Staten Island Performing Provider System

PRESENTATION TO DSRIP PROJECT APPROVAL AND OVERSIGHT PANEL

JOSEPH CONTE
EXECUTIVE DIRECTOR

JANUARY 22, 2016
Staten Island Performing Provider System (SI PPS)

We are a limited liability corporation formed by Richmond University Medical Center and Staten Island University Hospital to implement Project Management Function.

- PMO staff recruited solely for program execution

Goal: Improve the quality and transform the healthcare delivery system of Staten Island

Breadth:
- 4 out of 10 Staten Island residents affected by DSRIP
Strategic Approaches to Innovation, Program Accomplishments and Updates

- Completed 100% PPS partner contract sign-offs with 56 signed MSA’s
- Distributed over $10 million, 68% to non-hospital/CBO providers
- Supports Cross-PPS Collaboration
  - Regional Workforce PPS-wide Symposium
  - Lead for NYS PPS Cultural Competency (CC) and Health Literacy (HL) Collaborative
- Diverse CBO Integration: governance structure and projects, CCHL training and outreach
- Initiated innovative program to utilize Telemedicine in extended care setting
- Created Value Based Purchasing Population Health Improvement Program for community physicians
- Completed two rounds of INTERACT Training at nursing homes and Palliative Care assessment
- Leaders in workforce, training & benefits strategy; collaboration with unions, 1199TEF & community providers
<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>Long Term Care</th>
<th>Primary Care</th>
<th>Care Management</th>
<th>Home Care</th>
<th>Community Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration of Primary Care and Behavioral Health Services (3.a.i)</td>
<td>Implementing the INTERACT project (2.b.vii)</td>
<td>Integration of Primary Care and Behavioral Health Services (3.a.i)</td>
<td>Health Home At-Risk (2.a.iii)</td>
<td>Hospital-Home Care Collaboration (2.b.viii)</td>
<td>Patient Activation Activities (2.d.i)</td>
</tr>
<tr>
<td>1250</td>
<td>4274</td>
<td>342%</td>
<td>69</td>
<td>311</td>
<td>451%</td>
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<tr>
<td>Development of Withdrawal Management Services (3.a.iv)</td>
<td>Integration of Palliative Care into Nursing Homes (3.g.ii)</td>
<td>Evidence-based Strategies for Diabetes Management (3.c.i)</td>
<td>Care Transitions Intervention Model to Reduce 30 day Readmissions (2.b.iv)</td>
<td></td>
<td>Strengthen Mental Health &amp; Substance Abuse Infrastructure (4.a.iii)</td>
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<tr>
<td>100</td>
<td>124</td>
<td>124%</td>
<td>105</td>
<td>285</td>
<td>271%</td>
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<tr>
<td>Actively Engaged</td>
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<td></td>
<td></td>
<td>Increase Access to High Quality Chronic Disease Preventive Care &amp; Management (4.b.ii)</td>
</tr>
<tr>
<td>Q3 Target</td>
<td>Actual</td>
<td>Achievement Rate</td>
<td></td>
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</table>
### Project Advisory Committee Membership

**Substance Abuse/Behavioral Health**
- Bridge Back to Life
- Camelot of Staten Island
- CHASI
- Jewish Board of Family Services
- Project Hospitality
- Sky Light Center
- Staten Island Behavioral Health
- Staten Island Mental Health Society
- CBC
- YMCA Counseling Services
- Silver Lake Support Services
- South Beach Psychiatric Center
- NAMI Staten Island

**Nursing Homes**
- Carmel Richmond Healthcare and Rehab Center
- Clove Lakes Health Care
- Eger Lutheran Homes and Services
- Golden Gate Rehab and Health Center
- New Vanderbilt Rehab and Care Center
- Richmond Center for Rehab and Healthcare
- Seaview Hospital Rehab Center and Home
- Verrazano Nursing Home
- Silver Lake Specialized Care Center
- Staten Island Care Center

**FQHC**
- *Beacon Christian Community Center, Chair
  Community Health Center of Richmond
  Metro Health Clinic

**Home Care Agencies**
- ArchCare Home Care
- Visiting Nurse Association of Staten Island
- Visiting Nurse Services of New York
- Northwell Home Care

**Hospitals**
- Richmond University Medical Center
- Staten Island University Hospital

**Physician Groups**
- University Physicians Group
  - Victory Internal Medicine

**Community Alliances**
- A Very Special Place, Inc.
- AABR, Inc.
- Catholic Guardian Services
- Eden II School for Autistic Children
- Independent Living Association
- Lifestyles for the Disabled, Inc.
- Modest Community Services Association
- Staten Island Aid for Retarded Children
- GRACE Foundation of NY
- United Cerebral Palsy of NY
- HeartShare Human Services
- Lifespire, Inc.

**CBO Alliances**
- Person Centered Care Services
- LGBT Pride Center of Staten Island
- El Centro del Inmigrante
- YMCA New American Welcome Center
- Island Voice
- JCC
- Make the Road
- Staten Island Partnership Community Wellness

**Steering Committee**

**Contracted CBO**

**Faith based, Unions, LGU and MCO**
- NYC DOHMH
- Healthfirst PHSP, Inc.
- Empire BlueCross BlueShield, Healthplus
- New York State Nurses Association (NYSNA)
- 1199 SEIU
- UFT
- Ocean Breeze Pharmacy
- Nate’s Pharmacy
- Stapleton UAME Church
- Borough Hall
- FDNY/EMS

**Home Care Agencies**

**Nursing Homes**

**Community Alliances**

**Physician Groups**

**CBO Alliances**

**Steering Committee**

**Contracted CBO**

**Faith based, Unions, LGU and MCO**

**Home Care Agencies**

**Nursing Homes**

**Community Alliances**

**Physician Groups**

**CBO Alliances**
SI PPS Current Expenditures: $10,093,704

- PMO Administrative: 21%
- PMO Project Implementation (training, licensing and compliance): 2%
- Hospitals: 32%
- SNF/Home Care/Hospice: 21%
- Mental Health/Substance Abuse/Home Health: 6%
- Physician Groups and Practices: 1%
- PCP: 9%
- Community Providers and CBOs: 8%

$10,241,895 scheduled to be distributed by Jan. 31, 2016
56 Master Service Agreements by Provider Type

- Physician Groups and Practices: 30%
- Primary Care: 9%
- SNF/ Nursing Home/ Hospice: 23%
- Hospitals: 4%
- Community Health Providers: 4%
- CBOs: 12%
- Mental Health/ Substance Abuse/ Health Home: 18%
CBO Strategy: Engagement and Collaboration

Training Partnerships with CBO’s:
- Pride Center of Staten Island- LGBT Healthcare Equality
- Patient Centered Care Services- Sensitivity Training for Persons with Disabilities
- LEARN Committee/NYPL- Health Literacy

Diversity and Inclusion for all Staten Islanders
- Improved Language Access services for large immigrant population
- Health Literacy and Health Communication: SI PPS
  Health Literacy Healthy Partnerships
  - Project related, disease specific Health Literacy curriculum
  - Providers teach hands on health content to students
- Public Health Education campaign using SMS text messaging: SI textiPPS

Patient Activation
- El Centro, YMCA New Americans Welcome Center, Make the Road, JCC, Staten Island Opportunities Alliance, Island Voice

Social Determinants
- NYCHA
- Department of Education
- City Harvest/ DOH- Registered Dietician
- City Harvest- Rx for Food Referral Program
- Meals on Wheels
- Child Mind Institute
- Mayors Office of Immigrant Affairs
- Wagner College- Port Richmond Partnership
- Staten Island Immigrants Council

Healthy Neighborhoods Initiative
- Address key social determinants of health
- Neighborhoods selected by hotspotting data
- Improvement outcomes relate to 11 SI PPS Projects
- NYU Capstone Team
Cultural Competency and Health Literacy: PPS Network

Alignment of National Best Practices at all PPS Partner Sites

- Office of Minority Health: Culturally and Linguistically Appropriate Services (CLAS Standards)
- USDOHHS National Action Plan to Improve Health Literacy
- Human Rights Campaign: Healthcare Equality Index (LGBT Health Care Equality)

PPS-wide CCHL Training Initiatives to Date

- Roll-out 1199 TEF ‘Bias, Culture and Values’ training- 12/22/15
- PPS-wide Medical Interpreter Training program- January 2016
- Contract with CBO Pride Center of Staten Island for PPS-wide ‘LGBT Healthcare Equality Cultural Competency Training’ launch January 2016

Diversity and Inclusion Governance Committee

- Leaders from diverse CBO’s:
  - Faith Based
  - Cultural
  - LGU
  - Social Services
- Site Champions from each PPS partner site
- Patient Advisory Council
Future State

- Gathered data using workforce survey tool and in-person site visits, completed on 11/20/2015
- Data collected on over 11,500 healthcare workers
- Identified 182 New Hire DSRIP related positions
- 156 jobs designated for DSRIP are in non-inpatient arena
- Based on partner interviews, growth in jobs will be in the outpatient setting over the next four years

Current Workforce

- Health Worker/Health Coach/Navigator: 43
- RN/LPN/NP: 36
- Office/Data Tracking Support: 27
- Peer Navigator: 23

DSRIP- Incremental Target Workforce: Initial Estimate
DY1 and DY2

- Social Worker: 18
- Medical Assistant: 17
- Care Manager: 7
- Health Educator: 6
- Physicians/Psychiatrists: 5

Emerging Titles
Population Health Improvement: Changing the Model of Care and Engaging the Community

The PPS created Population Health Improvement programs to focus on value and quality and move away from volume-based care model:

- Pediatric Population Improvement Program, Adult Population Health Improvement Program and Behavioral Health Improvement Program
- Contracts with previously unaffiliated physician practices
- Support achievement of PCMH recognition
- Adoption of evidence based guidelines, use of EMR, proactive care paradigm, shared care plans
- Sharing health data with the PPS data warehouse and between providers using RHIO
- Incentivized payments are based upon meeting quality milestones

25% reduction in avoidable hospital use over 5 years
Utilizing Linkages with Community Based Providers for Effective Project Implementation

**Health Home at Risk: SI CARES**
- Partnership with SI’s Health Home Coordinated Behavioral Care and with Northwell Health Solutions

**Strengthen Mental Health and Substance Abuse Infrastructure**
- Collaboration with SI Partnership for Community Wellness/Tackling Youth Substance Abuse
- OASAS and Office of Mental Health

**Access to Chronic Disease Preventive Care Initiative**
- Linkage with Borough Hall’s Health and Wellness Program, Take Care NY, State Prevention Agenda

**Patient Activation and Community Health Navigation**
- Partnership with CHASI and Project Hospitality

**Collaboration with Local Governmental Units (LGU)**
- EMS, FDNY, NYC Mayor and Borough President’s Office, OASAS, OMH
Health Analytics: Program Development, Performance Monitoring and Hotspotting

Development and Monitoring

- SI PPS has extensive analytic capacity using data from multiple sources to direct programmatic efforts
- Hot-Spotting conditions and disparities by geographic location
- Focus includes health literacy and diversity factors to inform recruitment of new partners, refine nature of Community Based Organization relationships, and define training needs based on area/culture served

Hotspotting Selected Ambulatory Care Sensitive Conditions (ACSC)

Evidence from epidemiological studies on the causes of ACSCs suggests that not all the causal factors are “under primary care provider control.”

<table>
<thead>
<tr>
<th>Selected ACSC Disease</th>
<th>Factors outside direct physician control include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>• low socioeconomic status</td>
</tr>
<tr>
<td>Asthma</td>
<td>• cultural background</td>
</tr>
<tr>
<td>COPD</td>
<td>• older age</td>
</tr>
<tr>
<td>CHF</td>
<td>• availability of care providers</td>
</tr>
<tr>
<td>Hypertension</td>
<td>• geographical factors (i.e. distance to hospital)</td>
</tr>
<tr>
<td>CVS</td>
<td></td>
</tr>
</tbody>
</table>
SI PPS Data Integration

Data Source Utilization

1, 2, 4, 5, 8
SI PPS Data/Analytics Activity
- Create SI PPS master patient index (MPI)
- Clinical data warehouse
- Hot spotting
- Build patient registry

1, 5, 7, 8, 9
Cohort-based patient registry
- 3.c.i: Diabetes management
- 2.a.iii: Health home at risk
- 2.b.iv: Care transition to reduce 30 day readmissions
- 3.g.ii: Integration of Palliative Care into nursing homes
- 2.b.vii: INTERACT

3 Project 2.d.i
- Monthly data quality report and feedback to SI PPS partners

4 Domain 1 Performance Tracking (AE)
- Create SI PPS master patient index (MPI)

9 MAX Series
- MAX series to identify super utilizers
Staten Island Health Disparities

Diabetes 19-64 years - Unique Medicaid Claimants per 1000 Beneficiaries in 2014

Asthma 19-64 years - Unique Medicaid Claimants per 1000 Beneficiaries in 2014

Data Sources:
- DOH Medicaid member roster
- Salient database
- NYS Department of Planning Data
Prevalence of obese among NYC public school students living in a Staten Island zip code, grades K-8, during the 2012-13 school year

### Race / Ethnicity (%)

<table>
<thead>
<tr>
<th>Gender</th>
<th>North Shore</th>
<th>Mid Island</th>
<th>South Shore</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENDER</td>
<td>24.3%</td>
<td>23.1%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>18.0%</td>
<td>20.7%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Black*</td>
<td>21.3%</td>
<td>24.9%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>13.2%</td>
<td>23.4%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Race / Ethnicity (%)</td>
<td>21.4%</td>
<td>NYC Overall</td>
<td></td>
</tr>
</tbody>
</table>
Opioid - Unique Medicaid Claimants per 1000 Beneficiaries in 2014

Source: (1) Salient Interactive Miner  (2) DOH Member roster

Data Period: FY2014
Building Patient-Centered Medical Homes (PCMH) and Strengthening Primary Care

Staten Island has the lowest NCQA PCMH recognition rate of all NYC boroughs

Target State – NCQA 2014 PCMH Level 3
- 41 practices
- 109 primary care providers

SI PPS Strategy:
- Provide assessment & technical assistance to practices
- Support clinical integration
- Train workforce for team-based care
- Strengthen culturally and linguistically appropriate services
- Create a cross-partner learning collaborative

Evidence-based diabetes management
- Stanford Model for Chronic Disease Self-Management
- Implement evidence-based guidelines
- Create interdisciplinary care coordination teams

Care coordination for high risk patients
- Referrals to Health Home At-Risk care management agencies
- Screen patients for depression and substance abuse
- Co-locate behavioral health specialists
- Develop evidence-based standards of care

Integration of behavioral health
- Create interdisciplinary care coordination teams
- Referrals to Health Home At-Risk care management agencies
- Screen patients for depression and substance abuse
- Co-locate behavioral health specialists
- Develop evidence-based standards of care
Project Highlights

2.a.iii Health Home At-Risk Intervention Program

- 2 Health Homes and 6 CMAs have finalized agreements to provide care coordination services to target patients
- Adults and children who meet PPS approved criteria are being enrolled into program

3.a.i Integration of Primary Care in Behavioral Health Settings

- Primary Care & Behavioral Health Integration and Behavioral Health Workgroups
- Standardization of collocation, workflow and referral guidelines
- Licensure expansion and site renovations
Project Highlights

4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure

- Engaged multiple treatment providers, government agencies, CBOs, and other stakeholders
- Key informant interviews, focus groups, and claims analyses used to understand existing MEB services, community needs, barriers to care
- Partnerships with government agencies (e.g. NYC DOHMH) to align mental, emotional, behavioral (MEB) priorities

3.a.iv Development of Withdrawal Management Services

- 8 substance abuse providers enhance access to ambulatory detox in collaboration with OASAS and NYSDOHMH

Pilot program: Diversion of patients with less severe withdrawal symptoms from ER/IP

- 24/7 call center being developed
- Licensed provider and peer engagement resources

Unintentional overdose deaths involving heroin by borough of residence, New York City, 2000–2014*

* Data for 2014 are preliminary and subject to change
Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics

Overdose Deaths in NYC

Heroin

Staten Island

Bronx

Manhattan

Brooklyn

Queens

Age-adjusted rate per 100,000


Staten Island

Heroin

Overdose Deaths in NYC

Opioids

21
Long Term and Continuing Care Projects Highlights

2.b.vii Skilled Nursing Facility- INTERACT
- Two trainings completed in 2015 for all SI PPS partners:
  - Continuing Care Leadership Coalition (CCLC) provided training focused on communication tools at 7 SI PPS Partner Sites
  - Telemedicine Pilot

3.g.ii Palliative care training assessment for all 10 nursing homes complete
- Using the National Consensus Project Clinical Practice Guidelines for Palliative Care
- On-site palliative care performance improvement process

2.b.viii Home Care
- INTERACT training completed
- Hospital collaboration to improve discharge process

Telemedicine Pilot

Long-term Care Workgroup identified the need to address transfers that occur in the late evening and weekend hours
- Launched the telemedicine pilot allowing nursing home staff to initiate a telemedicine session with board certified emergency medicine physicians
  - Coverage hours: 5pm on Friday-> until 7am Monday
  - Medical evaluations via videoconferencing for patients include:
    - Evaluation
    - Video-assisted examination
    - Treatment plan
    - Discussion with the patient, nurse and/or caregiver
    - EMR documentation
Developing Competencies and Training Future Workforce

SI PPS utilized partner Workforce survey to identify:
- Training constraints: space/technology/staff coverage
- Current training resources
- Training gaps
- Challenges

DSRIP 101 Training:
- Baseline on how DSRIP impacts the healthcare system and the workforce
- Developed in conjunction with 1199 TEF, January 2016
- All training to be built upon this program

1199 TEF:
- Developing Community Health Worker curriculum with College of Staten Island, Fall 2016
- 1199 TEF Training Consultant to begin working with SIPPS, January 2016

Workforce Committee:
- Committee co-chairs: Rebecca Hall, 1199 TEF and Janice Maye, Camelot
Questions? Visit us at www.statenislandpps.org

Staten Island Performing Provider System, LLC

Partnering for Better Health.

A community partnership focused on improving the health of Staten Island’s residents

Working in Partnership to Serve You Better

Learn More