November 6, 2019
WELCOME
The Path of System Transformation

NYS DSRIP Program
- Project: Speed and Scale
  - Outcomes: System Transformation
- Project: Patient Engagement
  - Outcomes: Clinical Improvement

Integrated Delivery System
- Evidence Based Medicine
- Population Health Management

Value-Based Payment
- Improve Health Outcomes
- Improve Patient Experience
- Reduce Cost

THE TRIPLE AIM

Transformed Thinking
The Path of System Transformation

- Project: Speed and Scale
- Clinical Outcomes Improvement
- Project: Patient Engagement

Transformed Thinking


Community Integrated Care
Population Health Management

Achieve prepared for
Building toward

Triple Aim
Improved Outcomes, Quality Care, Reduced Cost

Payment System Transformation
Value Based Payment

Improved Outcomes, Quality Care, Reduced Cost
Targeted Transformation:

FLPPS
COMMUNITY NEEDS ASSESSMENT

- Need for **integrated delivery system** to address chronic conditions
- Need for **integration between physical and behavioral health** care systems
- Need to address **social determinants of health**
- Need to support **women and children**
FLPPS DSRIP PROJECTS & WORKSTREAMS

PROJECTS
1. Integrated Delivery System
2. ED Care Triage
3. Care Transitions
4. Transitional Supportive Housing
5. Patient Activation
6. BH / PCP Integration
7. BH Community Crisis Stabilization
8. BIP in Nursing Homes
9. Maternal/Child Health
10. Strengthen Mental Health/Substance Abuse infrastructure
11. Increase Access to Chronic Disease Prevention & Care

WORKSTREAMS
1. Workforce
2. Cultural Competency/Health Literacy
3. Information Technology
4. Transportation
Naturally Occurring Care Networks (NOCNs) Evolution

- Stand up projects and provide oversight
- Create inclusive, collaborative project teams
- Achievement of NYS milestones
- Assess the best way to cultivate community-level change
How did we do?
DSRIP PROJECT SUCCESS

232,000 Patients Engaged
99% Project Milestones met
Earned 85% of eligible dollars
FLPPS PROJECTS

Domain 1: DSRIP Implementation Progress
Domain 2: System Transformation Projects
Domain 3: Clinical Improvement Projects
Domain 4: Population-Wide Projects
Domain 1: DSRIP
Implementation Progress
Domain 2: System Transformation Projects
Integrated Delivery

- **122** FLPPS Partners connected with at least one RRHIO service

- **937** PCMH 2014 Level 3 certified providers

- **181** sites
ED Care Triage

- 17 hospitals engaged
- 55,952 patients engaged
- 7% PPV*  

*July 2016-October 2018
Care Transitions

- 34 partner organizations
- 26,517 patients engaged
- 2% PPR*  

*July 2016-October 2018
Transitional Supportive Housing

**PPS-Wide**
- 20 new beds
- 26 CBOs and hospitals
- 1,453 patients engaged

**UR, RRH & DePaul**
- 24% inpatient admissions
- 37% hospital days among RRH patients
- 66% of UR patients move from transitional housing to more permanent housing
Transitional Housing Pilot

- Partnering with homeless shelters
- Established direct communication
- Bi-weekly case conferences
- 100% adherence in follow-up homecare visits
Patient Activation

- Surveyed 108,609 individuals with Patient Activation Measure (PAM©) & engaged them in the health care system
Community Navigation

- **24** partner organizations

- **17,502 patients** navigated in 2018 alone
Domain 3: Clinical Improvement Projects
Integration of Primary Care & Behavioral Health Services

- 40 partner organizations
- 177,301 individuals received preventive care screening
- 4% antidepressant initiation*
- 5% antidepressant continuation*

*July 2016-October 2018
Behavioral Interventions Paradigm (BIP) in Nursing Homes

- **39** skilled nursing facilities
- BH Training for NPs + Geriatric Telepsychiatry
- **4,214** Patients engaged
- **30%** in depression among long stay residents
- **↓** Steady antipsychotic usage in dementia residents
Maternal Child Health

- 2,797 women engaged
- 29 Community Health Workers
- 3% in the occurrence of low birth weight*

*July 2016-October 2018
BH Community Crisis Stabilization

- 57 partner organizations
- 40,654 patients engaged in DY4 alone
- 14% PPV persons with BH diagnosis*

*July 2016-October 2018
Domain 4: Population–Wide
Domain 4: Population–Wide Projects

Strengthening mental health and substance abuse infrastructure

- **46** YMHFA training
- **850** individuals certified

Chronic disease preventive care and management

- Opioid use disorder
- **7%** initiation & engagement of treatment for AOD*
- **3rd** out of PPSs our size, engagement of treatment for AOD*

*July 2016-October 2018
Clinical Outcomes
(Sprint/Jog)
Quality Improvement
DY5/MY5 FLPPS Population Health Approach

System Transformation (Building Blocks)

Quality Improvement (Targeted Gap Closure)
MY4 Sprint

MY3 AIT target missed

DSRIP project milestone success ≠ clinical improvement

Innovative program to improve performance quickly
MY4 Sprint

11 measures were selected:

7. Adult and children access to preventive care metrics

2. Diabetes screening and monitoring for SMI/Diabetes

1. CV monitoring for SMI/CVD

1. Well care visits (5+ in first 15 months)
Health system and community partners were incentivized to participate in the MY4 Sprint.
MY4 Sprint Results

- Sprint measures met or exceeded targets: 91%
- Claim based measures demonstrated improved performance: 68%
MY4 SPRINT ➔ MY5 JOG

11 Sprint metrics + 10 additional metrics
MY5 Jog

Partner Gap Closure Estimate resulted in a forecasted PPS numerator shortfall in 14 of the selected MY5 Jog metrics.

= Yellow/Red metrics.

Yellow/Red metrics had two primary characteristics:
Behavioral health + Multi-provider collaboration needed to close a gap.
MY5 Jog Yellow/Red Metrics
MY5 Jog Results

### Adult Access Measures
- Adult Access - Preventive
- Child Access - Primary Care
- Childhood Immunizations
- Lead Screening
- Well Care Visits - 5+ in First 15 Months
- Child ADHD Medication F/U

### Child Access and Treatment Measures
- Antidepressant Medication Management
- Antipsychotic Medication Adherence
- CV Monitoring (CV and Schizophrenia)
- Follow Up after MH Inpatient
- Diabetes Monitoring for Pt w/ Schizophrenia and Diabetes
- Screening for Clinical Depression and Follow Up

### Behavioral Health Measures
- Antidepressant Medication Management
- Antipsychotic Medication Adherence
- CV Monitoring (CV and Schizophrenia)
- Follow Up after MH Inpatient
- Diabetes Monitoring for Pt w/ Schizophrenia and Diabetes
- Screening for Clinical Depression and Follow Up

Legend:
- Red: Goal not met
- Yellow: Goal about to be met
- Green: Goal met/exceeded
These rates of improvement did not occur by chance.

Improvement occurred through the concentrated efforts of our partners....

....working together towards improved health outcomes for our entire region.
Other Key Performance
FLPPS Performance on Claims - Based Metrics

Potentially Preventable ED Visits for Persons with a Behavioral Health Diagnosis

Highest rate of reduction within PPS attribution > 200,000 (n = 10)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>MY3</td>
<td>117.50918</td>
</tr>
<tr>
<td>MY5M3</td>
<td>100.7721291</td>
</tr>
</tbody>
</table>

% of Change
- MY3: -14.24%
- MY5M3: -0.32%

Numerator Change
- MY3: -0.32%
- MY5M3: 16.24%

Denominator Change
- MY3: 14.24%
- MY5M3: -0.32%

*Due to the State recalculation of Potentially Preventable ED Visits (1H1), only MY3, MY4 and MY5M1M2M3 results have been released for this measure.*
FLPPS Performance on Claims - Based Metrics

7 - Day Follow Up After Mental Health Inpatient Discharge

Higher rate of engagement with relatively stable denominator drives performance.
FLPPS Performance on Claims - Based Metrics

30 - Day Follow Up After Mental Health Inpatient Discharge

Highest rate of MY4 performance within PPS attribution > 200,000 (n = 10)
FLPPS Performance on Claims - Based Metrics
FLPPS Performance on Claims - Based Metrics

Despite significant increases in both overall Medicaid and health home attribution, FLPPS was 1 of only 4 total PPS (MY0-MY4) that demonstrated improved performance in each of the following 5 DSRIP key clinical outcome metrics.

- PPR
- PPV
- PPV-BH
- 30 day follow up after inpatient mental health discharge
- Engagement of Treatment for Alcohol and Other Drug Use Disorder
Transformation
Transformation

- Workforce
- Cultural Competency & Health Literacy (CC/HL)
- MAX Series
- Health Home
- Innovation Projects
- NOCN Projects
- System Transformation Projects
- VBP Education
Workforce

• Data collection
• Workforce Investment Organization (WIO)
• Learning Management System (LMS)
• LTC Resource Directory
Cultural Competency & Health Literacy

- **80** partner organizations
- **12** CCHL Operation Specialists
- CCHL learning collaboratives active within each NOCN
- 3D Health Literacy Virtual Reality Experience

Partner Organizations *receiving* Operations Specialists support
Medicaid Accelerated eXchange (MAX) Series

Rapid Cycle Continuous Improvement (RCCI) program that brings together frontline providers to redesign the way care is delivered to high utilizers.

<table>
<thead>
<tr>
<th>Decrease high utilizer 30-day readmissions and/or hospital utilization (All Payer)</th>
<th>Improve patient quality of life</th>
<th>Increase integration across care delivery system</th>
<th>Develop and build RCCI capability</th>
</tr>
</thead>
</table>

Increase integration across care delivery system
Medicaid Accelerated eXchange (MAX) Series
Percent Reduction in Inpatient Utilizations

- Arnot Ogden Medical Center: 58%
- Arnot Health System – St. Joseph’s Hospital – Behavioral Science Unit: 86%
- Geneva General Hospital: 75%
- Noyes Hospital: 89%
Mission Integration to Support DSRIP Objectives

- Focus on Social Determinants of Health
- Supporting access to healthcare
- Care Coordination and Collaboration among providers
- Decrease ER and Inpatient utilization
Health Home Pilot

40

20

CMAs reported:

- Increased contact with clients
- A higher level of Receptivity from clients
- Increased time to coordinate care with other providers
- Increased job satisfaction

$735,000
Integration
Innovation Projects

- **12** partner organization
- **13** projects*
- Care Coordination & Navigation

*Details in your Symposium folder

$2M
NOCN Initiatives

- 8 Partners
- 10 Projects*
- Care Coordination & Community Navigation

*Details in your Symposium folder

$500,000
System Transformation Projects

$28.7 M
Dollars invested to prepare partners for the shift to Value Based Care

84
Partner projects that support the transformation of our health care system for Medicaid patients

>60
Partner organizations who are contributing data and best practices to FLPPS

*Details in your Symposium folder
System Transformation

- Health Home, 2
- Health System, 13
- Behavioral Health, 14
- Care Management, 2
- BHCC, 2
- FQHC, 3
- IPA, 1
- Hospital, 2
- SNF, 1
- IDD, 3
- PCP, 11
- CBO, 31

[Diagram showing the distribution of various healthcare entities and their counts]
System Transformation Project Types
Sharing Best Practices: Learning Management System Groups

virtual network

Consistent best practices

Community supporting transformation
VBP Readiness

- VBP Readiness Assessments & Consultation
- VBP Educational Series
- Systems Transformation Projects
- CBO VBP Readiness Program
CBO VBP Pilot

- 18 months
- 12 large tier 1 CBOs
- 1,400 hours invested from each organization

United Way

$1M
Financial Update
DSRIP Partner Funds Flow

DSRIP DISTRIBUTIONS
Partner Funds Flow to date: $182M + Operational & Infrastructure Cost to date: $48M

DSRIP DISTRIBUTIONS
Additional Partner Funds Flow for current work in progress: $58M

FUTURE INVESTMENT IN SYSTEM TRANSFORMATION $97M
DSRIP Partner Funds Flow

- **DSRIP Project Implementation**: $168M
- **System Transformation & Community Investments**: $49M
- **Clinical Outcome Improvement Initiatives**: $23M
- **Reliable Dollar Budget**: $97M

Future Investment in System Transformation

62
Success through Collaboration

- Shared Goals
- Innovative Thinking
- New Partnerships
- Redefining Healthcare
Thank you!