

DSRIP Project Approval and Oversight Panel (PAOP)

February 2, 2017





PAST



PRESENT



FUTURE



2015

2016

2017 ONGOING / FUTURE STATE

Improving Care **OUTCOMES**

PMO April, 2015 Data Integration

Telemedicine Pilot with NH Workforce Symposium

Contracted 31 Partners and 2 CBOs Engagement with CSI

20% Partners engaged in training 1 Partner with PCMH

SI CARES Engagement 1199 SEU Funds Training & Employment Workforce Vendor

SI Connect 24/7 call center

HOPE Project

Contracted: 39 Partners 12 CBOs 16 PHIP 3 Colleges

Over 4,000 individuals engaged in training

Integrate Asthma and Obesity Health Initiatives

DY1	14.0%	DY2 Q1 & Q2	11.3%
Total AE	607		127
30-Day ER Rate	14.0%		11.3%

2.A.III: 19% Improvement

DY1	6.4%	DY2 Q1 & Q2	6.1%
Total AE	2944		3484
30-Day ER Rate	6.4%		6.1%

3.C.I: 4.7% Improvement

DY1	6.4%	DY2 Q1 & Q2	3.2%
Total AE	714		341
30-Day ER Rate	6.4%		3.2%

2.B.VII: 50% Improvement

DY1	14.4%	DY2 Q1 & Q2	13.6%
Total AE	327		405
30-Day ER Rate	14.4%		13.6%

3.A.IV: 5.6% Improvement

24/7 Crisis Stabilization Centers

UCP Telemedicine Pilot

ED Peer Counselors

Primary Care Symposium

6 Partners with PCMH

Palliative Care Symposium

Health Literacy Symposium

Avoidable Hospitalizations by 25%

Integrated Care

Palliative Care Innovation

Empowered Workforce Lean Processes

Expansion of Primary Care Capacity and PCMH

Integrated Asthma & Obesity initiatives

Focus on VBP & Quality Outcomes

Population Health Platform

Opioid Dashboard

Psyches Access

Engagement of Managed Care and local Government

School Health Services

SI Drug Prevention Portal



A Trained Workforce is a Transformed Workforce

Higher Education Partnerships

- Created CHW & Care Management Credit Certificate Programs at College of Staten Island (CSI)
- \$300,000 in Scholarships for PPS Partners
- Held CSI PPS Partner Day to discuss:
 - Future Curriculum Needs
 - Internships
 - Development of Hiring Pipeline



Training Scope



xG Health Care Management Training

- Engaging home care and hospital staff including nurses and physicians on transitions of care and chronic disease management:
 - COPD, Diabetes, Heart Failure



INTERACT

- All 10 Skilled Nursing Facilities trained on INTERACT
- 22 Certified INTERACT Facility Site Champions



Palliative Care Training

- Comprehensive Palliative Care training implemented All
- Participation from 10 Skilled Nursing Facilities



1199 TEF

- 22 different training courses offered



LEAN Training

- SI PPS sponsored LEAN education series for all partners
- PPS partners using LEAN for process redesign

Training Outcomes

- Over 15,000 hours of PPS partner training
- Partners and CBOs fully engaged in training
- 1,000 participants surveyed

Outcomes

- Improved patient access to clinical and social services
- Process improvement
- Improved communication and understanding

Reducing Hospitalizations Continuing Care Transformation



Advance Care Planning Explained

Top Videos Viewed by Patients and Families:

1. What is Palliative Care?
2. Advance Directives
3. Goals of Care: Advanced Dementia
4. The Conversation
5. CPR: Advanced Cancer

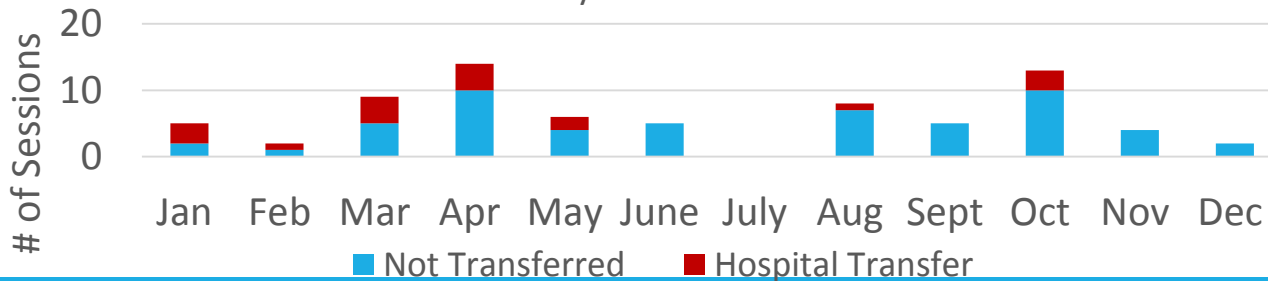


Palliative Care Symposium

- Keynote Speaker: Dr. Volandes
- Practitioner Engagement:
 - 154 attendees
 - 23 partner organizations

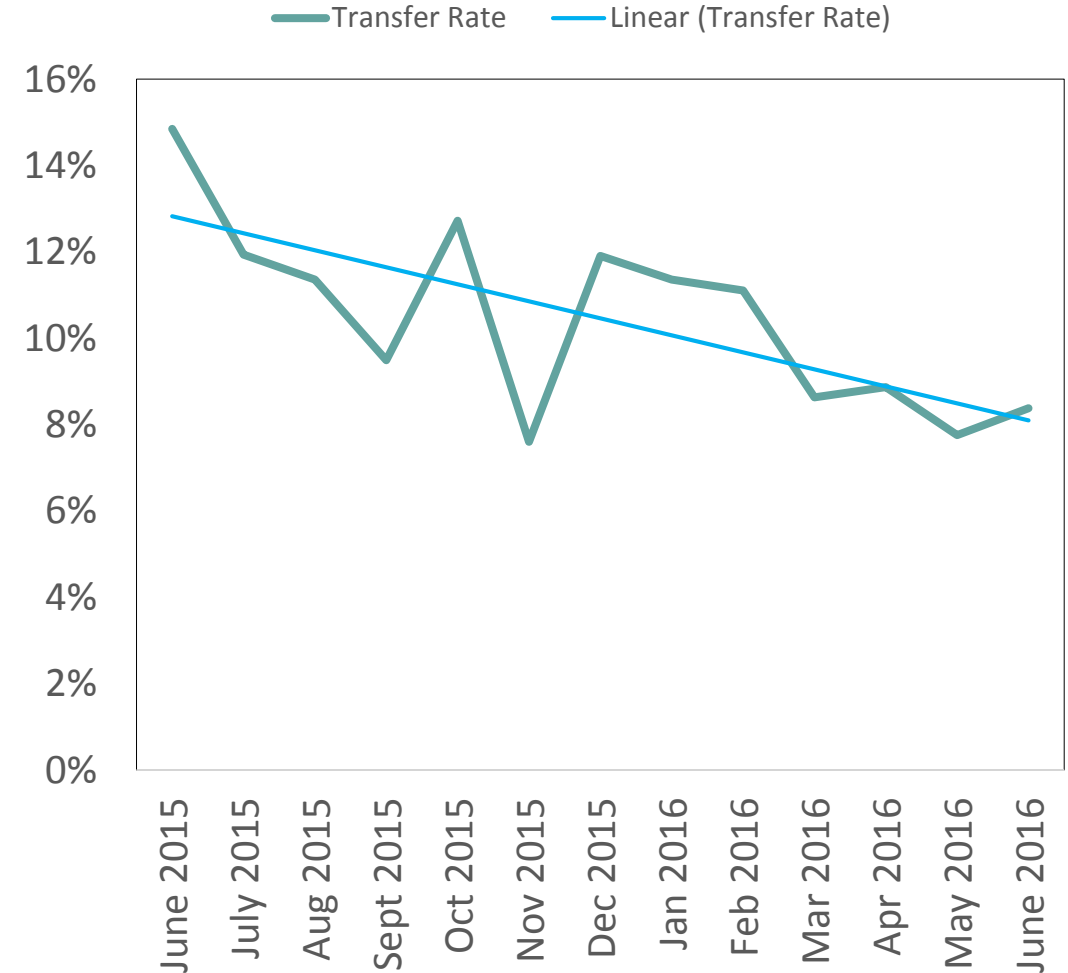
Innovative Technology

Telemedicine Outcomes - Nursing Homes and UCP Sites
January - December 2016



Home Care

Overall Transfer Rate: June 2015-June 2016





Expanding Primary Care & Care Management Capacity

- Provide technical assistance for 2014 PCMH Level 3 recognition
- Engaging 25 practices and 100+ PCPs in obtaining PCMH recognition
- Promote PCMH standards including care management, care coordination, chronic disease management and population health through partner training and clinical projects

Patient-Centered Medical Home



- 7 of 9 primary care sites co-located with Behavioral Health practitioners for screening & assessments
- Connecting partners to Mental Health Service Corps to support integration
- Collaboration with SIPCW to build buprenorphine prescriber capacity

Co-Location



- Enrolling primary care practices in hospital ED notification system to promote care coordination
- Care Plan Exchange Pilot
- DSRIP dashboard for tracking population health measures

Clinical Interoperability



- SI Cares Health Home includes 6 CMAs & 60+ referral partners
- 1700 individuals received care management services
- Health Coaches/Care Managers embedded in ambulatory sites to engage patients and educate staff

Health Home & Care Management





Medical Interpreters

- 35 New Qualified Medical Interpreters at 11 Partner Sites
- Spanish, Russian, Albanian, Hindi, Arabic, Mandarin



Video Remote Interpreting

- 20 Partner sites with new equipment
- Spanish & ASL 24/7



Cultural Awareness

Trainings:

- 6 CA/Train the Trainer
 - 12 Partner Sites
- 37 LGBTQ Trainings
 - 1009 Staff
 - 23 Partner Sites
- 4 Military/Integrative
 - 51 Staff
 - 10 Partner Sites
- 19 Disability Ally
 - 299 Staff
 - 16 Partner Sites
- 1,596 People trained 2016

"Patients are pleased to know that they are being heard and any issues are clarified. Many patients are grateful to know that they are not alone and have some ease into understanding their next step(s) in treatment."

Language Access

- 2015: 22 Sites
- 2016: 50 Sites (2 CBO)
- Supporting partners in ACA Section 1557 compliance



Site Champions

- Language Access Guidance
- REAL Data Standardization
- 14 Site Visits

Member of Statewide CCHL Planning Team

Health Literacy

- Health Literacy Learning Symposium
- 2 Simple Language Workshops
- 35 Documents Simplified





Population Health & CBO Integration

Healthy Neighborhoods

- 3 CBO's
- ✓ Wagner, St. Johns & CSI adopt local communities
- ✓ Engaged 120 CBO's
- ✓ CHANGE Tool data collection

Population Health

- 2 CBO's
- ✓ City Harvest Nutritionist
- ✓ 350 patient encounters-PCP, DOH, Mobile Market
- ✓ Make the Road NY Asthma home visit

Patient Activators

- 4 CBO's
- ✓ El Centro, MTRNY, YMCA, NAWC & JCC
- ✓ Outreach
- ✓ Navigation

Trust Builders

- 3 CBO's
- ✓ Health Literacy/Yoga classes, Canvas/Island Voice
- ✓ Archcare Faith Navigator/ Timebank
- ✓ NYC Yoga Project

Educators

- 4 CBO's
- ✓ Pride, PCCS, Intersections
- ✓ LEARN Network: Health Literacy Curriculum

Behavioral Health Integrators

- 1 CBO
- ✓ Staten Island Partnership for Community Wellness

15 Primary Care Practices



17 Community Based Organizations

Asthma

- Referrals from PCP, ED, Schools & Partners
- Data Share with NYC DOE
- SI Asthma Coalition

Tier 1 CBO Funding: \$733,293
 Total CBO Funding: \$778,293

Obesity

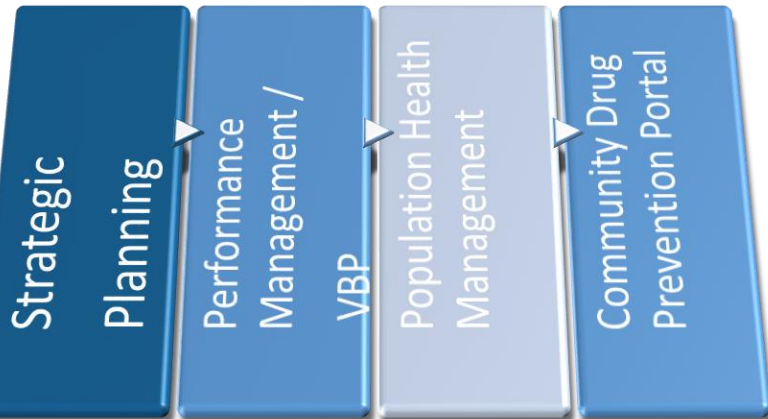
- Referrals: 90% of pediatric patients with BMI <95%
- 1:1 Counseling at PCP/Nutrition Workshops
- Rx for Food (405 distributed to date)



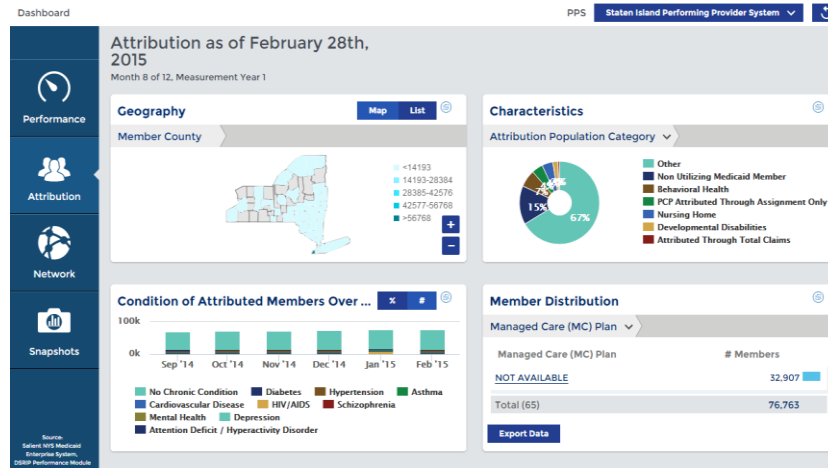
SI PPS Analytics: Tool Portfolio

Turn Data into Actionable Insights

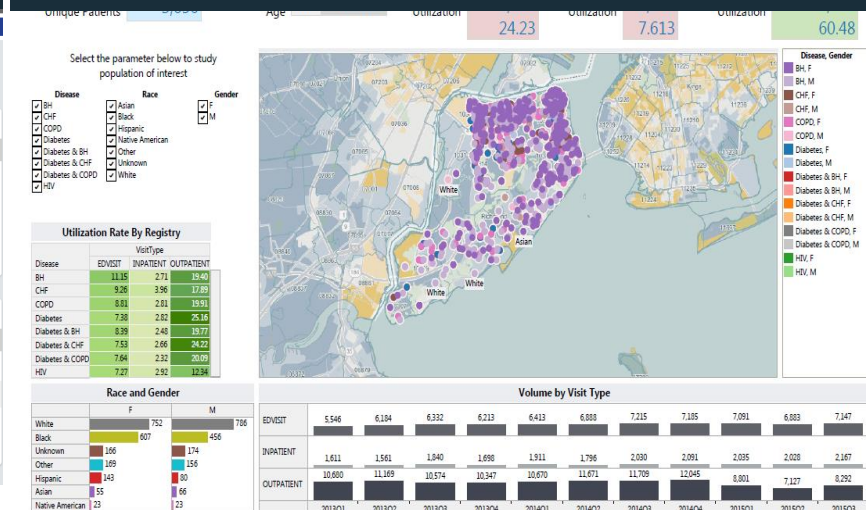
Program Areas



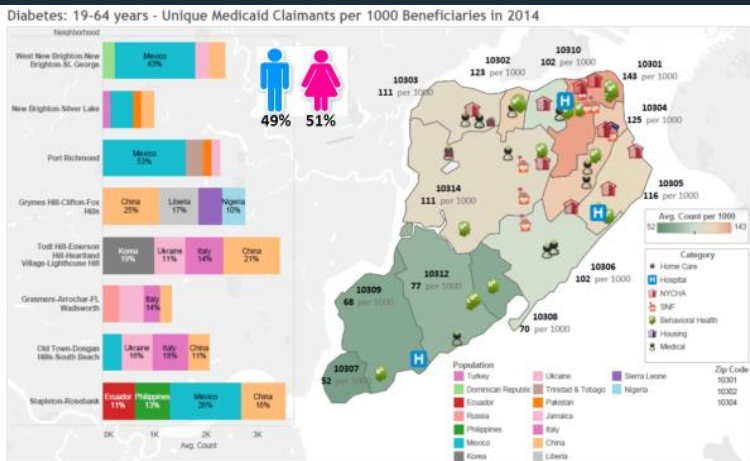
MAPP Dashboard - VBP



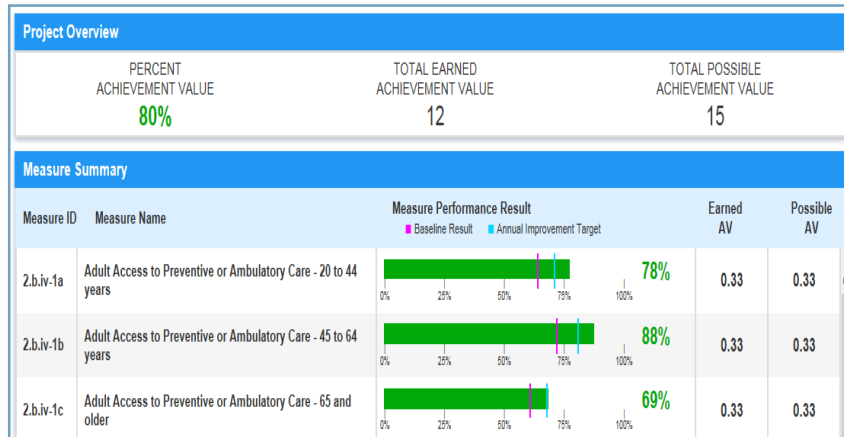
Population Health Management



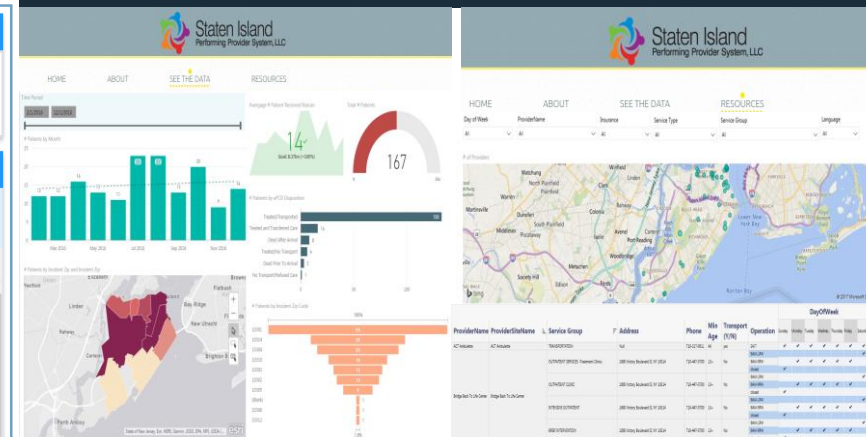
Healthcare Hotspotting



Partner P4P Dashboard



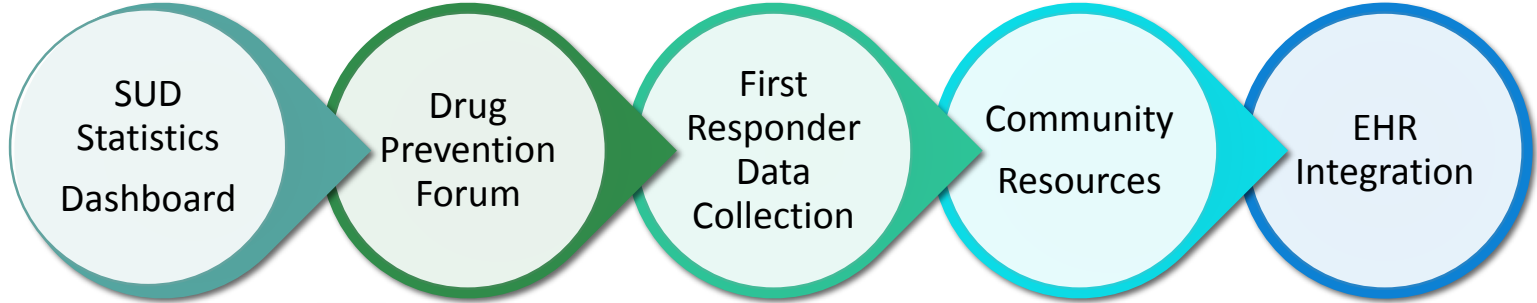
SI Drug Prevention Portal



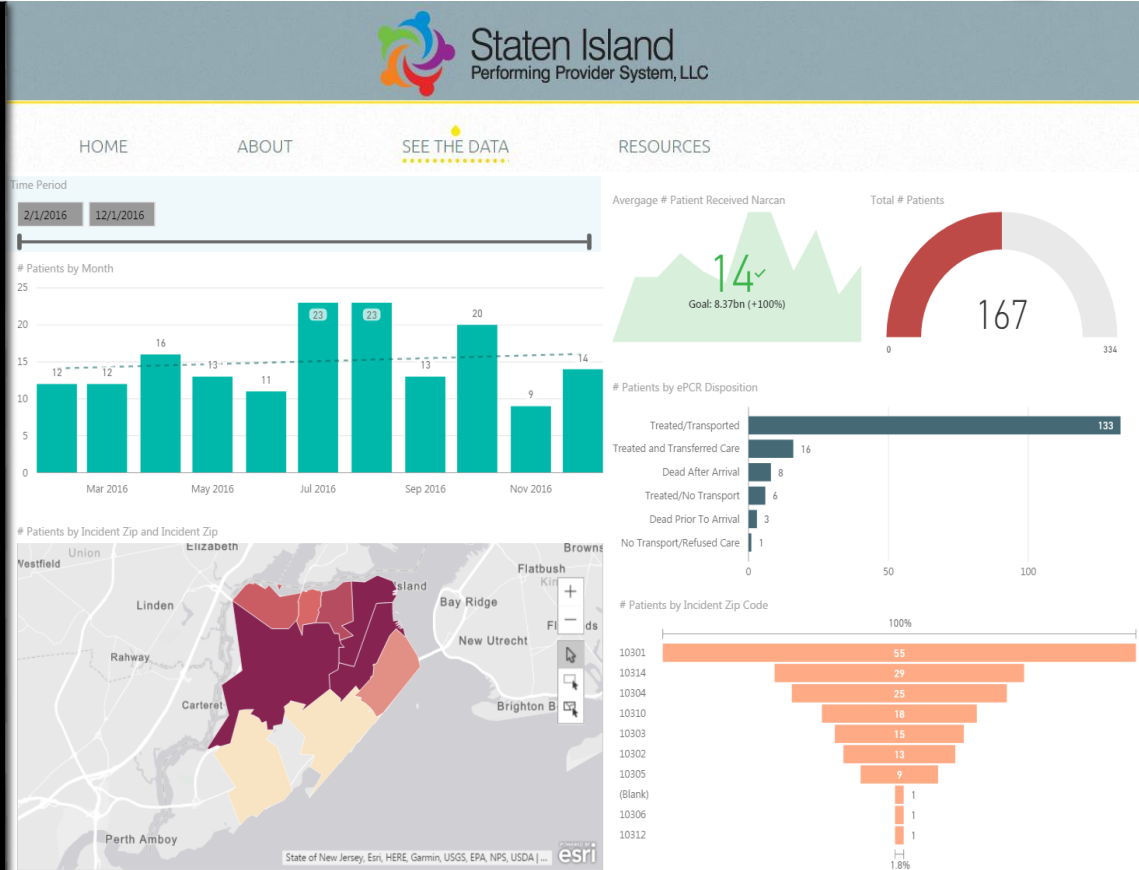


Staten Island Drug Prevention Portal

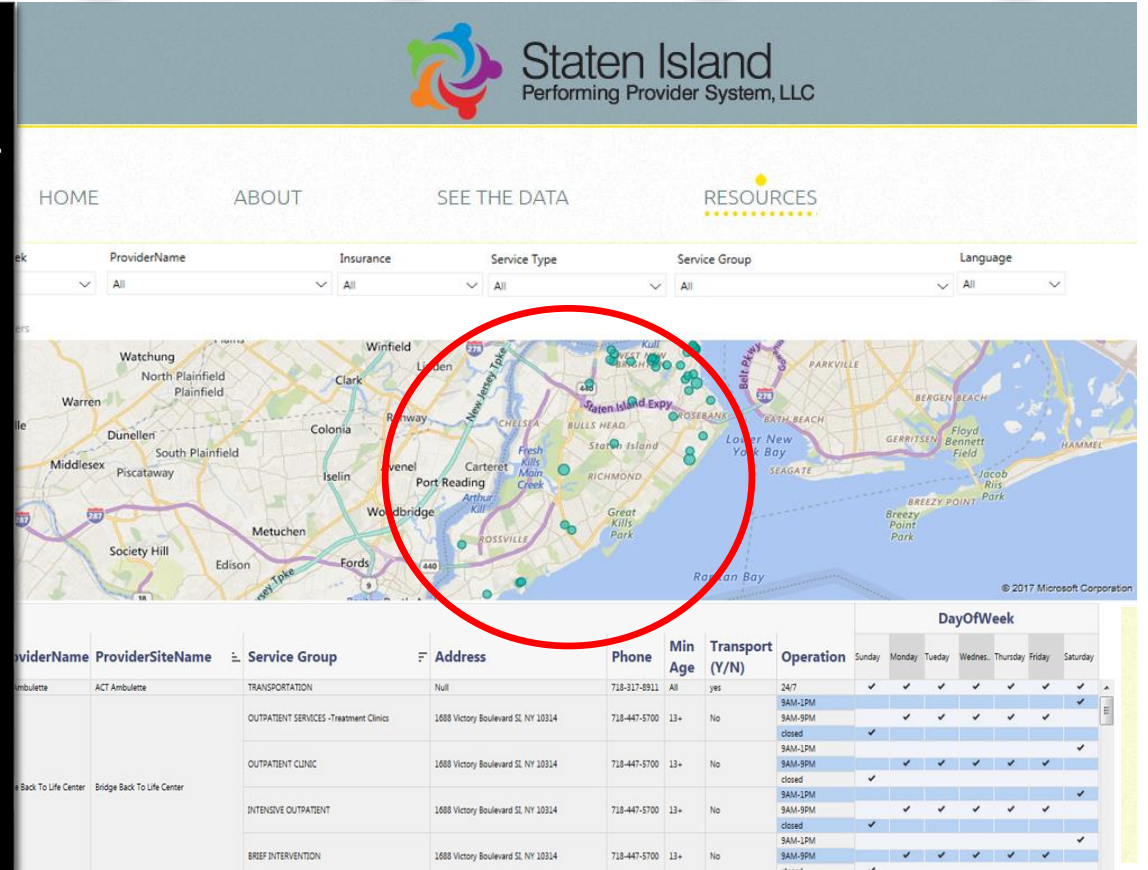
A single place where our community has **better access to the right resources** to fight drug overdose epidemic



Interactive SUD Analytics



SUD Provider Search Directory





Strengthening the Behavioral Health Infrastructure

Establishing and sustaining resources & partnerships to improve access and care



Improving Linkages to BH Services

24/7 Peer Support Network

- Growing capacity
- Staffing in clinical & criminal justice sites
- Long-term training program with CSI
- 24 Peers certified with PPS funds



24/7 SI Connect Call Center

- Appointments
- Transportation



ED Warm Handoff Pilot

Reduce avoidable SUD-related ED visits

- 119 patients engaged by peers in 6 weeks
- Expediting linkages to treatment providers



BH Specialists in ED



Peer Counselors in ED



SI Connect 24/7 call center



Provider Directory



SUD Treatment Providers



24/7 Crisis Stabilization Centers

Providing Integrative Care

Collaborative Care Pilot

Technical assistance for primary care practices to integrate behavioral health

Public Health Detailing

Providing all Staten Island PCPs with BH resources on Opioid Use Disorder, MAT, etc.

Reducing Stigma

Social Media Campaigns & Trainings

Feeling Blue
Awareness on MH issues during holidays



New Year's BH Wellness Resolution



Trainings for providers and front line staff

Watch Your Words Campaign



Expansion of Treatment Provider Availability

24/7 Crisis Stabilization & Respite Centers

24/7 Resource & Recovery Centers

Resource Guide

Provider Directory Search App



Heroin Overdose Prevention and Education (HOPE) Program

Post-arrest & pre-arraignment diversion

- In 7 days, 9 arrested and engaged by Peer Coach, 8 naloxone trained, 2 enrolled



HOPE Program Coordinator



Peer Mentors



24/7 Resource & Recovery Centers

Treatment / Service Providers



SI Connect 24/7 call center



Provider Directory





Heroin Overdose Prevention & Education (HOPE) Pilot Local Government & Public Health Collaboration



Committed to

- Promoting HOPE program
- Connecting clients to resources and services

Avoiding a criminal record positively impacts an individual's opportunities for education, jobs and housing

Engagement with local government agencies

24/7 access to peers, resources & services

PPS funding and support for

- Peer network
- 24/7 resource & recovery centers
- SUD treatment provider access

Public health focus addressing social determinants of health

Harm reduction strategies to prevent fatal overdoses

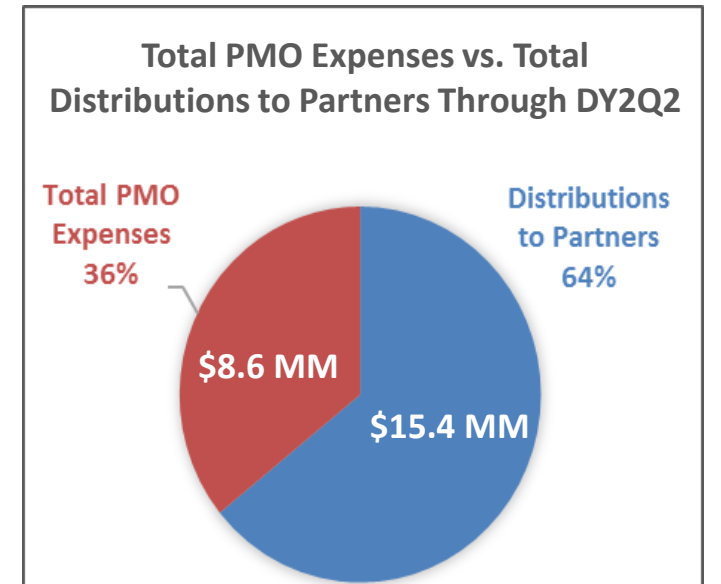
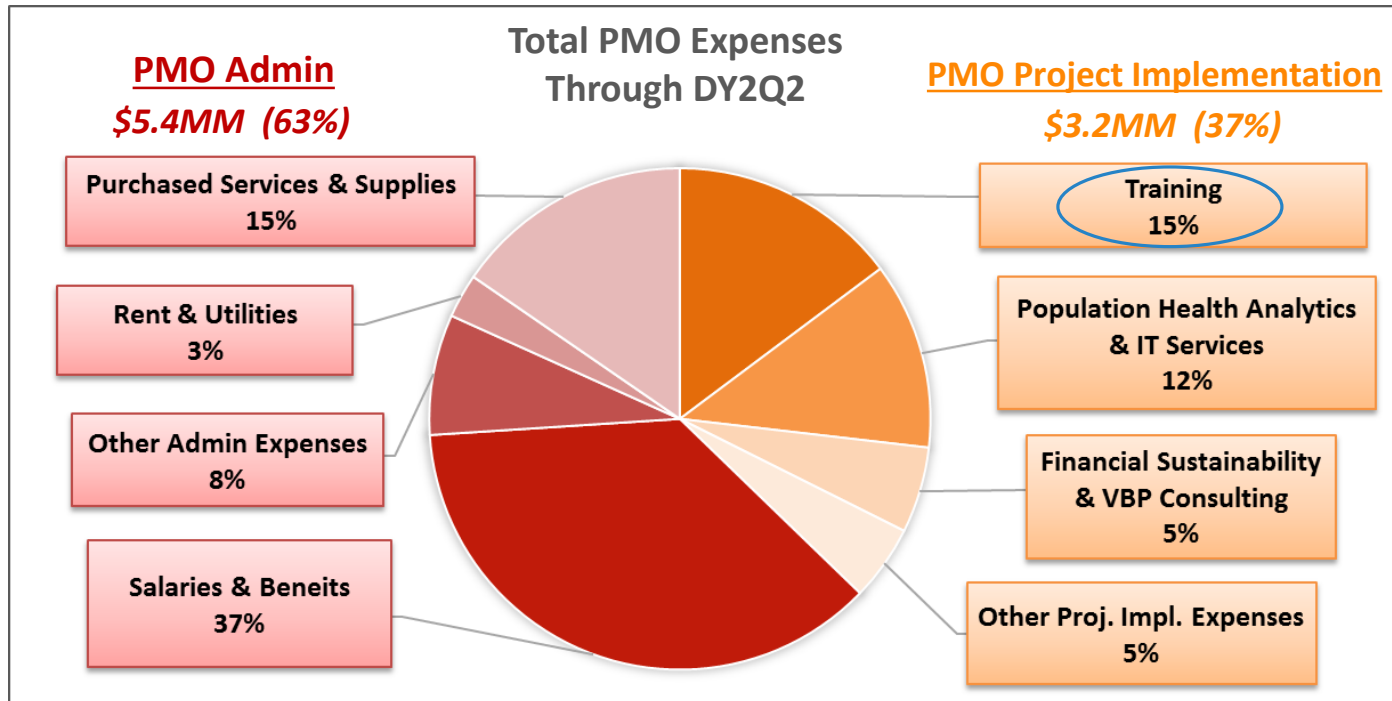
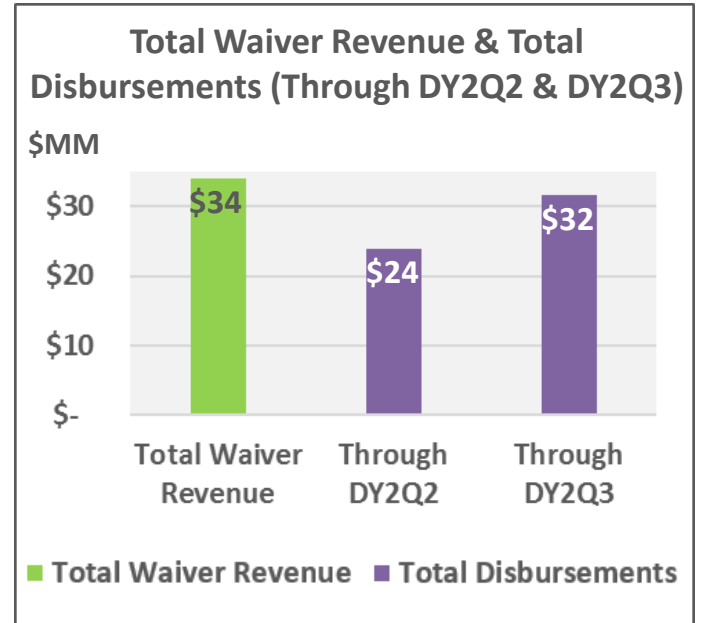
Peer mentors engage clients at precincts, provide naloxone training and distribute kits





Funds Flow Through DY2Q2

- Staten Island PPS disbursed 70% of its Waiver Revenue received through DY2Q2 and 93% through DY2Q3.
- Total PMO Expenses represents approximately 1/3rd of all disbursements and include a portion of Workforce spending.
- Of the ~\$8.6MM in Total PMO Expenses, \$3.2MM is related to Project Implementation.





SI PPS Community Partner Video





Opportunities & Challenges

Opportunities

Population Health

- Create Coalitions- Asthma, Obesity & SUD
- Focus Hot Spot/Chronic Disease
- Managed Care Organization Collaboration

Practice Innovation

- Grow PCMH
- Integrative Care Development
- Care Coordination

Diversion Program

- Redirect Non-Acute EMS Calls
- Enhance Care Coordination
- Resource Recovery Centers

Data Sharing

- PSYCKES Access
- Managed Care Organizations
- School Health Information Exchange
- RHIO

Challenges

Population Health

- MCO Resistant to engage with PPSs
- LGU Bureaucracy
- Restrictive Outdated Regulation

Practice Innovation

- Cost to Develop Team Care
- Lack of Funding to Support Team Care
- EMR Vendors

Diversion Program

- EMTALA/MHL Regulations & Implications
- Licensure of Providers for medical management/supervision
- Inclusion of law enforcement & BH response training

Data Sharing

- Regulation
- Technical
- EMR Vendors
- RHIO Consent Process