4th ANNUAL

NEW YORK STATE DSRIP LEARNING SYMPOSIUM

BEYOND THE FINISH LINE!

POSTER RECEPTION: TUESDAY, FEBRUARY 12TH 4:45-6:30PM

The Poster Guide on the following pages provides a full listing of detailed information for each poster.

The posters need your votes!

Posters will be on display throughout the duration of the event. Voting ends at the close of the poster reception at **6:30pm on Tuesday, February 12th**.

You have 3 tickets. Use these tickets to cast your votes for the poster(s) that best represent one or more of the areas below. Cast your votes by placing a ticket in the envelope mounted next to the poster(s) you select. Vote for the posters that best:

- **Demonstrate Impact:** optimize community and health system performance for measurable improvement
- **Build Effective Partnership:** enhance collaboration and connectivity between community and traditional health services
- **Address Social Determinants of Health:** provide services to address social and economic factors that impact health
- **Leverage Data and Information Systems:** share clinical and administrative data across boundaries to improve care delivery
- **Communicate Value:** make a convincing business case that services create value for system partners and patients
- **Spread and Scale Best Practices:** achieve widespread use of evidence-based practices
- **Sustain Impact Post-DSRIP:** incentivize and support care that optimizes health system performance

The 2019 NYS DSRIP Poster Awards will be presented on Wednesday, February 13th at 2:30pm.

LEVERAGING DATA | GALLERY

LD-1

Increasing HEALTHeLINK (RHIO) Patient Consent at Hospital EDs: A Lean Six Sigma Approach

This poster will share CPWNY PPS' approach in engaging hospital partners and HEALTHeLINK (Regional Health Information Organization) to increase Medicaid patient consent rates and HIE (Health Information Exchange) usage rates at hospital Emergency Departments (EDs). The four participating EDs see a total of 48,000 Medicaid patients per year; more than half of CPWNY's attributed population. The presenters will share their Lean Six Sigma approach to define the defects, measure capability, analyze root causes, improve the workflows, and control for sustainability; and present best-practice workflows, technological solutions, and before-after comparative studies.

Dapeng Cao, PhD, Manager, Health Care Analytics, Community Partners of WNY PPS

LD-2

Historical Issues and Solutions for Implementing Healthix Connectivity with Small Community Primary Care Practices

Building an Integrated Delivery System relies upon integrating data systems from a wide variety of providers. Northwell Health, under the DSRIP program, was tasked with connecting 46 small community Primary Care Practices using a diverse array of Electronic Health Record systems, which presented numerous challenges for all stakeholders, including Healthix. In this poster, Northwell Health will highlight historical issues and solutions to overcoming this challenge.

Nat Brown, Program Director, DSRIP**,** Northwell Health
Ani Arjune, Project Manager, Northwell Health

LD-3

Building Accountability in the Staten Island CARES Care Coordination Program to Improve P4P Outcomes

The Staten Island CARES program has focused on key process and outcome improvement strategies that enable its care coordination staff to align client engagement and care planning with closing gaps in care that impact pay-for-performance (P4P) outcomes. The poster will illustrate examples of the SI PPS P4P engagement checklist tool and script that care coordination providers have adopted in their routine work to improve P4P outcomes. The poster will also show the PPS key performance indicators that have enabled care coordination providers to expand and transform their capabilities to measure and monitor performance on engagement and outcomes-related metrics ranging from completing preventative visits to hospital ED and inpatient utilization.

Victoria Njoku-Anokam, Director of Behavioral Health and Care Management Initiatives, Staten Island Performing Provider System
Marianne Howard-Siewers, Clinical Consultant, Staten Island Performing Provider System

LD-4

Leveraging Data from Managed Care Organizations to Impact Performance

The Suffolk Care Collaborative operationalized a strategy with its providers to leverage patient-level data directly through the Managed Care Organizations' (MCO) portals. Focused action plans have been developed by the partners, establishing a process to leverage the available data to understand their patient attribution and specifically, address the Access to Care performance measures. The poster presentation includes information on their educational resources and ongoing support to manage the information available through the portals. By managing the panels and gaps in care reports, partners benefit through increased performance-based funds flow through DSRIP, enhanced MCO incentives, improved performance metrics, and better overall care to the patients attributed to the practice.

Ashlee McGlone, Provider Relations Manager**,** Suffolk Care Collaborative
David Karpf, Provider Relations Manager**,** Suffolk Care Collaborative

LD-5

Using Claims Data to Identify Opportunities for Better Care: The Performance of the Population Served

Patients often have relationships with multiple providers, but they may not have the right relationships to best address all their health needs. WMCHealth PPS has developed a novel approach using de-identified claims data through the Salient Interactive Miner to better understand which providers have relationships with patients whose care is reflected in DSRIP performance measures. Through an assessment of the Performance of the Population Served, WMCHealth PPS helped partners identify opportunities for engaging with patients to help them obtain the care they need.

Janet (Jessie) Sullivan, VP, Medical Director, Center for Regional Healthcare Innovation**,** WMCHealth PPS
Aby Diop, Senior Manager, Behavioral Health**,** WMCHealth PPS

LD-6

Utilizing DSRIP to Impact Population Care

Addressing the challenge of collecting, aggregating and analyzing the clinical data across these disparate sources, Northwell embarked on the project of building an Enterprise Data Warehouse to provide standardized integration of data from clinical, financial, operational and external systems to a unified data model and subsequent data marts to enable performance reporting and advanced analytics and data visualization capabilities for population health intelligence. Northwell Health's poster presenter will describe how they were able to build this data infrastructure for better management and coordination of patient care across multiple care settings.

Abraham Saraya, Director of Data Strategy, Northwell Health

LD-7

The Alliance Storytelling Collaborative: Making ideas stick!

Telling stories about the experiences of patients and health care professionals is well-established as an effective means of engaging others in improvement work. This will be more than a poster. It's an interactive 'pop up' podcast booth. Along with their poster describing the concept behind their storytelling collaborative, the poster presenters will have a recording booth set up to capture stories from other PPS and partners in attendance. They will also have laptops and headphones available for visitors to listen to clips of their published podcasts to date.

Jason Noxon, Director of Communications, Alliance for Better Health
Brittany Altieri, Project Manager, Alliance for Better Health

COMMUNITY INTEGRATION | MEETING ROOM 1

CI-8

Innovation & Collaboration Among North County Partners to Reduce Health Disparities

North Country Initiative partners are taking a variety of approaches to address social determinants of health and combat disparities associated with residing in rural areas. As evidenced in NCI's 2014 Community Needs Assessment, social conditions such as poverty, rurality, and lack of transportation prevent the Medicaid population from accessing care and from complying with treatment plans. This poster presentation describes many of their innovative approaches to the unique challenges of rural living, including "Rx Maps" with weekly prescriptions, grocery tours across all income levels, and ensuring transportation for medical appointments.

Joanna Loomis, Director of Provider Strategy and Transformation, North Country Initiative
Lindsay Knowlton, NCI Deputy Director, North Country Initiative

CI-9

Developing, Implementing, and Evaluating a Medical-Legal Partnership Model in Brooklyn

The CCB LegalHealth Clinic leverages a partnership between Community Care of Brooklyn (CCB) and the New York Legal Assistance Group (NYLAG) LegalHealth division. The program expands the NYLAG LegalHealth legal clinic model to reach patients in the CCB network throughout Brooklyn with social needs impacting their health. The Maimonides Department of Population Health receives and tracks referrals centrally then schedules appointments with the program's staff attorney. Presenters from Maimonides Medical Center will provide details about the program and what they are learning about the impact of intervening on the social needs of patients on health outcomes.

Rachel Leep, Manager, Health and Social Services Analysis**,** Maimonides Medical Center
Kayla Spence, Manager, Program Implementation & Partner Engagement, Maimonides Medical Center
Tomo Hirano, DSRIP Strategic Analyst, Maimonides Medical Center Department of Population Health
Shari Suchoff, Vice President for Population Health Policy & Strategy, Maimonides Medical Center Department of Population Health
Karen Nelson, Senior Vice President for Integrated Delivery Systems, Maimonides Medical Center Department of Population Health

CI-10

Addressing Health Disparities: From Emergency Department to the Community

NYU Langone Health's **(**NYULH) Emergency Department (ED) Care Triage program uses Community Health Workers (CHWs) in the ED to help high-risk patients address their Social Determinants of Health (SDOH). CHWs meet patients at the bedside and conduct a screen to identify SDOH that impact their well-being. Working remotely and in-person, CHWs create goals with patients such as, scheduling primary care visits, acquiring transportation to appointments, and assisting with housing and food benefits. Outcomes are documented in the patient's chart and a 'warm handoff' to the next level of care is provided when needed. These poster presenters will share stories of patient success and early analysis of their interventions.

Jason Hyde, Director, Patient Navigation Center**,** NYU Langone Brooklyn PPS
Richard Akobi, Assistant Director, Care Transitions**,** NYU Langone Brooklyn PPS

CI-11

Asset Based Community Partnerships

This presentation will showcase the partnership between Westchester Medical Center Health Performing Provider System (WMC PPS) and Planned Parenthood Mid-Hudson (PPMHV) in the town of Newburgh. Through their collaborative community engagement, workforce support, cultural competency and health literacy engagement, WMCHealth PPS supports an Asset Based Community model. Their collaboration with PPMHV has resulted in a greater understanding of the paradigm shift necessary to work with "vulnerable" communities by engaging their strengths and assets.

Lillian Jiménez, Sr. Manager, Community Engagement, WMCHealth Performing Provider System
Annette Marzan, Director of Community Outreach Projects**,** Planned Parenthood Mid-Hudson Valley
Lana Williams-Scott, Director of Diversity, Inclusion and Community Engagement for Planned Parenthood Mid-Hudson Valley**,** Planned Parenthood Mid-Hudson Valley

CI-12

Impact of a Community Health Worker Program on Caregivers of Children with Special Health Care Needs

The Special Kids Achieving Their Everything pediatric community health worker (CHW) program was designed to support caregivers of children with special health care needs (CSHCN). The program serves an urban, predominately publicly-insured, Hispanic population. The poster presenters will share details of their study demonstrating the feasibility and potential effects of a CHW intervention for CSHCN in a high-risk population, also well known to be high utilizers of care. Their data support the use of a CHW program to identify and address social determinants of health, including caregiver distress, and provides greater understanding of the many challenges that CSHCN face.

Marguerite Costich, Primary Care Research Fellow in Community Pediatrics, Columbia University Medical Center
Adriana Matiz, Associate Professor of Pediatrics, Medical Director of the Center for Community Health Navigation, Columbia University Medical Center
Patricia Peretz, Manager, Community Health and Evaluation, NewYork-Presbyterian
Jaimee Davis, Program Manager, Community Health Workers Programs, NewYork Presbyterian

CI-13

Potluck Power: Reciprocal Volunteer Exchange Program

Staten Island PPS and ArchCare have demonstrated the impact that volunteerism and socialization has on Timebank community members' health and happiness. Loneliness, one of the most common social determinants of health reported among Staten Islanders, but largely overlooked by health professionals, can have serious health consequences. This poster presentation will showcase the impact that the DSRIP funded Timebank is having across Staten Island, specifically, demonstrating results from a study on how the key tenants of Timebank, volunteerism and socialization, truly improves someone's health and wellness, or their 'happiness factor'.

Celina Ramsey, Director of Health Literacy, Diversity and Outreach**,** Staten Island Performing Provider System
Miriam Blesch
Laura Alfano

CI-14

A Prescription for Quality: Building Effective Medication Management Programs

Medication non-adherence is associated with suboptimal health outcomes including increased hospital admissions, morbidity and mortality, and increased healthcare costs. Given the complex nature of non-adherence, a multifactorial patient centered approach is required. With a goal to implement sustainable cost-effective solutions by augmenting existing patient care services, NYU Langone's pharmacy team partnered with clinicians, community organizations, insurance plans, and community pharmacies to coordinate and ensure safe and effective medication use across the continuum of care. This poster presentation details the pharmacy led program, their understanding of root causes of medication non-adherence and avenues to improve care.

Mariel Shull, Pharmacy Utilization Management Coordinator, NYU Langone Brooklyn PPS
Jennifer Oh, DSRIP Pharmacy Liaison**,** NYU Langone Brooklyn PPS

CI-15

Prescription (Rx) for Communication: Building Community Partnerships to Improve Medication Adherence

The Suffolk Care Collaborative initiated a pharmacy pilot program focused on linking provider practices with local, independent pharmacies to improve communication between them. The goals are to enhance existing and establish new communication strategies through which provider practices can receive early notification of patients at risk for not receiving their prescriptions. The poster presentation describes the process through which the task force was established, reviews how Salient data was leveraged to inform and guide the strategy, identifies the pilot materials that were developed, and explains how outreach to partners was conducted and projects were initiated.

Alyse Marotta, Administrative Manager, Behavioral Health, Suffolk Care Collaborative
Alexandra Kranidis, Project Manager, Suffolk Care Collaborative

CI-16

One-on-One Peer Mentoring Improves Diabetes Self-Management and Clinical Outcomes among Medicaid Beneficiaries

Every 21 seconds someone in the US is diagnosed with diabetes, with more than 100 million U.S. adults currently living with diabetes or prediabetes. This poster presentation showcases an innovative high-tech diabetes mentoring program model to effectively access, assess, and treat high-risk populations that demonstrated very encouraging results. The unique attributes of this program include producing a culture of camaraderie and high level of interpersonal trust, financial incentive for the mentors (workforce training), and mutual health and social benefits for both mentors and mentees. This is highly scalable and can be utilized within the population health management, value based framework to reduce health inequities.

Bonnie Reyna, Director of Community Workforce Transformation, WMCHealth PPS
Harmanpreet (Harman) K. Sidhu, Senior Program Manager, WMCHealth PPS
Scott Hines, Chief Quality Officer, Medical Director, Crystal Run Healthcare

CI-17

The Community Training Residency Educational Experience Program: A Grass Roots Disease Prevention Approach in Brooklyn

A key element in the clinical learning environment is the heuristic experience of impacting population health management on a grass roots level. As part of developing a professional workforce of providers, the Family Health Centers at NYU Langone Health residency program seeks to expose the primary care residents to the Community Based Organizations (CBOs) through working on a community engagement project in the areas of diabetes, asthma, behavioral health, tobacco use or HIV. Through this partnership with CBOs, the provider also receives training in health literacy, interpersonal skills, communication and public speaking. This poster presentation will describe this critical grass roots training approach in Brooklyn.

Neil A. Pasco, Residency Program Director, NYU Langone Brooklyn PPS
James L. David, Director of Patient Relations and Engagement**,** NYU Langone Brooklyn PPS

REDUCING POTENTIALLY PREVENTABLE HOSPITAL USE/IMPROVING FOLLOW-UP AFTER HOSPITALIZATION | GALLERY

RPPH-18

Improving Follow-Up After Psychiatric Hospitalization

OneCity Health PPS developed a collaboration to improve follow-up after psychiatric hospitalization. Acute facilities, the Office of Behavioral Health, Care Management, Health Home, outpatient providers, Managed Care Organizations, and PPS leadership worked together to implement a series of interventions aimed at improving timeliness and continuity of care following a psychiatric hospitalization. These poster presenters will share information about the interventions implemented across facilities and their results that indicate an 8.7% improvement in Follow-up After Psychiatric Hospitalization Results (30 days) during a six-month outcome period.

Andrew Kolbasovsky, Chief Performance Improvement Officer**,** OneCity Health
Prajakta Vagal, Senior Director, Office of Behavioral Health**,** NYC Health + Hospitals

RPPH-19

Improving Outpatient Treatment Following Psychiatric Discharge: The Impact of Community Health Workers in Bridging Treatment

Those who are psychiatrically hospitalized are known to have very poor rates of adherence to behavioral health (BH) outpatient treatment post discharge, leading to poor rates of medication compliance and frequent re-hospitalization. This poster presentation describes NYU Langone Brooklyn's effort to improve the rate of those who attend BH treatment in the community, by hiring and placing two community health workers (CHW's) on the team within the psychiatric unit. The CHWs engage patients, offer them assistance in attending outpatient BH appointments, and accompany them to those appointments as needed. Presenters will share their challenges, and successes and the impact of CHWs' support.

Jon Marelli, Program Manager, Behavioral Health and Primary Care Integration, NYU Langone Brooklyn PPS

RPPH-20

Improving Communications and Relationships between Care Management Agencies and Physicians through Pre-visit Planning

The poster presentation will share the experience of how care management agencies at Mount Sinai PPS worked together to develop and implement a pre-visit planning tool and process. While the initial purpose was to help close care gaps by working with patients directly, the Care Management agencies faced several challenges during implementation and recognized the importance for collaboration with referring providers. The presentation will highlight the experience in developing and implementing the tool and will also showcase how the Alliance for Positive Change was able to leverage this tool to develop an ongoing relationship with providers in the community, which has been key to moving forward together in value-based arrangements.

Neil Patel, Director, Performance Improvement**,** Mount Sinai PPS
Marcy Thompson, Chief Strategy Officer, Alliance for Positive Change

RPPH-21

Implementing Best Practices Across 10 Skilled Nursing Facilities to Reduce Sepsis Readmissions

This poster will describe how Staten Island PPS has implemented a standardized quality improvement initiative across all 10 skilled nursing facility (SNF) partners (3,114 certified beds). Staten Island PPS data showed that sepsis was the most common reason for hospital admissions across the 10 SNFs. Gaining 100% participation was achieved by providing evidence-based protocols, funding IV certification and phlebotomy training, and giving resources to partners. The content includes a brief background on Staten Island PPS, the nursing home partners, clinical capabilities, and INTERACT quality improvement implementation. This poster describes the quality improvement strategies that were utilized to begin the sepsis quality improvement initiative and what barriers were overcome with assistance from Staten Island PPS.

Mary Han, Director of Continuing Care and Quality Management**,** Staten Island Performing Provider System
Salvatore Volpe, Chief Medical Officer**,** Staten Island Performing Provider System
William Howe, Medical Director**,** Carmel Richmond Healthcare and Rehabilitation Center
Mary Beth Francis, Assistant Administrator, Carmel Richmond Healthcare and Rehabilitation Center

RPPH-22

Applying Rapid-Cycle-Improvement to Improve 7- and 30-Day Post Hospitalization Follow-up for Mental Illness

Data for the seven counties represented in the Montefiore Hudson Valley Collaborative (MHVC) network revealed that Rockland County was in last place for the care transitions for mental health patients metric between July 2016 and June 2017. With a shared interest in understanding the root causes of this result, MHVC and its partners in Rockland County teamed up to improve outcomes. Early findings show that while well intentioned, the number of “helping individuals” reaching out to people who are hospitalized is overwhelming. The poster presenter will share best practices to clarify roles and create an effective strategy for engaging people in follow-up treatment.

Kristin Woodlock, Chief Executive Officer Woodlock & Associates LLC**,** Montefiore Hudson Valley Collaborative

RPPH-23

Hospital and Skilled Nursing Facility Collaboration to Reduce Palliative Services Related Readmissions.

A very productive partnership between the NewYork-Presbyterian Queens PPS and Silvercrest Nursing Home expanded the reach of the organizations and resulted in significant awareness and education about palliative care services. The partnership also provided a structure in which the skilled nursing facilities (SNF) and the hospital are able to work closely. Using weekly phone calls, onsite meetings, chart reviews and data tracking, the partners assess readmission rates and review cases collaboratively. The early program results have shown reduced readmissions for the Silvercrest SNF. Their poster will highlight the key tools and attributes of the program along with its impact.

Marlon Hay, DSRIP, PMO Director, NewYork-Presbyterian Queens
Hoda Abdelaziz, DSRIP Nurse Practitioner, NewYork-Presbyterian Queens

RPPH-24

Reducing Hospital Utilization by Addressing the Unique Needs of At-Risk Patients in Brooklyn

After gathering input from Brooklyn hospitals, care management agencies, community-based organizations, post-acute providers, and other local stakeholders, the Maimonides Department of Population Health designed and implemented a 30-day care transitions initiative for its PPS network, tailored to address Brooklyn's highest need patients. As part of the initiative, transitional care teams at network hospitals create individualized, person-centered, 30-day care plans, work with patients in the hospital and throughout the 30 days post-discharge to address medication concerns, provide condition-specific education, and serve as links between patients and community-based clinical and social service providers. Poster presenters will describe this initiative along with its evaluation and results.

Kayla Spence, Manager, Program Implementation & Partner Engagement**,** Maimonides Medical Center
Shari Suchoff, Vice President for Population Health Policy & Strategy, Maimonides Medical Center
Karen Nelson, Senior Vice President for Integrated Delivery Systems, Maimonides Medical Center
Rachel Leep, Manager of Health and Social Services Analysis, Maimonides Medical Center
Natalie McGarry, Senior Analyst, Maimonides Medical Center

RPPH-25

Root Cause Analysis of 30-Day Re-hospitalizations From Skilled Nursing Facilities Using Self-Administered Electronic Survey

Re-hospitalizations carry additional risks for skilled nursing facility (SNF) residents who are often elderly, frail, and chronically ill. Loss of function, nosocomial infections, and delirium are among the numerous potential complications SNF patients face when hospitalized. It has been shown that re-hospitalizations from SNFs are often preventable. This poster presents an ongoing study of 30-day re-hospitalizations within the Albany Care Transition Coalition - a collaborative of regional SNFs and Albany Medical College to identify process elements that contribute to avoidable readmissions as potential targets for quality improvement initiatives.

Chaofan Yuan, Medical Student, Albany Medical College/Better Health for Northeast New York (BHNNY PPS)
Jonathan Fogel, Medical Student**,** Albany Medical College/Better Health for Northeast New York (BHNNY PPS)
Brandi Heinz Medical Student**,** Albany Medical College/Better Health for Northeast New York (BHNNY PPS)
Neha Pirwani Medical Student, Albany Medical College/Better Health for Northeast New York (BHNNY PPS)
Jihoon Choi Medical Student, Albany Medical College/Better Health for Northeast New York (BHNNY PPS)

RPPH-26

Co-Designing Transitions of Care Health Coaching for Patients with Congestive Heart Failure

This poster presentation describes the City Health Works and Mount Sinai St. Luke's Hospital (Mount Sinai PPS) co-designed transitions of care intervention with congestive heart failure inpatients at Mount Sinai St. Luke's hospital. Patients received health coaching from City Health Works during their transition from inpatient to outpatient, and based on promising health outcomes data, the partners are expanding their partnership to provide services to patients with congestive heart failure, diabetes, hypertension, and asthma.

Jamillah Hoy-Rosas, Chief Health Officer**,** City Health Works

RPPH-27

Stopping the Revolving Door: Advancing Community Paramedicine to Engage High Utilizers

During this session, presenters will describe how Nyack Hospital's ED-Care-Triage program transformed into a Community Paramedicine program, quickly yielding a 20% reduction in unnecessary utilization for a cohort of 230 high-utilizers. Funded by Montefiore Hudson Valley Collaborative, an innovative partnership with Rockland Paramedics, integrated technology to collect real-time data and create alerts. By identifying and engaging at-risk patients earlier, immediate downstream impact was demonstrated resulting in 40% fewer patients meeting high-utilizer criteria. Attendees will understand how the program was developed, its impact on unnecessary ED and hospital utilization, the key drivers of successful implementation, quantitative and qualitative results, and the program's impact on the care team's engagement and "joy" in work.

Alice Cronin, AVP/CIO, Montefiore Nyack Hospital
Timothy P. Egan, Chief Information Officer, Rockland Paramedic Services

RPPH-28

Scaling New Care Models: Standardizing and Implementing ExpressCare Across a Large Health System

Many patients present to the Emergency Department who do not require emergency care. To ensure these patients are getting the right level of care, as quickly and conveniently as possible, and in the most appropriate setting, OneCity Health and NYC Health + Hospitals launched ExpressCare, an urgent care service available to walk-in patients who do not require emergent care. This poster's presenter will highlight the journey from an early conceptual model to finalization of a standardized prototype, to a standardized model for quick implementation at all acute care settings within the health system.

Erfan Karim, Director of Innovation**,** OneCity Health PPS

BEHAVIORAL HEALTH/SUBSTANCE USE DISORDER INTEGRATION | PRE-FUNCTION

BHSUD-29

Advancing and Sustaining the Integration of Behavioral Health and Primary Care

The ability to provide patients with integrated behavioral health and primary care services is a well-known need and significant element for improving outcomes whether in a primary care or behavioral health practice. Achieving this goal comes with implementation challenges related to provider staffing, workflow changes, patient engagement, stigma, and others. This poster presentation will highlight how multiple primary care and behavioral health practices on Staten Island have broken through these barriers and successfully integrated services for engaging approximately 40,000 Medicaid individuals, contributing to a 68% reduction in their ED visits.

Victoria Njoku-Anokam, Director of Behavioral Health and Care Management Initiatives Staten Island Performing Provider System
Marianne Howard-Siewers, Clinical Consultant, Staten Island Performing Provider System
Sadia Choudhury, Director of Ambulatory Care Initiatives, Staten Island Performing Provider System

BHSUD-30

Implementation of a Simplified Depression Treatment Algorithm for Primary Care Physicians

The prevalence of major depressive disorder is estimated to be nearly 10% in primary care settings. Many primary care physicians identify a need to improve their skills in diagnosing and treating depression. With not enough psychiatrists available, this often means that many patients do not receive timely treatment for depression. These poster presenters will share a simplified algorithm that begins with screening of depressive symptoms using the PHQ-9 instrument to diagnose depression and initiating depression treatment. The algorithm uses well-established guidelines, but creates an easy to follow path for a busy primary care physician.

Jaskanwar Batra, Medical Director, Ambulatory Behavioral Health, NYU Langone Brooklyn PPS
Jon Marelli, Program Manager, BH and Primary Care Integration, NYU Langone Brooklyn PPS

BHSUD-31

The Living Room Crisis Day Respite: An Innovation Fund Project

Human Development Services of Westchester opened the Living Room: Crisis Day Respite Program in July 2017. A Living Room Crisis Respite is an evidence-based intervention that builds on the philosophy that a non-hospital environment designed to provide a comfortable, calm and relaxed environment is an alternative to an emergency department or inpatient stay for those who need a safe place to support their behavioral health. Those who visit The Living Room are called "guests". Poster presenters will describe in detail this alternative to an emergency room where guests are offered both peer and professional support to develop short and long term planning strategies to address their immediate situation. Guests of The Living Room report feeling supported and heard. They report a reduction of stress and symptoms that have led to the emergency department or hospitalization in the past.

Kathy Pandekakes, Chief Executive Officer, Human Development Services of Westchester
Kelly Darrow, Chief Program Officer, Human Development Services of Westchester

BHSUD-32

Mobile Medical Van Accelerates Development of Integrated Delivery System, Capital District to Eastern Long Island

This poster presentation will demonstrate how HRHCare Community Health has deployed two mobile health centers to nearly 20 behavioral health care management agencies in six counties across the Hudson Valley and Suffolk County, Long Island. Bringing primary care to meet community members in trusted settings such as these fosters improved preventive care engagement, chronic disease management, and healthcare system integration. The poster will showcase the similarities and differences between the approaches taken in each region, including: defining differences in populations of focus, designing program frameworks and processes, and delivering services and screenings. From there, the poster will highlight findings on best practices and impact. The deployment of mobile health centers across their network has accelerated HRHCare's capacity to reach behavioral health members and has improved access to primary and preventive care, creating a more seamless system across provider types and delivery settings.

Elba Bizoni, Operations Manager, Hudson Valley, HRHCare, Community Health
Eileen McManus, VP, Operations, HRHCare, Community Health
Carlos Ortiz, VP Operations, Long Island, HRHCare, Community Health
Jillian Annunziata, Sr. Project Manager, Strategy, HRHCare, Community Health
Allie Dubois, EVP/Chief Operating Officer, HRHCare, Community Health
Mirta Zapata, Nurse Manager, HRHCare Community Health

BHSUD-33

Getting to the CORE of Unnecessary Hospital Admissions Among High Utilizing Behavioral Health Patients

Coordinated Behavioral Care (CBC) used their DSRIP funds to develop and implement a six-month innovative intervention program known as CORE for Mount Sinai PPS patients with behavioral health diagnoses identified as high-utilizers of emergency and hospital services. The poster highlights the efforts involved in working with CBC and various health care providers in the inpatient and ambulatory care settings to design the program. The presenter will showcase the process for building a program to address the needs of some of the most challenging and demanding patients in health care, and the thought process for using the available data and creating a performance management and improvement plan.

Marissa Mendelsohn, Associate Director of Behavioral Health Integration, Mount Sinai PPS
Amy Whelan, Program Coordinator, The Bridge, Inc.

BHSUD-34

Lessons from Developing Short Term Crisis Respite Program for Behavioral Health Patients

This poster presentation will share highlights from ACMH, Inc.'s pilot program for Mount Sinai PPS's partners. The pilot program offers short-term crisis respite and transitional step-down accommodations to Medicaid patients who would not have otherwise been eligible for the service. The poster will highlight the program start-up process, challenges in program implementation, eligibility criteria, program services, and the success of the program demonstrated in aggregated program data from May 1, 2018 through December 31, 2018.

Moray Joslyn, Director, Clinical Integration, Mount Sinai PPS
Kearyann Austin, Program Director, Short-Term Crisis Respite and Transitional Step-Down Housing, ACMH, Inc.

BHSUD-35

Depression Screening and Treatment in Mental Health Clinics: Tracking Improvement in Depressive Symptomatology using the PHQ-9

This poster presentation details the development and implementation of a depression screening project at four Westchester Jewish Community Services (WJCS) mental health clinics across Westchester County. The workflow encouraged meaningful PHQ-9 screening for all new patients and weekly follow-up administration for clients above the clinical cutoff. It includes information on the infrastructure developed to support this initiative, including staff training and follow-up, weekly and quarterly data reports, and supervision protocols.

Patricia Lemp, Assistant Executive Director, Clinic-Based Mental Health Services
Westchester Jewish Community Services
Elana G. Spira, Director of Research, Westchester Jewish Community Services

BHSUD-36

Virtual Care in a Value-Based World: Innovative Applications of Telehealth in Rural Upstate New York

Telehealth and telemedicine technologies are developing at an unprecedented pace with the promise of improved patient care, access and outcomes, cost reduction, revenue generation, and streamlining of conventional healthcare delivery models. This method of delivering care has not yet been widely used in rural areas of Northern New York, but an Adirondack Health Institute PPS partner, Hamilton County Community Services, has adopted an innovative telehealth solution to address gaps in accessing care. Poster presenters will describe their solution and showcase their data that on evidence-based outcomes that are saving residents in rural areas time and transportation costs, while keeping care in the communities where it belongs.

Katy Cook, Project Manager, Telehealth**,** Adirondack Health Institute PPS
Robert Kleppang, Director of Community Services**,** Hamilton County Community Services

BHSUD-37

People in Recovery Need Connections: Implementing a Smartphone App to Support the SUD Population

Smartphone technologies and applications are becoming innovative and effective ways to engage patients across medical and behavioral health settings. CHESS Health developed an overall Addiction Treatment Platform that includes an evidence-based smartphone application for clients with substance use disorders to increase treatment adherence and prevent relapse. Multiple studies have proven the value and success of the app related to higher abstinence, fewer heavy drinking days and reductions in hospitalizations. Poster presenters will share information about adopting this technology and best practices for engaging clients within their programs.

Ashley Blauvelt, Managing Director, Strategic Initiatives & Operations**,** Staten Island PPS
Christine Lasher, Vice President, Customer Success, CHESS Health

BHSUD-38

Bupe Innovation in Primary Care-Practice Transformation

The Bupe Innovation in Primary Care-Practice Transformation details the transformation of SOMOS Primary Care practices to incorporate substance use services. The Bupe Group is a shared medical appointment approach that allows the medical provider to administer bupernorphine to eligible patients, while also providing medical and substance abuse education, peer support, and medication; the model also allows for multiple patients to be observed at once. Specifically, this poster will illustrate the stages of the change in transitioning Metropolis Medical office, a free-standing primary care clinic not affiliated with drug treatment programs, to a primary care office that assesses patients for substance use disorders (SUD), refers patients with SUD to community-based SUD clinics and prescribes buprenorphine to patients with opioid use disorders.

Diego Ponieman, Chief Medical Director, SOMOS Community Care
Martine Baron, Director of Care Management, SOMOS Community Care

BHSUD-39

Combating the Opioid Epidemic Using Real Time Data and Artificial Intelligence

Applying artificial intelligence (AI) technology to opioid tracking systems presents a novel approach to combating the opioid epidemic. Building on the NY National Guard's prototype streaming analytics platform that tracks real-time opioid overdoses and Narcan administration, and using a mobile app that has been piloted at St. Luke's-Cornwall Hospital, the Hudson Valley Interlink Analytic System (HVIAS) collects real time data as patients arrive to the emergency room. It then uses AI to predict overdose clusters that can inform rapid coordinated multi-stakeholder response and ultimately save lives. This poster presents this pilot, the impact it has had in Orange County and plans to spread this technology to other regions.

Julio Fernandez, Corporal, National Guard Counterdrug Taskforce
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STATE POSTER | MEETING ROOM 1

To DSRIP and Beyond: System Transformation Sets the Stage for VBP

Community-level collaborations focusing on system transformation, clinical improvement and population health have moved New York State towards the transformative DSRIP goals of improving NYS Medicaid. DSRIP investments have resulted in reductions in avoidable admissions, increasingly collaborative care, and a culture of innovation among participating providers across the delivery spectrum. These improvements have primed the NYS Medicaid program for widespread Value Based Payment (VBP) adoption, where gains in quality and efficiency enable a sustainable model of redesigned care delivery. This comprehensive review of Statewide metrics illustrates great progress over the past 4 years while highlighting areas for continued improvement.

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