

DSRIP Meeting Agenda

| | | | |
|----------------------|---|------------------------|---|
| Date and Time | June 15, 2016, 3-5pm | Meeting Title | NYP PPS Project Advisory Committee |
| Location | MSCHONY, 3959 Broadway, Tower 103 (1st floor) | Facilitator | David Alge |
| Go to Meeting | https://global.gotomeeting.com/join/237782405 | Conference Line | United States +1 (872) 240-3412 Access Code: 237-782-405 |

| Attendees | |
|---------------------------------------|--|
| Project Advisory Committee Membership | |

| Meeting Topic: How to End the AIDS Epidemic | Time |
|--|-------------|
| 1. Welcome (David Alge) | 3:00-3:05pm |
| 2. Introduce Case Study (Pete Gordon) | 3:05-3:10pm |
| 3. The Big Picture (Sharen Duke) | 3:10-3:20pm |
| 4. New York City Response (Julie Myers) | 3:20-3:45pm |
| 5. Community Collaboration – REACH (Pete Gordon, Sam Merrick, Steve Chang) | 3:45-4:05pm |
| 6. One Agency's Response – ASCNYC (Marcy Thompson) | 4:05-4:20pm |
| 7. Discussion of Case Study | 4:20-5:00pm |

| Action Items | | | | |
|--------------|-------|------------|----------|--------|
| Description | Owner | Start Date | Due Date | Status |
| | | | | |

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| Attendees | |
|---|--|
| Lauren Alexander (NYP) | David Alge (NYP) |
| Pete Gordon (NYP) | Sam Merrick (NYP) |
| Steve Chang (NYP) | Morgan Brewton-Johnson (NYP) |
| Ana Garcia (NYP) | Sharen Duke (ASCNYC) |
| Marci Allen (ASCNYC) | Julie Myers (NYCDOHMH) |
| Steve Munchnik (Upper Manhattan Mental Health Center) | Sandy Merlino (VNSNY) |
| Andy Nieto (NYP) | Julio Batista (NYP) |
| Lucia Capitelli (NYSPI) | Faith Gordon-Chambers (Lutheran Social Services of New York) |
| Lena Tran (NYP) | Eva Eng (ArchCare) |
| Dan Lowy (Argus) | Erica Eliason (NYCDOHMH) |
| Yaffa Ungar (Isabella) | Patrick O'Quinn (ACMH) |
| Victor Carrillo (NYP) | Carlos Molina (Hostos) |
| Faith Wiggins (1199 SEIU TEF) | Alessia Daniele (Weill Cornell Medical College) |
| Marci Thompson (NYP) | Mark Townsend (WHCP) |

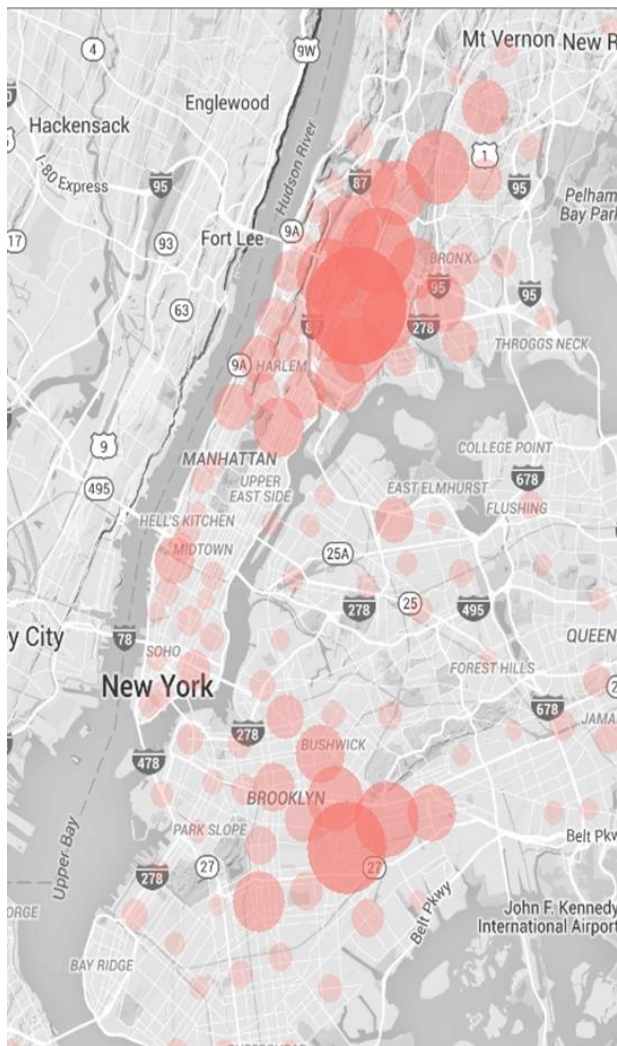
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| Action Items | | | | |
|---|------------------|------------|-----------|-------------|
| Description | Owner | Start Date | Due Date | Status |
| Share details about next meeting with PAC members | Lauren Alexander | 7/22/2016 | 8/19/2016 | In progress |
| Share materials from meeting/post to PPS website | Lauren Alexander | 7/22/2016 | 8/12/2016 | In progress |

PAC, 15Jun2016

COMMUNITY RESPONSE TO THE EPIDEMIC

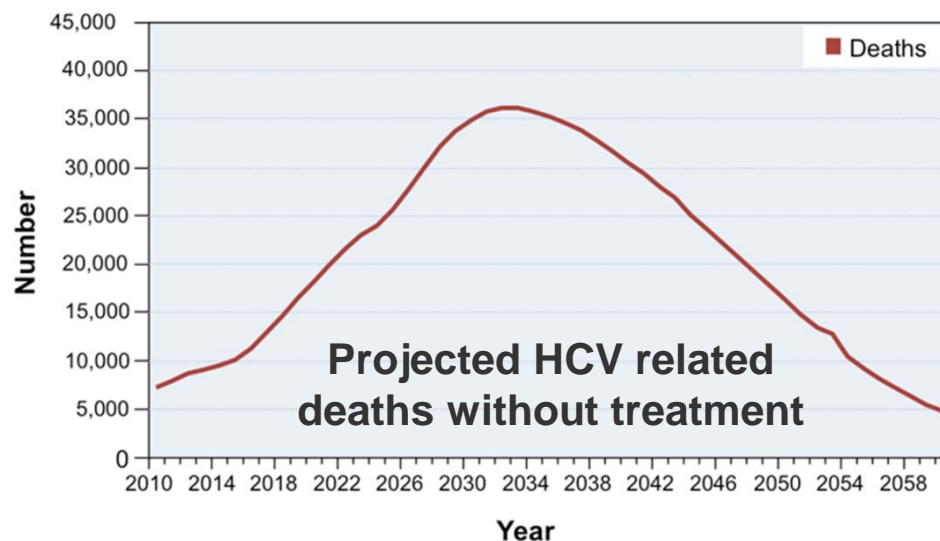
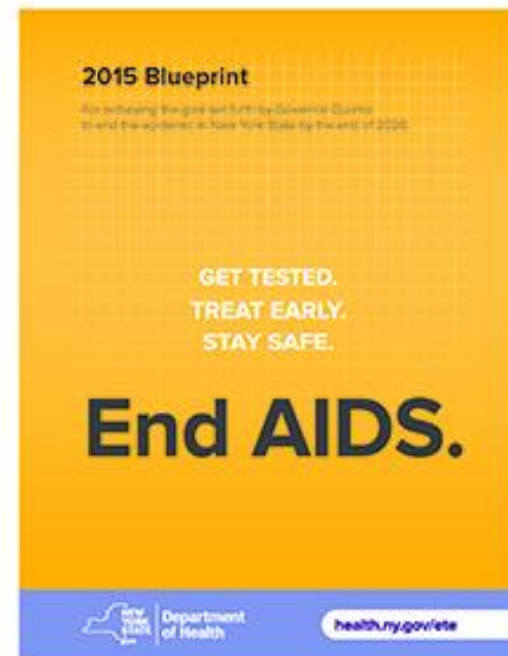
What we want to accomplish?



2014: 7,938 people living with HIV w/ Medicaid are not in care

End the AIDS Epidemic (PrEP & TasP)

Cure Hepatitis C



REACH – Collaborative



Ready to **E**nd **A**IDS &
Cure **H**epatitis **C**

Key Elements of Strategy

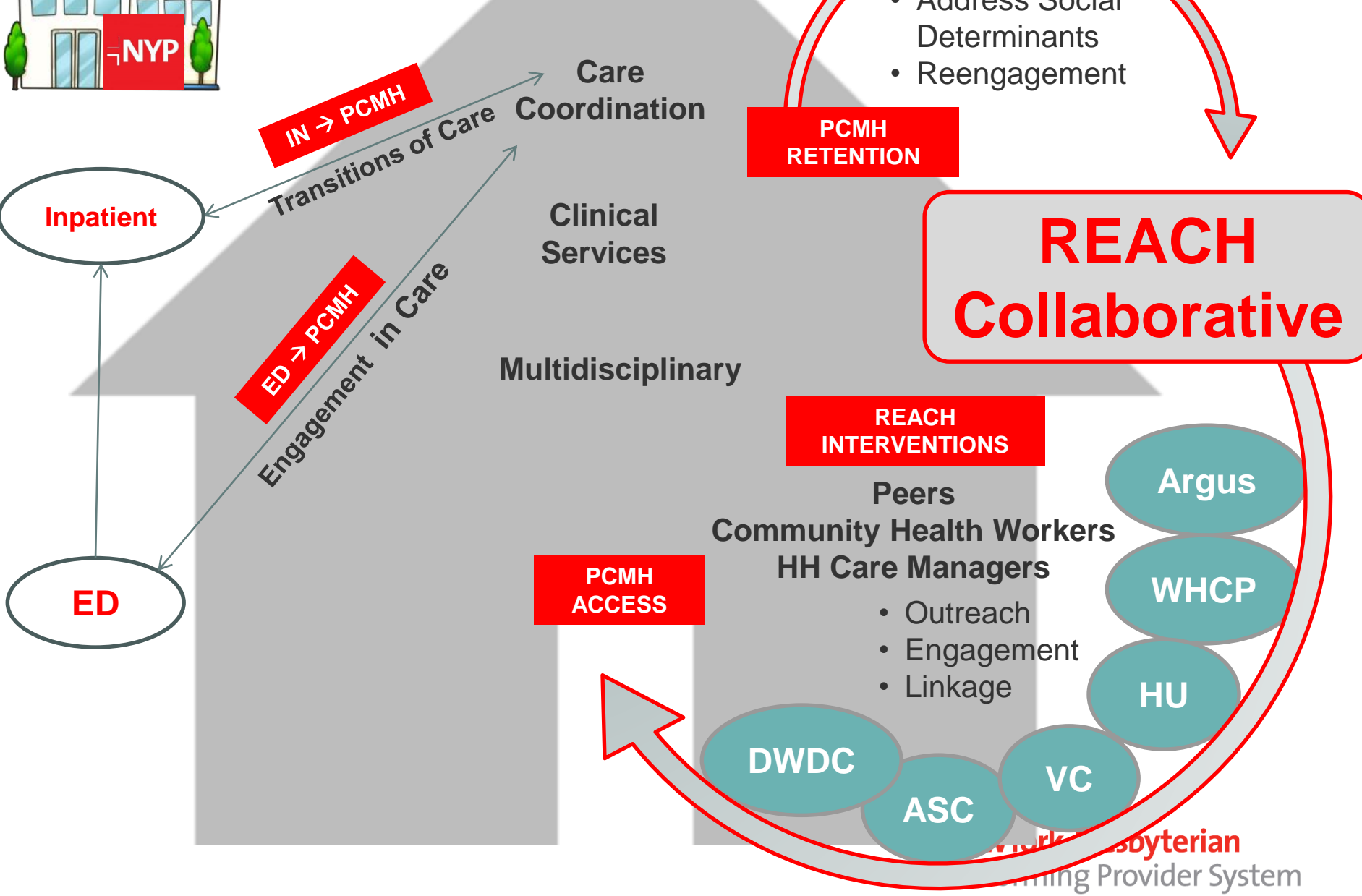
- **Collaborative Leadership →**
REACH Collaborative
- **Community Health Navigation & Coordination →**
Integrate a team of Community Health Workers, Peers and Care Managers/Coordinators
 - to increase outreach, screening, linkage, and retention to needed social and clinical services, and
 - to enhance self-efficacy and empower patients through building trust, motivational interviewing, education, and advocacy.

Key Elements of Strategy

- **Shared information system supported workflows →**
Allscripts Care Director and Healthix
- **Real-time linkage to services →**
Resource Mapping (e.g., Healthify)
- **Bring care to the patient →**
DSRIP waivers: Article 28, 31, 32
- **Expand access and capacity** for prevention (e.g., PrEP/PEP) and treatment for HIV and HCV →
 - Increase in providers (Psych NP, MD)
 - Care Coordination
 - Same day access



HIV/Hep-C PCMH



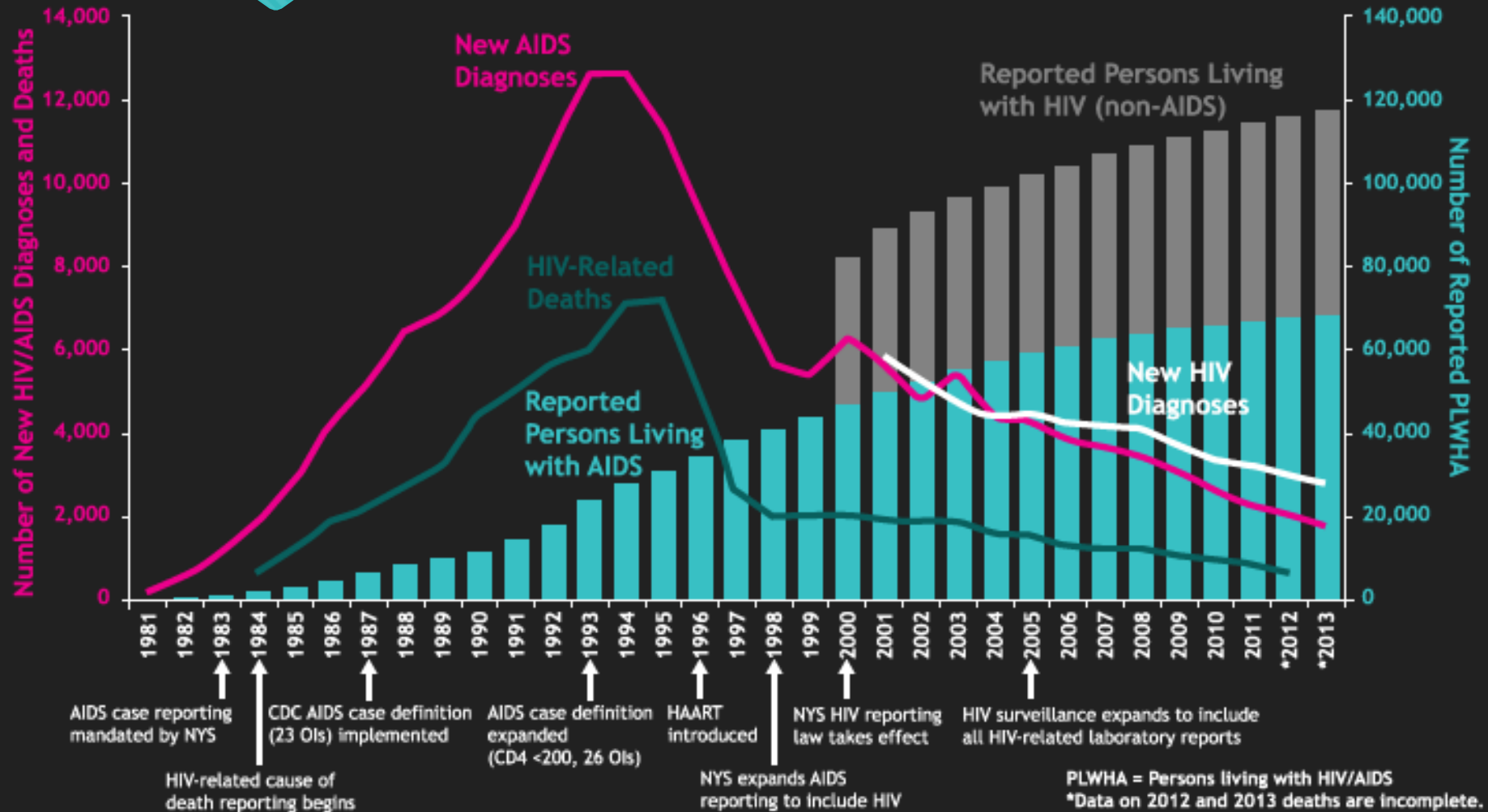
Ending the Epidemic: The NYC Approach

New York City

Department of Health & Mental Hygiene (DOHMH)

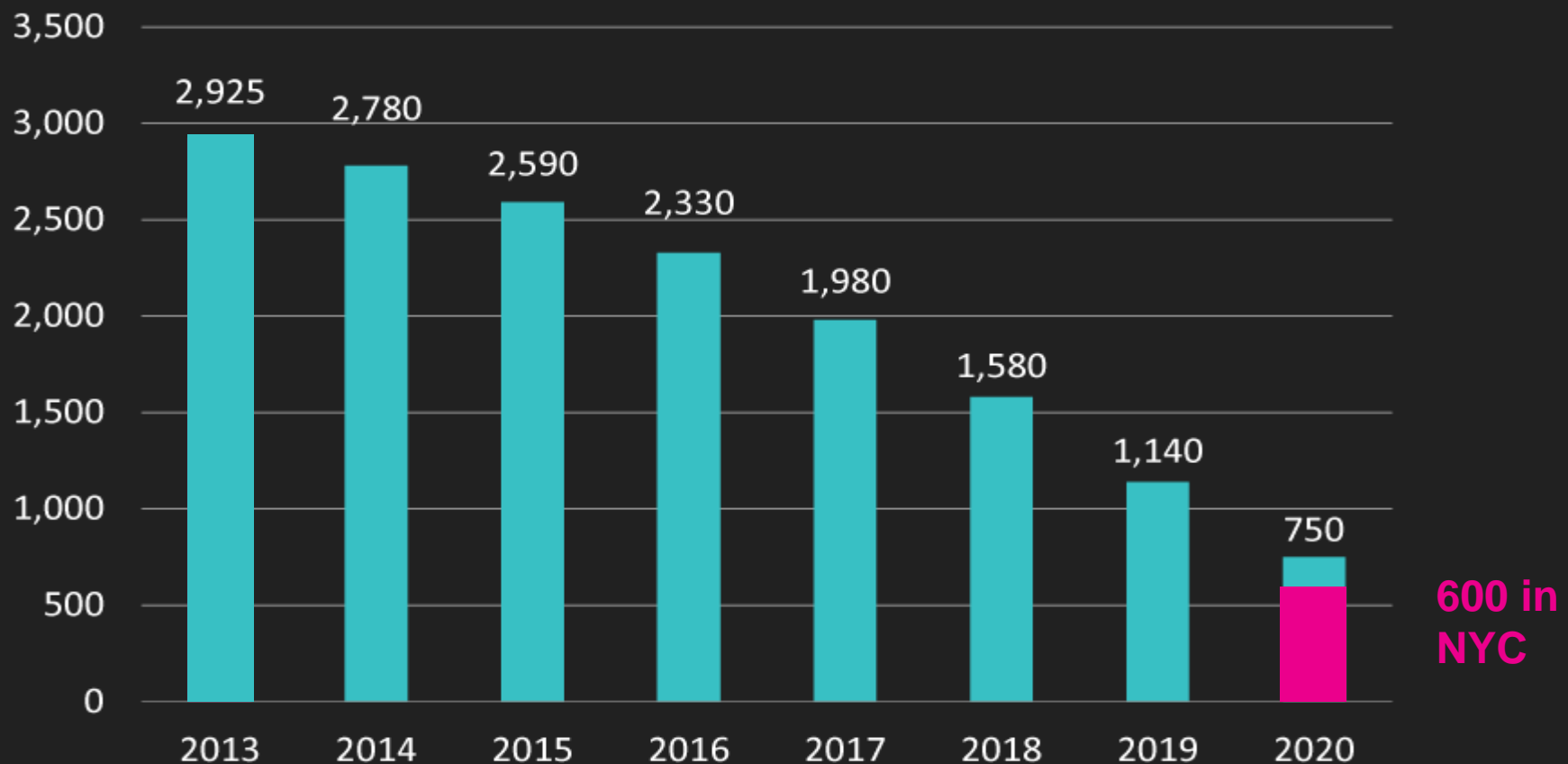
Email ete@health.nyc.gov Webpage nyc.gov/health/ete

History of the HIV Epidemic in NYC



Goal of Ending the Epidemic (ETE)

Estimated New HIV Infections in New York State



ETE in NYC: DOHMH, Partners & HASA

- Two sides of DOHMH's four-part strategy:
 - **External:** build partnerships to support the HIV prevention services of community-based clinics, organizations and coalitions across NYC
 - **Internal:** enhance and expand our STD clinics and HIV prevention services
- HIV/AIDS Services Administration (HASA)
 - Housing
 - Nutrition
 - Transportation

ETE Funders and Supporters

- NYC City Hall
- NYC City Council
- NYS AIDS Institute (NYS Department of Health)
- Centers for Disease Control and Prevention
- MAC AIDS Fund

ETE Preparation at DOHMH

- Convene a cross-divisional team to meet regularly
- Plan and track the implementation of initiatives, activities and evaluations
- Enhance facilities and hire 145 new staff
- Obtain materials and equipment
- Engage and consult with communities and other experts to inform our plans

ETE Implementation Strategy

1. Increase access to HIV prevention services
2. Promote innovative, optimal treatment for HIV
3. Enhance methods for tracing HIV transmission
4. Improve sexual health equity for all New Yorkers

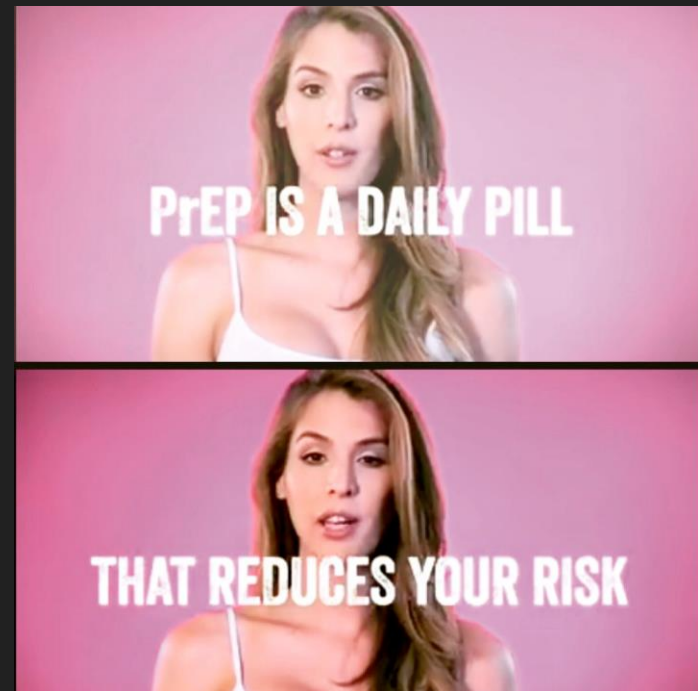
ETE Strategy: Across NYC

1. Increase access to HIV prevention services
2. Promote innovative, optimal treatment for HIV
3. Enhance methods for tracing HIV transmission
4. Improve sexual health equity for all New Yorkers

State of the “ART” HIV prevention

HIV antiretroviral therapy (ART) treatment can reduce transmission by up to 96%

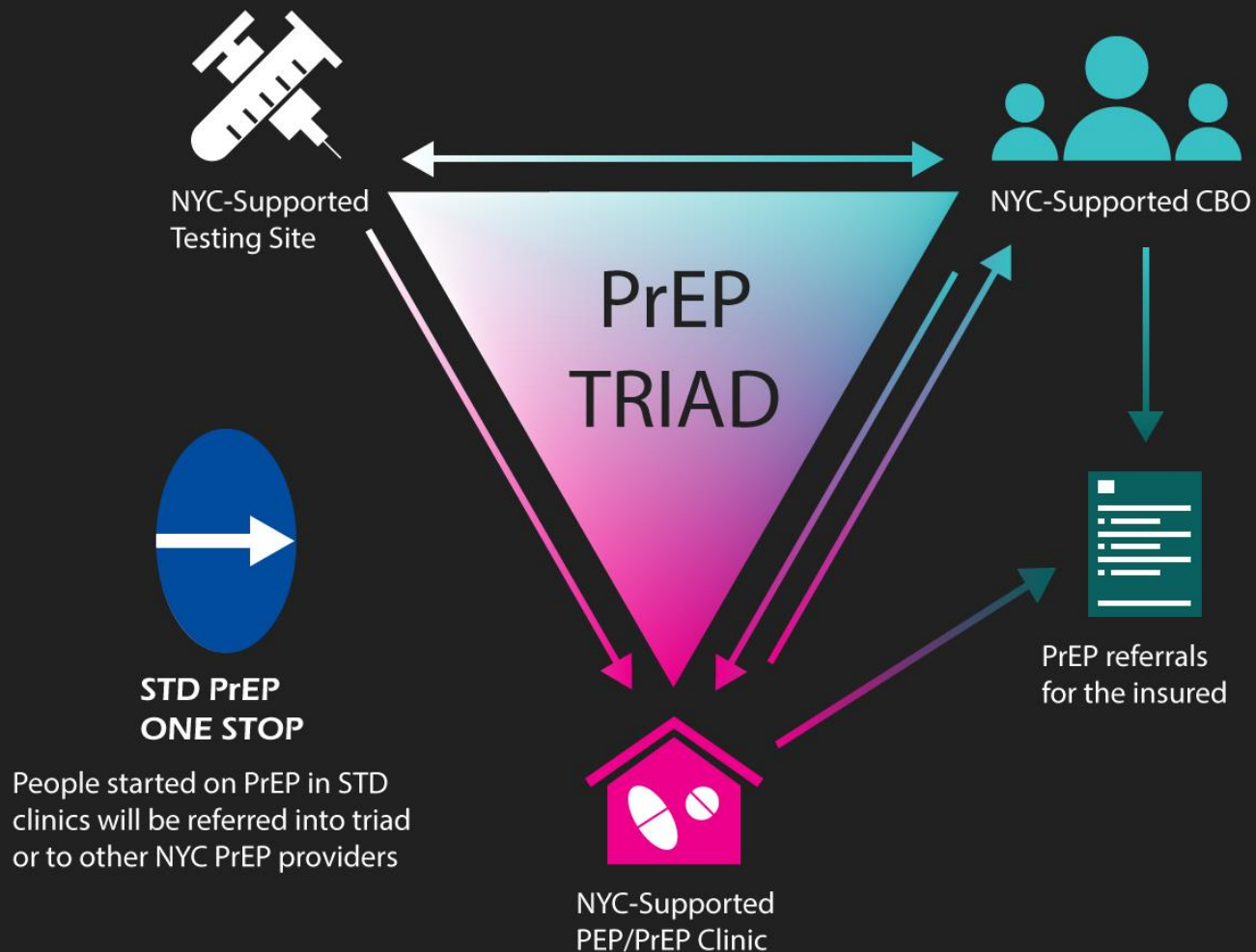
- Post-exposure prophylaxis (PEP)
- Pre-exposure prophylaxis (PrEP)



Access to PEP & PrEP Across NYC

- Open several PEP Centers of Excellence throughout NYC
- Launch a 24-hour PEP call center
- Provide status-neutral care coordination services
- Open PrEP pilot for adolescents
- Establish citywide PrEP network

#PlaySure PrEP Triads in NYC



Awareness of PEP & PrEP in NYC

- Scale up the #PlaySure campaign



- Scale up the existing provider detailing program to educate more providers about biomedical prevention strategies for HIV

Conduct PrEP Surveillance in NYC

Collect data about:

- Individuals who are eligible for PrEP
- Patients who initiate PrEP

ETE Strategy: Across NYC

1. Increase access to HIV prevention services
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Support Viral Load Suppression

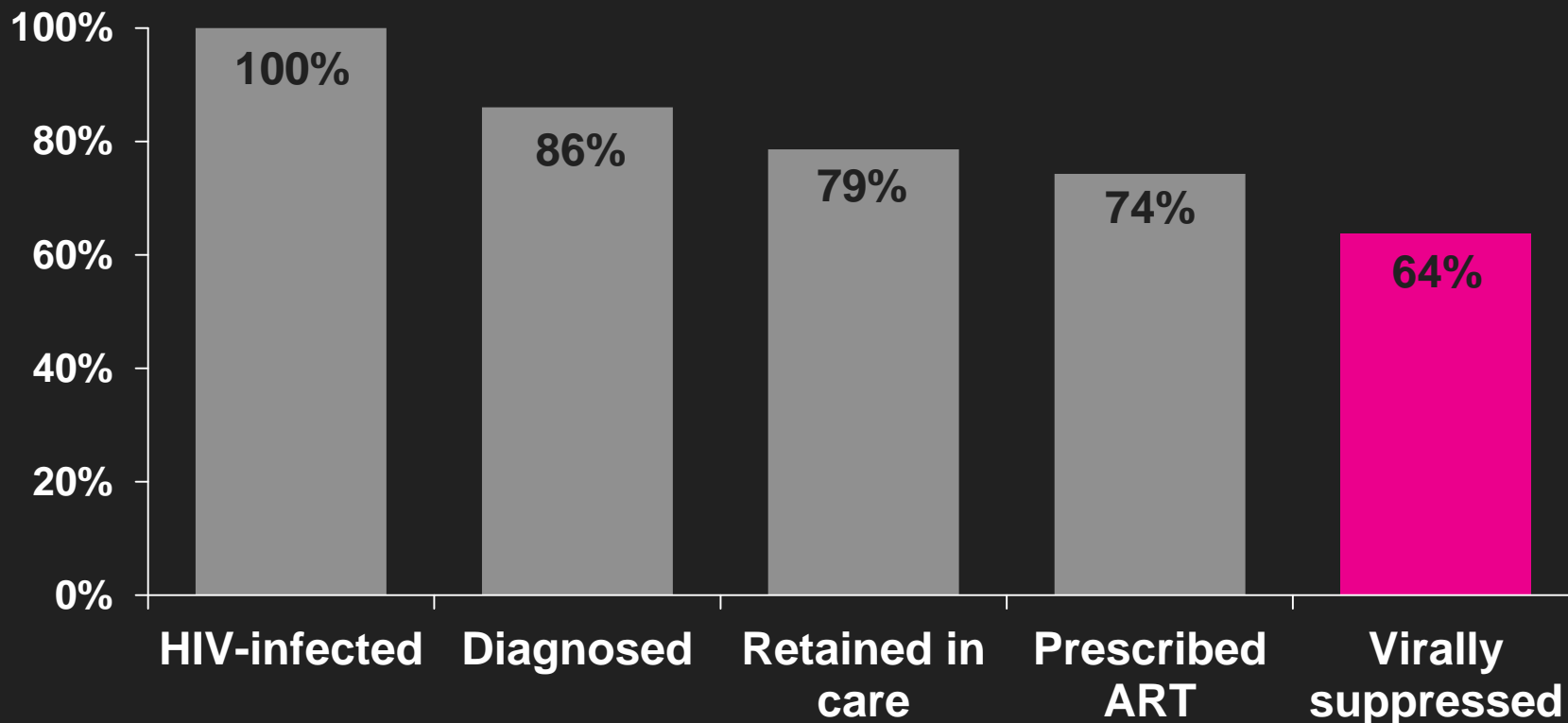
Contract with nonprofits to implement the “Undetectables” program, a viral load suppression model for HIV-positive persons



Housing Works

Support Viral Load Suppression

People Living with HIV and the Continuum of Care
New York City, 2013



ETE Strategy: Across NYC

1. Increase access to HIV prevention services
2. Promote innovative, optimal treatment for HIV
3. Enhance methods for tracing HIV transmission
4. Improve sexual health equity for all New Yorkers

Phylogenetic Testing

- Offer point-of-diagnosis genotype testing to providers caring for people newly diagnosed with HIV
- Use state-of-the-art scientific methods to “fingerprint” HIV strains in real time
- Map possible transmission networks and use information to provide timely partner notification and linkage to care services

ETE Strategy: Across NYC

1. Increase access to HIV prevention services
2. Promote innovative, optimal treatment for HIV
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4. Improve sexual health equity for all New Yorkers

Targeted Outreach and Support

- Provider trainings on sexual and gender-related health issues
- LGBTQ Patient Bill of Rights
- #BeHIVSure LGBTQ Coalition
- Trans-led and trans-focused organizations
- Programs for IV drug and crystal meth users

ETE Strategy: DOHMH STD Clinics

1. Increase access to HIV prevention services
2. Promote innovative, optimal treatment for HIV
3. Enhance methods for tracing HIV transmission
4. Improve sexual health equity for all New Yorkers

Why Focus on the DOHMH STD Clinics?

- Attract persons at highest risk who may face obstacles to accessing needed services elsewhere
- Easy access for all
- Existing STI services dovetail with new biomedical interventions for HIV

Enhancements to DOHMH STD Clinics

- Increased access to welcoming services
- Updated/renovated clinic facilities
- Expanded hours
- Expanded HIV services
- Expanded STI testing capacity
- Expanded prevention services
 - Navigational services
 - Reinstitution of screening visits
- Updated patient education materials
- Improved community engagement

HIV Prevention at DOHMH STD Clinics

HIV status-unknown patients

- Screen using the most rapid and sensitive methods available (4th generation rapid testing, testing for acute infection)

HIV-uninfected patients at risk

- Offer full 28-day course of PEP
- Start PrEP and navigate to PrEP provider for continuation of therapy
- Connect to primary care provider

HIV Treatment at DOHMH STD Clinics

HIV-infected patients

- ‘Jump-start’ immediate antiretroviral treatment for newly diagnosed patients along with other supportive services
- Use community-informed social work and navigation services to link HIV-infected patients to care

Thank you!

Ending the Epidemic: The NYC Approach

To contact us, please email:

ete@health.nyc.gov

For more information, please go to our webpage:

nyc.gov/health/ete

HEALTHCARE TRANSFORMATION

NYP PPS Project Advisory Committee

June 15, 2016

Sharen I. Duke, CEO, ASCNYC



CONTENTS

- 1 HEALTH HOMES
- 2 DELIVERY SYSTEM REFORM
INCENTIVE PAYMENT PROGRAM
(DSRIP)
- 3 VALUE BASED PAYMENTS
- 4 END THE EPIDEMIC (ETE)
- 5 ASCNYC STRATEGIC DIRECTIONS



Care Management: Intensive support to access medical care, pharmacy, housing, and other key services to promote wellness and self-sufficiency.

HEALTH HOMES

HEALTH HOMES



Health Homes are a collection of service providers who are committed to providing a continuum of care for Medicaid enrollees who are facing one or more chronic conditions.

- ❖ In 2012, New York State Medicaid developed Health Homes per the Affordable Care Act (ACA) in order to take advantage of the 90/10 Federal funding.
- ❖ The integrated service model of treating people living with HIV/AIDS holistically was a natural progression to expanding to address other chronic conditions.

HEALTH HOMES



Health Homes are responsible for:

- ❖ Reducing or eliminating costs associated with avoidable inpatient and ER visits
- ❖ Improving patient outcomes for Medicaid enrollees with multiple chronic illnesses (e.g., HIV, addiction, mental illness, diabetes, asthma, etc.)
- ❖ Expanding care management services

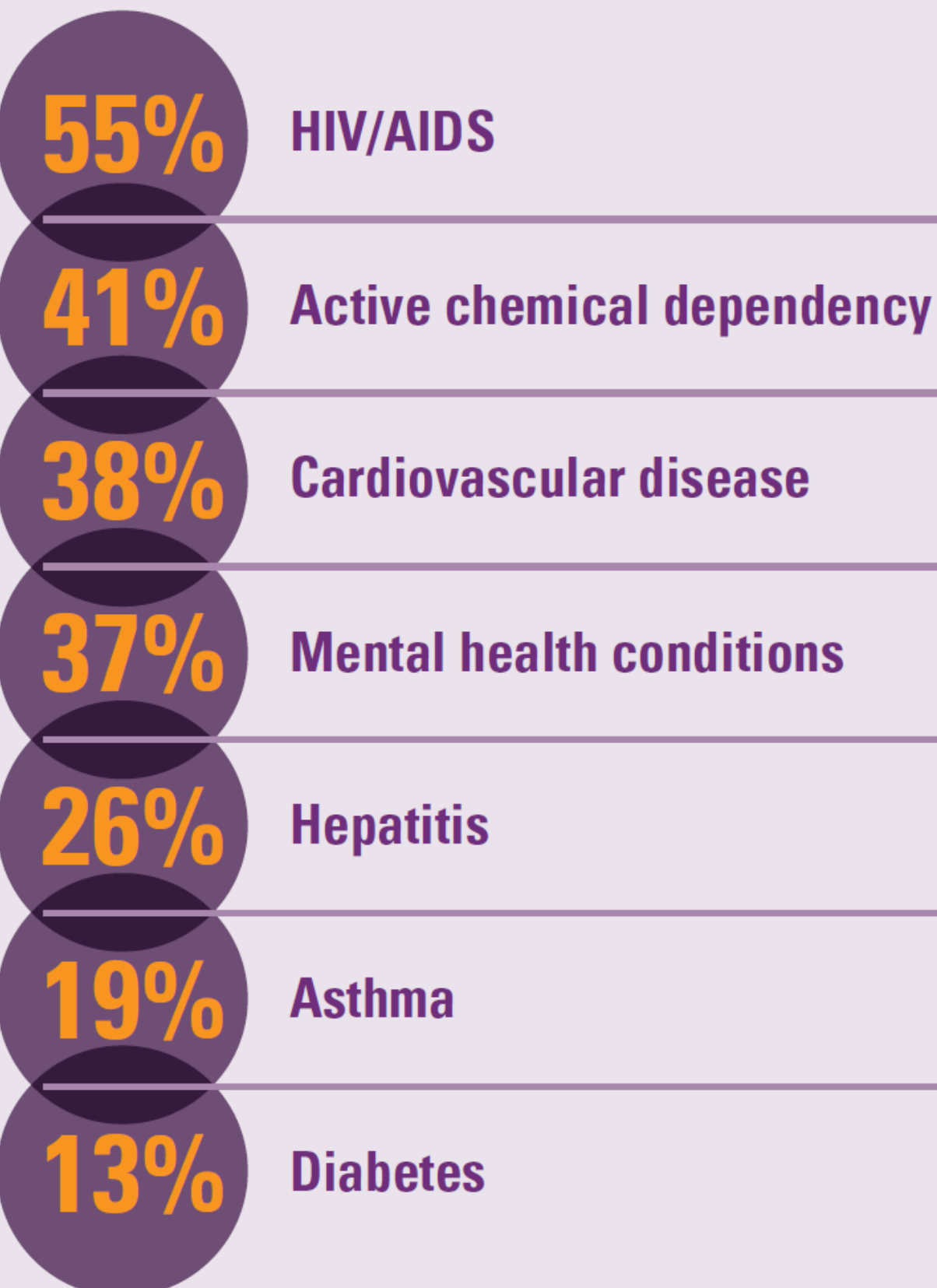
Case management programs had to navigate the transition from fee-for-service Medicaid to capitated rates (PMPM) for care management services for people living with HIV and other chronic illnesses.

HEALTH HOMES

Impacts on Community Providers

- ❖ New Billing System
- ❖ New HIT system
- ❖ New Staffing Model
- ❖ New Chronic Conditions
- ❖ New Staff Training Needs
- ❖ New Collaborations
- ❖ New Costs of Doing Business

Most of our clients have **MULTIPLE CHRONIC ILLNESSES**. We help these individuals get the care and support they need to feel better and get healthier.

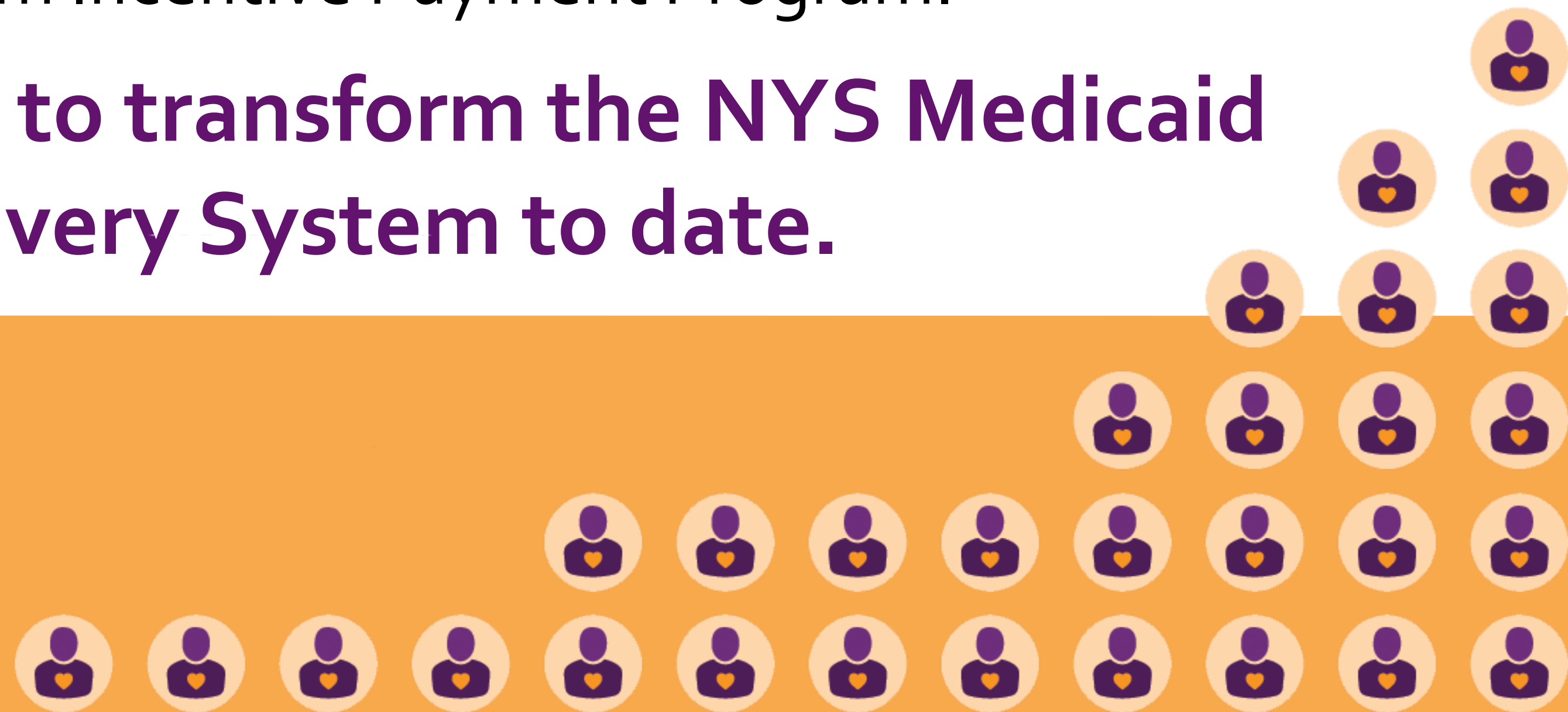


DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM (DSRIP)

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP)

- ❖ Medicaid serves 6 million people per year in New York State and costs nearly \$60 billion per year.
- ❖ The current Medicaid payment structure is based on volume, rather than value or outcomes; the more healthcare services delivered the more reimbursement received, regardless of results.
- ❖ In April 2014, Governor Cuomo announced an \$8 billion investment in Medicaid Redesign: Delivery System Reform Incentive Payment Program.

DSRIP is the largest effort to transform the NYS Medicaid Healthcare Delivery System to date.



DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP)

DSRIP Goals:

- ❖ ***SYSTEM TRANSFORMATION:*** From fragmented and overly focused on inpatient care towards integrated and community, outpatient focused
- ❖ ***IMPROVE PATIENT CARE:*** From a re-active, provider-focused system to a pro-active, community- and patient-focused system
- ❖ ***REDUCE HEALTHCARE COSTS:*** Reduce avoidable admissions, strengthen the financial viability of the safety net, and allow providers to invest in changing their business models

Develop an efficient, patient-centered and coordinated system of healthcare over a *5 year period: 2015-2020.*



DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP)

Commonly selected DSRIP Projects:

- ❖ Domain 2 Projects: ***Address System Transformation***
Create an Integrated Delivery System focused on population health management
- ❖ Domain 3 Projects: ***Clinical Health Improvement***
Evidence-based strategies for disease management in high risk/affected populations
- ❖ Domain 4 Projects: ***Population-wide Strategy***
Increase early access to and retention in HIV care
Strengthen mental health and substance abuse infrastructure across systems

DSRIP / PERFORMING PROVIDER SYSTEM (PPS)

- ❖ PPS—Performing Provider System—is composed of local collaborating providers who will implement DSRIP Projects over a 5-year period and beyond
- ❖ The majority of PPSs are hospital-led
- ❖ PPSs are held to common performance standards and timelines.
- ❖ Funding is directly tied to reaching program goals.



DSRIP / PERFORMING PROVIDER SYSTEM

- ❖ DSRIP / PPS is a market-driven system
- ❖ Designed to leverage the intellectual capital of medical and community providers
- ❖ To create innovative service models
- ❖ Resulting in reduced Medicaid costs and improved patient health outcomes



VALUE BASED PAYMENTS

VALUE BASED PAYMENTS

Patient-Centered Focus on Healthcare Rather than Provider Centered Focus

- ❖ The goal of Value Based Payment (VBP) is improved care for patients.
- ❖ VBP changes how we pay for patient care and encourages providers to work together.
- ❖ Providers will share in the savings that are created from delivering high value care.
- ❖ VBP will put patients at the center of the healthcare system, with providers working together to help make sure that patients receive the care they need, when they need it, from the provider best suited to provide it.

END THE EPIDEMIC (ETE)

ENDING THE EPIDEMIC

In June 2014, Governor Cuomo appointed a Task Force to create a plan for New York State to *End the AIDS Epidemic* by 2020.

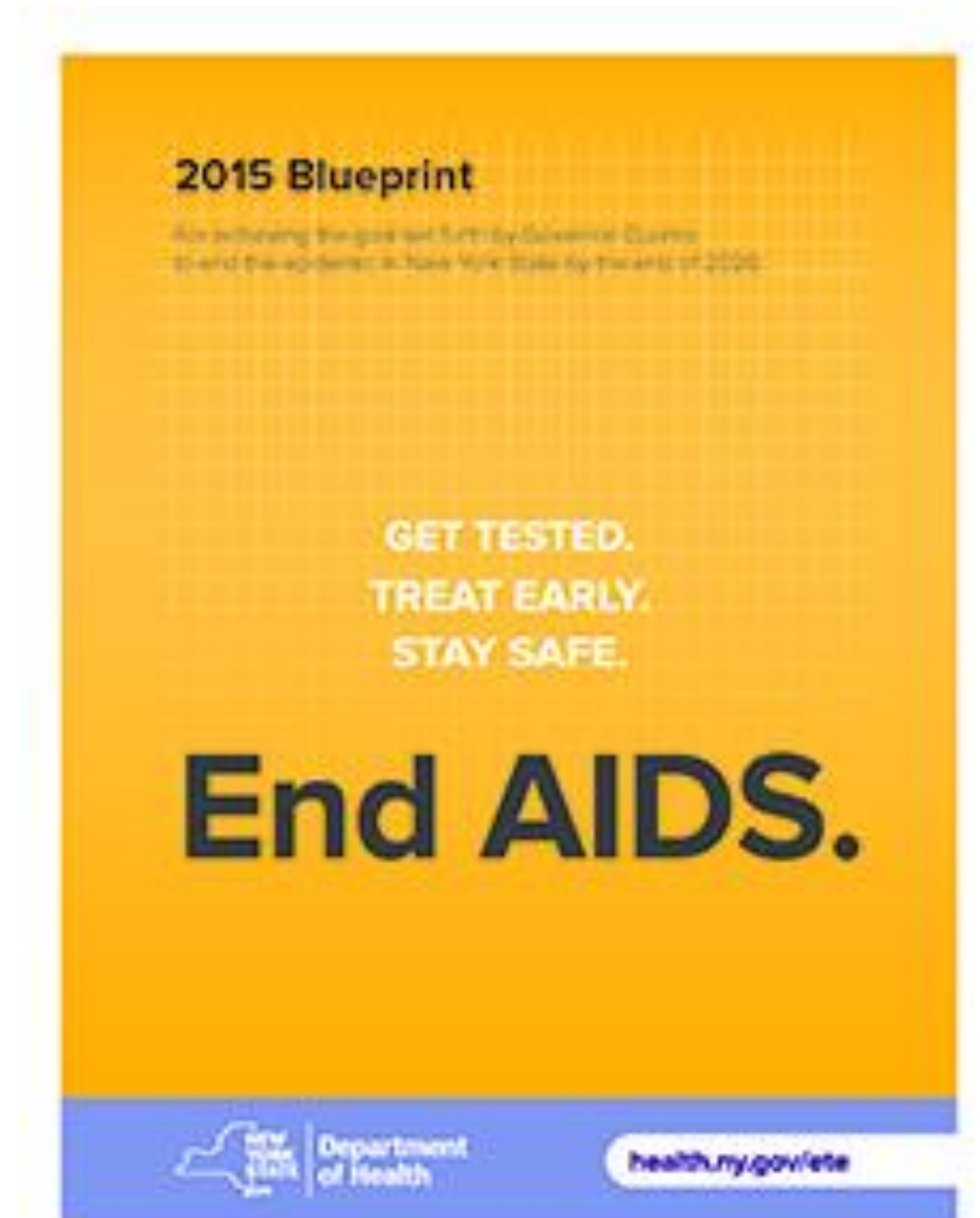
- ❖ The end of the AIDS epidemic in New York will occur when the total number of new HIV infections falls below the number of HIV-related deaths:
 - We must reduce the number of new HIV infections to 750 [from an estimated 3,000] by 2020.
- ❖ On January 13, 2015 the NYS Ending the Epidemic (ETE) Task Force completed its charge and finalized 44 committee recommendations that address HIV related prevention, care and supportive services.



ENDING THE EPIDEMIC

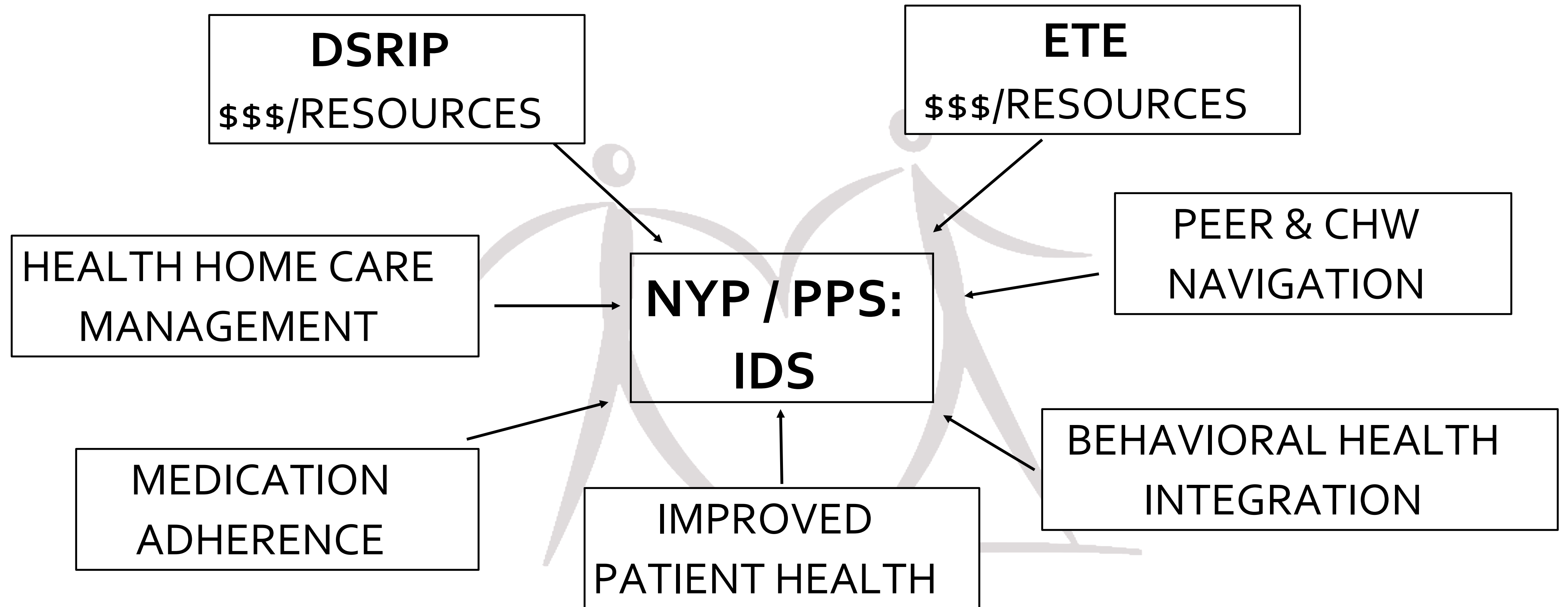
In June 2015, Governor Andrew M. Cuomo adopted the Blueprint to end the AIDS epidemic in NYS by 2020 by implementing a 3-point plan:

1. Identify all persons with HIV who remain undiagnosed and link them to health care.
2. Link and retain those with HIV in health care, to treat them with anti-HIV therapy to maximize virus suppression so they remain healthy and prevent further transmission.
3. Provide Pre-Exposure Prophylaxis (PrEP) for high risk persons to keep them HIV negative



STRATEGIC DIRECTIONS

INTERSECTION OF BUSINESS & MISSION



ASCNYC



positive change

212.645.0875 • www.ascnyc.org

www.ascnyc.org

DSRIP and HIV: A case example

- J.C. is a 37 year old female with AIDS who is currently admitted with fever, cough, and shortness of breath.
 - PMHX: advanced AIDS (CD4=51, HIV vl = 304,341, COPD, asthma, +Tob, +MJ, + methamphetamine
 - Not on anti-retroviral medications
 - Uses emergency department for care, no recent primary care or HIV care visits
 - Multiple recent hospitalizations

DSRIP and HIV: A case example

- Some additional factors:
 - Lives in the southwest Bronx with 8 children
 - Husband is incarcerated
 - There is a question of transactional sex work
 - Frequently elopes or leaves hospital AMA

MEDICAL-COMMUNITY COLLABORATION: ASCNYC & NYPH

NYP PPS Project Advisory Committee

June 15, 2016

Marcy Thompson, Director of Care Management

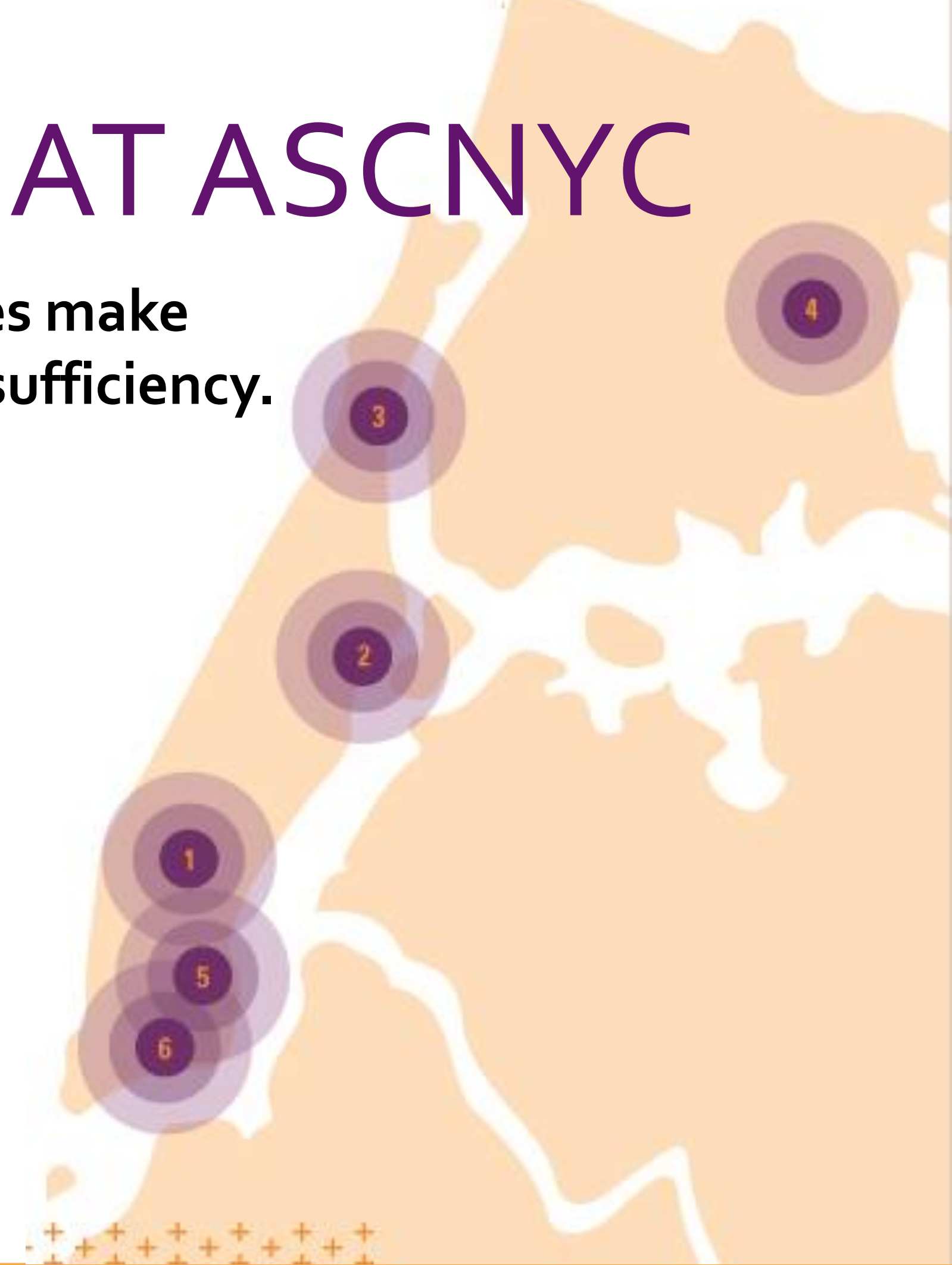


POSITIVE CHANGE IN ACTION AT ASCNYC

ASCNYC helps New Yorkers affected by HIV and other chronic illnesses make lasting positive changes towards health, housing, recovery, and self-sufficiency.

Each year, we help New Yorkers:

- Get tested for HIV
- Overcome addiction
- Access medical care to get their health back on track
- Escape homelessness
- Rejoin the world of work
- Replace isolation with community
- And lead healthier and more self-sufficient lives.



ASCNYC's **individualized, full-service approach** gives each person the unique **mix of support** he or she needs to **feel better, live better, and do better.**

MODELS OF COLLABORATION

- Co-locate Community Case Managers in Medical Facilities
- HIV Testing/Newly Diagnosed
 - Expedited confirmatory testing
 - Expedited medical appointment
- Joint grant-seeking

ASCNYC – NYPH DAC

HISTORY OF COLLABORATION

- COBRA Medicaid Case Management Dedicated Team (since 2004)
- Select Health Member Advocate & Education (since 2004)
- In-patient Discharge Planning w/COBRA (since 2006)
- Ryan White Care Coordination (since 2009)
- Robin Hood Foundation Inpatient Discharge Service Coordination (since 2010)
- CASA Washington Heights Community Center (since 2011)

CO-LOCATED CASE MANAGEMENT SERVICES

Community Care Managers Conduct:

- Appointment reminders
- Accompaniment to services
- Follow-up on missed appointments
- Entitlements advocacy
- Housing placement assistance
- Navigation to specialty care
- Case conferences
- Joint assessments and service plans



ASCNYC – NYPH DAC: PATH

Partners for AIDS Treatment and Health (PATH)

GOAL: Provide intensive care management and follow-up for HIV+ patients at risk of falling out of medical care, recruited from NYPH inpatient services

PATH— LINKAGE TO CARE

- Coordinated Inpatient Discharge Planning
- Linkage to out-patient medical care within 2 months of enrollment (appointment reminders, escorts to services, follow-up on missed appointments)
- Maintenance in out-patient medical care, evidenced by attending at least one PCP visit every 6 months
- Treatment Adherence Support and DOT
- Benefits Coordination, Housing Placement Assistance, and other social support services
- Navigation to specialty care
- Case conferences

PATH– LINKAGE TO CARE

- 18% of NYPH HIV admissions in 2014 were enrolled in PATH (128 out of 718 inpatients).
- 91% of PATH patients attended an outpatient medical visit within 2 months of program enrollment/hospital discharge (116 out of 128 PATH patients).

PATH– IMPACT ON VL SUPPRESSION

| PATH Patients, 2014 n=128 | Baseline VL | Follow-Up VL (> 2 VL tests) |
|------------------------------|-------------|--------------------------------|
| Undetectable (<400) | 26% | 70% |
| 401 - 99,999 | 44% | 15% |
| >100,000 | 27% | 11% |
| Not Available* | 3% | 4% |
| * due to death, jail, etc. | | |

PATH– IMPACT ON *SUSTAINED* VL SUPPRESSION

| PATH Patients, n=103 | 2012-2013 |
|----------------------------------|-----------|
| Undetectable (<400) | 80% |
| 401 - 99,999 | 16% |
| >100,000 | 6% |
| Not Available* | 2% |
| * due to death, jail, move, etc. | |

PATH SERVICES @ CASA WASHINGTON HEIGHTS

- CASA Washington Heights Community Center, located 5 blocks from NYPH, was established in 2011
- ASCNYC and NYP DAC joint programming @ CASA
 - Care Management
 - Pharmacy Access Center
 - Treatment Adherence Support & DOT
 - Cooking Classes & Nutrition Education
 - Support Groups & Educational Workshops
 - Harm Reduction & Substance Abuse Counseling
 - Peer Education, Training and Support Services

EVOLUTION

Care Management



Health Homes

PATH



DSRIP

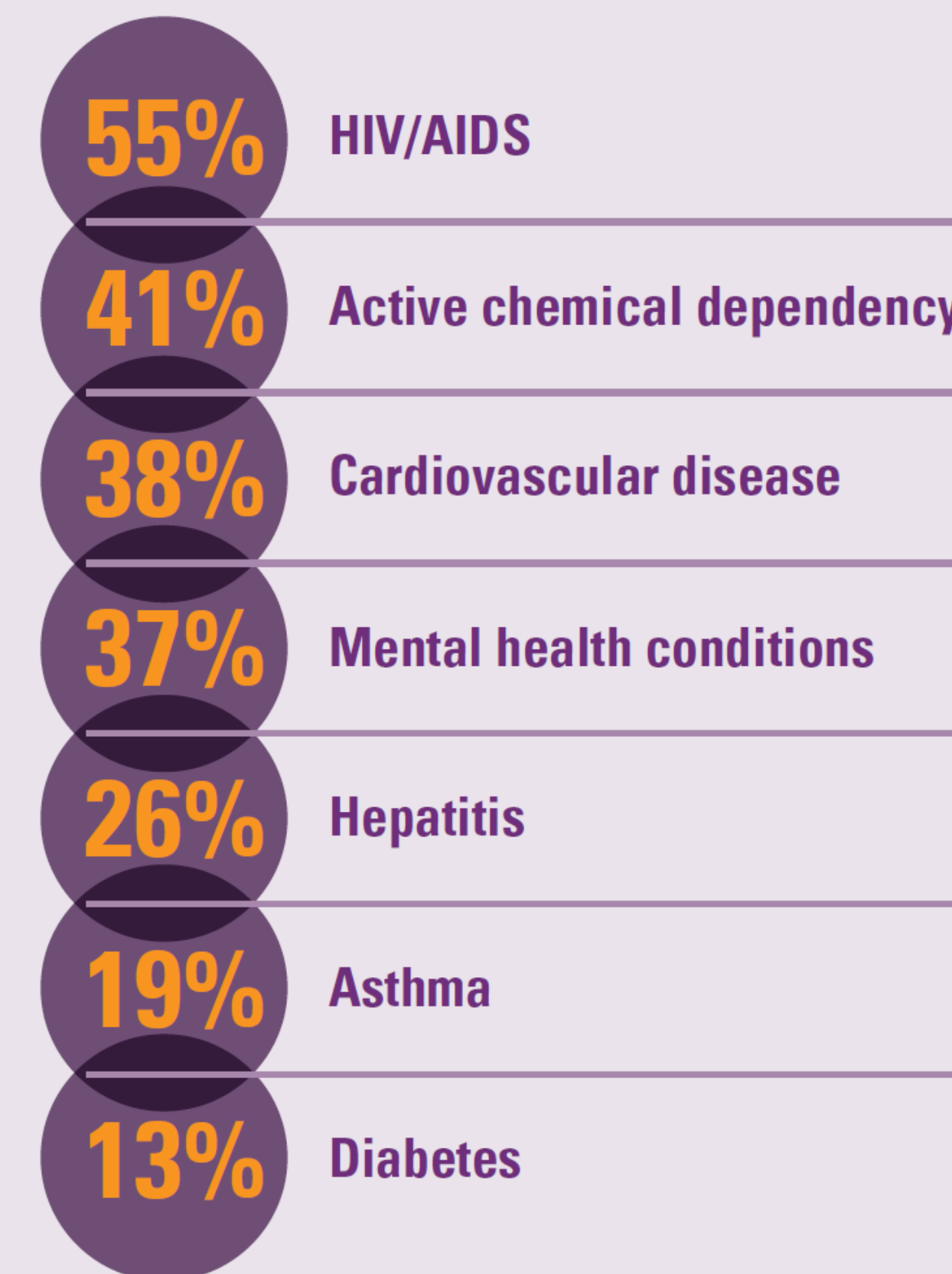
HEALTH HOMES

ASCNYC is a provider in four Health Homes:

- New York Presbyterian
- Mt. Sinai
- Community Care Management Partners
- Health & Hospitals Corporation

ASCNYC's service model of treating people living with HIV/AIDS holistically was a natural progression to expanding to address other chronic conditions.

Most of our clients have **MULTIPLE CHRONIC ILLNESSES**. We help these individuals get the care and support they need to feel better and get healthier.



HEALTH HOMES

ASCNYC Health Home Program

- 1,800 clients and 500 outreach clients monthly
- 52 Care Management Staff (intake, care coordination, outreach)
- 50 Peer Interns
- 15 Supervisors & Administrators (QA/finance/data/HR/exec)
- \$7MM annual revenues
- 47% of total agency revenues

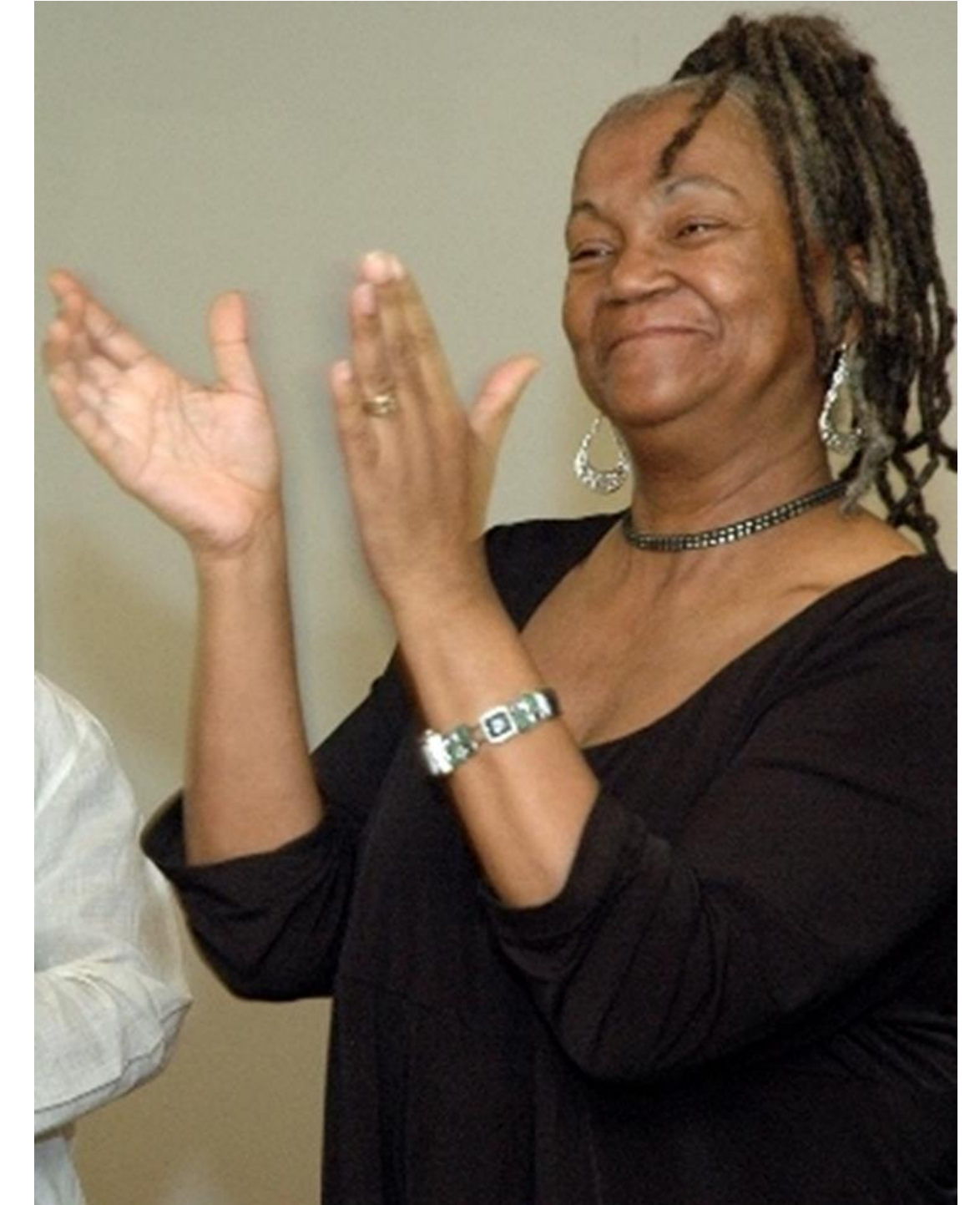


DSRIP / PERFORMING PROVIDER SYSTEM

ASCNYC Participation in NYP PPS

In NYP PPS, ASCNYC Participates in the following Projects:

- HIV
- Medication Adherence
- Community Navigation (including Peer Interns)
- Behavioral Health Integration
- Care Transitions



DSRIP

PPS's have the opportunity to integrate Peers into population health projects (e.g., HIV, diabetes, asthma, etc.) across medical facilities.

Peers will conduct:

- Outreach for Patient Activation/Linkage to Care
- Patient Navigation
- Coaching / Health Education
- Adherence Support
- Self-Management



ETE – ENDING THE EPIDEMIC

ETE was a catalyst for the creation of a Peer Workforce through the development of NYSDOH Peer Certification Criteria:

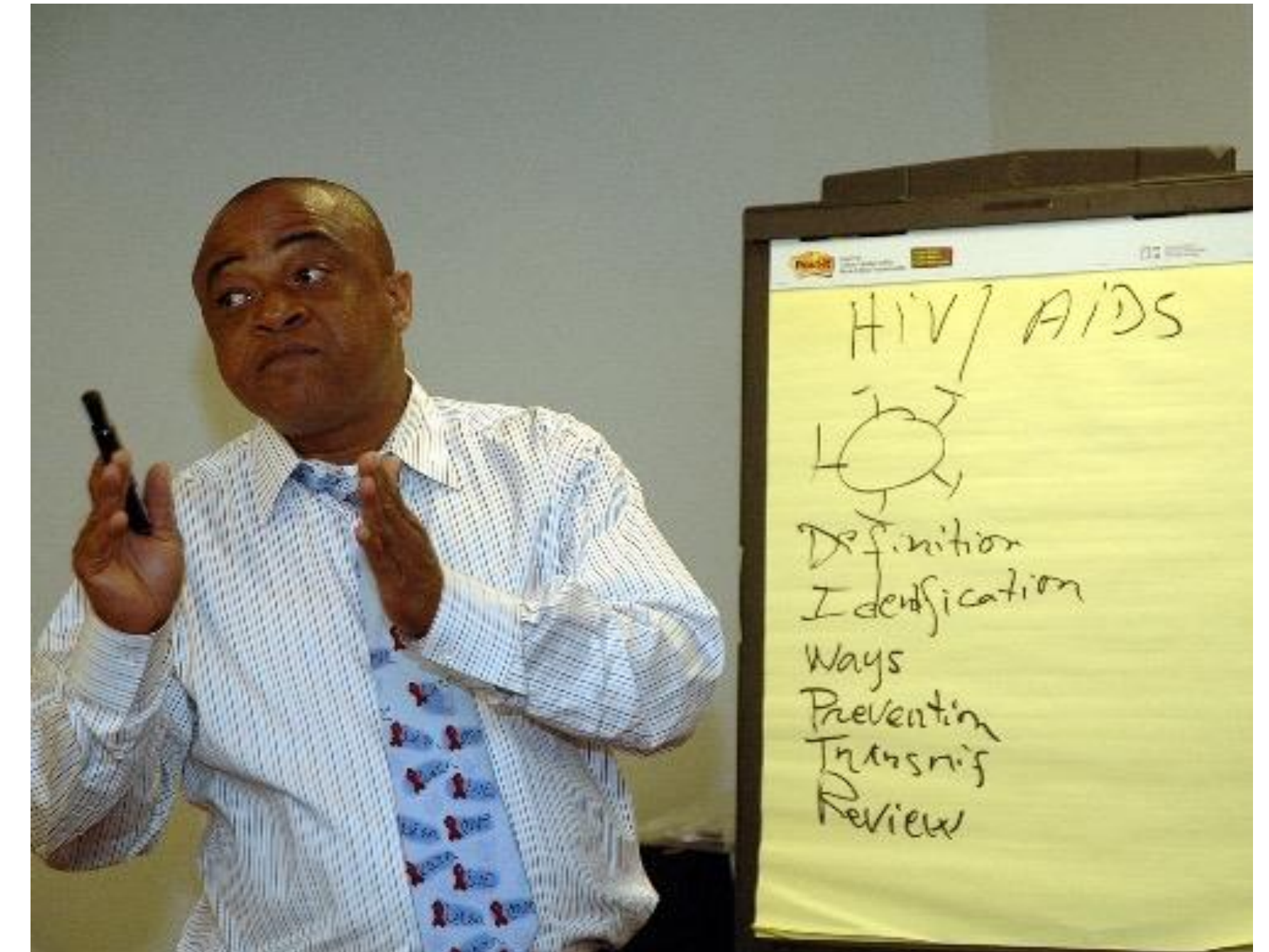
- 90 Training Hours
- 500 Field Placement Hours
- Written Exam

ASCNYC / Peer Power is an authorized training center for Peer Certification.



IMPACTS OF PEER OUTREACH & RECRUITMENT ON PEOPLE REACHED

ASCNYC Peer Health Coaches
conducted OUTREACH to **5,700**
PLWHA with a **78%** Success Rate of
finding and orienting the individual to
the MCO.



IMPACTS OF PEER NAVIGATION ON PEOPLE REACHED

Since 2014, ASCNYC incorporates Peer Navigators into Health Home Care Management teams resulting in linkage to care and increased viral suppression:

- **91%** HH care managed clients were consistently engaged in care
- **54%** were virally suppressed at intake
- **70%** were virally suppressed at 6 month follow-up



THANK YOU!

Marcy Thompson, Director of Care Management

marcy@ascnyc.org

www.ascnyc.org