NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	1/22/16, 9-10am	**Meeting Title**	NYP PPS Clinical Operations Committee
Location	Heart Center Room 3	**Facilitator**	Dr. Emilio Carrillo, Sandy Merlino
Go to Meeting	https://global.gotomeeting.com/join/158738573	**Conference Line**	Dial +1 (646) 749-3122 Access Code: 158-738-573

Invitees	
Chair: Sandy Merlino (VNSNY)	**Chair:** Emilio Carrillo, MD (NYP)
Alissa Wassung (God's Love We Deliver)	Tamisha McPherson (Harlem United)
David Pomeranz (Hebrew Home)	Lydia Isaac (NYC DOHMH)
David Chan (City Drug & Surgical)	Maria Lizardo (Northern Manhattan Improvement Corporation)
Jean Marie Bradford, MD (NYPSI)	Susan Wiviott (The Bridge)
Eva Eng (Arch Care)	
Bill Mead (St. Mary's Hospital for Children)	

Meeting Objectives	**Time**
1. Review of action items from last meeting	5 mins
2. Project Report: *Adult Ambulatory ICU* (Felicia Blaise)	15 mins
3. Project Status Reporting (Tiffany Sturdivant-Morrison)	15 mins
4. Public Sector Agency Coordination Plan (Tiffany Sturdivant-Morrison)	10 mins
5. Symposium Updates • Collaborator Symposium (Sandy Merlino) • PCMH Symposium (Dr. Emilio Carrillo)	5 mins
6. Cultural Competency/Health Literacy Strategy Update (Dr. Emilio Carrillo)	5 mins
7. Identify action items for next meeting	5 mins

Action Items				
Description	**Owner**	**Start Date**	**Due Date**	**Status**
Share new CMS rule regarding discharge	I. Kastenbaum	12/18/2015	1/15/2016	Not started

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Attendees	
Chair: Sandy Merlino (VNSNY)	**Chair:** Emilio Carrillo, MD (NYP)
Alissa Wassung (God's Love We Deliver)	Susan Wiviott (The Bridge)
Adriana Matriz (NYP)	Lydia Isaac (NYC DOHMH)
David Chan (City Drug & Surgical)	Tiffany Sturdivant-Morrison (NYP)
Jordon Foster (NYP)	Joseph Caseres (City Drug & Surgical)
Felicia Blaise (NYP)	Sam Merrick (NYP)
Elaine Fleck (NYP)	

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Action Items				
Description	**Owner**	**Start Date**	**Due Date**	**Status**
Discussion of a risk assessment tool at a future meeting	E. Carrillo/S. Merlino	1/22/16		Not started
Schedule meeting to discuss pharmacy engagement	PMO	1/22/16	2/17/2016	Complete
Revise Public Sector Template	T. Morrison	1/22/16	3/31/2016	In progress
Update on CC/HL strategy at next meeting	E. Carrillo	1/22/16	2/26/16	Not started

MINUTES

- Dr. E. Carrillo opened the meeting and reviewed the minutes and action items from the last meeting.
- Dr. E. Fleck presented on the Adult Ambulatory ICU project. She highlighted this project as being an opportunity to reach the sickest of the sick patients and implement a population health management strategy for the Ambulatory Care Network. She covered the following:
    - Project overview for the Adult Ambulatory ICU
    - Project personnel
    - Patient population identification and focus
    - Use of integrated visit model
    - Engagement with collaborator organizations
    - Successes and challenges
    - S. Merlino and A. Wassung both stressed the need for a risk assessment tool. Both parties agreed to share their organization's practices at a Clinical Operations Committee meeting. Dr. E. Carrillo suggested that D. Meyer be a part of this meeting.

  - D. Chan expressed interested with learning more about the project and being more involved. Dr. Carrillo asked the PMO to work with City Drug & Surgical to schedule meetings around pharmacy engagement.
- T. Morrison presented on the Project Status Report and the Public Sector Agency Template. It was suggested to add information on NYCHA and NYCDOHMH to the template. L. Isaac was asked to provide appropriate contacts.
- The following action items were identified, including:
  - Revision of the Public Sector Agency template
  - Update on the Cultural Competency and Health Literacy Strategy at the next meeting
  - Discussion of a universal risk assessment
  - Developing relationships with key collaborators
- The meeting was adjourned.

AMAZING THINGS ARE HAPPENING HERE

DSRIP
Adult Ambulatory ICU
Project Overview

January 22th, 2016

Elaine Fleck, MD, MPH
Felicia Blaise, MPH, MA

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DSRIP Adult Amb. ICU Overview

Focus:

1. Identifying and risk-stratifying ACCN (Adults with Complex Care Needs) patients to provide the appropriate level of resources and interventions

2. Maximizing patient care team roles and delivery of care to create a patient focused experience at the PCMH site, linking to community-based organizations and specialties

3. Developing enhanced IS-enabled capabilities to support population management of ACCN population and to enhance connectivity throughout the continuum of care. **(Community Based Organizations)**

4. Enhance disease management and preventative patient education

Commitment:

The Ambulatory ICU project will provide 2+ distinct services to our patients annually by the end of DSRIP Year 3. Approximately 8,500 of Adults with ACCN (Adults with complex care needs) with a relationship with the NYP/CU Ambulatory Care Network practices. (54,000 patients in the ACN)

Adult Amb. ICU Personnel

Position	ACN	DSRIP	Total
RN CM (Adult)	4	2.5	6.5
Behavioral Health Care Manager (SW)	1	1	2
Community Health Workers		3	
Depression Care Manager	2	1	3
Patient Navigator		1	
Panel Manager		TBD	

Status: Fully staffed as of December 2015

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How Do We Identify Our Population?

- Patients at highest risk for recurrent ER and inpatient admissions
  - Patients with 2 or more chronic conditions seen in the last 12 months with a combination of 4 or more ER and INP visits.

- Deliver Population/Patient based Data via Registry: Amalga/Tableau
  - West ACN Population: Patients seen in PCMH in last 12 months
    - PCMH Primary – 95 % of patients identified with primary
    - Diagnosis – chronic conditions ever
    - ER admissions/IP admissions/Risk of rehospitalizations
    - Clinical Data
    - Future: Expansion to social determinants of health

Focus: Highest Risk and High Risk

- Interdisciplinary Rounds
  - Weekly Reports of patients hospitalized and in ER
  - Entire Staff involved
  - RN Care Manager plays key role
  - Evaluate if the candidate for Health Home
  - Invite CBOs into IDTs to educate staff and create warm handoffs

    Scribe to ensure action items followed up
- Action items with identified patient care team staff SW, DSME, CHW, CBO's (substance abuse, behavioral health), MA, PFA

Integrated Visits: Adults with Chronic Care Needs(ACCN)

Comprehensive Plan of Care for High Risk Patients

Goals

- To improve the quality of health of patient with chronic complex care needs
- To reduce inpatient, emergency room visits, and/or "ambulatory sensitive admissions"
- To build a network of care providers to include support of providers in the community.
- To improve care-team satisfaction

- **Patient Care Team:** PFA, MA, RN, BHCM, CM, CHW, SW, Nutritionist, Pharmacist, Therapist, Physician.

Community Based Organizations

- Exploring options with a variety of community based organizations
- Categories:
  - Behavioral Health
  - Health Homes/ Care Coordination
  - Substance Abuse
  - Pharmacy

WINS

- Hiring All Staff
- Implementation of Interdisciplinary Rounds at AIM + Other ACN Sites
- Identification of IT Needs
  - SCM
- Initial meetings with CBO's

CHALLENGES

- Provider Reports / Registry
- Panel Manager
- ED-Alerts
- Vendor Credentialing
- Implementation of IT Needs
- Integrating additional staff and CBO organizations.

Questions and Discussion

Thank You!

Contact Us:

Elaine Fleck – emf12@cumc.columbia.edu
Felicia Blaise – feb9021@nyp.org

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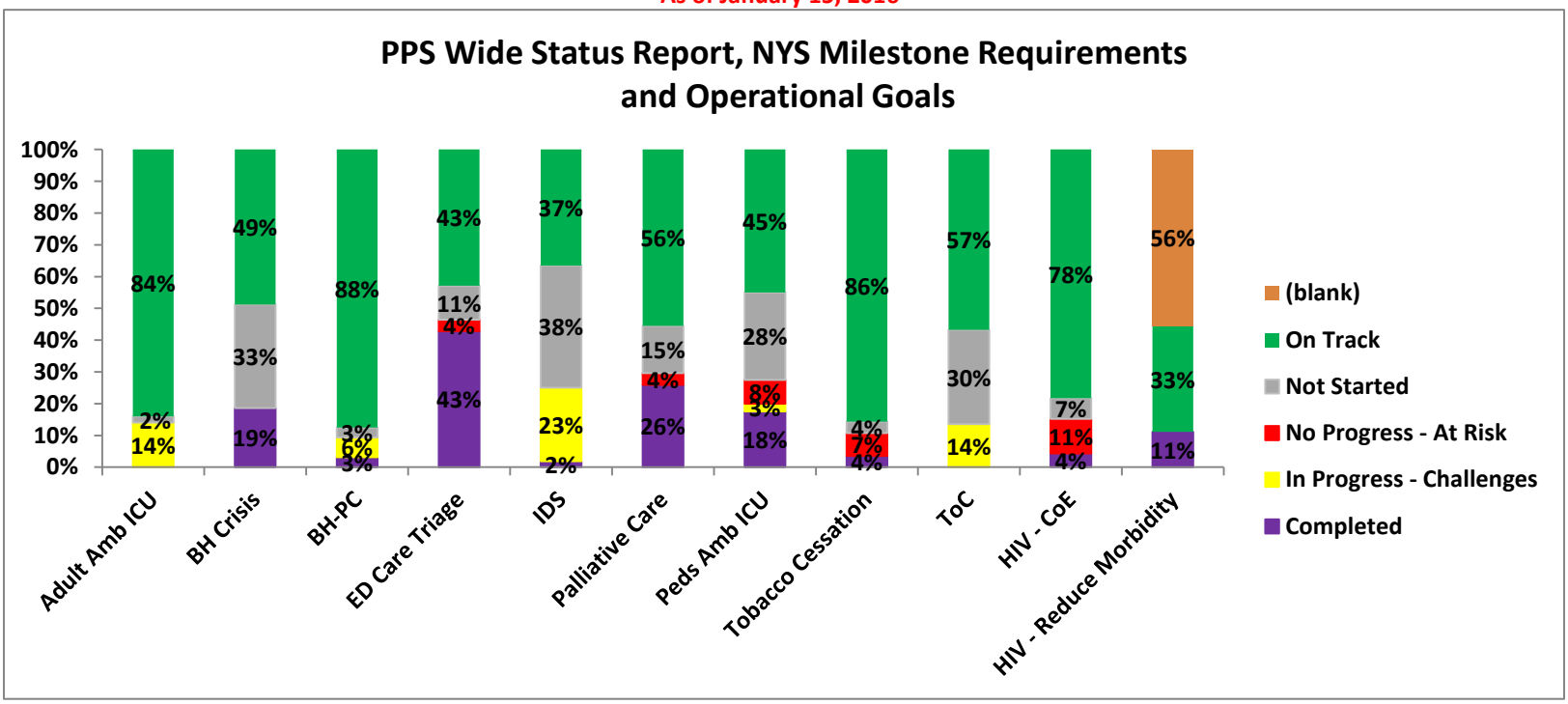
DSRIP Project Status Update

As of January 15, 2016



Data Highlights

- 58% reported "On Track"
- 10% reported "Challenges"
- 3% reported "At Risk"
- 11% reported "Completed"
- 19% reported "Not Started"

Cross Project Successes

- Great Collaborator Symposium (All)
- Great PCMH Symposium (All)
- Submission of proposed changes to SCM Tobacco screens (Tob)
- Successful meeting with St. Marys Home for Children (Peds)
- Fully Staffed (Adults)
- Palliative Care MD is onboard

Challenges

- Care Management / Health Homes - All
  - Develop process for bottom up referrals and coordination of HH with DSRIP projects
- Universal CM Assessment needs to be finalized and workflows developed to not duplicate efforts - All
- Notifications (ED and Inpatient alerts) to ACN Providers re: utilization - IDS
- Care plan transmission: what defines a care plan? Who should it be transmitted to? Consistent Care Plan needed across CM (ToC)
- Pharmacy Engagement: Need to define the medication management challenges, determine whether an IP or OP engaged pharmacy is needed and begin working with them. Med management is one of the important factors in reducing readmission (ToC)
- Onboarding collaborators to Healthix
- Developing cross agency / cross project workflows

Planning for DSRIP Year 2

- ED Alerts / Event Notification
- Program Membership / Patient Registries
- Interim Evaluation
- Healthix
- Health Homes
- Integration into the PCMH Model
- Workflows
- CHW
- Care Management