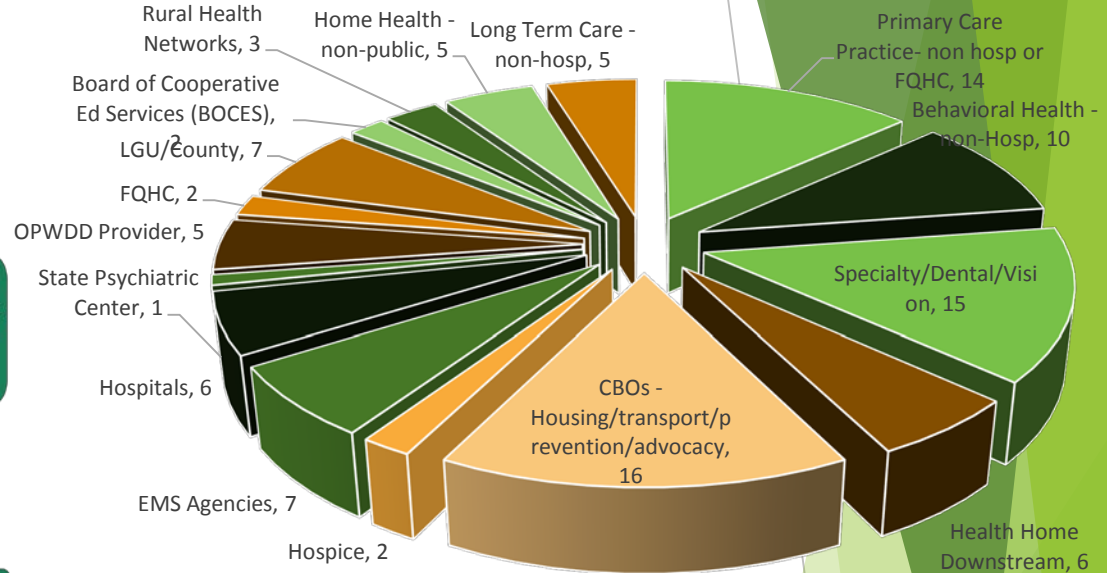
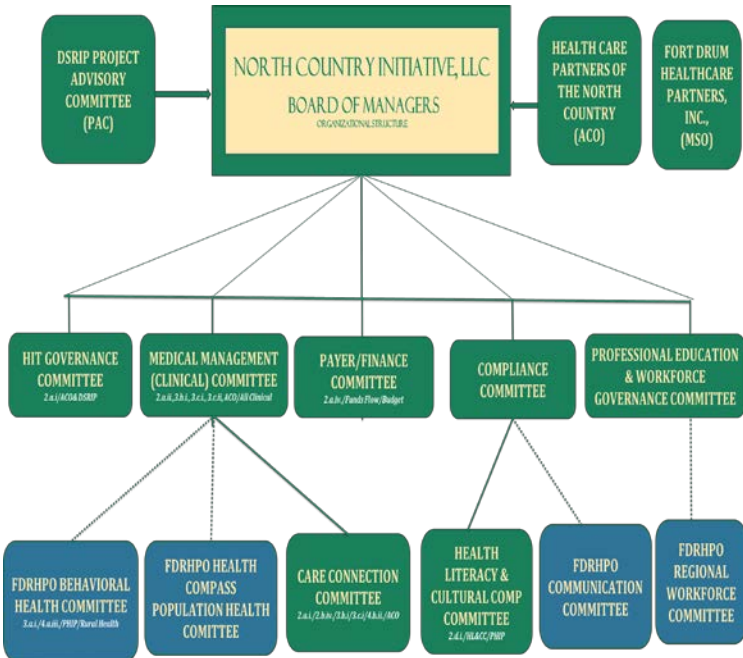
IT Connectivity and Engagement Infrastructure

- Implemented Epic Summer 2016 at NYU Lutheran Hospital and FHCs as part of Enterprise Clinical Platform
- Partners connected to Healthix (Qualifying Entity), covering nearly **84%** of total attribution
- Implementing engagement infrastructure (Salesforce) to support outreach, education, collaboration, and data collection



North Country Initiative - Governance

A physician led governance structure, with 18 of 25 board members being clinicians



A full committee structure with partner representation across the care continuum

Maimonides PPS

Collaboration with CBOs to enhance the efficacy of community engagement:

- Established Community Engagement Committee as a part of CCB's governance structure
- Engaged CBO consortium to develop CCB's Cultural Competency / Health Literacy Strategy
- Formed a Cardiovascular Disease Workgroup to explore community-based approach to understanding the barriers to good health that may be contributing to the incidence and prevalence of cardiovascular disease
- Collaborated with faculty and graduate students from MIT, faculty and students from Medgar Evers College, FQHC leaders and area high school students to design and implement a 'Community Asset Mapping Project' in Central Brooklyn

New York-Presbyterian Queens



Palliative Care Project-

EPEC (Education in Palliative and End-of-life Care) Training

- Palliative care education combines didactic sessions, video presentations, interactive discussions, and practice exercise focused on:
 - Communication
 - Ethical decision making
 - Psychosocial considerations
 - Symptom management

- Bi-monthly sessions rotated among Skilled Nursing Facility partners at their sites

- CME credits awarded

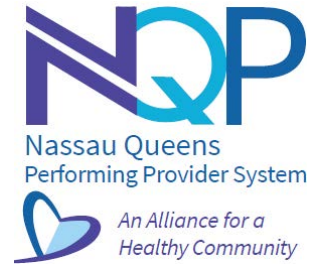
- Practitioners receive their certification in EPEC upon completion



Nassau Queens PPS

Successful Outreach to 2,000 Uninsured Individuals with the PAM[®] Survey

- In DY2 Q1, more than **2,000** uninsured individuals completed the PAM[®] survey
- Health systems partnered with community-based organizations (following RFA process) to conduct outreach, surveys, and coaching
- Surveys were collected in Emergency Departments and Hospital-based clinics



Are you uninsured?

Would you like to:

- Learn how to prevent or manage health problems?
- Learn what health care services and resources are available to you?
- Connect with a primary care doctor?

Let us help you be as healthy as you can be!

Call us at (516) 750-2645.



35 community partners contracted



17 facilities* engaged



716 partners trainings in PAM®
survey administration

*includes inpatient/hospital and neighborhood health centers



44,608 PAM® surveys administered



471 connected to Primary Care



359 connected to insurance

Community Partners of Western NY

Cultural Competency and Health Literacy:

- Contracted with the Community Health Worker Network of Buffalo (CHWNB) to implement the CCHL training strategy.
- CHWNB is representative of people living in the “hot spot” communities in need, motto is:
“Nothing without us, about us, is for us”
- Strategy focuses on biases, privilege, social justice and universal approach to literacy by bridging, mediating and facilitating understanding between and within communities and systems.



COMMUNITY PARTNERS OF WNY
Performing Provider System

Refuah CHC BH-Primary Care Integration

By integrating the care of mental and physical health, the PPS has drastically expanded its capacity

- Cultural transformation across partner organizations
- Primary care providers trained and empowered to treat and manage the most prevalent mental health conditions
- Social Workers support patients and PCPs in real time, offering immediate mental health evaluations and streamlined crisis management

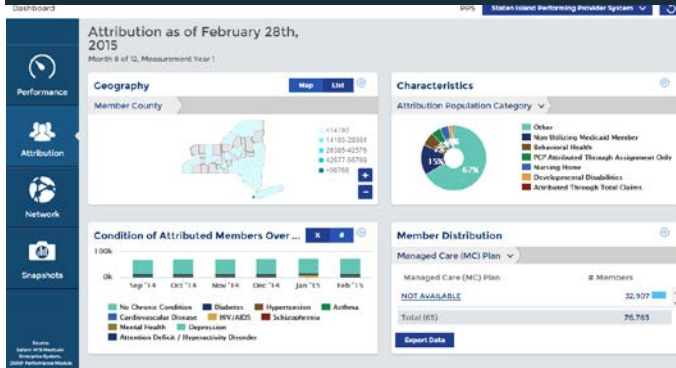
The child psychiatry waiting list at Refuah Health Center has plummeted: from 66 patients to 15 patients, from 8 months for a new evaluation to 4 weeks for a new evaluation



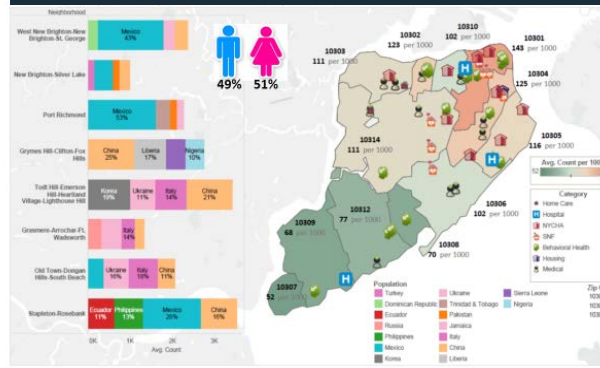


SIPPS Analytics Tool Portfolio - Turning Data into Actionable Insights

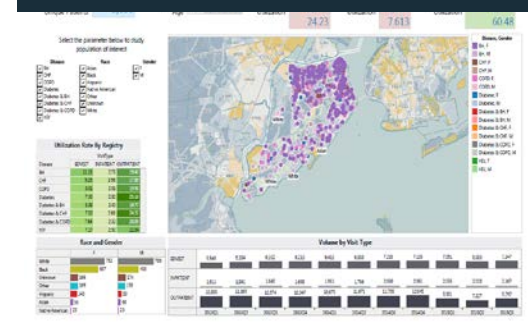
MAPP Dashboard



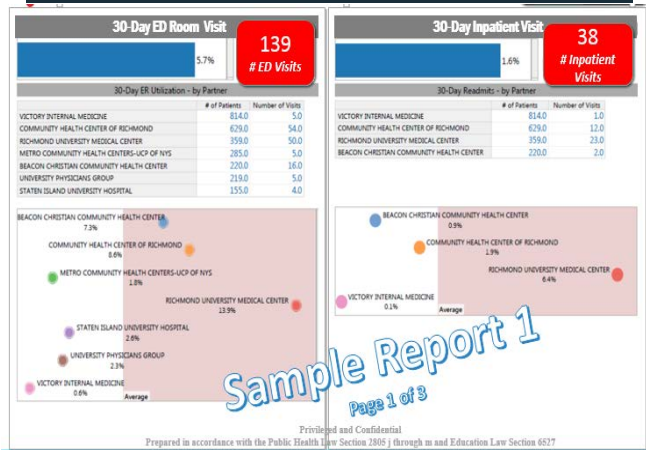
Healthcare Hotspotting



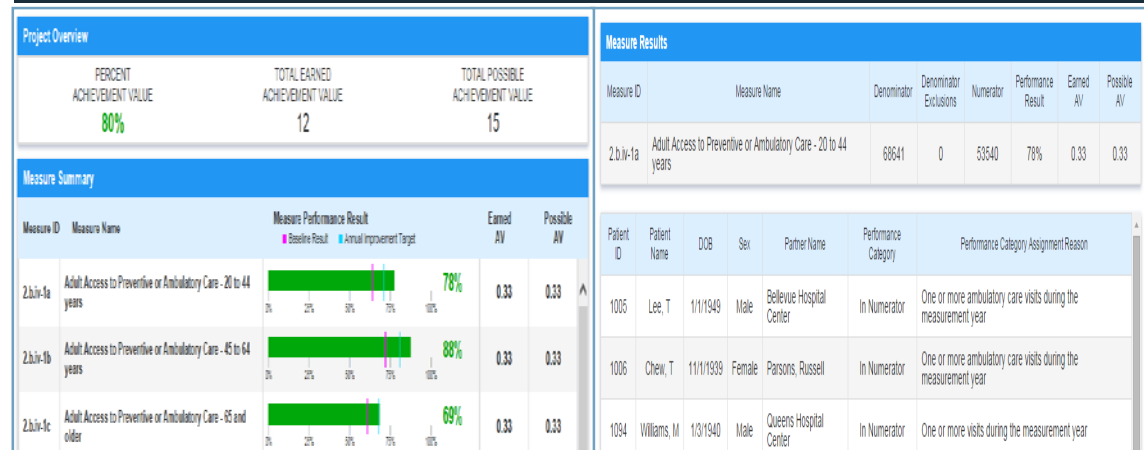
Population-based Registry 1.0



Utilization Report- Diabetes



Performance Management Dashboard



SBIRT IMPLEMENTATION IN HOSPITAL EMERGENCY DEPTS

SCC Administers an SBIRT Monthly Training Program

- **SBIRT Monthly Training Program** initiated in November of 2015 facilitated by an OASAS Certified SBIRT Training Provider
- **8 On-site Training Sessions** across 4 Suffolk County Hospitals Complete
- **An additional 4 hospitals** in Suffolk County scheduled to host trainings in 2016
- **97 Emergency Department Clinical Staff** completed training & received OASAS SBIRT Training Certificates

SBIRT Implementation in Suffolk County Hospital Emergency Departments

- **4 Suffolk County Hospitals** have Implemented SBIRT Screenings in their Emergency Departments
 - Southside Hospital
 - Brookhaven Memorial Hospital Medical Center
 - John T. Mather Memorial Hospital
 - Stony Brook Medicine

Going Beyond the DSRIP Scope of work!

- **SBIRT Training & Implementation** has expanded into primary care sites!
- To date, 2 trainings have been held for Stony Brook University Hospitals PCP sites (26 trainees)
 - Stony Brook Family Medicine
 - Stony Brook pediatrics
 - Stony Brook Internal Medicine

ADVOCATE COMMUNITY PROVIDERS PPS

Building Infrastructure from the Ground Up to Connect DSRIP's Broadest, Most Culturally-Diverse Network

- Centralizing two key **EHRs** (MDLand and ECW) that reach 80% of ACP's community-based physician network to allow for immediate capture of clinical data
- Lack of legacy systems provides clean slate for **innovation**
- Amazon AWS **cloud-based** HIPAA-compliant analytics stack that will service data needs for value-based payments
- Vendors in place to implement **PCMH certification** in physician practices
- Partnering with **Healthix** RHIO to connect ACP providers



Adirondack Health Institute

Withdrawal Management Capabilities (3.a.iv)

Citizen Advocated Inc. (CAI) – Franklin County

- Will open a 24/7 multi-functioning crisis center in Fall 2016 that will house a mobile crisis team in renovated space at University of Vermont Health Network-Alice Hyde Medical Center.
- A Psychiatric Nurse Practitioner has been hired and a Physician Board Certified in Addiction Medicine is on staff.

Champlain Valley Family Center - Plattsburgh

- Renovating a building for an OASAS-certified 820 Residential Services facility to provide structured residential treatment/recovery services 24/7 to persons recovering from substance use disorder.



MAX Series: SLCH/Cornerstone/ASFL/Horizon Medical

Multidisciplinary "Action" Team

89

High Utilizer Cohort

Target Patient Population



3 or more IP Admissions
6 or more ED visits



2015 Baseline Data



1,226 ED Visits
492 IP Admissions



Intervention

Quarterbacks from 3 partners and the hospital's care transition team connect patients to PCP/BH providers based on associated needs

2016 Outcomes



ED Utilization
(by cohort group)

Albany Medical Center PPS Workforce Achievements

Goal: Create a healthcare workforce that offers the same quality of care across the 3-PPS region

- Collaborated with Alliance for Better Healthcare (AFBHC) to provide preparation courses for employees eligible to sit for the Certified Asthma Educator exam
- Workforce leads from AMCH, AFBHC, and Adirondack Health Institute PPS meet monthly to collaborate on:
 - Curriculum development
 - Training coordination
 - Emerging titles development
- Will bring together leads for workforce and cultural competency to
 - Create consistency and efficiencies in training
 - Share resources and ideas
 - Eliminate duplication of training efforts for partners





110 registered portal users*

The **partner portal** enables users to:

- View contracts
- View partner-specific metrics
- View metrics definitions and reporting expectations
- Upload required reporting documents
- View implementation materials and toolkits
- View and submit invoices



346 support desk inquiries*

The **support desk** helps partners by:

- Providing a single point of contact to all partners
- Tracking partner inquiries
- Directing partners to appropriate resources
- Being available via e-mail or phone on weekdays from 9 a.m. to 5 p.m.

*As of August 18, 2016

Community Health Activation Program Collaboration with Healthfirst!

- **HealthFirst’s non-utilizing and low-utilizing Managed Medicaid beneficiaries are participating in our Community Health Activation Program (DSRIP Project 2di).**
- **Community Health Workers will be engaging beneficiaries through the PAM Survey, CFA Coaching and community navigation.**
- **Community Health Workers are prominently placed in “hot spots” to facilitate outreach & education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.**
- **Wellness Coaches are available to assist beneficiaries and build confidence, skills and knowledge for connecting with a provider, encouraging preventive care, and connecting with community resources.**

19,000 PAM Surveys Completed as of August 10, 2016

Refuah CHC CBO contracted to address disparities

Contracted with Konbit Nèg Lakay Haitian Community Center to address the diabetic disparities experienced in their community by:

- Providing transportation, with linguistically accessible dispatch, to and from medical appointments
- Offering Zumba exercise classes at the community center
- Holding educational sessions on diabetes prevention and evidence-based Stanford Diabetes Self-Management Programs (DSMP) in Creole

Plans to replicate this model in Spanish, Hindi, and Chinese-speaking target communities



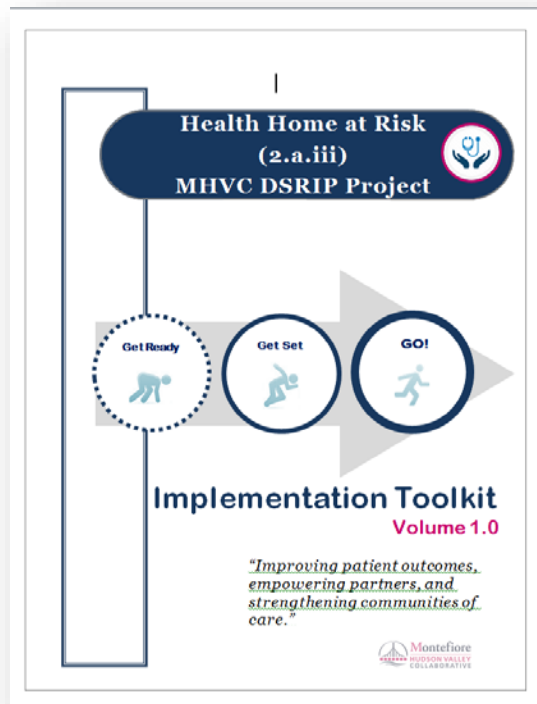
Central New York Care Collaborative, Inc. (CNYCC)

Workforce Strategy and Development

- Initial research of DSRIP impact on staffing levels has shown no net attrition
- Establishment of Workforce Committee
- Analysis of Workforce Competencies to Influence Training/Career Ladders
 - Input from Stakeholders (Partners) to help Guide Workforce Needs & Training
 - Identification of Project Specific Competencies
- Workforce Newsletter distributed across PPS to HR contacts
- Over 70% participation of CNYCC partners reported on the Compensation and Benefits survey



MHVC Launched Project Toolkits on August 5, 2016



Get Ready, Get Set, Go! Project Toolkits provide partners with...



Partners can access 5 Project Toolkits

- Health Home at Risk (2.a.iii)
- ED Care Triage (2.b.iii)
- Behavioral Health Integration (3.a.i)
- Cardiovascular (3.b.i)
- Asthma Management (3.d.iii)