DSRIP IMPACT REPORT

February 2020

Staten Island
Performing Provider System

STATEN ISLAND PPS **BOARD OF MANAGERS**

WHAT'S INSIDE

A LETTER FROM THE **EXECUTVE DIRECTOR**

Joseph Conte, PhD, CPHQ
Executive Director

"WE KNOW THERE HAS BEEN AN INDELIBLE IMPRINT OF CHANGE MADE ON OUR COMMUNITY THANKS TO THE LASTING AND TRUSTING RELATIONSHIPS FORMED THROUGH THE STATEN ISLAND PPS NETWORK."

The population health experiment known as DSRIP has created more healthcare innovation in the last five years than the preceding 20. By placing value over volume as the centerpiece of care delivery, institutions whose focus was previously heads in beds and high cost procedures were challenged to rapidly shift to population health and prevention. It quickly became clear that social determinants of health and the role that healthcare organizations must play in addressing them had to be prioritized. As that realization set in so did the importance of a focus on the value of partnerships with community-based organizations. Another sea change occurred in behavioral health – often overlooked for investments in infrastructure and staffing – as it began to be recognized as a full partner in delivering whole person care. The creation of Behavioral Health Care Collaboratives, law enforcement partnerships, opioid response initiatives and massive workforce investments are some examples of the manifesting of this new thinking. DSRIP initiatives have resulted in increased primary care access, significant reductions in ER utilization, preventable hospitalizations and readmissions – in many cases in excess of those originally contemplated in 2015. On Staten Island, we estimate a significant return on investment over the past five years. More importantly are the lives saved and quality of life that individuals will enjoy through these changes.

When we put a lens on the changes on Staten Island, it is certainly a reflection of state-wide improvements. We are proud to have led many of those innovations which are chronicled throughout the following report. Our partnerships with over 75 community organizations which include FQHCs, medical and behavioral health clinics, faith-based organizations, nursing homes, social service providers, hospice, home care, and local governmental units have forever changed care delivery. Access to social services like food, clothing, housing, and transportation have been greatly expanded using the WeSource social determinants of health platform designed by the Staten Island PPS team. This patient facing platform will soon be in use by many organizations throughout New York and the country.

Once the epicenter of the addiction crisis, Staten Island has seen a continuous reduction in overdose mortality since 2016, with 44% less deaths in the last year alone. Thousands of individuals are receiving addiction treatment through modalities like medication assisted treatment, harm reduction and residential programs. Dozens of practitioners have obtained MAT waivers to care for patients with substance use disorders. EDs have hired CRPAs educated through the PPS funded program, available 24/7 in many community settings. Access to addiction services and supports has expanded with a focus on stigma reduction at all levels of the delivery system. SI PPS has formed a National Collaborative Consortium on Substance Use Disorder bringing together partners from multiple states to develop new innovations and alternative payment models for SUD services to be launched in 2020.

Workforce investments have led to greater than 70,000 hours of training across our partner organizations. Relationships with the United States Department of Labor yielded the first federally approved Apprenticeship Program for Certified Nursing Assistants in New York State. Additionally, Staten Island is the only PPS in New York to have received a 3-year grant from the Health Resources and Services Administration to train 240 CRPAs and Community Health Workers. City-wide partnerships with institutes of higher education will produce new initiatives in the coming year enhancing workforce programs for justice involved populations and expansion of key programs to other areas.

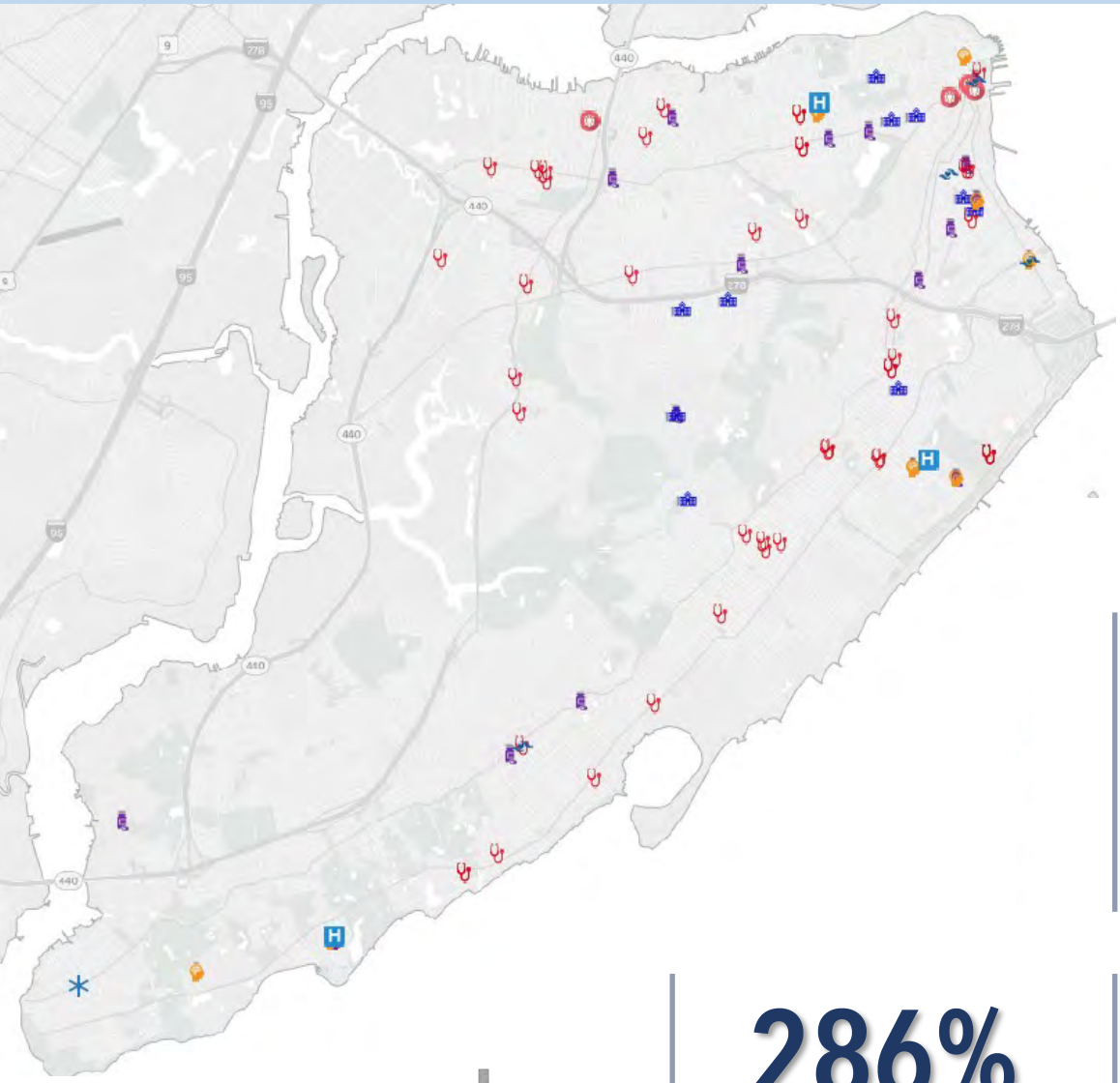
As we await a response from CMS regarding the application filed by the Department of Health for a DSRIP extension and renewal, much remains to be made clear in 2020. However, we know there has been an indelible imprint of change made on our community thanks to the lasting and trusting relationships formed through the Staten Island PPS network.

Joseph Conte

Joseph Conte, PhD
Executive Director
Staten Island Performing Provider System

A SYSTEM-WIDE APPROACH TO **QUALITY**

Improving quality of care, transforming the health care delivery system on Staten Island, and reducing preventable ER use and hospitalizations by 25%.



23%
Reduction in nursing home transfers to hospitals

36%
Reduction in overdose deaths (2016-2019)

286%
Increase in clients engaged in MAT since 2015

17%
Reduction in readmissions

130,000
Staten Island residents with Medicaid

50,000
Uninsured Staten Island residents

Over
12,000
Partner employees transforming healthcare delivery

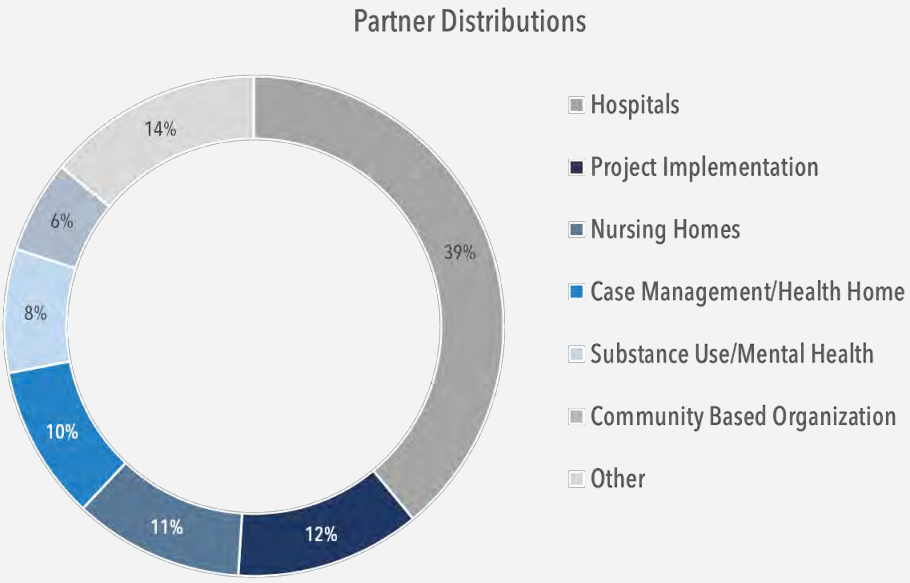
75+
Network partners

20
Community-based Organization partners

$103,000,000
Distributed to partners to date

$18,300,000
Invested in Workforce to date

$4,850,000
Invested in SDOH to date



DSRIP Projects

Evidence-based strategies for disease management in high risk/affected populations (adults only)

Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical & Community Settings

Implementation of Patient Activation Activities

Implementing the INTERACT Project (inpatient transfer avoidance program for SNF)

Hospital-Home Care Collaboration Solutions

Integration of Palliative Care into Nursing Homes

Innovative Strategies for Withdrawal Management

Strengthen Mental Health and Substance Abuse Infrastructure across Systems

Integration of Primary Care & Behavioral Health Services

Health Home At-Risk Intervention Program

Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions

PARTNER ACKNOWLEDGEMENTS

AdvantageCare Physicians
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Carmel Richmond Healthcare and Rehabilitation Center
City Harvest
Clove Lakes Health Care and Rehabilitation Center
College of Staten Island - The City University of New York
Community Health Action of Staten Island (CHASI)
Community Health Center of Richmond (CHCR)
Comprehensive Pediatrics
Coordinated Behavioral Care (CBC)
CP Unlimited
Dr. Scafuri & Associates
EG Healthcare
Eger Health Care & Rehabilitation Center
El Centro del Inmigrante
Friends of Mariner's Harbor
George Mason University
Golden Gate Rehabilitation & Health Care Center
Intersections International
Island Kids Pediatrics
Island Medical Specialists
Island Pediatrics
Island Voice
Jewish Board of Family and Children's Services
Jewish Community Center of Staten Island
Lourdes Pichay MD
Make the Road New York
Massachusetts Institute of Technology
Medical Practice Associates
Metro Community Health Center
New Vanderbilt Rehabilitation & Care Center
Northwell Health
NYC Yoga Project
Pediatric Healthcare
Person Centered Care Services
Pride Center of Staten Island
Project Hospitality
Richmond Center for Rehabilitation & Healthcare
Richmond Primary Care Specialists
Richmond University Medical Center
Saint Joseph's Medical Center
Sea View Hospital Rehabilitation Center & Home
Seamen's Society for Children and Families
Silver Lake Behavioral Health
Silver Lake Specialized Care Center
South Beach Psychiatric Center
South Shore Physicians
St. John's University
Staten Island Behavioral Network
Staten Island Care Center
Staten Island Mental Health Society
Staten Island Partnership for Community Wellness (SIPCW)
Staten Island University Hospital
Thomas Pediatrics
University Physicians Group
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YMCA Counseling Service
YMCA New Americans Welcome Center

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Councilman Steve Matteo
Senator Andrew J. Lanza
Senator Diane Savino
Assemblywoman Nicole Malliotakis
Assemblyman Joseph Borelli
Assemblyman Michael Cusick
Assemblyman Charles D. Fall
New York City Department of Health and Mental Hygiene
New York City Police Department
Thrive NYC
Greater New York Hospital Association
Healthcare Association of New York State
Staten Island Advance
SpectraMedix
StationMD
Wellth
E-Recovery Health
KPMG, LLP
BDO, LLP
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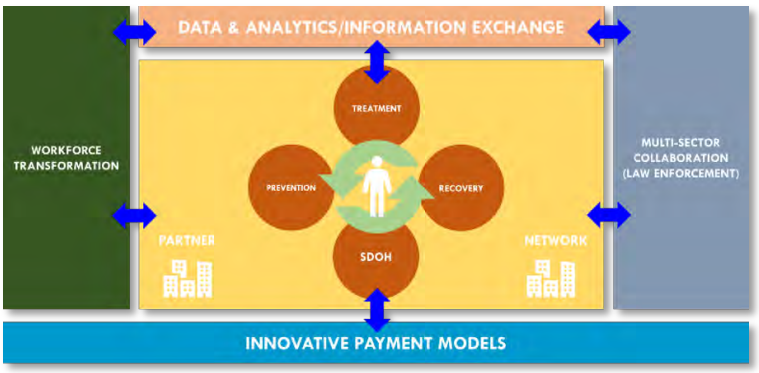
Public Consulting Group
DSRIP Project Advisory and Oversight Panel
TTL Strategy, Inc.
Helgerson Solutions Group, LLC
Remedy Partners, now Signify Health

BEHAVIORAL HEALTH

Since its formation in 2014, Staten Island PPS has become a national model for how to use data driven strategic business intelligence to create multi-agency collaboration, improve care quality, reduce costs and achieve population-level outcomes for people with behavioral health conditions. An integrated system of care framework has been applied across multiple domains including criminal justice, medical, behavioral and social service organizations, workforce, higher education and local government to mobilize all sectors to confront the opioid epidemic. The SI PPS coalition-building leadership provides the support necessary to implement operational strategies identifying gaps in resource, programs and data while focusing on assets in the community and transforming information into action.



A core mission of Staten Island PPS was an initiative undertaken to Strengthen Mental Health and Substance Abuse Infrastructure. SI PPS in partnership with Staten Island Partnership for Community Wellness developed the Behavioral Health Infrastructure Program (BHIP). The purpose of BHIP is to:

- increase access to behavioral health services 24/7;
- integrate behavioral health and primary care services;
- focus on upstream prevention and health promotion models;
- develop innovative data sharing models;
- expand the behavioral health workforce with new titles, trainings and apprenticeships;
- include partners such as law enforcement, local government, and managed care plans in solutions;
- develop new value-based funding payment models.

BHIP aims to build capacity across systems by leveraging and developing partnerships to provide effective, high quality, person centered care that supports improved health outcomes. BHIP goals are being accomplished by strengthening partnerships with community organizations, local government agencies, building capacity for collaborative care in primary care settings, providing cultural and linguistic trainings on behavioral health, and establishing an infrastructure for data sharing. BHIP has defined key priorities illustrated in this section and organized for impact by developing a governing structure that guides strategic initiatives, resource expansion, program implementation, and evaluation.

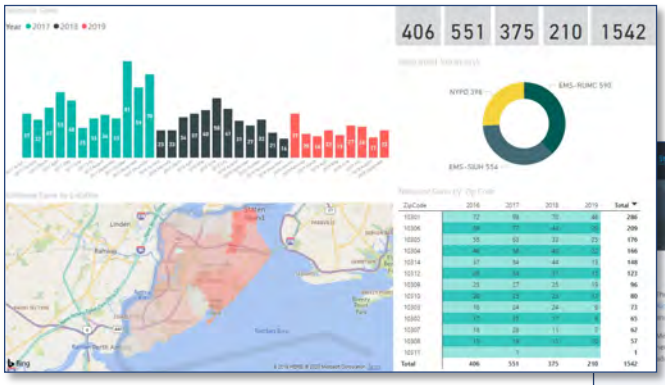
Multiple initiatives have been implemented through behavioral health and primary care detailing campaigns, working with state and city partners to address complex policy issues, offer training and workshops around prevention, integration, and stigma, and promote the expansion of harm reduction services and naloxone distribution to community members.

BEHAVIORAL HEALTH

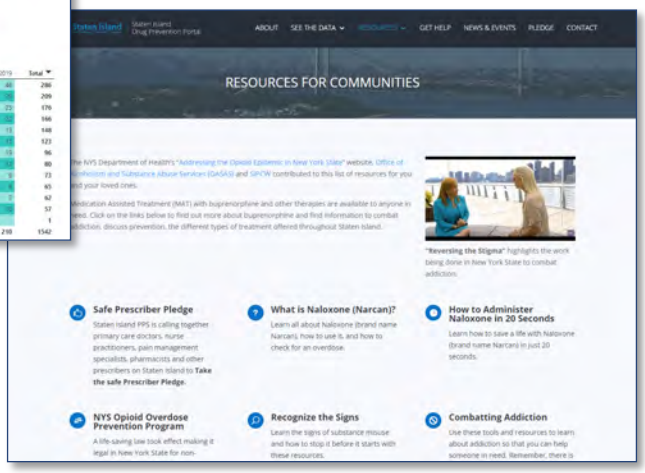
Staten Island Drug Prevention Portal

SI PPS created the Staten Island Drug Prevention Portal so community members, families, and professionals can access data in response to the opioid epidemic, while also providing resources to the community for treatment and education. The interactive data showcased on the site are naloxone saves and dispensed, opioid ED visits, hospital admissions, and overdose deaths.

sidrugpreventon.nyc



Naloxone Saves



Resources for Community Page

Predictive Analytics to Identify Rising Risk of Overdose

Working with multiple partners like the Richmond County District Attorney closely tracking overdoses and using multiple data sets allows SI PPS to analyze risk factors for victims of multiple overdose. SI PPS is working with Massachusetts Institute of Technology (MIT) in their Health Systems Innovation initiative to develop a predictive algorithm to identify individuals that are at risk of future or multiple overdose. This data will populate a centralized database to identify individuals at risk and prioritize outreach by an interdisciplinary co-response team.

SIHOPE.org, Developed by Richmond County District Attorney Michael E. McMahon

BEHAVIORAL HEALTH

Safe Prescriber Pledge

The Opioid Safe Prescriber Pledge campaign is a unique initiative to foster awareness and sustain safe prescribing practices. Healthcare providers are concerned about opioid-related risks but need knowledge and encounter barriers to manage addiction care. An educational campaign is an effective approach to enhance knowledge, prescribing behaviors, and patient expectations. Key provider champions, leaders, and experts in the community were engaged to develop 10 Safe Prescriber Pledge elements and a toolkit using evidence-based guidelines and resources. The multi-faceted outreach campaign kicked off with an educational seminar with participants from different healthcare background and specialties in attendance. Prescribers (i.e. physicians, PAs, and NPs), non-prescribers (i.e. nurses, pharmacists, administrators) and the general public were mobilized during this educational campaign. Upon reviewing the 10 elements and the toolkit, prescribers and healthcare providers signed the pledge, promising to uphold these elements in their practice.

361

Healthcare professionals to date who have taken the pledge

Safe Prescriber Pledge Elements

1. Prioritize non-opioid treatment options for pain
2. Utilize the Opioid Risk Tool (ORT)* to screen all patients before prescribing controlled substances
3. Use the NYS Prescription Monitoring Program (I Stop) before writing any prescription for opiates, benzodiazepines, Medication Assisted Treatment (MAT) medications
4. Follow Centers for Disease Control (CDC) guidelines for initial and chronic medication dosing*
5. Obtain patient agreement on the risks and benefits of opioids to patients who would be receiving acute and chronic opioid prescriptions*
6. Maintain an office policy and procedure* on safe and effective management of prescribing Controlled Substances (CS).
7. Prescribe Narcan for all patients on chronic opiates and MAT* and:
    a. Demonstrate how to use Narcan
    b. Share information about Narcan
    c. Distribute Narcan educational materials
8. Offer patients on chronic opiates, benzodiazepines and MAT information on "Tamper Resistant" caps, bottles or other medication containers
9. Complete a three-hour CME course in Pain Management, Palliative Care and Addiction every 3 years*
10. Promote safe return of unused controlled medications

*Supporting documents found in Staten Island PPS Safe Prescriber Pledge Toolkit.

sidrugprevention.nyc/safe-prescriber-pledge
View the pledge, toolkit, and Safe Prescriber List.

Specialty Breakdown	Signed Pledges
Total	**361**
Internal Medicine	93
NP	55
OB/GYN	24
Pediatrics	24
Psychiatry/Neurology Psychiatry	24
Pharmacy	23
PA	20
Dentistry	9
Other	89

BEHAVIORAL HEALTH

Integrated Services

Delivery of integrated behavioral health and primary care services to individuals ensures person-centered and timely coordination of care for individuals with both needs. Additionally, family medicine and pediatric practices participating with the PPS through the Population Health Improvement Project (PHIP) utilized social workers from the Mental Health Service Corps (MHSC). Participating partners can provide and bill for integrated services as permitted by New York State DOH. The PPS surveyed partners to assess mental health billing practices to help promote sustainability.

37,672

Medicaid individuals engaged in integrated care as of January 2020

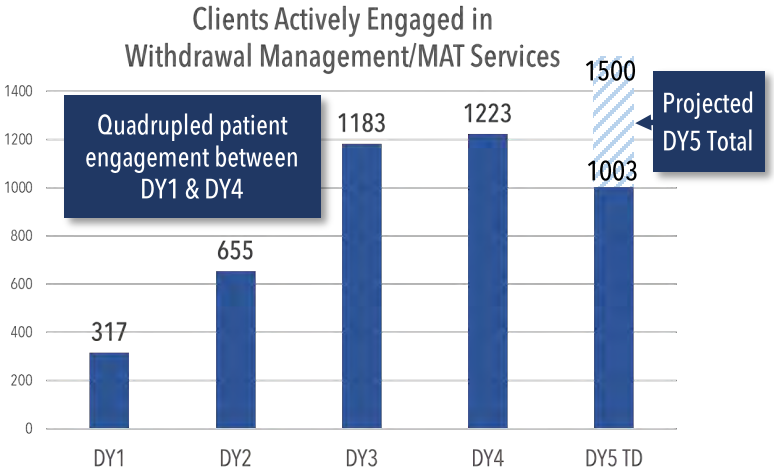
39%

Reduction in ED utilization for individuals who received integrated care

Nine participating primary care practices have integrated behavioral health specialists to deliver mental health and substance use disorder screenings and services to improve health outcomes.

Expansion of Withdrawal Management & Medication Assisted Treatment Services

Ancillary withdrawal services include medication assisted treatment (MAT) or medical management of mild or moderate symptoms of withdrawal from opioid or other substances within an OASAS certified setting. Medical staff monitor withdrawal symptoms and establish a treatment plan that includes the medication protocol (buprenorphine and/or other withdrawal agents) to achieve safe withdrawal management, clinical interventions to provide engagement, management of urges and cravings, and address cognitive and behavioral issues and recovery supports. SI PPS helped expand these services to nine substance use disorder treatment providers on Staten Island. The number of clients accessing these services has quadrupled since the start of DSRIP.



27%

Decrease in emergency department utilization

4,381 Patients engaged in ancillary withdrawal/MAT services

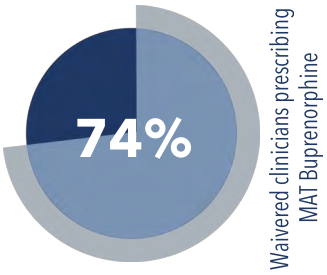
People who receive MAT have **6-month retention rates** (2014-2017 per OASAS)

BEHAVIORAL HEALTH

Standardized ED Buprenorphine Induction Protocol

3 Emergency Departments Implementing Bupe program

50+ Patients induced with Bupe in the ED & linked to outpatient care



50 New clinicians trained on MAT

The purpose of this initiative is to create a uniform ED program standard for Staten Island when introducing individuals to medication assisted treatment (MAT) with buprenorphine. A standardized protocol expands capacity and access to MAT, acting as a bridge for individuals to continue their care in outpatient settings of their choice. Services are available 24/7 via waivered providers in each ED setting on Staten Island. Individuals 18 and older are eligible at the present time, with ongoing collaborative development of a standardized protocol for adolescents to be implemented at a future time.

ED Warm Handoff

A high volume of patients with substance use disorders (SUD) present to Staten Island Emergency Departments, many of whom frequently return. While patients receive the proper medical care, the challenge of engaging patients to seek treatment or recovery support still prevails. The ED Warm Handoff Program was created to introduce peers in the Richmond University Medical Center ED for the first time. Peers were integrated as hospital staff to engage, educate, and advocate for patients, while supporting clinicians to connect patients to SUD services. The program serves as an intervention to better engage patients who present with SUD needs and to link them to an appropriate level of care in a timely manner. This initiative was launched with a 6-month pilot, from November 2016 to May 2017, and was also supported by several infrastructural system-level enhancements, including the expansion of treatment provider hours of operation, a 24/7 call center and online searchable provider directory, and support for the growth of a Staten Island peer workforce.

1700+ Peer engagements as of 1/2019

16% Warm handoffs to treatment providers on the same/next day

11x The national average acceptance rate of SUD services

Transformed ED culture of **managing SUD patients** and **reduced stigma**

BEHAVIORAL HEALTH

Heroin Overdose Prevention & Education (HOPE) Program

Working with NYPD, behavioral health providers, and local government units, the Office of the Richmond County District Attorney launched a pre-arraignment diversion model in January 2017. The program redirects low level drug offenders to community-based health services instead of jail and prosecution using peer recovery coaches. Peers engage with individuals in the NYPD precincts, explaining the program and training and distributing naloxone. Individuals participate in the program by agreeing to be screened at one of the 24/7 Resource & Recovery Centers on Staten Island. SI PPS funded the 24/7 operation of the Next Step Recovery Center operated by Community Health Action of Staten Island (CHASI) and peer education and training led by The Resource Training Center. The HOPE program goals are to reduce overdoses, improve health outcomes by exposing individuals to harm reduction services, peer mentors and divert persons with addiction from the criminal justice system and into recovery. Upon successful completion of the program and meaningful engagement with community services, the DA will decline to prosecute an individual's case and they will have no criminal record.

Richmond Country District Attorney Michael E. McMahon with SI PPS Executive Director, Joseph Conte and Managing Director, Strategic Initiatives & Operations, Ashley Restaino

HOPE Eligible	Peer met at Precinct	Went to Directly to Recovery Center	Received Naloxone Training	Naloxone Kits Distributed	Completed Assessment	Meaningfully Engaged
763	**722**	**66**	**621**	**603**	**663**	**603 (94%)**

*As of 1/13/2020

Following the success of the first HOPE program impacting individuals with low-level offenses, RCDA worked collaboratively on two additional programs with partners in the community to address substance use and overdose risk for individuals charged with misdemeanor offenses.

HOPE 2.0

HOPE 2.0 is an arraignment/post arraignment diversion program that expands the existing HOPE programming and services to individuals who have had more contact with the criminal justice system and are not eligible for HOPE 1.0 due to extensive criminal histories that include more graduated misdemeanor charges, some misdemeanor victim crimes, and/or felony arrests that are five or more years old. Even in its early stages, HOPE 2.0 has successfully engaged nearly 200 Staten Islanders, with a 65% acceptance rate at arraignment. More resources are being added to engage clients in the system.

HOPE 2.0 Offered	Offers Accepted at Arraignment	Completed Assessment at Recovery Center	Successful Completions
182	**199 (65%)**	**102 (86%)**	**54**

Overdose & Avoidance Recovery

The NYC Criminal Court designated a newly created Overdose and Avoidance Recovery (OAR) Court in Richmond County. The Court in Richmond County provides a calendar for judicial supervision of individuals participating in the HOPE 2.0 program and substance using defendants at high-risk of overdose. Additionally, the OAR Court accepts select cases from arraignment that are deemed ineligible for HOPE 2.0 if the defendant's attorney makes the request after determining that the defendant may be at high risk for overdose. HOPE 2.0 and OAR work collaboratively to address substance use in individuals charged with misdemeanor offenses.

OAR Offered	OAR Offers Accepted	Completed Assessment with Court Resource Staff	Successful Completions
47	**37 (79%)**	**30 (81%)**	**9**

BEHAVIORAL HEALTH

E-Recovery Addiction Treatment Platform

In 2018, SI PPS and the Office of the Staten Island Borough President partnered to pilot the E-Recovery Addiction Treatment Platform for substance use disorder recovery and relapse prevention among four SUD providers on Staten Island. The E-Recovery platform includes a patient-facing app, a provider-facing app and a case management dashboard to give individuals real time, 24/7 access to recovery services and supports. E-Recovery has shown to improve recovery outcomes including less relapse, higher abstinence, fewer heavy drinking days and increased treatment adherence. The patient-facing smartphone app called Connections, offers individuals clinician support through messaging, peer support through groups and message boards, medication and appointment reminders, weekly surveys, treatment plan goals, journals and inspirational videos and messages. SI PPS has access to an enterprise level data analytics and benchmarking platform to view utilization and outcomes for the providers participating using the platform. Recently, the Silberstein Center for Integrative Behavioral Health at Richmond University Medical Center has joined the program with 40 clients enrolled across two programs.

Provider	**Total**	YMCA	Bridge Back to Life	Richmond University Medical Center	Silberstein	Silver Lake Behavioral Health
Patients	**160**	**47**	**19**	**38**	**40**	**16**

*As of 1/30/2020

SI CONNECT

Staten Island Connect (SI Connect), a local, 24/7 call center was built to help providers and patients connect to substance use, mental health, and care management services. Professionals could call (844) 877-7828 or (844) 877-STAT any time, any day to make referrals and appointments for their clients. Agents were available to answer calls from community members and connected them to behavioral health providers, a care manager, and other community resources.

400+

Calls received from December 2016-January 2019

69%

Linked to behavioral health providers or care management providers

POPULATION HEALTH

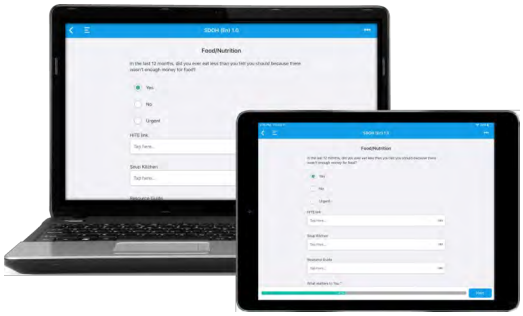
As milestone completion and project reporting draw to a close, SI PPS transformed its DSRIP program into a population health-based management program as reporting related projects and activities are coming to an end and DSRIP funding becomes more reliant on performance improvements. Since the start of DSRIP, the Staten Island PPS has implemented several population health and social determinant of health (SDOH) programs and initiatives using targeted hotspot maps and claims data, focusing on populations and neighborhoods with the highest needs. Throughout DY3, the PPS and its partners were focused on rapid cycle quality improvement, using data and analytics for targeted health interventions, and preparing for Value-Based Payment through training, education and MCO engagement.

Initially, interventions were primarily focused on population health domains and measures driven by DSRIP projects and associated performance measures. However, other high need populations and chronic conditions identified by claims analysis initiated the development of programs in other domains including asthma, diabetes, and social determinants of health.

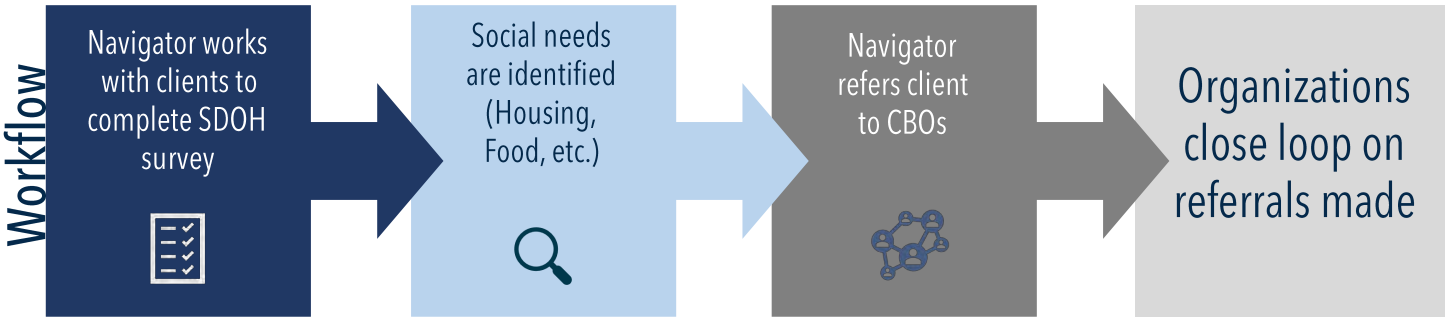
Most population health and SDOH initiatives are implemented by partners participating in DSRIP projects. Other programs are managed by separate contracts with CBOs or small primary care practices and fall outside the auspices of SI PPS selected projects but are aligned with Domain 4 deliverables and priority areas of the New York State Prevention Agenda. SI PPS population health programs aim to improve and prevent chronic conditions through person-centered, culturally competent, integrated and coordinated care.

POPULATION HEALTH

Social Determinant of Health Platform



In an effort to address social determinants of health (SDOH), SI PPS developed a proprietary and comprehensive platform called **WeSource**, a smartphone and desktop application that allows patients or health navigators to complete standardized SDOH assessments and make closed loop referrals to social service organizations. The platform is compatible with the local Regional Health Information Organization (RHIO), Healthix, linking clinical data and sending information back to the PPS data warehouse. With hotspotting and geomapping capabilities through an enterprise dashboard, organizations including local governments, managed care organizations, and health systems can better monitor and analyze population-specific data. Referral trends can be tracked over time, assisting organizations with making better investments in programs to address evolving social needs of specific communities.



June 1st, 2019 to January 19th, 2020

13,569
Total validated SDOH completed surveys

27,052
Total SDOH factors identified

8,034
Referrals made

POPULATION HEALTH

Health Literacy

Nearly 80% of Staten Island Medicaid beneficiaries with chronic illness report experiencing a Social Determinant of Health (SDOH) to their care managers. Feedback gathered from focus group participants correlate limited health literacy to social and lifestyle factors influencing their health.

Successful collaborations with a range of PPS partners through the Diversity and Inclusion task force, which governs the Cultural Competency and Health Literacy workstream, has led to the following accomplishments:

- Created Health Literacy guidelines from AHRQ and IOM tools
- Conducted network training on:
  - Health Literacy Train the Trainer
    - Effective communication
    - Plain language simplification
    - Teach Back
- Each partner site is currently using tools created by the PPS or AHRQ to implement quality improvement PDSA projects
- Partners use KPI's or patient survey results to measure success of each initiative satisfaction

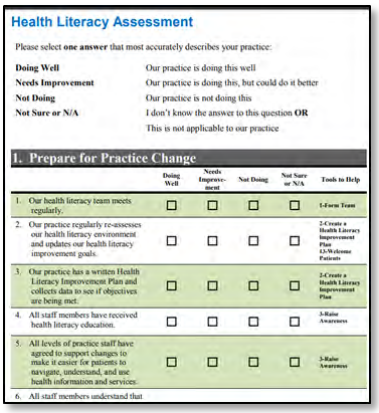
The goals of Staten Island Performing Provider System's Health Literacy initiative were to improve organizational and community health literacy, and to:

- Support partner network in 'Becoming Health Literate Organizations'
- Create Health Literacy Action Plans and site-specific quality improvement PDSA projects to impact performance measures and earn dollars
- Influence a variety of health literacy related SDOH factors impacting the community

14
Organizations

8
PDSA Projects

$8,611,994
Earned


Health Literacy Assessment

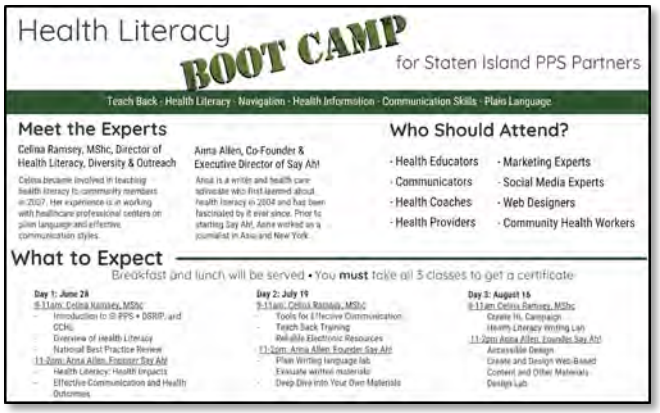
Please select **one answer** that most accurately describes your practice:

Doing Well	Our practice is doing this well
Needs Improvement	Our practice is doing this, but could do it better
Not Doing	Our practice is not doing this
Not Sure or N/A	I don't know the answer to this question **OR** This is not applicable to our practice

1. Prepare for Practice Change

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
1. Our health literacy team meets regularly.	☐	☐	☐	☐	1-Form Team
2. Our practice regularly re-assesses our health literacy environment and updates our health literacy improvement goals.	☐	☐	☐	☐	2-Create a Health Literacy Improvement Plan O-Welcome Patients
3. Our practice has a written Health Literacy Improvement Plan and collects data to see if objectives are being met.	☐	☐	☐	☐	2-Create a Health Literacy Improvement Plan
4. All staff members have received health literacy education.	☐	☐	☐	☐	3-Raise Awareness
5. All levels of practice staff have agreed to support changes to make it easier for patients to navigate, understand, and use health information and services.	☐	☐	☐	☐	3-Raise Awareness
6. All staff members understand that					

Health Literacy Assessment
Partner facilities conducted assessments and a gap analysis, then created an action plan to address health literacy at all points where patients interact with the system.


Health Literacy BOOT CAMP for Staten Island PPS Partners

Teach Back · Health Literacy · Navigation · Health Information · Communication Skills · Plain Language

Meet the Experts

Celina Ramsey, MShc, Director of Health Literacy, Diversity & Outreach

Celina became involved in teaching health literacy to community members in 2007. Her experience is in working with healthcare professional settings on plain language and effective communication styles.

Anna Allen, Co-Founder & Executive Director of Say Ah!

Anna is a writer and health care advocate who first learned about health literacy in 2004 and has been fascinated by it ever since. Prior to starting Say Ah!, Anna worked as a journalist in Asia and New York.

Who Should Attend?

- Health Educators
- Communicators
- Health Coaches
- Health Providers
- Marketing Experts
- Social Media Experts
- Web Designers
- Community Health Workers

What to Expect

Breakfast and lunch will be served • You **must** take all 3 classes to get a certificate

Day 1: June 28
8-11am: Celina Ramsey, MShc
- Introduction to IS PPS • DSRIP, and CCHG
- Overview of Health Literacy
- National Best Practice Review

11-2pm: Anna Allen, Founder Say Ah!
- Health Literacy: Health Impacts
- Effective Communication and Health Outcomes

Day 2: July 19
9-11am: Celina Ramsey, MShc
- Tools for Effective Communication
- Teach Back Training
- Reliable Electronic Resources

11-2pm: Anna Allen, Founder Say Ah!
- Plain Writing language lab
- Evaluate written materials
- Deep Dive into Your Own Materials

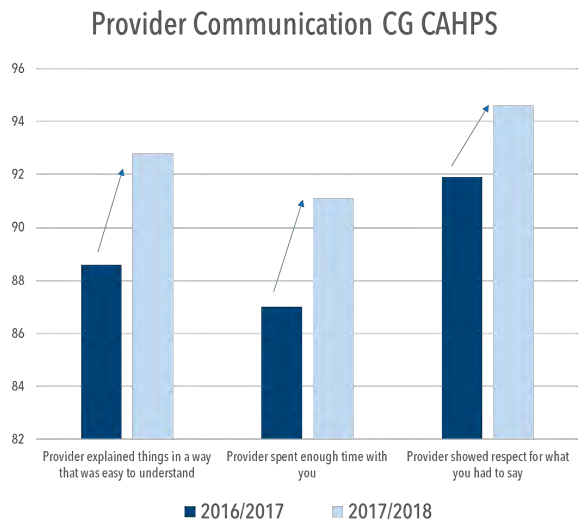
Day 3: August 16
8-11am: Celina Ramsey, MShc
- Create HL Campaign
- Health Literacy Writing Lab

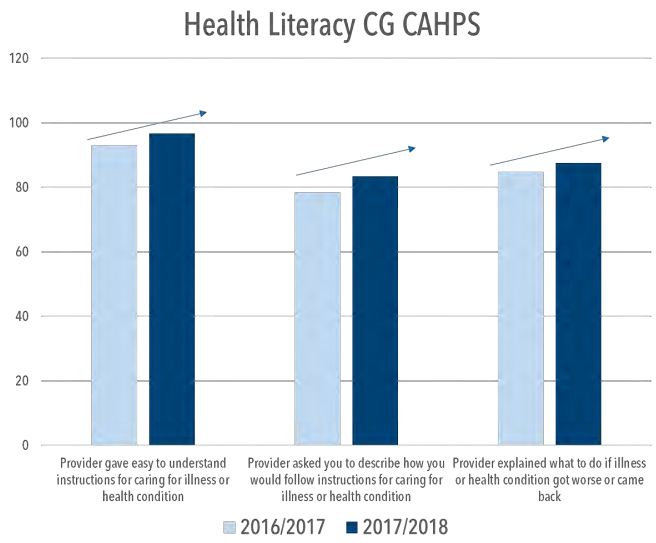
11-2pm: Anna Allen, Founder Say Ah!
- Accessible Design
- Create and Design Web-Based Content and Other Materials
- Design Lab

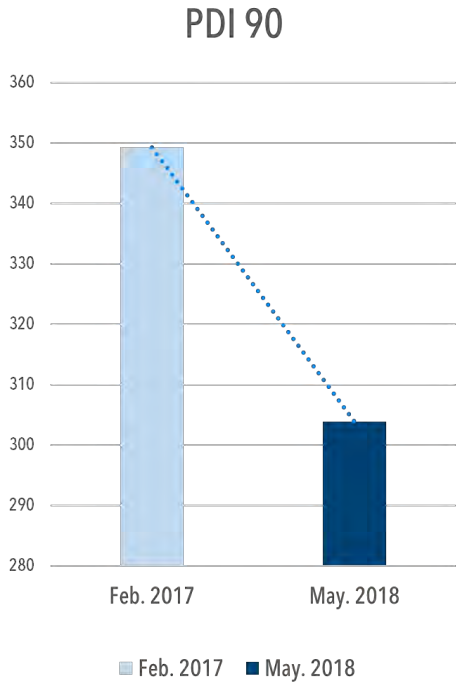
Health Literacy Bootcamp Training
Leverage community connections to places of worship, schools, housing, and community centers to conduct community health literacy workshops.

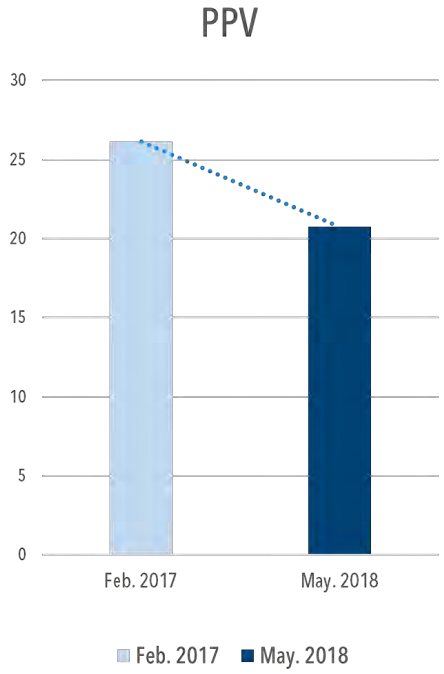
POPULATION HEALTH

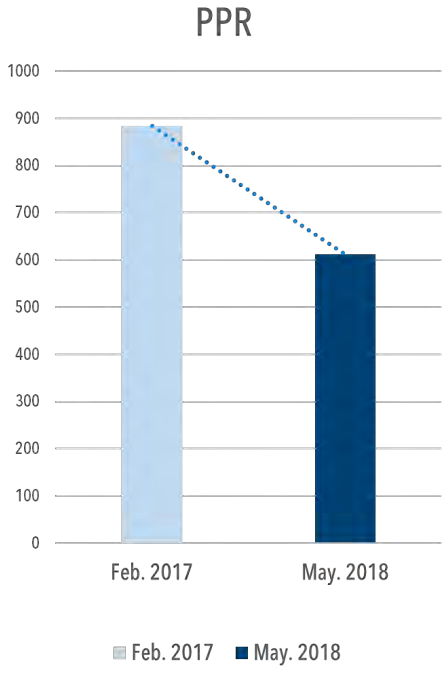
Health Literacy (continued)











Conclusions

- Health Literacy initiatives are flexible enough to be adapted effectively regardless of provider type, payor, organization size or services rendered
- Invest time to strategize on initiatives that influence different types of health literacy-related SDOH will impact patient populations
- Make the case for Health Literate Organizations by matching performance indicators to value-based dollars. Measure the success of health literacy projects and programs against performance indicators

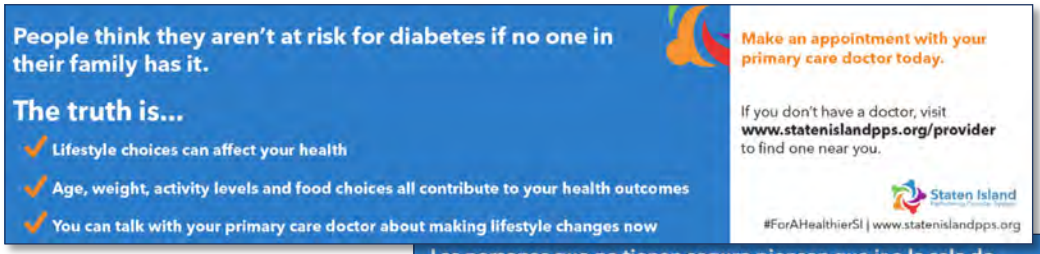
POPULATION HEALTH

Patient and Community Engagement

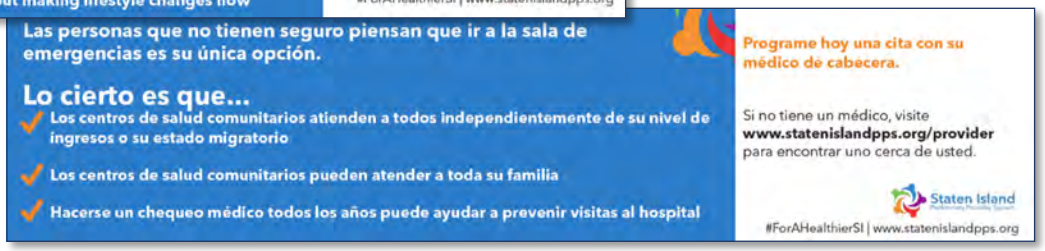
~5,720,388
Impressions on the Staten Island buses

~5,496,388
Impressions on the Staten Island ferry

In April of 2018, SI PPS launched a three-month public awareness campaign around diabetes, asthma, and primary care. The campaign was created to improve health literacy throughout the community. The main call-to-action was to reconnect people with their primary care provider. If the person reading the ads didn't have a provider, we linked them to the SI PPS website where they could find one close by. These ads were placed on the local buses and the Staten Island ferry and are available in English and Spanish. With the increased visibility of this campaign, community members were able to see the same ads on their commute everyday, which impacts behavior change.



Staten Island bus ads



14% Increase in overall website views

25% Increase in "Find a Provider" pageviews

Staten Island ferry ads

POPULATION HEALTH

SI CARES

Staten Island Community At-Risk Engagement Services (SI CARES) is a care coordination program that manages high-risk individuals who are ineligible for the New York State Health Home program by providing access to high quality health care and social support services.

Eight community care management agencies participating in the SI PPS network have implemented the SI CARES program including Coordinated Behavioral Care, Community Health Action of Staten Island, Jewish Board of Family & Children's Services, Project Hospitality, Staten Island Mental Health Society, Northwell Health Solutions, Seamen's Society for Children & Families, and Community Health Center of Richmond. Individuals must be active Medicaid members, have one chronic condition and be at-risk of developing another condition, and have social determinant of health barriers to be eligible. Members have a dedicated care manager or health coach providing short-term support. SI CARES aims to reduce risk factors and improve health for individuals monitored by key performance indicators.

8,348

Unique Medicaid individuals engaged in care management services on Staten Island since 2015

22%

Reduction in ED utilization for individuals that were engaged in SI CARES program (April 2015-Mar 2019)

SI CARES Health Coaches who have helped people on Staten Island obtain medical and social services

SI CARES patient empowerment video series
www.statenislandpps.org/si-cares

When you are **open** and **honest** about your concerns, your **PCP** can **better address** your **healthcare needs** as a whole.

POPULATION HEALTH

Primary Care Incentive Program

Targets for access to primary care performance measures were a continued challenge for SI PPS network providers. To help increase access to primary care visits, SI PPS created a primary care gift card incentive program for Medicaid members for the MY3-MY5 time period. A two-sided flyer was developed and distributed to partners and community members offering a free $15 Target gift card for providing evidence of visiting a primary care provider (PCP). The back of the flyer included a form to be filled out by primary care providers with patient consent and instructions for sending information back to SI PPS to be validated. Individuals must have been enrolled in Medicaid to be eligible to receive a gift card.

78
Individuals eligible for a gift card in **MY3**

→

71
Individuals eligible for a gift card in **MY4**

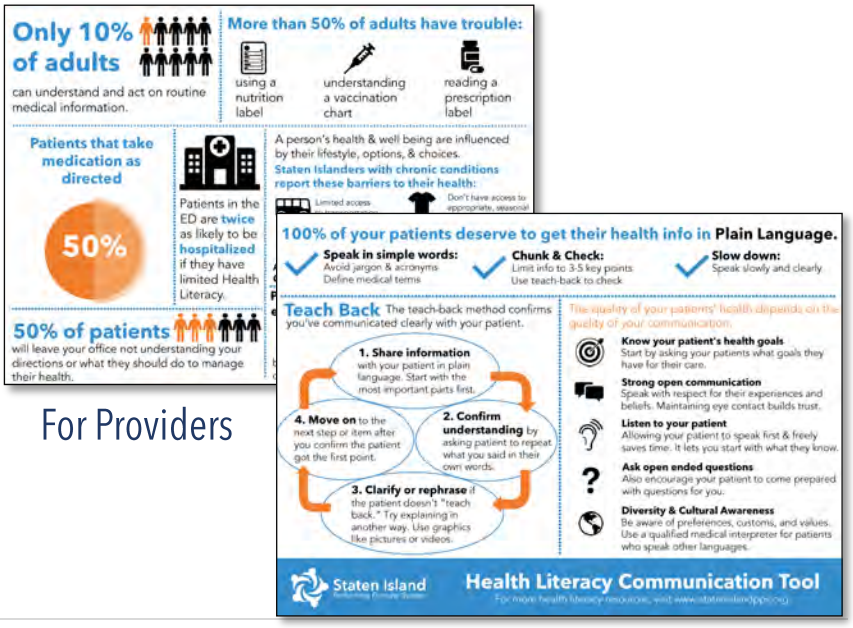
→

91
Individuals eligible for a gift card in **MY5**

Patient and Provider Communication Tools

Improving providers' and patients' health literacy and health communication skills can positively impact CAHPS survey and claims-based performance measures. Most of the provider communication survey measures are soft skills that need to be taught and practiced routinely. Results are primarily based on whether a patient feels like they were heard, plus assesses their actual health literacy skill set; by a person's knowledge of where and how to access services, how to navigate the system and whether there are other social determinant influencers; and depend on a person's knowledge of health issues and other social or lifestyle factors. The following Health Literacy Patient and Provider Communication tools were created for PPS partners to post and distribute to all patients and providers. These tools have been shared with MCOs and CBOs to ensure widespread community impact and performance improvement.

For Patients



For Providers

POPULATION HEALTH

Language Access

Agencies with multiple locations that have language access services

Video Remote Interpreting unites distributed to partners

Since rolling out the program in late 2015, SI PPS has helped agencies across Staten Island obtain low-cost language access services. People who prefer to communicate their health information in languages other than English can now seamlessly access free, high quality, video or phone interpretation services whether they are seen at a SNF, in an ED or at a CBO. Interpreting units have been distributed to PPS partners including outfitting both hospitals, all outpatient and behavioral health departments, seven skilled nursing facilities, several primary care practices and a multi-practice primary care organization with state-of-the art Video Remote Interpreting (VRI) . Communication is key to improved health outcomes. Staten Island immigrants, an estimated 30% of Staten Island's total population, are building trusting face-to-face relationships with their providers across the language divide. Staten Island PPS has trained close to 60 bilingual employees from partner sites to become Qualified Medical Interpreters in Spanish, Arabic, Albanian, Mandarin, Hindi and Russian.

Advance Care Planning Decisions

Advance Care Planning (ACP) Decisions is a resource for staff, patients, and families to improve the understanding of palliative care through short video clips. SI PPS funded all 10 nursing homes to access the videos for staff and patient education. The videos were developed by Dr. Angelo Volandes and Dr. Aretha Delight Davis. The videos are evidence based showing that an individual is more likely to have a goals of care conversation after viewing the video.

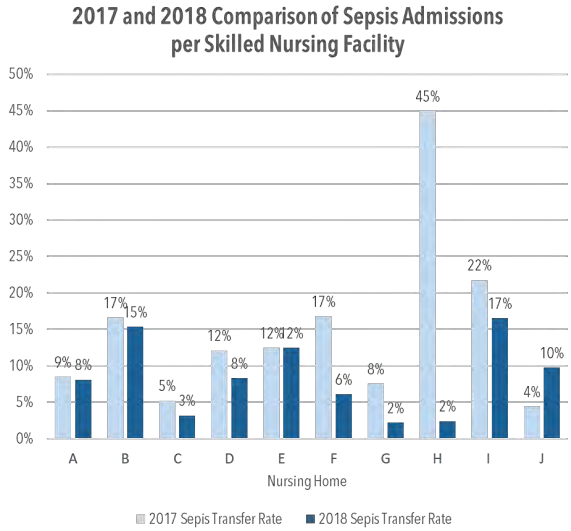
Top 10 Most Viewed Videos

Title	Viewings in Person	Viewings from Codes
Goals of Care: General Overview	31	132
What is Palliative Care?	82	76
Palliative Care: An Intro	15	48
Goals of Care: Advanced Dementia	16	19
Advance Directives	13	13
CPR: General Overview for Hospitalized Patients with Serious Illness	14	9
Goals of Care: Skilled Nursing Facilities	11	6
POLST	13	0
Feeding Tubes	8	4
Goals of Care: Advance Disease	2	7

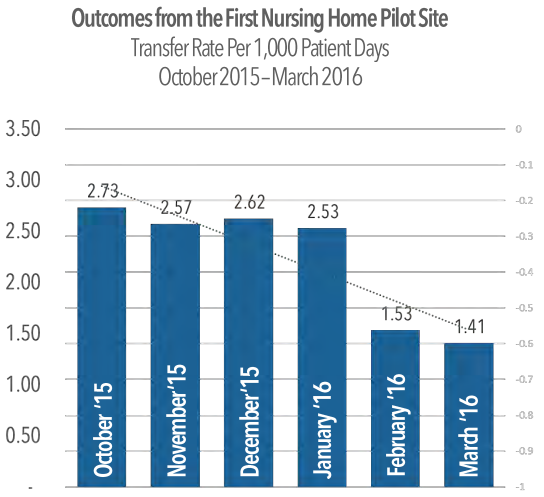
POPULATION HEALTH

Sepsis Protocol to Reduce Preventable Readmissions

Over the past three years across 10 Skilled Nursing Facilities (SNF) on Staten Island, there was an increase in hospital admissions with a primary diagnosis of sepsis or septicemia. SNF administrators agreed to "implement a standardized sepsis protocol based on Systemic Inflammatory Response Syndrome (SIRS) criteria to reduce preventable readmissions for nursing home residents. In July 2017, the initiative began with a Plan-Do-Study-Act (PDSA) cycle where the sepsis protocol was tested in one nursing home. After a successful testing period, SI PPS presented the protocol in October 2017 to all 10 SNFs where agreement was reached to implement the protocol in the respective facilities. SI PPS supported the initiative by providing implementation funds for the nursing homes to purchase necessary supplies to build a sepsis kit on each floor and provider IV starter kits on each unit. Through workforce transformation efforts, SI PPS provided IV certification and phlebotomy training, so the nurses could competently draw blood and administer IVs in the facilities.



Telemedicine Pilot for Persons With I-DD



Baseline data: October-December 2015 | Pilot data: January 2016-March 2016

Many persons with intellectual and developmental disabilities (I-DD) are admitted to the hospital for conditions and symptoms that can be managed in place. SI PPS funded a telemedicine pilot among 3 SNFs and 2 Cerebral Palsy of New York State (CP of NYS) sites providing video conferencing units. For individuals needing emergency treatment, staff at the sites could connect to board certified emergency medicine physicians, credentialed at the SNF or CP of NYS sites with privileges to create orders in the medical record. Physicians performed medical evaluations via video conferencing to examine patients and develop treatment plans with the nurse or caregiver. The availability of video conferencing units also expanded weekend coverage at the sites. Success of the pilot and reductions in preventable admissions for this population created opportunities for additional funding to expand the program among other CP Unlimited clinics.

POPULATION HEALTH

Wellth for Diabetes Management

Wellth is a patient-facing smartphone app that uses the loss aversion theory of behavioral economics to increase patient engagement with care plan compliance and track medication adherence. SI PPS partnered with Wellth to offer the app to patients at primary care practices to improve diabetes outcomes. The app helps patients form habits through a series of repeated triggers, behaviors and rewards. Patients with an a1c greater than 9 are enrolled in the program for 70 days. Every day, a patient gets an alert (trigger) from the app reminding them to take their diabetes medication and/or measure their blood glucose (behaviors). Patients upload photos of their medicine and blood glucose reading which are validated in the system by Wellth. Patients are offered $75 (reward) for staying adherent to their program. Failure to respond to Wellth alerts and completing desired behaviors results in the loss of $2 for each failed check-in. Every two weeks, patients can earn up to $15 payouts. Daily medication adherence and/or glucose readings are tracked and shared with SI PPS weekly.

After seeing success with Wellth's Type 2 Diabetes program, Staten Island PPS further collaborated with Wellth to launch a Gestational Diabetes program. The program incentivizes patients to measure their blood sugar levels 4x a day up to 16 weeks and earn up to $260 over the course of 16 weeks on the Wellth program. The program was launched in September 2019.

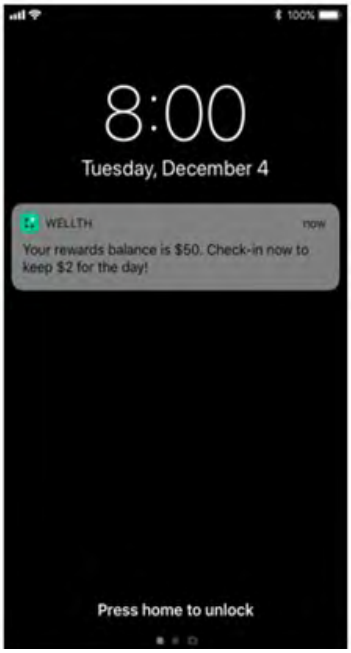
> *"The Wellth app has taught me to be more honest with myself about my health and my health condition…It makes you be more mindful. It helps you adjust to the lifestyle that's needed to live a healthy life."*
>
> -Cyntha, *Wellth app user*
>
> Hear about Cynthia's story:
> statenislandpps.org/when-health-is-wellth-cynthias-story

86% Adherence Rate

-1.25 Average reduction in A1c

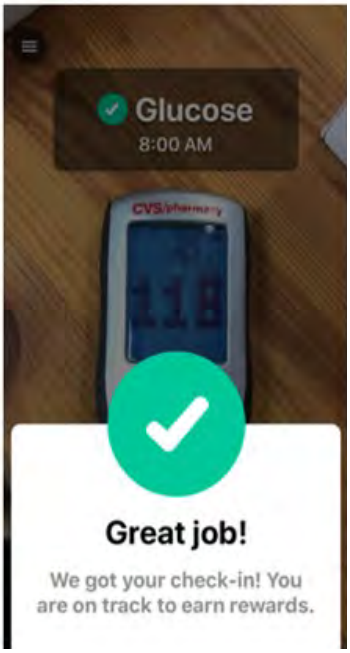
9,034 All time total submitted check-ins

Trigger



Behavior

Reward



POPULATION HEALTH

Bridge Home Rehousing Pilot

Individuals experiencing homelessness are often poorly connected to ongoing primary care and high utilizers of emergency medical services and avoidable hospitalizations. Individuals experiencing homelessness also have longer inpatient length of stay and use more emergency and episodic health services than those who are stably housed. In addition, individuals in shelter experience high rates and co-occurrence of chronic medical conditions, mental health issues and substance use disorders. To address these issues and improve health outcomes, SI PPS and the NYC Department of Homeless Services/Department of Social Services (DHS/DSS) collaborate to rehouse homeless individuals residing in NYC shelters. Both organizations signed a data sharing agreement to share rosters and match mutual clients for targeted outreach and engagement for reconnecting them to permanent housing. SI PPS has subcontracted with St. Joseph's Medical Center Residential Services team to engage with clients in shelters, check voucher status and eligibility, accompany individuals to apartment viewings, gather necessary paperwork and assist with client move-in and relocation. Clients are also enrolled in Home Base programs for ongoing coordination of public assistance and future homelessness prevention.

15

Families who have moved to stable housing to date.

Resulting in

~$740,000

Proxy cost savings in 6 months.

> *My stay at Project Hospitality was much appreciated, I'm happy they recommend me to St. Joseph's...I'm grateful for their help.*
>
> - Bridge Home Client, October 2018

Diabetes Self-Management Program

SI PPS provided implementation funding for the Community Health Action of Staten Island (CHASI) peer led Diabetes Self-Management Program following the Stanford CDSM model. People with diabetes learn how to manage an active and fulfilling lifestyle over 6 weeks through 2-hour interactive workshops. Participants are given Metro cards to assist with transportation to each class and a free workbook to help them manage their diabetes. Staten Island University Hospital also leads a Diabetes Self-Management Program run by a team of certified diabetes educators offering counseling sessions, group classes and support groups. Richmond University Medical Center and the YMCA Counseling Center offer National Diabetes Prevention Programs for individuals at-risk of diabetes or a diagnosis with pre-diabetes. The Diabetes Prevention Program is a one-year program with 16 weekly sessions and monthly meetings with topics covering healthy eating, physical activity, overcoming stress and staying motivated.

WORKFORCE

At the start of DSRIP, SI PPS conducted a survey to assess training, skills and hiring needs among our vast partner network of more than 70 organizations representing over 12, 500 employees. A key point of the survey was to identify skills and jobs necessary to help align patients with the right healthcare venues within the community. The survey also highlighted a shift from inpatient hospital care to the need to develop integrated care options outside the hospital.

During 2016 SI PPS, organized labor, partner organizations and institutes of higher education began to develop and deliver on building a training and recruitment platform to offer best in class programs. Since 2016, SI PPS has convened more than 50 partner organizations to offer more than 60,000 hours of training, for more than 20,000 partner staff. The training inventory consists of a training catalogue of more than three dozen short- and long-term courses in Population Health, Cultural Competency, Behavioral Health, Continuing Care, web-based Disease Management, and Patient Engagement. One key outcome of this platform was the introduction of a global Nursing Home approach to managing sepsis in nursing homes with the goal of reducing hospital admissions.

In 2017 and beyond, SI PPS began to develop and offer Adult Education Certificate Programs in conjunction with institutes of higher education. These more in-depth courses also offered a college credit component. The first Certificate Program was the Community Health Worker Program, which has since developed into four distinct tracks. To date 42 students have graduated from this program. The next Certificate Program developed was for a Certified Peer Recovery Advocate. This certification is designed for people with lived experience and in recovery from addiction. They are a key linchpin in helping engage patients in multiple settings into treatment and services for substance use disorders. Staten Island started with two certified peers and within the past two years, have trained more than 75 Peers to help address people with addiction. In addition, the program was the first in New York State to receive state certification.

Over time, SI PPS and partners looked at deeper issues impacting recruitment and retention. Nursing home partners identified a lack of skills for new hires, a longer time to train new hires, higher turnover resulting from poor skills, low morale and higher than needed overtime costs. Subsequently, the PPS convened the nursing home partners along with organized labor, higher education and the best incumbent front-line staff. The group examined the required curriculum for Nursing Assistants and through review identified missing skills deemed critical to Nursing Assistant success. A new curriculum was developed, obtained Federal approval from the US Department of Labor and launched the first federally approved, learn and earn Apprentice Program for Certified Nursing Assistants in New York State. The third cohort is currently launching and in process of developing an LPN Apprentice career ladder program.

The work has continued to mature based upon the needs of the workforce community, partner organizations and the healthcare market in general. SI PPS has received national and local recognition for our work and has provided advisory and development assistance to organizations around the world.

WORKFORCE DEVELOPMENT, DAY 1

Training was conducted by each organization in a silo fashion with no incentive to build cross organizational collaboration.

Many employers were faced with common problems of turnover, overtime created by turnover, inability to attract and retain staff, concerns with the skills/abilities of new hires and the need to retrain new hires.

There was no cohesive partner relationship with the College of Staten Island.

WORKFORCE

Resource Allocation

Identify numbers and organizations requiring training, develop a calendar of training events tied to budget dollars

Create a budget to accomplish the desired training

Build agreements with vetted training vendors with an eye toward developing and promoting local training resources

Involve partner organization and PPS internal staff, higher education, organized labor, front line staff in the design and/or redesign of new jobs and existing curriculum

Build on-line training catalogue and registration platform to promote ease of access and tracking

Our Results: Recognized Across the State and Beyond

60,000+ hours of partner requested/needed training to more than **20,000 participants** over **36 months.**

More than **50** partners accessed trainings

$200,000 in scholarships to **80+ students.**

40+ Community Health Workers

20+ Care Managers

90+ Certified Recovery Peer Advocates

100% Graduate rate for Community Health Workers

92% Graduate rate for Certified Recovery Peer Advocates

88% Of the scholarship/interns went from intern to employment with one of our local partners

Created a Masters degree in Health Care Administration

Embedded related college credit courses in our adult certificate programs

Developed four variations of CHW curriculum

> *I am a different person now that I have completed the [Certified Recovery Peer Advocate] training because I feel more centered and sure of what I will do with my future.*
>
> -Bette, CRPA Graduate

WORKFORCE

GRANT DEVELOPMENT

HRSA CRPA/CHW	$650,000	Awarded to SI PPS September 2019
Robert Wood Johnson Foundation	$300,000 request	Notified by RWJ in January 2020 that SI PPS in finalist round for grant review
NYS Consolidated Funding Application	$300,000 request	Notified by NYS (1/2020) SI PPS to submit budget request after SI PPS approved in round 1
JP Morgan Workforce Development	$5,000,000	Grant application filed January 2020
Lumina Foundation	Participation in the Healthcare Workforce Development Academy is supported by co-investment of Lumina Foundation, the National Fund, and SI PPS.	Academy participation provides exposure to best practices to access and leverage funding to support frontline workforce investment

ILR School

Cornell ILR conducted a multi-year study of SI PPS workforce efforts, cited positive impact in skills upgrading and called the work good Public Policy5.

U.S. DEPARTMENT OF LABOR

US DOL recognized SI PPS creation of Reg. Apprentice program for C.N.A. – **first in NYS** and Home Health Aide. Earn and learn- adoption at State and Federal level encouraged.

THE CITY UNIVERSITY OF NEW YORK College of Staten Island

College of Staten Island awarded the SI PPS, Presidents Medal in 2018 for our partnership in creating workforce programs to improve the local healthcare economy

National Fund for Workforce Solutions

In 2018, SI PPS was recognized as a Frontline Healthcare Worker Emerging Champion by CareerSTAT, an initiative of the National Fund for Workforce Solutions. SI PPS was selected to participate with 15 U.S. healthcare organizations in the Healthcare Workforce Development Academy, an intensive, 18-month peer learning experience.

BLU Business Leaders United for Workforce Partnerships

Participated with BLU to advocate on Capitol Hill for enhanced funding for Pell Grants and expanded WIOA funding to cover Continuing Ed. learning programs.

HRSA Health Resources & Services Administration

Health Resources and Services Administration (HRSA) awards PPS more than $650,00 in grant funding to continue our training program for CHW and CRPA 2019-2022

WORKFORCE

Cultural Competency & Health Literacy Training

It is a priority for Staten Island PPS to engage with Community Based Organizations in order to address barriers to Diversity, Equity and Inclusion under the Health Literacy and Cultural Competency workstream domain.

Staten Island PPS's Diversity and Inclusion Committee consists of a CC/HL Site Champion from partner sites who have contributed a significant amount of site specific information regarding training needs and gaps and has been accommodating these CBO partners to schedule and execute in-person trainings for their staff. Each training program is being implemented, measured and tracked to determine the impact cultural awareness and health literacy training for healthcare professionals has on health outcomes.

Diversity, Equity & Inclusion Training

LGBTQ Cultural Awareness Training

In collaboration with the Pride Center of Staten Island, this training includes an overview of LGBTQ terminology, health disparities impacting the LGBTQ community, and strategies to create a welcoming environment for LGBTQ people. The training advances a person-centered approach to working with LGBTQ patients and/or clients in healthcare settings. The training includes activities that focus on intersectionality and structural systems of oppression. Additionally, the training gives concrete tools to make healthcare environments more welcoming for LGBTQ patients and/or clients, as well as LGBTQ co-workers.

Disability Ally Initiative

Person Centered Care Services (PCCS) provides a series of trainings to PPS partner organizations under the Cultural Competency and Health Literacy workstream. The Disability Ally Initiative (DAI) is a one-hour training given to health care providers to increase knowledge of how to better support people with disabilities. After staff are given the education of disabilities culture, given communication tips, and trained on general etiquette, better relationships with people with disabilities are possible.

Interreligious Cultural Awareness

In collaboration with Tanenbaum, this workshop allows participants to:

- Explore the impact of today's trends of religious diversity in the patient population
- Dive into social identity and unconscious bias
- Examine topics at the intersection of religion and healthcare
- Learn to take a spiritual history
- Learn best practices for responding to religious expression
- Meet religious needs of today's patients

Veteran Military Cultural Awareness

In this workshop hosted by Intersections International, participants learn about the military-civilian divide and the impact it has both on reintegrating veterans and their families, as well as the civilian community. Facilitators join participants in dialogue around areas in which the divide is experienced (healthcare settings, in the community, in faith networks, and on the job.) Participants hear firsthand accounts of the military-civilian divide by veterans and their families.

Health Literacy Bootcamp

In collaboration with Say Ah!, the Health Literacy Boot Camp allows attendees to understand health literacy and the impact it has on health outcomes, to become equipped with effective communication skills, the ability to write and evaluate plain language using accessible design for health skills.

Building Equitable Healthcare Organizations

The Diversity, Equity and Inclusion (DEI) program was created in collaboration with Community Resource Exchange (CRE) to give leaders the tools and strategic guidance needed to deepen their identity awareness and leadership capacities to advance diversity, inclusion, and equity within and beyond their organization. The initiative is a series of interactive sessions over four months, plus one-on-one coaching support, for directors and senior leadership of Staten Island-based healthcare organizations.

Health Literacy Train the Trainer launched and conducted across **14 partner sites**

Both Staten Island University Hospital and Richmond University Medical Center committed to training ALL employees in LGBTQ healthcare equality taught by the Pride Center of Staten Island.

They have trained thousands of staff to date.

Cultural Awareness Modules

SI PPS's Cultural Awareness Modules are designed to focus on issues and groups experiencing health & social inequities on Staten Island. Four, 15-minute online learning modules teach users strategies for addressing diversity, equity, inclusion & health communication.













COMMUNITY-BASED ORGANIZATION **ENGAGEMENT**

Staten Island PPS had a unique approach to engaging with Community Based Organization partners at the start of DSRIP. Leveraging existing relationships between partners, project management staff and CBOs, SI PPS hosted several Community Breakfasts at community locations across Staten Island. There was great turnout and interest from non-PPS partners, local businesses, community groups and other community stakeholders as DSRIP project goals and impact on transforming the Staten Island health care system was developed.

Meetings were held with interested CBOs, community groups and cultural affiliations who showcased their programs and community work. Each group spoke to the number of Medicaid beneficiaries they currently reached and together with SI PPS, explored different project and population health needs to determine how best they could perform as a PPS partner and co-designed each program so that the Community Based Organizations committed to work they felt confident to accomplish.

Relationships were cultivated with each CBO, all of whom had existing infrastructure that could support expanding their functions to include a DSRIP project. SI PPS leadership made several visits to each site to present programs to all staff involved in each CBO and to explain the demographics of each community served. SI PPS teams were intimately involved, continually evolving program deliverables to meet the needs of our partners and community members.

Currently, 20 CBOs are engaged with SI PPS on multiple projects. Relationships with partners focused on Social Determinants of Health, Population Health, Healthy Neighborhoods and Diversity, Equity and Inclusion Training. Partnerships with CBOs related to a DSRIP project included Patient Activation, Care Coordination and Behavioral Health.

All CBOs focused on Social Determinants of are responsible for:

- Attending monthly touchpoint meetings
- Submitting monthly CBO reports which track project activities
- Participating in workgroup meetings

Benefits of CBO & PPS Partnership

- Partnerships with organizations serving Medicaid members
- Leverage existing relationships between CBO and community members
- Foundation for all services and interactions built on trust
- Expansive service area coverage of entire borough
- Access to network of PPS partners
- Financial and technical support: invoicing, data collection, program development, and outreach
- Access to data and healthcare analytics
- Inclusion in determining outcomes for community groups served
- Expansion of health-related programming
- New funding source
- Building internal capacity
- Access to PPS training, professional development, conferences and workshops
- Inclusion in value-based payment planning
- Connection to Managed Care Organizations for Social Determinant of Health interventions

COMMUNITY-BASED ORGANIZATION **ENGAGEMENT**

Asthma Home Visit Program

Although asthma wasn't selected as one of the 11 DSRIP projects Staten Island PPS would implement, it was included under the Domain 4 Chronic Disease Prevention Project. In order to address poor asthma outcomes experienced by Latinos and low-income residents in Staten Island, the Asthma Community Health Worker Home Visit Program (AHV) was created to bring services to families with children living with asthma. Make the Road NY's AHV Program offers comprehensive services to address household environmental conditions as well as provides community members with asthma education, referrals for legal services, assistance with tenant/landlord issues, health navigation and benefits enrollment services.

45 patients referred to IPM services

123 Home visits

108 Families

We have been able to purchase vacuums and give mattress covers to families, which helps them improve their asthma at home.

> *She demonstrated how to use the medication and explained what each medication does when my kids take it. Now I feel confident with my kids' medication and how they should be using it.* -Rosa, Asthma Home Visit Program Client

Faith-Based Peer Navigation

The Faith-Based Peer Navigator is a key focal point of ArchCare's Parish Health and Wellness Network on Staten Island. Through shared partnerships, ArchCare worked with Staten Island's faith communities to support them and their leadership by ensuring access to appropriate healthcare resources. The Faith-Based Peer Navigator planed and executed community and faith-based training programs with partner organizations to provide health education, as well as serve as a portal for appropriate referrals to the healthcare system by connecting with PPS partners.

Since Jan. 2017

201 Meetings at unique places of faith

36 Health Literacy Workshops

11,376 Individuals served at events & workshops combined

COMMUNITY-BASED ORGANIZATION **ENGAGEMENT**

TimeBank

Since Jan. 2017

144

Individuals Engaged in the TimeBank

The ArchCare TimeBank is a free, innovative, intergenerational volunteer service exchange program that enables its members to both provide and receive services, accessing critical assistance and at the same time feel useful and productive. The TimeBank movement has a 30-year history with over 40,000 participants in 38 nations around the world. The ArchCare TimeBank has been operating in the boroughs of Manhattan and Brooklyn since 2014 and has been shown to improve mental and physical health, quality of life and reduce social isolation of its participants. The expansion of the ArchCare TimeBank to Staten Island aligned with the overall goals of DSRIP, and with funding provided by SI PPS, became accessible to all Staten Island residents.

Cooking Matters at School

Cooking Matters is a 6-week, hands-on cooking and nutrition program integrated into the school day curriculum. Each week includes a new nutrition lesson focused on a different recipe. Schools receive bins containing all materials needed: cutting boards, knives, pots, pans, skillets, paper goods, and cleaning supplies. Each child gets to take home a free Cooking Matters book, which includes recipes, handouts, and worksheets. There is one additional parent class where children choose a recipe, work with their parents to make it and then taste the food together. There's also a free, one-day train-the-teacher for all teachers implementing the program so that after year one, it becomes sustainable.

Total
285 kids
47 parents
since 2017

P.S. 45
60 kids
10 parents

P.S. 21
60 kids
10 parents

P.S. 54
60 kids

P.S. 57
45 kids
15 parents

P.S. 13
60 kids
12 parents

Through the Cooking Matters at school, instructors:

- Capture children in their learning environment
- Reach large numbers at one time
- Give children and families a hands-on experience
- Encourage positive pressure from their peers
- Have the children participate in cooking and allow them to try new, healthy foods
- Give out entire cookbooks

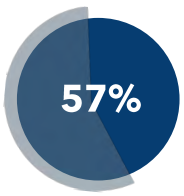
COMMUNITY-BASED ORGANIZATION **ENGAGEMENT**

Yoga & Empowerment for Recovery Support

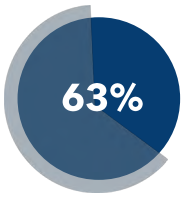
NYC Yoga Project is a non-profit whose mission is to provide underserved New Yorkers with access to yoga to create possibilities in their lives. The NYC Yoga Project partners with local recovery centers, rehabilitation centers, and treatment sites to provide a series of yoga and empowerment workshops to patients and clients. Certified volunteer yoga instructors who are trained in trauma-informed yoga principles also teach life skills and help students build confidence.

Staten Island PPS partnered with NYC Yoga Project to bring these resources to clients served by Behavioral Health and Substance Use Disorder partners. Partners including Camelot Counseling, YMCA Counseling Service and Canvas, have integrated the NYC Yoga Project empowerment series into their existing recovery treatment and group therapy sessions. NYC Yoga Project teaches new ways to manage stress and addiction through body movement, breathing and meditation. The type of yoga practiced is Vinyasa, which consists of 11 sequences and 53 postures. These poses and sequences help with being in the moment and thinking with the conscious mind. Students are always taught that anyone can practice and there are always modifications; it's accessible to anyone. Through the program, NYC Yoga Project has also helped students chart the course for a different type of future.

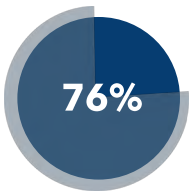
People in recovery who took an 8-week Yoga & Empowerment workshop use the these new skills and strategies to cope with stressful situations:



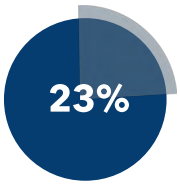
Use Yoga Techniques



Use Meditation



Use Breathing Techniques



Use Journaling

Students notice changes in the following:


97%
Stress and Coping


84%
Pain Relief


84%
Improved Sleep


89%
Improved Outlook


89%
Flexibility


81%
Socialization

Rx for Food

To address food insecurity issues faced by many Staten Island families, clinicians, care coordinators and social service providers write prescriptions for patients to get free access to healthy fruits and vegetables. No longer limiting access to City Harvest's mobile markets based on a patient's home address, all Staten Islanders can go pick up free healthy food for their entire family 2 times per month. Notable improvements in health outcomes including blood sugar monitoring, weight and blood pressure have been reported from patients who consistently pick up free produce. The program is run at FQHCs, a hospital and primary care practice locations, along with health coaches and navigators giving an Rx for Food for patients in their care. Richmond University Medical Center set up their own food distribution site at a local church so that on clinic days, patients can walk across the street to pick up their produce box. Another Center for Women's Health has also set up a City Harvest mobile van that parks outside their center on clinic days.

COMMUNITY-BASED ORGANIZATION **ENGAGEMENT**

Healthy Neighborhoods Project

Staten Island PPS's Healthy Neighborhood Project measures the "health" of Staten Island communities; specifically, on how polices are reflected in our built environment and their impact on local health disparities. Using the Centers for Disease Control (CDC) CHANGE tool, a data-collection survey tool, community-level data was collected in Phase I by three local colleges. Phase I data identified areas where change is most needed to relieve the burden of health disparities specific to the borough of Staten Island. Phase II focuses on community driven Health Improvement projects addressing social determinants and health disparities.

Two
$50,000
Grants awarded

7
Community convenings held to develop community action plans

South Shore YMCA is targeting **diabetes, asthma** and **drug abuse.**

Community Health Center of Richmond is targeting **childhood obesity** for **12,000 children.**

South Shore YMCA

Community Health Center of Richmond

MEET THE **TEAM**

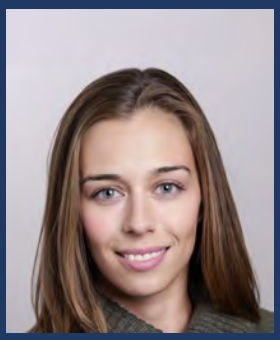
Staten Island PPS Staff

Joseph Conte, PhD, CPHQ
Executive Director

Salvatore Volpe, MD, FAAP, FACP, FHIMSS, CHCQM
Chief Medical Officer

Anyi Chen, PhD
Chief Information Officer

William Myhre, MPA
Senior Director of Workforce Transformation & HR



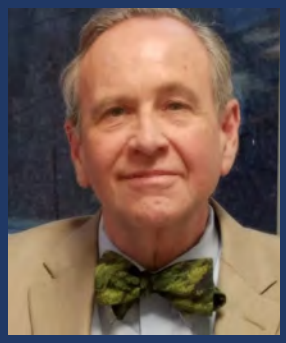
Ashley Restaino, MPH
Managing Director, Strategic Initiatives & Operations

Sadia Choudhury, MPA
Director, Ambulatory Care Initiatives

Mary Han, CPHQ
Director, Continuing Care & Quality Management

Nadeen Makhlouf, Pharm. D, MPH
Director, Clinical Engagement

Celina Ramsey, MShc
Director, Health Literacy, Diversity & Outreach



Mike Matthews, LCSW
Director, Behavioral Health

Valbona Lajqi, MBA
Operations Manager

Kristin Liberto, MBA
Finance Manager

Mark Slavutsky, MBA
Senior Business Intelligence Analyst

Reine Li
Business Intelligence Analyst

Dhruvit Patel
Software Engineer

Allison Romeo, MS
Staff Analyst

Lauren Tepfer
Communications & Marketing Analyst

Jordan Gerbasi
Project Support Specialist

Edina Kolenovic
Executive Assistant

STRIVING FOR **SUCCESS**

2016 Advanced Primary Care Leadership Award
Patient-Centered Primary Care Collaborative (PCPCC), August 2016

2017 Heritage Healthcare Innovation Awards
Crain's New York, May 2017

2018 DSRIP Learning Symposium Poster Award, Heal Category
NYS Department of Health, February 2018

Behavioral Health and Mental Health Honoree
2018 City & State Healthy New York Summit, April 2018

2018 Frontline Healthcare Emerging Campion
National Fund for Workforce Solutions, September 2018

The Wheels in Motion Award for Improving the Quality of Healthcare on Staten Island
Meals on Wheels

Dr. Richard M. Silberstein Award
Staten Island Mental Health Society, January 2018

Community Leadership Award
Christopher's Reason "A Beacon of Hope", September 2018

2018 Celestial Ball Honoree
College of Staten Island, December 2018

2019 Heritage Healthcare Innovation Award Nominee
Crain's New York, April 2019

Eleanor and Paul Proske Memorial Award for distinguished service to the poor
Project Hospitality, September 2019

PUBLICATIONS

Improving Behavioral Health Outcomes Through Collaborative Efforts and Strategies
Behavioral Health News, Fall 2017, p. 20

Exploring Value-Based Payment to Encourage Substance Use Disorder Treatment in Primary Care
Center for Healthcare Strategies, June 2018, p. 7

Mitigating a deadly crisis through innovation and Integration
Hospital Times, June 20, 2019

Enhanced CRPA and CHW Training and Workforce Transformation
Behavioral Health News, Summer 2019, p. 27

Workforce Capacities Case Study: Apprenticeships Answer Emerging Workforce Demands
American Hospital Association, October 2019

Measuring the impact of certified electronic health record technology on cost, quality and safety outcomes
International Journal of Computational Medicine and Healthcare, 2019, p.88 - 100

DISTINGUISHED VISITORS & **INTERNATIONAL PRESENTATIONS**

Presentations

NYC Health Business Leaders Health Forum
June 7, 2017

Big Data & Healthcare Analytics Forum
Boston, MA, October 23, 2017

14th Annual Columbia Healthcare Conference
February 16, 2018

Ignite U NY Population Health Summit
June 6, 2018

Big Data & Healthcare Analytics Forum
San Francisco, CA, June 13, 2018

Power of Data in VBP with Alliance and AHI
Lake George, NY, September 20, 2018

Empire State Opioid Epidemic Innovation Challenge Conference
September 2018

Washington DSRIP Learning Symposium
Seattle, WA, October 2018

"Leading Innovative Transformation" World Healthcare Congress Europe
Manchester UK, March 5, 2019

16th Annual Word Health Care Congress
Washington, DC, April 28, 2019

"VBP: Supporting Whole Person Care" Pennsylvania Dept of Human Services
August 15, 2019

"Learning Across Initiatives", CACHI-CDPH Convening
Sacramento, CA, August 22, 2019

"Data for Community Health" All In National Meeting
Baltimore, MD, October 14, 2019

International Visits & Visitors

"VBP Initiatives and Data Analytics"
NHS Chelsea and Westminster, UK, June 1, 2018

"New York Health and Social Care Innovation"
Manchester, UK, April 19, 2017

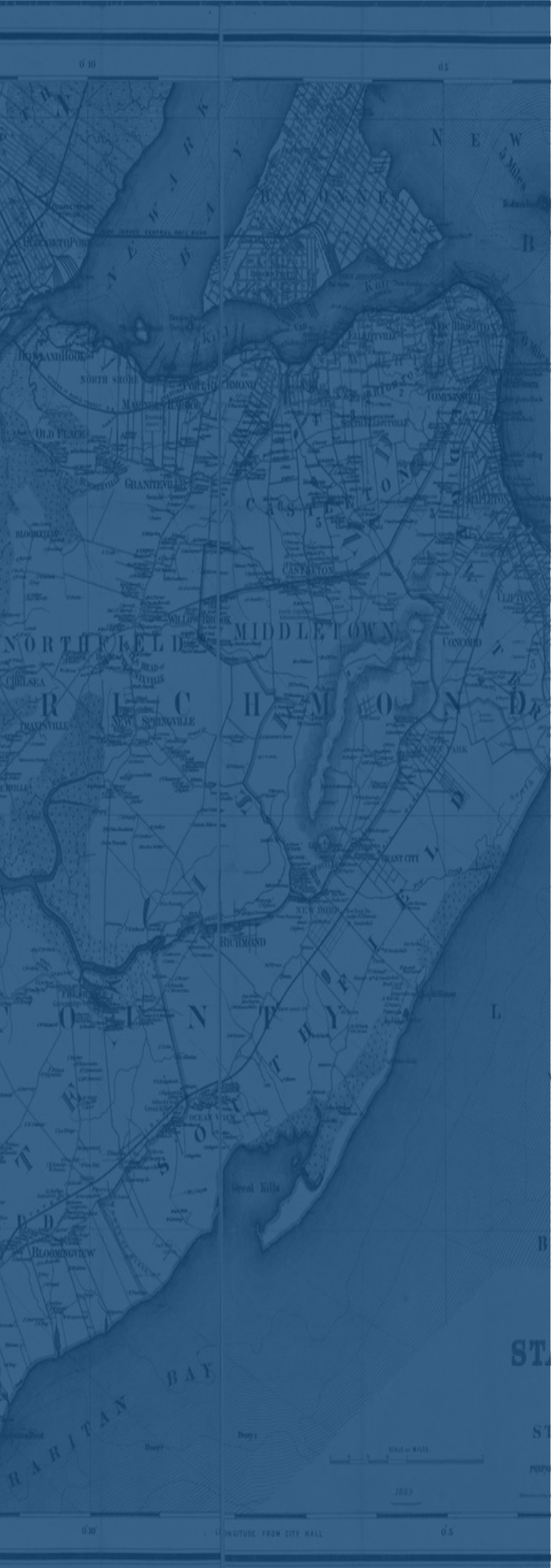
"Care Alliance of the Future"
NHS England, UK, April 18, 2017

"Center for Integrative Behavioral Medicine"
Kent County Council Visit to PPS

Kingdom of Saudi Arabia, Ministry of Health Visit to SI PPS

BayCare Health System & City of Philadelphia Visit to SI PPS, December 2019

"Data for Community Health" All In National Meeting, October 2019



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Designed by Lauren Tepfer