DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid

DSRIP Project Approval and Oversight Panel Working Session

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United Hospital Fund

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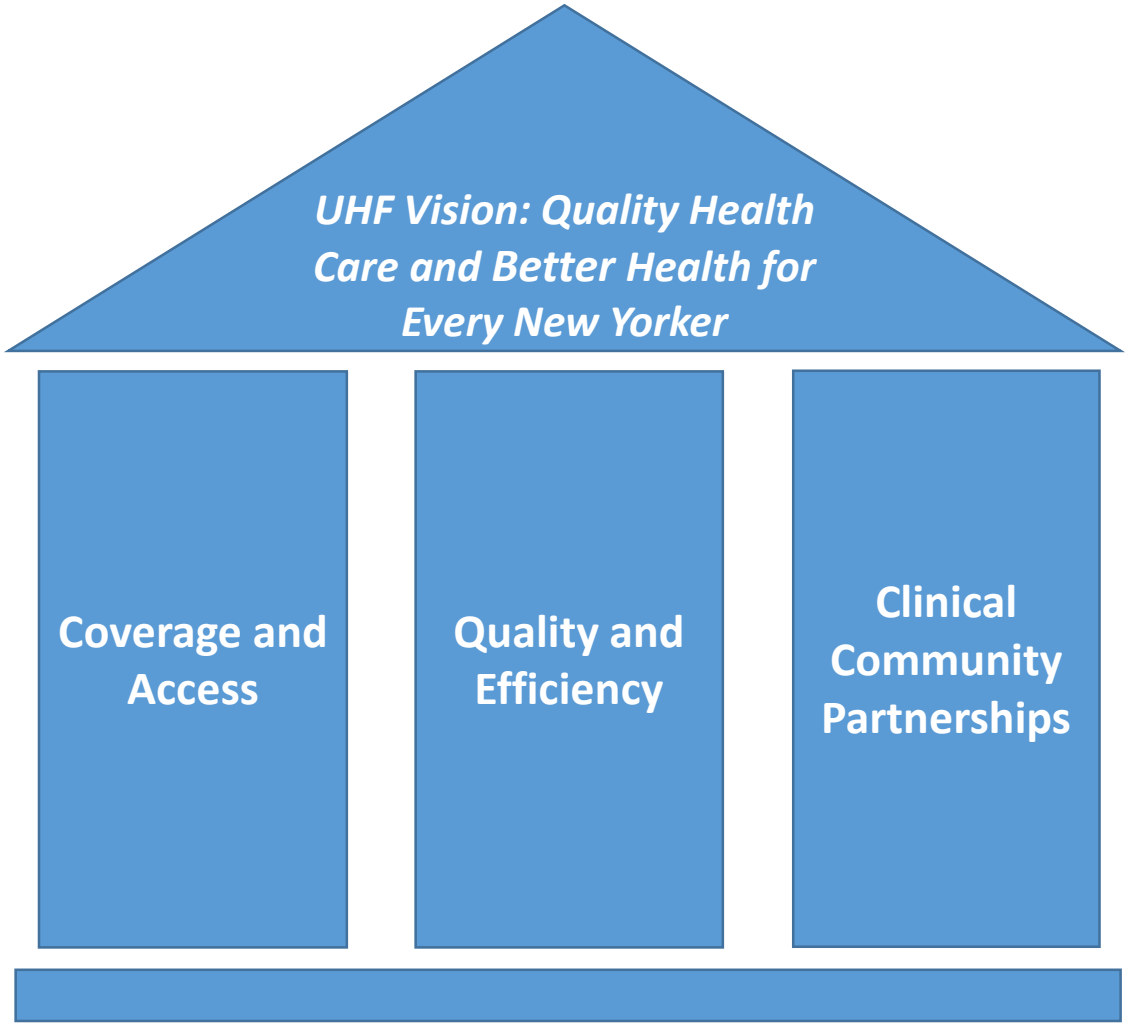
VISION

Quality health care and better health for every New Yorker

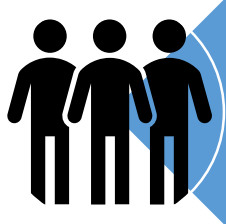
MISSION

United Hospital Fund works to build a more effective health care system for every New Yorker. An independent, nonprofit organization, we analyze public policy to inform decision-makers, find common ground among diverse stakeholders, and develop and support innovative programs that improve the quality, accessibility, affordability, and experience of patient care.

UHF Current Priorities and Activities



Independent research and policy analysis



Multi-stakeholder convening and collaboration

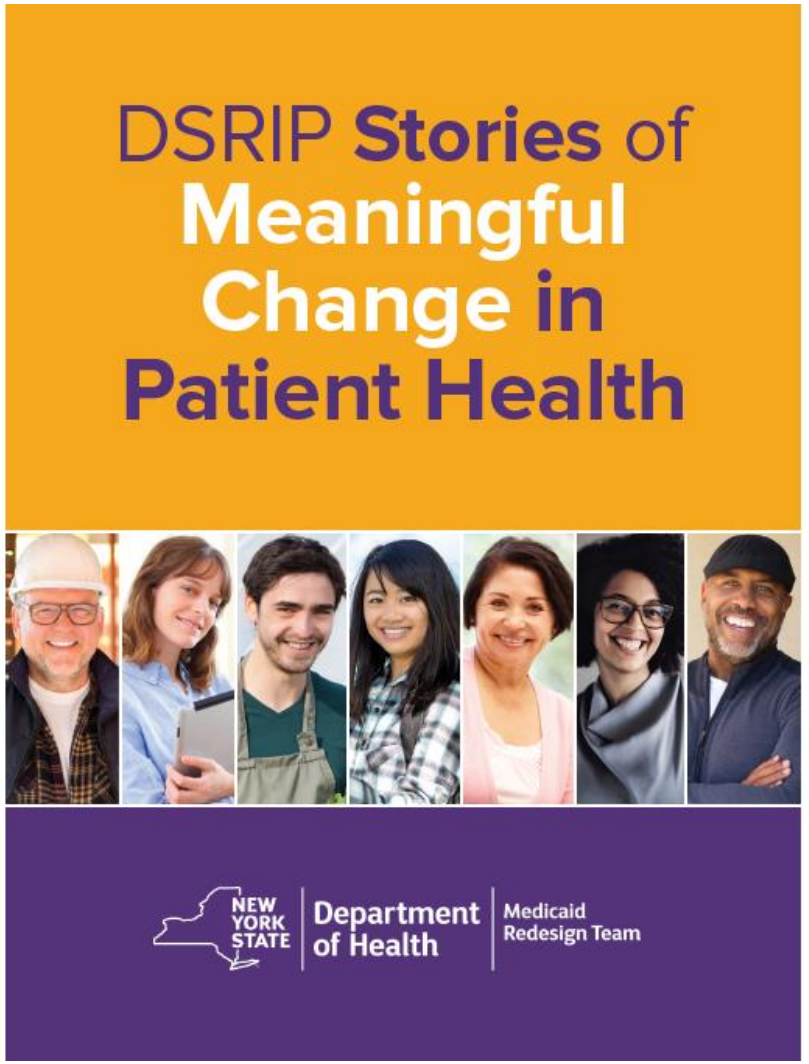
Develop and support innovative programs

Overview

- Rationale for Examining PPS Promising Practices
- Methodological Approach
- Key Themes and Selected Examples
- Important Caveats and Considerations
- Next Steps

Rationale: Why Focus on PPS Promising Practices?

- Understanding system change generating individual outcomes like those highlighted in ***DSRIP Stories of Meaningful Change in Patient Health***
- Begin to zero in on practices showing promise for improving DSRIP outcome measures
- Assess and categorize project-supporting infrastructure and promising project themes
- Start a conversation on how/whether scaling and spreading promising interventions could drive outcomes across Medicaid



Methodology: Searching for Promising Practices

- 2019 Learning Symposium submissions and PPS Innovation Fund projects, mapped to measures where PPSs achieved annual improvement targets in measurement year 3 (received from PCG)
- Publicly available DOH and PPS sources describing project work (including Social Determinants Innovation Summit and earlier Learning Symposia)
- Engagement with PPSs during and after 2019 Learning Symposium

Methodology: Mapping DSRIP Outcomes to Practices

- **Outcome Mapping:**
  - Developed broad measure categories from existing DSRIP measures
  - Mapped projects to measure categories they are very likely to affect, based on project design, patient and measure targeting, PPS and PCG information

- **<u>Broad categories of DSRIP measures</u>:**

Potentially Avoidable Services

Access to Primary and Preventive Care

Care Coordination and Care Transitions

Health Literacy

Clinical Improvement – Behavioral Health

Clinical Improvement – Diabetes

Clinical Improvement – Cardiovascular

Clinical Improvement – Asthma

Clinical Improvement – Perinatal Care

Four Key Themes Emerged Across Promising Practices

CORE INFRASTRUCTURE: building capacity to support DSRIP goals

SOCIAL NEEDS: developing new community partnerships, workflows, and workforces focused on social determinants

CARE MANAGEMENT & COORDINATION: enhancing care management and supporting care transitions, often for complex populations

BEHAVIORAL HEALTH: advancing integration and transformation that expands access to treatment and supports patient engagement

Core Infrastructure and Capacity Building

- **Practices that built new capacities to support DSRIP projects driving outcomes for attributed Medicaid members**
  - Developing networks for performance
  - Expanding technology and using data and analytics
  - Transforming primary care
  - Connecting clinical and community resources
  - Building quality improvement capacity across the care continuum
  - Leveraging infrastructure to serve high-need subpopulations

Core Infrastructure and Capacity Building - Examples

- **Developing Networks for Performance**
  - Forming a regional, clinically integrated network of physicians, FQHCs, hospitals, behavioral health providers, and CBOs
  - Developing strategies and performance goals to improve patient outcomes and prepare providers for value-based payment

- **Transforming Primary Care**
  - Enabling small primary care practices to achieve PCMH status
  - Training community health workers to support primary care
  - Fostering strong partnerships between community-based organizations and primary care to manage patients' social needs

Social Needs, Community Partnerships, and Cross-Sector Collaboration

- **Practices that developed new community partnerships, workflows, and workforces focused on social determinants**
  - Community health workers connecting patients to health and social services
  - Community partnerships engaging low-utilizers in care
  - Blending traditional care management models with community navigation
  - Leveraging local resources for chronic disease screening programs
  - Embedding nutrition assistance within health care settings
  - Addressing behavioral health through collaboration with justice and education sectors

Social Needs, Community Partnerships, and Cross-Sector Collaboration - Example

- **Addressing behavioral health using cross-sector collaboration between justice and health care systems**
  - Identifying gaps in behavioral health care for people at risk of incarceration and those about to be released from jail
  - Interventions: crisis-intervention training for police; diversion program; pre-release care management
  - Developed through local collaborations between hospitals, behavioral health providers, and the justice system

Care Coordination, Care Management, and Care Transitions

- **Practices that enhanced care management, care coordination and support for care transitions, typically targeting complex populations**
  - Using community health workers to help manage asthma
  - Targeting at-risk patients in need of care transition support
  - Using mobile health centers for chronic disease management
  - Supporting diabetes self-management through mentoring and workshops
  - Extending care management's reach through telemedicine
  - Delivering comprehensive care coordination to individuals at risk of Health Home eligibility

Care Coordination, Care Management, Care Transitions - Examples

- **Population Targeting: Care Transitions for At-Risk Patients**
  - New "transitional care team" workforce to provide safe and effective transitions for patients at-risk of hospital readmission
  - Enhancing post-discharge care planning and connecting patients to appropriate community-based clinical and social services

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- **Extending Care Management's Reach: Delivering Community-Based Telemedicine to Special Populations**
  - In-home triage and monitoring for individuals with IDD
  - Palliative care telemonitoring for patients with chronic disease
  - Telemedicine for behavioral health patients during/after crisis

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Performing Provider System

Behavioral Health Transformation and Integration

- **Practices that expanded access to treatment and supported better patient engagement in treatment**
  - Integrating primary care and behavioral health through provider capacity building and co-location
  - Investing in mobile crisis staff to expand BH access
  - Targeting individuals with complex BH and social needs
  - Diverting unnecessary BH hospitalizations through crisis stabilization
  - Transitioning individuals from inpatient psychiatric or detox/rehab settings using a non-clinical workforce
  - Expanding medication-assisted treatment to primary care

Behavioral Health Transformation and Integration - Example

- **Peer Support: Peer Coaches to Support Recovery for Substance Use Disorder**
  - Hiring peer recovery coaches to assist with care navigation/coordination for individuals with substance use disorders upon discharge from inpatient rehabilitation
  - Peer recovery coaches:
    - Help ensure attendance at outpatient appointments
    - Promote long-term engagement with outpatient treatment
    - Provide assistance with navigating health and social service systems

Montefiore HUDSON VALLEY COLLABORATIVE

Caveats and Considerations

- Examples above are illustrative of promising practices, but are neither exhaustive in scope nor definitively linked to specific results (in this scan)
- Ongoing quantitative and qualitative analysis recommended for evidence-informed targeting of promising practices for scale and spread
- Promising practices suggest that, with additional time and support to bridge the gap to VBP, DSRIP's substantial investments could yield a lasting impact
- Compared to other state waivers under consideration, these practices build evidence for more positive impacts from extending DSRIP
- Ultimate value of these practices is their impact on enrollees' health

Next Steps and Contacts

- Stay tuned – UHF report with additional detail in development
- UHF Medicaid Conference - July 18 at New York Academy of Medicine
  - Keynote - Donna Frescatore
  - DSRIP Panel with Greg Allen, Ann Monroe, and PPSs
  - Register at: https://uhfnyc.org/events/event/2019-medicaid-conference/
- UHF Medicaid Contacts
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