NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	10/23/15	**Meeting Title**	NYP PPS Clinical Operations Committee
Location	Heart Center Room 4	**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)	Tamisha McPherson (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)	
Jonah Cardillo (St. Mary's Hospital for Children)	

Meeting Objectives	**Time**
1. Revew of action items from last meeting	5 mins
2. Ratify Cultural Competency and Health Literacy Strategy	5 mins
3. Project presentation on Care Transitions to Reduce 30 Day Readmission by Julie Mirkin, MA, RN, NYP Vice President of Care Coordination	25 min 10 min
4. Project updates	5 min
5. Review of Committee deliverables	5 min
6. Next steps on project status reporting	5 mins
7. Identify action items for next meeting	

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Committee members to send feedback to Lauren Alexander re: the cultural competency strategy by Fri, October 2, 2015	Committee members	9/25/2015	10/2/2015	In progress

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Attendees	
Chair: Angela Martin (VNSNY)	Steve Chang (NYP)
Alissa Wassung (God's Love We Deliver)	Lauren Alexander (NYP)
Mary Hanrahan (NYP)	Adriana Matiz (NYP)
David Chan (City Drug & Surgical)	David Alge (NYP)
Jean Marie Bradford, MD (NYPSI)	Julie Mirkin (NYP)
Eva Eng (Arch Care)	David Albert (NYP)
Mary Blythe (NYP)	
Sam Merrick (NYP)	

Meeting Objectives	**Time**
1. Review of action items from last meeting	5 mins
2. Ratify Cultural Competency and Health Literacy Strategy	5 mins
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7. Identify action items for next meeting	

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Share project status updates with the committee via e-mail	L. Alexander	10/23/2015	11/20/2015	Completed
Share Julie Mirkin's slides with the committee via e-mail	L. Alexander	10/23/2015	11/20/2015	Completed
Share timeline for organizational deliverables development and Committee review	L. Alexander/I. Kastenbaum	11/9/2015	11/20/2015	Not started
Develop project status dashboard for Committee feedback	L. Alexander/I. Kastenbaum/Co-Chairs	10/23/2015	11/20/2015	Not started

Meeting Minutes:

- A. Martin opened the meeting.
- J. Mirkin presented on Care Transitions to Reduce 30 Day Readmission.
    - Her presentation covered the following:
        - Project objective
        - State requirements
        - The Care Coordination and Transitions of Care Models
        - Workflows for the Transitions of Care Model
        - Measures of success

        - Challenges
        - Next steps
    - Discussion centered around medication access, use of telehealth and medically tailored home-delivered meals as it relates to the work of the project.
- A. Martin presented the Cultural Competency and Health Literacy Strategy for final ratification. E. Eng moved to ratify. Dr. A. Matiz seconded.
- L. Alexander announced that she would share project status updates with the group via e-mail.
- L. Alexander reviewed the status of the Committee's organizational deliverables. She shared that the PMO would be mapping out a timeline for milestone development and approval and she would share this timeline with the Committee once complete.
- L. Alexander discussed next steps for project status reporting. She was interested in learning from the group how they would like to be kept up-to-date on the status of the projects. Options include a qualitative summary approach, a quantitative approach which examines a certain set of metrics, or a combination of the two. The group decided that a combination would be the best approach. Possible indicators to accompany a qualitative summary would include updates on which domain 1 milestones have been achieved, staff recruitment numbers, patient engagement numbers and a sampling of quality metrics. L. Alexander will work on developing a dashboard and share with the group for feedback.
- A. Martin closed the meeting.

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Cultural Competency / Health Literacy Strategy

Background: Much of the NYP PPS service area is comprised of linguistically isolated and culturally diverse ethnic and racial minorities. In response, the NYP PPS has adopted a patient-centered approach to cultural competency, known as the "Culture of One," which is aligned with the National Quality Forum's (NQF) Cultural Competency framework (Reference: A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency, NQF, April 2009). As part of the Culture of One, the NYP PPS realizes that the burden of clear communication and understanding is placed on the provider, not the patient. A patient's unique culture defines the illness experience and the target of effective treatment and care. On the other hand, the culture of a population determines the characteristics of successful public health and community health interventions.

Cultural Competency / Health Literacy Goal: The goal of the NewYork-Presbyterian Performing Provider Cultural Competency and Health Literacy Strategy is to develop a PPS-wide approach that respects diversity, focuses on clear communication, emphasizes the importance of understanding differences and engages the individual. As such, the Strategy will specifically focus on: **(a)** identifying key priority groups experiencing health disparities through a community needs assessment, **(b)** identifying factors to improve access to quality primary, behavioral, and preventive care, **(c)** surveying partners on their cultural competency and health literacy needs **(d)** enhancing communication with the attributed population, **(e)** deploying assessments/tools to assist patients with self-management, **(f)** improving provider and community-based organization's cultural competency**,** and **(g)** leveraging community-based interventions to reduce health disparities and improve outcomes.

Strategy: For Medicaid beneficiaries attributed to the NYP PPS and collaborators participating in the network, the NYP PPS will focus on:

a. **Identifying key priority groups experiencing health disparities through a community needs assessment**
   - **i.** The PPS will conduct a formal community needs assessment every three years, as required by New York State and/or the Attorney General.
   - **ii.** The Clinical Operations Committee (and ratified by the Executive Committee) will make recommendations on the re-allocation of programmatic resources to address identified populations.
   - **iii.** The PPS will collaborate with longstanding CBOs in communities to enhance understanding of community needs.

b. **Identifying factors to improve access to quality primary, behavioral, and preventive care**
   - **i.** The PPS Clinical Operations Committee (and ratified by the Executive Committee) will make recommendations on enhancing access to quality care. A subcommittee of cultural competency and health literacy experts from the PPS network will be developed to guide the work of the Cultural Competency and Health Literacy Strategy.
   - **ii.** The PPS will capture the necessary data to refine cultural competency and health literacy strategies, including (1) disparity sensitive outcomes, (2) measures associated with cultural competency, and (3) participation in relevant training.
   - **iii.** The PPS will measure improvements in levels of cultural competency amongst the workforce and provide feedback to network members, through such methods as patient satisfaction surveys and provider cultural competency pre- and post-tests.

c. **Surveying partners on their cultural competency and health literacy needs so that the PPS can provide support and resources as needed, including**
   - **i.** If and how partners currently provide cultural competency and health literacy training
   - **ii.** How partners currently handle health literacy in their organization

iii. How partners provide interpretation services to their clients

iv. Whether Project Leads have particular needs related to the individual projects (i.e. discharge summaries available in other languages)

d. **Enhancing communication with the attributed population**

i. The PPS will assist members with their interpretation needs.

ii. The PPS will develop a training/tip sheet on how to effectively interact with an interpreter. How to avoid the pitfalls of "false fluency" and refraining from the use of family interpreters or bilingual providers as ad hoc interpreters will be emphasized.

e. **Deploying assessments and tools to assist patients with self-management**

i. The PPS will develop patient portal content, including specialized, relevant, multi-lingual content to improve health literacy such as asthma-related materials for parents of asthmatic children and information about managing multiple chronic diseases for adults.

ii. The PPS will build on existing community forums to conduct outreach to the community around the self-management of conditions in a manner that addresses cultural, linguistic and literacy factors.

f. **Improving provider and community-based organization's cultural competency and health literacy strategies**

i. The PPS will adopt the "Culture of One" program to meet the distinct needs of the community and attributed beneficiaries. This approach treats patients as individuals whose culture is unique and a result of multiple social, cultural and environmental factors and avoids racial or ethnic stereotyping.

ii. A training based on the "Culture of One" curricula will be developed and delivered, which will train network members on best practices in cross-cultural communication. A series of live webinars will be conducted and a recording will be made available through the PPS Web site. In-person follow-up at staff meetings will take place to address any questions that staff may have.

iii. On online eLearning resource on cultural competency, such as Quality Interactions, will be made available to member organizations of the PPS. A webinar will be provided on how to use the resource.

iv. Trainings and resources on working with LGBT populations will be made available to network members.

v. Standards for health literacy will be developed for PPS members, for both written and verbal communication. Project Leads will be trained on health literacy standards and given access to a health literacy consultant to address any questions that arise around creation of written materials. Materials/training on health literacy techniques for delivering verbal information, such as the Teach Back method, will also be made available.

vi. A cultural competency/health literacy page of the NYP PPS Web site will be developed with materials, trainings, resources and assessment tools for PPS members. Tools to assist patients with self-management of conditions will be included. A general resource section as well as project-specific sections will be created.

vii. An overall guiding document for PPS members which outlines best practices for the provision of cultural and linguistically appropriate care will be developed. An attestation process for PPS members to acknowledge the guiding principles will be created.

g. **Leveraging community-based interventions to reduce health disparities and improve outcomes**

i. The PPS will co-invest in an ASCNYC-hosted Peer Training Institute, which will be a PPS center for CHW, Patient Navigator and Health Educator training serving all NYP PPS projects and Network Members.

ii. Culturally competent CHWs will serve as a link between patients and medical/social services. The CHWs will see patients in their homes and document their findings, e.g., psychosocial issues that may be hurdles to the delivery of optimal care and recommendations for referrals to community-based organizations.

AMAZING THINGS ARE HAPPENING HERE

Transitions of Care

Clinical Operations Committee – 10/23/2015

Julie Mirkin, MA RN, Vice President Care Coordination

NewYork-Presbyterian
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2.b.iv: Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions

- **Project Objective:** To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk readmission, particularly patients with cardiac, renal, respiratory, and/or behavioral health disorders.

2.b.iv Transitions of Care State Requirements

#	Requirement
1	Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2	Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post discharge protocols are followed.
3	Ensure required social services participate in the project.
4	Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5	Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
6	Ensure that a 30-day transition of care period is established.
7	Use EHRs and other technical platforms to track all patients engaged in the project.

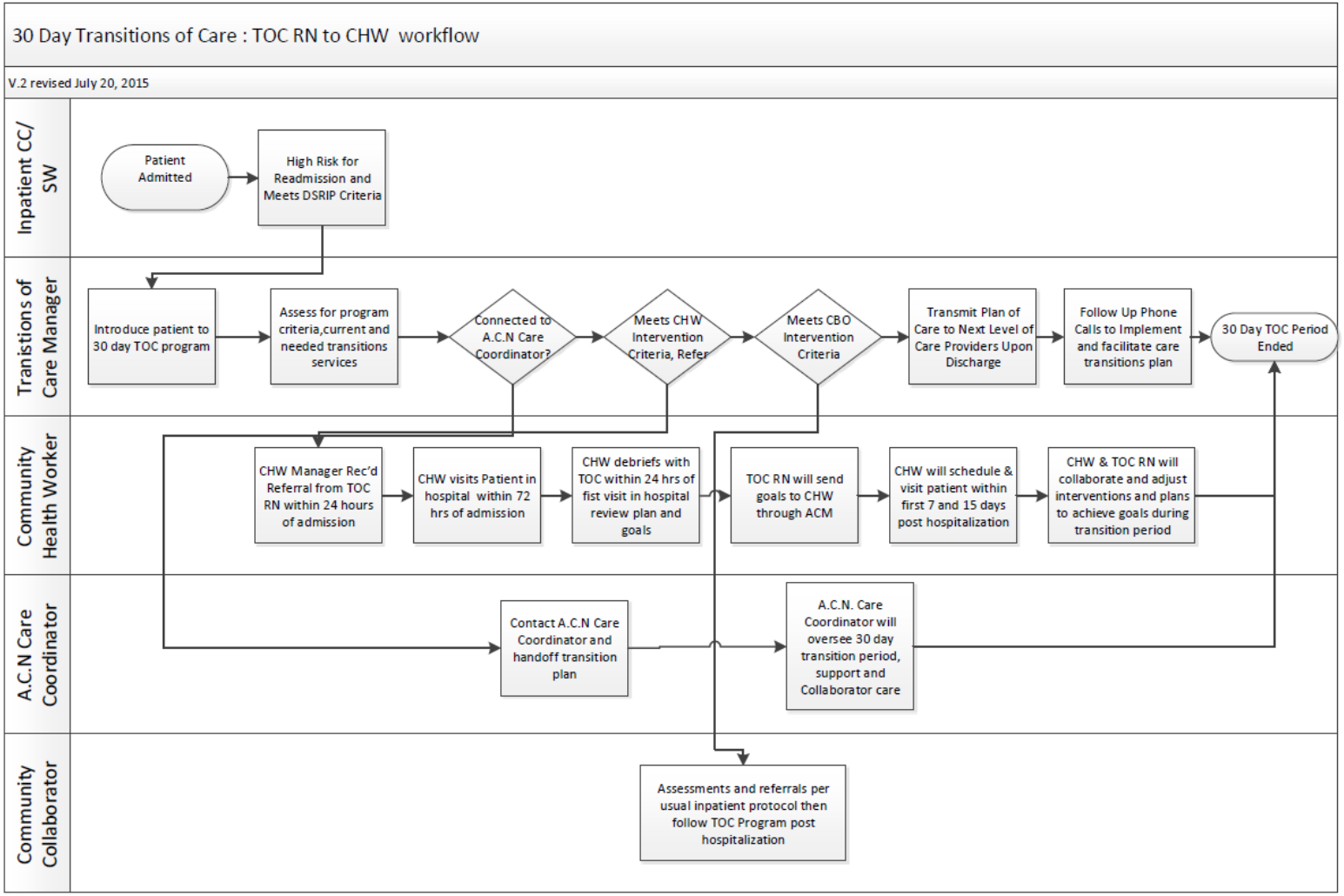
Laying the Foundation: The Care Coordination Model

- Structure
  - Staffing model and scheduling
  - Collaborative practice
    - Interdisciplinary Rounds
    - Eliminating silos
    - Education and training
    - Sense of “urgency”
- Roles and responsibilities
  - Accountability for outcomes
    - Patient
    - Financial
    - Organizational

Laying the Foundation: The Transitions of Care (ToC) Model

- Structure
  - Built on foundation of Care Coordination
  - Includes all Post Acute NYP entities
  - Collaborative practice
  - Warm handoffs
- Roles and responsibilities
  - Transitions of Care RNs (8 FTEs)
  - Community Health Workers (6 FTEs)
  - Pharmacy
- Collaboration with other DSRIP projects

Transitions of Care Model: Workflow between ToC RNs and CHWs



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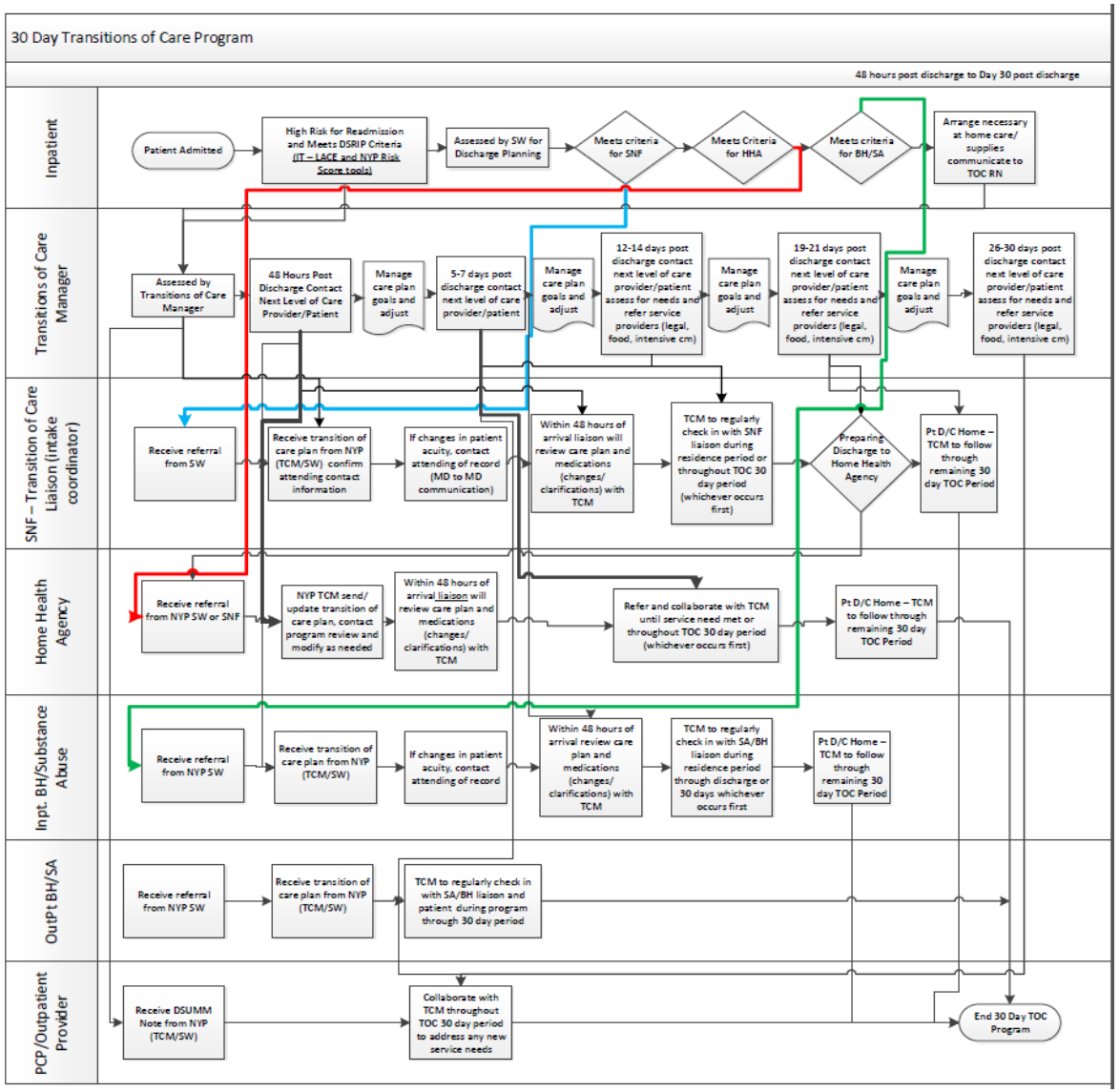
Transition of Care Model: Workflow between ToC RNs, Inpatient, SNFs, HHAs, and PCPs



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Other Activities

- Post Acute strategy
- Preferred partners
- Community Based Organizations
- Readmission Task Force

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Overall Measures of Success

- LOS
- Decrease in Readmissions
- Patient Experience
  - Discharge Planning
  - Transitions of Care
  - Denial Management
- DSRIP Patient Engagement targets
  - Year 1: 150 unique patients
  - Year 2: 1,269 unique patients
  - Year 3: 1,904 unique patients
  - Year 4: 2,538 unique patients

Challenges

- Integrated IT systems
- Risk stratification
- Hand-offs with Community Based Organizations
- Staffing
- Space
- Telehealth
- Discharge planning process

Next Steps

- Refinement of Transitions of Care RN role
  - Identification of patients
  - Patient load
  - Documentation
  - Capturing of data
- Relationship building with CBOs
- Leveraging telehealth
- Leveraging IT
- Implementation of CHW workflow
- PDSA education and training

Tab	Requirement Type	Milestone	Target Completion Dates	Calendar Date	Documentation	Initiating Committee	Status
Governance	Domain 1 Process Measure	Establish a clinical governance structure, including clinical quality committees for each DSRIP project	DY1, Q3	12/31/2015	Clinical Quality Committee charter and committee structure chart Subsequent quarterly reports will require minutes of clinical quality committee meetings to be submitted.	Clinical Operations	**Complete, Not-Submitted**
Cultural Comptency	Domain 1 Process Measure	Finalize cultural competency / health literacy strategy.	DY1, Q3	12/31/2015	Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes. Subsequent quarterly reports will require updates on the implementation of your cultural competency / health literacy strategy.	Clinical Operations	**Drafted, Committee Reviewed**
Governance	Key Issue	Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	DY1, Q4	3/31/2016	Agency Coordination Plan. Subsequent quarterly reports to require updates on implementation of Agency Coordination Plan, including evidence of interaction with local agencies.	Clinical Operations	**Not Started**
Practitioner Engagement	Key Issue	Develop practitioner communication and engagement plan	DY1, Q4	3/31/2016	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee Subsequent quarterly reports will require evidence of ongoing communication and engagement, in line with plan, evidence of active professional peer groups and performance reporting to these groups.	Clinical Operations	**Not Started**

Tab	Requirement Type	Milestone	Target Completion Dates	Calendar Date	Documentation	Initiating Committee	Status
Cultural Comptency	Domain 1 Process Measure	Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	DY2, Q1	6/30/2016	Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches Subsequent quarterly reports will require evidence of training programs delivered. PPSs will need to provide: a description of training programs delivered and participant-level data, including training outcomes.	Clinical Operations	**Not Started**
Practitioner Engagement	Key Issue	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	DY2, Q1	6/30/2016	Practitioner training / education plan. Subsequent quarterly reports will require evidence of training. PPSs will need to provide: a description of training programs delivered and participant-level data, including training outcomes.	Clinical Operations	**Not Started**
Pop Health	Key Issue	Develop population health management roadmap	DY2, Q2	9/30/2016	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities. Subsequent quarterly reports will require an update on the implementation of this roadmap.	Clinical Operations	**Not Started**
Clinical Integration	Key Issue	Perform a clincial integration 'needs assessment'	DY2, Q2	9/30/2016	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	Clinical Operations	**Not Started**

Tab	Requirement Type	Milestone	Target Completion Dates	Calendar Date	Documentation	Initiating Committee	Status
Clinical Integration	Key Issue	Develop a Clinical Integration Strategy	DY3, Q1	6/30/2017	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools Subsequent quarterly reports will require an update on the implementation of this strategy.	Clinical Operations	**Not Started**

Scorecard
Improvement
Attribution
Network
Value

Domain Scorecard

Domain 3.a > 3.a.i Integration of primary care & behavioral health

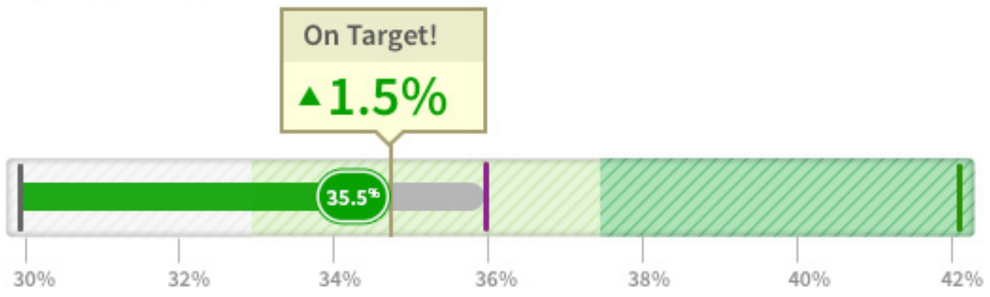
Measures as of DEC. 30, 2015 | Month 7 of 12

Baseline | Annual Goal | Annual High Perf. Goal | Monthly Target Zone | Monthly High Perf. Zone

PPV (for persons with BH diagnosis) per 100

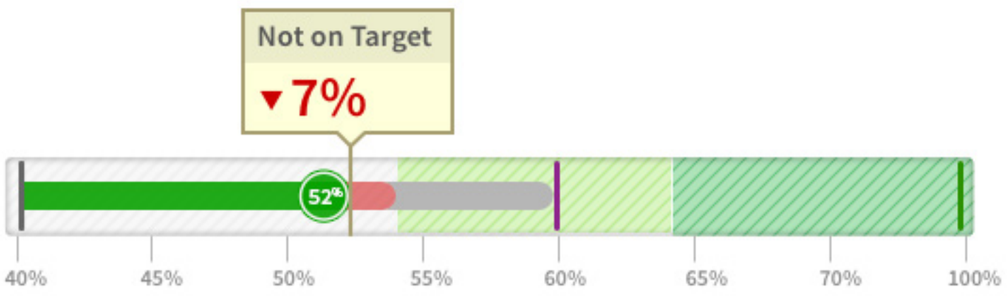
Explore >

Cardio Monitoring for People w/ Cardio Disease and Schizophrenia



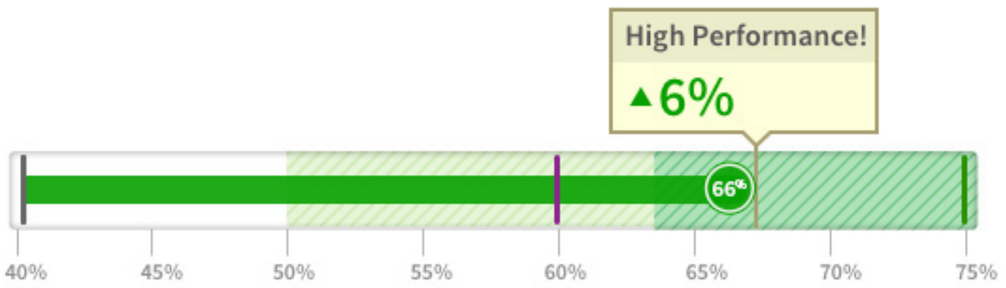
Explore >

Diabetes Screening for People w/ Schizo./BPD Using Antipsychotic Med.



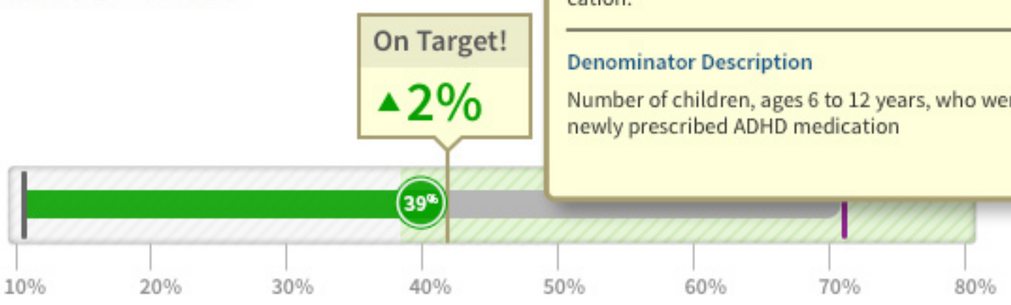
Explore >

Antidepressant Medication Management– Effective Acute Phase Treatment



Explore >

Follow-up care for Children Prescri... Initiation Phase



Explore >

Description of Measures

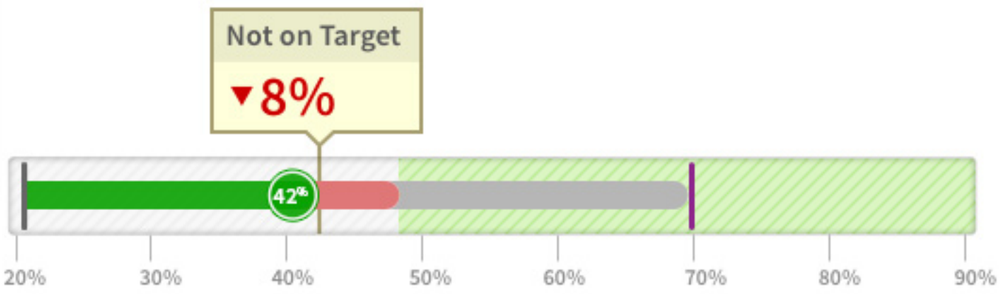
Numerator Description

Number of children who had one follow-up visit with a practitioner within the 30 days after starting the medication.

Denominator Description

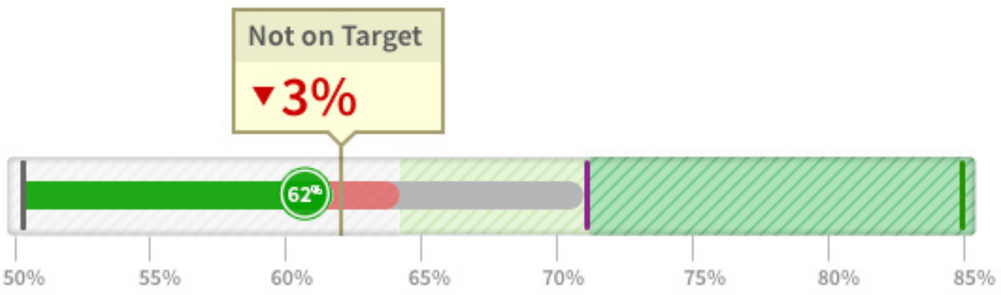
Number of children, ages 6 to 12 years, who were newly prescribed ADHD medication

Follow-up care for Children Prescribed ADHD Medications - Continuation Phase



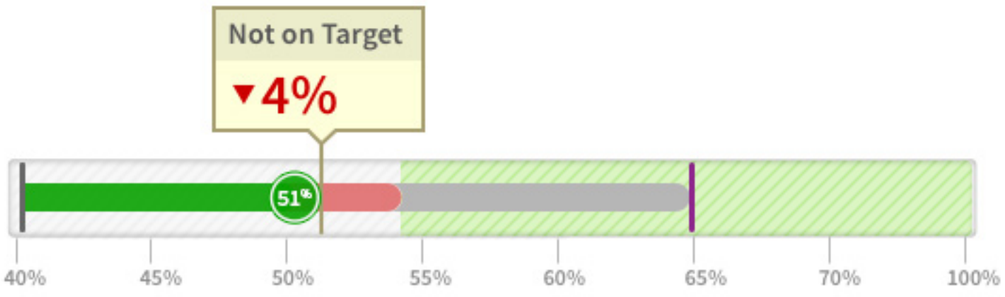
Explore >

Follow-up after hospitalization for Mental Illness – within 7 days



Explore >

Screening for Clinical Depression and follow-up



Explore >

Scorecard
Improvement
Attribution
Network
Value

Domain Scorecard

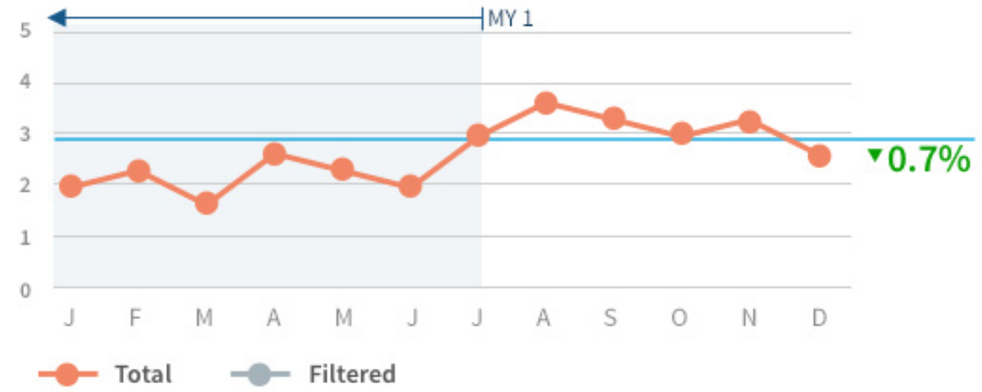
Domain 3.a > 3.a.i Integration of primary care & behavioral health > PPV (for persons w/ BH diagnosis) per 100

Measures as of DEC. 30, 2015

PPV (for persons with BH diagnosis) per 100

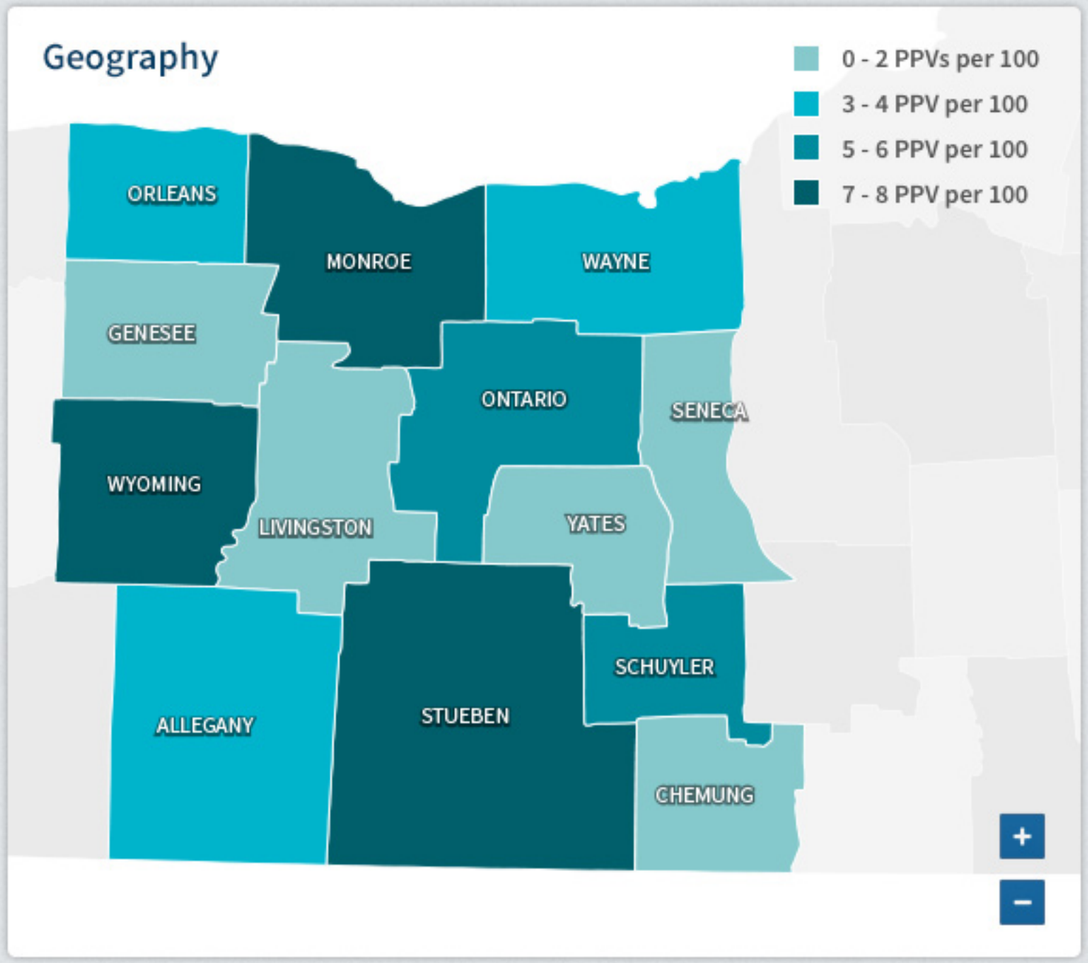
Trend

Range: Past 12 Months



Gender: All | Age Group: All | CRG: All

Geography



Score Distribution

Show: Bottom 10

Health Home > click PCP name or member count to view details

Health Home	# Members	PPV (for persons with BH diagnosis)
Anthony L. Jordan Health Corp.	117	33
Beacon Healthcare Strategies, LLC	45	22
Catholic Charities Community Serv.	5	19
Catholic Family Center	16	18
Coordinated Care Services, Inc.	42	16
Delphi Drug and Alcohol Council	54	14
DePaul Community Services	21	13
East House Corporation	19	12
Epilepsy-Pralid, Inc.	23	12
GR Health Home Network	12	12

Export Data

Prev. 10 1 2 3 4 Next. 10

Scorecard
Improvement
Attribution
Network
Value

Domain Scorecard

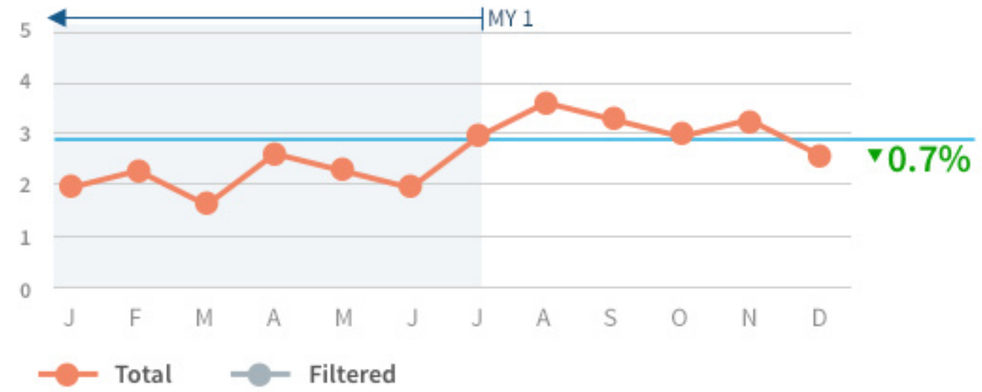
Domain 3.a > 3.a.i Integration of primary care & behavioral health > PPV (for persons w/ BH diagnosis) per 100

Measures as of DEC. 30, 2015

PPV (for persons with BH diagnosis) per 100

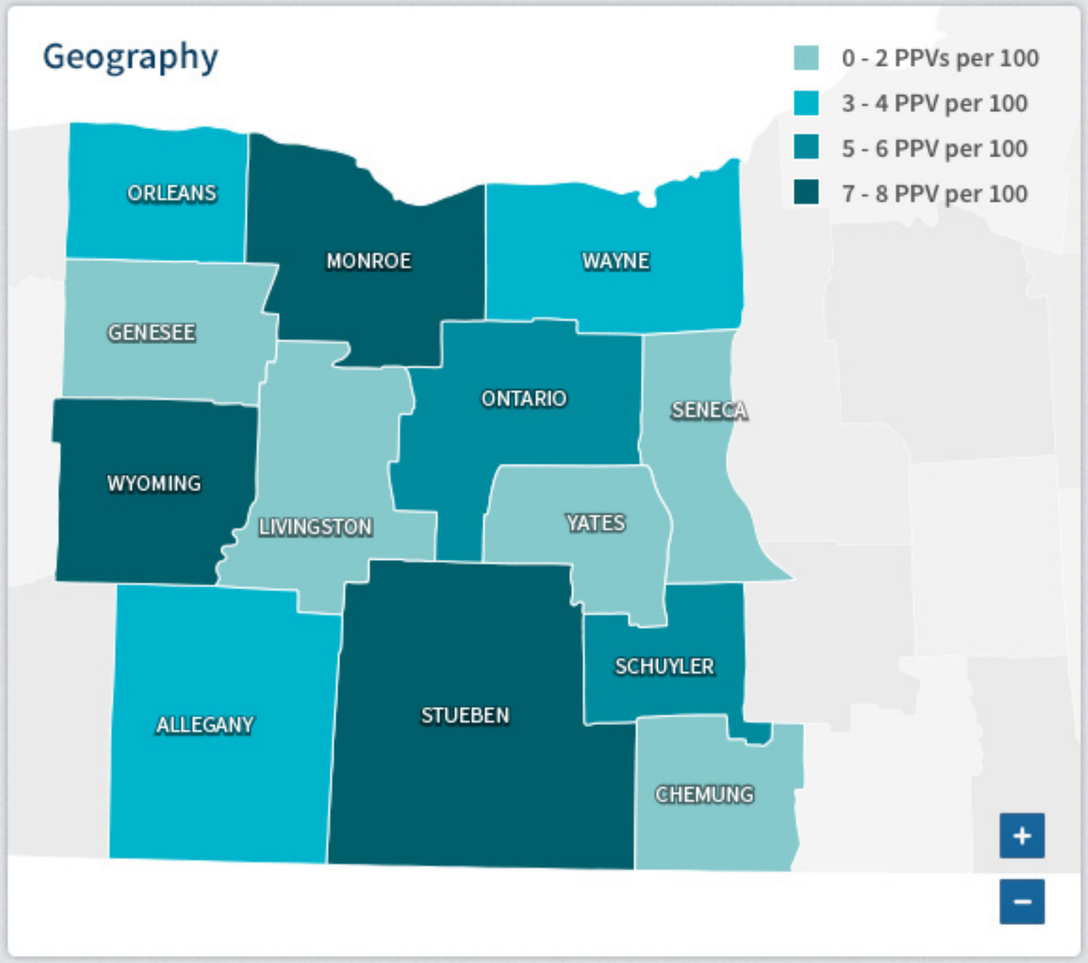
Trend

Range: Past 12 Months



Gender: All | Age Group: All | CRG: All

Geography



Score Distribution

Show: Bottom 10

PCP | *click PCP name or member count to view details*

Provider Name	# Members	PPV (for persons with BH diagnosis)
Dr. Carl Tucker	117	23
Dr. Guillermina Ashman	45	12
Dr. Christena Pilson	5	9
Dr. Harvey Gudino	16	8
Dr. Maybelle Wiseley	42	6
Dr. Kirsten Footman	54	4
Dr. Otilia Rosel	21	3
Dr. Earle Castro	19	2
Dr. Erlinda Visser	23	2
Dr. Brandee Vaughn	12	2

Export Data

Prev. 10 1 2 3 4 Next. 10

Domain Scorecard > Domain 3.a > 3.a.i I > PPV (for persons w/ BH diagnosis) per 100 > Dr. Carl Tucker

Scorecard
Improvement
Attribution
Network
Value

Dr. Carl Tucker

Export for SIM

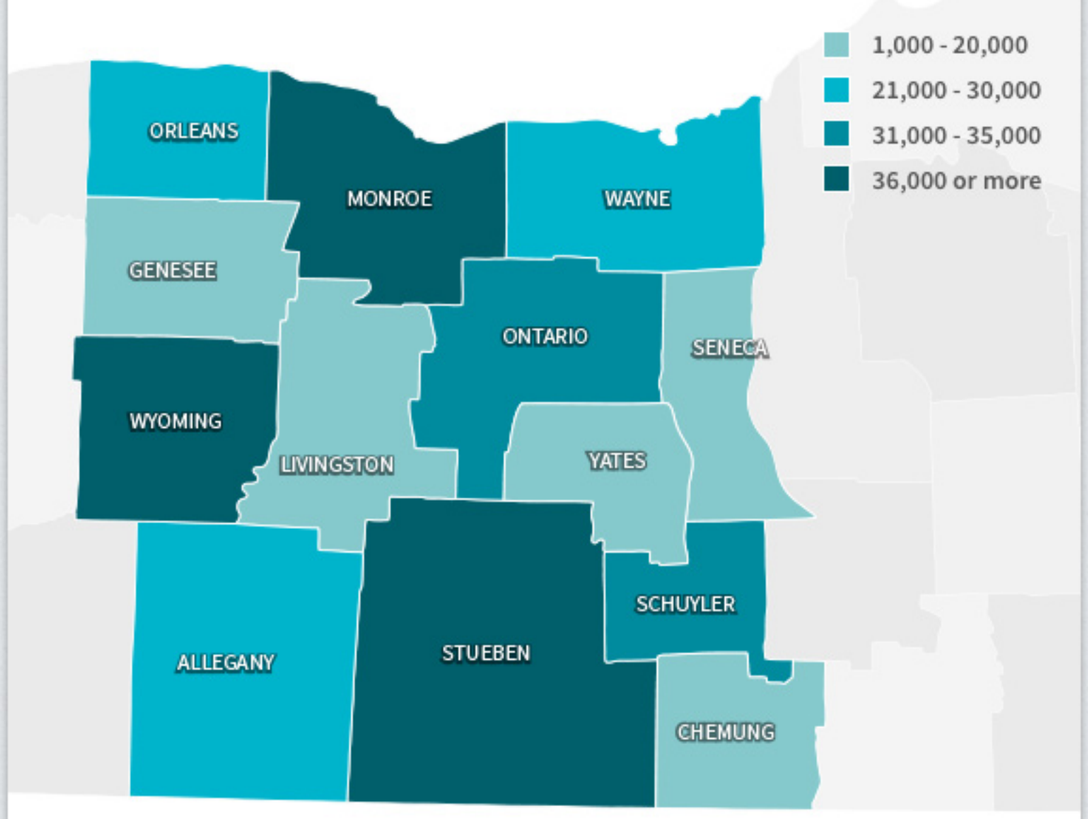
Members	CIN	PPVs ▼	Date of Birth	PCP	Health Home	Attribution Length
Rosendo Fallen	FF34593A	9	29/08/1945	Dr. Carl Tucker	HCR	5M
Blossom Fye	GR23950A	8	27/06/1952	Dr. Carl Tucker	Lake Shore Behavioral Health	3M
Mollie Ko	FR50732S	2	26/11/1954	Dr. Carl Tucker	GBUAHN	5M
Era Bickley	RE50320A	1	03/05/1961	Dr. Carl Tucker	Mental Health Services of Erie County	3M
Zandra Ulmer	FR45230B	1	24/06/1971	Dr. Carl Tucker	Niagara Falls Memorial Medical Center	4M
Vi Stayer	DF49060F	1	01/01/1974	Dr. Carl Tucker	HCR	11M
Minta Barnett	DN34829S	0	13/06/1978	Dr. Carl Tucker	Lake Shore Behavioral Health	2M
Shantay Devillier	ER43960C	0	10/01/1981	Dr. Carl Tucker	GBUAHN	5M
Iris Dymond	RG59306T	0	27/03/1981	Dr. Carl Tucker	Mental Health Services of Erie County	5M
Aretha Mable	DH43859O	0	26/10/1989	Dr. Carl Tucker	Niagara Falls Memorial Medical Center	3M
Laurine Wydra	RE45682A	0	15/07/1991	Dr. Carl Tucker	HCR	5M
Toshiko Acey	FR56920A	0	06/01/1994	Dr. Carl Tucker	Lake Shore Behavioral Health	2M
Jeffery Silvia	ER43685W	0	03/11/1998	Dr. Carl Tucker	GBUAHN	2M
Ginette Grieves	ER54829K	0	28/09/2004	Dr. Carl Tucker	Mental Health Services of Erie County	2M
Krystle Hepfer	KU73864T	0	16/02/2008	Dr. Carl Tucker	Niagara Falls Memorial Medical Center	6M
Ira Dessert	RT56925U	0	19/01/2011	Dr. Carl Tucker	HCR	4M
Dawna Vincent	TI83768B	0	14/11/2011	Dr. Carl Tucker	Lake Shore Behavioral Health	11M

Scorecard
Improvement
Attribution
Network
Value

Attribution

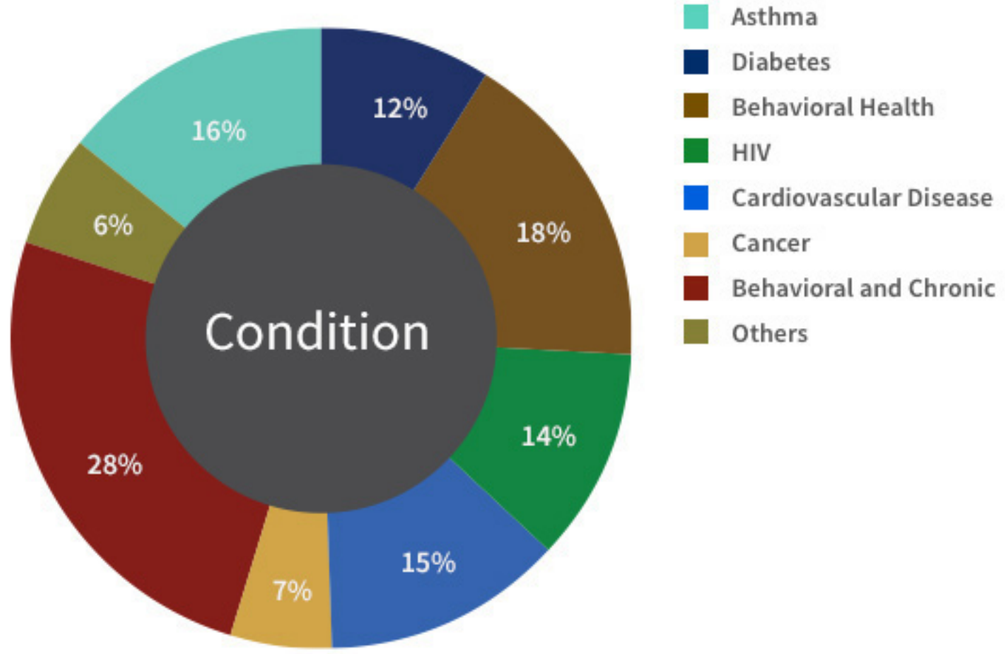
Atrribution as of DEC. 30, 2015

Geography



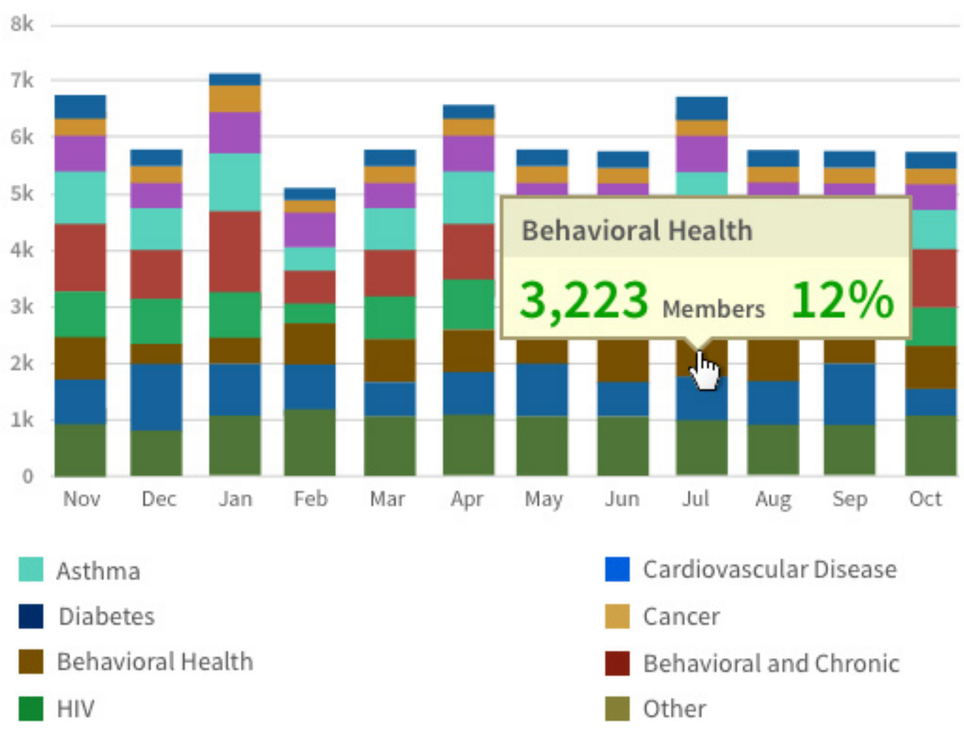
Characteristics

Condition



Condition of Attributed Members Over Time

% #



Member Distribution

PCP — *click PCP name or member count to view details*

Provider Name	# Members
Dr. Carl Tucker	117
Dr. Bernadette McGrath	55
Dr. Joshua King	43
Dr. Anna Hemmings	36
Dr. Jan Langdon	27
Dr. Stephanie Coleman	22
Dr. John Mackenzie	22
Dr. Luke Thomson	18
Dr. Eric Churchill	17
Dr. Rose Parsons	17

Export Data

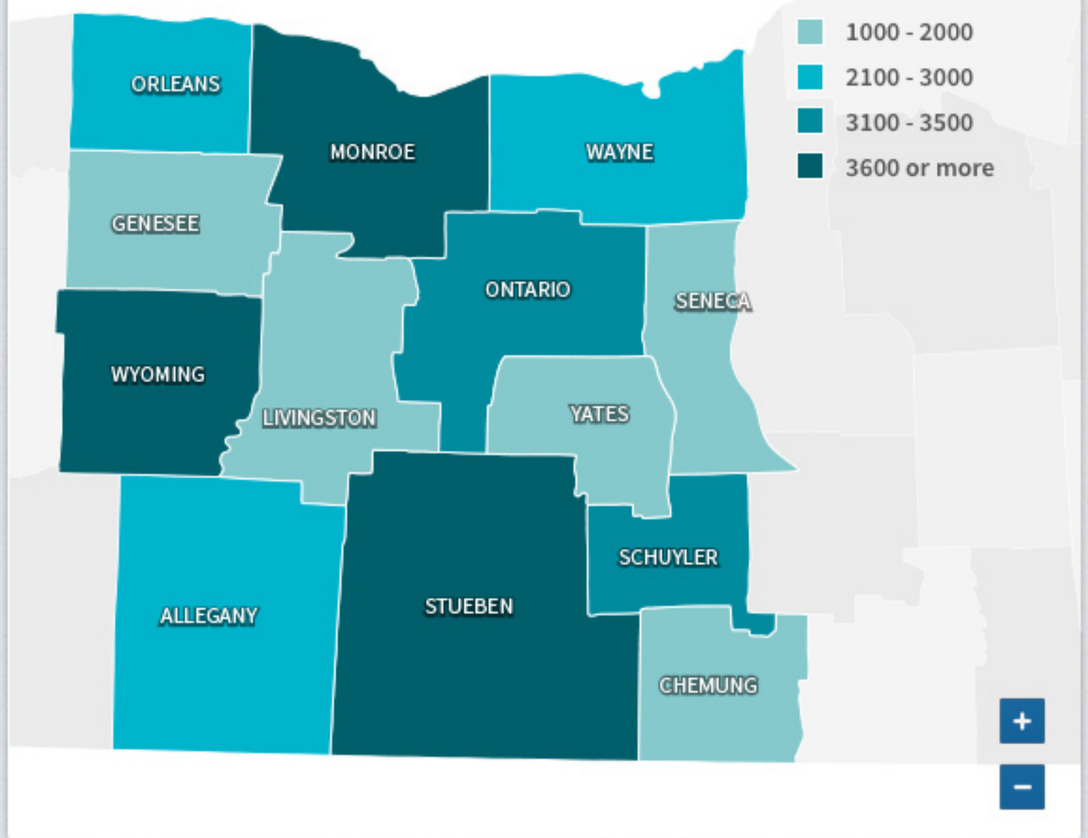
Prev. 10 1 2 3 4 Next. 10

Scorecard
Improvement
Attribution
Network
Value

Network

Network as of DEC. 30, 2015

Geography



Provider Counts

Classification

Classification	Provider Count
Non-PCP Practitioner	446
Primary Care Provider (PCP)	207
Behavioral Health	109
Case Management/Health Homes	189
Hospital	156
Pharmacy	145
Substance Abuse	144
Clinic	89
SNF/Nursing Home	84
Hospice	78

Export Data

Prev. 10 1 2 3 4 Next. 10

Visits In and Out of PPS

Date Range 4 2014 Through 4 2014

	Primary Care	Emergency Room	Inpatient
In PPS	13,522 90.5%	1,223 98%	115 90%
Out of PPS	1,432 9.5%	122 2%	2 10%
Total	14,954	1,345	117

NYP PPS Project Update
3.e.i. HIV COE

Please complete the following questions for your project(s) – submitting one for each project – by Wednesday, October 21st. This should reflect you activity between April 1, 2015 and September 30, 2015. You do not need to provide more than 2-3 sentences for each prompt.

Please provide an update on recruitment and training:

This HIV Center of Excellence project has successfully recruited a Program Manager and a Data Analyst. Based at the Comprehensive Health Program (CHP) on the Columbia Campus of NYP, we have hired an Attending Physician, an Adult Nurse Practitioner, a Care Coordinator, and a Nurse Care Manager. A Practice Care Facilitator was hired to support the Center for Special Studies (CSS) at Cornell Campus of NYP. We are currently interviewing for the Psychiatric NP and another physician for which we will need to identify additional funding to reach 1.0 FTE. In addition to the standard orientation, various staff have undergone training in the following areas: NYS End the Epidemic Initiative, IT systems, HIV/HCV prevention, care and treatment, HIV counseling and testing, population health, care management, use of social media to engage at risk youth, and general coaching and leadership.

Please provide an update on project implementation:

The project has focused initially on expanding access through the addition of a full-time nurse practitioner. She started on September 8th, 2015 and already has a caseload of 25-30 HIV primary care patients and has seen a steady stream of walk-in patients. Workflow development has focused on in-patient to out-patient transitions of care, engagement of new patients at risk for or living with HIV, and reengagement of existing patients that are lost to follow up (LTFU). The Practice Care Facilitator at CSS has started to work with the Social Work staff to coordinate efforts to reengage patients that are LTFU. The Care Coordinator, as part of the inpatient ID service team, has been actively supporting patients requiring transitions of care support and linking them to ambulatory medical case management services as needed. Next steps are to focus on integration of the project in the emergency department as well as integration of the RN Care Manager into the other Ambulatory Care Network sites to facilitate linkage and engagement of patients who could benefit from COE services.

Please provide an update on the use of IS In your project:

Randi Scott, DSRIP Data Coordinator who started on July 27th, 2015, has been actively working on a number of population health registries including the following:

1. Enhancements to an existing population health registry to include surveillance data on HIV, HCV and STIs across the Columbia Campus Ambulatory Care Network to facilitate identification of patients at risk or living with HIV/HCV that could benefit from care and treatment services in the COE.
2. Development of a new registry to support DSRIP work flows, in addition to other population health initiatives at CSS.

NYP PPS Project Update
3.e.i. HIV COE

3. Development of an NYP facility level HIV care cascade, consistent with the New York State End the Epidemic initiative to identify and address gaps.

In addition, the project has started a pilot of a new structured note to support patients needing transitions of care support from the emergency room or in-patient setting back to ambulatory care.

Please provide an update on the engagement of collaborators in your project:

This project has engaged six core community collaborators that offer a broad range of services with a long track record of meeting the needs of the target population. These partners have locations that extend from 20th street to 181st street of Manhattan and a catchment area that reaches into all five boroughs of New York City. Together they form a DSRIP Steering Committee that have met monthly since June, 2015 and covered topics which have included the following: shared mission and vision, DSRIP requirements and measurements, overview of the DSRIP sub-contracting process, using technology to create a user friendly resource map to support coordination of care, key information system functions to support effective cross-agency coordination of care, and presentations of the peer educator/navigator model and of mobile Apps to engage high risk men who have sex with men and to support treatment adherence. In addition there have been numerous smaller meetings with the leadership of each of the core collaborating partners to develop the staffing and intervention models to support DSRIP goals with anticipation of executing the subcontracts over the next month and the waivers allowing for colocation of Article 28 services.

Please describe your top three successes to-date:

1. Engagement of core community collaborators around a shared mission (as described above) into what we hope is a sustainable model beyond DSRIP.
2. Successful recruitment of all but one of the staff to enhance access, engagement, retention and care coordination in support of patients served by the Center of Excellence.
3. Significant progress in planning three population health registries to support DSRIP goals at both the Cornell and Columbia Campus of NYP.

Please describe your top three challenges to-date:

1. Recruitment of a psychiatric nurse practitioner was complicated by the last minute withdrawal of an accepted offer. As of the end of this reporting period, interviews were underway for another promising candidate.
2. Securing appropriate space for new staff. We are hoping that approval of the capital budget will provide necessary resources to address this.
3. Access to appropriate data to measure and report on scale and speed. This will hopefully be resolved soon through on-going discussions with the DOH and KPMG.