NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Welcome to the 2016 DSRIP Learning Symposium

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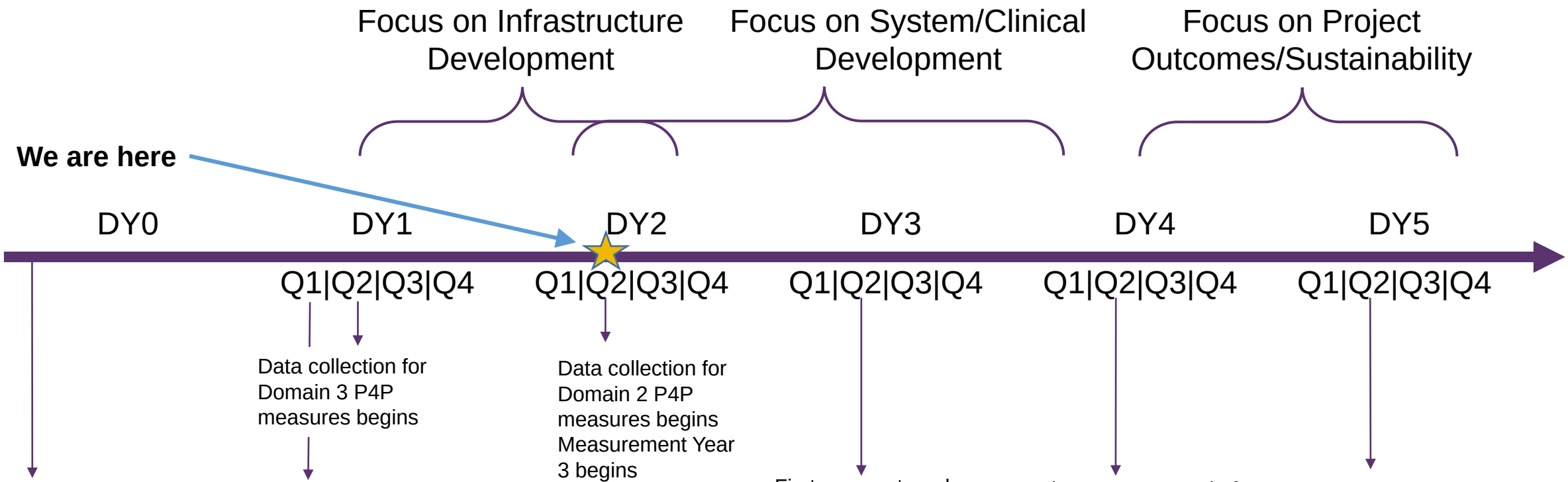
#NYDSRIPLS

September 20, 2016

Overview

- Current state of DSRIP
- Importance of Demonstration Year 3
- Collective success
- MAX series
- PPS roll call

Where are we now?



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DSRIP Year 2: How are PPS performing so far?

PPSs have earned 99.4% of all available funds to date!

$1.2B Total!

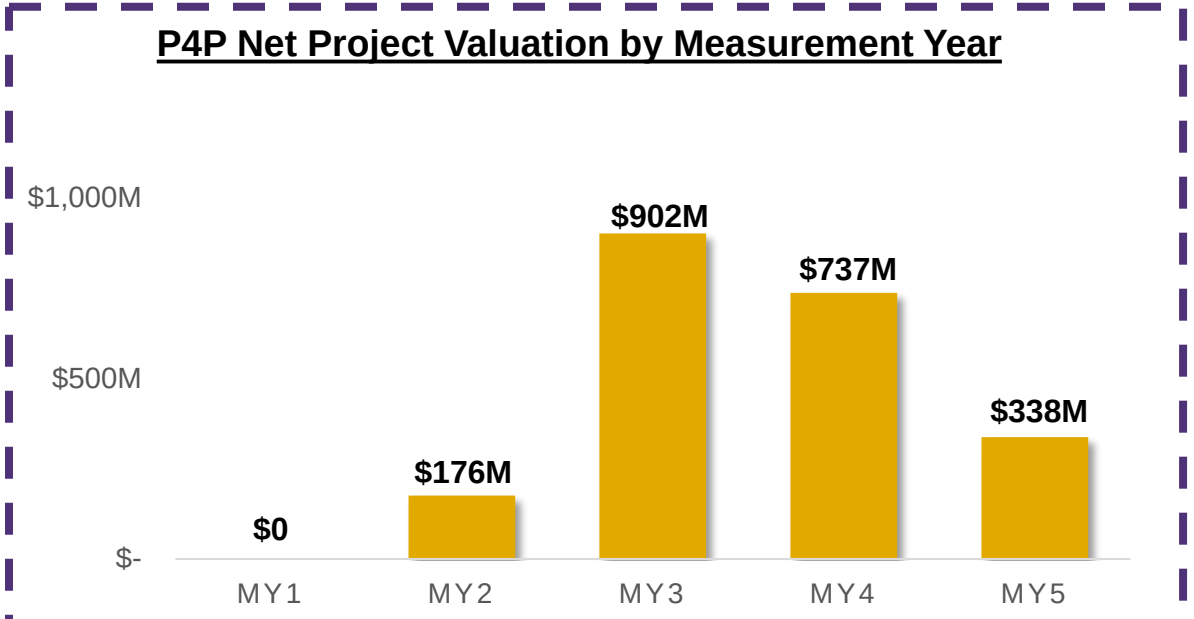
There is more work to do!

Where are we going?

☑ Pay for Reporting ☐ Pay for Performance

Measurement Year 3 (MY3) results = $902M in net project valuation

- MY3 P4P payments are split between payments in Demonstration Year 3 (DY3) (payment 2 - $502M) and DY4 (payment 1 - $400M).
- This represents **42%** of all P4P dollars available through the five years of DSRIP.



NY is a leading example of large system change

We have delegates here today from:

Virginia
Washington
The Netherlands
National Governors Association
Centers for Medicare and Medicaid Services
Office of Management and Budget

DSRIP is challenging normative models, leveraging what we know and boldly exploring what we don't, to redefine the healthcare delivery system.

A Collective Approach to Redesign

DSRIP is a coming together of people, places and services designed to change one of the largest systems in the world for maximum impact on population health and beyond.

The Five Conditions of Collective Success

Source: Stanford Social Innovation Review: http://ssir.org/articles/entry/collective_impact

1. Common Agenda

"Collective impact requires all participants to have a shared vision for change, one that includes a common understanding of the problem and a joint approach to solving it through agreed upon actions."

- Triple Aim: Better health, better care, lower costs
- Reducing avoidable hospital use by 25%
- Value vs. Volume

Source: Stanford Social Innovation Review: http://ssir.org/articles/entry/collective_impact

2. Shared Measurement Systems

"Collecting data and measuring results consistently on a short list of indicators at the community level and across all participating organizations not only ensures that all efforts remain aligned, it also enables the participants to hold each other accountable and learn from each other's successes and failures."

Performance Measures and Milestones

Outcomes in the Bronx matter in Buffalo

Embrace partner goals

Source: Stanford Social Innovation Review: http://ssir.org/articles/entry/collective_impact

3. Mutually Reinforcing Activities

“The power of collective action comes not from the sheer number of participants or the uniformity of their efforts, but from the coordination of their differentiated activities through a mutually reinforcing plan of action.”

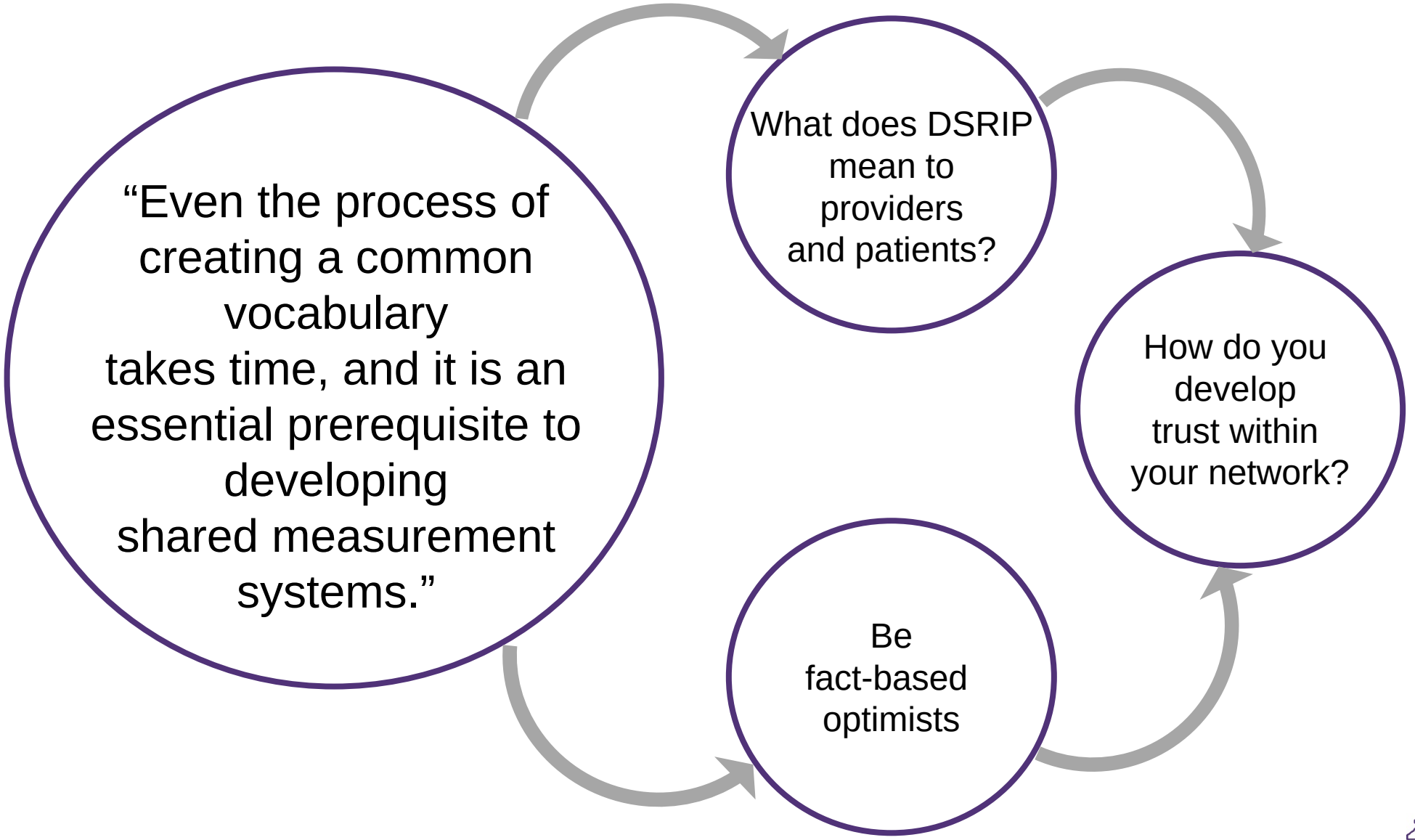
Collaborate-make healthcare a team sport

Shared governance-we are all in this together

Get involved with MAX

Source: Stanford Social Innovation Review: http://ssir.org/articles/entry/collective_impact

4. Continuous Communication



Source: Stanford Social Innovation Review: http://ssir.org/articles/entry/collective_impact

5. Backbone Support Organizations

"Creating and managing collective impact requires a separate organization and staff with a very specific set of skills to serve as the backbone for the entire initiative. Coordination takes time, and none of the participating organizations has any to spare."

PPS are the Backbone of DSRIP

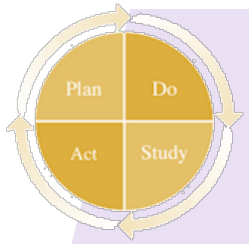
Backbone to PPS are executive offices and project management offices

Do not under resource the backbone

Source: Stanford Social Innovation Review: http://ssir.org/articles/entry/collective_impact

MAX – Next Steps

Opportunities for continued learning



Additional MAX Series

Rapid Cycle Continuous Improvement program designed to put **clinicians in the lead** to redesign the way care is delivered in support of the DSRIP goal

20 Action Teams,
representing approximately **200 Clinicians and Administrators**
will have the opportunity to participate in one of 2 Series

Series will focus on "**Targeting Avoidable Readmissions for High Utilizers**"

Program begins in **November 2016**

RECRUITING TEAMS NOW!

Of those who previously participated in a MAX series, on average across all three topics, 97% would recommend the program to their colleagues.

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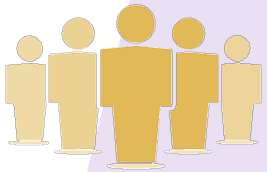
Opportunities for continued learning



MAX Train-the Trainer

Training program to **develop facilitators** within the Rapid Cycle Continuous Improvement Workshops and program; to enable them to **scale and sustain process improvement work throughout the system**

Up to **40 Participants**
from across all **25 PPSs**, as well as, provider sites and other organizations will have the opportunity to participate in the program

Program begins in **November 2016**

RECRUITING PARTICIPANTS NOW!

PPS Roll Call!

Primary Care Transformation

- All PCPs are utilizing certified EHR technology, are connected with local health information exchange and actively sharing health information among clinical partners
- 24% of practices will be submitting PCMH 2014 applications to NCQA by the end of DY2 Q2 and technical assistance is deployed to assist remaining practices achieve PCMH 2014 Level 3 by the end of DY3

ADVOCATE COMMUNITY PROVIDERS

Engaging community partners

- Trained and deployed 21 Community Health Workers (CHWs) and 2 CHW Supervisors across Bronx, Brooklyn, Manhattan, Queens
- Executed contracts with CBOs for a total of $250,000
- Conducted 12 community events with ~1,000 participants in Morrisania in the Bronx, the state's "sickest" community district
- Completed partnership agreements with 9 schools

Albany Medical Center

Law Enforcement Assisted Diversion (LEAD)

- PPS and Albany City Police initiative - divert individuals with mental illness, drug dependence, homelessness
- Reduce low level arrests and recidivism
- Officers given discretion to refer individuals to a case manager rather than jail; Case managers assist accessing network of needed services
- Anticipated healthcare costs will be reduced and/ or patient engagement will be increased
- Pilot program underway through the Katal Center for Health, Equity, and Justice, with case management provided by Catholic Charities

ALLIANCE for Better Health Care, LLC

Training and transforming the workforce

- To address workforce gaps for the delivery of home-based services, has contracted with Kettering National Seminars to offer Asthma Educator Examination Prep Courses
- A total of 33 licensed professionals representing partners, aligned CBO's and adjoining PPS recently completed course

BRONX HEALTH ACCESS

Connecting Providers

- 65% of key network partners are linked to RHIO
- Resources are allocated to develop system-wide reports to identify and link eligible patients with Health Homes and improve communication with PCPs around ED/IP admissions and missing services

BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

Implementing Community Health Programs

- Recognizing they know the community, speak the language, and have a strong track record of service delivery, have contracted with a.i.r. Bronx for the delivery of home-base asthma services

- Resourcing Health People Community Preventative Health Institute to deliver Diabetes Self-Management Program, offering classes for 600-800 students from community hot spots delivered by coaches recruited from the community

CARE COMPASS NETWORK

Integration of Primary and Behavioral Health

- 899/1019 PHQ-9 screenings completed of 1019 offered over 5 months (88%)
- 67 of 134 PHQ-9 screens scoring >15 referred to on-site BHC (50%)
- 78 patients with a PHQ-9 score of 15 higher received follow-up with BHC on-site
- Expanding program to include SBIRT in July 2016.

CNY CARE COLLABORATIVE

Integrating Behavioral Health Services into Primary Care Setting

- Over 40 contracted partner organizations participating in project
- Development of framework for workflows
- Relationship facilitation between PCPs and BH providers
- Development of Standards of Care protocol
  - Screenings for Substance Abuse and Depression
  - Focus on obesity, diabetes, cardiovascular disease
- **Approximately 14,000 actively engaged patients to-date**

COMMUNITY CARE OF BROOKLYN

Engagement of HH and CMAs

- Brooklyn Health Home and CBC Health Home active participants in CCB governance committees and key workgroups
- Agreements with 5 Care Management Agencies providing on-site support at network hospitals
- Expanded use of Health Home care management / care coordination systems and processes to support care transitions, Health Home at Risk and PCMH+ initiatives

COMMUNITY PARTNERS OF WNY

Performing Provider System

Telemedicine Expansion

- Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services
- Partnering with Women and Children Hospital to contract with a third party vendor Specialist on Call (SOC).
- Clinical areas of focus have been inpatient neurology, outpatient neurology, and acute critical care.
- Additional pilot programs under development for additional use of telemedicine component.

FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

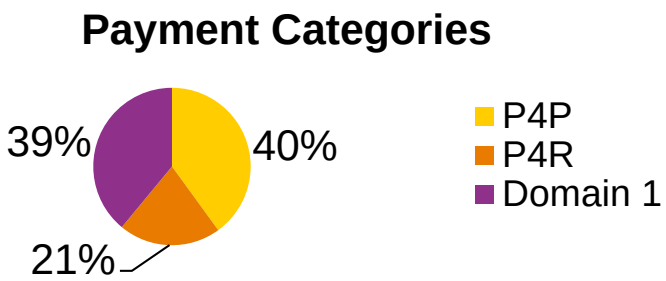
Transitional Housing Support

- Implementing an innovative partnership to address social determinants of health by providing a transitional housing solution.
- DePaul Community Services (CBO) dedicates psychiatric and medical step-down beds for
  Rochester Regional Health and UR Medicine.
  - **80%** Psychiatric Patients Transition to Permanent Housing
  - **61%** Medical Patients Transition to Permanent Housing
  - **30x** Cost Savings to Medicaid
- Improved Quality of Life and Health Outcomes

Leatherstocking Collaborative Health Partners

Accomplishments:

- Assigned metric “ownership” to individual leaders.
- Educated partners on P4P impacts and the potential to lose AVs if performance goals are missed
- Development of multiple P4P summaries and education tools
- Business Intelligence dashboard development based on EMR data for real-time performance.



Millennium
COLLABORATIVE CARE

Maternal and Child Health

- Community Health Workers outreaching to, knocking on doors, and connecting with our community around health screening and preventive care
- Paraprofessional within the healthcare team with standardized screening tools and the ability to assist in the community addressing social determinants of health.
- More than 600 mothers and mothers to be engaged and being following through pregnancy and the first 2 years of child's life

Montefiore HUDSON VALLEY COLLABORATIVE

Addressing Community Needs

- St. Luke's Cornwall Hospital identified that food insecurity is a pressing issue faced by large number of their high utilizer patient population.
- As a result of the MAX program, the Action Team has began collaborating with a local food agency to install a food pantry in the hospital.
- Now providing healthy food to food insecure patients and reducing unnecessary utilization of the emergency department.

Mount Sinai

Defining value among CBO partners

- Developed a clinical values scorecard to identify potential contributions of CBOs using industry benchmarks for their provider type.
- Using the results to:
  - Define pilot project participants
  - Identify effective ways to contract with CBOs
  - Drive integration of CBOs into value based payment arrangements

Patient Activation

- Successful outreach to more than 2,000 uninsured individuals with the PAM® survey
- Health systems partnered with CBOs to conduct outreach, surveys, and coaching
- Surveys were collected in Emergency Departments and Hospital-based clinics

NYC HEALTH+ HOSPITALS | ONECITY HEALTH

Patient Activation

- 35 community partners contracted
- 17 facilities* engaged
- 716 partners trainings in PAM® survey administration
- 44,608 PAM® surveys administered
- 471 connected to Primary Care
- 359 connected to insurance

NewYork-Presbyterian
Performing Provider System

Care transitions intervention model to reduce 30-day readmissions for chronic health conditions

- Hired 8 RN Transitional Care Managers, developed evidenced based protocol to standardize the level of care for over 500 patients engaged
- Established contracts with 3 CBOs, on-boarded 6 CHWs for home and follow-up appointment visit accompaniment

NewYork-Presbyterian Queens

Connecting Providers

- Brightpoint Health serves a predominately homeless patient population with almost half of their patients presenting from nearby shelters.

- Through the MAX Program, Brightpoint Health has created an integrated care team including Health Homes as an active member to better connect and engage with their patient population directly in the shelter.

NYU Lutheran
NYU LANGONE HEALTH SYSTEM

Integrating Behavioral Health and Primary Care for patients with diabetes

- PHQ 2 screening increased from 28% to 89% among 230 patients
- Improved warm handoff from ED to health center services
- Implemented a “Prescription for Health” personalized diet and exercise plan into the EHR
- Pilot will be expanded to other sites

Collaborating with Higher Education

- Provider Incentive Programs
    - Approximately $3 million for recruitment of 11 PCPs, 3 Nurse Practitioners, 2 Physician Assistants, 2 Psychologists, 2 Psychiatrists and 2 Dentists; Licensed Clinical Social Worker & Certified Diabetes Educator
- Regional Expansion of Graduate Medical Education providing financial support of residency spots at local GME Program, rotations at regional sites, minimum 3 year commitment to work in region

RCHC
REFUAH COMMUNITY HEALTH COLLABORATIVE

Integration of mental and physical health care

- The child psychiatry waiting list at Refuah Health Center has plummeted: from 66 patients to 15 patients, from 8 months for a new evaluation to 4 weeks for a new evaluation
- PCPs trained and empowered to treat and manage mental health conditions
- Social Workers offer immediate mental health evaluations and streamlined crisis management

Staten Island Performing Provider System

Telemedicine Expansion

- Focused on nursing home, disability and aging-in-place populations
- Perform medical evaluations via videoconferencing for patients, providing Weekend Coverage
- 65% improvement in Patient Transfer Rate in 2nd month of pilot
- Transfer rate per 1000 decreased from 2.53 to 1.53 and continued to 1.41 in the 3rd month

Suffolk Care Collaborative

SCC Care Management Organization is operational

- Embedded in 4 PCP practices with plans to support 40 within 6 months
- Providing TOC services to 1 hospital with plans to support 5 within 6 months
- Goal to enhance patient self-care abilities, improve access to community resources and cut avoidable admissions through population health management

WMC Health | Performing Provider System (PPS)
Westchester Medical Center Health Network

Regional Population Health Promotion
Through the Hudson River DSRIP Public Health Council, in collaboration with MHVC PPS and RCHC PPS:

- Collaborating with 45+ government agencies and CBOs on Tobacco Cessation(4.b.i) and Cancer Screening (4.b.ii) public health projects.
- Adopted NYS Prevention Agenda's cancer screen rates as benchmark
- Launched timely anti-vaping campaign aimed at high school students—way ahead of new FDA ban (8/8/2016) on e-cigarette and vaping sales to those under 18.
- Distributed over 5,000 posters in high schools throughout the Hudson Valley.

Continue to drive change through learning

Over the next three days:

Keynotes:

- How does DSRIP fit into other national and international efforts to reform healthcare
- What has been learned from MAX
- How to facilitate large-scale system change

Plenaries:

- How are partners implementing VBP
- How is change happening at the practice level
- How is transformation aided by performance measurement
- Preparing community based organizations for DSRIP

Breakouts:

- Innovative care delivery designs
- The nature of evolving DSRIP partnerships
- Successfully engaging patients

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Keys to Success at the Learning Symposium

- **Look around the room-commit to talking to colleagues you have not met yet**
- **Share your ideas and feedback, ask questions**
- **Make connections to collaborate in the future**

One more thing…

Day 2 guest speaker is…

Bruce Mau

from the The Massive Change Network!

Questions?

Additional information available at:

https://www.health.ny.gov/mrt

https://www.health.ny.gov/dsrip

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DSRIP@health.ny.gov

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