Minutes
NQP Project Advisory Committee
June 15, 2016
8:30AM – 11:00AM
NUMC Auditorium

Welcome & NQP Updates

- DSRIP is now in Year 2
- Progress reports and updates are posted on the DOH and NQP websites should NQP partners need any additional information
- NQP has 2 contracts with community-based organization's (CBOs) related to the 2di Patient Activation project
- Most requirements of DSRIP's prescribed metrics and measures relate to primary care and behavioral health providers as well as SNFs; therefore, PPSs are struggling to identify the best way in which to collaborate with CBOs
- Focus for next few quarters
    - Working with NQP's 60+ SNF partners to implement the INTERACT program
    - Supporting transformation of PCPs to PCMH 2014 Level 3 standards, in compliance with NCQA guidelines
    - Shifting from PPS planning phase to Hub-based implementation
- Midpoint Assessment- State will assess PPS performance against many areas (governance, metrics, provider network, financial viability)
    - As part of this process, State will release a 360 Survey for PPS partners to complete to gather feedback on participation, communication, funds flow, etc.
        - PPPs will review feedback and adjust processes accordingly
        - NQP partners will receive additional information and guidance on this in the near future
- DOH CBO Planning Grant RFA
    - Information on intention and eligibility requirements is included in the PAC slides
        - Additional information is also posted on the grants form website
    - Questions are due by Friday to OHIPContracts@health.ny.gov

Resources

Health Information Tool for Empowerment (HITE)

Carla Nelson- CNelson@GNYHA.org
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- Tool managed by GNYHA, an advocacy and member organization representing healthcare entities mainly in NY
- HITE has been used as a tool to connect individuals to health and social services in the NY area for over 10 years
    - Contains information on 5000 services
    - Tool is free and web-based
    - Intended audience: Frontline service providers (Case management, social work, discharge planning, counselors)

- GNYHA maintains website and conducts outreach to educate individuals on the website and trainings
- Example of HITE service:
    - Individual receives Supplemental Nutrition Assistance Program (SNAP) benefits, but additional support is needed
    - Click "Social Services" category
    - Check boxes related to specific services (food pantry/ meals) and indicate desired locations
    - Can filter by age, population demographics, etc.
- HITE additional features
    - Indicates payment requirements (i.e. free or insurance required)
    - User can save listings to personal account- login to see past/saved information
    - Eligibility calculator- screening tools to help determine benefits
    - State, local, across country
- Community Connections- information on community groups and meetings for networking, sharing resources, collaborate to address issues
- Update process- contact organizations directly
    - Annually or more often, as needed
- HITE/GNYHA is looking to expand information on Long Island resources
    - Please contact Carla or Francesca to provide feedback or to ask questions related to the website; users may also use the website contact page to submit feedback or questions
- DSRIP collaboration
    - GNYHA has provided data dump to PPS on information on all 5,000 resources
    - PPSs have used this data for community needs assessment and to do deeper dive into what services are available to determine where they can fit into the projects
    - Discuss how HITE can fit into the workflow among other resources, etc.
- GNYHA will work with organizations to conduct trainings/presentations on the tool as requested

United Way of Long Island- 211

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- 2010: 211 Long Island created- primarily Nassau and Suffolk counties
- 4,000 agencies with 10,000+ services
    - Most users are service providers (e.g. social workers)
- Free, web-based service; can be accessed with mobile devices
- Part of the Alliance of Information Referral Systems
    - Leverages AIRS guidance for style, data entry, service points
        - Complies with all national certification standards

- 211 has 2 specialized databases- one for development and intellectual disabilities and another for veteran services
    - 17 major categories- housing, substance abuse, etc.
    - Can sort by zip code, taxonomy terms, and several other factors
    - Works with organizations to update information
    - Health insurance enrollment and support services
- 211 offers training on the website at offices or onsite at their library; contact Beverly to set up a session
- Maintains a separate tab for emergencies to get up-to-the-minute information about disease outbreak (e.g. Zika)
- Users can create and save dedicated searches on specific areas identified by organizations (veteran services, etc.)
- Events calendar- includes information on community events such as trainings and support group meetings
- As of now, website is only available in English; software upgrade this year may support other languages; call center does have ability to translate into many language

Long Island Health Collaborative

- LIHC was established 3 years ago under NY Prevention Agenda
    - Includes 60+ organizations (all LI hospitals, CBOs, academic centers, health plans, etc.)
- 2014- NY State DOH released RFP to support collaboration among different groups – LIHC won grant
- LIHC has a 3 pronged approach
    - Programming- promotion campaign to promote physical activity and good nutrition
    - Public outreach- education on population health and taking responsibility for one's own health
    - Policy– improvements to support better health (improved walkways, lighting, etc. to encourage walking and biking)
- CBOs are vital to success of efforts and transformation for the State
    - CBOs are boots on the ground- they understand the communities in which they operate and individuals' needs and wants
    - Held 2 CBO summits to gather feedback from CBOs about needs and barriers to care/access

CBO and NQP Collaboration

- CBO Activities- presented by Gwen O'Shea President/CEO, Health & Welfare Council of Long Island (HWCLI)
    - HWCLI- serves at-risk populations
    - 20% of "health" relates to physical care; 80% is affected by social determinants of health

- Collaboration Example 1: Silicon Valley- Center for Independent Living
    - Care coordination agreement with hospital systems to work on 30 and 60 day transition plans
    - CBO understands assets in the community and can transition more seamlessly and quickly- can offer that knowledge to assist hospital system with care coordination
- Collaboration Example 2: Montefiore and Community Life
    - Community life "owns" a certain number of beds in the facility, whether needed or not, to accommodate individuals
    - Medication management, etc. to address needs of the individual
- 2di and Long Island
    - Community organizations know where uninsured individuals are located and are already existing assets and trusted resources in the community
    - Engaged in activation and navigation

Roundtable Discussions

ED Alternatives

Existing Knowledge of ED Alternatives

Through these discussions, NQP and CBOs identified several alternative care options for individuals needing non-emergent treatment. They included urgent care/ walk-in clinics (some of which are near EDs) and nursing hotlines/ telephonic triage that can direct individuals to appropriate care or services. CBOs noted that there is generally little awareness of ED alternatives, except for those seeking specialty services, such as mental health and substance abuse support. Those in need of behavioral health services are generally aware of services such as the mobile crisis hotline and crisis centers. However, most frequent users of the emergency room for medical issues are transient and difficult to engage and educate, however there are a variety of reasons patients may choose to use the emergency room, including but not limited to cost, accessibility, immigration fears and habit.

Current Education on ED Alternatives

CBOs and NQP identified a few methods by which individuals can learn about ED alternatives:

- Referrals by a provider or from a healthcare facility; follow ups by these providers and facilities through calls or text messages
    - Some providers also educate on proper preventative care before discharging patients
- Education through community organizations such as churches/faith groups, libraries, schools, health fairs
- Handouts and other materials may be provided at provider/healthcare facilities or at community settings
- Public awareness campaigns

- Social media education: videos/pop-up ads on internet; twitter blasts/YouTube videos from organizations such as OASAS; email notifications with educational information

Opportunities for Education

CBOs, generally, acknowledged an opportunity to improve education on ED alternatives:

- Be more proactive than reactive (e.g. Detroit's Maternal Infant Health Program- home visitation for pregnant women and infants on Medicaid to promote health wellbeing)
- Leverage community ambassadors/trusted resources to raise awareness and conduct community workshops
- Expand advertising in clinical and community settings- doctors' offices, newspapers, social media, community organizations, faith-based organizations, schools
    - In addition to medical services, education on social services (e.g. food pantry, transportation, housing)
    - Local hashtag can also be used to facilitate education and conversation as well as ads on the radio.
- Begin education at admission, in addition to discharge (e.g."10 things you could do other than be here")
- Identify frequent ED visitors and target these individuals with relevant education
- Multi-disciplinarian teams- allow providers of a different specialty (e.g. behavioral health providers) into facilities to screen patients once referral made without patient needing to be relocated
- Target general population (not necessarily those in need) with education
    - Emphasize educational programs in public schooling
- Offer incentives (e.g. lunches) at educational forums
- Emphasize user-friendliness: consider culture, linguistic needs, educational level
- Education included in transportation vehicles/ drivers trained to educate individuals

Discharge Planning

NQP Partner/CBO roles in discharge

NQP's partners can offer the following services in discharging individuals:

- Transitions of care programs/oversight of discharge
- Collaboration with treatment teams/providers to transition individual
- Medication management
- Outpatient substance abuse
- Behavioral health hand off
- Home care (e.g. medication management)
- Social services
- Making appointments and ensuring individual adheres to schedule
- Following up with providers on necessary or provided care/services
- Accept discharged patients

Opportunities for Improvement

- Better communication with hospitals/clinicians
- Formalized CBO involvement in workflows
    - Hand-offs to CBO/ more care coordination
    - Integrate community health workers and care managers
- Increased face-to-face discussion between individual and care/service provider
- More house calls/ verifying that individual is discharged to stable living environment
- Care plan determined and discussed at discharge
    - Appointment scheduled at point of service
    - "What to expect"
- Improved education- medication compliance, ED alternatives
    - Education on non-medical needs as well
- More effective screening process
- Transportation
- Formalized follow up process between service/care providers and with individual
    - Connection to centralized information- including 211 and HITE
- Resources in different languages