NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	7/22/16, 9-10am	**Meeting Title**	NYP PPS Clinical Operations Committee
Location	Heart Center Room 4	**Facilitator**	Dr. Emilio Carrillo, Sandy Merlino
Go to Meeting	https://global.gotomeeting.com/join/676507237	**Conference Line**	Dial +1 (408) 650-3123 Access Code: 676-507-237

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

Meeting Objectives	**Time**
1. Review of action items from last meeting 2. Governance Committee Rotation 3. Post-Acute Care Update, Julie Mirkin 4. Integrated Delivery System Presentation, Isaac Kastenbaum, Maria Moreno 5. Review of Population Health Milestone 6. Identify action items for next meeting	2 mins 10 mins 15 mins 15 mins 15 mins 2 mins

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Move to a bimonthly, 2-hour meeting schedule beginning after the July meeting	L. Alexander	6/24/2016	7/22/2016	In progress
Develop monthly update to send to Committee on off-meeting months	L. Alexander/Co-Chairs	6/24/2016	8/31/2016	In progress
Submit Cultural Competency and Health Literacy Strategy to Executive Committee for approval	L. Alexander/E. Carrillo	6/24/2016	7/18/2016	Complete

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Chair: Sandy Merlino (VNSNY)	**Chair:** Emilio Carrillo, MD (NYP)
Danielle Christenson (God's Love We Deliver)	Lauren Alexander (NYP)
Carol Cassell (Arch Care)	Julie Mirkin (NYP)
Patrick Germain (NYC DOHMH)	Morgan Brewton-Johnson (NYP)
Ana Gallego (NYC DOHMH)	Rachel Naiukow (NYP)
Isaac Kastenbaum (NYP)	
Maria Moreno (NYP)	

Meeting Objectives	**Time**
1. Review of action items from last meeting	2 mins
2. Governance Committee Rotation	10 mins
3. Post-Acute Care Update, Julie Mirkin	15 mins
4. Integrated Delivery System Presentation, Isaac Kastenbaum, Maria Moreno	15 mins
5. Review of Population Health Milestone	15 mins
6. Identify action items for next meeting	2 mins

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Share results of Governance Committee rotations	L. Alexander	7/22/2016	8/10/2016	In progress
Update Outlook invite to reflect bimonthly, 2-hour meeting schedule	L. Alexander	7/22/2016	8/10/2016	In progress
Send monthly update during August	L. Alexander/Co-Chairs	7/22/2016	8/31/2016	In progress
Submit Population Health Roadmap to Executive Committee for approval	L. Alexander/E. Carrillo	7/22/2016	8/31/2016	In progress
Share slides from VBP bootcamp	L. Alexander	7/22/2016	8/10/2016	In progress

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Performing Provider System

PPS Committee Procedures

Committee Membership Guidelines (Excerpted from Charters):

1. Committee will be comprised of 11 members, with two chairpersons, for the Finance, Clinical Operations and Executive Committees. The IT/Data Governance Committee will be comprised of 11 members, with three chairpersons.
2. With the exception of the initial term, which will be an extended term lasting 18 months, Committee membership will be rotated in 12 month terms; at the completion of a term, 3 PPS network members will be rotated off (through a random-selection process nearing the end of the term). Committee members will serve, at a maximum, thirty-six 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 and a PPS Network collaborator co-chair will be chosen by a vote at the first meeting of each term. Collaborator Chairpersons will rotate every twelve months, with a first term of 18 months to reflect the extension of the committee members' terms.
5. Committee members who miss three consecutive meetings will be removed and replaced.

Committee Membership Rotation:
Nearing the end of a Committee members' term, three PPS collaborator members will be randomly selected to be rotated off of the Committee. This will occur through the following process at a regularly-scheduled Committee meeting:

1. An Excel template will be used to randomly rank Committee members.
2. Ten cards will be placed in a bag; three that are labeled "excused" and seven that are labeled "remain." A Committee member will pull from the bag. As cards are pulled, they will be assigned to the Committee members, as ordered from the Excel template.
3. The drawing will stop once three members have been identified as "excused."

Those members identified as "excused" will step down from their positions at the conclusion of the 12th month (or 18th month for the first term). Committee Co-Chairs (non-NYP) will also be included in the drawing.

Those members who have missed the past three consecutive meetings (without prior notification to the Chairs or PMO) will automatically be chosen as one of the three members to be excused.

Those members who actively wish to step down from their participation in the Committee will need to submit their request to ppsmembership@nyp.org. Their open position will be included in the positions to be replaced, unless three absences have already been identified.

Replacing Committee Members Post-Transition:
To fill the three open positions on the Committee, the PPS PMO will send an open call to the PPS network members to notify them of the openings across all Committees. PPS network members will have to respond with their ranked preference for Committee placement, including the identified senior representative for each Committee.

New members will be prioritized by (in descending order):

1. Network members not previously on Committees;
2. Network member preference for participation in Committees; and
3. Network members to only be represented on a single committee.

Electing New Term PPS Network Member Co-Chair:
PPS Network Member Co-Chairs will serve 12 month leadership terms on Committees (18 months for the first term); s/he will have the ability to remain on the Committee, pending the outcomes of the lottery process described above, as a non-chair member.

After the new membership of a Committee is formed, an open call will go out to the Committee members for volunteers to serve as the Co-Chair. In order to support continuity of Committee operations, priority will be given to members who served in the previous term. If there are multiple representatives interested in the Co-Chair position, a web-based election will be hosted.

If there is no interest in Co-Chair, the previous term's Co-Chair, if still on the Committee, will be given the opportunity to continue in his/her role.

AMAZING THINGS ARE HAPPENING HERE

Integrated Delivery System

NYP PPS Clinical Operations Committee

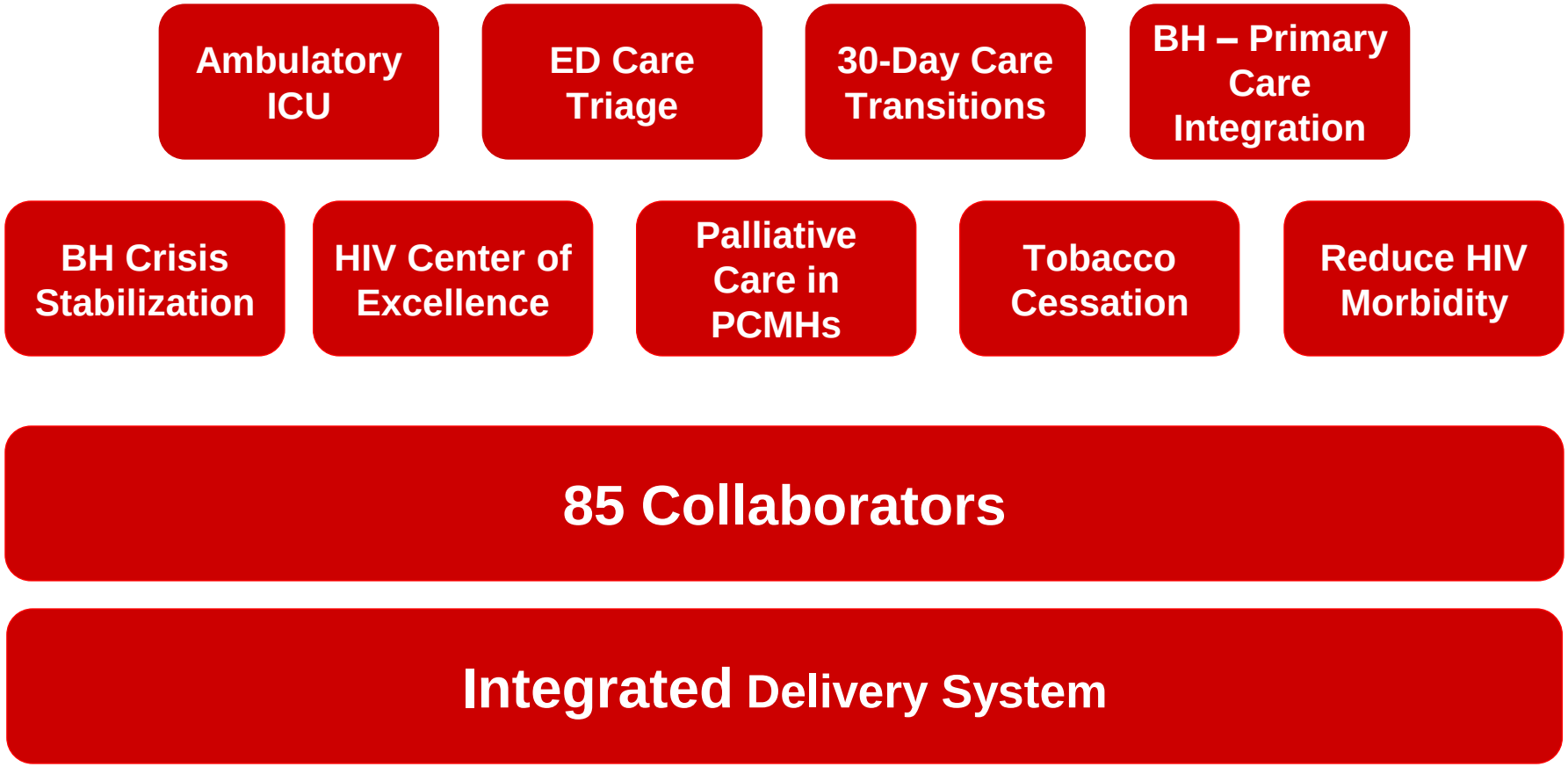
Friday, July 22,2016

NewYork-Presbyterian
Performing Provider System

NYP PPS: Integrated Delivery System Requirements

1. All PPS providers must be in the Integrated Delivery System
2. Utilize partnering HH and ACO population health management systems
3. Ensure patients receive appropriate health care and community support
4. Ensure that all PPS safety net providers are actively sharing EHR systems with local exchanges
5. Ensure that all EHR systems used by safety net providers meet MU and PCMH Level 3 standards
6. Perform population health management by actively using EHRs or other platforms
7. Achieve 2014 Level 3 PCMH primary care certification for all PCPs
8. Contract with Medicaid MCOs
9. Establish monthly meetings with Medicaid MCOs
10. Re-enforce the transition toward by VBP by aligning compensation to patient outcomes
11. Engage patients in IDS through outreach and navigation activities, including leveraging CHWs, peers, and culturally competent CBOs

NYP PPS: Integrated Delivery System



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NYP PPS IDS: Goals

Develop a network to support "collective impact"

- Create inventory of resources to support projects
- Governance structure
- Engage collaborators meaningfully to improve patient care

Adopt a PPS-wide, medical home anchored population health management strategy & interconnected infrastructure to support projects

- PCMH/Meaningful Use Certification
- Alignment with the Health Home & ACO
- Cultural Competency
- Risk Stratification/Empanelment
- IT Enhancements
- Quality Improvement
- CHWs, Peers, and Field-Based Staff

Engaging collaborators & MCOs to identify a VBP strategy

- VBP assessment
- Performance Measures
- Optimize billing opportunities to support financial sustainability

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NYP PPS IDS: Current Status of Collective Impact

- Collaborator workgroup identifying vendor to provide up-to-date inventory of community resources across NYC
- NYPH and ASCNYC co-investing in development of Community Empowerment Collaborative Training Center
- Governance Committees and workgroups actively guiding PPS major milestones
- Active communication through PPS website, newsletter, and outreach to non-engaged collaborators; new events to come
- Development of project-specific workgroups / collaboratives
- Development of broad education for PPS network (palliative care, cultural competency, etc.)

NYP PPS IDS: Current Status of PCMH-Anchored Interconnected Strategy

- Submitting NYPH (14 practice) PCMH application; sub-contracted with Primary Care Development Corporation to support independent community physician application
- Rolling out Healthix connectivity to collaborators*
- Rolling out Allscripts Care Director (ACD) to highly-connected collaborators
- Recruiting and training ~30 CHWs, Peers, and other field-based staff
- Developing standardized referral processes across PPS
- Finalizing EHR capability to identify patients' engagement in care management programs

**Currently delayed due to CRFP funds*

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NYP PPS IDS: Current Status of Sustainability and VBP

- **Pursuing receipt of Medicaid claims data to understand network performance**
- **Completion of PPS Value-Based Payment and Financial Health surveys**
- **Evaluating additional billing opportunities to support sustainability**
- **Workgroup formed to discuss strategies to achieve sustainability through value-based payments**

NYP PPS IDS: Challenges

- CRP funding delays have limited the ability to rollout Healthix and Allscripts Care Director (ACD) to collaborators
- Expansion of days/hours at NYPH PCMHs
- Engaging all 80+ collaborators in a meaningful way
- Encouraging cross-collaborator engagement within the NYP PPS
- Educating all members of the NYP PPS of the services available within the network
- Streamlining referral processes and improving bi-directional communication between collaborators

NYP PPS IDS

NYP PPS IDS

Questions?

NewYork-Presbyterian
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Population Health Management Roadmap

Milestone #1: Develop population health management roadmap

The DSIRP program has transformed the mechanisms by which the state of New York views and addresses population health management. The NewYork-Presbyterian Performing Provider System aims to be at the forefront of that transformation, achieving the triple aim of improved care, improved healthcare outcomes and lower costs for the betterment of both providers and the populations they serve. To that end, the PPS has consolidated efforts surrounding population health management such that quality, efficient and culturally competent care can be delivered to all populations it serves.

Roadmap:

The NewYork-Presbyterian Performing Provider System (NYP PPS), through its 9 interventions and Integrated Delivery System project, is rapidly developing the infrastructure, processes, and relationships to be successful in the DSRIP program and future value-based endeavors. This population health management infrastructure will include three components:

1. Effectively targeting populations for high-value impact/return;
2. Developing the necessary IT infrastructure to support an integrated delivery system;
3. Developing the necessary delivery system, including PCMHs when appropriate, to meet the needs of the target population;

Targeting Populations for High-Value Impact

The goal of the PPS in creating a comprehensive population health management strategy is to adopt a person-centered, cross-cultural approach that does not stereotype individuals, provides targeted resources to populations on the basis of social, clinical, and cultural characteristics and promotes linguistic access and health literacy for all patients. As a starting point for these efforts, the PPS conducted a Community Needs Assessment in 2014 in order to paint a detailed picture of the populations being served and their nuanced health needs. The Assessment called attention to a number of geographical areas and demographics with significant health disparities relative to NY State metrics, which the PPS plans to address in a nature complementary to and reflective of the NYS Prevention Agenda.

The Community Needs Assessment indicated that New York City performs worse than NY State in the majority of indicator categories, with disparities occurring most commonly in the Bronx with some present in Manhattan. For example, NYC has a much higher rate of new HIV diagnoses than NYC and the United states, with disparities occurring in Bronx County and Manhattan—the racial disparity is largest in Manhattan where the difference in rates between Black and White new HIV diagnoses is 76.2 per 100,000. Similarly, 18.1% of adults in the Bronx self-reported as current cigarette smokers—above the NY State average of 16.2%.

As an example as a targeted approach to address these disparities, the project 4.c.i (Reduce HIV Morbidity) aims to reduce HIV morbidity by increasing surveillance in the NYP PPS geography through community-based programs that identify those at risk for HIV, provide community-based risk reduction counseling and HIV prevention services, and facilitate PrEP and PEP to increase the likelihood that they remain HIV negative after a potential exposure. Outcomes will be measured in terms of the number of patients who received and filled at least two sequential anti-viral prescription scripts within the previous Demonstration Year. The PPS established a goal of 5040 patients having filled at least two sequential anti-viral prescription scripts within the previous Demonstration Year by the end of DY4 Q4.

In addition to focusing on addressing disparities, the PPS will also develop the population health management tools (registries, care management protocols, community-based interventions) to target specific populations. These populations may include frequent-utilizers of emergency department and inpatient services, patients that are not connected to longitudinal primary care or behavioral health, and/or patients that are not connected to stable housing.

Developing the Necessary IT infrastructure

The IT infrastructure for the NYP PPS will support the development of an integrated delivery system for the PPS's Medicaid population. The project has eight main components: (1) development of an automated work flow platform to support care coordinators; (2) enhancements to the electronic health records (EHR) applications; (3) procurement and implementation of an automated application for mobile Community Health Workers and peers; (4) development of health information exchange so that members of the care team can interact optimally; (5) data interfacing capabilities to move data among applications; (6) enhancements to the NYP patient portal for patients in Ambulatory ICUs; (7) development of an analytics platform to support the PPS; and (8) selection and implementation of a community resource tool.

1. Work Flow Support for Care Coordinators

The PPS will extend Allscripts Care Director (ACD), an application that supports the work flows of care coordinators to multiple Collaborators across the care continuum. The application enables care coordinators to care for registries of patients; manage tasks related to those patients; and document assessments, care plans, problems, goals, interventions and future tasks. The application includes embedded guidelines to ensure adherence to appropriate care. A requirements analysis will be carried out, after which the vendor will customize the application to meet the needs of the partner organizations.

2. EHR Enhancements

The inpatient and outpatient EHR at NewYork-Presbyterian Hospital (NYPH), Sunrise Clinical Manager (SCM) and EPIC, will be enhanced to support the work flows of physicians and nurses. Alerts and reminders will be created to notify these care providers about patients eligible for specialized services. For example, SCM and EPIC will notify the physician and nurse when they are seeing a patient who is in the Ambulatory ICU program or who is eligible for ED triage services. The EHR also will be enhanced to enable specialized documentation templates so that

quality data or other information relevant to the DSRIP program (e.g., tobacco cessation counseling, order sets for patient navigators) can be captured.

3. Support for Community Health Workers (CHWs), Peers and other Field-Based Staff

Culturally competent CHWs, Peers and field-based staff (e.g. CASACs) 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. Because CHWs are mobile, a wireless-enabled tablet-based application is necessary for documentation. After a requirements-gathering process, hardware and software will be selected, the application will be implemented and CHWs will be trained in the use of the hardware and application. The application will allow both free-text and structured documentation approaches. The PPS will leverage lessons learned as part of a NYS eHealth Collaborative Digital Health Accelerator project in which NYP piloted electronic documentation for CHWs.

4. Health Information Exchange

NYPH currently connects to the State Health Information Network for New York (SHIN-NY) via its regional health information organization (RHIO), Healthix. Currently, only a minority of NYP PPS Collaborators are Healthix participants. Sixty-nine (69) Collaborators will join Healthix and participate in SHIN-NY-based health information exchange activities. Thirty-four (34) of those organizations will contribute their full clinical data set to Healthix so that other Collaborators can use those data. Twelve (12) organizations will contribute encounter data, so records of encounters can be tracked by the RHIO. The remaining 23 organizations will contribute patient lists to Healthix so they can view the data of other Healthix participants.

Healthix will support hospitals, nursing homes, home care agencies, FQHCs and doctors by providing centralized patient record look-up, clinical event notifications, secure direct messaging and patient analytics and reporting, which will ultimately enhance care management and coordination.

5. Data Interfaces

We will create additional data interfaces—including inter-application interfaces—to increase data availability to members of the care team. Examples include the ability to: (1) upload files to the NYPH Enterprise Master Patient Index so that attributed patients and patients enrolled in each of the DSRIP projects can be identified; (2) transmit specialized documentation data from the EHR to ACD to be shared appropriately with Collaborators across the continuum; and (3) transmit data in structured form from ACD and the EHR to the NYP PPS analytics platforms so that management and quality reports can be created.

6. Enhancements to Patient Portal

MyNYP.org, NYPH's PHR, will serve as the patient portal for patients enrolled in Ambulatory ICU programs. We will create specialized, relevant content to improve health literacy such as asthma-related materials for parents of asthmatic children and information about managing multiple chronic diseases for adults. The content will be clinically oriented but also provide information about Collaborators and social services available.

This content will also be made available to other community-based providers within the network.

7. Analytics Platform

The analytics platform will provide population health management capabilities for the PPS. The platform will identify eligible patients, receive identifying information from NYS and combine it with NYPH medical records and PPS-wide care coordination platform data (see #2). Analysts will create data marts that—with graphical front-end tools—will provide management reports, quality reports, reports for regulatory reporting purposes, lists of patients meeting specific criteria that need care coordination services and predictive models that identify likely high utilizers of care. The analytics platforms will leverage NYPH's existing database hardware and analytics software, but additional application software, database servers and hard disk storage will be needed to support the PPS.

8. Community Resource Tool

A workgroup consisting of representatives from throughout the PPS was formed to address a lack of an internal source of information for community resources. The workgroup examined the market extensively and recommended Healthify, a New-York based software company that works with healthcare organizations to coordinate care with community-based organizations to improve outcomes and lower costs for vulnerable beneficiaries. At this time, we are seeking to purchase access to the community resource directory only. The directory's features are extensive and include ability to track factors such as cost, capacity, hours of operation, languages spoken as well as ability to comment on or rate resources. Ultimately the tool will complement efforts to create a fully integrated delivery system by providing ease of access to information about community resources. The Westchester PPS has already contracted with Healthify so there is precedence for using this platform in a PPS Network.

Developing the Necessary Delivery System, Including Plans for achieving PCMH 2014 Level 3 certification:

New York-Presbyterian Hospital's affiliated practices are in the process of reviewing required documentation through the NYPH Office of Community Health for submission to NCQA for Level 3 certification. This recognition is expected by the end of 2016.

The NYP PPS has subcontracted with Primary Care Development Corporation (PCDC) to provide advisement and technical assistance on all documents and workflows required to achieve NCQA Level-3 designation to the PPS's six Independent Community Physicians. These physicians will receive advisement and technical assistance on all documents and workflows required to achieve NCQA Level-3 designation.

The PPS is currently providing regular check-ins and support to FQHC PPS members —Charles B. Wang Community Health Center, Harlem United, and Community Healthcare Network—in order to ensure Level three certification achievement on appropriate timelines for their respective Medicaid managed care contracting strategies and DSRIP requirements.

PCMH 2014 Level 3 certified provider organizations

New York-Presbyterian Hospital/Weill Cornell Medical Center – Corporate

1. Center for Special Studies – David E. Rogers Unit
2. Center for Special Studies – Glenn Bernbaum Unit
3. Helmsley Medical Tower Pediatrics Ambulatory Care
4. Helmsley Medical Tower Women's Health
5. Weill Cornell Medicine Associates
6. Weill Cornell Medicine Associates at Wright
7. Wright Center on Aging

New York-Presbyterian Hospital/Columbia University Medical Center – Corporate

1. Associates in Internal Medicine (AIM)
2. Audubon Practice
3. Comprehensive Health Program
4. Farrell Family Medicine Practice
5. Rangel Practice
6. Washington Heights Family Health Center
7. Broadway Clinic

Federally Qualified Health Centers

1. Charles B. Wang Community Health Center
2. Harlem United
3. Community Healthcare Network

Independent Community Physicians

1. Andres Pereira, MD
2. Sofia De La Cruz, MD
3. Gabriel Guardarramas, MD
4. Jose Jerez, MD
5. Theodore Docu, MD

As of 7/20/2016

IT system screenshot:

The following screenshot depicts our Population Health Risk dashboard, which was created to allow patient care teams to manage their high risk, rising risk, and low risk population in real time based on ED utilization and number of chronic conditions. The dashboard is updated on a daily basis.

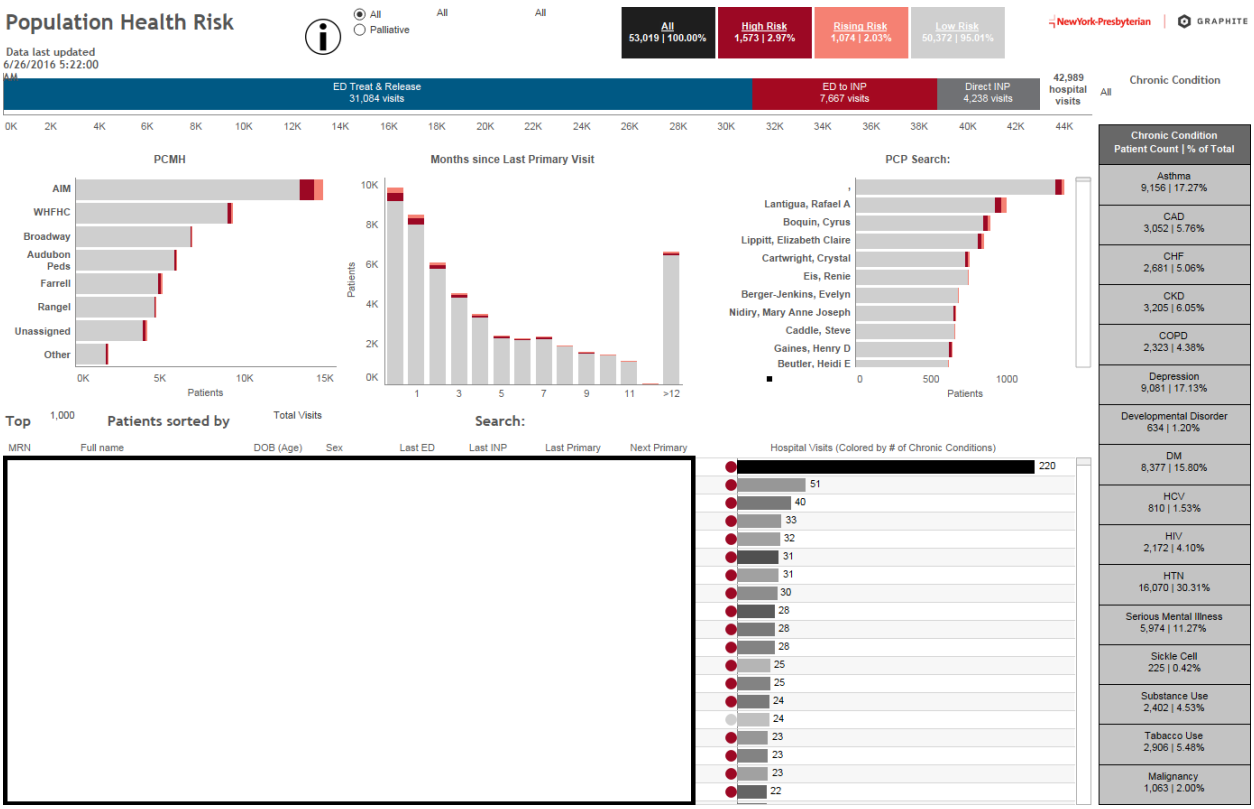
This dashboard allows teams to identify where patients are falling out of the system and connect them with the appropriate services to help prevent ED readmissions.

The dashboard is supported by two IT systems, Amalga and Tableau.

> Amalga is a health IT platform from Microsoft for integrating data from disparate sources. The platform is designed to provide health care professionals with real-time clinical, administrative and financial information about patients in a single view.
>
> Tableau is a computer software that interfaces with Amalga to provide interactive data visualization capabilities.
>
> Tableau pulls data from Amalga. Amalga pulls from different sources such as Eagle (Billing) and the EHR to provide patient information.

The following dashboard depicts a number of metrics including:

> Number of patients at varying levels of risk for recurrent ER and inpatient admissions, with high risk including patients with 2 or more chronic conditions seen in the last 12 months with a combination of 4 or more ER and INP visits and rising risk including patients with 2 or more chronic conditions seen in the last 12 months with a combination of 3 or more ER and INP visits.
>
> Number of patients seen at each PCMH stratified by the above risk designations.
>
> Months since last primary visit for patients seen, stratified by the above risk designations.
>
> Count of patients seen with chronic conditions separated by each condition as a percentage of overall chronic condition patient count.



As of 7/20/2016

Population Health Management

Milestone #1: Develop population health management roadmap

Minimum Standards of Supporting Documentation to Substantiate Successful Completion of the Milestone: The PPS must demonstrate that the roadmap has been successfully and formally established. The PPS must provider the IA:

- A copy of the PPS's population health management roadmap that addresses:
  - IT infrastructure required to support a population health management approach, such as the creation of a population health dashboard based on available data sets and registries.
  - Plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations, such as by using a learning collaborative for the necessary training and support to attain PCMH certification.
  - Identify priority target populations and define plans for addressing their health disparities by establishing goals that reflect the State of New York's Prevention Agenda.

- A list of PCMH 2014 Level 3 certified provider organizations

- Screenshot or reports from the IT system used to support the PPS's population health management roadmap.

Validation Process: As part of its oversight responsibilities, the IA will be validating the completion of Domain 1 milestones and measures. The IA will conduct a more extensive review of certain information to ensure the information submitted by the PPS is accurate and verifiable. Furthermore, the IA will:

- Review the population health management roadmap to assure that it meets the minimum standards.

- Review a random sample of the providers identified to verify their PCMG 2014 Level 3 certification.

- Review screenshots of the dashboard or output from other IT systems to ensure that IT infrastructure is sufficient to support the PPS' health management approach.

Minimum Standards of Supporting Documentation to Substantiate Ongoing Quarterly Report Updates: After the successful completion of the initial milestone, the PPS must provide the following information to the IA each quarter.

- Updates on the implementation of the population health management roadmap.

Validation Process: The IA will perform the validation process similar to the methodology described above.