Delivery System Reform Incentive Payment Program (DSRIP) Whiteboard Video- "Best Practices in DSRIP Year 3" – Companion Document

This document provides examples of innovations and best practices currently happening throughout all 25 Performing Provider Systems (PPS). It is not intended to be a comprehensive collection of such examples. PPS websites and newsletters are additional sources.

To view more information about each PPS click here, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/index.htm.

1. Establish an Innovation Fund

Adirondack Health Institute

- $3.9 million RFP awards to 10 partner organizations, funding 14 innovative projects
- 2 of these awards to Tier 1 CBO partners
    - Citizen Advocates
        - Project "inSHAPE": Health promotion and coaching interventions in the areas of nutrition, fitness, social inclusion, and community engagement, targeting those with serious mental illness and high-risk health metrics
    - The Open Door Mission
        - Pathway Home Project: Expand the organization's new location to include a training room, day room, resource and learning center, and health clinic to impact social determinants of health in the community

Millennium Collaborative Care

- MCC contracts with multiple CBOs through an RFP process.
    - Maternal and Child Health: Engaged with several CBO partners including Buffalo Prenatal Perinatal Network, Jericho Road, Southern Tier Community Health Center and Niagara Falls Memorial Medical Center Health Home
    - Patient Activation: The National Witness Project, Planned Parenthood, Healthy Community Alliance, Greater Buffalo United Healthcare Network, Niagara Falls Memorial Medical Center Health Home
    - CCHL: Through RFP process, MCC has funded the Erie Niagara Area Health Education Center (ENAHEC), Inc to conduct cultural competency and health literacy trainings

Care Compass Network

- Significant PPS investment in Innovation Fund, administered via RFP
- $4 million awarded to date, with another $2 million RFP to be issued November 2017
- 17 partner RFPs funded to date, including:
    - Mobility Management of Southern NY: $225K awarded to implement transportation tool kit and voucher program, as well as to expand the GetThere Call Center hours and services
    - Fruit and Vegetable Prescription Program (Rural Health Network): $125K to implement a FVRx program to increase knowledge, skills and behaviors around health food consumption

- Alcohol and Drug Council of Tompkins County: $500K grant to support the development of a stabilization center

The New York and Presbyterian Hospital

- First RFP about to be awarded
- Final details under negotiation, award will be up to $300K
- Project to provide high-risk care management to NYP/Milstein campus

Central New York Care Collaborative

- CNYCC initiated and awarded several RFPs
  - Behavioral Health Crisis Stabilization Services Expansion
    - Funded programs include community-based mobile crisis and peer respite services
  - Collaborations for Health
  - Centering Pregnancy Education Programs
  - Third Party Proposal Review

Montefiore Hudson Valley Collaborative

- Recently launched Innovation Fund $1.2m for partners and 850k for Tier 1 CBO
  - 34 Letters of interest received, 20 invited to send in proposals and contracts to be executed in September 2017
  - Priority given to applications demonstrating multidisciplinary and cross-partner coordination that impact high priority metrics
- RFP to target CBOs and enhance collaboration throughout partner network and support healthier communities in Hudson Valley
- MHVC will empower CBOs by providing resources to assess infrastructure needs, linkages to clinical partners and the integrated network through NYAPRS
- MHVC will also support CBO sustainability post-DSRIP by providing technical assistance to CBOs in applying for RFPs and identifying future funding opportunities, among other efforts

Bronx Partners for Healthy Communities

- First round of RFP in process with funding recommendations to be made in September 2017
  - BPHC created an Innovations Proposal Review Workgroup to review the 88 submissions received from 34 partner organizations
- Budgeted $5.7M for DY3, up to $250K per project
- Five funding focus areas
  - IT Innovations in Care Delivery, Patient Engagement and Education:
  - Change Management and Performance Improvement:
  - Partnerships and Communications
  - Finance and Payment Innovations
  - Social Determinants of Healthcare Access and Utilization

Bronx Health Access

- Set aside $1M for a “CBO RFP Grant Program”
- 5 CBOs have been awarded to date with one additional pending
- RFP will remain open until $1M allocated

- Grants require progress reporting to PPS, which is intended to assist CBOs prepare for VBP

Finger Lakes Performing Provider System

- $2.5 million Innovation Fund launched DY3; awards to be distributed November 2017
- RFP for 12 months to support partners in moving outcomes during DSRIP and beyond
- Targeting Tier 1 CBOs with minimum $3M operating budget who can demonstrate ability to impact high priority metrics
- Selected CBOs will be paired with an organizational development consultant to support VBP transition

Nassau Queens PPS

- Recently launched $265,000 Innovation Fund to engage up to 27 Tier 1 CBOs by end of DY3
- Will not be soliciting RFPs, but using the Fund as part of its contracting strategy to accelerate funds flow to Tier 1 CBOs
    - Contracted CBOs will receive a total of $20K over 6 months
- CBOs will conduct community forums, receive/make referrals, attend trainings, and report on project activities
- Additional funding may be made available in the future for enhanced services

2. Adopt Best Practices with Data

Alliance for Better Health Care

Alliance is now able to help providers pinpoint which patients under their care are most in need of intervention to address specific population health concerns, defined by the Department of Health (DOH) performance measures.

By comparing a list of Medicaid patients under the care of a provider with performance data Alliance accesses through various DOH sources as part of DSRIP, Alliance is able to help providers identify which of their patients are most in need of outreach. For example, Alliance can show a provider which of her patients have not had their asthma control medication prescription filled in 6 months, a clear indicator that the patient may not be managing his asthma as effectively as the provider would like.

This kind of data is available across all performance measures, showing which patients do not yet qualify as having met the specific measurement as defined by DOH. With this insight, providers can plan how to best reach their patients who need their care the most and how to maximize their impact on the health of the community.

Community Partners of Western New York

Community Partners of Western New York (CPWNY) has worked closely with providers, community-based organizations, and local governments to implement two programs designed to positively impact families, newborns, and expectant mothers. In partnership with Chautauqua County, CPWNY has implemented the Nurse-Family Partnership (NFP) program. Currently, upwards of 60 families are enrolled into this evidence-based program that provides in-home care and support to current and expectant mothers. CPWNY recently hired two additional nurses, and is working to expand the reach of the program to upwards of 100 families.

In addition to the NFP, CPWNY is partnering with the Buffalo Urban League to implement a Prenatal Community Health Worker program in Erie County. This program aims to improve coordination of care in the Catholic Health clinics. Currently, five Community Health Workers (CHWs) are working in the community, based out of five different clinics. CPWNY is looking to expand this program and recruit additional CHWs. Although the program currently targets the prenatal population, CPWNY hopes to expand into pediatrics and behavioral health.

The New York and Presbyterian Hospital

Using what they learned in the MAX series about rapid cycle improvement, the team at New York Presbyterian held an Emergency Department Improvement Retreat to discuss opportunities to reduce potentially avoidable ED utilization across the continuum of care. The retreat was the culmination of a three-month discovery process, led by a workgroup inclusive of project managers, clinical leads, and PPS collaborators, including Tier 1 CBOs. Four main themes emerged: Access to care, Communication between providers and patients, Care Coordination, and Specific Diagnoses/Social Determinant Needs of high utilizers. The retreat resulted in several actionable plans and initiatives, including embedding CBOs in ED to provide on-site and post-discharge services, distributing cellphones to high-risk patients in order to be able to engage and connect them with care and a pilot to embrace patient with high utilization who suffer from substance use disorders, primarily alcohol, and capture them into treatment options

Staten Island Performing Provider System

From the start of DSRIP, SIPPS has been leading the way utilizing real time data and incorporating it, along with all other available data sources, into its population health platform and sharing these aggregate data transparently via the SIPPS website. Of particular note, is the launch of its drug prevention dashboard, a dynamic, user-driven dashboard accessed via a public website that allows individuals, families, community members and professionals centralized access to real time data and resources in response to this crisis.

Care Compass Network

While awaiting completion of its third-party population health platform, Care Compass is using what's available today in MAPP and Salient, along with information regarding low and non-utilizers to analyze primary care access and project expansion needs. The PPS is doing this to ensure that when these patients are activated and engaged they will have adequate capacity at primary care practices across the PPS network to accommodate the increased load. This is a great example of not waiting for the perfect pop health strategy and working with what you have now to improve performance.

Community Care of Brooklyn

Community Care of Brooklyn regularly uses SIM data provided by the Department, CCB tracks the PPS and its partners' performance through their own internal system. The system is based on schedules arranged between the PPS and its partners. Schedules are developed to help CCB achieve its gap to goal at the partner level, therefore affecting the entire PPS. As part of agreeing to the schedule, partners report on a subset of measures monthly. The subset of measures is determined by CCB based on the partners' patient population and PPS goals. To support its partners, CCB developed reference guides that indicate key activities the partner

should be completing to meet its goals. In addition, a member of the PPS team visits smaller "mom and pop" PCPs onsite to support the efforts detailed in their schedules. Partners receive quarterly scorecards based on their performance. Bonus payments based on individual and PPS performance are available at the end of the schedule period.

NYU Langone Brooklyn PPS

In order to successfully close Measurement Year 3, NYU Langone Brooklyn PPS did a form of what has been coined "sprint to the finish". Towards the end of MY3, the PPS could share specific patient information with partners. NYU Langone had their two biggest partners start closing specific, prioritized gaps (i.e. behavioral health measures), and one of their partners successfully identified about 90% of patients with prioritized gaps in care.

Advocate Community Providers

Advocate Community Providers (ACP) is partnering with Arcadia Healthcare Solutions, which will enable ACP to aggregate clinical data from hundreds of sources and create a comprehensive picture of patients' health. Arcadia will help ACP gain a holistic understanding of the health of the 650,000 Medicaid beneficiaries under the care of the network's 2,000 neighborhood physicians in the Bronx, Manhattan, Brooklyn, and Queens. ACP will launch Arcadia Analytics in three key practices throughout New York City: Academy Medical Care, Pediatrics 2000, and AW Medical Office. These practices were selected for their close working relationship with ACP and will serve as model analytic baselines for the rest of ACP's providers.

With the capacity to gather data from multiple sources – more than 500 electronic health records, as well as DSRIP insurance claims – Arcadia Analytics will support the shift to VBP by generating a comprehensive picture of a patient's health and enabling physicians to make better informed diagnoses, coordinate care across specialties, close care gaps, and ensure adherence to medication and care plans. Arcadia Analytics also will provide ACP with sophisticated data visualization tools to better understand medical expenses and utilization, including cost trends, cost variability, and in-and-out of network referral patterns.

New York Presbyterian/Queens:

NYPQ has both taken a high-level population view as well as a patient-centered approach to data at the PPS. One of their early clinical integration projects that yielded strong results was to conduct a root cause analysis of every patient who was transferred from a SNF to the hospital. This multidisciplinary review identified factors that were incorporated into the model for improvement. One outcome was the development of new warm handoff procedures to improve hospital-SNF communication and reduce avoidable ED visits and readmissions. In addition, NYPQ PPS is now highly integrated with hospital QI and sharing PPS population health resources to identify high utilizers in the ED.

Suffolk Care Collaborative

SCC has ramped up its efforts to include performance metrics in its partner contracts this DY. To do this, they are replicating the metric algorithms and utilizing real time provider data as much as possible. They are now focusing on the behavioral health algorithms and getting under the covers of the attribution logic and rate codes being used to assign behavioral health patients. SCC is working closely with the DOH team and 3M to complete this modeling and will

be incorporating findings into P4P payments to downstream providers. This focus on performance and using real time data in its population health platform will help the PPS and providers achieve improvement targets.

3. Address the Social Determinants of Health at Individual and Community Levels

Mount Sinai PPS

Mount Sinai St. Luke's is implementing three pilots of a social determinants of health screening. The pilots will target inpatients in the trauma service, patients with a diagnosis of sickle cell disease presenting in clinic or the inpatient service, and patients with a diagnosis of congestive heart failure. The screening tool was derived from best-practice and guidelines by the Mount Sinai PPS is being customized for each service with feedback from clinical leaders in each area. Screeners will use NowPow within the Community Gateway to address positive screens, incorporating this work into their clinical care. Mount Sinai St. Luke's aims to incorporate Z codes from positive screens in our EMR to help us further understand the role social determinants play in population health risk stratification and care management.

Montefiore Hudson Valley Collaborative

The boundaries of Montefiore doctor-patient conversations are expanding from the territory of "What's the matter?" into the region of "What matters to you?" according to Damara Gutnick, MD, Medical Director, Montefiore Hudson Valley Collaborative (MHVC). On June 6, MHVC participated in the international What Matters To You Day, an initiative introduced by the Institute for Healthcare Improvement in 2012. "By asking patients about what is important to them and listening to what they say, we can learn from our patients and design care plans that incorporate their goals and priorities, which are more likely to be followed," says Dr. Gutnick. "If we can show patients that we care and we're aware, that builds stronger partnerships, and improves outcomes." Dr. Gutnick hopes that every clinician will adopt this approach to uncover underlying factors that may interfere with a patient's plan of care, and to identify essential support services that may be beneficial.

Finger Lakes Performing Provider System

FLPPS and the Rochester-Monroe Anti-Poverty Initiative (RMAPI) are working together with United Way of Greater Rochester, Common Ground Health and a diverse network of committed providers to build an interconnected, person-centered system of health and human services, powered by a single information platform, to improve the health and economic prosperity of individuals and families living in poverty.

Given the common agenda and shared target population between two state-sponsored initiatives: DSRIP and ESPRI, a formal collaboration was initiated to coordinate resources, strategies and expertise. As a result of this partnership, early wins are beginning to emerge. For example, FLPPS recently funded a United Way strategy that aims to build the

organizational readiness of community-based emergency services providers in preparation for value-based payment. The ability of these organizations to deliver high-value social supports to a high-risk, high-poverty population is an acknowledged critical input in the emerging system of care. This example demonstrates one of many opportunities that the collaborative is pursuing to refine and coordinate the system to reduce both poverty and health disparities.

4. Adopt a Regional Approach to Crisis Intervention

3 PPS Mid-Hudson Collaboration – Refuah Community Health Collaborative, Montefiore Hudson Valley Collaborative, WMCHealth

Dutchess County Stabilization Center opened in February 2017 and is the first facility of its kind in New York State. County. Residents of all ages – adults, youth and families – can receive services 24/7 for addiction, anxiety, depression, emotional distress, family issues and/or intoxication. No one denied services due to inability to pay or lack of insurance. Mobile Crisis Team can travel to residents in crisis and bring them to the center and law enforcement officers are trained and diverting appropriate patients to the center instead of ED or jail.

Central New York Care Collaborative

Central NY is supporting the expansion of Behavioral Health Crisis Stabilization Services throughout its 6-county region. CBOs from all tiers are engaging with the PPS to enhance crisis infrastructure in the 6-county region. Thanks to DSRIP, there will be mobile crisis teams in all 6 counties and 4 of the 6 counties will offer crisis respite services.

5. Mobilize Around High Priority Community Health Needs

Leatherstocking Collaborative Health Partners

Leatherstocking and the Bassett Healthcare Network are empowering primary care clinics to include use of buprenorphine for treatment of OUD (opioid use disorder) as part of comprehensive primary care. The project enables them to join their OASAS colleagues in efforts to stem the opioid epidemic, encourages a harm reduction approach to treatment, and considers OUD as a chronic medical condition. The project has increased access to treatment by embedding addictions specialists in primary care clinics and by getting physicians and mid-levels licensed to prescribe Suboxone, an opioid frequently used to help wean patients off heroin or prescription painkillers. So far, 25 doctors can prescribe Suboxone and 15 nurse practitioners and physician assistants are in the process of getting their licenses for it. To date, 154 patients have been treated.

Leatherstocking recognizes that clinical care is one part of a broader strategy: Earlier this year, Leatherstocking organized a Heroin and Opioid Summit in collaboration with New York State Senator James Seward and Bassett Healthcare Network. The goal of the summit was to understand all of the efforts underway in the region to address the crisis and engage in a conversation about how best to move forward toward workable solutions. Among those in

attendance were members of the law enforcement community, local and state government officials, county public health representatives, members of the substance abuse treatment and recovery community, medical and mental health professionals, leaders and faculty from area colleges and others. Additionally, Leatherstocking is working with local Judge Brian Burns and an Oneonta clinic to conduct a pilot collaboration between the drug court and primary care.

Better Health for Northeast New York

Better Health for Northeast New York (BHNNY) has partnered with CDPHP, a prominent physician-led regional MCO, to sponsor a care management program for their region. By partnering with an MCO with an effective community-based care management program, BHNNY is working to develop a sustainable program that minimizes any negative impact on patients and providers. BHNNY is utilizing population health data analytics to identify priority groups for initial care management interventions including patients with frequent ED visits or hospitalizations and patients without PCP assignment. The goal of the program is to address identified needs in the community including medication adherence and self-management support. Additionally, BHNNY hopes to increase access to primary care, behavioral health and health home services and enhance communication and data sharing through increased use of care plans and access to HIXNY (RHIO). The collaboration also enables to PPS to address relevant Social Determinants of Health (SDH) including housing, transportation, and community-based support for members with asthma & hypertension.

North Country Initiative

As a result of a comprehensive Community Health Survey and Assessment, NCI identified diabetes as a health concern for the region and has since been committed to reducing the region's diabetes rate which currently hovers around 10 percent. Across their network, NCI has established five locations that offer the nationally recognized Diabetes Prevention Program and 11 locations that offer nationally recognized self-management programs for diabetes and other chronic diseases and participation in local Diabetes Prevention Programs has increased 12 percent across the region.

NCI has also prioritized this need in the development of their regional care coordination structure. Since care coordination is a crucial part of NCI's strategy for improving the region's health and reducing fragmentation within the healthcare delivery system, NCI is committed to creating an effective and sustainable care management platform across Jefferson, Lewis and St. Lawrence counties. To provide NCI Primary Care teams with access to a Certified Diabetes Educator (CDE), NCI has embedded CDEs into the Care Coordination team. The CDE will provide consultative assistance to care managers with an overall goal of improving health literacy, patient self-efficacy, and patient diabetes self-management.

OneCity Health

OneCity Health has launched a home-based environmental management program designed to reduce avoidable hospitalizations among New York City children who suffer from frequent or severe asthma attacks. In addition to several H+H patient care sites, SUNY Downstate Medical Center and community providers are participating in this program. Community Health Workers from 8 community partners, including VillageCare and a.i.r.nyc provide the home assessments.

After identifying a patient with frequent or severe asthma attacks, the primary care team develops an Asthma Action Plan and refers the patient to a community health worker. The

community health worker meets with the patient and reinforces recommendations from the clinical team, including self-monitoring strategies and instructions on the correct use of medications. In addition, the community health worker conducts a home visit to evaluate the environment for asthma triggers, such as rodents, pests, mold, and dust. Based on the assessment, the community health worker can provide pillow cases and cleaning supplies, instruct families in home-cleaning strategies, and engage with the New York City Department of Health & Mental Hygiene—OneCity Health's partner providing professional cleaning and pest management—at no cost to the patient. OneCity Health's community partners have already completed over 500 home assessments, with plans to expand the program to hundreds more children and families this year.

"Our goal is to improve the quality of life for affected children, making sure they don't miss school or avoid physical activity due to their asthma. That begins with creating a care plan focused on prevention, making sure patients don't need to come to the emergency department or spend the night at the hospital because of asthma attacks," said Andrew Kolbasovsky, Chief Program Officer, OneCity Health.