NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	6/26/15	**Meeting Title**	NYP PPS Clinical Operations Committee
Location	Milstein 1HN-151	**Facilitator**	Dr. Emilio Carrillo, Angela Martin
Go to Meeting	https://global.gotomeeting.com/join/158738573	**Conference Line**	Dial +1 (646) 749-3122 Access Code: 158-738-573

Invitees	
Chair: Angela Martin (VNSNY)	**Chair:** Emilio Carrillo, MD (NYP)
Alissa Wassung (God's Love We Deliver)	Crystal Jordan (Harlem United)
David Pomeranz (Hebrew Home)	Ana Garcia (NYC DOHMH) – Web
David Chan (City Drug & Surgical)	Maria Lizardo (Northern Manhattan Improvement Corporation)
Jean Marie Bradford, MD (NYPSI)	Susan Wiviott (The Bridge)
Eva Eng (Arch Care)	Emilio Carrillo, MD (NYP)
Jonah Cardillo (St. Mary's Hospital for Children)	

Meeting Objectives	**Time**
1. Review Action Items from Last Meeting	5 mins
2. Review Project Successes and Challenges	20 mins
a. Integrated Delivery System (D. Alge)	
b. HIV Center of Excellence (P. Gordon)	
3. Review/Finalize Other Committee Deliverables	20 mins
a. Ratify Committee Charter	
b. Discuss Process for Cultural Competency and Health Literacy Strategy	
4. Identify Action Items for Next Meeting	5 mins

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Schedule review of projects	I. Kastenbaum	5/29/15	-	
Share NYP Regional Health Collaborative Articles	E. Carrillo	5/29/15	-	

Next Meeting:

- Review Cultural Competency and Health Literacy Strategy

Following Meeting:

- Review Approach to Performance Measurement / Rapid Cycle Evaluation

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DSRIP Meeting Minutes

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Attendees	
Chair: Angela Martin (VNSNY)	**Chair:** Emilio Carrillo, MD (NYP)
Jose Caseres (City Drug & Surgical)	Crystal Jordan (Harlem United)
Eva Eng (Arch Care)	Ana Garcia (NYC DOHMH)
Jonah Cardillo (St. Mary's Hospital for Children)	Peter Gordon, MD (NYP)
Steven Chang, NP (NYP)	Sam Merrick, MD (NYP)
David Alge (NYP)	Isaac Kastenbaum (NYP)
Mary Hanrahan (NYP)	Adriana Matiz, MD (NYP)

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Meeting Minutes:

- A. Martin opened up the meeting with introductions of the Committee and other attendees.
- A. Martin provided quick overview of the Washington Heights-Inwood Regional Health Collaborative and CHW articles that were distributed prior to the meeting. E. Carrillo added that the RHC is the basis of a collective impact approach – one that will be mirrored for the PPS efforts.
- D. Alge presented on the PPS Integrated Delivery System project. He provided a high-level overview of the four strategies: (1) developing the necessary network, (2) population health management strategy, (3) medical home-anchored care management, and (4) sustainability planning.
    - P. Gordon asked about the PPS' approach to collective impact.
    - J. Cardillo and A. Martin asked about the PPS's approach to contracting. D. Alge suggested a phased approach, (1) participation agreements, (2) scopes of work, and (3) quality agreements. J. Cardillo agreed that a phased approach was best.
    - A. Garcia suggested that the PPS contact collaborators to reinforce their participation in the network; many collaborators have asked DOHMH what they should be doing.

- P. Gordon presented on the Domain 3 and 4 HIV Projects. These projects were well-aligned with the NYS/Cuomo End the Epidemic campaign.
    - S. Chang emphasized the need for HIE and interoperability
- I. Kastenbaum walked Committee through charter. E. Carrillo prompted the vote. E. Eng moved to ratify. J. Cardillo seconded.
- J. Carrillo noted that the next meeting would focus on developing a cultural competency and health literacy strategy for the PPS. There was group discussion about the best approach – provider-level education or patient-tailored approach.

Next Meeting:

- Review Cultural Competency and Health Literacy Strategy
- Review Transitions of Care Project

Following Meeting:

- Review Approach to Performance Measurement / Rapid Cycle Evaluation

AMAZING THINGS ARE HAPPENING HERE

HIV Projects

3.e.i – HIV Center of Excellence

4.c.i – Decrease HIV Morbidity

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Agenda

1. Intervention Goals and Objectives
2. Overview of NYS Metrics
3. Potential Role of PPS Collaborators
4. What our attributed population, or patients, will see as the difference

Intervention Goals and Objectives

End the HIV Epidemic

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Intervention Goals and Objectives

- Decrease incidence of new HIV infections
  - Increase HIV Testing
  - Pre-Exposure Prophylaxis (PrEP)
  - Treatment as Prevention (TasP)
- Increase linkage to care and sustained care engagement
- Address barriers to accessing care
  - Structural, clinical, psychosocial

HIV DSRIP Projects – One Population Based (Domain 4) and one Program Based (Domain 3)

- **Decrease HIV Morbidity**
  - Decrease HIV and STD morbidity and disparities. Increase early access to and retention in HIV Care
  - Increase peer-led interventions around HIV care navigation, testing, and other services
  - Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration, and mental health
  - Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care
  - Promote delivery of HIV/STD Partner Services to at-risk individuals
  - Educate patients to know their rights to be offered HIV testing
  - Cultural competency training for providers

- **HIV Center of Excellence**
  - Mental Health Services
  - Providers
  - Care Coordinators
  - 'Practice transformation'
  - Walk-in capacity
  - Enhanced STI, PrEP, PEP
  - Provider 'out-posting'
  - Integration with D4 (population) efforts

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Overview of New York State Metrics

- **Decrease hospitalizations by 25% over the 5 year project period**
- **Decrease ER visits by 25% over the 5 year project period**
- **By December 31, 2017, reduce the newly diagnosed HIV case rate in New York by 25% to no more than 14.7 new diagnoses per 100,000.**

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Overview of New York State Metrics

Measure (16 in all)	Source	Reporting Responsibility	Payment
HIV/AIDS Comprehensive Care : Engaged in Care	QARR 2015	NYS DOH	PFP
HIV/AIDS Comprehensive Care : Viral Load Monitoring	QARR 2015	NYS DOH	PFP
HIV Viral Load Suppression	NQF	PPS and NYS DOH	PFR/PFP
HIV/AIDS Comprehensive Care : Syphilis Screening	QARR 2015	NYS DOH	PFP
Cervical Cancer Screening	NQF	NYS DOH	PFR/PFP
Chlamydia Screening	NQF	NYS DOH	PFP
Premature Death (3 measures)	NYS Vital Statistics	NYS DOH	PFR
Preventable Hospitalizations (3)	SPARCS	NYS DOH	PFR
Health Insurance Rates (18-64)	US Census	NYS DOH	PFR
Smoking Cessation (3)	HEDIS 2015	NYS DOH	PFR/PRP

Potential Role of PPS Collaborators

Vast

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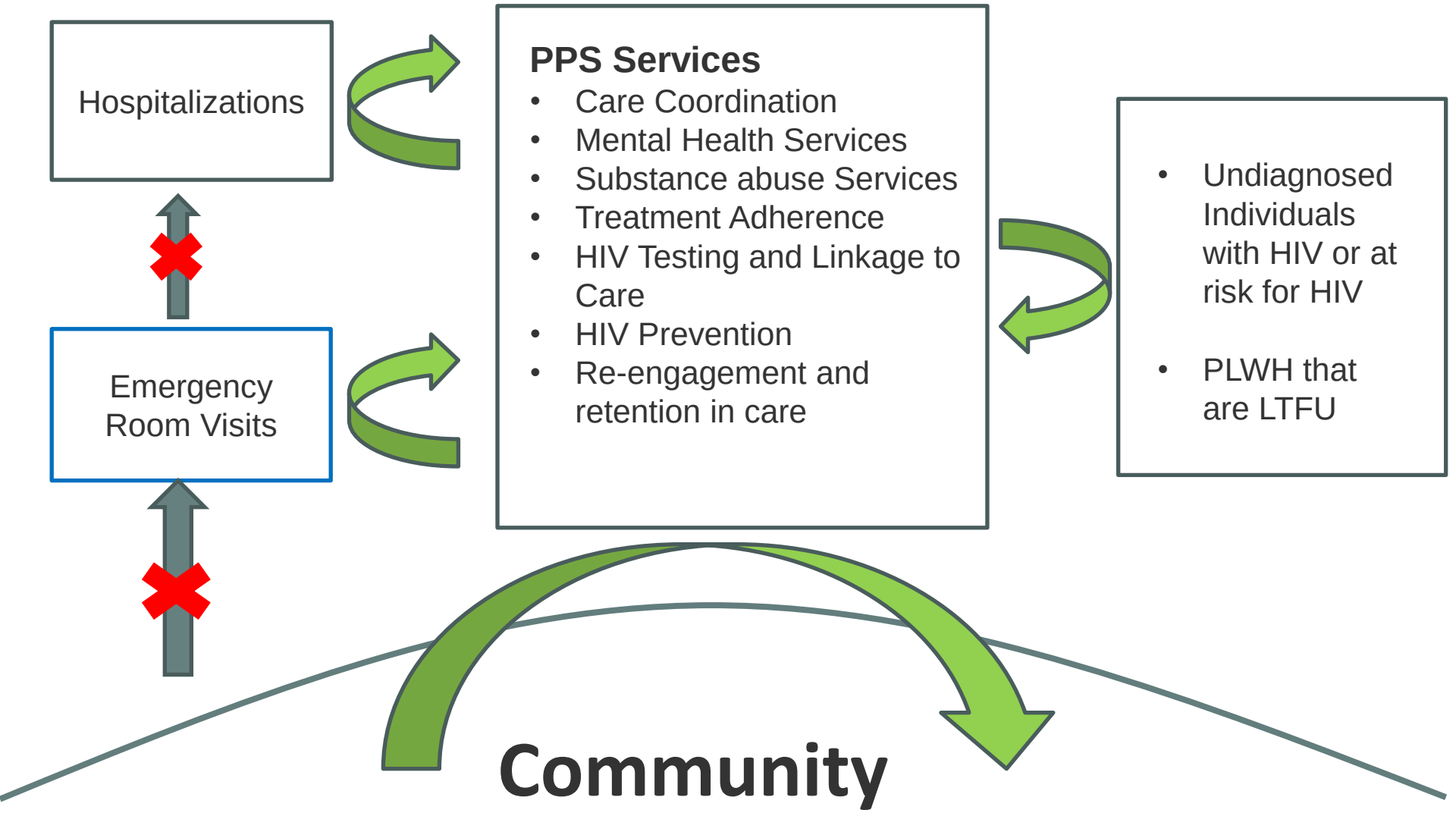
Potential Role of PPS Collaborators



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Potential Role for PPS Collaborators

Decrease HIV Morbidity

- Decrease HIV and STD morbidity and disparities. Increase early access to and retention in HIV Care
- Increase peer-led interventions around HIV care navigation, testing, and other services
- Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration, and mental health
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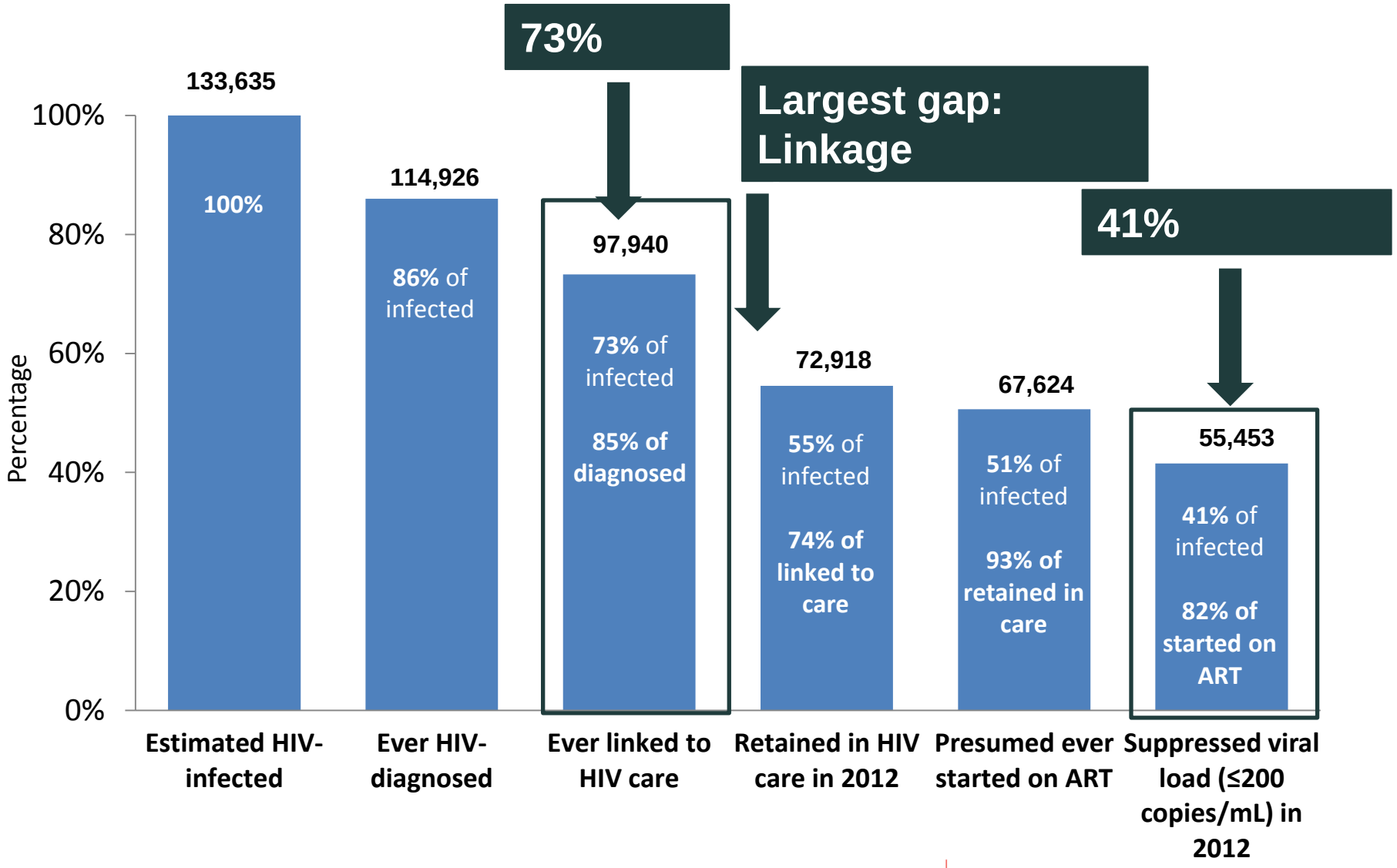
2012 HIV Care Continuum (NYC)



As reported to the NYC DOHMH by June 30, 2013.

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What will be different for patients?

Empowerment

Health Outcomes

Peer Support

Access

Care Coordination

Community Health

Ending the HIV Epidemic

Health Literacy

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Questions?

- Steven Chang, NP
  - NYP HIV DSRIP Project Manager
    - stc7003@nyp.org,
- Peter Gordon, MD
  - Medical Director, Comprehensive Health Program
    - gordonp@nyp.org
- Sam Merrick, MD
  - Medical Director, Center for Special Studies
    - stm2006@med.cornell.edu

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AMAZING THINGS ARE HAPPENING HERE

NYP PPS Integrated Delivery System

Project 2.a.i Overview

David Alge, VP, Integrated Delivery Systems Strategy

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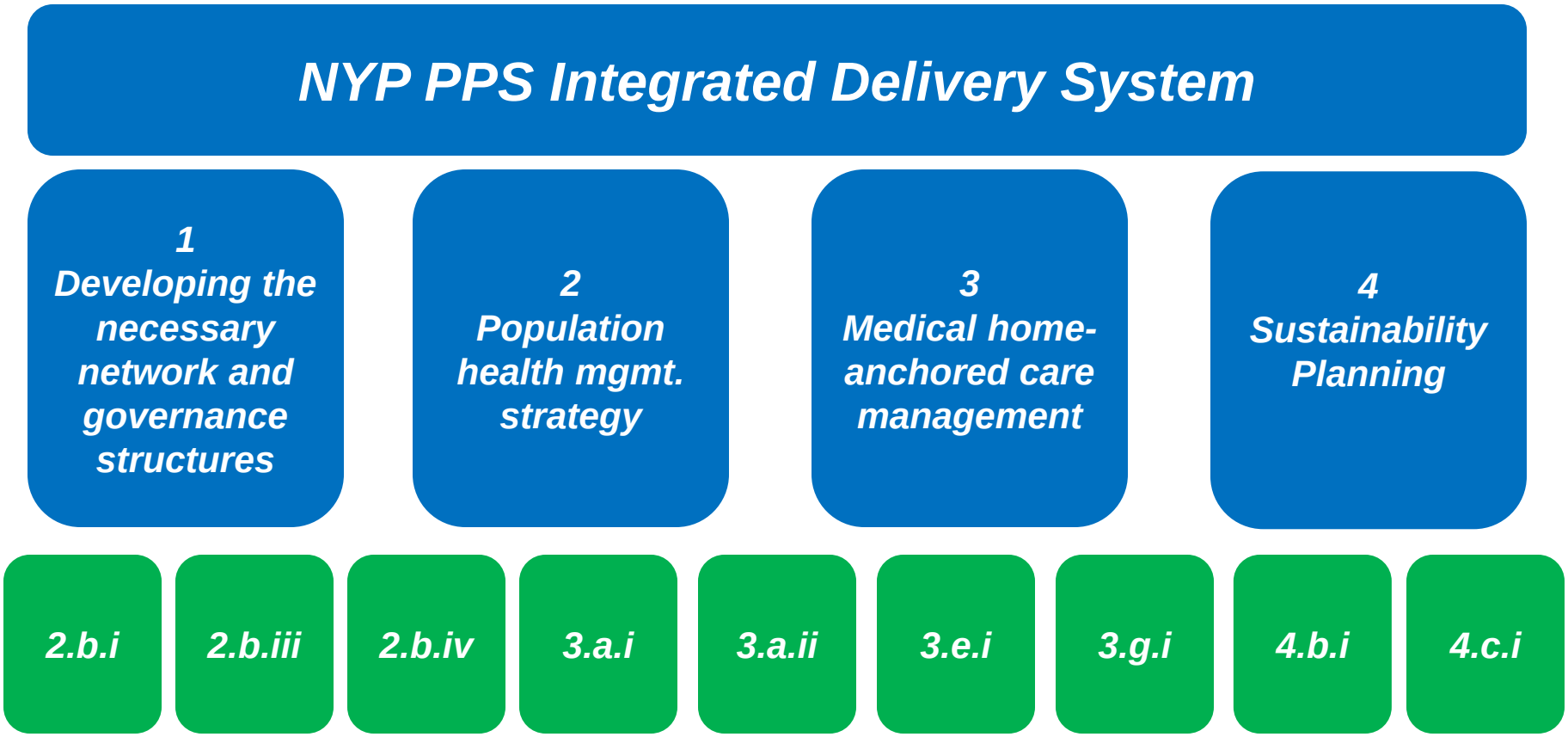
NYS 2.a.i Project Requirements

- …include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS…; additionally…payers and social service organizations, as necessary…
- Utilize partnering HH and ACO population health management systems and capabilities...
- Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
- Ensure that all PPS safety net providers are actively sharing EHR systems with…RHIO/SHIN-NY and…among clinical partners...
- Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3...
- Perform population health management by actively using EHRs and other IT platforms, including...targeted patient registries...
- Achieve 2014 Level 3 PCMH…certification, expand access to primary care providers, and meet Meaningful Use standards...
- Contract with Medicaid MCO and other payers, as appropriate, as an integrated system and establish value-based payment...
- Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
- Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
- Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent CBOs...

NYP PPS IDS Framework



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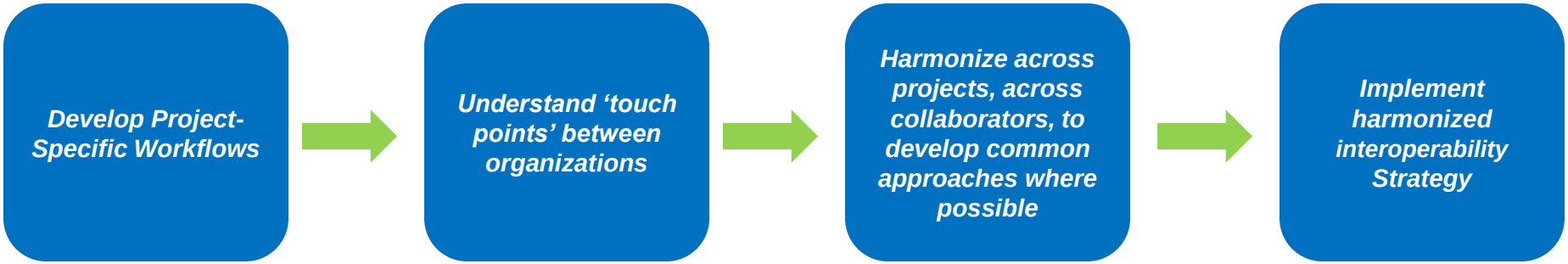
NYP PPS IDS (1): Developing the Network…

- **Identify the full array of primary care, mental health, social services, and other services to support DSRIP projects**
- **Execute agreements with Network Members outlining their roles in meeting DSRIP goals and the basic expectations for Network Members**
- **Engage PPS members in an effective governance structure that both meets the NYS Requirements and also secures community-wide buy-in to programmatic, financial and strategic direction.**

Action Step	Anticipated Timing
PPS Committee Initiation	On-Going
PPS Collaborator Scope of Work(s)	Late Summer 2015
PPS Participation Agreements	Fall 2015

NYP PPS IDS (2 & 3): Anchored Care Management

- Processes will be developed that connect attributed beneficiaries to longitudinal and comprehensive medical care (e.g. PCMHs)
- Attributed patients will be stratified within their medical home and across projects
- Coordination with NYP and PPS members' health homes and Medicare ACO (MSSP) activities to ensure non-duplicative infrastructure
- Ensuring participating practices achieve NCQA 2014 Level-3 PCMH or NYS Advanced Primary Care recognition
- Create an interconnected information infrastructure to support team-based care across the PPS members:



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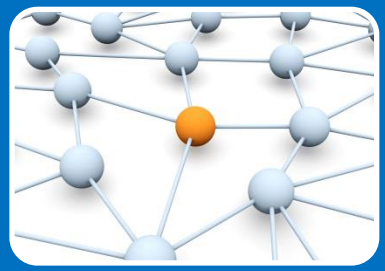
NYP PPS IDS (3) Cont.: Interoperability Strategy



Leverage RHIO

- Sharing of clinical data
- Support for event notification

Spread Allscripts Care Director

- Collaborative care management
- Similar to Health Home

Implement Direct Messaging

- Supports one-to-one referrals
- May be relevant when want to send data to one party but not make it available to all, e.g., mental health

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NYP PPS IDS (4): Sustainability Planning

- **Engage collaborator and managed care organizations to develop a PPS-wide value-based payment strategy:**
  - **Assess PPS membership readiness and capacity to engage in value-based payment models**
  - **Establish monthly meetings with MMCOs to discuss payment reform**
  - **Coordinate PPS participation in government and other externally initiated value-based payment programs (MSSP, CMMI, multi-payor pilots, bundled payments, etc.)**
  - **Develop an upside-only Medicaid shared savings pilot with MMCOs and/or NYS Medicaid**

New York and Presbyterian Hospital PPS
Clinical Operations Committee Guidelines

Co-Chair: Dr. J. Emilio Carrillo, VP of Community Health, NewYork-Presbyterian Hospital
PPS Network Co-Chair: Angela Martin, Director, Strategic Account Development, VNSNY

Charter:

The Clinical Operations Committee will provide recommendations for the New York and Presbyterian Hospital Performing Provider System's clinical and programmatic standards. The committee will be comprised of leaders with clinical and programmatic experience with representation from a variety of provider-types across the entire PPS.

The committee will ultimately be responsible for:

1. Establishing the necessary clinical and programmatic strategies to succeed in the performance period
2. Establishing standard care protocols for transitions of care
3. Communication plans to Collaborators, community stakeholders and Medicaid beneficiaries
4. Establishing a single Clinical Quality governance structure, including feedback mechanisms and the regular review of standardized performance measures
5. Reviewing the progress of projects and individual PPS Network members and making recommendations to the Executive Committee for programmatic/membership changes

The Committee may, at times, form small workgroups to complete specific tasks that include (as outlined in the NYS DSRIP Implementation Plan):

1. Perform a clinical integration 'needs assessment'
2. Develop a Clinical Integration Strategy
3. Finalize cultural competency / health literacy strategy
4. Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material)
5. Develop practitioner communication and engagement plan
6. Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda
7. Oversee transition of safety net providers to meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
8. Oversee that all PPS providers are included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.
9. Develop plans to leverage partnering HH and ACO population health management systems and capabilities to implement the strategy towards evolving into an IDS.

New York and Presbyterian Hospital PPS
Clinical Operations Committee Guidelines

Membership

1. Committee will be comprised of 11 members – with two chairpersons
2. Committee membership will be rotated in 12 month terms; at the completion of a term, 3 members will be rotated off (through a random-selection process in the 7th month of the term). Committee members will serve, at a maximum, thirty months.
3. Committee member organizations will be required to be represented by leadership; proxies will not be permissible
4. A NYP Vice President will serve as one of the chairpersons; the PPS Network collaborator will be chosen based on a vote at the first meeting of each term. Collaborator Chairpersons will rotate every ten months.
5. Committee members that miss 3 consecutive meetings will be removed and replaced

Co-Chair Responsibilities:

Clinical Operations Committee Co-Chairs will be responsible for: (1) preparing for meetings, (2) preparing/reviewing meeting agendas and notes, (3) working offline with Committee Members to push Committee efforts forward, (4) reviewing Committee deliverables, and (5) presenting to Executive Committee, when appropriate. Co-Chairs will serve a 12-month term.

Focus:

1. Committee will be responsible for advising the Executive Committee
2. Committee will be required to draft recommendations to be presented to the Executive Board monthly by the Chairperson(s)

Operations:

1. A majority of the members of the Committee shall constitute a quorum for the transaction of business. The vote of a majority of the members present at a meeting at the time of such vote, if a quorum is then present or the unanimous written consent of all members thereof, shall be the act of the Committee.
2. Committee will be required to submit minutes and attendance to the NYP PPS Project Management Office (PMO)
3. Committee meetings will be hosted in-person at NYP or Collaborator locations - a GoToMeeting/telephone option will also be offered.
4. NYP will provide a staff person to support the committee