VITAL2015
Connect. Inspire. Lead.

Care Coordination among DSRIP Partners

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3:00 - 3:30 pm

AMERICA’S ESSENTIAL HOSPITALS

OVERVIEW OF PRESENTATION

- New York State DSRIP Overview
- Brooklyn Health Statistics
- DSRIP Projects Selected by the OneCity Health PPS
- How to Organize the Work
- Challenges

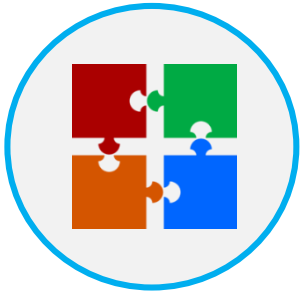
New York State DSRIP Overview

NEW YORK STATE DSRIP OVERVIEW

The Delivery System Reform Incentive Payment (DSRIP) program is a $6.42B performance-based program that will fund public and safety net providers to transform the NYS health care delivery system.

Goals:

- Transform the safety net system
- Reduce *avoidable* hospital use by 25% over 5 years (admissions & readmissions)
- Concurrent pursuit of the Triple Aim (better care, improved health, reduced cost)
- Ensure delivery system transformation continues beyond the waiver period through managed care payment reform

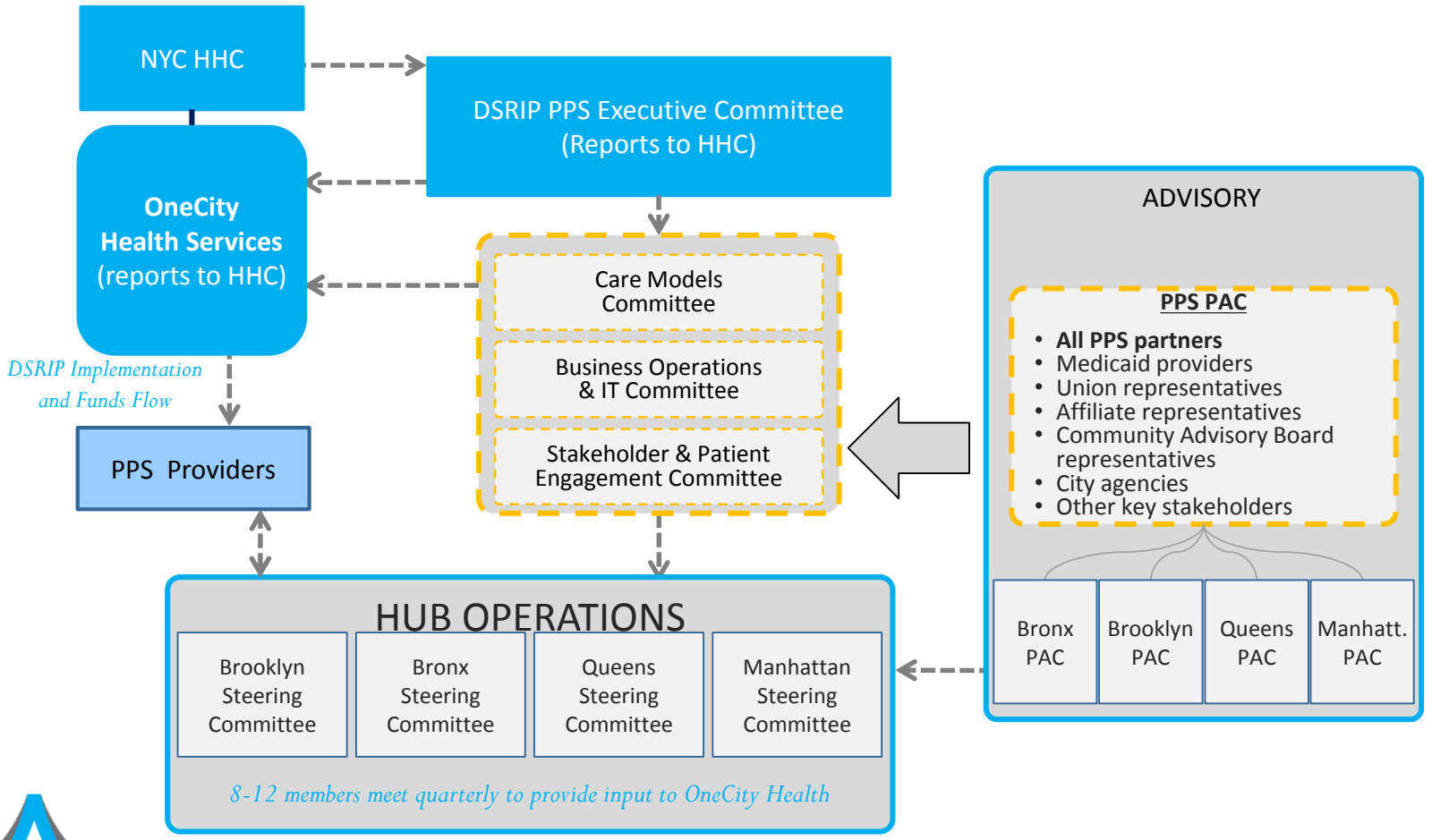


Key Program Components:

- Statewide funding initiative for public hospitals and safety net providers
- Only coalitions of community/regional health providers are eligible (to create a Performing Provider System – PPS)
- DSRIP projects based on a menu of interventions approved by CMS and NYS
- Payments to providers based on their performance in meeting outcome milestones and the State achieving statewide metrics

ONECITY HEALTH PPS GOVERNANCE

PARTNER AND COMMUNITY ENGAGEMENT CRITICAL FOR GOVERNANCE



Brooklyn Health Statistics

OUR BROOKLYN COMMUNITY HEALTHCARE STATUS: KEY COMMUNITY NEEDS ASSESSMENT FINDINGS

- Within Brooklyn, “Observed-over-Expected” Composite Prevention Quality Indicator measures (PQI) vary significantly by zip code, and are typically the highest in North/Central Brooklyn (1 = expected)
  - » Diabetes PQI: .30 – 1.69
  - » Respiratory PQI: .23 – 1.82
  - » Circulatory PQI: .34 – 1.47
- North/Central Brooklyn accounts for the highest number of preventable Medicaid beneficiary admissions across chronic diseases
- Primary care physician shortage in Northeast Brooklyn, where the majority of Medicaid beneficiaries live
- Across many indicators, Brooklyn’s health status is declining

OneCity Health DSRIP Projects

ONECITY HEALTH PPS PROJECT LIST
(7 PRIORITY PROJECTS SHADED)

Domain 2: System Transformation	
2.a.i	Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management
2.a.iii	Health Home At-Risk Intervention Program: Proactive Management of Higher Risk Patients Not Currently Eligible for Health Homes through Access to High Quality Primary Care and Support Services
2.b.iii	Care Triage for At-Risk Populations
2.b.iv	Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions
2.d.i	"Project 11" Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

Domain 3: Clinical Improvement Projects	
3.a.i	Integration of Primary Care and Behavioral Health Services
3.b.i	Evidence-Based Strategies for CV Disease Management in High Risk/Affected Populations (Adults Only)
3.d.ii	Expansion of Asthma Home-Based Self-Management Program
3.g.i	Integration of Palliative Care into the PCMH Model

Domain 4: Population-Wide Projects	
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)
4.c.ii	Increase early access to, and retention in, HIV care (Focus Area 1; Goal #2)

EVOLUTION TO CARE TRANSFORMATION AND VALUE-BASED PAYMENTS

DSRIP PPS PRIORITY PROJECTS

2015

- Care Transitions (ED, 30 day readmissions, CV Disease Mgmt, Health Homes)
- Primary Care Related (Behavioral Health and Palliative Care)
- Home Based Asthma
- Other Projects
- *Integrated Delivery System, Patient Activation, HIV, Substance Abuse*

NEW COMPETENCIES

2015 to 2018

- Tiered Care Management
- Patient Self Management
- Referral Criteria and Timeframes
- PCP Follow-Up
- Patient Risk Assessment
- Comprehensive Care Planning

FINANCIAL/TRANSFORMATION GOALS

2018 to 2020

- Create a Patient and Family Centered Delivery System
- Decrease potentially avoidable ED visits
- Decrease potentially preventable hospital admissions
- Provide greater access to primary care
- Integrate primary care and behavioral health in outpatient setting
- Form a Services Organization (CSO) as nexus for population health
- Engage uninsured and low/non utilizing patients in care

Payment for Process Measures | **Payment for Outcomes**

EXPANDING PRIMARY CARE (NCQA LEVEL 3) · TRANSITION TO VALUE-BASED CARE AND REIMBURSEMENT

INFRASTRUCTURE, COMPETENCIES, AND CATALYST FUNDING

Workforce Strategies (new roles and skills will be required)
EHR Meaningful Use, Data Sharing
Cultural Competency/Health Literacy
Rapid Cycle Evaluation
Budget and Funds Flow (shift to value-based reimbursement)
Financial Sustainability

How to Organize the Work

HOW TO APPROACH THE WORK

- Transformation does not occur through projects
- Have to organize the work in a way that makes sense for organizations and communities
- Determine priority functions to support DSRIP
- Partnerships and community engagement essential

DOWNSTATE DSRIP PLANNING AND OVERSIGHT

- **TRANSPARENCY**
- **BROAD ENGAGEMENT**

- A Steering Committee includes representatives from across the organization and other key stakeholders
  - » Hospital
  - » Schools and Centers
  - » Community Groups
  - » Labor
  - » Students

- An Implementation Committee includes individuals with competencies most connected to the work
  - » Primary Care
  - » Care Coordination
  - » Evidence Based Care
  - » Cultural Competence
  - » Health Disparities
  - » Liaisons with CBOs
  - » IT
  - » Finance

PRIORITY AREAS FOR SUPPORTING DSRIP

- Strengthening our Downstate **Patient Centered Medical Homes (PCMH)**
- Building a robust **Care Management** infrastructure
- Enabling change through **IT**
- **Informed by the community**

IT COMPONENTS FOR DSRIP

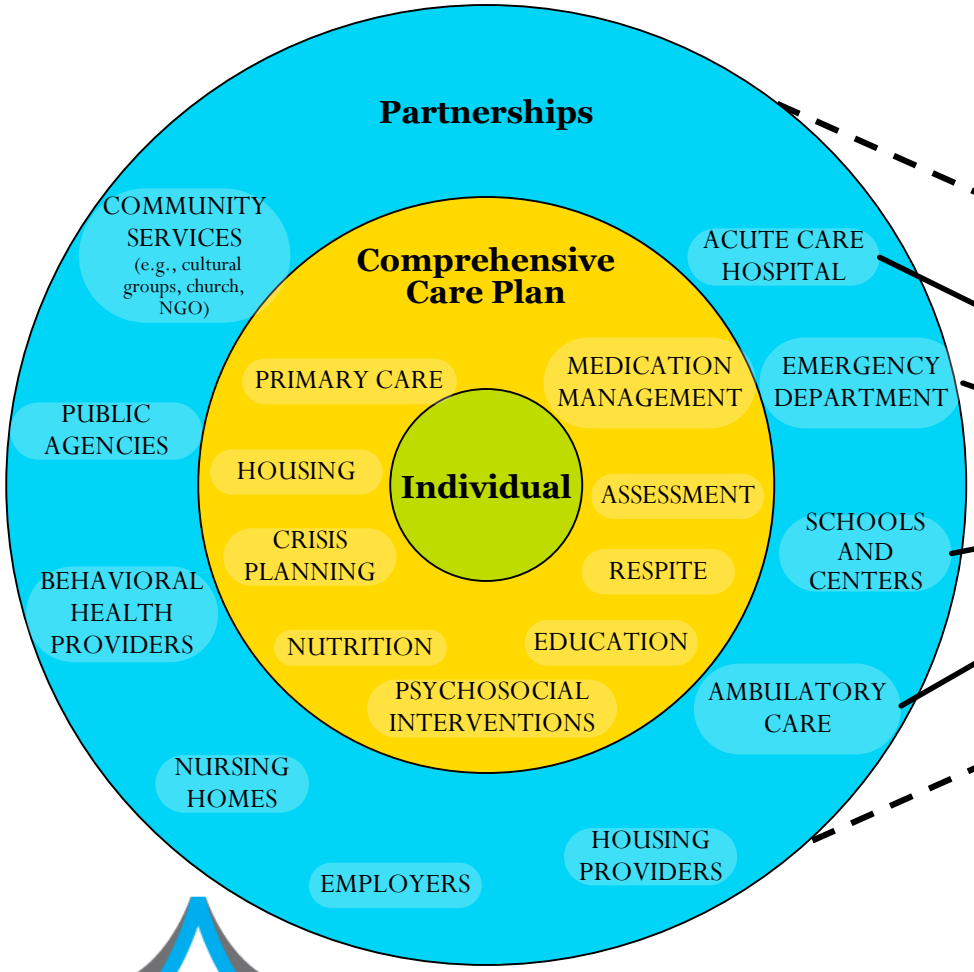
Increased data analytics to support DSRIP metrics

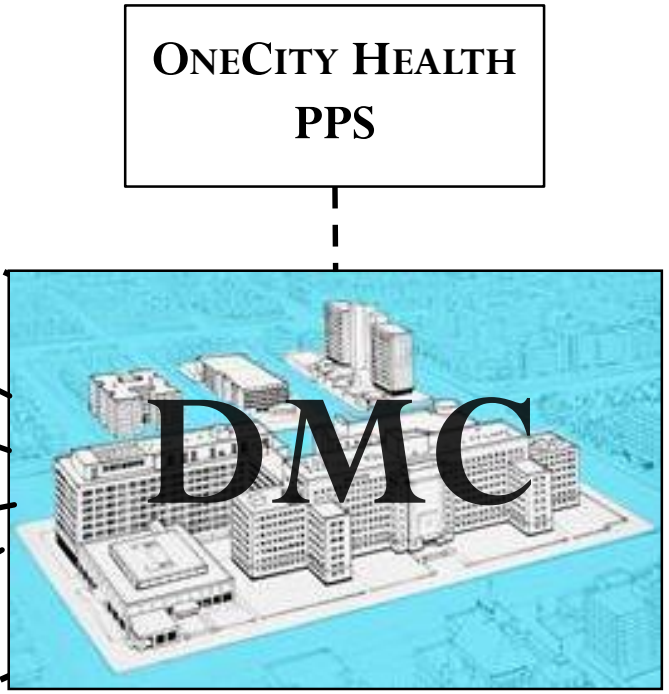
Technology expansion

Data Sharing across Downstate and PPS to support coordinated care and DSRIP Goals

Requires executive level commitment to aligned technology and data standardization

DSRIP WORK DEPENDS ON PARTNERSHIPS AND COMMUNITY ENGAGEMENT





COMMUNICATION AND ENGAGEMENT KEY TO SUCCESS

COMMUNITY

- Downstate had a solid base with community
  - » strong relationship with CBOs through a multi-year Brooklyn Health Improvement Project (BHIP) and state grant
  - » ties to the community through Arthur Ashe Institute and the Center for Health Disparities
- Held many focus groups with community groups to get input for planning
- **Hosted weekly planning meetings at Borough Hall with over 100 partners**

ELECTED OFFICIALS

- Meetings with the Brooklyn delegation for updates

LABOR

- Regular meetings and updates important
- All PPS projects have a workforce component and labor must be engaged

Challenges

CHALLENGES

- Funds are insufficient to support transformation work
- Hard to explain the work to most stakeholders
  - » expectations of a windfall of cash to support current healthcare
- Goal of shifting away from inpatient services is counter to labor priorities
  - » retraining is essential but will not mitigate the concerns
- Technology costs largely not covered by DSRIP but needed for transformation and PCMH requirements
  - » excludes many community physicians
- Changing work processes within hospitals is difficult
- Changing patient utilization of healthcare and lifestyle is a long and complex process

Progress to Date and Next Steps

PROGRESS TO DATE

- Closer relationship with Kings County Medical Center (major PPS and academic partner)
  - » Exploration to integrate some clinical departments and pursue administrative efficiencies
  - » Commitment to use common IT solutions and data standardization as possible
  - » Joint pursuit of state capital grants vs competitive
  - » Increased alignment of the two public institutions to better serve a very challenging community in a highly competitive environment

THE ROADMAP FOR CARE TRANSFORMATION

MOVING TO RIGHT CARE, RIGHT PLACE, RIGHT TIME

2015

- Expanded Care Management
- Expanded PCMH
- Community Outreach

- IT Expansion and Data Exchange
- Data Driven Care
- Increased Partnerships
- Prevention and Wellness

Downstate, with many partners, is serving people in the community in many ways and locations

2020

SHIFTING TO COMMUNITY BASED CARE AND WELLNESS
IT IS HARD WORK THAT TAKES TIME

"I'm going to order a broiled skinless chicken breast, but I want you to bring me lasagna and garlic bread by mistake."