Partner Success Stories

December 2020

Staten Island
Performing Provider System

In reflecting back on Staten Island PPS's achievements as this chapter of DSRIP comes to an end, the most successful initiatives that result in improved care to individuals, organizational excellence and population health improvement start more often in the lunchroom than the board room. This is dedicated to our partners who did the hard work, implemented the programs, cared for the people who needed it most, when they needed it most and get up every day and do it again. This is in recognition of their passion and singular effort.

VETERANS

Staten Island PPS is working to serve veterans, a crucial and under-served population of men and women, many of whom are unidentified by most healthcare providers. During the COVID-19 crisis, Staten Island PPS received grant funding from New York Community Trust and New York State Health Foundation to serve as the backbone organization for building the infrastructure to improve delivery of health and social services to veterans on Staten Island. Through the program, we work closely with the New York City Department of Veterans Services (NYC DVS), and partnered with the Staten Island American Legion, Staten Island University Hospital, Richmond University Medical Center, Project Hospitality, CHASI, Meals on Wheels, Bridge Back to Life and Silver Lake Behavioral Health, Staten Island Veterans Center, Harbor VA Hospital and other healthcare providers and CBOs. All told, Staten Island PPS has been progressing towards our goals of identifying 4,000 veterans, connecting with 1,000 of them, and providing services to 400 vets to ensure this already vulnerable group isn't left behind during this unprecedented healthcare crisis.

Staten Island PPS partners are conducting peer-to-peer outreach to connect with veterans at home to determine their medical, behavioral and social service needs. Staten Island PPS providers developed a structure for implementing a project to address the needs of the Veteran population while meeting the goals of the grants. Staten Island PPS also worked with US Veteran Paul Dietrich, Vice Commander of the Richmond County American Legion for assistance with developing partner outreach materials and facilitating connections to other veteran organizations. PPS partners were trained on Veteran cultural competency principles and participated in Suicide Prevention Crisis Mapping meetings jointly convened by Staten Island PPS and NYC Department of Veterans Services.

Staten Island PPS partners accomplished the following goals:

- Conducted outreach to connect and engage with Veterans at home or in the community to determine current medical, behavioral and social service needs
- Deployed technology offered by Staten Island PPS to survey and refer for SDOH needs

- Provide necessary medical, behavioral and social service interventions to Veterans as needs are identified

A significant component of this program used a proprietary closed-loop SDOH referral platform called WeSource, developed and managed by Staten Island PPS.

In a few short months, we have built a comprehensive partner network that is building capacity and competencies to better serve military service members and veterans on Staten Island. Partners are using the various tools (for example, in-person, Staten Island PPS chatbot and/or texting) to first reach out to vets and then for continued communication and support.

Of the program goals, we are proud to report the following success:

- Over 2,000 Veterans have been contacted
- 389 referrals to social services were made
- 7 additional referrals made by Meals on Wheels case management staff
- 22,692 meals delivered

This program has allowed Staten Island PPS the opportunity to form new partnerships with agencies serving veterans and helped expand the ability and competencies of network partners to help veterans better connect to services in the community including medical, behavioral health supports and social services. The foundation of this program and its preliminary outcomes have helped secure additional funding to sustain the program.

WORKFORCE

To meet the demand for health care workforce development and expansion, Staten Island PPS partnered with the College of Staten Island and SEIU/1199 Training and Education Fund to sponsor an apprenticeship program and short- and long-term training strategies. Results from a 2015 partner survey indicated unmet training and job development needs. Health care delivery is moving towards a greater emphasis on community -focused care, creating new positions such as community health worker (CHW) and certified peer recovery advocate (CPRA). To help hospitals and health systems meet emerging workforce demands, Staten Island PPS developed new training programs specifically for impeding needs for certified nurse aides (CNAs), CHWs and CPRAs to address the opioid crisis.

These programs have been proven affective and one example is a graduate who got accepted into the Healthcare Management Graduate Program at the College of Staten Island. Beata works at the Community Health Center of Richmond as the Manager of Patient Financial Services.

Beata started as a graduate of the Community Health Worker Training program. Even though Beata has been working in the healthcare field for 18 years, she wanted to continue her education and take away all that she could from the program. Through the CHW program, Beata learned how to control bias, take a step back to see other perspectives, and generally how to feel more comfortable when working through her patients' issues. The hands-on learning and sharing of experiences stuck with her as well because she was able to hear how other people deal with issues and how they handle them. She now takes what she's learned from the program and applies it to her work every day, being proactive instead of reactive. She felt that the CHW program was extremely helpful for her, even in her management position.

Beata plans to continue her education even further past the Healthcare Management graduate program since healthcare is ever-changing, and

she always wants to stay up to date. She wants to set the example for her team that you can never have too much education or experience.

To further prove that apprenticeship programs are successful, Staten Island PPS, in partnership with the College of Staten Island, was the recipients of the recent Continuing Education Association of New York's Outstanding Business/Organization Collaboration Award. The PPS and CSI were recognized for the joint impact in advancing workforce development an economic development within the borough of Staten Island.

PALLIATIVE CARE

Staten Island PP held a meeting with skilled nursing facilities (SNFs) on Monday, November 23, 2020. On that same day, the U.S. Department of Health & Human Services "announced plans to allocate initial doses of Regeneron's investigational monoclonal antibody therapeutic, casirivimab and imdevimab, which received emergency use authorization from the U.S. Food and Drug Administration on November 21, 2020, for treatment of non-hospitalized patients with mild or moderate confirmed cases of COVID-19 at high risk of hospitalization".

It was reported that SNFs need help advocating for more doses of the monoclonal antibody therapy to be distributed to them as it becomes available. Currently, there are less than 3,000 doses provided to New York State Department of Health from the federal government. The SNFs are requesting that future doses be dispersed to them as much as possible considering the population that they serve. The SNF administrators and medical directors agreed that DSRIP initiatives on early identification of changes in condition through INTERACT and the sepsis protocol was beneficial to have in place already. The heightened clinical capabilities in SNFs including IV medications and oxygen concentrators have allowed clinicians to safely manage residents in the facility. If SNFs could receive an adequate amount of monoclonal antibody therapy, then they could manage residents with COVID-19, reduce unnecessary hospitalizations, and potentially reduce mortality.

IMPLEMENTING SOCIAL DETERMINANT OF HEALTH EFFORTS

Staten Island PPS launched a new SDOH platform and app that will help connect individuals and families to health and social service resources. The Social Determinant of Health App launched July 1, 2019. Through the first year of service over 18,000 surveys were completed with over 27,000 factors identified and nearly 60% closure rate within 30 days.

Where we live, learn, work and play can affect how long and how well we live, according to The Robert Wood Johnson Foundation Commission to Build a Healthier America. These parts of your life can impact your well- being even more than your genetics or health status. The social determinants of health (SDOH) are factors that affects your health but are often out of your control. These factors can be economic or social. They include education, economic stability, housing, transportation, safety and access to food.

SDOH more often impact people of color, lower educational achievements, immigrants, underserved and financially challenged. These groups of people have less access to stable housing, nutritious food and other basic resources. They are often less connected to health resources. For example, if a man with diabetes doesn't have a regular place to live, he might not have a refrigerator to store his insulin shots. He might not have a place to cook food. This impacts how that person can care for his health. It may cause him to have symptoms and go to the emergency department often. He may eat at cheap and convenient fast-food places and develop other health issues.

Staten Island PPS Launches New App

Research has made it clear that these factors make it harder to make healthy choices and connect to the right care. In this regard, Staten Island PPS created the Social Determinant of Health App. With the help of social service agencies, partners in he community and local government the app will connect individuals in need to local services,

allow for follow-up to close the loop of the referral and feed responses to the electronic health record of the client.

An important benefit of the app is to allow for a population level summary of survey responses of community members, including families. This census like assessment has never been conducted at this level of detail for factors that are so highly correlated with health outcomes according to Joseph Conte, PhD the PPS executive. It allows for the identification of where programs and resources can be targeted to achieve the highest ROI. What is important is immediately connecting individuals to resources and not leaving a recognized gap in a SDOH.

Clients often are given a referral or suggestion about where to go for help, but then follow through is poor and the cycle of neglect and need continues to impact health. It can be for a lot of reasons–time, transportation issues or finances. The strategy associated with this tool is to have navigators checking for needs and then instantly connecting people to resources on-the-spot, so there is a better chance of people getting the right help in timely way.

Who Uses The App?

The app was implemented by community-based organizations, social care providers, immigrant service organizations, mental health club houses, hospitals, FQHC's and primary care partners. Partners who are using the app have been trained in care coordination, motivational interviewing, health literacy and SDOH. Trusted community organizations that focus on the underserved, homeless and indigent like Project Hospitality and Community Health Action will also be using the new screening app. The survey can be completed in under 5 minutes on a patient's own phone or by a navigator on a tablet. Referrals can be sent directly to the patient's phone or via paper referral.

Staten Islanders will be screened at places like the library, social service providers, the food pantry, where they go for ESL classes or where they see their doctor. The point is for patients can have both their medical and social needs addressed seamlessly at a variety of touchpoints. Once a need is identified, navigators will follow each case to ensure all needs are met.

The data collected from this program will help determine the most pressing health factors affecting neighborhoods. The tool can be adapted to any locality with tailored referrals within specific community. The ability to do periodic surveys of large segments of the community will allow for snap shots of evolving needs and yield the same level of analytics

Outcomes

In analyzing claims data, we determined that individuals who are engaged with SDOH assessment and services have reductions in preventable ER use of 26% and preventable hospitalizations of 42%.

The partners involved in this effort include:

- Camelot Counseling
- Community Health Action of Staten Island
- Community Health Center of Richmond
- EG Healthcare
- El Centro del Inmigrante
- Island Voice
- Jewish Community Center of Staten Island
- Make the Road New York
- Metro Community Health Centers
- Project Hospitality
- Richmond University Medical Center
- Silver Lake Support Services
- South Beach Psychiatric Center
- Staten Island Mental Health Society
- Staten Island University Hospital
- Venture House
- Victory Internal Medicine
- YMCA