NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	4/22/16, 9-10am	**Meeting Title**	NYP PPS Clinical Operations Committee
Location	1HN-144	**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)	Amy Shah (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	2 mins
2. Update on the Cultural Competency/Health Literacy Workgroup	5 mins
3. Presentation on Healthix, Patricia Hernandez	15 mins
4. Review of Project Status Report, Tiffany Sturdivant-Morrison	10 mins
5. Presentation on the ED Care Triage project, Dr. Peter Steel	25 mins
6. Identify action items for next meeting	2 mins

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Share information about post-acute care workgroup	J. Mirkin	3/25/16	5/27/2016	In progress
Invite P. Hernandez to upcoming meeting to present on Healthix	L. Alexander	3/25/16	4/22/2016	Complete
E-mail project status report and process/outcome metrics to group	L. Alexander	3/25/16	4/12/2016	Complete
PMO to consider development of patient education materials around DSRIP	PMO	3/25/16	--	In progress
F/U at next meeting on March 2016 project status report with regard to HIV Centers of Excellence	T. Sturdivant-Morrison	3/25/16	4/22/2016	Not started
Finalize Practitioner Engagement Milestones based on Committee feedback	L. Alexander and I. Kastenbaum	3/25/16	4/8/2016	Complete

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Attendees	
Chair: Sandy Merlino (VNSNY)	**Chair:** Emilio Carrillo, MD (NYP)
Alissa Wassung (God's Love We Deliver)	Mary Hanrahan (NYP)
Peter Steel (NYP)	Amy Shah (NYC DOHMH)
David Chan (City Drug & Surgical)	Tiffany Sturdivant-Morrison (NYP)
Jean Marie Bradford, MD (NYPSI)	Susan Wiviott (The Bridge)
Eva Eng (Arch Care)	Patricia Hernandez (NYP)
Sam Merrick (NYP)	

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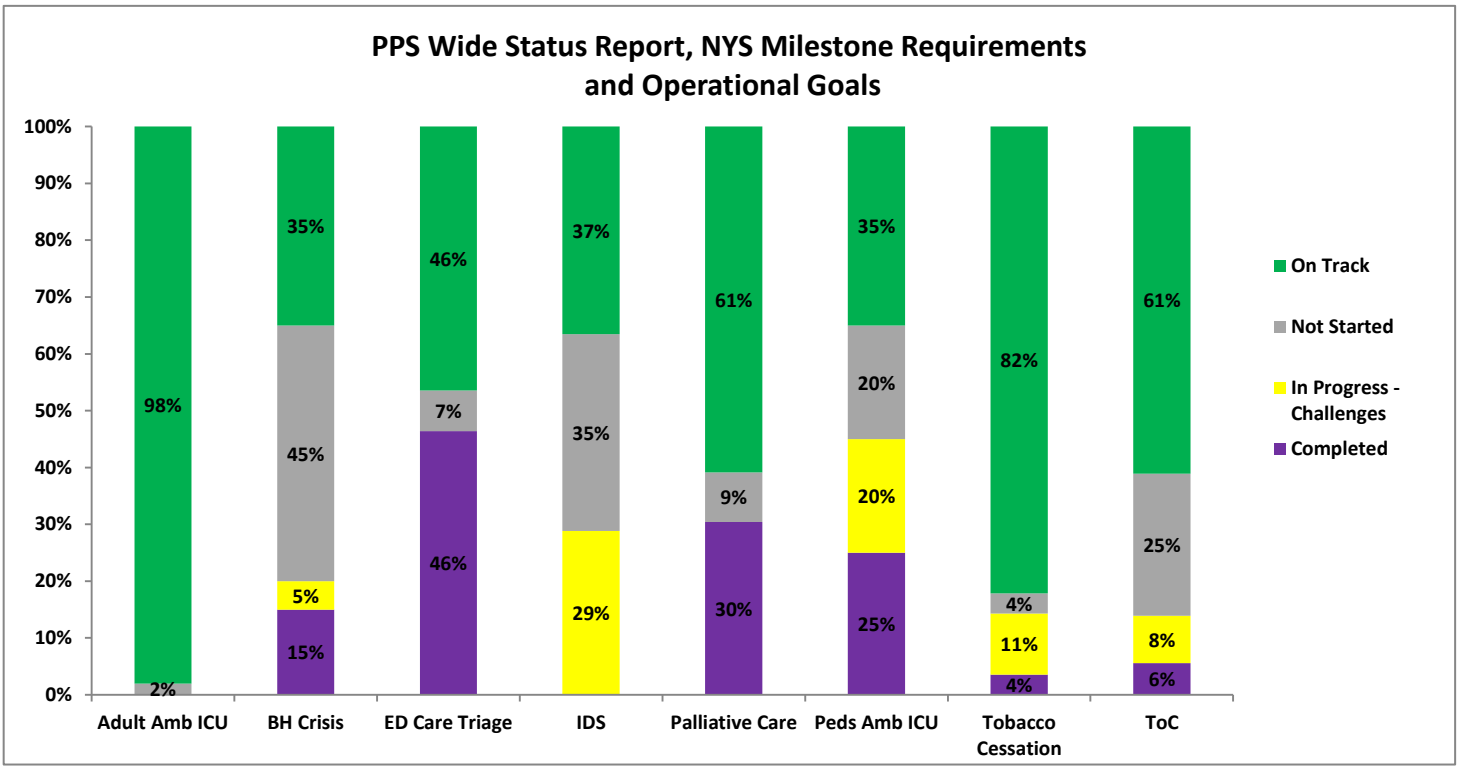
Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Invite P. Hernandez to next meeting to finish Healthix presentation	L. Alexander	4/22/2016	5/27/2016	Complete
Send Healthix questions in advance of P. Hernandez presentation	Committee Members	4/22/2016	6/17/2016	In progress

Project Status Update
As of April 21, 2016

Excludes BH-PCP, HIV-COE, and HIV-MOR



Data Highlights

- 62% reported "On Track"
- 9% reported "Challenges"
- 12% reported "Completed"
- 17% reported "Not Started"

Ongoing Challenges

All

- Implement and train staff on process for bottom up referrals to ensure accountability and proper use of HH CMs

Adult

- Need to hire additional staffing
- Prioritization of project activities needed to ensure appropriate resourcing and sustainability

Palliative Care

- Patient engagement metrics are difficult to capture given current processes; Need to review workflows and documentation to ensure touches will consistently be captured in reporting

ToC

- Work flows with Health Home and other outpatient Care Management services not well defined; Processes need to be refined to ensure patients are appropriately referred during transition

Cross Project Successes

All/IDS

- Recruitment for CHW positions underway; The CHWs will play an important role in the Interdisciplinary Team meetings and providing support to patients in the community
- IT enhancement for patient registries completed; Several projects will now be able to finalize registries and develop population - specific registries and dashboards
- Infrastructure that will lead to event notification being finalized; Physicians within the PCMH will now have access to these alerts
- Trainings on Healthix consenting up and running within the PCMH

Adult Ambulatory ICU

- Panel Management Coordinator position finalized and posted. This new position will assist with empanelment and population health management within PCMH sites
- Meetings with collaborators scheduled throughout DY2, Q1

Palliative Care

- Interviewing for Program Assistant. Once hired, staffing for the Outpatient Palliative Care Services team will be complete

Behavioral Health

- Finalizing collaboration plans with two community - based collaborators to further the continuum of care for Behavioral Health patients
- Solid plan to continue with project implementation despite leadership and NYS requirement changes

Pediatric Ambulatory ICU

- Meetings with collaborators scheduled throughout DY2, Q1

TOC

- Several IS templates (assessments, care plan) completed and will go live by the end of DY2, Q1

AMAZING THINGS ARE HAPPENING HERE

DSRIP Project 2.b.iii
ED Care Triage

NYP PPS Clinical Operations Committee

Friday, 4/18/2016

Peter A D Steel, MD

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Project Overview

BACKGROUND:

1997 - 2011, US ED visits grew from 94.9 to 136.3 million

Avoidable Emergency Department (ED) use estimates:

- 56% of total ED utilization
- Approx. 38 billion USD a year in wasteful healthcare spending

ED Over-crowding may lead to:

- Delayed treatment initiation in ED
- Increased length ED stay in ED
- Compromised quality of care in ED
- Reinforcement of episodic care

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Project Overview

PROJECT GOALS:

- Identify ED patients who would benefit from referral to follow-up care
- Assure that the referrals take place & follow-up care is initiated

PATIENT NAVIGATOR GOALS:

- Improve access to care for patients discharged from the ED
- Empower & educate patients to appropriately access & utilize health care services
- Health care team mission to support patients to continuous, non-episodic care

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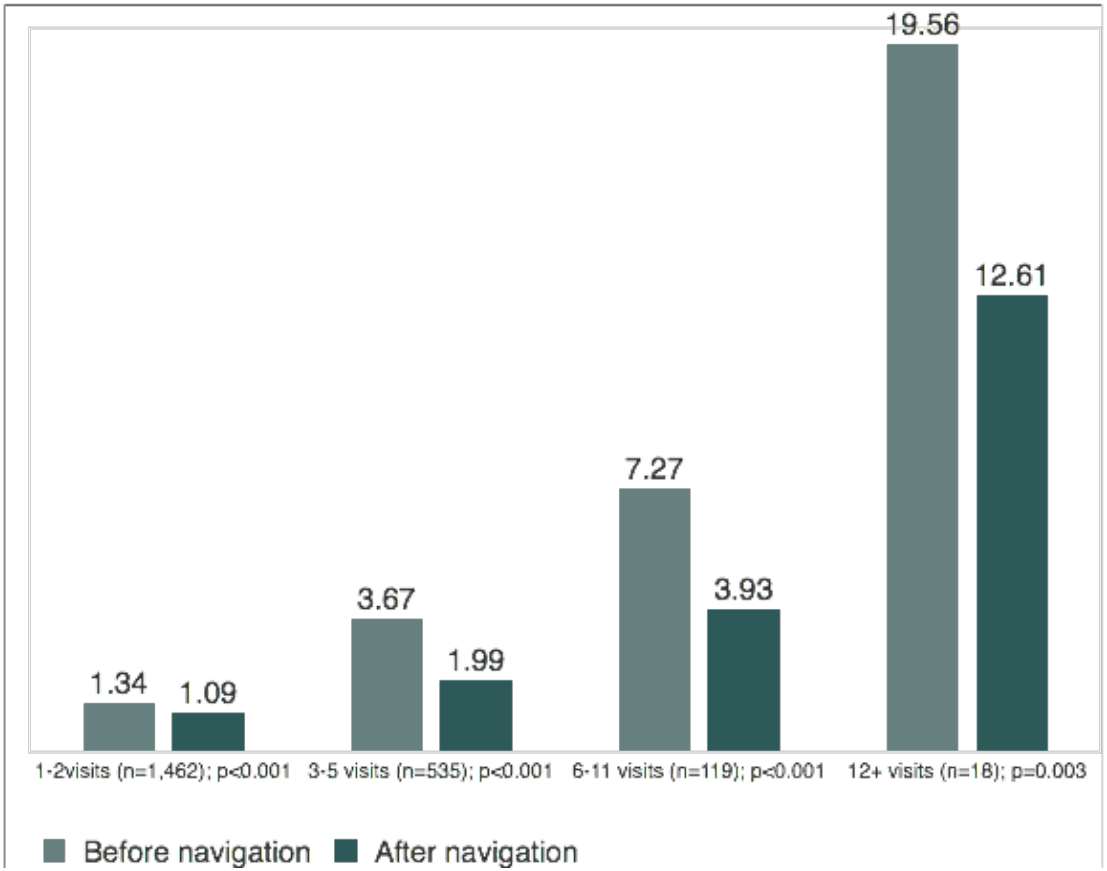
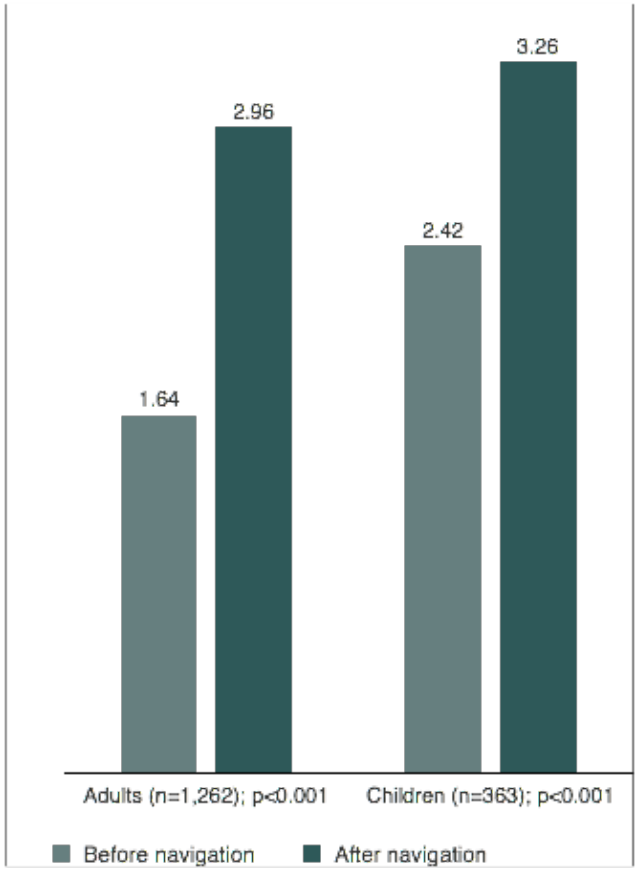
Project Overview

CUMC Patient Navigator Outcomes

ED Utilization 12 Months Pre- and
12 Months Post-Navigation



ACN Visits 12 Months Pre- and
12 Months Post-Navigation



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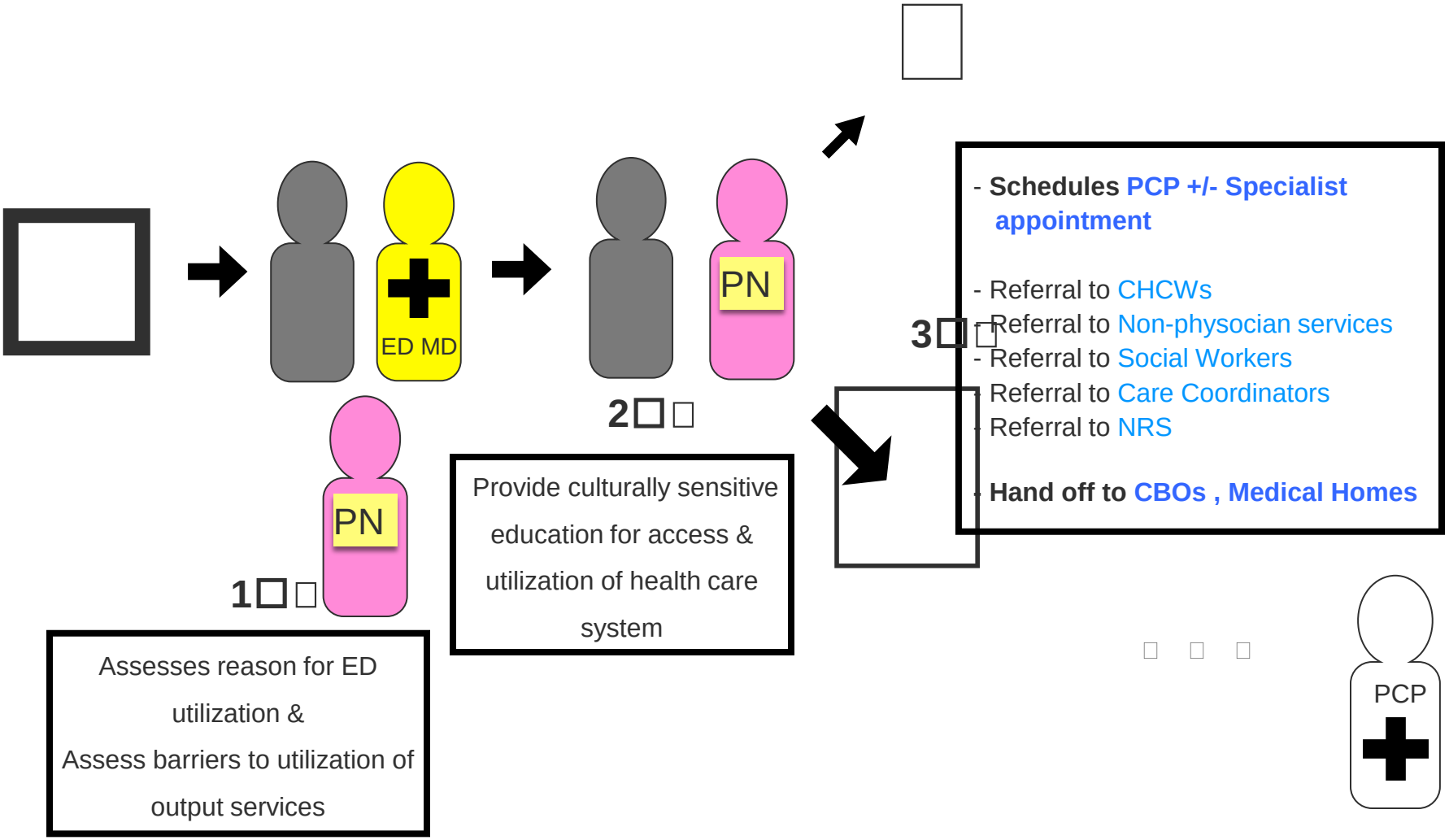
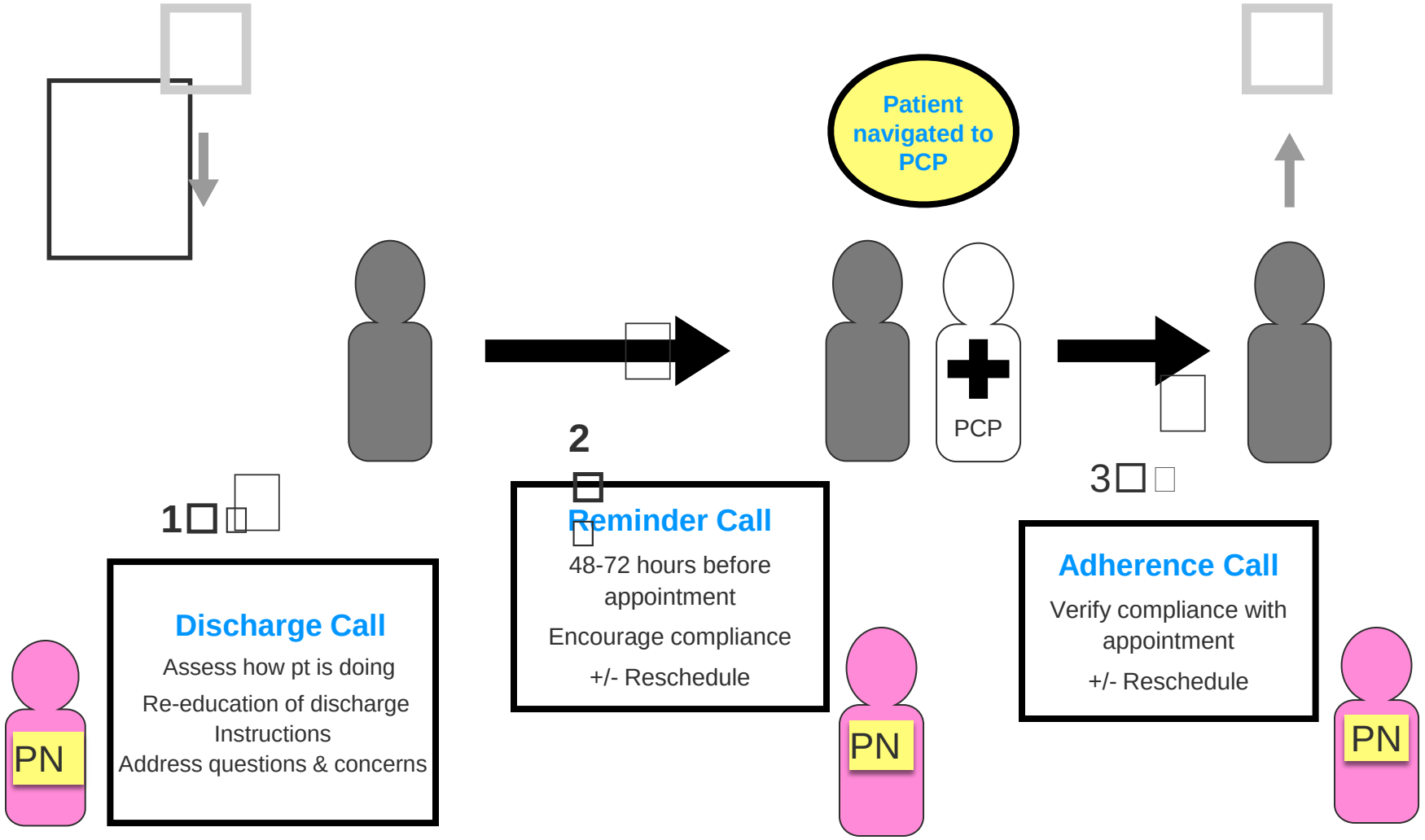
Current State of the Project



Current State of the Project



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How Funds Are Being Spent

NYP PERSONEL BUDGET FULL YEAR			
PROJECT ROLE	**FTE**	**SITE**	**COST**
Patient Navigator	8.0	WCMC	
Supervisor	1.0	WCMC	
Program Manager	0.5	WCMC	
Office Assistant	0.5	WCMC	
Supervisor	1.0	LMH	
Patient Navigator	3.0	LMH	
Program Manager	0.5	LMH	
Office Assistant	0.5	LMH	
Patient Navigator	4.0	CUMC / ALLEN	
Physician	0.1250	WCMC / LMH	
Project Manager	1.0	ALL CAMPUSES	
SUBTOTAL NYP PERSONEL COSTS			**1,480,025**
NYP NON-PERSONEL BUDGET FULL YEAR			
SUBTOTAL NYP NON-PERSONEL COSTS			**46,380**
CAPITAL COSTS			
SUBTOTAL CAPITAL COSTS			**52,601**

Results to Date

Scale and Speed Metric:

The number of participating patients presented at the ED and appropriately referred for medical screening examination and successfully redirected to PCP as demonstrated by a connection with their Health Home care manager or a scheduled appointment within 4 weeks of ED discharge

Scale and Speed Commitment:

At the completion of Year 3, ED Care Triage will schedule follow-up appointments for 21,497 Medicaid beneficiaries

Results to Date: April – December 2015

- **5,173 Medicaid ED Discharges Navigated on West campuses**
- **416 Medicaid ED Discharges Navigated on East campuses**

Successes

Cross-campus integration of optimized model

Enhanced ED-outpatient transitions

- **ACN and PPS workflows**
- **Non-PPS relationships established**
- **Healthix**
- **ED culture re: 30 day readmissions**

Multi-tiered Care Coordination / Social Services / NRS

DSRIP project collaborations eg: HIV

Challenges

IT work flow solutions:

- Front end integration
- Portable devices

Lower Manhattan staffing

Measuring non-throughput impacts

- Financial impact of reduced inpatient utilization
- Financial impact of increased outpatient utilization
- Patient satisfaction
- Qualitative quality measures

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AMAZING THINGS ARE HAPPENING HERE

NYP PPS
Healthix Implementation

4/22/2016

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NYP PPS Healthix Connectivity Strategy

- By utilizing Health Information Exchange, the NYP PPS can support team-based care throughout the PPS network.
- Since January 2016, the NYP PPS has been conducting Health Information Readiness Assessments with its collaborators in order to understand each organization's IT infrastructure and current RHIO connectivity.
- Kickoff Meetings
  - Review of HIE Assessment
  - Overview of Healthix
  - Discussion of workflows
  - Transition to scoping/planning meetings with Healthix

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Healthix Implementation Progress

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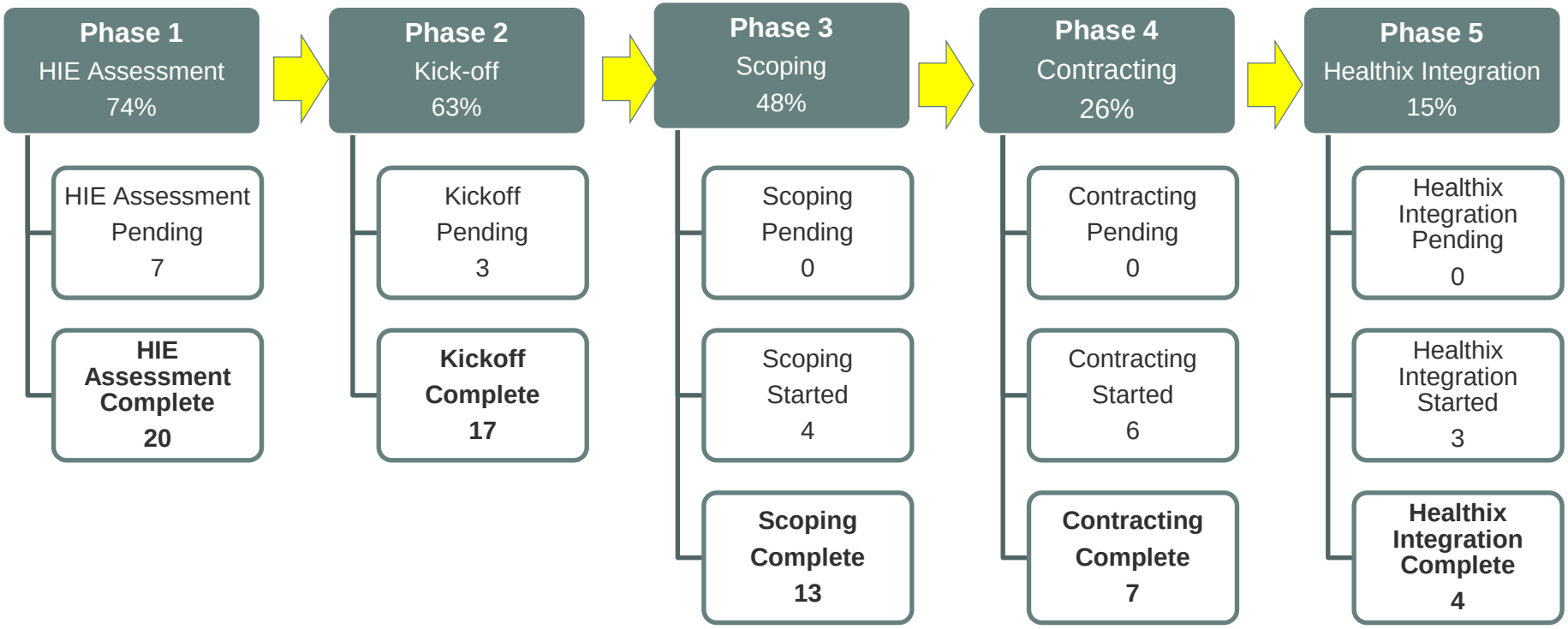
27 “Highly Connected” Collaborators
March 2016



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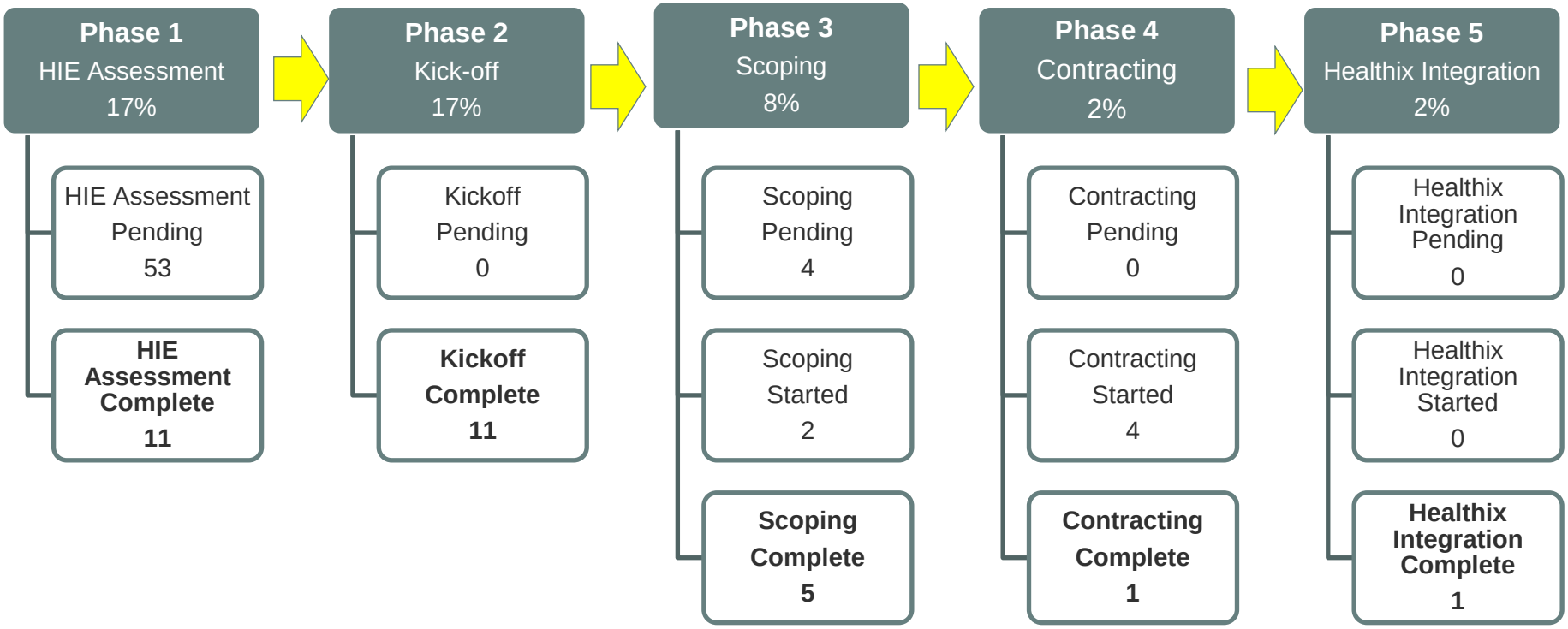
64 “Connected” Collaborators
March 2016



The 1 Collaborator Integrated is already connected to Health Link NY RHIO. They will not connect to Healthix.

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Gap Mitigation Approach

Non-Healthix Participants No EHR, EHR cannot share data with Healthix	Non-Healthix Participants EHR can share data with Healthix	Healthix Participants EHR not currently sharing data with Healthix	Healthix Participants EHRs that share data with Healthix
Will be scoped and contracted Will receive portal access and dial tone services	Will be scoped and contracted	Will be newly scoped with a revised contract	Achieve Healthix connectivity for all collaborators

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Accessing Healthix Data

Consent

- **There is no consent needed for organizations to send data to Healthix since Healthix is a business associate under HIPAA**
- **Consent is required to access or view patients/clients' data. -A patient must provide written consent in order for a provider at the organization to view the data.**
- **Once Healthix connected, PPS Collaborators will consent patients/clients during registration**

Benefits of Healthix Utilization

- **Sharing a patient record across health providers may reduce unnecessary labs/images and can prevent adverse drug events.**
- **Obtaining a comprehensive snapshot of a patient's medical history across providers and time**
- **Healthix Clinical Event Notifications (CENs) facilitate the management of patients, especially those with chronic diseases. Physicians/Clinicians are notified via CENs based on a variety of clinical events (hospital discharges, ER visits and more).**
- **Allows for team members (outside the hospital walls) to have access to shared data and coordinate care among all team members/organizations**