NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Staten Island PPS

Appendix PPS Narratives

November 2016

www.health.ny.gov

Prepared by the DSRIP Independent Assessor

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: 2.a.iii

Challenges the PPS has encountered in project implementation:
Staten Island PPS has partnered with 2 care management organizations, CBC (the lead Health Home on Staten Island) and Northwell Health Solutions, to provide care coordination services to health home at-risk qualified individuals under its SI CARES program. The PPS challenges include: • The complexity of developing a business model resulted in a contract for the primary partner being implemented in December • Both Health Home partners required a ramp up period to recruit staff, develop and implement outreach/educational materials required to conduct direct patient enrollment during the first year of implementation. Additional staff needed to be hired, trained, oriented, and integrated in multiple provider sites and other settings to target and engage at-risk individuals. • The complexity of the patient population requires an iterative approach to identification, engagement and effective care coordination.
Efforts to mitigate challenges identified above:
SI PPS and its care management partners are focused on increasing and strengthening provider engagement as well as direct patient outreach and engagement. • Direct patient outreach and engagement – o Staff are now in place and being integrated at multiple provider locations to target at-risk patients and to increase timely patient engagement through warm handoffs o Culturally competent and health literate patient outreach materials have been developed and are being distributed widely o Patient educational materials including a video series are being developed to empower and better engage more patients • Increasing provider engagement – o Providers who refer patients will receive consistent and standard communications from the care management provider to ensure that they stay engaged in their patient's progress o Providers will receive consistent reports of patients who had recent ED visits and/or inpatient admissions as well as potentially eligible patients that they have engaged themselves through other projects (e.g. diabetics) but not referred for care coordination services o Regular touchpoints and workgroup meetings with providers will continue to address referral volume and improving workflows and communications
Implementation approaches that the PPS considers a best practice:

- Linking the technology platform of the health home with the SI PPS data warehouse and the RHIO has enabled significant data sharing, utilization monitoring and event notification, this is a first in NYS
- Creating a partnership with 2 Health Homes (including the lead Health Home on Staten Island) that already provide care coordination services and building on their experiences to support this project is a best practice.
- Coordinating partnerships between these Health Home providers, resulting in on-site recruitment for patients by HH staff to encourage referrals, strong collaboration, and promote an integrated care team approach for managing each patient's chronic condition and social service needs.
- Sharing data reports of at-risk patients or superutilizers of ED and inpatient services with providers that are actionable is a best practice.
- Developing key performance indicators and a standard process for collecting and evaluating data from 2 partners to evaluate the success of the program is a best practice.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

- Both care management partners, are connected to the RHIO and receive immediate alerts on patients that visited the ER or being hospitalized. Both organizations have established processes for ensuring follow up on such patient alerts.
- The SI PPS robust data warehouse and analytics platform is enabling the ability to perform population health management and to develop targeted patient registries that are actionable for providers and care managers.
- HH partner care managers are using comprehensive care management plans to engage patients in this project. Standard processes are also being implemented to engage at risk patients with care management plans. SI PPS in collaboration with both partners have also defined what constitutes as a meaningful update to a care management plan for any patient
- Evidence-based practice guidelines for the care management of chronic conditions have been collected and reviewed by the project workgroup and Clinical Committee.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

SI PPS expanded the eligibility criteria for Health Home At-Risk to include pediatric patients who qualify for the New York State Health Home Program i.e. have 2 or more chronic conditions or a single qualifying chronic condition (HIV or SMI). This was necessary to ensure that Health Home eligible pediatric patients also receive care coordination services before the NYS Health Home program is operational. Once the Children's Health Home program, Health Home eligible pediatric patients will no longer be included in the PPS's Health Home At-Risk program, but transitioned to the Health Home program.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: 3.a.iv

Challenges the PPS has encountered in project implementation:
• Actively engaged definition – Initially, the actively engaged definition was unclear to providers. Providers needed additional clarification to ensure that they were accurately identifying and reporting engaged patients for this project. • Low referral and intake of new patients – Some providers have expressed concerns about their ability to meet actively engaged targets due to low volume of referrals and intake of new patients in withdrawal, lack of patient adherence to complete induction, and the growing number of patients already in treatment. • Limited ambulatory withdrawal management services during off-business hours – Some patients tend to seek ambulatory detox services outside regular business hours. Meeting this need requires significant expansion of providers' current capacity, which is not currently supported with funding through this project. • MCO approval and reimbursement issues – Multiple providers have expressed several concerns with MCOs including delays in getting authorizations for suboxone medication or other treatment, delays in reimbursement or denial of claims (which some have attributed to delays in software updates for new APG rates under the DSRIP MRT transformation), lack of MCO staff knowledge on substance use disorder services
Efforts to mitigate challenges identified above:
• Actively engaged definition – SI PPS worked closely with State representatives to address questions from providers and develop clarifications. Clarifications were distributed to providers. • Low referral and intake of new patients – Providers are ensuring continuous patient follow up, engagement of patient's significant other to support adherence, increased education and outreach to the community, and improvement of referral relationships. Providers are also encouraged to complete motivational interviewing and care coordination training to support patient engagement. In addition, a six-month pilot is being planned to allow the warm handoff of patients from the ED to community SUD treatment providers. The pilot is being supported by a 24/7 call center/hotline, certified addiction recovery peer counselors and licensed/credentialed behavioral health specialists that are placed in the ED to engage patients and confirm a complete handoff. • Limited ambulatory withdrawal management services during off-business hours – Some providers have extended their business hours to accommodate more patients, while others are exploring their ability to increase capacity. • MCO approval and reimbursement issues – SI PPS continues to engage Medicaid Managed Care Organizations to provide sufficient coverage for withdrawal management services.

NEW YORK STATE | Department of Health

Implementation approaches that the PPS considers a best practice:

- SI PPS is implementing a 6-month pilot to support the warm handoff of patients from the ED to community SUD treatment providers. The pilot is being supported by a 24/7 call center/hotline, certified addiction recovery peer counselors and licensed/credentialed behavioral health specialists that are placed in the ED to engage patients and confirm a complete handoff.
- The monthly PPS led meetings among 12 competing organizations has resulted in more effective and coordinated services for this at-risk population, enhanced clinical protocols and outcome measurements
- The PPS is utilizing its EDW to monitor population health statistics on this cohort to evaluate ED, inpatient utilization as well as to evaluate their enrollment in HH.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

SI PPS has designated a project medical director, who is board certified in addiction medicine, has the required training and privileges to use buprenorphine and suboxone, has familiarity with other withdrawal management agents, and brings significant multi-year experience treating individuals with substance use disorders. The project medical director will provide leadership and guidance on clinical best practices, achieving performance metrics, and innovative efforts to reduce ER visits and hospitalizations among the SUD patient population.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:
• Care transitions programs were unique processes to the two PPS partner hospitals with lack of uniformity or measurement criteria. • Staff for new positions had to be brought on board and trained in the new approach. • The process of building affiliations with Medicaid Managed Care Organizations requires detailed negotiation and legal relationships.
Efforts to mitigate challenges identified above:
• The PPS adopted the Seven Essential Elements of a Care Transitions Bundle from the National Transitions of Care Coalition. The documents include the core components of an evidence-based care transitions model without being too prescriptive on any one particular model. • The funds flow model incorporated position funding for care managers • One hospital is pursuing a vendor relationship with an experienced home care agency in the PPS network in order to implement a formal care transitions program to supplement the existing discharge model. • The PPS has scheduled multiple MCO visits to refine relationships to support project implementation.
Implementation approaches that the PPS considers a best practice:
• The PPS definition for actively engaged patients includes Patients as actively engaged if they have a follow-up appointment scheduled prior to discharge. • Through its Health Home At Risk Project, the PPS has developed a strong relationship with the Staten Island Health Home and its downstream care management agencies, thus facilitating improved relationships with the hospitals. We anticipate that these relationships will also support coordination of care for care transitions. • The PPS is using registry data to identify cross project service utilization and population health issues.

NEW YORK STATE | Department of Health

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
The PPS governance structure requires consensus in the development of policies and procedures related to clinical practice.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
• Significant hospital utilization is driven by behavioral health patients. While the project is supposed to focus on chronic diseases, the clinical team has highlighted to need to focus on improved care transitions for behavioral health patients with medical co-morbidities. This enhanced linkage is being identified for implementation.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: 2.b.vii

Challenges the PPS has encountered in project implementation:
• Having diverse ownership models within the 10 facilities including for-profit and not-for-profit, and different religious affiliations has been a challenge when trying to create uniformity in terms of program development. • The need to train several hundreds of individuals at each institution is challenging for the staff to find appropriate coverage. • The PPS does not have governance authority over the unique organizations. • There are technology challenges including having multiple electronic health record platforms.
Efforts to mitigate challenges identified above:
• We created a Long-term Care Workgroup with representation from all 10 skilled nursing facilities in the project, and all decisions are reached based on a consensus model that has worked well in identifying solutions. • We identified training and education methodologies including having on-site training e.g. INTERACT training and palliative care training (will be discussed in 3.g.ii). The extensive focus on training has helped staff be involved in performance improvement. This has been accomplished by having facility champions who ensure that the train-the-trainer model reaches all staff. • The Long-term Care Workgroup meetings include representation from both of the hospital's emergency departments and ambulatory care departments in addition to all 10 skilled nursing facilities. By having a common improvement methodology through the Certified INTERACT Champion training we are able to advance the DSRIP goals on reducing patient transfers and improving the quality of care within the organizations. • The reporting of project deliverables has been facilitated through the use of project management software, Performance Logic to overcome the varying technology platforms. Additionally, the PPS' electronic data warehouse can feed back registry information and related project deliverables in a common format.

NEW YORK STATE | Department of Health

Implementation approaches that the PPS considers a best practice:

- The use of telemedicine has been instrumental for chronic condition management through optimal utilization of the clinical capabilities at the skilled nursing facility. We have analyzed the results from the first telemedicine pilot which shows a significant reduction in hospital transfers.
- We developed a standardized dashboard of transfer rates which contributes to quality improvement efforts. We are also able to prioritize training based on the top reasons for transfer.
- We developed a standardized nursing home to emergency department transfer form after both emergency departments and all 10 skilled nursing facilities agreed upon the essential data fields to incorporate on the form. All 10 skilled nursing facilities have begun implementation of this form and have increased physician-to-physician communication.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

- The most recent trainings were the Certified INTERACT Champion Training on May 3rd and 4th, 2016, and monthly INTERACT coaching calls from June through August 2016 for all 10 skilled nursing facilities. The Certified INTERACT Champion Training was a training for the leader(s) who will initiate and sustain all INTERACT trainings. The coaching calls were organized for the INTERACT Champions to speak with the instructor about their implementation successes and challenges. All these trainings also allowed for collaboration among Champions from different organizations to gain ideas from each other.
- The next steps will be to ensure the durability of the training by continuing to support the INTERACT Champions and learning from one another's quality improvement findings and action plans. The Long-term Care Workgroup that occurs bimonthly will allow each organization's leadership team to present their primary findings from the quality improvement summaries and what areas they will target to improve care processes. We will also continue the standardized dashboard of transfer rates to drive the quality improvement discussions.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

- There are no changes to populations.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: 2.b.viii

Challenges the PPS has encountered in project implementation:
• Providers have expressed that patients with a managed care plan do not get approval on all the necessary referrals for requested home care services at the start of care. This has caused a gap in care during the hospital to home transition. • Historically, it has been difficult tracking and trending all hospitalizations for the home care agencies' patients due to some patient-initiated emergency department transfers that do not get reported back to the home care agency. • The PPS does not have governance authority over the unique organizations. • There are technology challenges including having multiple electronic health record platforms.
Efforts to mitigate challenges identified above:
• We have introduced each home care agency to the Staten Island Community At-Risk Engagement Services (SI CARES) which helps link patients to the care coordination services needed. We will continue to implement solutions that bridges the gap in the transition process. • We developed a standardized dashboard of transfer rates. This methodology is possible because of our PPS' hospital data feeds and will help us capture the patients who otherwise may have not shown up in the home care agencies' hospitalization database. We are able to give the dashboards to the home care agency and look at the top reasons for transfer to prioritize training. • We have a Home Care Hospital Collaboration Workgroup with representation from all four home care agencies and both hospitals. The leadership members have been engaged in INTERACT training to learn and collaborate together. By having a common improvement methodology through the INTERACT training, we are able to advance the DSRIP goals on reducing patient transfers and improving the quality of care within the organizations. • The reporting of project deliverables has been facilitated through the use of project management software, Performance Logic to overcome the varying technology platforms. Additionally, the PPS' electronic data warehouse can feed back registry information and related project deliverables in a common format.

NEW YORK STATE Department of Health

Implementation approaches that the PPS considers a best practice:

- Implementing a standardized methodology that provides a dashboard of transfer rates to the home care agencies allows us to continually trend data to see performance improvement and also allows us to set data-driven goals.
- On a consistent basis, the organizations utilize the INTERACT quality improvement tools to review hospitalized patients and how they may have prevented the avoidable transfers. The INTERACT quality improvement summary tool aggregates the findings which can then be shared with their internal team and also at the PPS level at the Workgroup meetings.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

- The next steps will be to ensure the durability of the training by continuing to support the INTERACT Champions and learning from one another's quality improvement findings and action plans. The Home Care Hospital Collaboration Workgroup that occurs bimonthly will allow each organization's leadership team to present their primary findings after completing their quality improvement summaries and what areas they will target for improvement.
- We will utilize our data on top reasons for transfer to organize training on chronic care management.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

- There are no changes to populations.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: 2.d.i

Challenges the PPS has encountered in project implementation:
• The PAM survey requires use of Insignia Health's Flourish database. The Flourish database and analytics are insufficient for the data collection required under the project plan is not easily modifiable for DSRIP needs. As a result, we have focused on data quality and need for additional databases to support project implementation. • Because of the higher than expected proportion of survey results being rated as category 3 and 4, highly engaged, Insignia Health considers them as outliers. Insignia Health has raised this concern as a statewide phenomenon based on their national research. • Managed care organizations have yet to share utilization data with us to help us identify the low and non-utilizing Medicaid patients until legal relationships are executed.
Efforts to mitigate challenges identified above:
• We have implemented a quality assurance process to flag data collection errors and allow partners to correct those errors. In addition, we regularly communicate with partners about PAM level distribution and percentages of surveys flagged as outliers. • We have created a separate data collection system for community navigators. • We are participating in Insignia Health's Super User Training to create a more standardized training experience for partners that will hopefully reduce outliers and better align PAM level distribution. • We are beginning to see how the claims database can help us identify low and non-utilizing Medicaid patients. • Staten Island University Hospital is now receiving low and non-utilizer lists from HealthFirst.
Implementation approaches that the PPS considers a best practice:
• As PAM is a tool new to Staten Island, we began the project as a pilot with a small number of partners to better understand issues around survey administration. • In order to reach the large population committed for this project, we engaged the major Medicaid clinical providers, including FQHCs', private physician practices and Health Home on Staten Island. • To create the community navigator program of the project, we contracted with CBOs that already have developed trusted relationships with the underserved communities of Staten Island. These CBOs run programs ranging from day laborers center to food pantry to ESL classes and more. • We have divided our project model into two components: o Outreach: CBO partners who can reach the disengaged, uninsured, etc. in a community setting and help to navigate them to clinical partners. Emergency department partners who

can identify patients who have come in for an avoidable visit and help to navigate them to outpatient partners.
    - In-reach: Clinical partners who have the training and expertise to conduct health coaching, goal setting, etc. with patients for disease self-management.
- Integrated Project 2.d.i with the 2.a.iii Health Home At-Risk project to ensure that CBOs are helping to connect eligible clients to the Health Home At-Risk project and engaging the care management agencies to PAM their clients for Project 2.d.i.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

A monitoring process for those responsible to counsel and engage patients following survey completion is being implemented.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

The PPS committed to surveying 80,000 Medicaid enrollees and uninsured residents by DY4. With 130,000 Medicaid enrollees on Staten Island and an estimated 50,000 uninsured residents, this survey goal is equivalent to approximately 44% of all eligible people. In order to meet that target, the PPS must pursue surveys with Medicaid enrollees outside of the State DOH's low and non-utilizer categories.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: 3.a.i

Challenges the PPS has encountered in project implementation:
Co-location is a new phenomenon for most providers. The requirements for combined licensure requirements, article 28, 31, 857, etc. are complex and billing procedures are limiting factors for service delivery on the same day which is the most effective approach for non-adherent patients. There has also been long wait times for licensure and waiver approvals. • Recruitment of staff for both services is complex and costly. • Screening tool selection and adoption was an initial challenge, depression screening was more readily adopted, and substance use screening has been slower. • Motivational Interviewing training has not been adopted as readily by primary care partners. • The physical space and medical equipment regulatory requirements for providing medical services at behavioral location requires costly renovations. Certain health partners requested a waiver to relocate to a new location. These providers are still in the process of relocating and have experienced some delays.
Efforts to mitigate challenges identified above:
• Partners are informed and participate in State-hosted Integrated Services Webinars to help them understand DSRIP licensure waiver requirements and address their implementation questions • Three of the seven primary care practices applied for and were accepted for the NYC DOHMH Mental Health Service Corps which provides licensed clinical social workers at no cost to support integration. • We are connecting private physician groups with behavioral health partners to arrange for a co-located primary care physician or nurse practitioner • The PPS is launching borough-wide SBIRT training for practitioners. • The PPS is encouraging primary care partners to provide proof of Motivational Interviewing training for staff if they choose not to participate in PPS sponsored training. • SI PPS advocates on partner's behalf when needed to address regulatory issues and accelerate approvals. • SI PPS has allocated funding to support providers who need to acquire medical equipment.
Implementation approaches that the PPS considers a best practice:

- The PPS, along with Borough Hall and the Staten Island Partnership for Community Wellness, hosted an island-wide primary care event to highlight how primary care providers can address the substance use epidemic on Staten Island. Speakers included leadership from NYC DOHMH and CME credits were made available.
- The PPS has recruited medical personnel and facilitated relationships between behavioral and medical providers to create new co-location opportunities.
- We created an interdisciplinary Integration Workgroup that brings together primary care and behavioral health partners every other month to have focused conversations about Project 3.a.i.
- Behavioral health providers work collaboratively to develop an integrated care workflow that can be incorporated into current clinical workflows at each co-located sites.
- SI PPS hosted a successful webinar with the physician integration expert from the State's team for providers to learn more about integration strategies, best practices, and address implementation questions and challenges

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

In its DSRIP application, the PPS committed to co-locating primary care services at 16 behavioral health sites. As a result we partnered with 2 hospitals, 3 mental health clinics and 7 community-based substance use disorder treatment clinics for Model 2. However, the DOH has modified project components to be mental health sites only. We want to ensure that MAPP will capture the important co-location work that we are doing with substance use clinics.

Updates to the Model 2 project requirements distributed in June 2016 indicate that the co-located primary care provider must "practice at least 2 days a week (16 hours) at each of the primary care sites". Several behavioral providers have successfully co-located a 0.2 FTE Physician or NP to date. However, a new 0.4 FTE requirement places a new challenge for such providers and may impact their ability to meet the updated requirement.

Providers have been advised to request for expansion of their current licensure threshold. One provider submitted its application in March 2016 and is still awaiting approval of its DSRIP 3.a.i licensure threshold application.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

Partners and community members have expressed a need for more pediatric mental health services on Staten Island. The PPS is looking to expand co-location to pediatric practices.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: 3.c.i

Challenges the PPS has encountered in project implementation:

- Collecting data on completed A1Cs for patients and identifying the at-risk population is a process unique to each organization. With multiple EMRs' and no initial access to claims data identifying the target population has been a challenge.
- In anticipation of PCMH recognition, many partners have already sent staff to care coordination trainings in the past year.
- The process of building affiliations with Medicaid Managed Care Organizations requires detailed negotiation and legal relationships.

Efforts to mitigate challenges identified above:

- The PPS has developed an at-risk diabetes registry to facilitate identification of at-risk patients and proactive engagement of those patients.
- Access to claims and MAPP data this past June has facilitated improved identification and patient targeting.
- The PPS is requiring partners to submit evidence of past staff care coordination trainings if they choose not to sign up staff for the PPS sponsored trainings.
- The PPS has scheduled each MCO for a second visit to refine relationships to support project implementation.

Implementation approaches that the PPS considers a best practice:

- The PPS identified a CBO that was already running the Stanford Model Chronic Disease Self-Management Program and contracted with them to expand their workshops to other partner locations and launch the Diabetes Self-Management Program. Moving forward, we intend to work with them to facilitate Spanish diabetes workshops.
- The PPS is using registry data to identify cross project service utilization and population health issues.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

- The PPS governance structure limits our ability to create policies and procedures related to clinical practice.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

N/A

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: 3.g.ii

Challenges the PPS has encountered in project implementation:
• Having diverse ownership models within the 10 facilities including for-profit and not-for-profit, and different religious affiliations has been a challenge when trying to create uniformity in terms of program development. • The need to train several hundreds of individuals at each institution is challenging for the staff to find appropriate coverage. • The PPS does not have governance authority over the unique organizations. • There are technology challenges including having multiple electronic health record platforms.

Efforts to mitigate challenges identified above:
• We created a Long-term Care Workgroup with representation from all 10 skilled nursing facilities in the project. All decisions are reached based on a consensus model that has worked well in identifying solutions. • We identified training and education methodologies that have enabled SI PPS to reach over 2,300 trained employees by having on-site training at all 10 skilled nursing facilities. SI PPS contracted with two training partners, Staten Island University Hospital and Visiting Nurse Service of New York. The 37 preferred practices formulated by the Consensus Project and adopted by the National Quality Forum lays the foundation for the training. A Survey Monkey was created utilizing the preferred practices and was completed by all 10 participating facilities. Thereafter, the training leads met with the palliative care teams at the 10 SNFs to have focused interview sessions. Training began with the first module in April 2016. • The reporting of project deliverables has been facilitated through the use of project management software, Performance Logic to overcome the varying technology platforms. Additionally, the PPS' electronic data warehouse can feed back registry information and related project deliverables in a common format.

NEW YORK STATE | Department of Health

Implementation approaches that the PPS considers a best practice:

- By having a common improvement methodology through the palliative care training, we are able to advance the DSRIP goals on reducing patient transfers and improving the quality of care within the organizations.
- The Long-term Care Workgroup meetings include representation from both of the hospital's emergency departments and ambulatory care departments in addition to all 10 skilled nursing facilities.
- We developed a standardized dashboard of transfer rates which contributes to quality improvement efforts. We are able to link reasons for transfer with patients who are, and are not on palliative care.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

- We have trained over 2,300 employees for Module 1 – Intro to Palliative Care, and Module 2 – Pain Management which have all been in-person trainings taking place on-site, and at all three shifts (day, evening, and night).
- The palliative care teams and clinicians will incorporate evidence-based videos part of "The Conversation" application to facilitate advance care planning with patients.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

- There are no changes to populations.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: <Please Select>

Challenges the PPS has encountered in project implementation:

Project 4.b.ii Increase Access to High Quality Chronic Disease Preventative Care & Management

The challenges to the project included:

1. Lack of access to strategic planning data to prioritize health conditions.
2. The wide variety of EHRs used by the providers.
3. The variability of the EHRs inherent ability to help perform population management.
4. Limited available staff in some of the practices.
5. Limited experience of some of the providers and their staff with population management principles.
6. Limited resources of some of the practices.
7. Resistance from many of the long time practicing doctors to change as well as to adding additional screening protocols.

Efforts to mitigate challenges identified above:

1. Implementation of high level analytic at PPS to support planning and performance monitoring.
2. Onsite review of the practices' EHRs and discussions with administrative office staff.
3. Development of customized CPT codes to be used in conjunction with ICD10 codes to permit tracking of diagnoses, procedures and referrals to manage patients using evidence-based guidelines.
4. Review of evidence-based guidelines with practice leaders.
5. Engaging outside practice management educators help practices transition to value based payment using evidence-based guidelines.
6. Partnering with other organizations such as City Harvest to provide Nutritional counseling and healthy food supplies.
7. Partnering with local colleges to create healthy neighborhoods.
8. Partnering with local government agencies to more effectively coordinate existing programs.
9. Creation of educational programs for topics as Substance Abuse, Palliative Medicine etc.
10. Offering Cultural Competency and Health Literacy programs.
11. Offering coordination with Community Based Organizations to help address the social determinants of health.

NEW YORK STATE | Department of Health

Implementation approaches that the PPS considers a best practice:

1. On-site review of the project with the medical and administrative staff.
2. Leveraging pre-existing programs in a more synergistic manner.
3. Facilitating the creation of healthy neighborhoods to ensure sustainability.
4. Hotspotting and Geomapping to analyze population health trends

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

1. Convening an expert panel of 3 to 4 physicians to review evidence based protocols around asthma and obesity and give recommendations to the larger group.

2. I would also add engaging and partnering with office of school health to identify children with uncontrolled asthma and those with BMI over 95th percentile (and potentially signing a data sharing agreement ?)

3. Partnering with CBC for care coordination and encouraging the physicians to refer patients with 1 or more chronic disease to them.

4. Engaging with housing organizations to assess living conditions and triggers for conditions such as asthma as well as with organizations to educate the community on triggers and root causes.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Staten Island Performing Provider System, LLC

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:

SI PPS in collaboration with the project lead, SIPCW, have built the foundation for this project by establishing partnerships, researching evidence based promotion/disorder prevention programs and practices, creating and leveraging resources, and collecting data.

- Initially, the availability of robust patient-level data, particularly on co-occurring behavioral health and physical conditions, to support the project needs and to drive implementation strategies was minimal.
- Prior to DSRIP, multiple community efforts and discussions led by SIPCW (TYSA) were already in progress. Avoiding overlap with these existing efforts and workgroup discussions can be difficult as it involves addressing similar system challenges with the same administrators, clinicians, government partners, and community leaders who participate in the SI PPS projects and committees/workgroups. SI PPS and SIPCW is sensitive to limiting "meeting burn-out" for these groups.
- Determining how best to align this population-level project with the PPS' clinical projects is an ongoing task to ensure that it is not disconnected, but remains collaborative and supported with evidence-base practices.
- While leadership support and buy-in has been abundant among partner organizations, engaging physicians (specifically primary care physicians) and front-line clinicians has been a challenge.
- Strengthening the behavioral health infrastructure requires significant expansion in provider service capacity as well as the development of existing and new workforce.

Efforts to mitigate challenges identified above:

- Access to Medicaid claims data supplemented with data from government agencies, key informant interviews, focus groups, and other sources will enable further analysis and insights to support the project implementation. The SI PPS robust data warehouse and analytics platform is enabling the ability to perform advanced population health management and provide insights to support infrastructure improvements for behavioral health.
- SIPCW and SIPPS are strategically using the existing SIPCW and DSRIP discussion forums to address similar challenges and work efforts, share ideas and work progress, and leverage similar resources in a collaborative manner. Virtual meetings are often being used to bring leaders together and to encourage meeting participation and continuous engagement.
- Government representatives have been engaged in Steering Committee and Workgroup meetings to assist with communicating up to date implementation progress and available resources that SI PPS can leverage. In addition, an inventory of existing and new government initiatives and resources was developed and is being maintained on a regular basis.

- SIPCW staff have been included in workgroups focused on the clinical projects. In addition, BHIP efforts are presented during clinical workgroup discussions as needed.
- SI PPS and SIPCW continue to engage physicians and other clinicians in workgroup efforts through frequent communications, educational events such as the July 19th Island-wide Primary Care Event, and other methods. Physicians are also being engaged as advisors to specific workgroups such as the "Moving Toward Collaborative Care" workgroup.
- SI PPS and SIPCW are exploring and implementing more opportunities to provide trainings to both behavioral health and primary care providers to better serve the mental health and substance use disorder populations. Some providers have increased their current capacity to provide services and meet additional demand in the community, while others are exploring their ability to increase capacity. A significant focus has been placed on increasing peer support services in both clinical and community settings in the form of a new workforce. As a result, efforts are underway to recruit certified peer counselors and to establish a Peer Counselor Training and Development Program.

Implementation approaches that the PPS considers a best practice:

- Utilizing a collective impact model approach, reaching consensus on a common language to ensure that all stakeholders understand the terms used within our discussions, creating multi-disciplinary Committees and Workgroups that brings treatment providers, hospitals, community-based organizations, mental health advocates, consumers, and representation from local government agencies to tackle specific behavioral health related initiatives. Workgroups include: Warm Handoff Pilot Workgroup, Moving [Primary Care Providers] Toward Collaborative Care Workgroup, Behavioral Health Detailing Workgroup, Community Education/Media Messaging Workgroup, and Data Workgroup.
- Developing the Withdrawal Management Warm Handoff Pilot initiative, which is part of the wider effort to reduce hospital inpatient admissions, future ED visits, and increase access to outpatient 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 counselors 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.
- Engaging recipients of care, persons in recovery, peers, advocates and families through focus groups to share experiences and feedback on project efforts and strategies.
- The PPS, along with Borough Hall and the Staten Island Partnership for Community Wellness, hosted an island-wide primary care event to highlight how primary care providers can address the substance use epidemic on Staten Island. Speakers included leadership from NYC DOHMH and CME credits were made available.
- Aligning and leveraging community, local/state government resources to support project efforts, for example, Mental Health Corps and Primary Care Information Project (PCIP).
- Utilizing evidence based or research informed practices
- Utilizing data to track outcomes and generate insights to support ongoing and future project efforts

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

- In order to better understand the mental, emotional, and behavioral health (MEB) issues on Staten Island, services available, and barriers to care as well as to identify gaps and guide our workgroups and initiatives, Key Informant Interviews (KIIs) and focus groups were. The KIIs included behavioral health and primary care providers. The focus groups were held with consumers and support networks.
- During the first BHIP steering committee, members participated in a "data walk through" that included Medicaid hot spot maps, community and provider needs assessment, community health profiles, the KIIs and focus group data. The data walk through allowed the stakeholders to get a picture of the behavioral health issues on Staten Island.
- A behavioral health provider directory was developed to assist health professionals and community residents know where treatment and prevention services are available.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

This project initially targeted the Medicaid population. However, through key informant Interviews and focus groups we conducted, we learned that those with private/commercial insurance face similar barriers to care. Therefore, the Steering Committee recommended inclusion of all those with substance use disorder (SUD) and mental health illness, regardless of their insurance or lack of insurance.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting
the overall organizational efforts to date.

PPS Name: <Please Select>

Highlights and successes of the efforts:
On March 31, 2016 the Staten Island PPS completed its first year of operations. The summary that follows describes our successful approach to implementing the 11 DSRIP projects and 7 work streams. Perhaps as important have been the results in building an extraordinary inclusive network of committed providers and community based organizations needed to achieve the necessary transformation to redesign healthcare. Impacting the care and quality of services for nearly 180,000 individuals in our community is an incredible responsibility. To make the changes required without governance authority or direct operations controls requires a collaborative engagement of individuals motivated primarily by the desire to transform the healthcare landscape and in so doing improve our community health outcomes. Without question SI PPS has been a leader in several critical areas amongst all of the PPS state-wide. In Health Information Technology and Analytics, Workforce, Health Literacy and Cultural Competency and Community Based Organization (CBO) development we have been able to provide direction and create a path forward amid significant complexity. Our collaborative style has resulted in the PPS sponsoring Workforce Symposium attended by 8 PPS from around the region, leading the CC/HL breakout sessions at the State-wide learning session in NYC and Rochester and conducting a DOH Webinar on SI PPS' Health IT and Analytics platform. From the standpoint of project implementation, our partners from the largest hospitals to the most modest sized community based organizations have contributed to training, clinical practice development, standard setting and revisions of long standing practices that have improved access and clinical quality. The PPS has been successful from the actively engage standpoint. After a miss in the DY1, Q2 requirement for 2.a.iii the PPS has met all targets up to an including DY2 Q1 tallies. By reaching out to new partner groups through the innovative Population Health Improvement Program in adult, pediatric and behavioral health practices, the local voluntary physicians have been brought into the improvement orbit. For many it is the first exposure to value based payment, deploying advanced population health technology and electronic evidence based standard adoption. Co-location has been jump started in a number of partner sites especially the behavioral locations with PPS support for recruitment and practice expansion. Our innovation has also led to the deployment of telemedicine in nursing homes and developmental disabilities residences, a first for Staten Island and New York State. Our results are encouraging and lead us

to believe that state-wide adoption of this approach could save tens of millions of dollars in avoidable hospital utilization. Further innovative strategies include the development of a pilot program tentatively proposed for deployment in the Fall of 2016 with EMS and the behavioral health agencies of NYS and NYC. By providing targeted intervention to high utilizing 911 callers and redirecting services to more appropriate settings, resources can be more appropriately utilized and outcomes can be improved by better care coordination.

In palliative care we are providing all nursing home partners web based videos that introduce patients to advanced care planning and Palliative Care concepts in 14 different languages. Coupled with Interact education, palliative clinical training for staff and medical personnel, we believe palliative care will find an expanded place in nursing home services. Finally, realizing that there was a huge gap in language access services, the PPS has created a medical interpreter training program for employees at partner sites, which has been augmented by video remote interpreting and translation vendor services.

All of the above would not be sustainable if our workforce was not changing with the transformation that the system is undergoing. The PPS has partnered with the 1199 Training and Education Fund to create DSRIP 101 and VBP 101, the College of Staten Island to create a Community Health Worker program and numerous CBO's to engage staff and leadership throughout the PPS in forming a core understanding of culturally competent and health literate care required in the new health delivery paradigm.

The following narrative will provide an in-depth review of the organizational efforts that have been implemented with some view toward future direction.