COMMUNITY PARTNERS OF WNY

Performing Provider System

Discussion with PAOP
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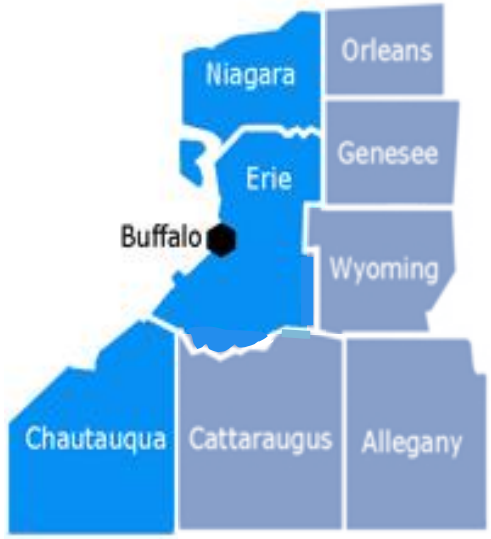
PPS Overview

- Attribution: 81,000 patients
- Current annual operating budget: $11 million
- Categorized as a “small” PPS by NYS Dept of Health

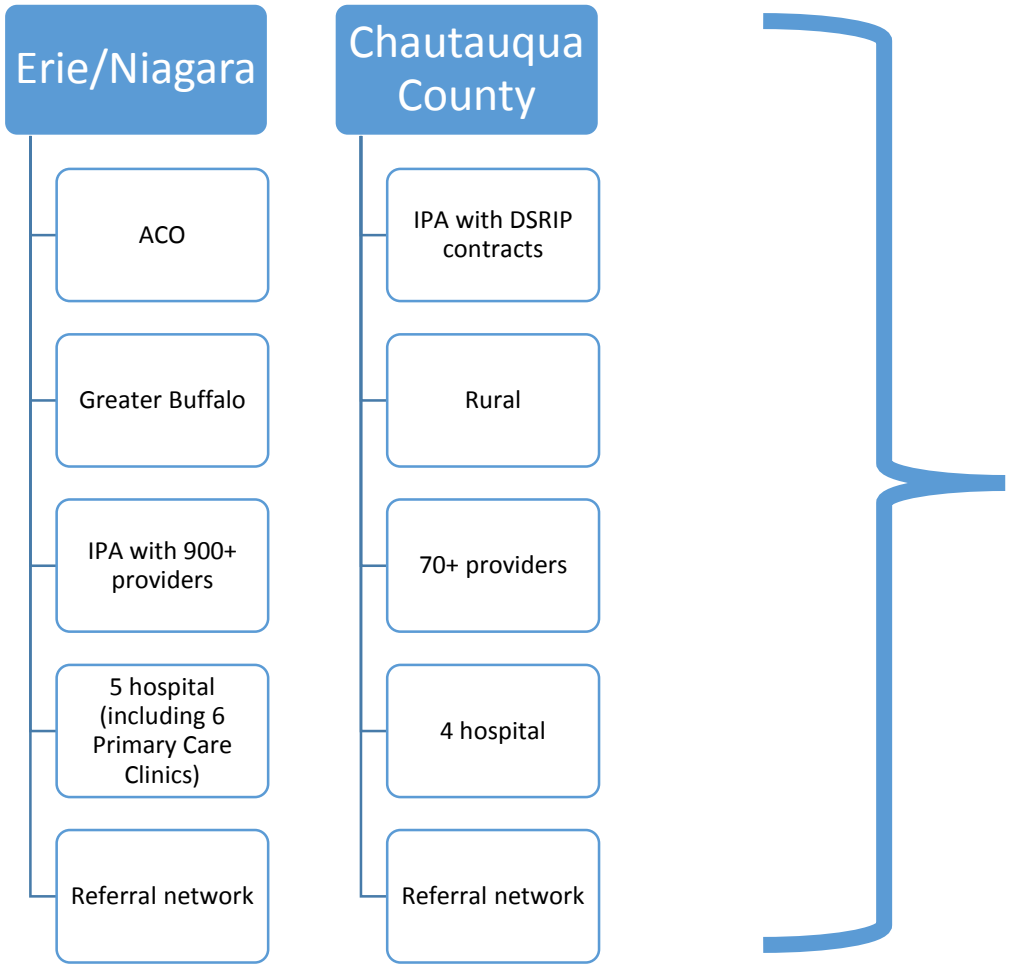


Midpoint Assessment Recommendations

- Findings were as expected
  - Organizational Level
  - Project Level

- Analysis by IA and its process provided opportunities to enhance partner involvement and participation.
- The analysis itself was received positively by the network.

Organizational Recommendation-Engagement

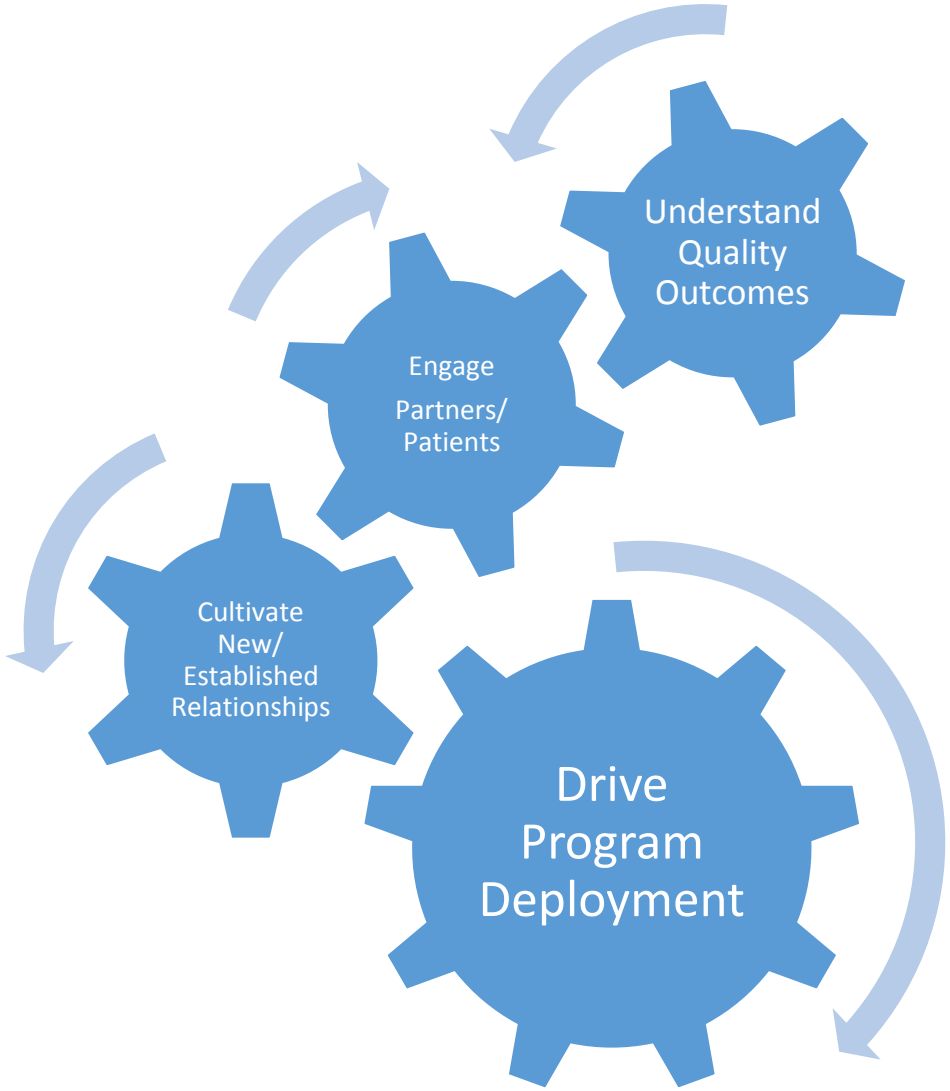


- Care management program and advisors
- Practice level support, Clinical Transformations
- Mature population health management efforts & value based contracting with managed care organizations
- Quality Improvement
- Cooperation with community organizations
- Referral network includes Behavioral Health, Home Health and Long Term Care

Partner & Provider Engagement Key Elements

- Provider engagement is often with partners' established contracting entities with strong trust relationships.
  - Umbrella organizations like large scale hospital systems, IPAs, physician networks
  - Care coordination and care management are often centralized resource models
- New contracts for project related deliverables are where highest levels of engagement are.
  - Often new project related funds flow equals "engagement"
  - Highest engagement also includes partners collaborating on common goals
    - PCMH efforts
    - Patient feedback initiatives
    - Placement of Community Health Workers, Social Workers, Patient Navigators

Project Level Recommendations



Emergency Department Triage

- Electronic systems
  - Direct primary care clinic scheduling
  - Care management module
- Connecting patients to primary care
  - Patient Navigators--Embedded at high-volume Medicaid Emergency Departments
  - Call center—Phone follow up
  - Referrals to Health Home, Care Management
- Relationships-strong support from ED and clinic leadership

Maternal & Child Health

- Community Health Worker model in Erie County
- Employed by CBO, embedded at high-volume Medicaid primary care clinics
- Patient support “beyond the walls” of the clinic

Plans for Expansion

Project Level Recommendations

Palliative Care Integration in Primary Care

- Focus will remain on supporting practices to integrate the palliative conversation into the primary care visit and interactions
- Address improvement of data collection at PCP sites for diverse modes of providing care and counseling. Referrals are one type of engagement, others include but are not limited to:
  - symptom management
  - advanced care planning
  - completion of a MOLST form
- Process improvements include but are not limited to:
  - secure texting across care team
  - algorithm for identifying patients

Project Level Recommendations

Telemedicine

- In-sourcing solutions
  - Orleans Community Health Center, in-sourcing for cardiac professionals with Catholic Health
  - OB/GYN providers in-sourcing for Maternal Fetal Medicine ultra-sound consults with WCA hospital in Jamestown, NY
- Assess barriers and explore ways to enhance DSRIP initiatives
  - Behavioral health/primary care integration
  - Emergency department triage/prevention

Systematic Areas of Concern

Identified by patients and staff at Primary Care

Supported by Community Needs Assessments

- Transportation
  - Limited public solutions
  - Constraints on Medicaid Services (MAS) for some constituencies
- Other, which translate to Health Home recruitment:
  - Food security
  - Housing
- Other, Regulatory Concerns
  - CMS Article 28/31
  - NYS Telemedicine

Challenges provide opportunities for supporting community benefit programs and outreach to CBOs

Highlight: Behavioral Health (BH) Integration with Primary Care (PC)

- Location of BH counselor in PC sites
  - Private partnerships with substantial Medicaid volume
    - One of these partnerships including local government unit in Niagara County
  - Hospital based PC clinics (Article 28)
    - DSRIP offsetting the cost due to lack of clarity on billing
- Fully integrated site with private PC and BH partnership
  - Long term budget is 100% sustainable in 3 years
- Support mobile BH units

Highlight: Prevention Programs (Domain 4)

Promote Emotional, Mental, and Behavioral Well-Being (4.a.i.)

- 2016-2017 school-based programs are in progress
- “Just Tell One” public awareness campaign
- Partnership with Millennium for maximum community impact

Highlight: Cultural Competency/Health Literacy (CC/HL)

- CCHL incorporated into CPWNY projects
- Key collaborations that support CPWNY CCHL strategy
  - Community Health Worker Network of Buffalo
- Community-based initiatives to reduce disparities
  - Focus groups in each counties
  - Self Management education
- Key next steps
  - Working with regional multi-cultural committee for long-term sustainability

Workforce Transformation Update

- Multiple workforce shortages due to the lack of qualified professionals in the area and attrition. These shortages are expected to carry through the DSRIP initiative.
  - Recruitment and retention activities by network partners are opportunities to share effective strategies
- Work to date has identified trainings/skill development needs.
    - use of computer aided learning
- Reinforcing communication between (between State and PPS as well as PPS and facility)
  - Positive feedback on DSRIP 101 video
  - Planning and shared activity on workforce with Millennium and Rural-AHEC help reinforce goals of DSRIP

Thank you!

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Our Winter 2016/2017 newsletter:

http://wnycommunitypartners.org/wp-content/uploads/2016/12/Winter-Newsletter-2016.pdf

SERVING NIAGARA, ERIE AND CHAUTAUQUA COUNTIES

COMMUNITY PARTNERS OF WNY

Performing Provider System

WINTER 2016/2017 NEWSLETTER

Behavioral Health: Breaking Barriers

Community Partners of WNY (CPWNY) is teaming up with area behavorial health partners to achieve success in the project 3.a.i. Integration of Primary Care and Behavorial Health Services. One of the main collaborators for this project is Spectrum Human Services.

Often times, barriers prevent people from getting the behavioral health help they need. Access to treatment locations and the stigma that surrounds seeking that type of help can present major challenges. In order to address these issues, a Licensed Clinical Social Worker (LCSW) from Spectrum Human Services has joined the care team at OLV Family Care Center to offer services right within the primary care setting.

"Studies will show you and tell you that, really, a truly integrated team of people focused on the whole individual, not just their physical health needs or behavioral health needs, but a team that is really able to cohesively meet an individual's needs, in a comfortable environment, is the person's best opportunity for making and maintaining positive changes," expressed Julie Gutowski, Managing Director of Clinical Services at Spectrum.

That's where David Casassa comes in. Casassa, a Life and Clinical Social Worker, has an office located in the OLV Family Care Office, and is available for almost immediate consult, if needed. Once a provider at OLV recognizes that a person might have greater needs than just the physical component of their health, they are able to walk the individual over to Casassa for a consult. In the case that he's not available, that person will be scheduled for an appointment in the near future at the same location.

"Sometimes, especially if you're working with somebody who might have a substance abuse disorder or mental health disorder, seeking treatment for behavioral health disorders can be very stigmatizing, and I think having David onsite, at OLV, removes some of those barriers," Gutowski says. "One of the most remarkable aspects of this program is that sometimes the people that we work with may have a difficult time actually getting into a site, and so they have phone calls, and that doesn't necessarily work in traditional outpatient mental health. Through this partnership, we're really able to focus on what they're hoping to achieve and how they can better improve the quality of their lives."

(Continued on pg. 2)

Case Study

The following case illustrates how the behavioral health project is working to address the needs of DSRIP patients:

An individual presented who receives her primary care services at the OLV Family Care Center. She has a significant substance disorder and is pregnant. While working with the medical team, they recognized that she could use support from the behavioral health partner, so they paired her with David Casassa, the Life and Clinical Social Worker from Spectrum Human Services. David performed screenings and was able to give her referrals for other levels of care. One recommendation was for Lighthouse Women's Residence, a residential program that gives treatment in-house for women who are pregnant or have children and who have a substance use disorder. The program is a long-term intervention that can significantly change someone's life by addressing the disorder while still allowing mothers to be near their children in a safe environment.