NEW YORK STATE | Department of Health | Medicaid Redesign Team

NYAPRS 12th Annual Executive Seminar: When You've Seen One PPS / DSRIP…

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April 21, 2016

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The 2014 MRT Waiver Amendment Continues to further New York State's Goals

Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system

In April 2014, New York State and CMS finalized agreement Waiver Amendment

- Allows the State to reinvest $7.3 billion of $17.1 billion in Federal savings generated by MRT reforms
- $6.4 billion is designated for **Delivery System Reform Incentive Payment Program** (DSRIP)

The waiver will:

- Transform the State's Health Care System
- Bend the Medicaid Cost Curve
- Assure Access to Quality Care for all Medicaid Members
- Create a financial sustainable Safety Net infrastructure

The DSRIP Challenge – Transforming the Delivery System

Largest effort to transform the NYS Medicaid Healthcare Delivery System to date

- From fragmented and overly focused on inpatient care towards integrated and community focused
- From a re-active, provider-focused system to a pro-active, patient-focused system
- Allow providers to invest in changing their business models

Patient-Centered	• Improving patient care & experience through a more efficient, patient-centered and coordinated system.
Transparent	• Decision making process takes place in the public eye and that processes are clear and aligned across providers.
Collaborative	• Collaborative process reflects the needs of the communities and inputs of stakeholders.
Accountable	• Providers are held to common performance standards and timelines; funding is directly tied to reaching program goals.
Value Driven	• Focus on increasing value to patients, community, payers and other stakeholders.

Over 5 Years, 25 Performing Provider Systems (PPS) Will Receive Funding to Drive Change

A PPS is composed of regionally collaborating providers who will implement DSRIP projects over a 5-year period and beyond

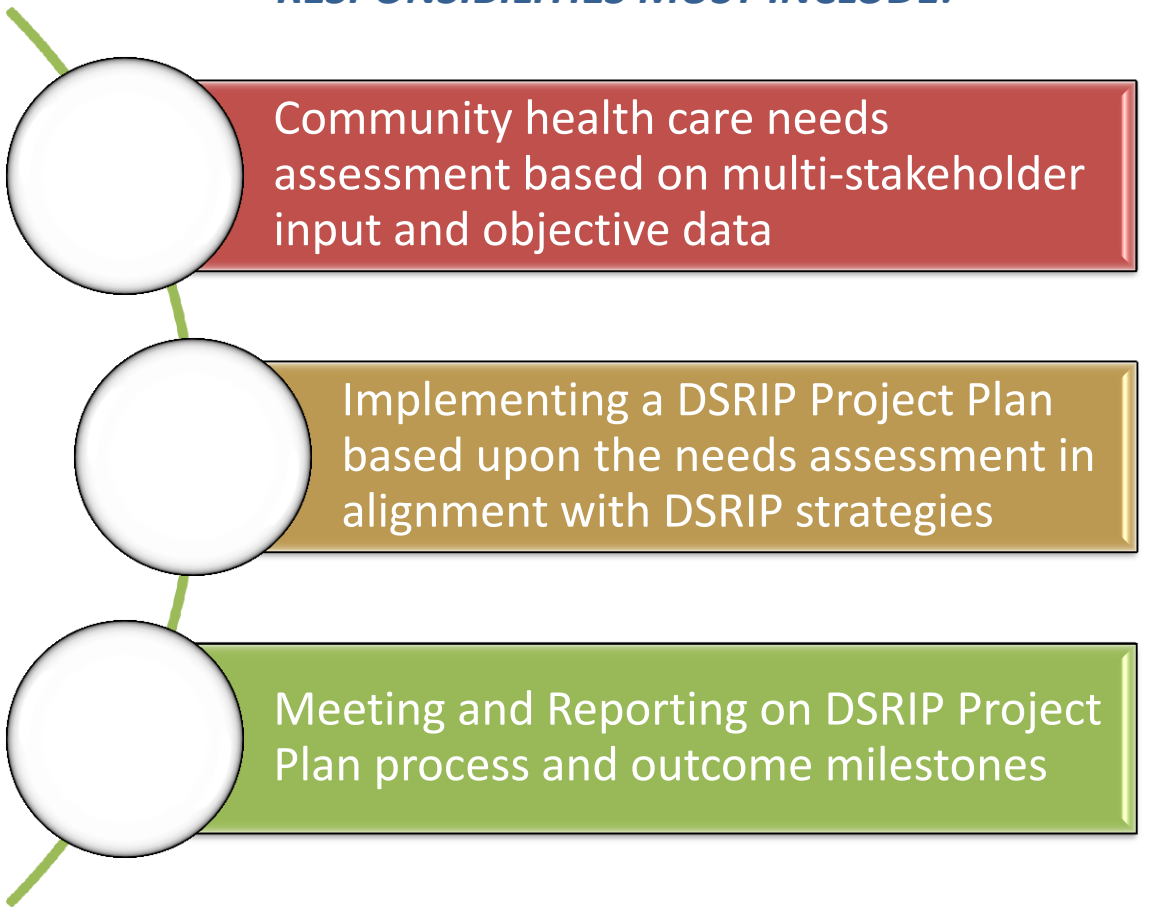
Each PPS must include providers to form an entire continuum of care

- Hospitals
- PCPs, Health Homes
- Skilled Nursing Facilities (SNF)
- Clinics & FQHCs
- Behavioral Health Providers
- Home Care Agencies
- Community Based Organizations

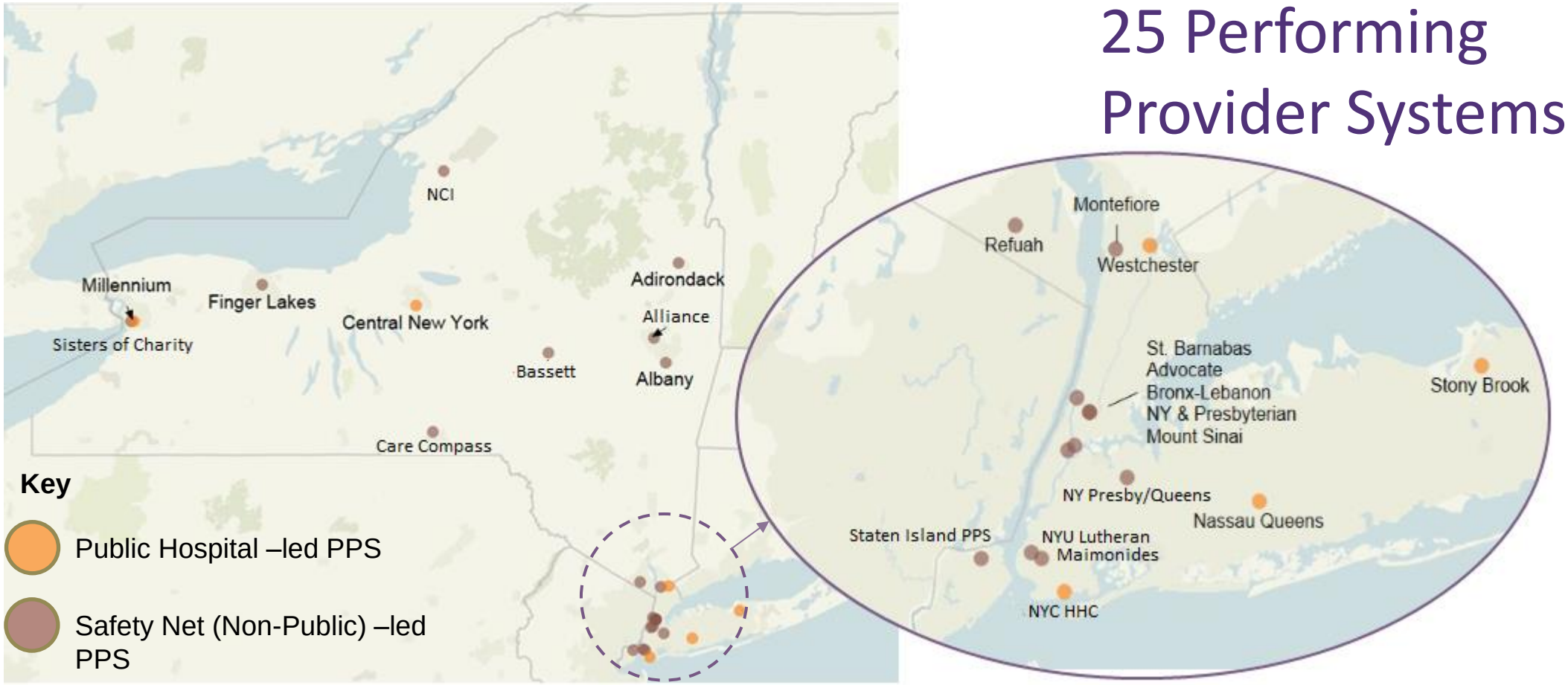
Statewide goal:

- 25% of avoidable hospital use ((re-) admissions and ER visits)
- No more providers needing financial state-aid to survive

RESPONSIBILITIES MUST INCLUDE:



Performing Provider Systems (PPS)



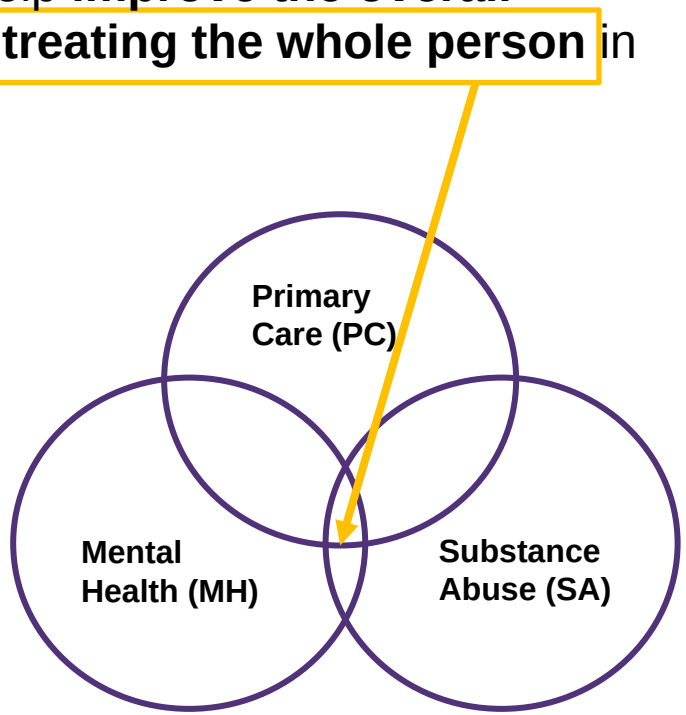
The Need for Service Integration

Healthcare providers recognize that many patients have comorbid physical and behavioral healthcare needs, yet services in New York State have traditionally been provided and billed for separately.

The integration of physical and behavioral health services can help **improve the overall quality of care** for individuals with multiple health conditions by **treating the whole person** in a more comprehensive manner

Current Integration of Behavioral Health* and Primary Care in New York State

- The publicly funded mental health system serves over **600,000** Medicaid members, representing 12% of total Medicaid Members throughout the State
- This accounts for about **$7 billion in annual expenditures** or 12% of New York's total Medicaid spent
- Approximately **50%** of this spending goes to inpatient care



** Within DSRIP, the term "Behavioral Health" also encompasses mental health and substance abuse*

Statewide Summary of Behavioral Health Members

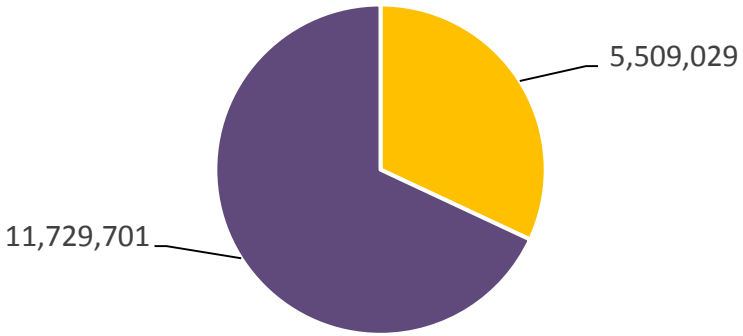
Total Pop. Excluding BH Pop.
Behavioral Health Population

A disproportionate amount of annual total cost of care and hospital visits in New York State can be attributed to the Behavioral Health population.

Overview:

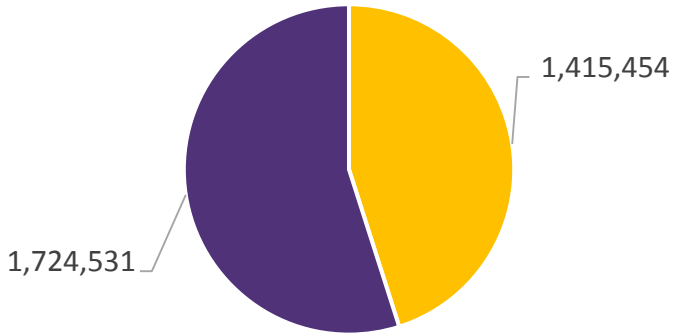
- Medicaid members diagnosed with BH account for **20.9%** of the overall population in New York State
- The average length of stay (LOS) per admission for Behavioral Health users is **30%** longer than the overall population's LOS
- Per Member Per Month (PMPM) costs for Medicaid Members with BH dx is **2.6** times higher

Medicaid members diagnosed with BH account for 32% of PCP visits



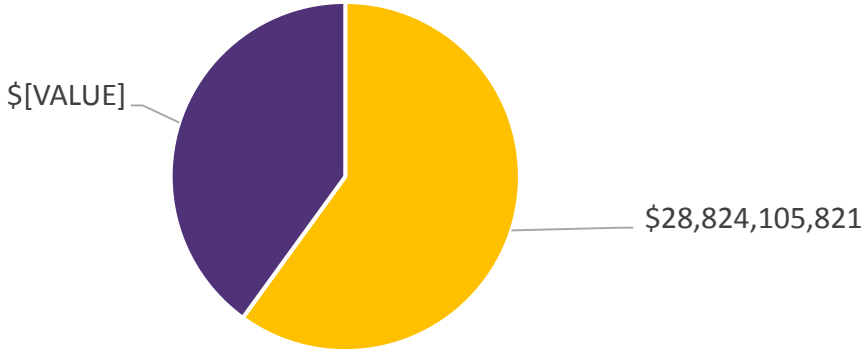
Total population: 17,238,730

Medicaid members diagnosed with BH account for 45.1% of all ED Visits



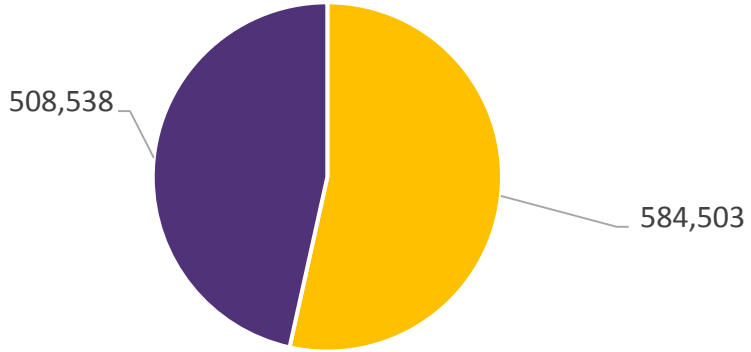
Total ED visits: 3,139,985

Medicaid members diagnosed with BH account for 60% of the total cost of care in New York State



Total cost: $48,048,379,392

Medicaid members diagnosed with BH account for 53.5% of admissions



Total admissions: 1,093,041

** This data includes Members with 1+ Claims with primary or secondary diagnosis of behavioral health issues*

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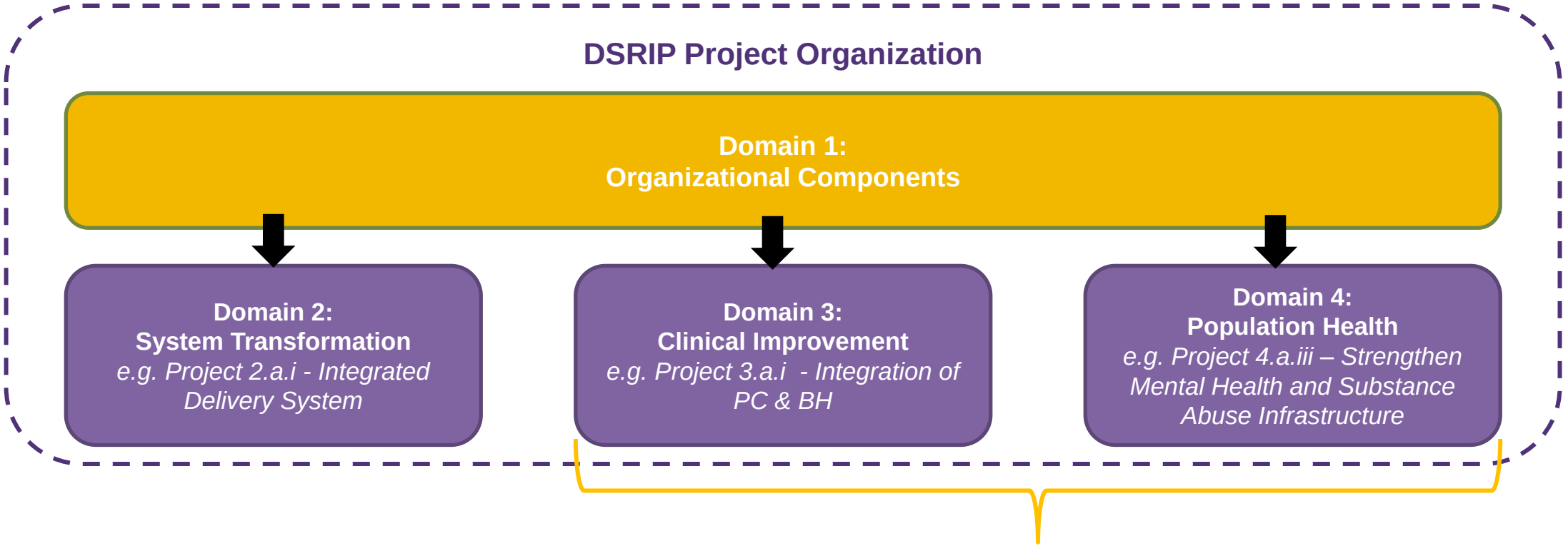
DSRIP Project Implementation

Performing Provider Systems (PPSs) committed to healthcare reform by choosing a set of Projects best matched to the needs of their unique communities.

DSRIP Projects are organized into Domains, with Domain 1 focused on overall PPS organization, and Domains 2-4 focused on various areas of transformation. All projects contain metrics from Domain 1.

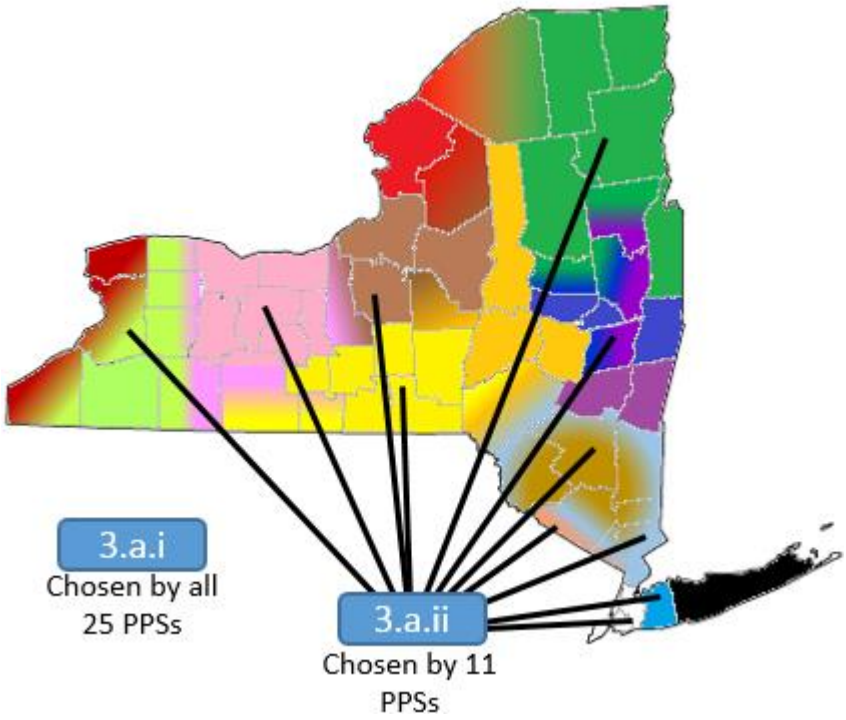


DSRIP Requirements to Achieve Service Integration

In the early stages of DSRIP, PPSs were required to implement at least one behavioral health strategy project from the Domain 3 – Clinical Improvement Projects category.

3.A Projects: Behavioral Health

- 3.a.i - Integration of primary care and behavioral health services
- 3.a.ii - Behavioral health community crisis stabilization services
- 3.a.iii - Implementation of evidence-based medication adherence program (MAP) in community-based sites for behavioral health medication compliance
- 3.a.iv - Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
- 3.a.v - Behavioral Interventions Paradigm (BIP) in Nursing Homes



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DSRIP Project 3.a.i

All 25 PPSs chose to participate in DSRIP Project 3.a.i, however each PPS chose different models for integration.

PPS	# actively engaged	Model 1	Model 2	Model 3
Adirondack Health Institute PPS	44965	x	x	
Advocate Community Partners	215344	x	x	x
Albany Medical Center Hospital PPS	38269	x		
Bronx-Lebanon Hospital Center PPS	30000	x		x
Community Partners of Western New York	64468	x	x	
Central New York Care Collaborative	67000	x	x	
Alliance for Better Health Care PPS	57533	x	x	
Finger Lakes PPS	109250	x	x	x
NYU Lutheran Medical Center PPS	28192	x		x
Maimonides Medical Center PPS	83000	x	x	x
Millennium Collaborative Care	22700	x	x	
Bassett Medical Center PPS	13009	x	x	
Montefiore Medical Center PPS	133734	x	x	x
Mount Sinai LLC PPS	100000	x	x	x
Nassau University Medical Center	115576	x	x	
New York City Health and Hospital's Corporation, as fiduciary for the HHC-led PPS	106477	x	x	x
Refuah Community Health Collaborative PPS	15000	x	x	
Staten Island PPS	15000	x	x	
Samaritan Medical Center PPS	12000	x	x	x
St. Barnabas Hospital (dba SBH Health System)	91800	x	x	x
Stony Brook University Hospital	45059	x	x	x
The NewYork and Presbyterian Hospital PPS	2258		x	
The NewYork-Presbyterian/Queens PPS	12759	x	x	x
Southern Tier PPS	53970	x	x	
Westchester Medical Center PPS	31000	x		
Total	1508363	24	21	12

Standard Framework for Integration

With efforts moving towards full collaboration in an integrated practice, there are key elements and steps to achieve this.

Referral		**Co-Located**		**Integrated**	
Key Element: Communication		Key Element: Physical Proximity		Key Element: Practice Change	
Level 1 Minimal Collaboration	Level 2 Basic Collaboration at a Distance	Level 3 Basic Collaboration On-Site	Level 4 Close Collaboration On-Site with some System Integration	Level 5 Close Collaboration Approaching an Integrated Practice	Level 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities	In separate facilities	In same facility not necessarily same offices	In same space within the same facility	In same space within the same facility (some shared space)	In same space within the same facility, sharing all practice space

Service Integration Options for Healthcare Providers

A provider may opt to pursue the integration of primary care, mental health, and/or substance use disorder services by obtaining a license or certificate from each corresponding agency (Department of Health (DOH), Office of Mental Health (OMH) or Office of Alcoholism and Substance Abuse Services (OASAS)).

DSRIP Project 3.a.i Licensure Thresholds allow **up to 49% of visits** to be for non-licensed / non-certified services, without requiring an additional license or certification.

- For these licensure thresholds to apply, the provider must be identified as part of a PPS 3.a.i project and have the appropriate DSRIP regulatory waiver for one of the following:

Facility licensed by **DOH** MH and/or SA services	Facility licensed by **OMH** PC and/or SA services	Facility certified by **OASAS** PC and/or MH services

If two or more licenses/certifications are obtained, the provider must follow the programmatic standards of each licensing agency in order to stay compliant.

Current Challenges to Service Integration

Some of the service integration challenges PPSs are currently facing have stemmed from primarily three categories:

	Challenge	How the State is Assisting
Federal vs. State Regulations	• Barrier to physical co-location • NY State has the authority to waive State level regulations, not Federal regulations	• Developing guidance document on co-location arrangements
Billing for Services Rendered	• State is unable to provide regulatory waiver that allows for reimbursement of two visits in one day	• Published an Integrated Services FAQ and Billing Matrix (March 2016)

Expected Benefits of Service Integration

Integration of primary care and behavioral health services improves population health and provides additional benefits:

Improved Process of Care

- Improved communication leading to more coordinated care
- Improved recognition of MH disorders
- Increased Primary Care Providers (PCPs) use of BH intervention
- Decreased stigma of MH conditions

Clinical Outcomes and Service Benefits

- Improved understanding of patient needs
- Improved patient and provider satisfaction
- Improved clinical outcomes

Economic Benefits

- Reduced unavoidable hospital utilization
- Increased productive capacity
- Reduced medical costs

Case Study: FQHC Action Team

An example from Topic 2 of the MAX Series (PC/BH integration):

Problem Statement: There is an increasing need to provide BH services for depression to patients with a Patient Health Questionnaire (PHQ)*-9 screening score over 10 points**.**

Goals: 1) Improve patient and staff experience through collaboration, and 2) improve access to care and service delivery through measurable and reportable outcomes.

Actions to address the problem:

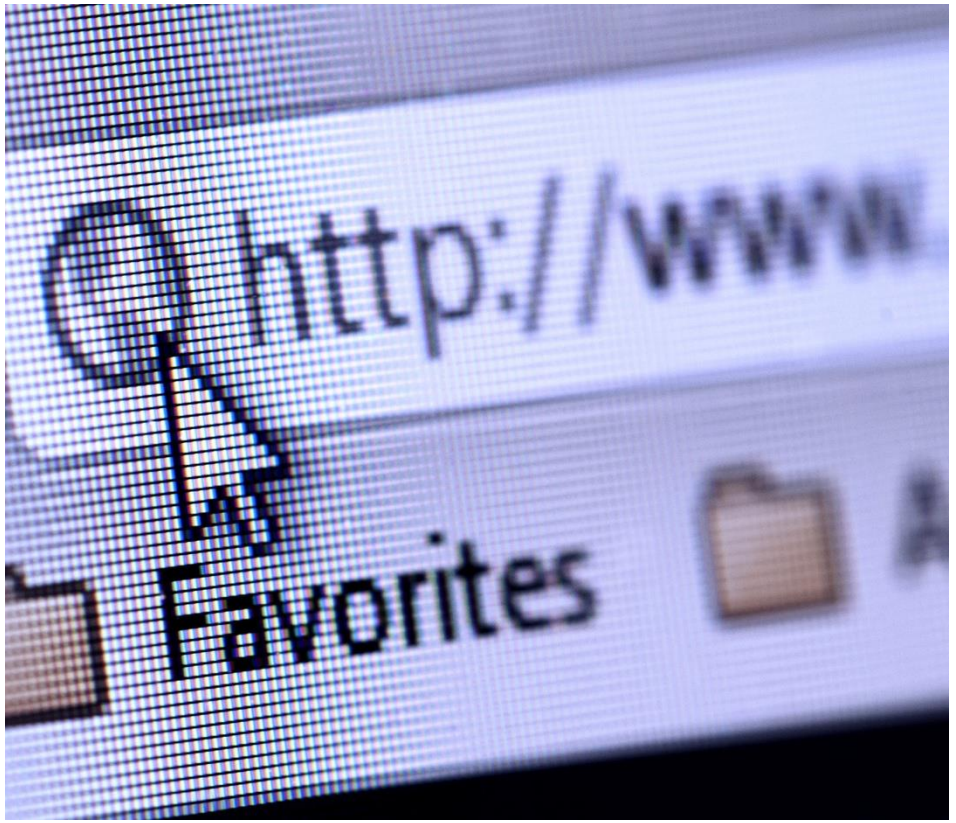
1. Refine/streamline embedding behavioral health into primary care
   - Social Workers attend daily morning huddles and PCPs are provided information on how to contact BH
2. Retrain Medical Assistants on PHQ-2 and PHQ-9 administration and address cultural diversity of patient population
   - PHQ-9 screening tools in Spanish, Haitian and Creole were added for patient use
   - New PHQ administration training developed for Medical Assistants
3. Measure patient 'no-show' rate by provider
   - Patient reason for no-show are documented during follow-up calls to help identify barriers to care

Initial results:

- Implementation of new processes have resulted in **7 warm handoffs** (2-3 patients /week) to BH
- New tracking of patient no-shows to date: 40% (6/15) of no-show patients **rescheduled after follow-up calls**

Questions?

DSRIP e-mail:
dsrip@health.ny.gov



April 21, 2016

FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

NYAPRS 12th Annual Executive Seminar

Session 1:

"When You've Seen One DSRIP…"

Carol Tegas

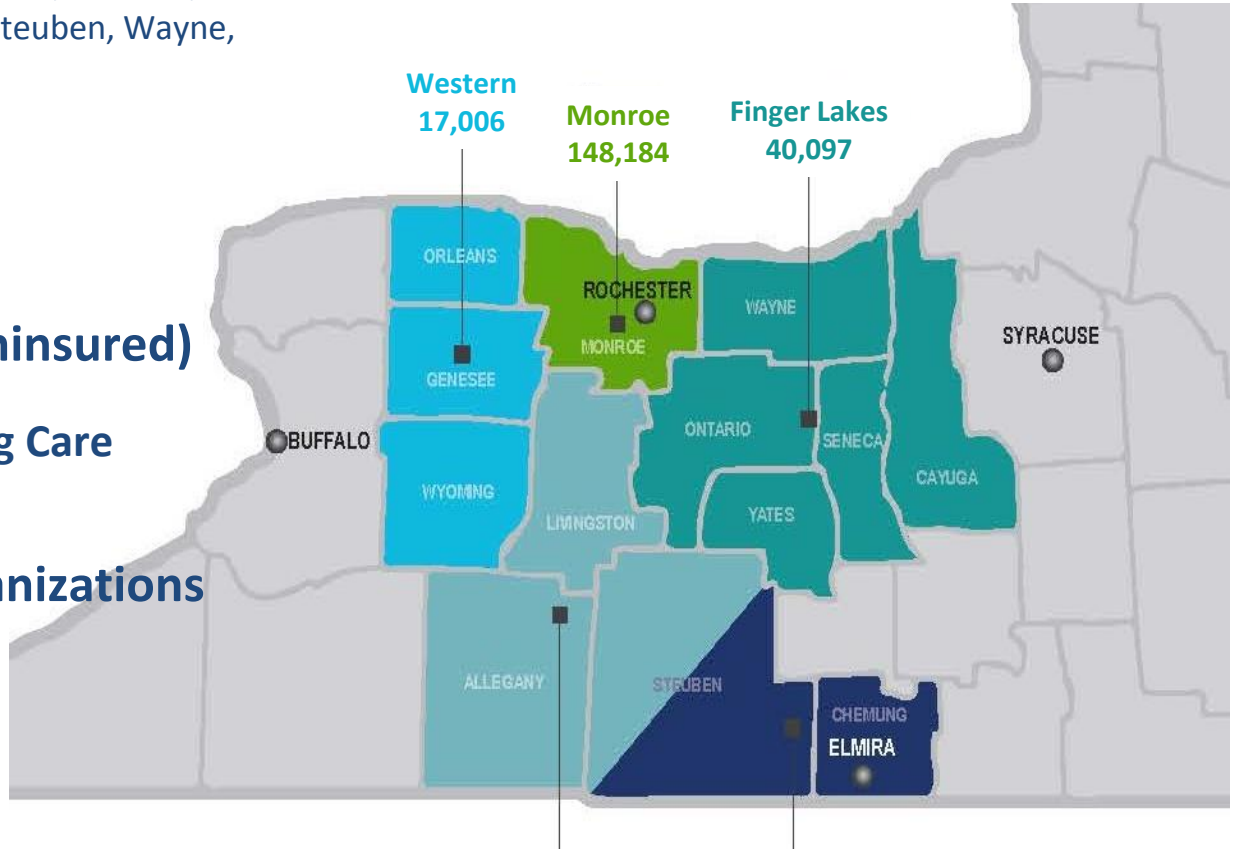
Executive Director

FLPPS FINGER LAKES PERFORMING PROVIDER SYSTEM

FLPPS Overview

Finger Lakes PPS (FLPPS)

- **13 Counties -** Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates
- **1.5M Population**
- **~400,000 Lives (including 100K uninsured)**
- **5 Naturally Occurring Care Networks (NOCNs)**
- **~600 Partner Organizations**
- **19 Hospitals**
- **~6,700 Providers**
  Primary Care, SNF, Hospice, Specialists, Pharmacies, etc.



$565M Award

Targeted Transformation: Defining a Focus

Community Needs Assessment

- **Need for integrated delivery system to address chronic conditions**
  - Chronic conditions leading cause of Years of Potential Life Lost
  - Chronic disease 85% of potentially preventable hospitalizations
- **Need for integration between physical and behavioral health care systems**
  - 24% of all Medicaid-only discharges for primary BH diagnosis
- **Need to address social determinants of health**
  - Transportation & Housing - large barriers
- **Need to support women and children**
  - Infant mortality rate higher than state average

FLPPS DSRIP

Workgroups

1. Workforce
2. Cultural Competency/Health Literacy
3. Information Technology
4. Transportation

Projects

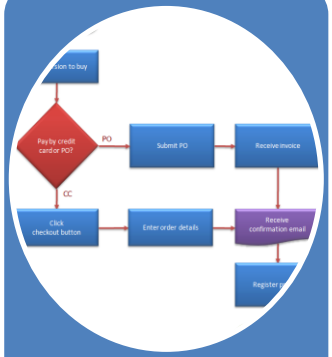
1. Integrated Delivery System
2. ED Care Triage
3. Care Transitions
4. Transitional Housing
5. Patient Activation for Special Populations
6. Behavioral Health Integration in PCP
7. Crisis Stabilization
8. Behavioral Interventions in Nursing Homes
9. Maternal/Child Health CHW program
10. Strengthen Mental Health/Substance Abuse infrastructure
11. Increase Access to Chronic Disease Prevention & Care

Early Successes

First PPS to Enter Performance-Based Contracts

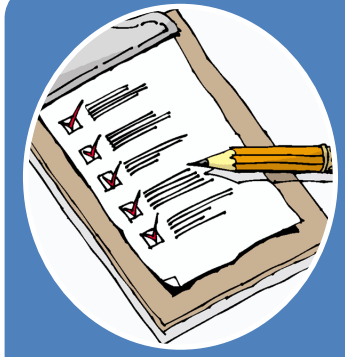
Early Funds Flow Based on Engagement, Reporting & Performance

First PPS to Deploy Partner Relations Team



Advanced Project Design

Workflow Approach



One of First PPSs to Receive & Use Member Roster from NYS

Characteristics of PPS Early Success

DY1 & DY2: 100% Achievement Values Earned

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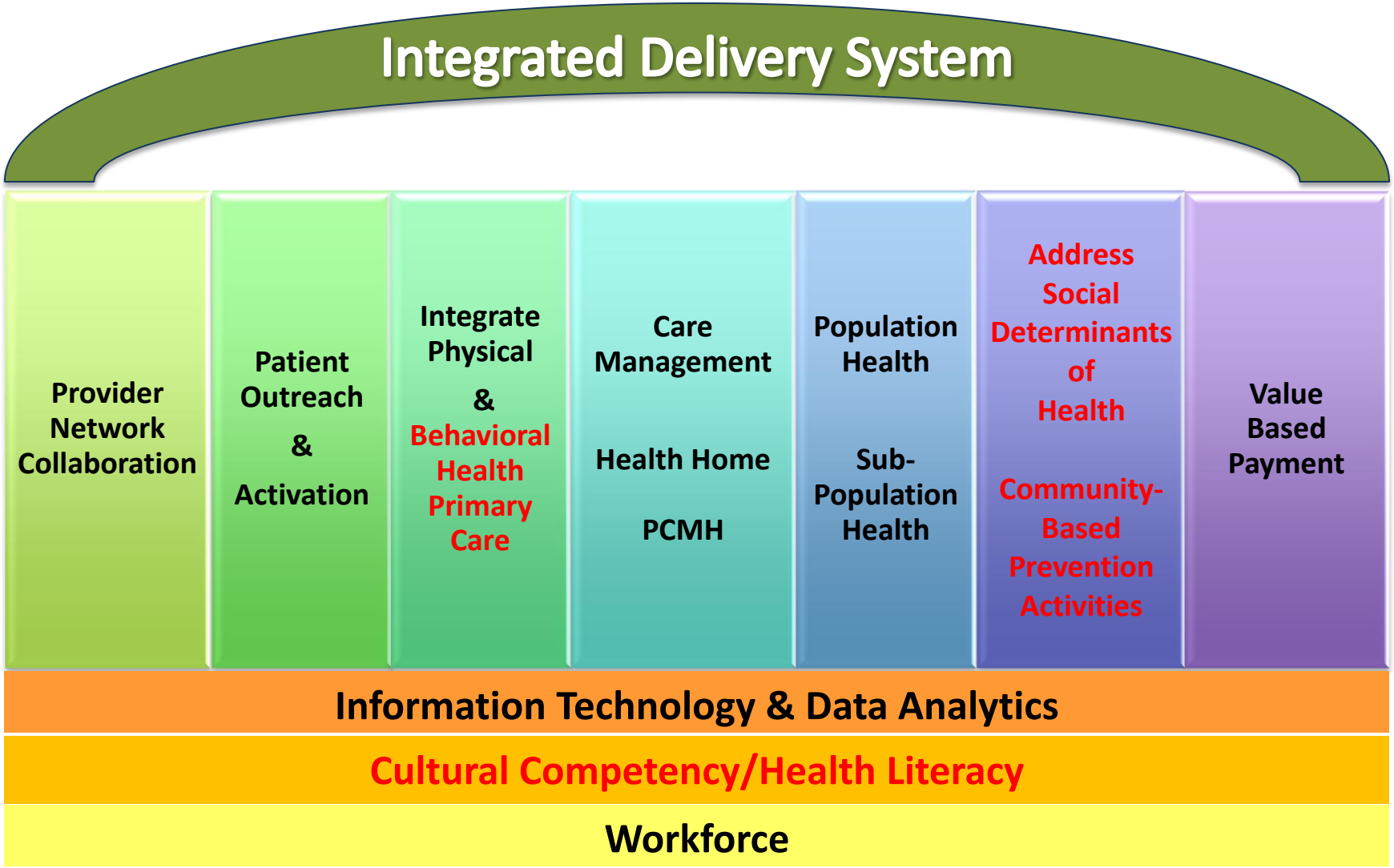
Transformation through DSRIP: IDS

System Integration & Data Analytics

Key Pillars of the IDS



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Project 4.a.iii

Strengthen Mental Health & Substance Abuse Infrastructure Across Systems

FLOWER Formation

- The **F**inger **L**akes **O**rganization for **W**ellness, **E**ducation, and **R**ecovery (FLOWER) Partnership
  - Born from initial collaboration and discussions with FLPPS partners on key ideas towards implementing activities for the MEB DSRIP project
- The purpose of the group is to:
  - Develop and improve the mental health and substance abuse infrastructure in the FLPPS region
  - Facilitate the implementation of evidence-based practices
  - Collect standardized data to assure the delivery of high value interventions that move
- Priority population for project implementation:
  - At-risk families and individuals impacted by the criminal justice system

FLOWER Membership

- Membership includes a breadth of community partners:
  - Family members of persons in recovery, including those who are/were incarcerated
  - Providers to the target population
  - Policy makers/regulators
  - Employers/business community
  - Managed care organizations/insurance companies
  - Criminal Justice/law enforcement
  - Faith community
  - Academic community
  - Foundation/development
  - Schools (college, high school, elementary)
  - Media
  - Advocacy groups
  - Other Partners, as identified

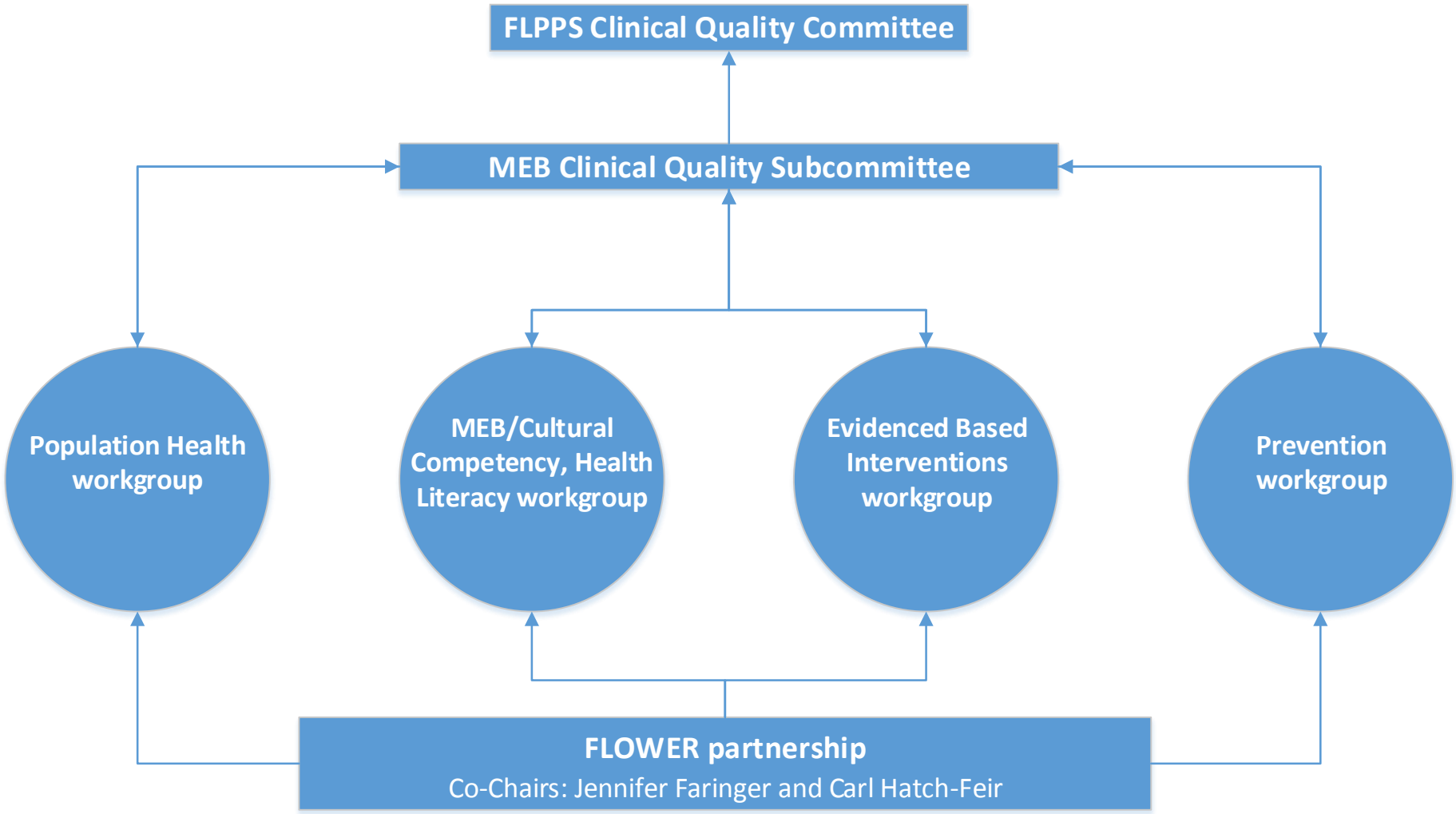
Quarterly Partnership Engagement

- September 2015:
  - Establish productive working relationships across our 13-county region to assure the success of Partnership Project
  - Gain an understanding of the mental, emotional, and behavioral health needs of identified target populations
  - Describe resources and assets organizations could provide to address project priorities
  - Identify and express role agencies could play during implementation of the developing community health improvement plan
  - Keynote speakers:
    - Catherine Cerulli, JD, PhD, *Overview of the Courts System. Therapeutic Justice: Behavioral Health and Courts Working Together*
    - Kate Ebersol, *Population Health Methodologies*

Quarterly Partnership Engagement

- January 2016
  - Identify key elements of a theoretical and practical framework for prevention-building to improve population health and health equity
  - Examine and learn from recent health and social movements
  - Elicit workgroup participation among partners building a process of accelerating a movement for population health improvement and health equity
  - Keynote speakers:
    - Melody Lee, *Law Enforcement Assisted Diversion (LEAD) Program*
    - Kris Nyrop, *Law Enforcement Assisted Diversion (LEAD) National Support Director at Public Defender Association*

FLOWER Structure



Deliverables

- The MEB (FLOWER) Partnership will develop and disseminate a compendium of high-value, evidenced-based interventions and policies that promote MEB health and prevent MEB disorders, which can be implemented across the FLPPS region
- Implementation Plan Timeline: DY5Q2 – 9/30/19

Challenges in Partnering

- Articulating Value Proposition of DSRIP to BH/SA Agencies:
  - Limited Funds Flow ability due to low attribution
  - Partner's focus on other efforts to maximize margins; difficult to prioritize system transformation work
  - Bringing providers together who have not been traditionally part of Medicaid scene, but have value in participation: judicial/legal, law enforcement, neighborhood free clinics, etc.
  - Perceived lack of voice and impact on decision-making
  - Partner fatigue
  - MEB Project: hardest to implement, biggest infrastructure to build with new collaborations, great amount of research necessary for evidence-based best practices, longest term, hardest to move needle

Overcoming Challenges: Engagement

- BH/SA Representation in Board, Governance, Subcommittees & Workgroups
- County and Local Government Units
  - Mental Health Directors Fully Engaged in All Layers of Governance and Projects Work
  - Engagement through Contracting, Data Sharing, Education and Population Health Activities

Overcoming Challenges: Strategy

- CBO Strategy - Clinical, Non-Clinical, Resource Partners
  - Central Approach
    - Collaboration with United Way, Council of Agency Executives and Finger Lakes Health Systems Agency
    - CBO Leaders from Government, Faith-Based, and Other Support Service Organizations
  - NOCN (Regional) Approach
    - Inventory of CBO Services at Regional Level
    - Tie Projects to CBO Services – what community-based services should be included in a project to move performance metrics? Are there model programs that can be grown across region?
    - Identify CBO Partners
    - Identify Gaps
    - Targeted Engagement at Regional Level
    - Facilitate Collaboration between Clinical and CBO

Overcoming Challenges: Funds Flow

- Early Contracting for Safety Net and Non-Safety Net Partners to continue engagement momentum
- DSRIP Projects – as appropriate based on provider type/role; tied to project metrics
- Other Potential Dollars:
  - Innovation Projects – Under development
    - Incubator fund for intervention and prevention activities
    - Process in which a CBO can engage, provide value, show outcomes and draw dollars
    - Tied to Overall Outcome Metrics
      - Reduce Avoidable ED Use
      - Reduce Avoidable Hospital Admissions/Readmissions
      - Improve Clinical Outcomes
  - Sub-Contracting with Safety-Net Partners
  - Participation in Non-DSRIP Grant Opportunities, such as Accountable Health Communities

Intersection of Clinical & Community

- PPS's need to leverage BH/SA/CBO services in an IDS
- Hospital systems will bear risk in future VBP models; will need to partner with providers/CBOs who help to reduce total cost of care
- How can you position yourself to be a preferred provider and create a source for referrals?
- What is your value proposition?
  - Prevention – before acute episode
  - Intervention – referral after acute episode
  - Expertise in Cultural Competency/Health Literacy

Opportunities for Partners

- Connect Organizational Mission, Activities and Outcomes to DSRIP Projects, and Overall Goals for System Transformation
  - Achieve Triple Aim
    - Reduce Costs
    - Improve Patient Experience
    - Improve Patient Outcomes
- Create Value Proposition
  - Collect data
  - Monitor the health outcomes tied to programs and interventions
  - Analyze cost-benefit of interventions
  - Identify high-value programs
  - Inclusion in Value Based Payment design and implementation in the future

Value Based Payment: NYS Vision

- NYS Value Based Payment Roadmap
- "In the near future…the State envisions culturally competent community based organizations (CBOs) actively contracting with PPSs …to take responsibility for achieving the State's Prevention Agenda.
- "DSRIP starts to build the infrastructure to take on housing, job placement, community inclusion, and criminal justice alternatives as levers to increase population health."

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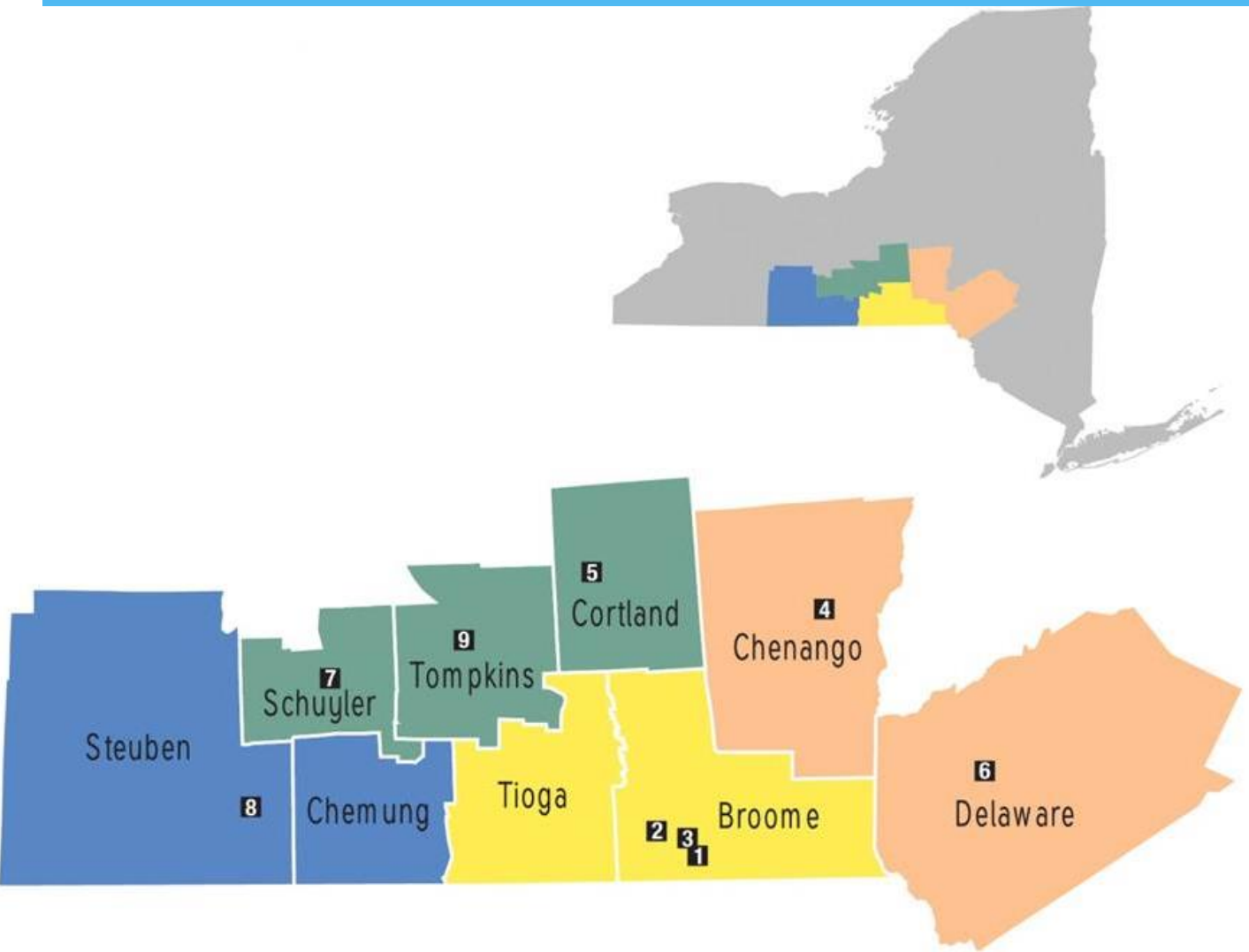
Thank You

CARE COMPASS NETWORK

Care Compass Network Region



Broome County
1 UHS Binghamton General Hospital
2 UHS Wilson Medical Center
3 Our Lady of Lourdes Hospital

Chenango County
4 UHS Chenango Memorial Hospital

Cortland County
5 Cortland Regional Medical Center

Delaware County
6 UHS Delaware Valley Hospital

Schuyler County
7 Schuyler Hospital

Steuben County
8 Corning Hospital (Guthrie System)

Tompkins County
9 Cayuga Medical Center

CCN BACKGROUND

* Developed 2014 from the integration of two forming PPS
  * Rural Integrated Network (Schuyler, Tompkins, Cortland)
  * Southern Tier PPS (Steuben, Chemung, Tioga, Broome Chenango and Delaware
* Comprised of five hospital systems, an FQHC Network and more than 100 Community Based Organizations
* Incorporated as a 501 c-6
* 11 Member Board of Directors, one BOD from each health system, one BOD from the FQHC and five CBO board members

How We Got to the Table

* Southern Tier PPS
  * Lourdes and UHS made the decision to partner
  * UHS was determined to be lead entity due to Medicaid Health Home experience and experience in large mother baby and behavioral health programs
  * Lourdes and UHS reached out to Guthrie , the CBO community and encourage them to come to a meeting to learn about DSRIP
  * CBOs reached out to other CBOs

How We Got to the Table

* Rural Integrated PPS
  * Cayuga and Cortland came together
  * Cortland became the lead entity
  * Hospitals and the FQHC reached out to CBO
* Each emerging PPS adopted a similar approach
  * Create an open stakeholders group, which evolved into the Project Advisory Committee (PAC)
  * Engage each stake holder group in project selection

How We Got to the Table

* When the Planning Design Grants were awarded, DOH indicated that the Rural Integrated PPS was too small and needed to integrate.
* Decision was made to join with Southern Tier PPS
* STRIPPS was born! (dba Care Compass Network)
* Initial integration presented a challenge since both PPS had already selected projects and they did not select the same ones
* Held a stakeholders meeting with over 120 in attendance to select a project slate for the newly integrated PPS
  * Cost: Time
  * The inclusive approach became a foundation for an enduring bond among the organizations
* Formed teams and leadership around each project and initiative such as work force, information management, governance etc…..
* Largely voluntary effort produced the application.
* Once application was awarded, formal organization structure implemented

Shared Learning and Premium Communication

* Given the large size of the stakeholder group, a PAC Executive Committee was formed
  * Plans the stakeholder meetings
* During the application and the first year or operations, Stakeholders (Full PAC) met every two weeks.
  * Average attendance:60-80 in person plus Web Ex attendees ranging from 30 -40

Benefits

* We KNOW each other
* Everyone has an opportunity to engage
* We share a vision
* We share an common knowledge and understanding of the people we are trying to serve
* We are willing to work together and coordinate care and services
* We see new possibilities we did not see before
* We have a warm connection to the community

The Challenges

* Formalizing. Now there is Money……
  * Contracting
  * Fast tempo
  * Figuring out where everyone fits
  * Entering into new services
  * Figuring out how it all works together to achieve the desired outcome – Lower utilization of hospital based care and more active engagement of Medicaid Members.
* Maintaining strong communication as we move into managing performance together

Benefits/Challenges – CBO Perspective

* Benefits
  * Opportunity to help build a network of integrated healthcare that many organizations have long advocated for
  * Real collaboration between many different systems and providers
  * Opportunity to develop lacking or underdeveloped infrastructure and utilize innovative approaches to achieve better health care outcomes
  * Advanced knowledge & expertise (MCO negotiations)
  * The consumer is the center of care – if they fail, it's on US!
* Challenges
  * Time (Webinars, trainings, meetings, etc.)
  * Developing your own infrastructure
  * Helping a Board of Directors understand these changes
  * Simultaneous "MRT-related" happenings --- MHH, DSRIP, HCBS, CMHH etc.
  * Staff development

Staten Island
Performing Provider System

Staten Island Mental Health Society & Staten Island Performing Provider System

FERN ZAGOR, PRESIDENT/ CEO, SIMHS

JOSEPH CONTE, EXECUTIVE DIRECTOR, SI PPS

APRIL 21, 2016

Staten Island Performing Provider System (SI PPS)

We are a limited liability corporation formed by Richmond University Medical Center and Staten Island University Hospital to implement Project Management Function.

- PMO staff recruited solely for program execution

Goal:

Improve the quality of care and transform the healthcare delivery system of Staten Island

Partners:

- Over 75 fully engaged
- 100% contracted healthcare providers, agencies, and community-based organizations

Impact:

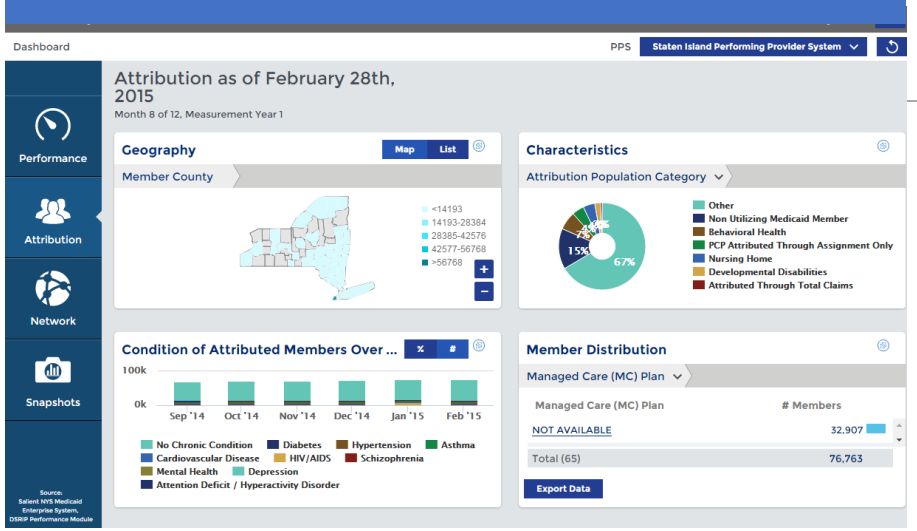
- 4 out of 10 Staten Island residents affected by DSRIP

11 PROJECTS

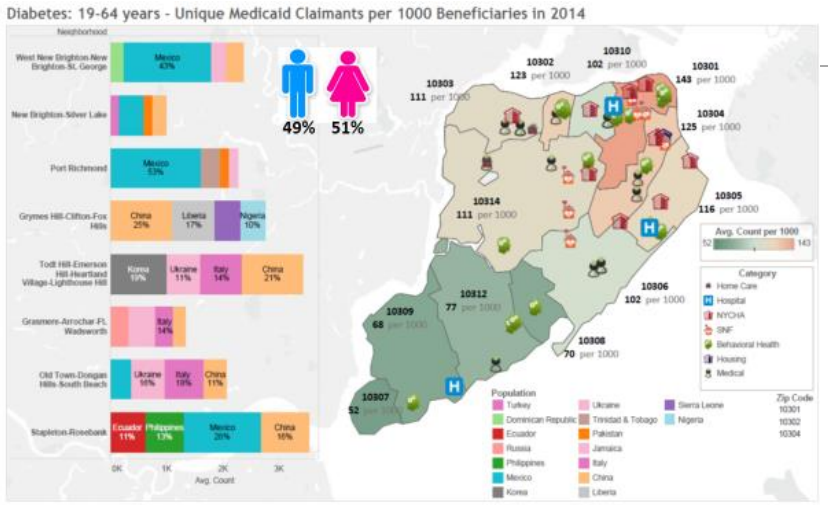
Behavioral Health	Long Term Care	Primary Care	Care Management	Home Care	Community Projects
Integration of Primary Care and Behavioral Health Services (3.a.i)	Implementing the INTERACT project (2.b.vii)	Integration of Primary Care and Behavioral Health Services (3.a.i)	Health Home At-Risk (2.a.iii)	Hospital-Home Care Collaboration (2.b.viii)	Patient Activation Activities (2.d.i)
Development of Withdrawal Management Services (3.a.iv)	Integration of Palliative Care into Nursing Homes (3.g.ii)	Evidence-based Strategies for Diabetes Management (3.c.i)	Care Transitions Intervention Model to Reduce 30 day Readmissions (2.b.iv)	Increase Access to High Quality Chronic Disease Preventive Care & Management (4.b.ii)	Strengthen Mental Health & Substance Abuse Infrastructure (4.a.iii)

Staten Island PPS Analytics Tool Portfolio

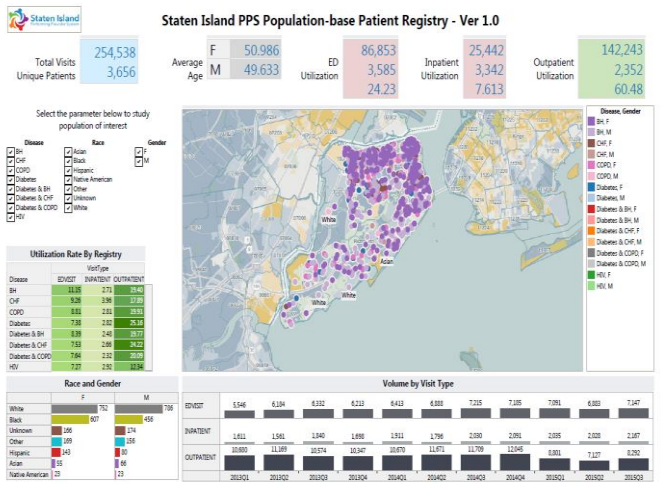
MAPP Dashboard



Healthcare Hotspotting

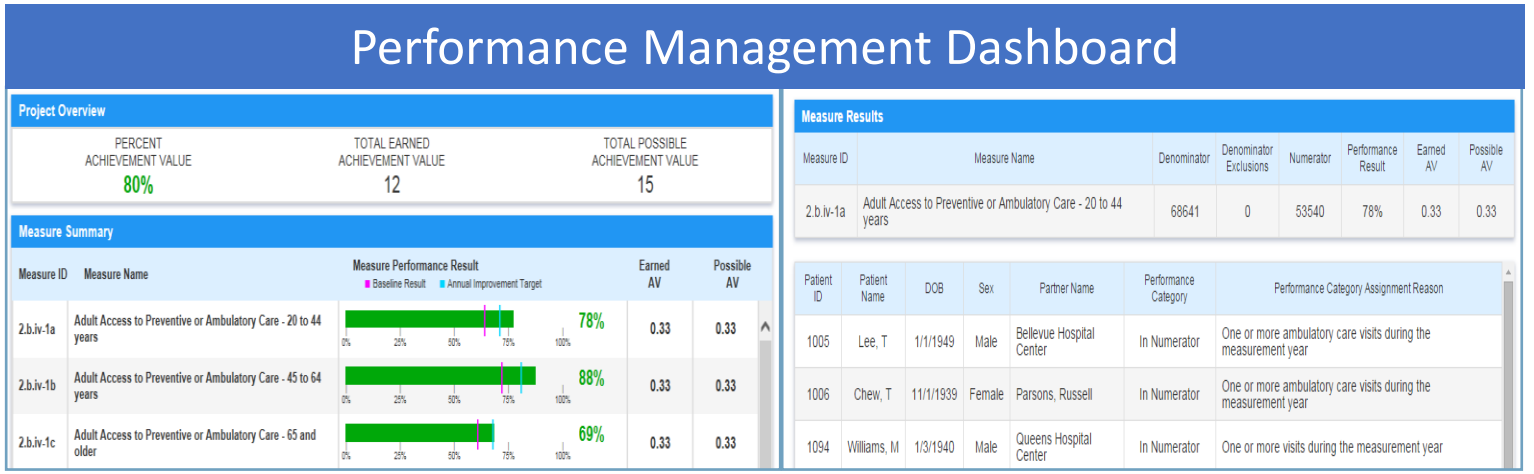


Population-based Registry 1.0



Strategic Planning ▷ Performance Improvement ▷ Population Health Management

Performance Management Dashboard



Health Analytics: Program Development, Performance Monitoring and Hotspotting

Development and Monitoring

- SI PPS has extensive analytic capacity using data from multiple sources to direct programmatic efforts
- Hot-Spotting conditions and disparities by geographic location
- Focus includes health literacy and diversity factors to inform recruitment of new partners, refine nature of Community Based Organization relationships, and define training needs based on area/culture served
- Analytic focus on evidence based outcomes
- Medicaid member roster use-case

Hotspotting Selected Behavioral Health Conditions

Evidence from epidemiological studies on the causes of Behavioral Health conditions suggests that not all the causal factors are "under primary care provider control."

Selected BH Disease
Opiod
Mental Health
ETOH
Co-Occurring

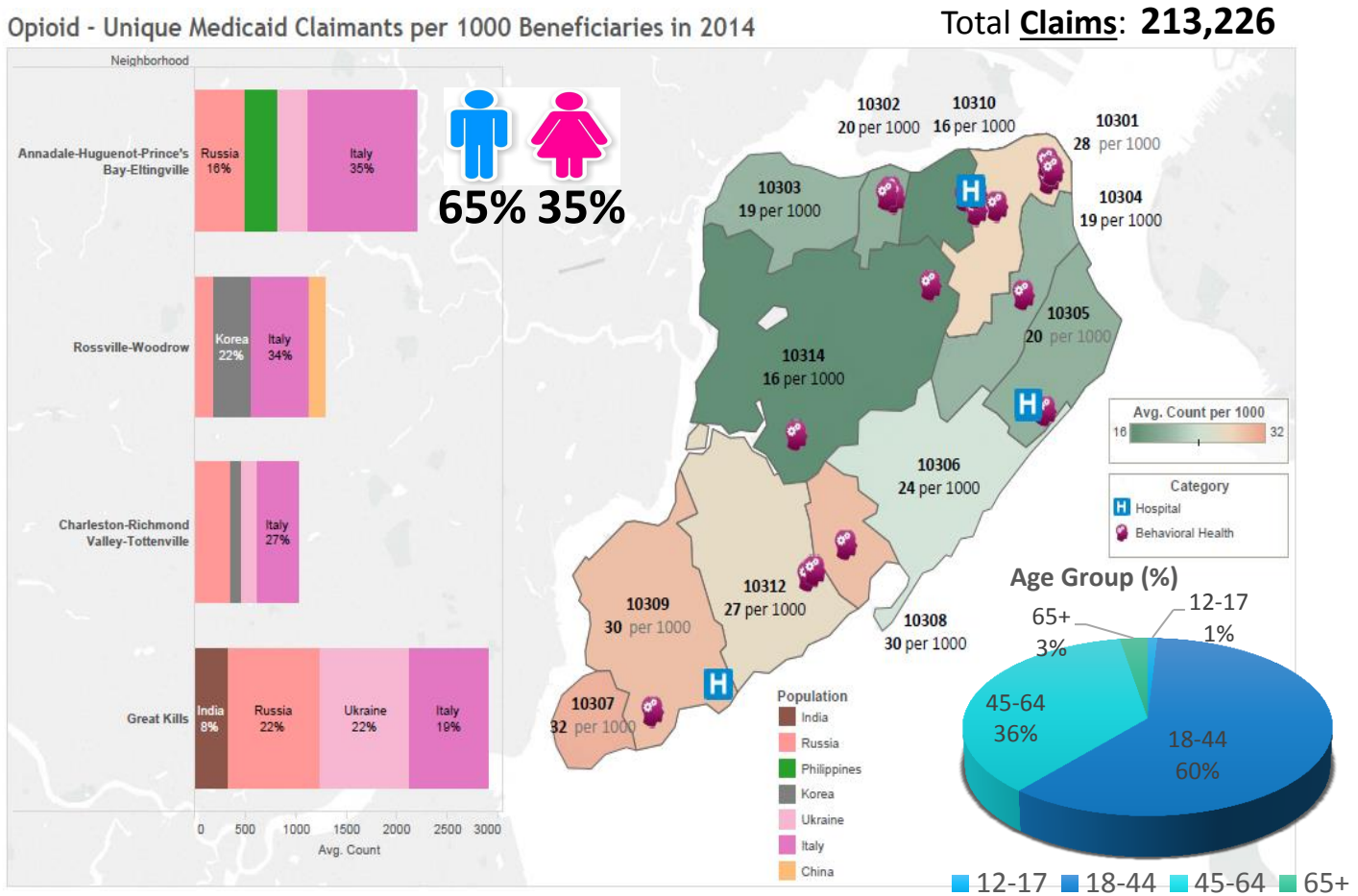
Factors outside direct physician control include:

- low socioeconomic status
- cultural background
- older age
- availability of care providers
- geographical factors (i.e. distance to hospital)

Use Case: Substance Abuse Epidemic

Overlaying data to strategically target key hot spots

Geomapping: Nation of Origin Overlay

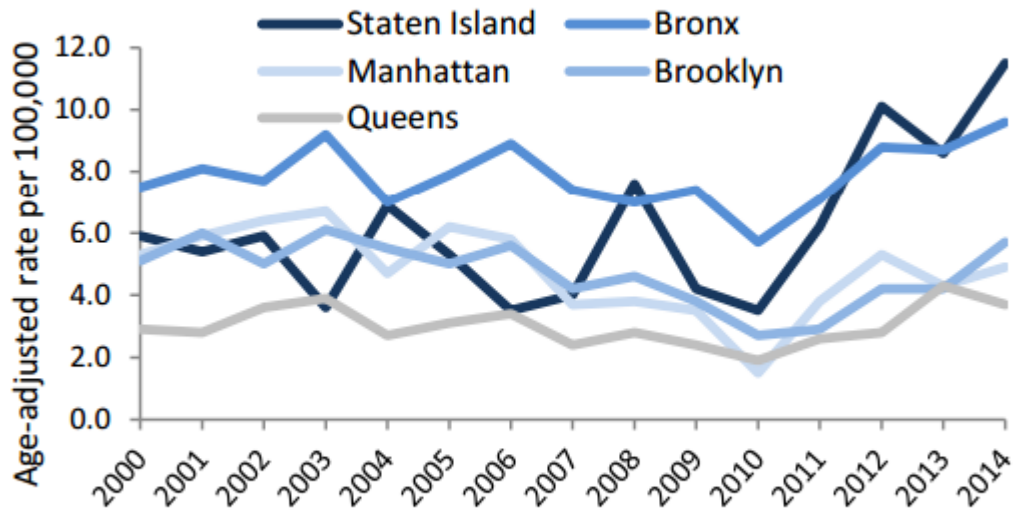


Staten Island ↑ Overdose Deaths in NYC

Overdose Deaths in NYC → Heroin

Overdose Deaths in NYC → Opioids

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



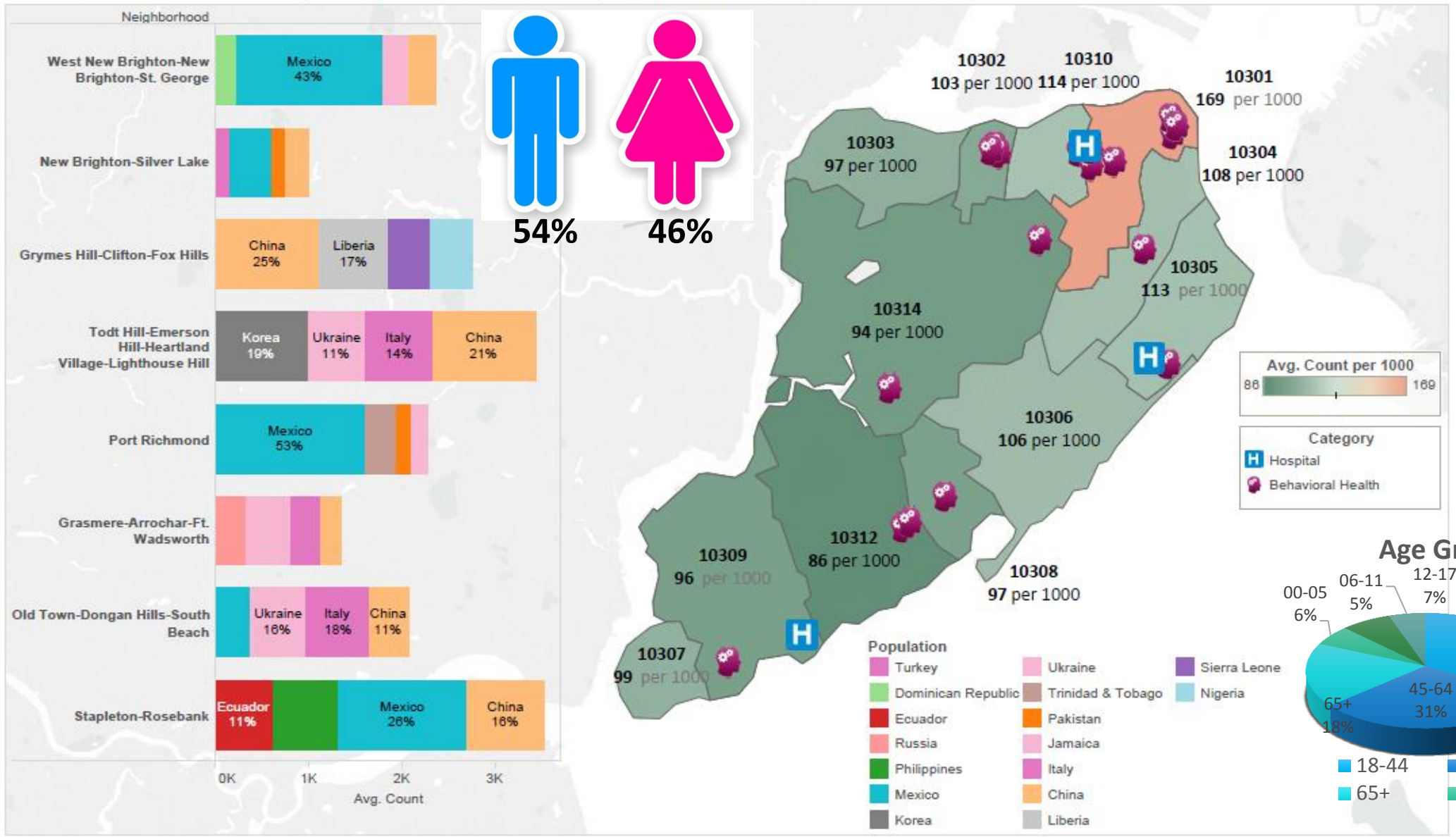
* Data for 2014 are preliminary and subject to change

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

Source: (1) Salient Interactive Miner (2) DOH Member roster Data Period: FY2014

Geomapping: Nation of Origin Overlay

Total BH **Claims**: **587,411**



Population Health Improvement: Changing the Model of Care and Engaging the Community

The PPS created Population Health Improvement programs to focus on value and quality and move away from volume-based care model:

- Pediatric Population Improvement Program, Adult Population Health Improvement Program and Behavioral Health Improvement Program
- Contracts with previously unaffiliated physician practices
- Support achievement of PCMH recognition
- Adoption of evidence based guidelines, use of EMR, proactive care paradigm, shared care plans
- Sharing health data with the PPS data warehouse and between providers using RHIO
- Incentivized payments are based upon meeting quality milestones

Moving Towards Collaborative Care

- The overall goal of BHIP is to strengthen the mental health and substance abuse infrastructure across systems and move towards a more collaborative patient-centered approach for all Staten Islanders regardless of insurance type.
- This workgroup is facilitating the implementation of the building blocks of collaborative care around Staten Island.
  - These building blocks include, but are not limited to, universal screening for depression and substance use and the concomitant comfort level of providers in addressing these conditions, warm handoffs to behavioral health specialists, treatment within the primary care practice (when feasible), Primary Care Physician (PCP) detailing campaigns, and communication that support the co-management of a patient's condition.

Utilizing Linkages with Community Based Providers for Effective Project Implementation

Health Home at Risk: SI CARES

- Partnership with SI's Health Home Coordinated Behavioral Care and with Northwell Health Solutions

Strengthen Mental Health and Substance Abuse Infrastructure

- Collaboration with SI Partnership for Community Wellness/Tackling Youth Substance Abuse
- OASAS and Office of Mental Health

Access to Chronic Disease Preventive Care Initiative

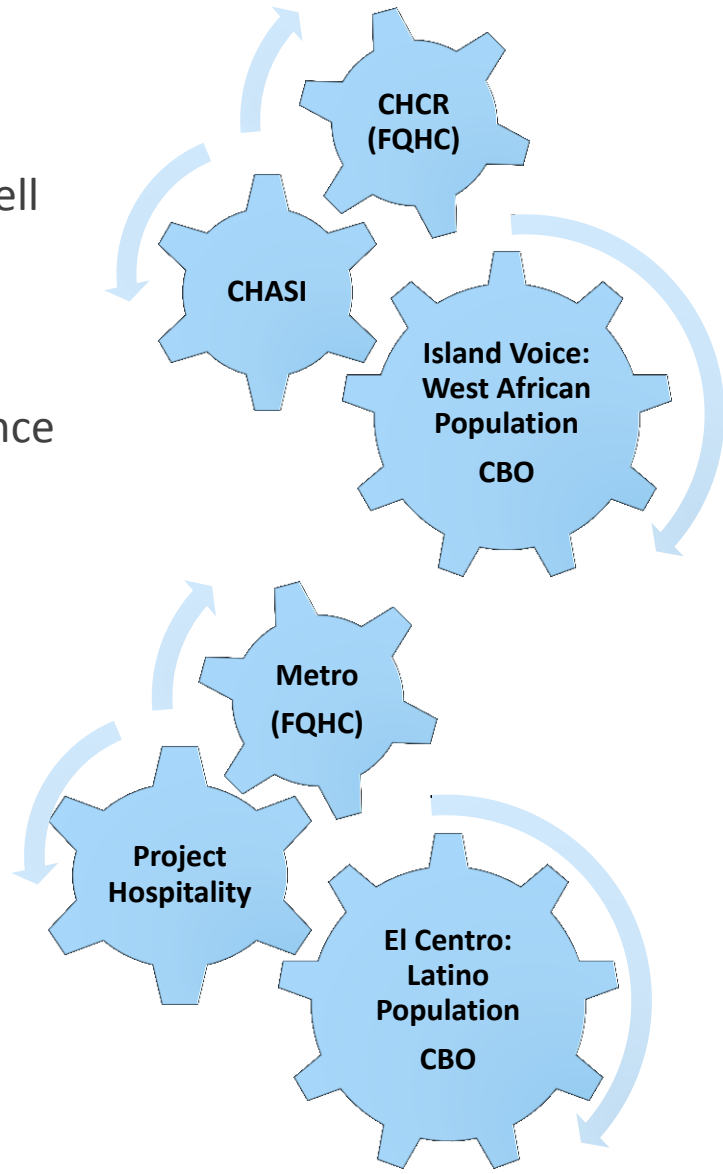
- Linkage with Borough Hall's Health and Wellness Program, Take Care NY, State Prevention Agenda

Patient Activation and Community Health Navigation

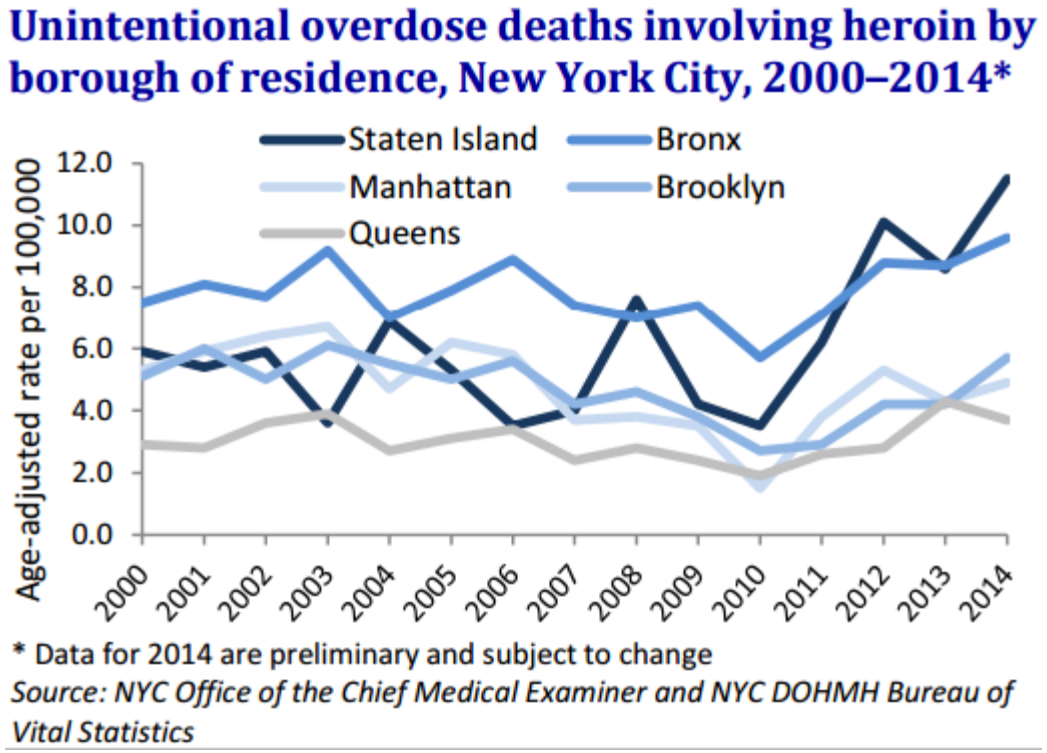
- Partnership with CHASI and Project Hospitality

Collaboration with Local Governmental Units (LGU)

- EMS, FDNY, NYC Mayor and Borough President's Office, OASAS, OMH



Project Highlights



4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure

- Engaged multiple treatment providers, government agencies, CBOs, and other stakeholders
- Key informant interviews, focus groups, and claims analyses used to understand existing MEB services, community needs, barriers to care
- Partnerships with government agencies (e.g. NYC DOHMH) to align mental, emotional, behavioral (MEB) priorities

3.a.iv Development of Withdrawal Management Services

- 7 substance abuse providers are engaged to reduce inappropriate inpatient/ER visits
- **Pilot program:** Diversion of patients with less severe withdrawal symptoms from ER/IP
  - 24/7 call center being developed
  - Licensed provider and peer engagement resources

Addressing the Substance Abuse Challenge through Rapid Cycle Change and Improvement

- Partnership with 9 substance abuse treatment providers to provide ambulatory detox services

- Engagement with non-providers
  - OASAS
  - CBOs (e.g. SIPCW-TYSA)
  - Local government units (e.g. NYC DOHMH)

- Rapid cycle communication via workgroups and focus groups to
  - Share best practices
  - Provide continuous feedback
  - Collaborate on solutions

Warm Handoff Pilot for Withdrawal Management Services

This initiative is part of the wider effort to reduce hospital admissions and increase access to community-based behavioral health (BH) services. This workgroup will focus on developing a warm handoff system within Emergency Departments (EDs) staffed by behavioral health specialists and certified peer specialists for patients in need of substance abuse treatment services (including opioid treatment program/withdrawal management services). This pilot will connect these patients with community based outpatient treatment services in a timely fashion. This group will:

- Design and develop the pilot including:
  - Workflows within the emergency departments
  - Bringing peer certification programs to Staten Island
  - Developing a Staten Island call center
  - Ensuring availability of providers to accommodate handoffs from EDs on 24/7 basis
- Evaluate pilot
- Work to expand initiative and align with other government/community efforts as appropriate

Project Highlights

2.a.iii Health Home At-Risk Intervention Program

- 2 Health Homes and 6 CMAs have finalized agreements to provide care coordination services to target patients
- Adults (and children) who meet PPS approved criteria are being enrolled into program

3.a.i Integration of Primary Care in Behavioral Health Settings

- 2 Workgroups: Primary Care & Behavioral Health and Behavioral Health
- Standardization of collocation, workflow and referral guidelines
- Licensure expansion and site renovations

Behavioral Health (BH) Detailing

This workgroup will develop proposal and implement training materials. The group will work with the Performing Provider Systems (SIPPS) to provide cultural and linguistic trainings on Mental, Emotional, and Behavior (MEB) health promotion, screening tools, treatments, and overall education on collaborative care. The group will:

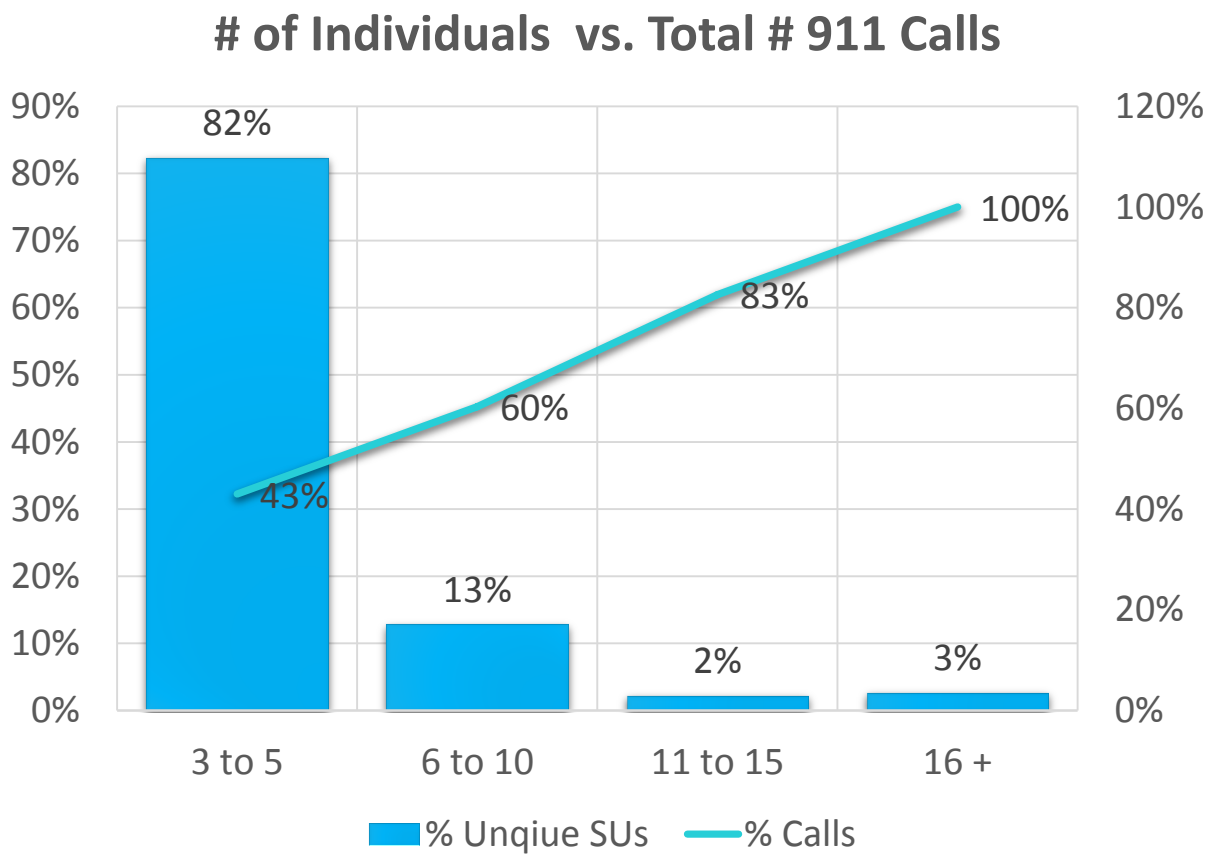
- Identify BH trainings needed
- Develop culturally and linguistically appropriate trainings
- Identify target physicians and providers
- Create a schedule of trainings to be provided

CommunityEducation/Media Messaging

BH issues are often misunderstood and considered taboo. BHIP is working to engage and educate the community, recipients of care, and providers of care on substance abuse and mental health issues as part of one's overall wellness. Efforts will also be made to educate on treatment services available in the Staten Island community. This workgroup will develop education materials and media messages to increase awareness and reduce stigma. This group will:

- Develop and or leverage education materials
- Develop media messaging campaigns on topics identified by Steering Committee
- Research and develop other strategies that can increase awareness and reduce stigma
- Develop and/or leverage existing Mental , Emotional, and Behavior (MEB) promotion/disorder prevention models (TYSA, ThriveNYC)

Staten Island PPS EMS Project



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

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

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

Chief Complaint (All)

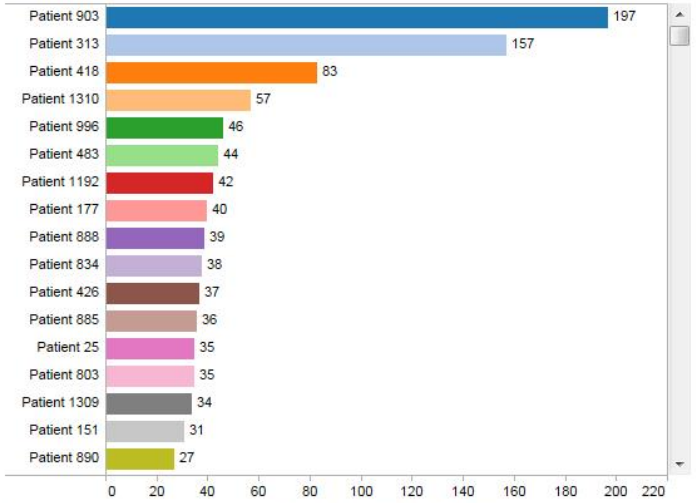
Dispatch Code (All)

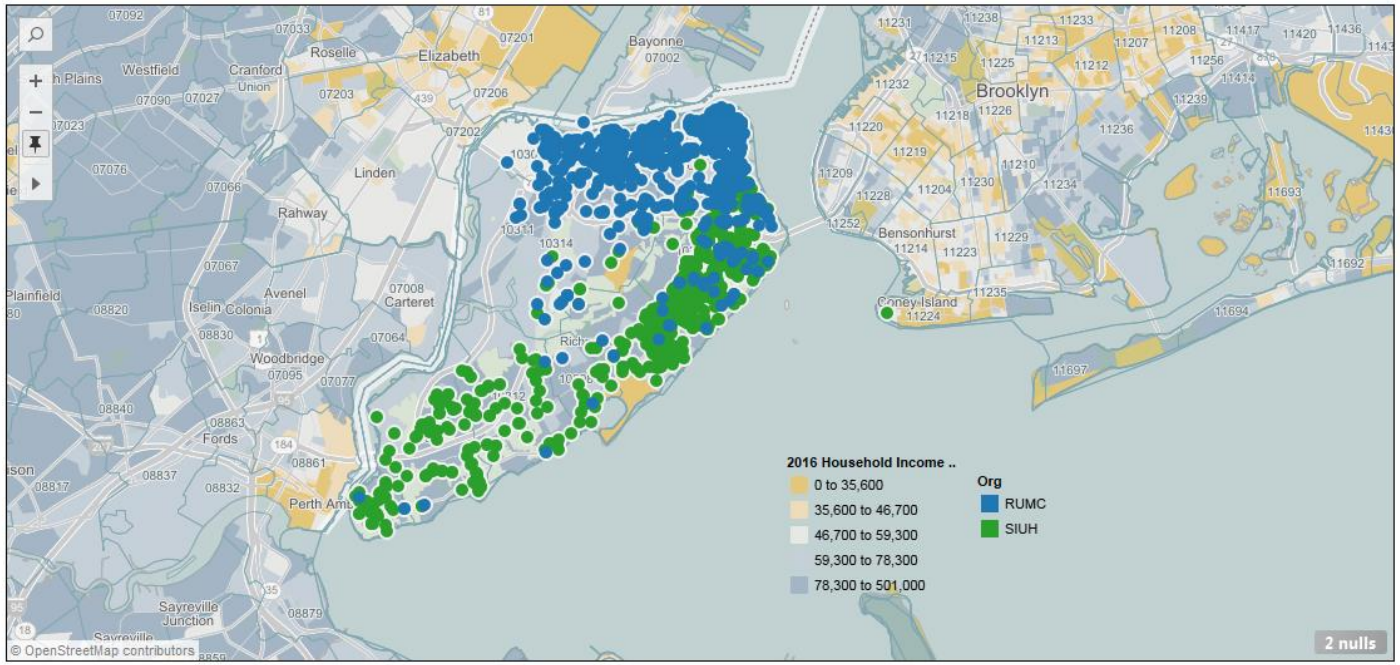
Org
- (All)
- RUMC
- SIUH

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

Super Utilizers (Rank by # of Calls):

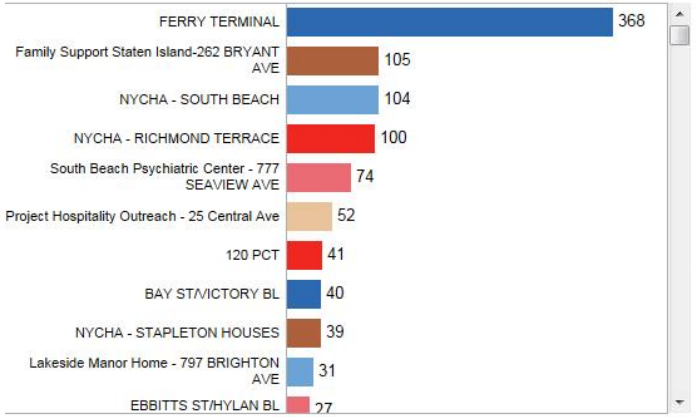
(All)



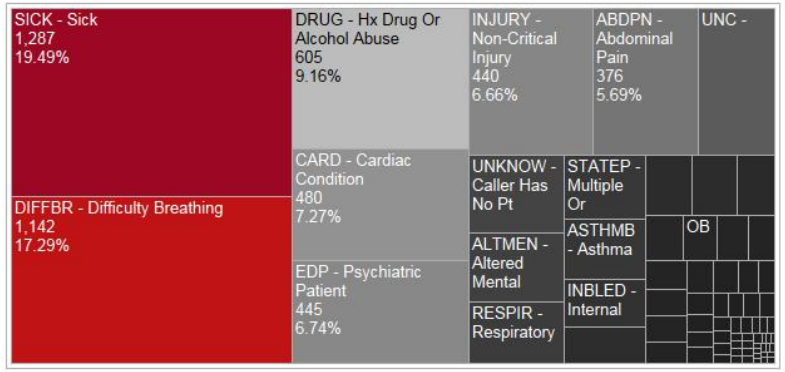


Incidence Locations (Rank by # of Calls):

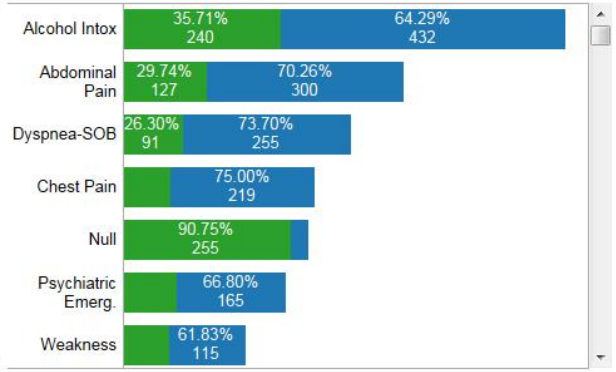
(All)



Dispatch Codes



Top Chief Complain



Map | Call_Pattern | totalCalls | totalCost | totalSU | totalCalls_RUMC | totalCalls_SIUH | Chief_Complain | Sheet 12 | DispatchCode | Sheet 11 | SU_TOTAL | Loc_Chart | SU_DshBoard | Su_DshBoard2

DEMO

SI PPS EMS Analyzer

Where are the calls originated?

What are the 911 Calls about?

Responding to Care – Potential Options

- Alternative Out Reach Teams – Providers at scene of calls
- Use of Alternative Settings -Addiction Crisis Beds Medically Monitored
- Active care management & outreach engagement for those patients with history of high utilization
- Use of Mobile Crisis Teams with behavioral Health Competencies
- Predictive approach – active outreach to locations with high volume of calls, i.e. place outreach teams to actively engage those in need
- Assess and actively engage for Health Home/ health Home at Risk or other case management options

Staten Island
Performing Provider System, LLC

The CBO Experience

Why This is Working

From Beginning:

- Inclusive
- Transparent
  - Programmatically
  - Administratively
  - Financially
- Strong leadership we can trust at all levels
- Priorities and Goals clearly stated
- Support of innovative approaches

And More Reasons

- Use of a Collective Impact Approach
  - Evidence based
  - Shared common agenda
  - Outcome/data driven
  - Stakeholders across the entire community
- Sense of ownership of process and outcomes
- Collective Pride in Performance

Summary & Conclusions

- Employing Collective Impact Model Engages all Stakeholders
- DSRIP Programs are well aligned with Community Concerns
- Non-hospital partners are critical drivers of new paradigms in care, coordination
- Co-location and integrated care model expansion is critical
- Engaging physicians at all levels screening, prescribing, PCMH path is vital
- Employing advanced analytics brings clarity and precision to program development