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DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid

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Introduction

Background

In April 2014, New York State finalized a groundbreaking agreement with the federal government that allowed the state to innovate in its Medicaid delivery systems and invest in its own health care infrastructure. This agreement—the section 1115 Medicaid Redesign Team (MRT) demonstration waiver—allowed New York to reinvest \$8 billion in federal savings generated by MRT reforms. The Delivery System Reform Incentive Payment (DSRIP) program is the single largest component of the MRT waiver, providing investments to promote community-level collaboration and system reform, with a specific goal of achieving a 25% reduction in avoidable hospital use over five years.

Under DSRIP, health and social care providers across the state formed collaborative networks called Performing Provider Systems (PPSs) to implement innovative demonstration projects focused on system transformation, clinical improvement, and population health improvement. In early 2019, the Office of Health Insurance Programs at the New York State Department of Health (DOH) asked the Medicaid Institute at United Hospital Fund (UHF) to review PPS projects, assess common themes across the projects, and identify key lessons that could inform conversations about the future of DSRIP beyond the end of the program (March 31, 2020, under the current waiver terms); this report is the result of UHF's review. It is also a natural companion to DOH's previously published patient-level [*DSRIP Stories of Meaningful Change in Patient Health*](#), which highlights a handful of real-life successes in improving outcomes by putting the needs of the patient front and center.

Overview

The goal of this report is to present a selection of PPS examples from the first four years of the DSRIP program that show promise for improving outcomes. These promising project-level demonstrations suggest opportunities for larger outcome improvement across Medicaid if given the appropriate time and resources for effective scaling and replication.

The report opens with examples of developing the infrastructure necessary to deliver on PPS projects. The report then presents three sections of specific PPS project examples—reflecting three major themes—that leverage the infrastructure elements discussed in the opening section. In these sections, each example's heading begins with a key subtheme (e.g., workforce) that may appear across multiple projects. The major themes and subthemes are also shown in the index beginning on page 36, which lists all PPS infrastructure and project examples described in this report. However, these examples are in no way intended to represent the full breadth and depth of promising practices that DSRIP has fostered across the state.

In researching the examples and identifying common themes, the following takeaways emerged:

- Substantial infrastructure is required to support projects with sufficient scope to drive outcome improvement across large populations of Medicaid members attributed to individual PPSs.
- Projects targeting complex patients, who drive much of Medicaid utilization and spending, can substantially improve outcomes for small groups of patients (and likely generate cost savings). These projects could be especially promising to the extent that their lessons can be applied to new projects or populations; their collective impact could enhance PPS-wide and statewide performance on some DSRIP measures.
- DSRIP has greatly accelerated the focus on social determinants of health by facilitating partnerships between health care providers, community-based social service organizations, and other community partners, and by producing new workflows and non-clinical workforces to address the social needs of Medicaid members.
- For the most complex populations, substantial care management/coordination and support for care transitions appear necessary to change patients' trajectories. Moreover, the promising practices highlighted here do not necessarily address coordination with other similar efforts happening outside of DSRIP.
- Given the prevalence of individuals in Medicaid with behavioral health needs, the heterogeneity of those needs, and this population's relatively high utilization and costs, some of the most promising practices focused on expanding access and developing new approaches to meeting patients where they are as ways to better engage them in treatment.

As noted in the methodology that follows, the promising practices identified for this report were chosen in part based on a subjective assessment of the likelihood projects could have a positive effect on the DSRIP measures that track the success of both individual PPSs and the DSRIP program statewide. Examples in the opening infrastructure section are not mapped to DSRIP outcome measures because the focus of those examples is on developing the infrastructure itself, not how that infrastructure might have been used to improve outcomes. For nearly all examples in the three subsequent sections—focused, respectively, on social needs and cross-sector collaborations; care management, coordination, and transitions; and behavioral health clinical improvement—promising practices are mapped to the broad categories of DSRIP measures, as identified by UHF and shown below, that they might affect.¹ In many of these examples, the narrative also highlights specific measures identified as targets of those practices. The specific measure results in the narrative are PPS-reported, and these sometimes include outcomes beyond DSRIP measures proper.

Broad Categories of DSRIP Measures Mapped to Promising Practices

(For the DSRIP outcome measures these groupings comprise, see the Appendix.)



Potentially Avoidable Services



Health Literacy



Clinical Improvement: Diabetes



Access to Primary and Preventive Care



Clinical Improvement: Behavioral Health



Clinical Improvement: Asthma



Care Coordination and Care Transitions



Clinical Improvement: Cardiovascular Disease



Clinical Improvement: Perinatal Care

The Appendix displays each specific DSRIP measure included in the categories above. Certain measures have been excluded from the categorization—especially measures for which data are not available or those that include uninsured populations in addition to Medicaid. Measure categories were mapped to each promising practice based on reviews of project design, specific patient populations and measures targeted by a project, and additional information provided by the PPSs and by Public Consulting Group (as described below). It is important to note that the mapping of measure categories to promising practices and the highlighting of any specific measures in the narrative reflect educated, empirical, but ultimately subjective assessments of the DSRIP measures that a given project is most likely to affect. This mapping is not meant to suggest that a promising practice is specifically or exclusively responsible for observed PPS performance on a given DSRIP measure.

Methodology

Investigation of promising practices began with a review of PPSs' 2019 DSRIP Learning Symposium submissions and PPS projects that used an innovation fund or similar vehicle for implementation. This information was self-reported by the PPSs to DOH and provided to UHF by the DSRIP Account Support Team, Public Consulting Group (PCG). The initial information provided by PCG emphasized projects from PPSs that achieved annual improvement targets in measurement year 3 on related DSRIP metrics.

The core source material was supplemented with a targeted review of previous [DSRIP Learning Symposium](#) presentations, PPS websites and newsletters, Medicaid Accelerated eXchange ([MAX](#)) [series materials](#), the [DSRIP Best Practices in Year 3 Whiteboard Video](#) and [companion document](#), [Project Approval and Oversight Panel](#) materials, and [Social Determinants of Health Innovation Summit](#) presentations. In total, over

500 discretely identifiable PPS practices were examined across the core source material and supplemental sources.

An initial review of promising practices and emerging themes was shared with the New York State Department of Health (DOH) and PCG in advance of the [2019 DSRIP Learning Symposium](#). Following a deeper exploration of PPS projects during and after the Symposium, at least one example from each PPS was identified (to ensure representation of diverse contexts), promising practices were adjusted, and additional PPS-reported outcomes were connected with the examples, consistent with PPS presentations and posters. The information in this report reflects research completed by mid-March 2019, and so excludes any PPS progress or outcomes that may have become available since.

There are a number of important limitations in this qualitative assessment of DSRIP promising practices. First, the core source material and much of the supporting documentation comes directly from the PPSs and has not been independently verified by DOH, PCG, or UHF. The initial information provided by PCG was a reasonable starting point for selection, but it may have inadvertently excluded some similarly promising practices that could not otherwise be identified via other sources. Where possible, that initial information was supplemented by additional PPS-reported outcomes and UHF analysis of PPS performance in other measurement years. However, many of the promising practices focus on small subsets of the PPSs' attributed populations, and those projects therefore may not have had sufficient scope to have discernible effects on PPS-wide performance on DSRIP measures. Further, even with larger projects, controlled comparisons were not available to isolate projects' specific effects on DSRIP measures from other potential sources of variation in PPS performance.

In sum, while the practices highlighted here are indeed promising, without more controlled studies with comparison cohorts and adjustment for confounding factors, it is not yet possible to suggest that these promising practices are directly responsible for PPS performance on any particular DSRIP metric.

Core Infrastructure and Capacity Building

Achieving the broad goal of 25% reduction in avoidable hospital use while improving performance on a large set of other DSRIP measures requires new infrastructure, as well as many new skills and capacities across a wide array of participating providers and community organizations. Efforts by PPSs to put that infrastructure in place include many rich examples of the intense collaboration necessary to succeed under DSRIP.

The examples of promising practices that follow are consistent with the types of infrastructure necessary for a high-performing integrated delivery system. While these capacities are not directly mappable to performance on DSRIP metrics,² they underpin each PPS's ability to manage DSRIP projects and improve on the associated achievement targets. Most of the initiatives undertaken by PPSs over the past four years have been supported by one or more of the core infrastructure elements cited here.

A number of PPSs are leveraging their infrastructure and partner capacity to move from fee-for-service provider reimbursement toward value-based payment (VBP)—a shift in Medicaid that is also part of the MRT waiver, and which DSRIP is designed to help facilitate. However, the shift to VBP in Medicaid may require additional time and logistical considerations for newly organized provider networks to accept clinical and financial responsibility for the health and health care provided to defined populations. One major step in this process is the formation of a legal provider entity that can contract for health services. Network development is a key precursor to forming such an entity—and essential for developing a truly integrated delivery system.

Developing Networks for Performance

The first step in building a high-performing health care delivery system is to define the network; this means identifying participants and partners and clarifying their roles. Best practices for network development also include being explicit with provider partners about expectations and what support they will receive; having a clear and legitimate network governance process; and giving network participants a voice in decisions and resource allocation.

PPSs have approached network development in two ways:

1. developing focused networks around specific populations, problems, and projects
2. at a PPS-wide or regional level, forming networks of health care providers and community-based social service organizations (CBOs) as a step toward creating sustainable independent practice associations

and accountable care organizations positioned to accept and operate under VBP contracts

The Cohort Management Program of **Care Compass Network (CCN)** PPS is focused on better serving defined populations of complex patients. CCN created a series of networks that included clinical and community service providers it identified as most relevant to the needs of specific cohorts of complex patients. Each network established goals for performance improvement for its defined cohort. To meet these goals, networks developed strategies to improve patient outcomes by identifying required resources and deciding how funds from CCN would flow to its network partners. CCN facilitated network formation and helped partners define, assess, and risk-stratify their respective patient cohorts. CCN also supported networks in using rapid-cycle process improvement techniques to better integrate services, and it provided networks with tools to track cohorts' service engagement and key quality indicators. The networks gained experience managing a continuum of services across a group of coordinating providers being held accountable for patient outcomes, a key to succeeding under future VBP arrangements.

The **North Country Initiative (NCI)** approached network development on a larger scale, building a regional network on a foundation already in place—due in large part to the work of the Fort Drum Regional Health Planning Organization. NCI is a clinically integrated network, whose governance and committee structures include representatives of the region's physicians, federally qualified health centers (FQHCs), hospitals, behavioral health providers, and CBOs. NCI has invested DSRIP funds to support key program interventions and to support the regionwide infrastructure serving Medicaid providers and their patients. Over the past decade, NCI, its related organizations (including the Fort Drum Regional Health Planning Organization, which provides a range of services to support NCI), and its network partners have put in place many elements of an integrated delivery system necessary for future value-based payment, including a Medicare accountable care organization.

Recognizing that sustainability planning was essential, NCI sought input from all partners for a formal sustainability strategy that would enable it to continue to provide services and support projects undertaken by the PPS. NCI has expanded and formalized its network (which now includes 88 partner entities across the three-county region) and formed a regional independent practice association with clear governance and decision-making processes. In addition to creating an entity aligned with DSRIP's VBP contracting goals, this infrastructure allows NCI to use a variety of financial levers to incentivize, support, and sustain interventions focused on improving the health of its attributed population. The independent practice association will serve as a contracting entity for partners to

enter into value-based arrangements with payers, which—it is hoped—will eventually provide adequate funding to maintain the organization’s infrastructure and its successful interventions.

Expanding Technology and Using Data and Analytics

A second foundational element of a sustainable, high-performing, integrated delivery system is robust health information technology. Identifying and improving care for defined populations across the care continuum requires two types of information technology support:

1. clinical information systems, such as electronic medical records and regional health information exchanges that support direct care delivery, identify and follow high-risk patients, and alert providers when their patients are admitted to hospitals or discharged from them
2. data analytics that use clinical and claims data to target and better manage the care of complex patients and populations, as well as measure performance and support continuous quality improvement

Adirondack Health Institute (AHI) PPS has developed a sophisticated data analytics capacity capable of supporting both direct care provision and network-level quality improvement and care management. To understand partners’ performance and support closing gaps to achievement goals, AHI created unique dashboards for each PPS partner based on claims data. These partner dashboards have allowed AHI to focus its limited resources on the partners with the greatest opportunity for improvement and those in need of the most assistance. AHI has used this same programming to analyze different disease cohorts (e.g., diabetics) and to design effective quality improvement initiatives. AHI is currently assessing whether new health data analytics can adequately evaluate its initiatives’ effectiveness and identify more areas for improvement.

Transforming Primary Care

A third foundational element of high-performing delivery systems is a primary care network built on the medical home model.³ Medical homes are the locus for managing population health, developed to assess and respond to patients’ health and social needs; provide preventive care; manage chronic diseases; closely manage referrals and care transitions; and target, track, and manage the care of high-risk patients. Many PPSs have helped fund the practice transformation efforts necessary for their affiliated primary care practices to become patient-centered medical homes (PCMHs).⁴ This investment has improved practices’ capacity to manage the care of complex patients.

Practice transformation can lead to workforce investments by creating care teams and expanding the roles and skills of staff. Most PPSs have also encouraged routine screening for social determinants of health (SDH) in the primary care workflow. Responding to identified social needs has led PPSs to add community health workers (CHWs), peers, and navigators as part of the primary care team and across the care continuum. They have also partnered with CBOs, increasing their ability to identify and respond to social needs.

SOMOS Community Care was among New York's leaders in supporting transformation of its affiliated primary care practices, enabling a total of 646 clinicians to achieve PCMH recognition.⁵ Essentially all of SOMOS's primary care providers work in small primary care practices, a group that has historically been underrepresented in the PCMH program.⁶ In parallel, SOMOS invested in the training and deployment of a cadre of CHWs to work with its primary care practices—supporting care management efforts, and providing outreach and education in surrounding communities. Further, SOMOS has fostered strong partnerships between CBOs and primary care to more effectively address patients' economic insecurity and implement a broad spectrum of social needs interventions: case management and entitlement assistance, legal services to prevent eviction, other housing-related services, and home-delivered meals to address food insecurity. SOMOS's social needs intervention has three major goals: improving quality and continuity of care, supporting high-need patients, and assisting primary care physicians in meeting their patient engagement performance goals.

Connecting Clinical and Community Resources

SOMOS provides but one example of how DSRIP has encouraged stronger relationships between clinical and community partners, which is yet another foundational element of high-performing delivery systems. Other PPSs have made similar investments to support these linkages, and some provide potential models for sustaining these connections.

The **Alliance for Better Health PPS** offers a CBO-driven model for strengthening links between CBOs, primary care, and other health care providers to serve a high-need subpopulation. With PPS support, Interfaith Partnership for the Homeless opened the Capital Region's first medical respite program in March 2017. This program provides temporary shelter for homeless individuals who need a safe recuperative environment following hospital discharge, allowing them to access care and supportive services such as meals, personal care, home care, medications and other treatments, and assistance with transitioning to permanent housing. The PPS reports that the program is reducing hospital readmissions and connecting participants to primary care, sometimes for the first time in

their lives, as well as facilitating connections to behavioral health services and Health Homes. The PPS has also helped Interfaith build its capacity to meet key outcome measures and to pursue longer-term funding through managed care contracts.^{7,8}

Capacity-building and sustainability efforts may look different for community-based organizations that serve linguistically and culturally diverse communities. This is especially true in the Bronx, which informed efforts by the **Bronx Partners for Healthy Communities (BPHC)** to engage with, and fund, CBO infrastructure development through activities such as cultural responsiveness training, “train the trainer” sessions on health literacy and health care system navigation skills, and value-based payment capacity building.⁹ For example, 606 individuals from 27 social service agencies have engaged in at least one of the 29 courses developed collaboratively between BPHC and its community partners. In particular, the Community Health Literacy Program has trained 48 community educators at 7 CBOs, and these educators have engaged over 9,500 community residents on topics such as seeking and using health insurance or navigating the health care system. The community educators meet monthly to share strategies and community reactions as they continually improve tactics for delivering the curriculum and connecting community members to needed services. Simultaneously, BPHC has provided cultural responsiveness training to community behavioral health and primary care providers.

BPHC also developed and led a training program to help its CBO partners determine how to evaluate program impact and communicate the value of their services. Nine CBO partners participated in the training sessions, which included four in-person meetings, six webinars, and ongoing technical assistance via e-mail and telephone. Four themes guided the training: principles of evaluation, data collection, communicating impact and value, and leveraging other collaborators’ data. The PPS paid CBOs to account for time spent in the trainings. As part of the training program, each CBO produced a written description of its organization’s mission, a plan for evaluating one of its programs, and a report providing evidence of the value that its work brings to health systems. The PPS reports that its partnership efforts have enabled CBOs to develop skill sets and infrastructure that enable them to demonstrate their value to health plans and other providers.¹⁰

Building Quality Improvement Capacity Across the Care Continuum

Another key element of high-performing integrated delivery systems is the ability to go beyond traditional ways of measuring health care quality (which have focused on outcomes for individual providers) to emphasize

the quality of care received by patients from different providers and in different service settings. This requires providers to generate data that can help identify opportunities to improve quality across the care continuum, working together to improve outcomes for shared patients. DSRIP provided the impetus and data necessary for improving the care of patients and populations seeing different providers. For instance, a number of PPS initiatives have focused on transitions of care between hospitals, homes and other community-based settings, and nursing facilities—moments when patients are at particularly high risk of falling through the cracks.

Recognizing such opportunities to improve quality across the care continuum by collaborating with skilled nursing facilities (SNFs), the **NewYork-Presbyterian Queens (NYPQ) PPS** formed a long-term care committee with its 27 partner SNFs. The committee meets quarterly to coordinate long-term-care-based DSRIP projects; review data on hospital admissions, readmissions, and other quality metrics; and facilitate related quality improvement initiatives. Examples of these initiatives include a warm hand-off policy between hospitals and SNFs upon inpatient discharge, and the INTERACT program (Interventions to Reduce Acute Care Transfers) across partnering SNFs, which evidence suggests may reduce nursing home hospitalizations.^{11,12} Some of these initiatives focus on SNFs with the very highest readmission rates. For example, NYPQ worked with Silvercrest Skilled Nursing Facility to reduce its residents' emergency department use and hospital readmissions by developing SNF protocols for common clinical decisions around evaluation, management, and transportation and by implementing more systematic palliative care referrals. The PPS reports that, as a result of these activities, Silvercrest's hospital readmission rate decreased from 31% (in January–March 2018) to 23% (in April–November 2018).¹³

Bringing It All Together to Serve High-Need Subpopulations

The final element necessary for high-performing integrated delivery systems is the ability to weave together, across varying reimbursement streams, the infrastructure pieces described above when serving high-need/high-cost patients. Building on its existing Designated AIDS Centers, the **NewYork-Presbyterian PPS (NYP PPS)** leveraged DSRIP and other funding streams to further transform its already robust HIV/AIDS care and prevention services. Spanning the care continuum—including emergency departments and hospitals, three ambulatory HIV Centers of Excellence, six CBOs, and the NYP Ambulatory Care Network—the PPS's providers have tackled a broad range of clinical quality improvement and prevention activities focused on patients with HIV/AIDS. The Centers of Excellence approach to practice transformation reflects the foundational elements of primary care transformation described above. The Centers integrate all

primary care and behavioral health services, partner with CBOs on social needs, and deliver care using a team-based complex care coordination model that meets the specialized needs of people living with HIV.

As New York State launched the End the Epidemic initiative, NYP PPS developed the Ready to End AIDS and Cure Hepatitis C (REACH) Collaborative to best meet its own DSRIP project goals around reducing population-level HIV morbidity. The involvement of CBOs (many with long histories serving people living with HIV/AIDS), community health workers, and peers was vital to the outreach efforts necessary to make a population-level impact. Throughout these DSRIP projects and other related efforts, NYP used a bevy of multi-institutional outreach and performance dashboards to track individual patients and population-level outcomes. Altogether, the PPS reports that these efforts increased screening, pre-exposure prophylaxis (PrEP) prescriptions, and long-term engagement with coordinated care while reducing viral loads. DSRIP also helped NYP PPS leverage other HIV service transformation support funds and created a path for sustaining many of these efforts through the Medicaid Health Home program.¹⁴

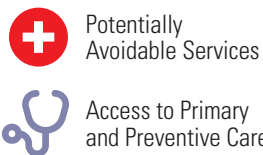
Leveraging Infrastructure for Project Performance

The three sections that follow present a wide range of examples of promising practices that take advantage of both the broad infrastructure developed by PPS for partnering with providers and community organizations, and project-specific infrastructure designed to meet project-specific goals.

As the current DSRIP waiver nears completion, it is important to consider the scope of the infrastructure that has been developed, the project-specific and broader population health outcomes that this new infrastructure has helped to initiate, and the potential for leveraging these promising practices to sustain these outcomes. Though more time may be needed to scale and spread these promising practices through VBP arrangements, the pieces are coming together to make such a future possible.

Social Needs, Community Partnerships, and Cross-Sector Collaborations

It is now commonly accepted that unmet social needs are a major determinant of health outcomes and health care spending. In response to these recognized influences, New York State DSRIP funding supports a number of projects that identify and address unmet social needs within the Medicaid population. Leveraging PPSs' newly developed community resource infrastructure, DSRIP funding also supports CBO partnerships and cross-sector collaborations aimed at improving outcomes for specific populations. These alliances often rely on new types of workers to tackle complex care management and navigation to social needs resources. The examples that follow illustrate the diversity of promising practices to address social needs, but are in no way an exhaustive compilation of the myriad partnerships and collaborations facilitated by DSRIP.



Workforce: Using Community Health Workers to Connect Patients to Health and Social Services

Investments in the health care workforce are important for increasing the number of professionals qualified to screen Medicaid members for unmet social needs and connect them to social services. **NYU Langone Brooklyn PPS** developed an emergency department (ED) care triage program, based on the Stanford Coordinated Care model, using community health workers (CHWs) to support high-risk patients with unmet social needs who seek care in the ED. Launched in September 2017, the program employs six full-time CHWs who screen patients at the bedside for a range of social needs, including unstable housing and food insecurity. CHWs then develop achievable goals targeting the unmet needs that most affect patients' ability to manage their health. After patients leave the ED, CHWs follow up via a home visit within 72 hours, and then follow up weekly for the remainder of the 30-day program. During this time, CHWs provide patients with care management and a warm handoff to health care and social service providers; they also help patients schedule primary care visits, secure transportation to appointments, and apply for public benefits such as housing and food assistance. As needed, CHWs also connect patients with longer-term care supports, such as the hospital's Health Home program.

The PPS reports that since September 2017, CHWs have enrolled 686 out of 1,724 eligible patients in the program, achieving an enrollment rate of 40%. Program participants' most commonly reported social challenges are unstable housing, food insecurity, transportation, social isolation, and

unemployment. Over 75% of participants have met their goals in acquiring medical care, transportation, food supports, and financial benefits. Sixty-eight percent have met their goal of receiving support in applying for housing assistance. In addition, when analyzing a cohort of 54 participants, the PPS found that ED use decreased from 184 visits in the 12 months preceding program enrollment to 56 visits in the 6 months post-enrollment.¹⁵



Population Targeting: Using Community Partnerships to Engage Low Utilizers in Care

CHWs have often been used to identify high-risk patients who frequently use health care services and connect them with primary medical and social service providers. However, CHWs may also connect with people who *underutilize* health care services because they lack the knowledge and skills to navigate the system. **Suffolk Care Collaborative PPS** developed its Community Health Activation Program in partnership with eight CBOs that provide general social services—such as health insurance and Supplemental Nutrition Assistance Program (SNAP) enrollment support—and one FQHC. CHWs from these nine organizations identify low- and non-utilizing Medicaid patients and uninsured individuals, and then use the Patient Activation Measurement (PAM) survey to assess their ability to manage their health and health care needs. Several of the partner organizations use an outreach model in which CHWs enter the community to find and recruit people who are eligible for the program. Other partners, such as the FQHC, use an “in-reach” model designed to engage patients when they seek services.

After CHWs screen and enroll individuals, they use the PAM score to guide individualized goals and design interventions consistent with patients’ needs—most commonly, connecting patients with primary care providers. CHWs help patients overcome barriers to engaging in care, such as scheduling primary care appointments, arranging transportation, and providing additional follow-up and support as needed. The PPS reports that, since June 2015, CHWs have connected over 40,000 low- and non-utilizing Medicaid members and uninsured individuals to primary care and social services, and that PAM scores have improved among this population. The program is aligned with DSRIP goals of improving access to primary care, while also increasing patient activation and engagement.¹⁶



Potentially Avoidable Services



Access to Primary and Preventive Care

Care Management: Blending Traditional Models with Community Navigation to Avert Unnecessary Services

Medicaid members with complex medical, behavioral, and social needs often use hospital services at significantly higher rates than other members. In many cases, use of these services could have been avoided through better navigation of the health system and existing community resources. Building on its Patient Activation project, which seeks to improve patients' navigation through the health system, **Finger Lakes PPS (FLPPS)** utilizes community navigators to connect individuals with clinical and non-clinical resources throughout its network. The community navigator often performs a role similar to that of a community health worker or care manager, helping individuals schedule appointments and transportation, or accompanying individuals to their appointments.¹⁷

FLPPS currently partners with 26 organizations, including CBOs, behavioral health care providers, care management agencies, hospital systems, and FQHCs, who have connected over 17,000 individuals to resources that include food, housing, transportation, dental and behavioral health services, and primary care. In some cases, the Community Navigation program has been transformative for partners: for example, Catholic Charities of Steuben has trained all staff members to serve as community navigators and developed internal incentives to reinforce its focus on navigation. The PPS reports that its community navigation efforts have demonstrated improvement in several DSRIP-aligned measures: potentially preventable ED visits, potentially preventable ED visits for behavioral health, and access to primary care. With an eye toward sustainability, FLPPS has also used the past three years of experience to build cohorts of high-performing community navigation partners and other CBOs and help prepare them for value-based payment contracting.



Potentially Avoidable Services



Access to Primary and Preventive Care



Clinical Improvement: Cardiovascular Disease

Community Partnerships: Leveraging Local Resources to Promote Heart Health

While some DSRIP efforts emphasize how the health care system can drive referrals to community resources to meet social needs, other efforts leverage community resources to advance population health and connect individuals back to primary care providers. To more effectively manage the prevalence of high blood pressure and cardiovascular disease in Western New York, **Millennium Collaborative Care PPS** has implemented a comprehensive community screening intervention. The program is part of the Million Hearts Initiative, a national program to prevent one million heart attacks and strokes by 2022.¹⁸ Since Millennium's screening program began in 2016, 26 events have taken place in churches, community

centers, and schools in high-risk ZIP codes, with over 600 attendees receiving blood pressure screening, medication evaluation, and education on diet and physical activity.¹⁹ Of those screened, the PPS found that nearly 70% had pre-hypertension or high blood pressure. After screening, efforts are made to engage individuals in treatment through linkage to their pre-existing primary care provider, or by providing individuals with a list of available PCPs. For those who are Health Home eligible, Health Home staff assist in making the linkage to care. In partnership with the National Witness Project, the PPS has also incorporated blood pressure screenings in local barbershops, dubbed “The Barbershop Project.”²⁰ As of January 2018, the project had expanded into 12 beauty salons and barbershops in Buffalo and Niagara Falls. Ultimately, increasing the number of touchpoints for adult preventive care is designed to create downstream benefits for health systems in the area, such as controlling high blood pressure and reducing potentially preventable ED visits and hypertension-related hospital admissions.



Potentially Avoidable Services



Access to Primary and Preventive Care



Clinical Improvement: Cardiovascular Disease



Clinical Improvement: Diabetes

Integration: Embedding Nutrition Assistance Within Health Care Settings

Some PPSs have used their partnerships with CBOs to integrate social services into the health care setting, enabling patients to receive support for social needs while receiving medical care, rather than having to seek social services outside of the health system. **Nassau Queens PPS**, in collaboration with Northwell Health’s Long Island Jewish Valley Stream Hospital and several CBOs, developed a coordinated “Food as Health” strategy to connect patients who are food insecure and have a nutrition-related diagnosis with the appropriate resources based on their specific needs. Patients from one inpatient unit and one outpatient clinic at LIJ Valley Stream are screened for food insecurity using the Hunger Vital Sign survey. Individuals who screen positive are assessed by a registered dietitian to determine if the patient’s diagnosis is nutrition-related and what form of support to offer them. All food-insecure patients with a nutrition-related diagnosis are eligible to receive an emergency food supply, nutrition education, SNAP enrollment support, and social support through community resource navigation. At discharge, ambulatory patients who meet program eligibility criteria are given fresh produce and non-perishable food items from an on-site food resource center staffed by partners like Island Harvest. Individuals with limited mobility, but who can cook for themselves, are connected with home food delivery services from organizations like Long Island Cares Mobile Food Pantry or Meals on Wheels. Patients with the most complex set of challenges—who are homebound, cannot shop or cook for themselves, and have diagnoses requiring significant dietary restrictions—are provided home-delivered, medically tailored meals from God’s Love We Deliver.

Since its inception in August 2018, the hospital has screened over 800 patients for food insecurity, with 251 patients identified as food insecure. The hospital reports that the food program may have contributed to improved HbA1c scores; increased primary care visits, SNAP enrollment, and connection to community resources; and decreased food insecurity, ED use, and readmissions.²¹



Clinical Improvement:
Behavioral Health

Cross-Sector Collaboration: Addressing Behavioral Health Across the Justice and Health Care Systems

DSRIP has also supported cross-sector collaborations between the health care system and other sectors to improve outcomes for specific populations. **Adirondack Health Institute PPS** and the justice system in the Glens Falls Region partnered to support people at risk of, or recently released from, incarceration. The PPS started by sponsoring a one-day Sequential Intercept Mapping workshop to identify gaps in behavioral health care services for people at risk of incarceration following a 911 call and for those being released from jail. Then, the PPS convened a cross-sector workgroup—including judges and district attorneys; parole, corrections, and police officers; behavioral health providers; and ED and hospital representatives—to develop a plan for closing these gaps. The resulting plan included three interventions:

1. A 40-hour crisis-intervention training program for police officers, aimed at reducing the number of arrests after a 911 call and focusing on de-escalation strategies
2. A pre- and post-arraignment diversion program focused on behavioral health treatment as an alternative to arrest and incarceration
3. A care management program for individuals with behavioral health needs who are about to be released from jail. Care managers visit these individuals before release and develop post-discharge plans to connect them to treatment after release.²²



Potentially
Avoidable Services



Clinical Improvement:
Behavioral Health

CASE STUDY: FOSTERING CROSS-SECTOR COLLABORATIONS TO TARGET BEHAVIORAL HEALTH IN SCHOOLS

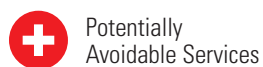
Schools in underserved communities may have insufficient capacity to meet their students' disproportionately greater behavioral health needs. To strengthen schools' capacity in this area, four PPSs—**Bronx Health Access, Bronx Partners for Healthy Communities, Community Care of Brooklyn, and OneCity Health**—and the Jewish Board of Family and Children's Services partnered with four behavioral health providers, the New York City (NYC) Departments of Education and Health and Mental Hygiene, and underserved NYC public schools to create the 100 Schools Project. Financed by the PPSs and administered by the Jewish Board, the program focuses on prevention and early identification of behavioral health problems among students, using coaches to train teachers and staff and deliver crisis support and behavioral health referrals to students and families. In turn, the program also aims to improve students' educational outcomes, such as reductions in truancy and suspensions.

Launched in September 2016, the project includes 92 of the city's most underserved middle and high schools, where students experience higher rates of homelessness, disability, and chronic absenteeism than the overall NYC student population. (The original goal was to recruit 100 schools, but five schools chose not to participate, and three others closed after joining.) According to the Jewish Board, the behavioral health coaches have trained over 8,000 teachers and staff as of December 2018. They have also conducted over 2,800 coaching sessions and over 1,400 classroom observations to help teachers improve their management of student behavioral health challenges.

Satisfaction surveys show that most school staff view the trainings as valuable, with 93% reporting that the training material was relevant and 89% reporting comfort with implementing the training. In addition, 911 call data suggest that participating schools have been more effective in resolving student crises. For instance, in 2018, about half (49%) of all behavioral health crises in which police responded to 911 calls at participating schools were mitigated without an arrest and without the student needing to leave school, compared to a quarter (26%) of such crises across all city schools. The Jewish Board also reports that the 100 Schools Project has led to improvements in classroom learning environments and in teacher morale.²³

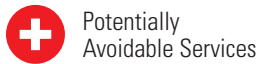
Care Coordination, Care Management, and Care Transitions

PPSs' infrastructure development and efforts to address social needs both embody one of DSRIP's key goals: supporting new statewide investments that are focused on improving care coordination, care management, and care transitions. Workforce investments and strategies for targeting at-risk populations are often critical ingredients for improving care management, as are efforts to bridge gaps across settings and institutions—particularly for patients undergoing care transitions or living with multiple chronic conditions. Whether emphasizing broad improvements in care coordination for all Medicaid members, or improving care transitions for specific populations, the examples below represent merely a handful of the promising practices PPSs have developed for providing care management that reduces members' avoidable hospitalizations and advances their physical, behavioral, and social well-being.



Workforce: Investing in Community Health Workers for Chronic Disease Management

Successful care management often requires new workforce investments, such as contracting with partners to incorporate new staff within clinical workflows and building capacity among new and existing staff. **OneCity Health** illustrates such investments in its community health worker home visitation program for managing childhood asthma. Under this program, clinical providers develop Asthma Action Plans (AAPs) for children with asthma and refer each child to one of eight partnering community-based organizations with existing CHW programs. CHWs then visit families' homes to support the AAPs, perform home assessments, and arrange integrated pest management visits for pest and mold remediation when asthma triggers are identified. The program's key workforce investment involved training CHWs and clinical staff to support expansion of asthma services into home settings. The PPS trained 29 CHWs on asthma basics, home environment assessments, and general CHW practices. The PPS also trained 620 clinical providers (physicians, registered nurses, and nurse practitioners) according to the Physician Asthma Care Education (PACE) model, an evidence-based program to improve treatment of children with asthma.²⁴ Between the program's full implementation in June 2017 and December 2017, OneCity Health reported that pediatric asthma admission rates (PDI-14) decreased by 25%, and that overall avoidable pediatric admissions also fell. The PPS also views these initiatives and workforce investments as consistent with DSRIP's goals of improving medication management for people with asthma.²⁵



Population Targeting: Managing Care Transitions for At-Risk Patients

Workforce expansions often support efforts to target care management to new populations, such as patients experiencing care transitions. **Community Care of Brooklyn PPS** provides a good example of how such population targeting can be linked to a comprehensive care transition strategy. Beginning in October 2015, the PPS expanded its care management workforce with new transitional care nurses (TCNs) and managers organized into transitional care teams (TCTs), which provide safe and effective transitions of care for patients at particular risk for readmission. At-risk patients are identified through a modified LACE tool (which assesses length of hospitalization stay, acuity of admission, comorbidities, and ED utilization), a social determinants of health screening tool, and clinician judgment.²⁶ These patients are referred to TCNs, who use assessments to create 30-day care-transition plans. In turn, the transitional care teams work with patients in the hospital and during a 30-day post-discharge period to address medication concerns and administer condition-specific teaching. TCTs also serve as a key link between patients and community-based clinical and social service providers. Accordingly, these care transition activities are intended to align with DSRIP's emphasis on reducing potentially avoidable ED visits and readmissions. Evaluations of the initiative's effects are ongoing: for instance, comparing patients' ED visits before and after receiving their 30-day care plans to contemporaneous ED use within comparison groups, the PPS found reductions in the percentages of TCT patients with ED visits that range from 1.5% to 6.9%. The PPS found similar reductions in the percentages of TCT patients with inpatient admissions, ranging from 11.5% to 18.7%.²⁷



Regional Care Management: Tracking High Utilizers Across Multiple Settings to Bridge Gaps in Coordination

For patients who rapidly cycle out of and back into care settings, divisions and competition among peer institutions can pose major obstacles to targeting and delivering effective care management. **Central New York Care Collaborative (CNYCC) PPS** has attempted to overcome these barriers by fostering a regional collaboration to exchange information and implement best practices for a shared population of high-utilizing patients. Initiated in March 2018, this collaboration was driven by three Syracuse-based hospitals participating in New York's Medicaid Accelerated eXchange (MAX) Series: St. Joseph's Health System, SUNY Upstate University Hospital, and Crouse Hospital. Each of these health systems had separately developed strategies to meet the needs of its

high-utilizing patients, such as St. Joseph’s nurse care management infrastructure, SUNY Upstate’s Intensive Transitions Team, and Crouse’s redeployment of social workers as care managers. After recognizing that many high-utilizing patients were receiving care from all three health systems, these CNYCC partners developed new processes for sharing clinical information on high-utilizers and shepherding them into a single hospital’s care management infrastructure—thereby bridging gaps in coordination across these providers.

This regional MAX collaboration accompanied each health system’s individual efforts to strengthen care management across settings. One such example was SUNY Upstate’s MAX project, completed in the spring of 2017, which focused on high utilizers’ care pathways and improving warm handoffs to Health Homes, home care agencies, and other community partners. This MAX project aimed to improve care management and follow-up for patients’ behavioral health conditions, palliative care needs, and other underlying drivers of utilization, and its success in reducing hospital readmissions complements the PPS’s broader focus on reducing potentially avoidable services. CNYCC continues to build other community collaborations supporting reductions in hospital admissions and readmissions, such as Rome Memorial Hospital’s MAX project, which has strengthened the hospital’s links to community partners that serve individuals with developmental disabilities and older adults who are dually eligible for Medicaid and Medicare.²⁸



Integrating Care Management: Using Mobile Health Centers to Bring Chronic Disease Management to Behavioral Health Patients

Bridging gaps in care management can involve other strategies, such as integrating services into new settings. A key example is integrating physical health into behavioral health care. **Montefiore Hudson Valley Collaborative (MHVC) PPS** and **Suffolk Care Collaborative (SCC) PPS** have developed van-based mobile health centers, operated by Hudson River Health Care, an FQHC, to deliver chronic disease screening and monitoring to patients with behavioral health conditions. This model draws upon evidence that improving collaboration and communication between medical and behavioral health providers can support more effective and sustainable integration efforts.²⁹ Since October 2017, one mobile health center and its dedicated staff have served MHVC members with severe and persistent mental illness at 10 behavioral health sites in the Hudson Valley, with a focus on cardiovascular and diabetes monitoring. Beginning in April 2018, a second mobile health center

has served SCC members at 11 behavioral health sites on Long Island, providing them with a broader array of primary care services—such as physical examinations, sick visits, and routine vaccinations—in addition to cardiovascular and diabetes monitoring. Between March 2018 and November 2018, the MHVC program screened 176 patients and observed a 58% increase, relative to baseline, in their adherence to recommended follow-up after positive screens for cardiovascular disease or diabetes. The PPSs have identified MHVC’s program as supporting DSRIP goals related to cardiovascular and diabetes monitoring for individuals with behavioral health needs and SCC’s program as supporting goals related to improving adult access to primary care.³⁰



Integrating Care Management: Blending Prenatal Care and Patient Support to Improve Birth Outcomes

Some innovative strategies for addressing gaps in care management emphasize blending services that have traditionally been segmented. **Bronx Health Access PPS’s** implementation of the Centering Pregnancy group-based model for prenatal care demonstrates how combining primary and preventive care with social support has the potential to improve prenatal care, birth outcomes, and patient satisfaction—aligning with DSRIP goals related to perinatal outcomes and access to primary care. The evidence-based Centering Pregnancy model brings together groups of 8 to 10 expectant mothers for a series of two-hour prenatal visits combining regularly scheduled individual examinations with social support and group-based prenatal education (in topics such as gestational development and healthy behaviors). Evidence suggests that Centering Pregnancy participants experience improved birth outcomes—with reduced likelihood of preterm delivery, low birthweight births, and NICU stays—as well as improvements in access to prenatal care, gestational weight gain, and breastfeeding.³¹

From 2017 to 2018, the number of Bronx Health Access’s Centering Pregnancy participants grew from 52 to 81.³² Over the same period, the PPS reported that program’s preterm birth rates ranged from 7% (2017) to 4% (2018), both lower than the Bronx’s overall preterm birth rate of 9.6% as of 2016.³³ Moreover, the PPS reported improvement in breastfeeding rates among program participants during the same two years. Beyond these effects, evidence from the field suggests that investments in the Centering Pregnancy model may ultimately generate net cost savings—a key reason why the model has also been included within New York’s broader First 1,000 Days on Medicaid initiative.³⁴



Potentially
Avoidable Services



Clinical Improvement:
Behavioral Health

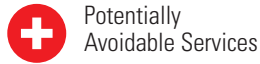


Clinical Improvement:
Diabetes

Patients as Care Managers: Supporting Diabetes Self-Management Through Mentoring and Workshops

While some promising practices focus on extending care management's reach across different settings or blending services within the same setting, other efforts focus on building patients' capacity for self-management. **WMCHHealth PPS** offers two complementary examples of self-management initiatives focused on diabetes. First, the Diabetes Self-Management Program (DSMP) involves a partnership between the PPS, the Lower Hudson Valley Perinatal Network (as lead CBO), and six other CBOs to provide evidence-based workshops designed to teach self-management skills to participants with Type 2 diabetes. The program uses the Self-Management Resource Center model, an evidence-based program developed by Stanford University.³⁵ Under this model, patients attend six weeks of small-group workshops where they learn techniques for improved eating habits, exercise, communication with health care providers, and goal-setting. Since the program's initial implementation in January 2018, 89 Medicaid members have completed the program, and before-and-after surveys have found consistent increases in DSMP participants' reported self-management behaviors and knowledge of diabetes.

Additionally, WMCHHealth has partnered with Inquisithealth to implement an evidence-based, one-on-one peer mentoring program for Medicaid patients with uncontrolled diabetes.³⁶ In this pilot, patients at Crystal Run Healthcare with high HbA1c levels were matched to peer mentors with good diabetes self-management skills. These mentors supported patients' diabetes self-management through phone calls, text messages, and video-based learning over a six-month period. The PPS found an average HbA1c reduction of 1.55% for 52 peer-mentoring participants between October 2016 and January 2018. According to WMCHHealth, the peer-mentoring program and the DSMP most directly align with DSRIP goals related to diabetes-related measures (including diabetes monitoring for people with schizophrenia) and reducing potentially preventable ED visits and readmissions.³⁷



Potentially
Avoidable Services



Access to Primary
and Preventive Care



Clinical Improvement:
Behavioral Health

Extending Care Management's Reach: Delivering Community-Based Telemedicine to Special Populations

Extending care management across settings and supporting disease self-management reveal some natural opportunities for telemedicine, whereby health care services are delivered to patients and their caregivers via information and communication technology. **Community Partners of Western New York PPS** includes three partner organizations implementing community-based telemedicine programs: Catholic Health System, Endeavor Health Services, and People Inc. Representing just one example of these programs' promising practices, People Inc. has implemented an ED triage program for individuals with intellectual and developmental disabilities. Recognizing that physically traveling to health care providers can be difficult for these individuals, People Inc. implemented a telemedicine program for triaging, treating, and monitoring non-urgent illnesses and injuries in patients' homes. People Inc. reports that their ED triage program has provided 818 Medicaid encounters (for 439 unique members) between the program's inception in August 2017 and December 2018, and that the program has reduced unnecessary ED and urgent care visits and improved continuity of care between patients, physicians, nurses, and direct care staff. Catholic Health's palliative care telemonitoring program and Endeavor's behavioral health telemedicine program share similar goals of reducing avoidable ED visits and hospitalizations, while also enhancing access to primary care, supporting integration of palliative care into primary care via patient-centered medical homes, and improving clinical care for those with behavioral health conditions.³⁸

The examples above demonstrate a wide range of practices with potential to improve care coordination, care management, and care transitions for Medicaid members. This section's final case study shows how a PPS might combine several of these approaches—such as workforce investments and population targeting—into a comprehensive, PPS-wide strategy.



Potentially Avoidable Services



Access to Primary and Preventive Care



Care Coordination and Care Transitions



Health Literacy

CASE STUDY: PROVIDING COMPREHENSIVE CARE COORDINATION TO AN AT-RISK POPULATION

Staten Island PPS (SIPPS) has partnered with Staten Island’s two Health Homes (Coordinated Behavioral Care and Northwell Health Solutions), as well as Community Health Center of Richmond and the Seamen’s Society for Children and Families, to provide care coordination staff and services for its SI CARES program. SI CARES offers health coaching and community support to individuals “at risk” of Health Home eligibility—defined as PPS members with at least one chronic health condition and at risk of developing another condition.

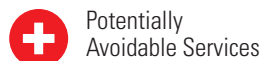
The program’s care coordinators help at-risk members access needed health care and social support services. The PPS trains these staff on chronic condition and care coordination fundamentals, value-based-payment and pay-for-performance measures, and health literacy and cultural competency standards. The PPS has also developed checklists, scripts, and motivational interviewing strategies for the care coordinators to identify and close specific gaps in care that could affect DSRIP performance. Examples include assisting members with accessing primary care and referring members for condition-specific screenings or follow-up visits.³⁹

SI CARES also uses sophisticated tools for targeting and tracking at-risk patients, such as the PPS’s data warehouse and connections to its local regional health information organization (RHIO). For instance, the PPS’s data warehouse generates reports identifying ED and inpatient super-utilizers, while the RHIO provides immediate alerts on ED visits and inpatient admissions. Patients who eventually become Health Home-eligible are identified through these tools and through the front-line care coordination staff, whose connections to the Health Homes allow for seamless care management during changes in patient status.

The PPS uses key performance indicators to measure and monitor care coordination staff performance on patient engagement, clinical outcomes (ranging from primary care utilization to chronic disease management), and social determinants of health interventions. SIPPS reports that over 7,500 members received SI CARES between April 2015 and October 2018, and that these members’ ED use was reduced by 22% over that period. Ultimately, the SI CARES design is consistent with DSRIP priorities in multiple areas, such as reducing avoidable ED visits and hospitalizations, improving access to primary care and care coordination, and advancing PPS members’ health literacy.⁴⁰

Transforming and Integrating Behavioral Health Care

Many themes within this report’s promising practices are integral to clinical improvement for behavioral health (BH) care, a DSRIP project focus selected by all 25 PPSs. With each project’s implementation, BH transformation has taken a different form to address the needs of specific Medicaid patient populations. Several core practice elements have emerged, such as integrating primary care and behavioral health, investing in the behavioral health workforce, targeting individuals with complex behavioral health needs, reducing emergency department (ED) use through crisis stabilization, utilizing peers to support recovery, and developing new responses to the opioid epidemic. The promising practices described below represent only a small subset of PPS projects that showcase how the pursuit of high-quality, accessible behavioral health care may help drive positive outcomes.



Potentially Avoidable Services



Access to Primary and Preventive Care



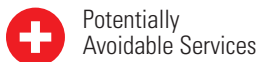
Clinical Improvement: Behavioral Health

Integration: Merging Primary Care and Behavioral Health Through Investments in Provider Capacity and Co-location

Since DSRIP’s beginning, all PPSs have selected projects to improve the integration of behavioral health and primary care. **Refuah Community Health Collaborative (RefuahCHC) PPS** has developed multiple strategies to advance the integration of primary medical care and BH services. Operationally, RefuahCHC has supported integration through data sharing and workforce expansion, incentivizing partners to connect to data via the regional health information organization and hiring 27 mental health providers, 37 primary care providers, and 15 additional staff to provide care management and patient navigation. The PPS has also developed and assessed “core protocols” for all of its providers, asking if practices have certain standards in place for BH care—such as procedures to ensure outpatient follow-ups within seven days of discharge for mental health hospitalizations, or to ensure that every patient on antipsychotics is screened for diabetes.

Further, RefuahCHC has contributed funding to expand primary medical care services for patients seeking chemical dependency treatment at St. Christopher’s Inn, a homeless shelter and drug rehabilitation center. The PPS has also implemented new workflows and delivery models within the primary care setting to achieve integration. These include a capital renovation project to assimilate BH providers within primary care and OB/GYN departments and the introduction of the AIMS (Advancing Integrated Mental Health Solutions) consultative psychiatry model to empower primary care providers to manage anxiety, depression, and

ADHD with the support of the mental health team. RefuahCHC reports that efforts like these have contributed to more than 1,000 mental health “warm handoffs” across all departments, the elimination of waiting lists for therapy or psychiatry across all ages, and generally strong performance on DSRIP behavioral health goals. More broadly, these integration activities are aligned with DSRIP objectives such as reducing preventable ED visits, improving access to primary care, improving follow-up after hospitalization for mental illness, diabetes screening for individuals on antipsychotics, BH medication adherence, and other behavioral health quality goals.⁴¹



Workforce: Investing in Staff and Expanding Access to Behavioral Health Care

Workforce shortages and high staff turnover are oft-cited challenges in strengthening access to behavioral health care, particularly for community-based providers. **Better Health for Northeast New York (BHNNY) PPS** provides an example of workforce investment resulting in positive outcomes for both staff and patients. Throughout its region, BHNNY has supported expansion of BH mobile crisis services through growth and integration of pre-existing crisis services and investment in new pilot projects.

One such pilot featured the expansion of the Mental Health Association of Columbia and Greene Counties’ Mobile Crisis Assessment Team (MCAT), which provides mobile and intensive crisis services, wellness checks, and assistance with care transitions. To meet growing local demand for mobile crisis services, MCAT service hours were extended from 8 hours per day to 14 hours per day, and licensed, non-clinical, and peer specialist staff were added to assist in recovery planning and to connect individuals in crisis to community supports. Using 12 months of data from when the initiative began in May 2017, BHNNY suggests that these expansions have contributed to a 20 percentage-point increase in response to requests for face-to-face services, hospital diversion rates of 91.5%, decreased staff turnover, and increased ability to provide telephone-based services. The PPS has described MCAT’s focus on ED diversion as consistent with DSRIP’s fundamental goal of reducing potentially avoidable services.⁴²



Potentially
Avoidable Services



Access to Primary
and Preventive Care



Clinical Improvement:
Behavioral Health

Population Targeting: Identifying Individuals with Complex Behavioral and Social Needs

Using and sharing data to target individuals with complex behavioral health needs is a crucial step in the success of PPS initiatives, but creating a risk stratification method that effectively identifies individuals most appropriate for an intervention can be difficult. To overcome such challenges, **Mount Sinai PPS** has used data hot-spotting to identify patients with BH diagnoses and high ED/hospital use and to connect them to a six-month intensive care management program called CORE (Community Outreach for Recovery and Engagement). Delivered by The Bridge in partnership with Coordinated Behavioral Care Independent Practice Association, this program uses information from EMRs, the Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES), and clinical referrals to target patients with a behavioral health diagnosis and either one hospital readmission or six or more ED visits.⁴³ As of December 31, 2018, preliminary results for a cohort of 31 program participants suggest that all individuals with a known BH admission received a follow-up appointment within seven days of discharge, and that metabolic testing was completed for 67% of patients with open diabetes monitoring or cardiovascular disease care gaps. Combined with efforts to facilitate primary care appointments, this program complements DSRIP's focus on improving adults' use of primary care while promoting better outpatient care and follow-up for behavioral health conditions.⁴⁴

In tandem with its Mount Sinai effort, Coordinated Behavioral Care Independent Practice Association has helped arrange a partnership between **Staten Island PPS** and Project Hospitality to develop the HEALTHi (Helping, Engaging, and Linking to Health Interventions) program. The PPS uses EMR data to identify high-risk patients and works with patients' providers to enroll these individuals in the program, which provides six months of intensive care management. This includes 24-hour access to team support, weekly home visits, frequent check-in calls, accompaniment to appointments, assistance with transportation, and support for unmet social needs. The PPS reports that as of February 2019, 70 high-risk patients were enrolled in the HEALTHi program, and that many have already completed the six-month intervention. Over 95% of the participants have visited primary care physicians, and over 70% of those with substance use problems have initiated and engaged in treatment. Most participants (as applicable to their diagnoses) have adhered to their antidepressant and antipsychotic prescriptions (90%), have had a diabetes screening (70%), and have filled a prescription for asthma (64%). Over 80% of participants have not had an ED visit since enrollment.⁴⁵



Potentially
Avoidable Services



Clinical Improvement:
Behavioral Health

Crisis Stabilization: Preventing Unnecessary Behavioral Health Hospitalizations

Individuals experiencing a behavioral health crisis may often not need treatment in the emergency department or hospital if they can access successful de-escalation resources in an ambulatory setting. To help reduce ED utilization, Northwell Health Cohen Children's Medical Center collaborated with **Nassau Queens PPS** to open a BH urgent care center for children 5-17 years old who present with mental health crises.⁴⁶ Co-located with pediatric ambulatory services, the urgent care center acts as a bridge to children's BH treatment, which is often difficult to access. The program closes this gap by providing mental health assessments, treatment referrals, treatment initiation (if necessary), and care coordination with schools, pediatricians, or other community resources.

Of the nearly 1,200 children seen in the behavioral health urgent care center during 2018, only 5% required treatment in the emergency department (94% of visits were treat-and-release). Nearly half of the children seen in the center were referred from local schools (46%), while a third were self-referred (34%). According to Northwell, the urgent care service has contributed to noticeable decreases in ED volume for pediatric BH crises. These urgent care activities align with DSRIP's aim to reduce potentially preventable ED visits and improve behavioral health care measures, such as appropriate follow-up and medication management for children prescribed ADHD medication.



Potentially
Avoidable Services



Clinical Improvement:
Behavioral Health

Care Transitions: Helping Psychiatric Inpatients Return to the Community

Recognizing that a behavioral health event requiring hospitalization can provide a critical moment for supporting individuals in the recovery process—thereby preventing potential readmissions—**WMCHHealth PPS** implemented the “Transition of Care Wellness Model.” The program supports individuals transitioning from the inpatient psychiatric setting back into the community. WMCHHealth has funded follow-up services from behavioral health clinicians (through Coordinated Behavioral Health Services IPA) and from peers (through Independent Living Systems and People USA).

Under this program, individuals in the psychiatry unit are introduced to a behavioral health clinician and peer before they are discharged; this prepares them to receive peer support services and an in-home clinical assessment from a BH clinician 48-hours post-discharge. Behavioral health clinicians are generally reimbursed under the Medicaid managed

care licensed behavioral health practitioner benefit while peer support services are funded entirely through DSRIP dollars.⁴⁷ Collaboration between these clinical and community-based services has helped individuals who have been discharged complete outpatient follow-up appointments and obtain assistance navigating community resources, such as crisis respite or transitional housing. PPS data from 2018 suggests that about 400 Medicaid individuals have received follow-up services from clinicians and peer-run organizations, improving patient outcomes like medication management, adherence to antidepressants or antipsychotics, follow-up after hospitalization for mental illness, and potentially preventable readmissions.⁴⁸



Peer Support: Using Peer Coaches to Support Recovery for Substance Use Disorder

For substance use disorders, care transitions and follow-up treatment may be more effective with assistance from peers who have already navigated the system from detoxification through rehabilitation and recovery. To support peer-led recovery and improve patients' transitions from inpatient to outpatient care, **Montefiore Hudson Valley Collaborative (MHVC) PPS** provided Innovation Funds to Arms Acres, an inpatient detoxification and rehabilitation facility licensed by the New York State Office of Alcoholism and Substance Abuse, to hire two certified recovery coaches. These peer recovery coaches meet a variety of needs for individuals transitioning out of Arms Acres into early recovery: ensuring attendance at the first outpatient appointment, making a connection with recovery supports in the community, providing assistance with the navigation of health and social service systems, and offering help rescheduling missed appointments.⁴⁹

During 2018, peer recovery coaches ensured that 100% of the 122 transitioning patients attended their first outpatient appointment. Of those, 80% of recovering patients attended their first appointment within seven days of discharge, and nearly 96% kept their second appointment. Arms Acres found that when patients had peer support, they completed more routine discharges, experienced better transitions to (and long-term engagement with) outpatient treatment, and had lower rates of readmission. These efforts are consistent with DSRIP performance goals related to sustaining engagement in alcohol and drug treatment and connecting adults to primary and preventive care. Going forward, Arms Acres has begun to calculate the true return on investment for peer recovery coaches, with plans to seek VBP arrangements that can sustain these services through shared savings.



Potentially
Avoidable Services



Clinical Improvement:
Behavioral Health

CASE STUDY: ADDRESSING THE OPIOID CRISIS BY EXPANDING MEDICATION-ASSISTED TREATMENT IN PRIMARY CARE

The transformation and integration of Medicaid patients' behavioral health care is being tested by the ongoing opioid crisis, which is hitting the health system on all fronts: in emergency departments, hospitals, outpatient clinics, and community-based care. In upstate New York, **Leatherstocking Collaborative Health Partners PPS** partnered with Bassett Healthcare Network and the University of Massachusetts Medical School to address the growing opioid epidemic. The organizations used Project ECHO (Extension of Community Healthcare Outcomes) to empower rural office-based providers in Central New York to treat opioid use disorder (OUD) with medication-assisted treatment (MAT).⁵⁰ The PPS has integrated MAT into office-based settings by hiring an addiction medicine psychiatrist, providing on-site training and electronic consultation resources for staff through the TeleECHO clinic, and pursuing Drug Addiction Treatment Act (DATA) waivers to license qualified clinicians as prescribers. From December 2016 to December 2018, approximately 45 new clinicians and mid-level staff members have been licensed to prescribe, and over 400 patients have initiated Suboxone treatment with a 77% retention rate after 24 weeks.⁵¹ These activities are linked to broader DSRIP efforts to improve initiation of, and ongoing engagement in, alcohol and other drug dependence treatment, and to reduce potentially avoidable ED visits, hospitalizations, and readmissions (including those associated with OUD and its comorbidities).

Leatherstocking PPS has also recognized that increasing access to opioid addiction treatment requires work beyond the walls of the clinic. Acting as a regional convener, the PPS organized a heroin and opioid summit in collaboration with New York State Senator James L. Seward to study efforts already underway in the region. Together, they sought workable solutions across sectors of law enforcement, local and state government, public health, members of the treatment and recovery community, medical and mental health professionals, and academic faculty. Finally, the PPS tapped a local judge and clinic to pilot a collaboration between the drug court and primary care.

Conclusion

During the summer and fall of 2019, the Department of Health will be working with a broad array of stakeholders to conceptualize the next phase of DSRIP under a Medicaid waiver extension/renewal request. The promising practices here suggest that—with additional time and support to bridge the gap to VBP—DSRIP’s substantial investments could yield a lasting impact. The new infrastructure and workforce investments, provider and community relationships, quality improvement strategies, and population-specific targeting and care management capacities facilitated by DSRIP have created the necessary conditions to sustain New York Medicaid’s progress on health care and social support access, quality, and costs well beyond 2020.

The promising practices presented in this report are not yet certified best practices, but PPS-reported outcomes suggest that broader-scale adoption could support continued progress in lowering Medicaid costs, improving access and quality, and further leveraging DSRIP investments to date. While VBP may be a long-term vehicle for promoting replication and scale-up of these practices, it is premature to expect emerging payment reform strategies to fully support the kinds of substantial infrastructure necessary for sustaining DSRIP’s progress. As future waiver conversations accelerate, it will be important to consider opportunities for ongoing support of the impressive work highlighted in this report.

Appendix: UHF Categorization of DSRIP Measures Aligned with Promising Practices

Potentially Avoidable Services

Pediatric Quality Indicator #90 (Overall Composite)
Potentially Avoidable Emergency Room Visits
Potentially Avoidable Readmissions
Prevention Quality Indicator #90 (Overall Composite)

Access to Primary and Preventive Care

Adult Access to Preventive or Ambulatory Care—20 to 44 Years
Adult Access to Preventive or Ambulatory Care—45 to 64 Years
Adult Access to Preventive or Ambulatory Care—65 and Older
Children's Access to Primary Care—12 to 24 Months
Children's Access to Primary Care—25 Months to 6 Years
Children's Access to Primary Care—7 to 11 Years
Children's Access to Primary Care—12 to 19 Years
Getting Timely Appointments, Care, and Information (Q6, 8, 10, and 12)
Non-Use of Primary and Preventive Care Services
Primary Care—Length of Relationship
Primary Care—Usual Source of Care

Care Coordination and Care Transitions

CAHPS Measures—Care Coordination With Provider Up-to-Date about Care Received from Other Providers

Health Literacy

Health Literacy—Describing How to Follow Instructions
Health Literacy—Explained What to Do If Illness Got Worse
Health Literacy—Instructions Easy to Understand

Clinical Improvement: Behavioral Health

Adherence to Antipsychotic Medications for People with Schizophrenia
Antidepressant Medication Management—Effective Acute Phase Treatment
Antidepressant Medication Management—Effective Continuation Phase Treatment
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
Diabetes Monitoring for People with Diabetes and Schizophrenia
Diabetes Screening for People with Schizophrenia or Bipolar Disease Who Are Using Antipsychotic Medication
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 Visits within 44 Days)
Follow-up after Hospitalization for Mental Illness—within 7 days
Follow-up after Hospitalization for Mental Illness—within 30 days

Follow-up Care for Children Prescribed ADHD Medications—Continuation Phase
Follow-up Care for Children Prescribed ADHD Medications—Initiation Phase
Initiation of Alcohol and Other Drug Dependence Treatment (1 Visit within 14 days)
Potentially Preventable Emergency Department Visits (for Persons with BH Diagnosis)



Clinical Improvement: Cardiovascular Disease

Controlling High Blood Pressure
Discussion of Risks and Benefits of Aspirin Use
Medical Assistance with Smoking and Tobacco Use Cessation—Advised to Quit
Prevention Quality Indicator #7 (Hypertension Admission Rate)



Clinical Improvement: Diabetes

Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
Comprehensive Diabetes Care—All Three Tests (HbA1c, Dilated Eye Exam,
Nephropathy Monitor)
Prevention Quality Indicator #1 (Diabetes Short-Term Complications Admission Rate)



Clinical Improvement: Asthma

Asthma Medication Ratio (5–64 years)
Medication Management for People with Asthma (5–64 Years)—50% of Treatment
Days Covered
Medication Management for People with Asthma (5–64 Years)—75% of Treatment
Days Covered
Pediatric Quality Indicator #14 (Asthma Admission Rate)
Prevention Quality Indicator #15 (Asthma in Younger Adults Admission Rate)



Clinical Improvement: Perinatal Care

Frequency of Ongoing Prenatal Care (Receiving 81% or More of Expected Prenatal Visits)
Prevention Quality Indicator #9 (Low Birth Weight Rate)
Prenatal and Postpartum Care—Timeliness of Prenatal Care

Index: Promising Practices by Theme and Performing Provider System

Project Themes: Brief Project Descriptions	PPS(s)	Page
Core Infrastructure and Capacity Building		7
Developing Networks for Performance. Creation of multiple clinical and community service provider networks most relevant to serving complex patient cohorts, for the purpose of developing targeted strategies and performance goals to improve patient outcomes and prepare providers for value-based payment (VBP).	Care Compass Network	7
Developing Networks for Performance. Building a regional clinically integrated network of physicians, federally qualified health centers (FQHCs), hospitals, behavioral health providers, and community-based organizations (CBOs), that evolved into a regional independent practice association that could enter into VBP arrangements with payers.	North Country Initiative	7
Expanding Technology and Using Data and Analytics. Developing sophisticated data capacity to support performance improvement through claims-based partner dashboards, and to inform care management and quality improvement via disease cohort analyses.	Adirondack Health Institute PPS	9
Transforming Primary Care. Supporting primary care practice transformation by enabling small primary care practices to achieve patient-centered medical home recognition, training community health workers (CHWs) to support primary care practices, and fostering strong partnerships between CBOs and primary care to more effectively manage patients' social needs.	SOMOS Community Care	10
Connecting Clinical and Community Resources. Partnering with CBOs to serve homeless individuals post-hospital-discharge through medical crisis respite with supportive medical and social services, and building CBO capacity to develop and track key outcomes important for longer-term funding via managed care contracts.	Alliance for Better Health PPS	10
Connecting Clinical and Community Resources. Collaborating with community partners on developing cultural responsiveness and health literacy training, and on building CBO capacity through infrastructure development, including VBP-readiness training on program evaluation principles, data collection and collaboration, and communicating impact and value.	Bronx Partners for Healthy Communities	11
Building Quality Improvement Capacity Across the Care Continuum. Collaborating with skilled nursing facilities (SNFs) to coordinate long-term-care-related DSRIP projects, review hospitalization data and other quality metrics, and implement related quality improvement initiatives focused on goals such as reducing SNF residents' emergency department use and hospital admissions.	NewYork-Presbyterian Queens PPS	12
Bringing It All Together to Serve High-Need Subpopulations. Improving care for HIV/AIDS patients by building on existing infrastructure to implement clinical quality improvement and prevention activities across the care continuum, integrating HIV/AIDS services with a team-based complex care coordination model and social supports, and leveraging CBOs, CHWs, and peers to improve population health.	NewYork-Presbyterian PPS	12

Social Needs, Community Partnerships, and Cross-Sector Collaborations	14
<p>Workforce: Using Community Health Workers to Connect Patients to Health and Social Services. Utilizing CHWs in the emergency department to screen high-risk patients at bedside for social needs and provide patients in need with achievable goals and 30 days of follow-up care management and navigation.</p>	<p>NYU Langone Brooklyn PPS 14</p>
<p>Population Targeting: Using Community Partnerships to Engage Low Utilizers in Care. Using CHWs at partner CBOs and an FQHC to identify individuals who underutilize health services and connect them to primary care and social services.</p>	<p>Suffolk Care Collaborative PPS 15</p>
<p>Care Management: Blending Traditional Models with Community Navigation to Avert Unnecessary Services. Partnering with CBOs, behavioral health providers, care management agencies, and FQHCs to use trained community navigators to connect individuals to resources like food, housing, transportation, dental and behavioral health (BH) services, and primary care.</p>	<p>Finger Lakes PPS 16</p>
<p>Community Partnerships: Leveraging Local Resources to Promote Heart Health. Implementing comprehensive community-based heart health education, blood pressure screening, and linkage to primary care in partnership with local churches, community centers, schools, and beauty salons and barbershops.</p>	<p>Millennium Collaborative Care PPS 16</p>
<p>Integration: Embedding Nutrition Assistance Within Health Care Settings. Establishing a comprehensive Food as Health program that connects food-insecure patients with nutrition-related diagnoses to the most appropriate on-site, community, and in-home food resources based on disease complexity and mobility.</p>	<p>Nassau Queens PPS 17</p>
<p>Cross-Sector Collaboration: Addressing Behavioral Health Across the Justice and Health Care Systems. Developing interventions to close the gaps in behavioral health care for people at risk of incarceration and those about to be released from jail through local cross-sector collaborations between hospitals, behavioral health providers, and the justice system.</p>	<p>Adirondack Health Institute PPS 18</p>
<p>Case Study: Fostering Cross-Sector Collaboration to Target Behavioral Health in Schools. Partnering with a non-profit social services agency, behavioral health providers, and underserved New York City public schools to provide behavioral health coaches who help teachers and other school staff deliver crisis support and referrals to students with behavioral health needs.</p>	<p>Bronx Health Access; Bronx Partners for Healthy Communities; Community Care of Brooklyn; OneCity Health 19</p>

Care Coordination, Care Management, and Care Transitions		20
Workforce: Investing in Community Health Workers for Chronic Disease Management. Building capacity among new and existing staff to implement a CHW home-visitation program for managing child asthma by training CHWs and clinical providers to support expansion of asthma services.	OneCity Health	20
Population Targeting: Managing Care Transitions for At-Risk Patients. Identifying patients at-risk for hospital readmission and developing a new “transitional care team” workforce to provide safe and effective transitions of care for these patients, through enhanced post-discharge care planning and connections to appropriate community-based clinical and social services.	Community Care of Brooklyn PPS	21
Regional Care Management: Tracking High Utilizers Across Multiple Settings to Bridge Gaps in Coordination. Forming a regional hospital collaboration to exchange information and implement best practices for providing care management to a shared population of high-utilizing patients, leveraging concurrent health system initiatives to strengthen care management across settings and partners such as hospitals, home care agencies, and Health Homes.	Central New York Care Collaborative PPS	21
Integrating Care Management: Using Mobile Health Centers to Bring Chronic Disease Management to Behavioral Health Patients. Bridging gaps in care management by integrating physical and behavioral health care through the operation of van-based mobile health centers that deliver primary care services and screenings to patients at multiple behavioral health provider sites.	Montefiore Hudson Valley Collaborative PPS; Suffolk Care Collaborative PPS	22
Integrating Care Management: Blending Prenatal Care and Patient Support to Improve Birth Outcomes. Implementing the Centering Pregnancy group-based model for prenatal care and education to better combine primary and preventive care with social support services that are traditionally segmented.	Bronx Health Access PPS	23
Patients as Care Managers: Supporting Diabetes Self-Management Through Mentoring and Workshops. Building patients’ capacity for self-management through CBO-provided, small-group educational workshops and through an evidence-based, one-on-one peer mentoring program that strengthens diabetes self-management skills.	WMCHealth PPS	24
Extending Care Management’s Reach: Delivering Community-Based Telemedicine to Special Populations. Fostering three different community-based telemedicine programs for hard-to-serve subpopulations: one that provides in-home triage and monitoring of non-urgent conditions for individuals with intellectual and developmental disabilities, and two others focused on palliative care and behavioral health patients, respectively.	Community Partners of Western New York PPS	25
Case Study: Providing Comprehensive Care Coordination to an At-Risk Population. Supporting individuals identified as “at risk” of future Health Home eligibility by building partnerships between the PPS, two Health Homes, a community health center, and a CBO to train care coordinators in providing health coaching and community support to these individuals and to align care coordination performance with DSRIP goals.	Staten Island PPS	26

Transforming and Integrating Behavioral Health Care		27
<p>Integration: Merging Primary Care and Behavioral Health Through Investments in Provider Capacity and Co-location. Integrating primary care and behavioral health services through multiple strategies, including: data sharing, workforce expansion, development of shared behavioral health protocols, new workflows and delivery models, and a capital renovation project.</p>	Refuah Community Health Collaborative PPS	27
<p>Workforce: Investing in Staff and Expanding Access to Behavioral Health Care. Expanding mobile behavioral health crisis stabilization through extended hours for mobile crisis services and new peer specialist staff to connect individuals with community supports and to assist in recovery planning.</p>	Better Health for Northeast New York PPS	28
<p>Population Targeting: Identifying Individuals with Complex Behavioral and Social Needs. Targeting high-risk patients through clinical data, utilization data, and clinical referrals in order to connect them with 6-month intensive care management programs that include linkages to appropriate outpatient care and community social supports.</p>	Mount Sinai PPS; Staten Island PPS	29
<p>Crisis Stabilization: Preventing Unnecessary Behavioral Health Hospitalizations. Creating a behavioral health urgent care center, co-located with pediatric ambulatory services, to divert children in mental health crisis from the emergency department by providing assessments, referrals, treatment initiation and management, and coordination with primary care providers, schools, and other community resources.</p>	Nassau Queens PPS	30
<p>Care Transitions: Helping Psychiatric Inpatients Return to the Community. Supporting individuals transitioning from inpatient psychiatric units to community-based settings using collaborative, in-home follow-up visits from behavioral health clinicians and ongoing peer support from partnering CBOs.</p>	WMCHealth PPS	30
<p>Peer Support: Using Peer Coaches to Support Recovery for Substance Use Disorder. Hiring peer recovery coaches to assist with care navigation and coordination for individuals with substance use disorders following discharge from inpatient rehabilitation, including connecting such individuals to appropriate outpatient services and supports.</p>	Montefiore Hudson Valley Collaborative PPS	31
<p>Case Study: Addressing the Opioid Crisis by Expanding Medication-Assisted Treatment in Primary Care. Addressing the opioid epidemic on multiple fronts, including equipping staff in primary care settings to provide medication-assisted treatment (MAT) through training and ongoing consultation; licensing additional clinicians to prescribe MAT; convening a regional Opioid Summit; and piloting a collaboration between a local drug court and primary care providers.</p>	Leatherstocking Collaborative Health Partners PPS	32

Endnotes

Introduction

- ¹ United Hospital Fund developed these measure categories based on information from the DSRIP Measure Specification and Reporting Manual. The categories represent thematic groupings that are more detailed than the four DSRIP Project Domains (e.g., Domain 3, Clinical Improvement Projects), but broader than project-specific measurement bundles (e.g., Project 3.a.i. Integration of Primary Care and Behavioral Health).

For the underlying measurement information, see:

New York State Department of Health. September 2018. *DSRIP Measure Specification and Reporting Manual: Measurement Year 5*. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2018/docs/2018-09-30_measure_specific_rpting_manual.pdf

Core Infrastructure and Capacity Building

- ² PPSs are required to meet a range of “overall project progress” (i.e., DSRIP Domain 1) measures focused on the processes of setting up the core infrastructure and governance necessary to deliver on individual projects. Performance on these progress metrics does not directly correlate with performance on “system transformation” (Domain 2) and “clinical improvement” (Domain 3) measures discussed in the other sections of this report. https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2018/docs/2018-09-30_measure_specific_rpting_manual.pdf
- ³ Advanced Primary Care: A Key Contributor to Successful ACOs, <https://www.pcpcc.org/resource/evidence2018>
- ⁴ Burke, G. April 2019. *Patient-Centered Medical Homes in New York, 2018 Update: Drivers of Growth and Challenges for the Future*. New York: United Hospital Fund. Available at: <https://uhfnyc.org/publications/publication/pcmh-new-york-2018-update/>
- ⁵ SOMOS DSRIP Year 3 milestone, validated by Independent Assessor, based on individual NPIs.
- ⁶ NYC Population Health Improvement Plan Small Practice Project. <https://uhfnyc.org/publications/publication/nyc-hip-small-practice-project/>
- ⁷ New York State Department of Health. November 2018. *1115 Medicaid Redesign Team (MRT) Public Comment Transcript*. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/2018/2018-11-29_public_comment_transcript.htm

- 8 Interfaith Partnership for the Homeless. May 2018. *Medical Respite Turns One*. Available at: <http://www.interfaithpartnership.com/2018/05/medical-respite-turns-one/>
- 9 New York State Department of Health. *DSRIP Independent Assessor: Mid-Point Assessment Report, Bronx Partners for Healthy Communities PPS, Appendix Narratives*. November 2016. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrrip/pps_map/midpoint/appx_narrative/sbh.pdf
- Bronx Partners for Healthy Communities PPS. December 2017. *Connecting our Community to Care* Blogpost. Available at: <http://www.bronxphc.org/2017/12/07/connecting-our-communities-to-care/>
- 10 Bronx Partners for Healthy Communities PPS. February 2019. DSRIP Learning Symposium Presentation. Available at: <http://www.dsriplearning.com/documents/presentations/Alabama-Travers/2.12%20Presentations/Sprint%20E6%20Building%20CBO%20Capacity%202.12/Sprint%20E6%20Building%20CBO%20Capacity%202.12.pdf>;
- Bronx Partners for Healthy Communities PPS. December 2018. Presentation at the Institute for Healthcare Improvement National Forum. Available at: http://app.ihi.org/FacultyDocuments/Events/Event-3135/Presentation-17288/Document-14719/Presentation_D26E26_Winning_Trust_update_12.12_Kauffmann.pdf;
- 11 Ouslander, J.G., Lamb, G., Tappen, R., Herndon, L., Diaz, S., Roos, B.A., Grabowski, D.C. and Bonner, A. 2011. Interventions to reduce hospitalizations from nursing homes: evaluation of the INTERACT II collaborative quality improvement project. *Journal of the American Geriatrics Society*, 59(4), pp.745-753. Available at: <http://www.pathway-interact.com/wp-content/uploads/2017/04/INTERACT-Evaluation-JAGS-April-2011.pdf>
- 12 New York Presbyterian Queens PPS. March 2019. PPS-provided information on SNF collaborations.
- 13 New York Presbyterian Queens PPS. February 2019. DSRIP Learning Symposium Poster. Available at: http://www.dsriplearning.com/documents/presentations/posters/RPPH23_Hospital%20and%20Skilled%20Nursing%20Facility%20Collaboration%20to%20Reduce%20Palliative%20Services%20Related%20Readmissions.pdf
- 14 New York Presbyterian PPS. March 2019. PPS-provided information on NYP Designated AIDS Center. See also PPS website for HIV/AIDS project descriptions, available at: <https://www.nyp.org/pps/projects/hiv-center-reducing-hiv-morbidity>.

Social Needs, Community Partnerships, and Cross-Sector Collaborations

Workforce: Using Community Health Workers to Connect Patients to Health and Social Services

¹⁵ General resources for more project information:

NYU Langone Brooklyn PPS. February 2019. DSRIP Learning Symposium Poster. Available at: http://www.dsriplearning.com/documents/presentations/posters/CI10_Addressing%20Health%20Disparities%20From%20Emergency%20Department%20to%20the%20Community.pdf

Insignia Health. Patient Activation Measure Website. Available at: <https://www.insigniahealth.com/products/pam-survey>

Population Targeting: Using Community Partnerships to Engage Low Utilizers in Care

¹⁶ General resources for more project information:

Suffolk Care Collaborative PPS Website. Community Health Activation Program (CHAP). Available at: <https://suffolkcare.org/aboutDSRIP/projects/2di>

Care Management: Blending Traditional Models with Community Navigation to Avert Unnecessary Services

¹⁷ General resources for more project information:

Finger Lakes PPS Website: Community Navigation and Patient Activation. Available at: <https://flpps.org/Projects/Patient-Activation>

Finger Lakes PPS. Primary Care Plan Update, 2017. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/pc_plans/updates/fingerlakes.pdf

Community Partnerships: Leveraging Local Resources to Promote Heart Health

¹⁸ Million Hearts Initiative information. Available at: <https://millionhearts.hhs.gov/>

¹⁹ General resources for more project information:

Millennium Collaborative Care, Annual Report. Available at: <http://millenniumcc.org/wp-content/uploads/MCC-Annual-Report-Booklet.pdf>

Millennium Collaborative Care, DSRIP Projects and Highlights: Evidence-Based Strategies for Cardiovascular Disease. Available at: <https://millenniumcc.org/cardiovascular-disease-management/>

Millennium Collaborative Care. April 27, 2017. *Millennium, Greater Buffalo United Ministries, University at Buffalo School of Nursing Launch 2017 Million Hearts Cardiovascular Screenings Initiative*. Available at: <https://millenniumcc.org/millennium-greater-buffalo-united-ministries-university-at-buffalo-school-of-nursing-launch-2017-million-hearts-cardiovascular-health-screenings-initiative/>

²⁰ General resources for more project information:

Niagara Gazette, Initiative Recruits Barbers and Beauticians in Community Health Efforts. September 19, 2017. Available at: <https://millenniumcc.org/niagara-gazette-initiative-recruits-barbers-and-beauticians-in-community-health-efforts/>

Millennium Collaborative Care, *Beauty & Barber Shops Blood Pressure Screenings Initiative Expands to Six Erie County/Buffalo Locations*. Available at: <https://millenniumcc.org/beauty-barber-shops-blood-pressure-screenings-initiative-expands-to-six-erie-county-buffalo-locations/>

Integration: Embedding Nutrition Assistance Within Health Care Settings

²¹ General resources for more project information:

Nassau Queens PPS. February 2019. DSRIP Learning Symposium Presentation. Available at: <http://www.dsriplearning.com/documents/presentations/Broadway%20Ballroom%203-4/2.12%20Presentations/Sprint%20D9%20Food%20as%20Health%202.12/Sprint%20D9%20Food%20as%20Health%202.12.pdf>

Northwell Health, Island Harvest, God's Love We Deliver, and Long Island Cares. *Food as Health: Addressing Food Insecurity in a Clinical Setting*. Poster presentation at the Association for Community Health Improvement 2019 National Conference. March 20, 2019.

Cross-Sector Collaboration: Addressing Behavioral Health Across the Justice and Health Care Systems

²² General resources for more project information:

Adirondack Health Institute PPS. February 2019. DSRIP Learning Symposium Presentation. Presentation not yet available.

Policy Research Associates. *The Sequential Intercept Model*. Available at: <https://www.prainc.com/sim/>

Case Study: Fostering Cross-Sector Collaboration to Target Behavioral Health in Schools

²³ General resources for more project information:

Bronx Health Access, Bronx Partners for Healthy Communities, Community Care of Brooklyn, and OneCity Health PPSs. February 2019. DSRIP Learning Symposium Presentation. Available at: <http://www.dsriplearning.com/documents/presentations/Highrock/2.12%20Presentations/Sprint%20D7%20Schools%20and%20Community%20Partners%202.12/Sprint%20D7%20Schools%20and%20Community%20Partners%202.12.pdf>

Care Coordination, Care Management, and Care Transitions

Workforce: Investing in Community Health Workers for Chronic Disease Management

²⁴ Controlled studies have found that patients of PACE-trained providers had fewer days with asthma symptoms, fewer emergency room visits, and reduced hospitalizations compared to other patients. See National Heart, Lung, and Blood Institute. *Physician Asthma Care Education (PACE): Evidence*. Accessed February 2019 at: <https://www.nhlbi.nih.gov/health-pro/resources/lung/physician-asthma-care-education/evidence.htm>

²⁵ General resources for more project information:
OneCity Health. February 2019. DSRIP Learning Symposium Submission.

OneCity Health. *Expansion of Expansion of Home-Based Environmental Asthma Management: Toolkit for Community Health Worker Services*. Available at: https://www.onecityhealth.org/wp-content/uploads/3_Phase-III_Asthma-Home-Visit-Program-Toolkit_CHWs_Asthma_vf.pdf

OneCity Health. *Asthma Education: For Partnership in Care Action Plan*. Available at: https://www.onecityhealth.org/wp-content/uploads/17MISC0061-Asthma-Action-Plan-Webinar_vF.pdf

OneCity Health. Asthma Archives. Available at: <https://www.onecityhealth.org/tag/asthma/>

Greater New York Hospital Association and New York Academy of Medicine. April 2018. *Partnerships Between New York City Health Care Institutions and Community-Based Organizations* (Case Study Two: LSA Family Health Service and OneCity Health). Available at: https://nyam.org/media/filer_public/9f/5b/9f5b33a3-0795-4a1a-9b90-fa999e9ddf8e/hco_cbo_partnerships_digital.pdf

Population Targeting: Managing Care Transitions for At-Risk Patients

- ²⁶ The LACE tool has been validated by a number of studies, such as: Van Walraven, C., et al. 2010. Derivation and validation of an index to predict early death or unplanned readmission after discharge from hospital to the community. *Canadian Medical Association Journal*. 182(6), pp.551-557. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845681/>
- ²⁷ General resources for more project information:
Community Care of Brooklyn PPS. February 2019. DSRIP Learning Symposium Poster. Available at: http://www.dsriplearning.com/documents/presentations/posters/RPPH24_Reducing%20Hospital%20Utilization%20by%20Addressing%20the%20Unique%20Needs%20of%20At-Risk%20Patients%20in%20Brooklyn.pdf

Regional Care Management: Tracking High Utilizers Across Multiple Settings to Bridge Gaps in Coordination

- ²⁸ General resources for more project information:
Central New York Care Collaborative PPS. February 2019. DSRIP Learning Symposium Impact Exhibition.
New York State Department of Health. May 2018. *Regional MAX Collaboration* (panel discussion). Video archive available at: <https://youtu.be/xQI-Muf8szg>
New York State Department of Health. November 2018. *CNYCC PPS-Wide Annual Meeting 2018*. Available at: <https://cnycare.org/media/3195/keynote-address-greg-allen-nysdoh.pdf>
New York State Department of Health. 2018. *MAX Series Case Studies, January-July 2017*. Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/max/docs/2017-jan-jul_max_case_studies.pdf

Integrating Care Management: Using Mobile Health Centers to Bring Chronic Disease Management to Behavioral Health Patients

- ²⁹ Muse, A. R., Lamson, A. L., Didericksen, K. W., & Hodgson, J. L. 2017. A systematic review of evaluation research in integrated behavioral health care: Operational and financial characteristics. *Families, Systems, & Health*. 35(2), pp. 136-154. Available at: <http://dx.doi.org/10.1037/fsh0000276>

³⁰ General resources for more project information:

Montefiore Hudson Valley Collaborative PPS and Suffolk Care Collaborative PPS. February 2019. DSRIP Learning Symposium Poster. Available at: http://www.dsriplearning.com/documents/presentations/posters/BHSUD32_Mobile%20Medical%20Van%20Accelerates%20Development%20of%20Integrated%20Delivery%20System,%20Capital%20District%20to%20Eastern.pdf

Integrating Care Management: Blending Prenatal Care and Patient Support to Improve Birth Outcomes

³¹ University of Wisconsin Population Health Institute. September 2016. *What Works for Health: Centering Pregnancy*. Available at: <http://whatworksforhealth.wisc.edu/program.php?t1=22&t2=16&t3=110&id=433>

³² Program data as reported within Bronx Health Access's PPS Impact Exhibition Submission for the 2019 DSRIP Learning Symposium (see below).

³³ Bureau of Vital Statistics, New York City Department of Health and Mental Hygiene. *Summary of Vital Statistics 2016*. Available at: <https://www1.nyc.gov/assets/doh/downloads/pdf/vs/2016sum.pdf>

³⁴ General resources for more project information:

Bronx Health Access. February 2019. DSRIP Learning Symposium: PPS Impact Exhibition Submission.

Bronx Health Access. March 2017. *Improving Maternal Child Health in the Bronx*. Available at: https://www.bronxhealthaccess.org/fileadmin/SiteFiles/BronxHealthAccess/8_Resources/BHA-Town-Hall-Presentation_3.17.17.pdf

New York State Department of Health. March 2019. *First 1,000 Days Initiative: Project Descriptions: Centering Pregnancy*. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/first_1000.htm

Evidence of Centering Pregnancy's potential return on investment is available from: Gareau, S., et al. July 2016. Group prenatal care results in Medicaid savings with better outcomes: a propensity score analysis of Centering Pregnancy participation in South Carolina. *Maternal and Child Health Journal*, 20(7), pp.1384-1393. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26979611>

Patients as Care Managers: Supporting Diabetes Self-Management Through Mentoring and Workshops

³⁵ Self-Management Resource Center. *Diabetes: Articles & Published Research*. Available at: <https://www.selfmanagementresource.com/resources/bibliography/diabetes>

³⁶ This program draws upon evidence from randomized clinical trials showing that peer mentoring can reduce HbA1c levels. See:

Long, J.A., Jahnle, E.C., Richardson, D.M., Loewenstein, G. and Volpp, K.G., 2012. Peer mentoring and financial incentives to improve glucose control in African American veterans: a randomized trial. *Annals of Internal Medicine*. 156(6), pp.416-424. Available at: <https://annals.org/aim/fullarticle/1090722/peer-mentoring-financial-incentives-improve-glucose-control-african-american-veterans>

Thom, D.H., Ghorob, A., Hessler, D., De Vore, D., Chen, E. and Bodenheimer, T.A., 2013. Impact of peer health coaching on glycemic control in low-income patients with diabetes: a randomized controlled trial. *Annals of Family Medicine*. 11(2). pp.137-144. Available at: <http://www.annfammed.org/content/11/2/137.long>

³⁷ General resources for more project information:

WMCHHealth PPS. February 2019. DSRIP Learning Symposium Submission.

WMCHHealth PPS. February 2019. DSRIP Learning Symposium Poster. Available at: http://www.dsriplearning.com/documents/presentations/posters/CI16_One-on-One%20Peer%20Mentoring%20Improves%20Diabetes%20Self-Management%20and%20Clinical%20Outcomes%20among.pdf

New York State Department of Health. November 2016. *DSRIP Independent Assessor: Mid-Point Assessment Report (Westchester Medical Center PPS)*. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/appx_narrative/westchester.pdf

Extending Care Management's Reach: Delivering Community-Based Telemedicine to Special Populations

³⁸ General resources for more project information:

Community Partners of Western New York PPS. February 2019. DSRIP Learning Symposium Session. Available at: <http://www.dsriplearning.com/documents/presentations/Saratoga%20Ballroom%202/2.13%20Presentations/Breakout%20G3%20Telemedicine%202.13/Breakout%20G3%20Telemedicine%202.13.pdf>

Case Study: Providing Comprehensive Care Coordination to an At-Risk Population

³⁹ Motivational interviewing is widely recognized as an evidence-based intervention strategy for supporting treatment of behavioral health conditions and chronic disease. For example, see: Rubak, S., Sandbæk, A., Lauritzen, T. and Christensen, B., 2005. Motivational interviewing: a systematic review and meta-analysis. *British Journal of General Practice*. 55(513), pp.305-312. Available at: <https://bjgp.org/content/bjgp/55/513/305.full.pdf>

⁴⁰ General resources for more project information:

Staten Island PPS. February 2019. DSRIP Learning Symposium Poster. Not yet available.

New York State Department of Health. November 2016. *DSRIP Independent Assessor: Mid-Point Assessment Report (Staten Island PPS)*. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/appx_narrative/staten_island.pdf

Transforming and Integrating Behavioral Health

Integration: Merging Primary Care and Behavioral Health Through Investments in Provider Capacity and Co-location

⁴¹ General resources for more project information:

Refuah PPS Project Advisory Committee Meeting Presentation, June 2018 and Refuah PPS Project Advisory Committee Meeting Presentation, March 2017. Available at: <http://www.refuahchc.org/presentations-webinars/>

Refuah Community Health Collaborative, Primary Care Plan Update 2017. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/pc_plans/updates/refuah.pdf

Refuah Health Center, MAX Presentation. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/learning_symposiums/docs/max_posters/refuah.pdf

Refuah Community Health Collaborative Website, Behavioral Health and Primary Care Integration. Available at: <http://www.refuahchc.org/behavioral-health-primary-care-integration/>

Workforce: Investing in Staff and Expanding Access to Behavioral Health Care

⁴² General resources for more project information:

Better Health for Northeast New York PPS. February 2019. DSRIP Learning Symposium Submission.

Better Health for Northeast New York PPS Presentation. Available at: https://www.parsonscenter.org/images/SATRI/Psychosis_Handouts/BHNNY-Peer-Presentation---Brendon-Smith.pdf

Population Targeting: Identifying Individuals with Complex Behavioral and Social Needs

⁴³ PSYCKES (Psychiatric Services and Clinical Knowledge Enhancement System) is a web-based portfolio developed by the New York State Office of Mental Health using administrative data from NYS Medicaid claims to generate quality indicators and summarize treatment histories. For more information see: https://www.omh.ny.gov/omhweb/psyckes_medicaid/about/

⁴⁴ General resources for more project information:

Mount Sinai PPS Initiative description, available at: <https://partner.mountsinai.org/web/mspps/initiatives>

The Bridge Initiative description, available at: <https://www.thebridgeny.org/core/>

DSRIP Learning Symposium Poster, 2019. Available at: http://www.dsriplearning.com/documents/presentations/posters/BHSUD%2033_Getting%20to%20the%20CORE%20of%20Unnecessary%20Hospital%20Admissions%20Among%20High%20Utilizing%20Behavioral%20Health.pdf

DSRIP Learning Symposium Presentation, 2019. Available at: <http://www.dsriplearning.com/documents/presentations/Broadway%20Ballroom%203-4/2.12%20Presentations/Breakout%20C5%20Innovative%20ICM%202.12/Breakout%20C5%20Innovative%20ICM%202.12.pdf>

Coordinated Behavioral Care. Fall 2018. *Building an Integrated Delivery System Through Community Collaborations*. <http://www.cbcare.org/wp-content/uploads/2018/10/Jorge-Petit-Building-an-Integrated-Delivery-System-BHNews-Fall-2018-Issue.pdf>

- ⁴⁵ General resources for more project information:

Staten Island PPS. February 2019. DSRIP Learning Symposium Presentation. Available at: <http://www.dsriplearning.com/documents/presentations/Broadway%20Ballroom%203-4/2.12%20Presentations/Breakout%20C5%20Innovative%20ICM%202.12/Breakout%20C5%20Innovative%20ICM%202.12.pdf>

Crisis Stabilization: Preventing Unnecessary Behavioral Health Hospitalizations

- ⁴⁶ General resources for more project information:

DSRIP Learning Symposium Presentation, 2019. Available at: <http://www.dsriplearning.com/documents/presentations/Travers/2.12%20Presentations/Breakout%20B3%20Northwell%20Health%202.12/Breakout%20B3%20Northwell%20Health%202.12.pdf>

Northwell Health service description: <https://pediatrics.northwell.edu/departments-services/pediatric-emergency-medicine/programs-services/pediatric-behavioral-health-urgent-care-center>

Care Transitions: Helping Psychiatric Inpatients Return to the Community

- ⁴⁷ For more information on the NYS Medicaid Managed Care Licensed Behavioral Health Practitioner benefit, see the following: <https://www.omh.ny.gov/omhweb/bho/docs/guidance-on-licensed-behavioral-health-practitioner-benefit.pdf>. Medicaid fee-for-service patients must receive follow-up appointments at a clinic and are often assisted by peers.

- ⁴⁸ General resources for more project information:

DSRIP Learning Symposium Poster, 2018. Available at: [http://www.dsriplearning.com/2018/library/presentations/posters/PR01_Transition%20of%20Care%20Event%20Model%20\(Demonstration%20Pilot\).pdf](http://www.dsriplearning.com/2018/library/presentations/posters/PR01_Transition%20of%20Care%20Event%20Model%20(Demonstration%20Pilot).pdf)

DSRIP Stories of Meaningful Change in Patient Health, 2019. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2019/stories.htm

Peer Support: Using Peer Coaches to Support Recovery for Substance Use Disorder

⁴⁹ General resources for more project information:

DSRIP Learning Symposium Presentation, 2019. Available at: <http://www.dsriplearning.com/documents/presentations/Saratoga%20Ballroom%202/2.12%20Presentations/Breakout%20C3%20Recovery%20Coaches%202.12/Breakout%20C3%20Recovery%20Coaches%202.12.pdf>

Case Study: Addressing the Opioid Crisis by Expanding Medication-Assisted Treatment in Primary Care

⁵⁰ The ECHO (Extension of Community Healthcare Outcomes) model trains and mentors primary care providers in the treatment of patients with complex conditions. The TeleECHO clinic recruits providers to participate in DATA-2000 buprenorphine waiver trainings and provides ongoing support for evaluation of substance use disorders and behavioral health disorders. For more information see: <https://www.ncbi.nlm.nih.gov/pubmed/26848803>.

⁵¹ General resources for more project information:

DSRIP Learning Symposium Presentation, 2018. Available at: http://www.dsriplearning.com/2018/library/presentations/breakout-sessions/E6_Project%20ECHO.pdf

DSRIP Whiteboard Video, “Best Practices in DSRIP Year 3.” Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/best_pract_dy3.htm

DSRIP Stories of Meaningful Change in Patient Health, 2019. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2019/stories.htm

DSRIP Learning Symposium Presentation, 2019. Available at: <http://www.dsriplearning.com/documents/presentations/Saratoga%20Ballroom%202/2.12%20Presentations/Breakout%20B5%20Addressing%20the%20Opioid%20Epidemic%202.12/Breakout%20B5%20Addressing%20the%20Opioid%20Epidemic%202.12.pdf>