NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	3/17/17, 9-10:00am	**Meeting Title**	NYP PPS Clinical Operations Committee
Location	GoTo only	**Facilitator**	Dr. Steven Kaplan, 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:** Steven Kaplan, MD (NYP)
Alissa Wassung (God's Love We Deliver)	~~Terri Udolf (St. Christopher's Inn)~~
~~Susan Wiviott (The Bridge)~~	~~Amy Shah (NYC DOHMH)~~
~~David Chan (City Drug & Surgical)~~	~~Maria Lizardo (Northern Manhattan Improvement Corporation)~~
Jean Marie Bradford, MD (NYPSI)	Catherine Thurston (SPOP)
~~Genevieve Castillo (Methodist)~~	Lauren Alexander (NYP)
Dan Johansson (ACMH, Inc.)	Andrew Missel (NYP)
Alvin Lin (NYC DOHMH PCIP/REACH)	Gil Kuperman (NYP)

Meeting Objectives	**Time**
1. Review of action items from last meeting	5 mins
2. Next steps on combined Clinical Operations and IT/Data Governance Governance Committee Meeting (Co-Chairs)	10 mins
3. Review of performance metrics (A. Missel)	20 mins
4. Clinical Integration Needs Assessment and Strategy approval (L. Alexander/A. Missel)	5 mins
5. Community Provider Quality Improvement Lead (Lauren Alexander)	10 mins
6. Next steps	5 mins

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Inform L. Alexander if you or your organization would like to participate in cultural competency and health literacy efforts	Committee	2/3/2017	Ongoing	
Share Health Home FAQs and referral form with Committee	L. Alexander	2/3/2017	2/17/2017	Complete
Review metrics at next meeting	L. Alexander/ A. Missel	2/3/2017	3/17/2017	Complete
Schedule conference call to discuss shift to performance metrics in more depth	L. Alexander/ A. Missel	2/3/2017	3/3/2018	Complete
Review remaining agenda items at next meeting or via e-mail	L. Alexander	2/3/2017	3/10/2017	Complete
Reminder re: available resources for Cultural Competency and Health Literacy and contact info for pay-for-performance metrics coaching	A. Missel	3/17/2017	3/24/2017	Complete

AMAZING THINGS ARE HAPPENING HERE

Crash Course in DSRIP Pay-for-Performance (P4P) Metrics

Clinical Operations Committee

March 17, 2017

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Performing Provider System

Take-Aways from DSRIP P4P Metrics Overview

1. NYP PPS accountable for 44 P4P metrics
2. Each metric has unique definition set by a national body
3. Measurement Year (MY) cycle (and delay in performance update)
4. PPS Goal = Improve each metric by at least 10% each MY
5. Claims data are not our only source of information

PPS Lead Partner Required to Report on Four Domains of DSRIP Measures

- Domain 1 – Infrastructure Development for Project Success (Process)
  - Ex) PPS has a standard clinical protocol for Ambulatory ICU services
- **Domain 2 – System Transformation (Process)**
  - Ex) Adult Access to Preventive or Ambulatory Care
- **Domain 3 – Clinical Outcome Improvements (Outcomes)**
  - Ex) Medical Assistance with Smoking and Tobacco Use Cessation
- Domain 4 – Population-Focused Improvements (Outcomes)
  - Ex) Percentage of cigarette smoking among adults

NYP PPS P4P Metrics Dashboard

Measures		Population Line Alignment - *Use drop down arrows to sort for your Population Line*						5 Year Goals								*Values are projected until validated by NYS (~ 6-9 months after close of MY)*										
																MY2 = Jul' 15-Jun'16		MY3 = Jul' 16-Jun'17		MY4 = Jul' 17-Jun'18		MY5 = Jul' 18-Jun'19			
Measure ID#	Measure Name	Adult Medicine	Pediatric Medicine	Sexual Health	Community Providers	Social Determinants/ CBO	Transitions/ High-Utilizers	Goal	Statewide 5-Yr Goal (% or Rate)	PPS 5-Yr Goal (% or Rate)	MY1 Denominator (# Count)	MY1 Numerator (# Count)	MY1 Performance (% or Rate)	Gap to PPS 5-Yr Goal (% or Rate)	Gap to PPS 5-Yr Goal (# Count)	MY2 Target Change	MY2 $ Available	MY3 Target Change	MY3 $ Available	MY4 Target Change	MY4 $ Available	MY5 Target Change	MY5 $ Available	5-Year Total P4P Value
3-9	Follow-Up after Hospitalization for Mental Illness - Within 7 Days	X	X			X	X	Incr.	74.2%	56.4%	331	156	47.1%	9.3%	31	9	$ 76,355	8	$ 96,127	7	$ 88,282	7	$40,065.00	$ 300,829
3-10	Follow-Up after Hospitalization for Mental Illness - Within 30 Days	X	X			X	X	Incr.	88.2%	69.6%	331	198	59.8%	9.8%	32	9	$ 76,355	8	$ 96,127	8	$ 88,282	7	$40,065.00	$ 300,829
2-1	Potentially Avoidable Emergency Room Visits	X	X		X	X	X	Decr.	6.1	30.2	78,834	33,746	42.8	-12.6	(9,952)	(2894)	$ -	(2604)	$ 542,431	(2344)	$ 394,118	(2110)	$181,293.00	$ 1,117,842
2-2	Potentially Avoidable Readmissions	X	X		X	X	X	Decr.	180.7	431.8	81,118	457	563.4	-131.6	(107)	(31)	$ -	(28)	$ 542,431	(25)	$ 394,118	(23)	$181,293.00	$ 1,117,842
2-10	Adults w/ Preventive or Ambulatory Care Visit in Last Year - 20 to 44 years	X			X	X		Incr.	91.1%	86.8%	20,131	17,019	84.5%	2.3%	453	132	$ -	119	$ 180,810	107	$ 131,373	96	$60,431.00	$ 372,614
2-11	Adults w/ Preventive or Ambulatory Care Visit in Last Year - 45 to 64 years	X			X	X		Incr.	94.4%	92.4%	11,572	10,581	91.4%	1.0%	116	34	$ -	30	$ 180,810	27	$ 131,373	25	$60,431.00	$ 372,614
2-12	Adults w/ Preventive or Ambulatory Care Visit in Last Year - 65 and older	X			X	X		Incr.	94.4%	92.3%	968	882	91.1%	1.2%	11	3	$ -	3	$ 180,810	3	$ 131,373	2	$60,431.00	$ 372,614
3-1	Potentially Preventable Emergency Department Visits (for Persons with BH Diagnosis)	X			X	X	X	Decr.	35.3	70.2	3,653	3,232	88.5	-18.3	(668)	(194)	$ 152,709	(175)	$ 192,255	(157)	$ 176,563	(142)	$80,131.00	$ 601,658
3-41	Cervical Cancer Screening	X			X			Incr.	83.9%	74.6%	17,906	12,479	69.7%	4.9%	875	254	$ -	229	$ 51,252	206	$ 93,841	185	$42,588.00	$ 187,681
3-42	Chlamydia Screening (16 - 24 Years)	X	X	X	X			Incr.	80.0%	77.7%	4,107	3,158	76.6%	1.2%	49	14	$ 116,969	13	$ 124,648	11	$ 93,841	10	$42,588.00	$ 378,047
2-3	Potentially Preventable Admissions - Adults (PQI 90)	X			X			Decr.	321.1	743.2	50,232	569	1,132.7	-389.5	(196)	(57)	$ -	(51)	$ 542,431	(46)	$ 394,118	(41)	$181,293.00	$ 1,117,842
3-2	Antidepressant Medication Management - Effective Acute Phase Treatment	X			X			Incr.	60.0%	55.6%	813	433	53.3%	2.3%	19	5	$ 76,355	5	$ 96,127	4	$ 88,282	4	$40,065.00	$ 300,829
3-3	Antidepressant Medication Management - Effective Continuation Phase Treatment	X			X			Incr.	43.5%	40.7%	813	319	39.2%	1.5%	12	3	$ 76,355	3	$ 96,127	3	$ 88,282	3	$40,065.00	$ 300,829
3-4	Diabetes Monitoring (Both LDL-C Test & HbA1c Test) for People with Diabetes and Schizophrenia	X			X			Incr.	89.8%	73.3%	82	53	64.6%	8.7%	7	2	$ 152,709	2	$ 192,255	2	$ 176,563	2	$80,131.00	$ 601,658
3-5	Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	X			X			Incr.	89.0%	81.7%	303	236	77.9%	3.8%	12	3	$ 152,709	3	$ 192,255	3	$ 176,563	2	$80,131.00	$ 601,658
3-6	Cardiovascular Monitoring (LDL-C Test) for People with Cardiovascular Disease and Schizophrenia**	X			X			Incr.	92.2%	71.1%	10	6	60.0%	11.1%	1	NA	NA	NA	NA	NA	NA	NA	NA	$ -
3-11	Screening for Clinical Depression and Follow-Up Plan	X			X			Incr.	56.2%	41.5%	325	110	33.8%	7.7%	25	7	$ -	7	$ 96,433	6	$ 176,563	5	$80,131.00	$ 353,127
3-12	Adherence to Antipsychotic Medications for People with Schizophrenia	X			X			Incr.	76.5%	65.6%	237	142	59.9%	5.7%	13	4	$ 152,709	4	$ 192,255	3	$ 176,563	3	$80,131.00	$ 601,658
2-8	CAHPS - Provider is Usual Source of PCP Care (Q2)	X	X		X			Incr.	92.5%	84.6%	203	163	80.4%	4.2%	8	2	$ -	2	$ 271,215	2	$ 197,059	2	$90,647.00	$ 558,921
2-9	CAHPS - Length of Primary Care Relationship >/= One Year (Q3)	X	X		X			Incr.	86.5%	83.5%	269	220	81.9%	1.6%	4	1	$ -	1	$ 271,215	1	$ 197,059	1	$90,647.00	$ 558,921
2-17	CAHPS - Getting Timely Appointments, Care and Information (Q6, 8, 10, and 12)	X	X		X			Incr.	92.5%	85.1%	149	121	81.2%	3.9%	6	2	$ -	2	$ 542,431	1	$ 394,118	1	$181,293.00	$ 1,117,842
2-22	CAHPS - Provider Up-to-Date about Care Received from Other Poviders (Care Coordination)	X	X		X			Incr.	91.9%	85.5%	179	147	82.2%	3.4%	6	2	$ -	2	$ 542,431	1	$ 394,118	1	$181,293.00	$ 1,117,842
3-15	Medical Assistance with Smoking and Tobacco Use Cessation - Advised to Quit	X			X			Incr.	95.6%	86.3%	43	35	81.4%	4.9%	2	1	$ -	1	$ 17,084	0	$ 31,280	0	$14,196.00	$ 62,560
3-16	Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Medication	X			X			Incr.	83.9%	71.6%	43	28	65.1%	6.5%	3	0	$ -	1	$ 279,618	1	$ 556,347	1	$276,729.00	$ 1,112,694
3-17	Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Strategies	X			X			Incr.	75.3%	64.9%	43	25	59.5%	5.4%	2	0	$ -	1	$ 279,618	1	$ 556,347	0	$276,729.00	$ 1,112,694
3-13	Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	X	X					Incr.	57.1%	48.9%	1,497	668	44.6%	4.3%	64	19	$ 76,355	17	$ 96,127	15	$ 88,282	14	$40,065.00	$ 300,829
3-14	Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	X	X					Incr.	28.3%	18.4%	1,497	197	13.2%	5.2%	78	23	$ 76,355	20	$ 96,127	18	$ 88,282	16	$40,065.00	$ 300,829
3-38	HIV/AIDS Comprehensive Care - Engaged in Care			X				Incr.	91.8%	89.6%	1,347	1,192	88.5%	1.1%	15	4	$ 116,969	4	$ 124,648	4	$ 93,841	3	$42,588.00	$ 378,047
3-39	HIV/AIDS Comprehensive Care - Viral Load Monitoring			X				Incr.	82.7%	63.2%	1,347	713	52.9%	10.2%	138	40	$ 116,969	36	$ 124,648	32	$ 93,841	29	$42,588.00	$ 378,047
3-40	HIV/AIDS Comprehensive Care - Syphilis Screening			X				Incr.	85.4%	66.7%	1,319	750	56.9%	9.8%	129	38	$ 116,969	34	$ 124,648	30	$ 93,841	27	$42,588.00	$ 378,047
3-43	Viral Load Suppression			X				Incr.	69.0%	63.9%	359	220	61.3%	2.7%	10	3	$ -	2	$ 51,252	2	$ 93,841	2	$42,588.00	$ 187,681
2-4	Potentially Preventable Admissions - Children (PDI 90)		X					Decr.	41.4	435.4	16,980	109	641.9	-206.5	(35)	(10)	$ -	(9)	$ 542,431	(8)	$ 394,118	(7)	$181,293.00	$ 1,117,842
2-13	Children w/ PCP Visit in the Last Year - 12 to 24 months		X					Incr.	100.0%	96.8%	3,597	3,422	95.1%	1.7%	60	17	$ -	16	$ 135,608	14	$ 98,529	13	$45,323.00	$ 279,460
2-14	Children w/ PCP Visit in the Last Year - 25 months to 6 years		X					Incr.	98.4%	95.0%	6,029	5,620	93.2%	1.8%	108	31	$ -	28	$ 660,674	25	$ 623,596	23	$307,857.00	$ 1,592,127
2-15	Children w/ PCP Visit in the Last Year (or Prior Year) - 7 to 11 years		X					Incr.	100.0%	98.7%	5,550	5,439	98.0%	0.7%	38	11	$ -	10	$ 660,674	25	$ 623,596	23	$307,857.00	$ 1,592,127
2-16	Children w/ PCP Visit in the Last Year (or Prior Year) - 12 to 19 years		X					Incr.	98.8%	97.7%	8,308	8,063	97.1%	0.6%	51	15	$ -	13	$ 660,674	12	$ 623,596	11	$307,857.00	$ 1,592,127
3-7	Follow-up care for Children Prescribed ADHD Medications - Initiation Phase		X					Incr.	72.3%	70.0%	196	135	68.9%	1.1%	2	1	$ -	1	$ 310,750	1	$ 613,348	0	$302,599.00	$ 1,226,697
3-8	Follow-up care for Children Prescribed ADHD Medications - Continuation Phase**		X					Incr.	78.7%	67.0%	23	14	60.9%	6.1%	1	NA	NA	NA	NA	NA	NA	NA	NA	$ -

** Metrics with denominators < 30 are not eligible for waiver reimbursement. If the denominator rises > 30, the measure will become eligible to the PPS.

Microsoft Excel Worksheet

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Metric Example:
Adults with Primary Care Visit in Past 12 Months

- **Full Name:** Adult Access to Preventive or Ambulatory Care
- **NYP Metrics #:** 2-10 (20-44 yo), 2-11 (45-64 yo), 2-12 (65+ yo)
- **Definition Source:** HEDIS
- **Numerator Description:** Number of adults who had an ambulatory or preventive care visit during the measurement year
- **Denominator Description:** Number of adults ages 20 to 44 as of June 30 of the measurement year

2-10: Adults 20-44 yo Performance

- 5 Yr PPS Goal = 86.8%
- MY1 = 17,019/20,131 patients (84.5%)
- Gap to Goal = 453 patients (2.3%)
- 5 Yr Total P4P Value = $372,614

P4P Metrics Assigned by Project Participation

How our specific metrics were assigned:

- Standard set of metrics for all PPSs
- NYP PPS' 10 projects => 44 P4P metrics
- Diverse metric types (clinical, outcomes, process) and definitions sources
- All metrics validated in QI literature and established nationally

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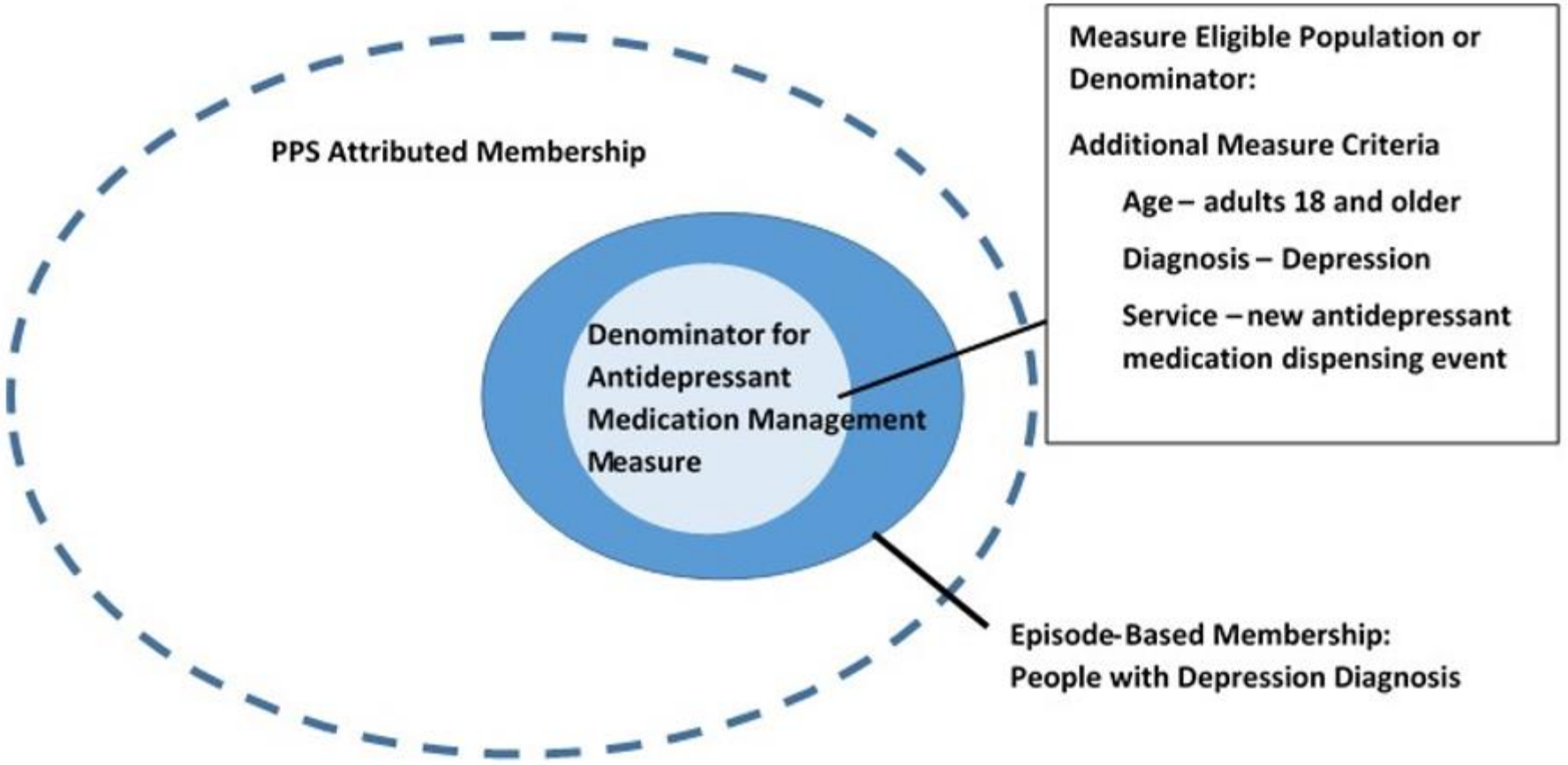
Illustration of How a Measure Population is Derived from the Total PPS Attributed Population



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PPS Performance Defined by Four Values

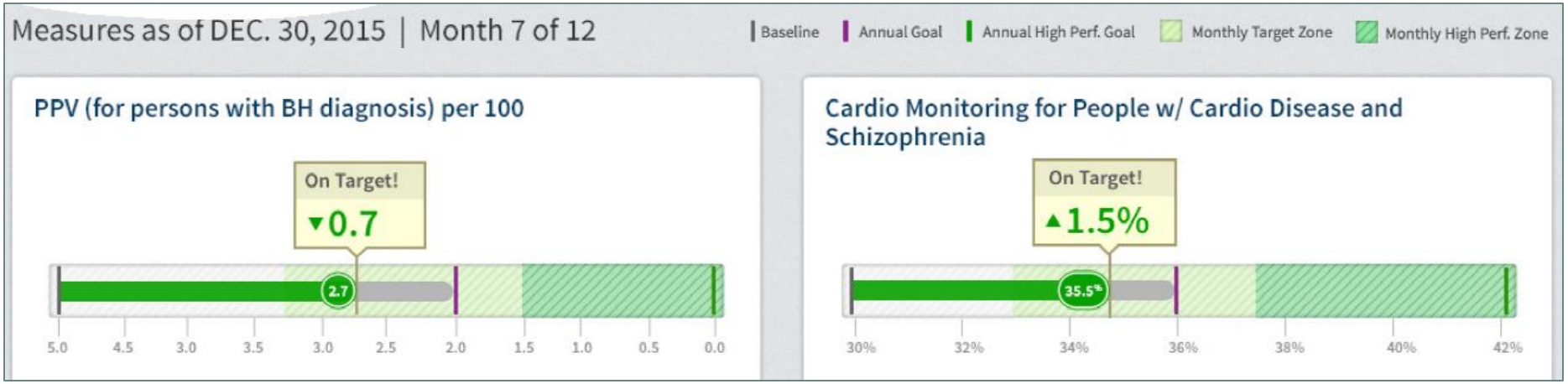
1. **Baseline**
   - PPS performance at start of each Measurement Year (MY)

2. **Annual Goal**
   - PPS target to receive full reimbursement
   - Select metrics have Annual *High Performance* Goal (extra $)

3. **Five-Year PPS Goal**
   - PPS target for end of NYP DSRIP

4. **Five-Year NYS Goal**
   - Statewide target

Performance Elements on Sample P4P Metrics



Example: PPV (for persons with behavioral health diagnoses)

1. Baseline = 5.0 potentially preventable ER visits (PPV)
2. Annual Goal = 2.0 potentially preventable ER visits (PPV)
3. Current Performance = 2.7 potentially preventable ER visits (PPV)
4. Five-Year PPS Goal = 0.0 potentially preventable ER visits (PPV)

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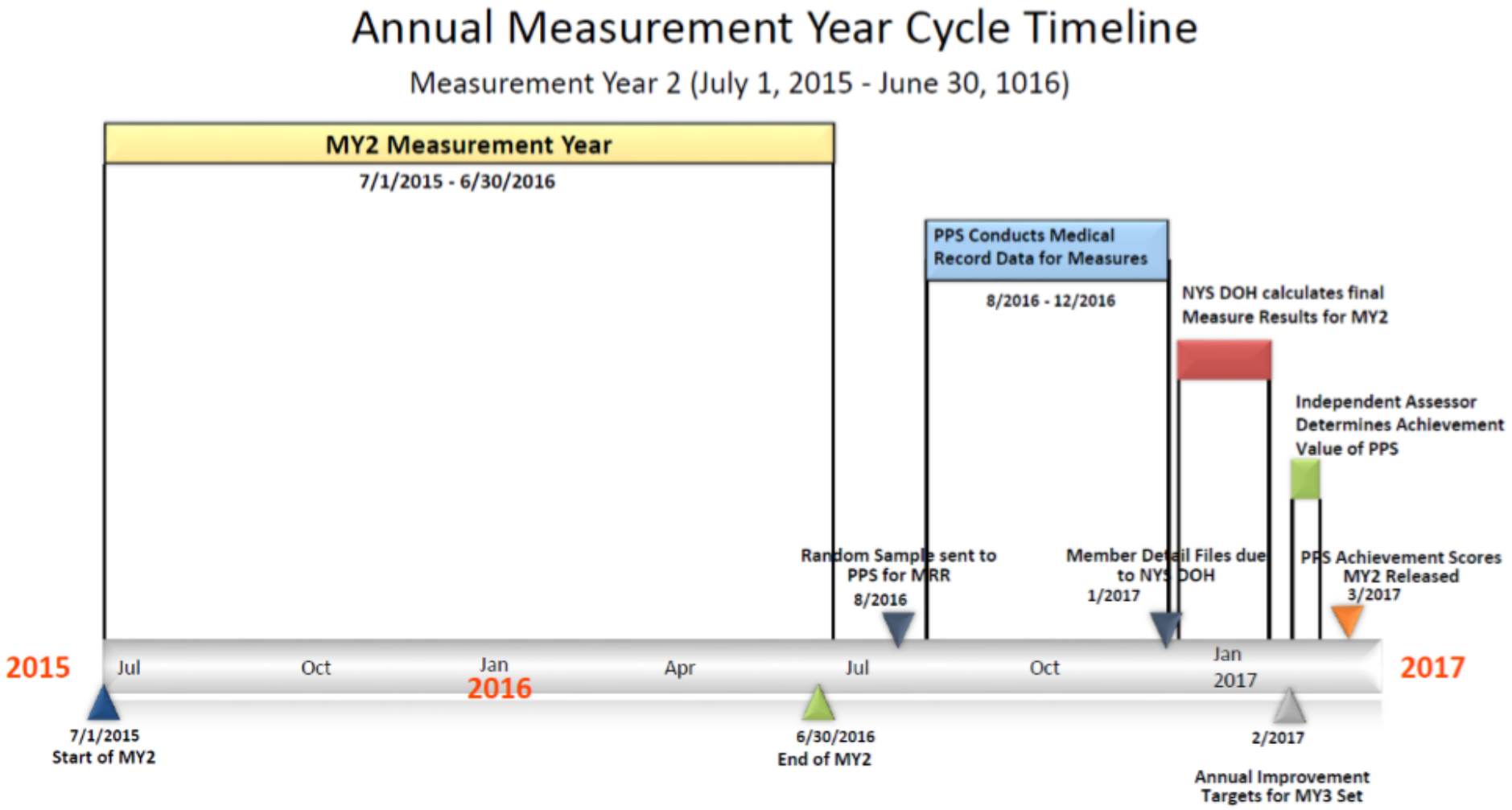
Important Measurement Elements to Remember

1. **Measurement Year (MY)**
   - July 1 – June 30; Aka measurement period; Period of activity that counts as the PPS' performance

2. **Review Period**
   - 6 months immediately after MY closes
   - PPS medical record review
   - NYS calculates PPS' MY performance; Indep. Assessor (IA) validates

3. **MY Performance Release Date**
   - Approx. March following close of MY
   - NYS informs PPS of past MY's performance

NYS Sets Performance Baseline & Targets



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PPS Data Sources for Tracking Performance Measures

Data Source	Access	Limitations
New York State Medicaid Analytics Performance Portal (MAPP)	• Claims data in summary format • Trends analyses • Geographic analyses • Access to patient- and provider-level data	• Data are old (1+ year) • Cannot export data • Patient-level data not exportable • Provider-level data not always available by organization
Salient Interactive Miner (SIM)	• 10+ years of Claims data in raw, deidentified format • Data updated every 2 weeks • Some (not all) P4P metrics are reprdocued within the tool	• Data are deidentified • Trends analyses are challenging • Challenging to attribute patients to individual providers • Claims data are not always representative of actual activity due to billing challenges • Steep learning curve to use tool
Raw New York State Medicaid Claims Data	Currently working on security protocols w/ NYS to accept raw claims data • Data will be identifiable	• Need to develop competencies in Medicaid claims data analysis • Data not immediately matched to NYP MRNs • Claims data are not always representative of actual activity due to billing challenges
NYP Electronic Health Record (EHR) and Administrative Data (e.g. "Amalga," Tableau, etc.)	Currently working on reproducing high-priority NYS metrics on internal data – will need clinical input on prioritization and proxy definitions • Access through normal TRAC data request fulfillment processes • Data are up-to-date	• Only NYP data, does not include other providers' dataExtended build period means dashboard not available until after Jan. 1, 2017

How the PPS is Supporting Providers & Partners with Actionable Data

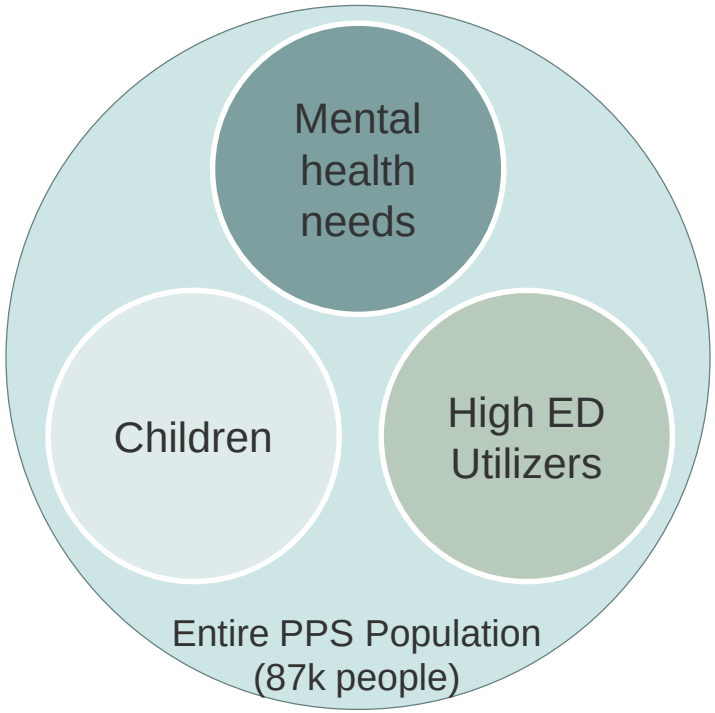
1. Opening multiple data sources
2. Training on data mining tools
3. Building performance dashboard
4. Population Lines accountable to specific performance measures
5. Governance Committees – What activities?
   - Monitoring performance
   - Identifying trends
   - Guidance to Population Lines

Appendixes

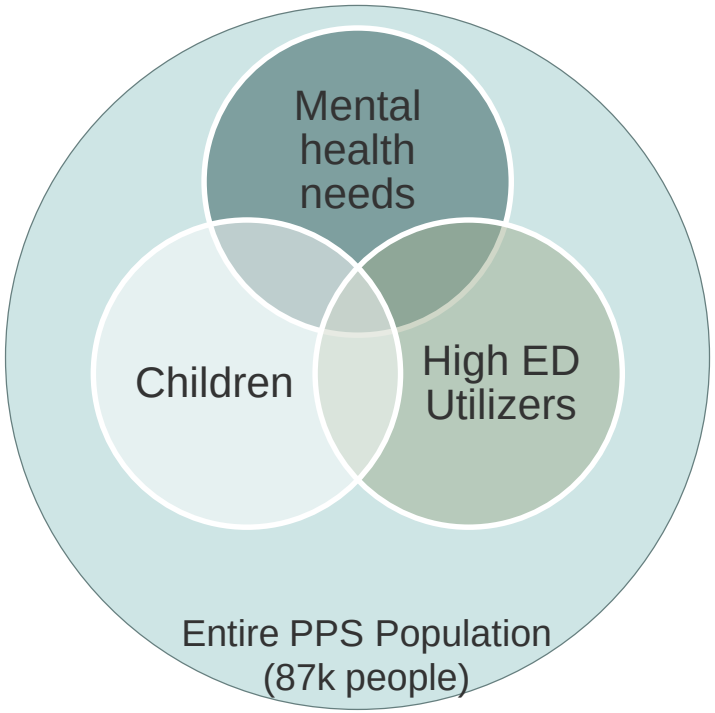
Project Structure Hampers Focus on P4P Metrics

- PPS operations by *Projects* create silos
- PPS operations by *Population Lines* maximize natural overlaps

Pre-Pivot, Focus = P4R



Post-Pivot, Focus = P4P



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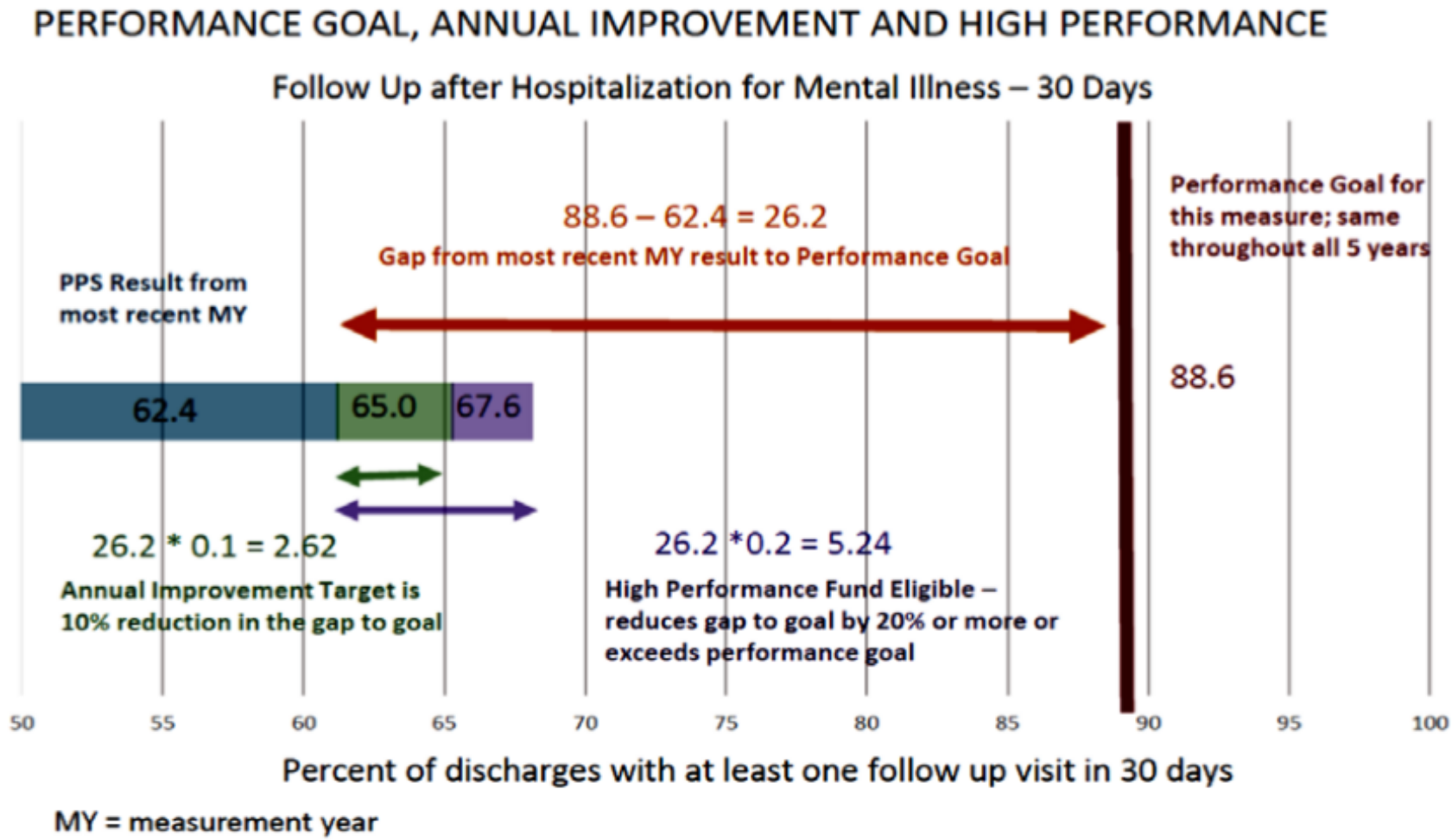
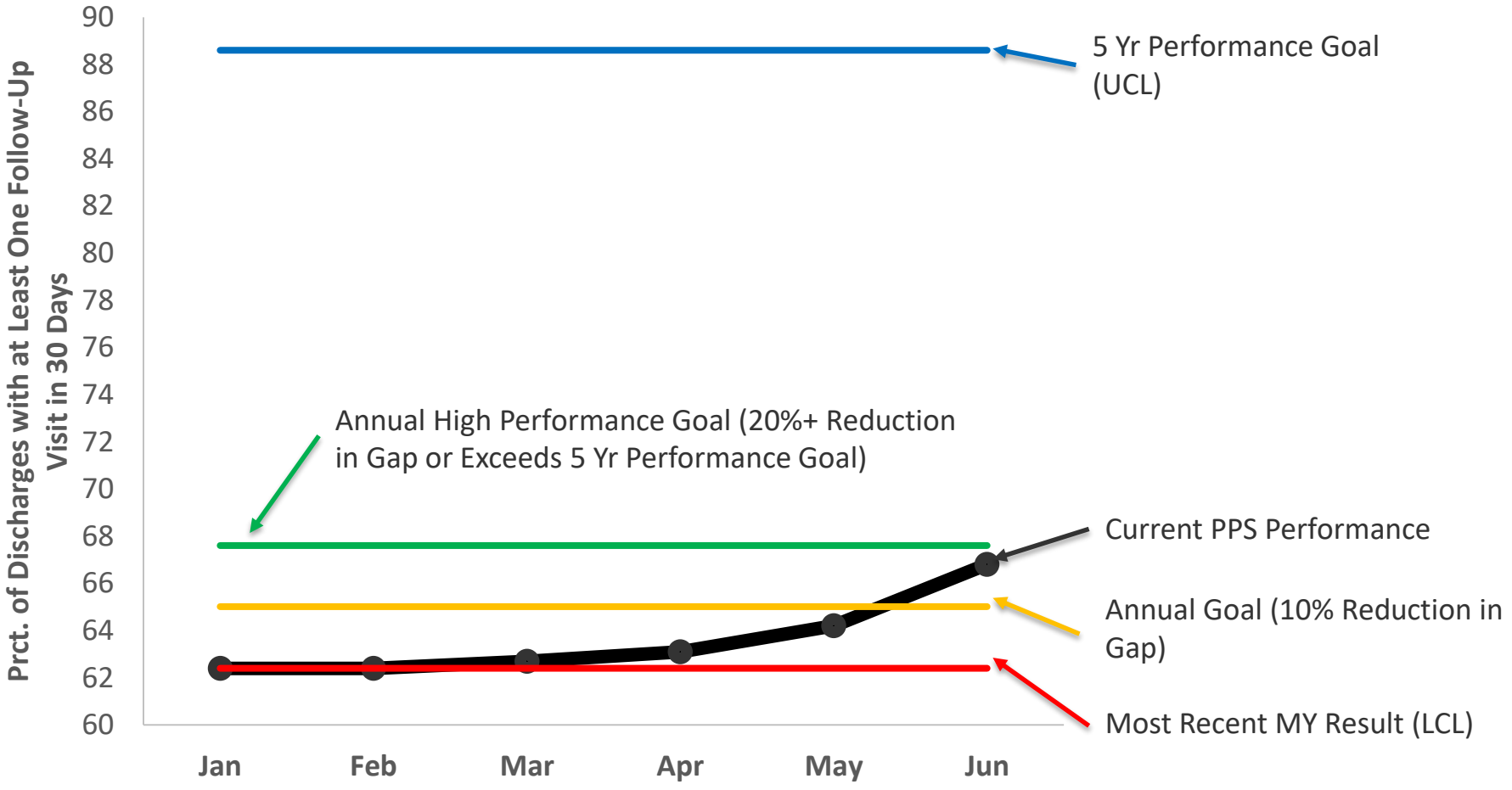
How Performance Goals & Improvement Targets are Set



Visual of DSRIP Annual Performance Targets



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A Closer Look at the New York State Medicaid Analytics Performance Portal (MAPP)

- Claims data in summary format
- Trends analyses
- Geographic analyses
- Access to patient- and provider-level data

MAPP Tool
Screenshots

Domain	ID	Measure Name	Projects Associated with	Numerator Description	Denominator Description	Reporting Responsibility	Source	Payment: DY 2 and 3	Payment: DY 4 and 5	5-Year Dollar P4P Value (excludes P4R Value)
Two	2-10	Adult Access to Preventive or Ambulatory Care - 20 to 44 years	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of adults who had an ambulatory or preventive care visit during the measurement year	Number of adults ages 20 to 44 as of June 30 of the measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 372,613.84
Two	2-11	Adult Access to Preventive or Ambulatory Care - 45 to 64 years	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of adults who had an ambulatory or preventive care visit during the measurement year	Number of adults ages 45 to 64 as of June 30 of the measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 372,613.84
Two	2-12	Adult Access to Preventive or Ambulatory Care - 65 and older	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of adults who had an ambulatory or preventive care visit during the measurement year	Number of adults ages 65 and older as of June 30 of the measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 372,613.84
Three	3-11	Screening for Clinical Depression and Follow-Up Plan	3.a.i - 3.a.iv	Number of people screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen	Number of people with a qualifying outpatient visit who are age 18 and older	PPS and NYS DOH	Medical Record Review	P4R	P4P	$ 353,127.00
Three	3-16	Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Medication	3.b.i - 3.b.ii, 3.c.i - 3.c.ii, 3.e.i, 3.h.i	Number of responses "Sometimes,' 'Usually' or 'Always' discussed cessation medications	Number of respondents ages 18 years and older, who smoke or use tobacco some days or every day	NYS DOH	CG-CAHPS (administered by NYS)	P4R	P4P	$ 1,112,693.90
Three	3-17	Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Strategies	3.b.i - 3.b.ii, 3.c.i - 3.c.ii, 3.e.i, 3.h.i	Number of responses 'Sometimes,' 'Usually' or 'Always' discussed cessation methods or strategies	Number of respondents ages 18 years and older, who smoke or use tobacco some days or every day	NYS DOH	CG-CAHPS (administered by NYS)	P4R	P4P	$ 1,112,693.90
Three	3-52	IPOS Q2 - Pain Experienced	3.g.i - 3.g.ii	Number of patients offered or provided an intervention for the question	Number of survey respondents who selected "Moderately," "Severely," or "Over-whelmingly"	NYS DOH	PPS-Completed Survey	P4R	P4P	$ 185,815.65
Three	3-53	IPOS Q2 - Symptoms Experienced	3.g.i - 3.g.ii	Number of patients offered or provided an intervention for the question	Number of survey respondents who selected at least one "Moderately," "Severely," or "Over-whelmingly" fot shortness of breath, nausea, weakness, vomiting, poor appetite, constipation, etc.	NYS DOH	PPS-Completed Survey	P4R	P4P	$ 185,815.65
Three	3-54	IPOS Q3 - Anxious about Illness or Treatment	3.g.i - 3.g.ii	Number of patients offered or provided an intervention for the question	Number of survey respondents who selected "Sometimes," "Most of the time," or "Always"	NYS DOH	PPS-Completed Survey	P4R	P4P	$ 185,815.65
Three	3-55	IPOS Q5 - Depression Feeling	3.g.i - 3.g.ii	Number of patients offered or provided an intervention for the question	Number of survey respondents who selected "Sometimes," "Most of the time," or "Always"	NYS DOH	PPS-Completed Survey	P4R	P4P	$ 185,815.65
Three	3-56	IPOS Q11 - Advanced Care Planning	3.g.i - 3.g.ii	Number of patients offered or provided an intervention for the question (healthcare proxy, Living Will, Organ Donation, Documentation of Oral Advance Directive)	Number of people who selected "None"	NYS DOH	PPS-Completed Survey	P4R	P4P	$ 185,815.65
Three	3-1	Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) +/-	3.a.i - 3.a.iv	Number of preventable emergency visits as defined by revenue and CPT codes	Number of people with a BH diagnosis (excludes those born during the measurement year) as of June 30 of measurement year	NYS DOH	MCD Claims	P4P	P4P	$ 601,657.84
Three	3-10	Follow-up after hospitalization for Mental Illness - within 30 days	3.a.i - 3.a.iv	Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 7 days of discharge	Number of discharges between the start of the measurement period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders	NYS DOH	MCD Claims	P4P	P4P	$ 300,829.00
Three	3-12	Adherence to Antipsychotic Medications for People with Schizophrenia	3.a.i - 3.a.iv	Number of people who remained on an antipsychotic medication for at least 80% of their treatment period	Number of people, ages 19 to 64 years, with schizophrenia who were dispensed at least 2 antipsychotic medications during the measurement year	NYS DOH	MCD Claims	P4P	P4P	$ 601,658.00

Domain	ID	Measure Name	Projects Associated with	Numerator Description	Denominator Description	Reporting Responsibility	Source	Payment: DY 2 and 3	Payment: DY 4 and 5	5-Year Dollar P4P Value (excludes P4R Value)
Three	3-13	Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	3.a.i - 3.a.iv	Number of people who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence	NYS DOH	MCD Claims	P4P	P4P	$ 300,829.00
Three	3-14	Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	3.a.i - 3.a.iv	Number of people who initiated treatment AND who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence	NYS DOH	MCD Claims	P4P	P4P	$ 300,829.00
Three	3-2	Antidepressant Medication Management - Effective Acute Phase Treatment	3.a.i - 3.a.iv	Number of people who remained on antidepressant medication during the entire 12-week acute treatment phase	Number of people 18 and older who were diagnosed with depression and treated with an antidepressant medication	NYS DOH	MCD Claims	P4P	P4P	$ 300,829.00
Three	3-3	Antidepressant Medication Management - Effective Continuation Phase Treatment	3.a.i - 3.a.iv	Number of people who remained on antidepressant medication for at least six months	Number of people 18 and older who were diagnosed with depression and treated with an antidepressant medication	NYS DOH	MCD Claims	P4P	P4P	$ 300,829.00
Three	3-4	Diabetes Monitoring for People with Diabetes and Schizophrenia	3.a.i - 3.a.iv	Number of people who had both an LDL-C test and an HbA1c test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and diabetes	NYS DOH	MCD Claims	P4P	P4P	$ 601,658.00
Three	3-5	Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	3.a.i - 3.a.iv	Number of people who had a diabetes screening test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication	NYS DOH	MCD Claims	P4P	P4P	$ 601,657.84
Three	3-6	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	3.a.i - 3.a.iv	Number of people who had an LDL-C test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and cardiovascular disease	NYS DOH	MCD Claims	P4P	P4P	$ -
Three	3-9	Follow-up after hospitalization for Mental Illness - within 7 days	3.a.i - 3.a.iv	Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 7 days of discharge	Number of discharges between the start of the measurement period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders	NYS DOH	MCD Claims	P4P	P4P	$ 300,829.00
Two	2-1	Potentially Avoidable Emergency Room Visits +/-	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of preventable emergency visits as defined by revenue and CPT codes	Number of people (excludes those born during the measurement year) as of June 30 of measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 1,117,841.51
Two	2-17	Getting Timely Appointments, Care and information (Q6, 8, 10, and 12)	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number responses 'Usually' or 'Always' got appt for urgent care or routine care as soon as needed, got answers the same day if called during the day or response as soon as needed if called after hours	Number who answered they called for appointments or called for information	NYS DOH	CG-CAHPS (administered by NYS)	P4R	P4P	$ 1,117,841.51
Two	2-2	Potentially Avoidable Readmissions +/-	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of readmission chains (at risk admissions followed by one or more clinically related readmission within 30 days of discharge)	Number of people as of June 30 of the measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 1,117,841.51
Two	2-22	CAHPS Measures - Care Coordination with provider up-to-date about care received from other providers	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number responses 'Usually' or 'Always' that doctor informed and up- to-date about care received from other providers	All responses with member seeing more than one provider	NYS DOH	CG-CAHPS (administered by NYS)	P4R	P4P	$ 1,117,841.51
Two	2-3	PQI 90 - Composite of all measures +/-	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of admissions which were in the numerator of one of the adult prevention quality indicators	Number of people 18 years and older as of June 30 of measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 1,117,841.51
Two	2-4	PDI 90 - Composite of all measures +/-	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of admissions which were in the numerator of one of the pediatric prevention quality indicators	Number of people 6 to 17 years as of June 30 of measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 1,117,841.51

Domain	ID	Measure Name	Projects Associated with	Numerator Description	Denominator Description	Reporting Responsibility	Source	Payment: DY 2 and 3	Payment: DY 4 and 5	5-Year Dollar P4P Value (excludes P4R Value)
Two	2-8	Primary Care - Usual Source of Care - Q2	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Percent of Reponses 'Yes'	All Responses	NYS DOH	CG-CAHPS (administered by NYS)	P4R	P4P	$ 558,920.75
Two	2-9	Primary Care - Length of Relationship - Q3	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Percent of Responses at least '1 year' or longer	All Responses	NYS DOH	CG-CAHPS (administered by NYS)	P4R	P4P	$ 558,920.75
Three	3-15	Medical Assistance with Smoking and Tobacco Use Cessation - Advised to Quit	3.b.i - 3.b.ii, 3.c.i - 3.c.ii, 3.e.i, 3.h.i	Number of respondents who were advised to quit	Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day	NYS DOH	CG-CAHPS (administered by NYS)	P4R	P4P	$ 62,560.00
Three	3-40	HIV/AIDS Comprehensive Care - Syphilis Screening	3.e.i	Number of people who were screened for syphilis in the past year	Number of people living with HIV/AIDS, ages 19 years and older	NYS DOH	MCD Claims	P4P	P4P	$ 378,047.00
Three	3-41	Cervical Cancer Screening	3.e.i	Number of women who had cervical cytology performed every 3 years or women, ages 30 to 64 years, who had cervical cytology/human papillomavirus (HPV) co- testing performed every 5 years	Number of women, ages 24 to 64 years	NYS DOH	MCD Claims	P4R	P4P	$ 187,681.09
Three	3-42	Chlamydia Screening (16 - 24 Years)	3.e.i	Number of women who had at least one test for Chlamydia during the measurement year	Number of sexually active women, ages 16 to 24	NYS DOH	MCD Claims	P4P	P4P	$ 378,047.00
Three	3-38	HIV/AIDS Comprehensive Care - Engaged in Care	3.e.i	Number of people who had two visits for primary care or HIV related care with at least one visit during each half of the past year	Number of people living with HIV/AIDS, ages 2 years and older	NYS DOH	MCD Claims	P4P	P4P	$ 378,047.00
Three	3-39	HIV/AIDS Comprehensive Care - Viral Load Monitoring	3.e.i	Number of people who had two viral load tests performed with at least one test during each half of the past year	Number of people living with HIV/AIDS, ages 2 years and older	NYS DOH	MCD Claims	P4P	P4P	$ 378,047.00
Three	3-43	Viral Load Suppression	3.e.i	Number of people whose most recent viral load result was below 200 copies	Number of people living with HIV/AIDS	PPS and NYS DOH	Medical Record Review	P4R	P4P	$ 187,681.09
Two	2-13	Children's Access to Primary Care - 12 to 24 months	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of children who had a visit with a primary care provider during the measurement year	Number of children ages 12 to 24 months as of June 30 of the measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 279,460.38
Two	2-14	Children's Access to Primary Care - 25 months to 6 years	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of children who had a visit with a primary care provider during the measurement year	Number of children ages 25 months to 6 years as of June 30 of the measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 1,592,127.30
Two	2-15	Children's Access to Primary Care - 7 to 11 years	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of children who had a visit with a primary care provider during the measurement year or year prior	Number of children ages 7 to 11 years as of June 30 of the measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 1,592,127.30
Two	2-16	Children's Access to Primary Care - 12 to 19 years	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Number of children who had a visit with a primary care provider during the measurement year or year prior	Number of children ages 12 to 19 years as of June 30 of the measurement year	NYS DOH	MCD Claims	P4R	P4P	$ 1,592,127.30
Three	3-7	Follow-up care for Children Prescribed ADHD Medications - Initiation Phase	3.a.i - 3.a.iv	Number of children who had one follow-up visit with a practitioner within the 30 days after starting the medication	Number of children, ages 6 to 12 years, who were newly prescribed ADHD medication	NYS DOH	MCD Claims	P4R	P4P	$ 1,226,696.83

Domain	ID	Measure Name	Projects Associated with	Numerator Description	Denominator Description	Reporting Responsibility	Source	Payment: DY 2 and 3	Payment: DY 4 and 5	5-Year Dollar P4P Value (excludes P4R Value)
Three	3-8	Follow-up care for Children Prescribed ADHD Medications - Continuation Phase	3.a.i - 3.a.iv	Number of children who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits in the 9-month period after the initiation phase ended	Number of children ages 6 to 12 years, who were newly prescribed ADHD medication and remained on the medication for 7 months	NYS DOH	MCD Claims	P4R	P4P	$ -
Two	2-21	H-CAHPS - Care Transition Metrics (Q23, 24, and 25)	2.a.i - 2.a.v, 2.b.i - 2.b.ix, 2.c.i - 2.c.ii	Average of Hospital specific results for the Care Transition composite using Strongly Agree and Agree responses	Hospitals with H-CAHPS participating in the PPS network	NYS DOH	H-CAHPS	P4R	P4P	$ 1,117,841.51

NewYork-Presbyterian
Performing Provider System

NewYork-Presbyterian Performing Provider System (NYP PPS)

Clinical Integration Needs Assessment & Strategic Plan

NewYork-Presbyterian
Performing Provider System

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NewYork-Presbyterian
Performing Provider System

Part I: Clinical Integration (CI) Needs Assessment

Objective

The NewYork-Presbyterian Performing Provider System (NYP PPS) defines "clinical integration" as a continuous effort to align the comprehensive continuum of services, conditions, providers and settings. The ultimate goal of clinical integration is to achieve alignment across these factors to deliver care that is safe, timely, effective, equitable and patient-focused.

The NYP PPS is committed to creating an accessible, integrated delivery system for the patients and communities it serves. The PPS has identified, through a needs assessment process conducted in consultation with its organizational committees, project teams and the PPS Clinical Operations Committee, three strategic focus areas for improving clinical integration across the network. Part I of this document details a Clinical Integration Needs Assessment which has identified specific risks and gaps in each of these strategic focus areas and presents mitigation strategies to address them. Part II of this document presents strategies to capture the opportunities and mitigate the risks with each strategic focus area.

The strategic focus areas are:

1. Care Transitions Management;
2. Technology Infrastructure;
3. Training & Change Management.

NYP PPS Overview of Integrated In-Network Providers

The NYP PPS is a network of 83 diverse providers and community collaborators (see Table 1) jointly committed to improving the health and wellbeing of patient populations while addressing unnecessary hospital and emergency department utilization and the social determinants of health. Of these, seven providers are also health home downstream partners. NewYork-Presbyterian Hospital (NYPH) is the anchor institution for this collaboration, which delivers acute care across six campuses and primary care through its Ambulatory Care Network (ACN).

The NYP PPS has classified network collaborators by five service types (Primary Care & Other Specialty, Post-Acute, Pharmacy, Community-Based and Mental Health & Substance Use, with further indication if an organization is also a downstream Health Home partner).

Table 1: Number of Providers in NYP PPS by Provider Type

Provider Type	Count in Network
Primary Care & Other Specialty	14
Post-Acute	21
Pharmacy	11
Community-Based	23
Mental Health & Substance Use	14

Please refer to Appendix A for the comprehensive list of collaborators which the PPS will engage in its Clinical Integration Strategy. The PPS collaborates with this network of providers to implement the 10 DSRIP projects. Projects such as Ambulatory ICU, ED Care Triage, Integrated Delivery System and Transitions of Care help the PPS to better assess the current state of clinical integration and are vehicles for leading change within the provider network. In combination with the steering committees from each of these projects, the PPS actively engages its organizational committees and the PPS Clinical Operations Committee to discuss, plan, implement and monitor integration efforts.

Care Transitions Management Needs Assessment

Current State

In order to accomplish the mutual goal of managing patient transitions of care, the NYP PPS actively cultivates relationships between four NYP hospitals, in-network community collaborators, NYP Transitions of Care Managers (TCMs) and Ambulatory Care Network (ACN) RN Care Managers.

The PPS Transitions of Care Project on-boarded six Community Health Workers (CHWs) who are employed by the Northern Manhattan Improvement Corporation, Hamilton-Madison House and Lenox Hill Neighborhood House. The key functions of the CHW role include:

1. Home visits and assessment of non-medical causes of readmission, such as lack of transportation or food insecurity;
2. Accompanying patients to post-discharge follow-up appointments with primary care provider(s);
3. Addressing patient pharmaceutical challenges through pursuit of a Pharmacist resource for medication reconciliation and direct patient education;
4. Using electronic health records and IT systems to share patient information, facilitate the transmission of care plans to subsequent care settings and send hospital discharge paperwork to next-level providers.

The Project also developed a training/orientation shadowing protocol to facilitate the partnership between TCMs and CHWs and successfully launched the CHW model as of October 2016. Specialized CHW assessments and follow-up notes have been created in AllScripts Care Director, the vehicle for CHW documentation. Additionally, the Transitions of Care team holds bi-weekly calls with the CHW program and the Health Home to improve collaboration and address real-time challenges. Currently, the team is in the process of evaluating an electronic referral mechanism to both entities.

Transitions of Care is also collaborating with home care agencies to expand transitional care workflows and implement a transportation aide program from hospital-to-home and home-to-subsequent care settings throughout the 30-day post-discharge period.

Gaps & Risks

Within the PPS, staff and resources which impact care transitions are fragmented across inpatient, ambulatory, community and post-acute providers. Historically, transformation efforts have resulted in care plans which are not shared across practice areas, have created protocols which subject patients to

redundant outreach by PPS staff and care pathways that fragment and complicate care for patients. All of these realities serve only to widen gaps in care, rather than close them.

Risks to the PPS from such a misalignment manifest themselves in multiple ways. First, front line clinical teams receive redundant, incomplete or even conflicting guidance for activities which are critically important to successful clinical integration, such as risk stratification and prioritization, staff roles and chronic condition management. Second, referral workflows and care pathways between inpatient, ambulatory and post-acute providers, CBOs and health homes vary greatly by practice setting, placing patients at increased risk of adverse events when transitioning between practice settings.

Technology Infrastructure Needs Assessment

Current State

Effective clinical integration will require the sharing of clinical and other relevant information with network providers and be readily accessible for all providers across the patient care spectrum. The PPS envisions a connected care environment where a single patient's care can be collaboratively managed by providers in hospitals, ambulatory clinics, Community Based Organizations, (CBOs) and elsewhere. Collaborative management will consist of agreed upon workflows that are supported by various information technology capabilities.

IT systems infrastructure is a significant investment for the PPS and for participating network members. In order to support quality improvement, the PPS leverages multiple documentation and data systems, including the Healthix RHIO, NYS Medicaid Analytics Performance Portal, the Salient Interactive Miner, NYP's EHRs, the Healthify tool for community resource referral management, future distributions of NYS Medicaid claims data and the collaborators' documentation systems.

Gaps & Risks

The PPS network is currently pursuing an enhanced IT infrastructure through a variety of mechanisms for its collaborators. For some providers, this meant becoming PCMH-certified or enhancing their level of certification or joining the RHIO. For others, it meant learning and utilizing Allscripts Care Director and tracking and monitoring registries of Medicaid beneficiaries participating in the PPS. A fragmented IT infrastructure leads to challenges in developing new tools to support collaborative workflows and in analytic tools to support rapid-cycle improvement.

Training & Change Management Needs Assessment

Current State

Optimizing Collaborative Clinical Governance, Clinical Programs and IT Infrastructure are central activities to the PPS's success and also represent transformational changes to the way care is delivered and evaluated. As with all transformational changes (particularly those carried out across diverse organizational cultures), individual participants have experienced the changes in different ways and at

different rates. On one extreme, some participants have welcomed change with open arms, while conversely others have offered pointed resistance. The sources of resistance have been diverse.

Gaps & Risks

Unmanaged, resistance to change has the potential to significantly delay the clinical quality, patient experience and utilization improvements sought by the DSRIP program. The PPS also does not operate in a vacuum. Clinical teams and administrative leaders alike face pressures from state and federal regulators and from participation in other value-based reimbursement models (PCMH, MSSP ACO, etc.).

Conclusion

The NYP PPS, with guidance from the PPS Clinical Operations Committee, completed an in-depth analysis of the current state of clinical integration and identified associated risks. The NYP PPS is committed to leveraging all available resources to ensure that each risk is managed appropriately and that both network collaborators and patients realize tangible benefits from the DSRIP projects. This plan will guide the clinical integration strategic planning process for the PPS and will continue to evolve as collaborator and organizational needs change throughout the DSRIP initiative's life-cycle.

Next Steps

To take action on the Clinical Integration Needs Assessment the PPS will recommended appropriate mitigation strategies including technology infrastructure for adoption and, through collaborative clinical governance bodies, expand its support of integrated transitions of care planning and training opportunities which support both the DSRIP goals and those of providers across the network.

Part II: Clinical Integration (CI) Strategy

Providers to Be Integrated

The NYP PPS is committed to deepening its understanding of in-network provider activities. As the PPS begins to discuss rapid-cycle workflow and quality improvement efforts at the provider level, early activities to advance the current state of clinical integration could include:

- Mapping each network provider and their requirements for clinical integration (including IT systems use, referral patterns and/or treatment protocols);
- Stratifying collaborators into phases of PPS-supported technology infrastructure roll-out;
- Surveying collaborators to better understand gaps in clinical and operations skills development.

Care Transitions Management Mitigation Strategy

The primary focus areas of this strategy is to strengthen continuity of care between inpatient care, primary care and subsequent post-acute settings in order to reduce the risk of avoidable readmissions within 30 days. The target population is patients who have an increased likelihood of readmission or who are deemed at-risk by their care team (psychosocial and medical determinants). Particular focus is given to patients with three or more inpatient admissions in the past twelve months and/or patients who have challenging medication regimens.

The PPS has already launched or committed to participating in clinical programs that target major opportunities in care improvement. These include:

1. Embedding RN Transitional Care Managers (TCMs) on inpatient medicine and cardiac units who work with patients and interdisciplinary care teams for 30 days post-discharge in order to:
    a. Educate patients and caregivers on disease and self-management;
    b. Facilitate timely follow-up with primary care provider(s);
    c. Coordinate medical and social service needs to overcome barriers to safe transitions.
2. Identification and management of high-risk patients (such as those with multiple chronic conditions, severe mental illness or HIV/AIDS) through newly created patient stratification tools, discussion at daily Interdisciplinary Rounds (IDR) meetings and direct provider referral;
3. Enhancing care transitions services and collaboration with next-level of care providers through workflows, structured hand-offs and case conferences with home care agencies, ambulatory clinics, the NYP Health Home and community-based organizations employing Community Health Workers (CHWs). The project employs CHWs who collaborate with TCMs to facilitate and reinforce disease-focused education in a linguistically and culturally-appropriate manner to patients and caregivers.

Technology Infrastructure Mitigation Strategy

The IT infrastructure for the PPS has eight main components covering key data points for shared access and the key interfaces that will have an impact on clinical integration.

Key Data Points

1. Patient ADT feed;
2. Assigned PCP with contact information;
3. Assigned Care Manager with contact information;
4. Medication list;
5. Care plan notes for discharge instructions, follow-up appointments and crisis stabilization plan;
6. Tools for integrating information regarding community resources and care received out-of-network, such as Healthify and Healthix.

Key Interfaces to Impact Clinical Integration

1. Workflow 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 manage registries of patients; track 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. This application is also used by the NYP Health Home.

2. EHR Enhancements

   The inpatient and outpatient EHRs 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. 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. The PPS will also work with its collaborators to enhance their documentation platforms, as appropriate and necessary.

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

   Culturally competent CHWs, Peers and field-based staff (e.g. CASACs) serve as a link between patients and medical/social services. The CHWs 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 were selected, the application was implemented and CHWs have been trained in the use of the hardware and application.

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 twenty-three (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 Enterprise Master Patient Indices 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 the 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 Medical Center PPS has already contracted with Healthify so there is precedence for using this platform in a PPS Network.

Training & Change Management Mitigation Strategy

Training opportunities have already been provided in several areas to address needs in the areas of care coordination across settings, clinical documentation tools and communication for coordination and operations staff. Examples of such trainings include:

- "Transitional Care Protocol" – Review of the 10-day care transitions workflow;
- "AllScripts Care Director (ACD) Application Training" – Use of the ACD tool for DSRIP project teams;
- "Care Management and the Health Home;"
- Three-day intensive Care Management training;
- "Bridges to Better Health and Wellness" – CHW and Care Managers in community mental health settings;
- MAX Series – trainings and train-the-trainer sessions on developing robust quality improvement projects to impact high-utilizers and patients with needs in managing transitions of care;
- "DSRIP CHW and Patient Navigator Events" – self-care workshop, change management training, managing patient with asthma and COPD.

Please reference the Training Template for a complete list of relevant trainings conducted to-date.

In addition to ensuring that training opportunities of these types remain available to NYPH and in-network staff, the PPS will also continue to use a structured change management approach, partnering with NYPH and the collaborators' institutional change management resources. The PPS believes that being able to manage change is a core skill for any leader in the network. Over time, stakeholders will receive training in methods for addressing resistance and managing change throughout a project lifecycle, and in how to identify the root causes of resistance to change. Upon delivery of these trainings, the PPS expects to realize improvements in the time-to-completion of key deliverables and participation in governance meetings.

To date, the PPS has engaged senior leaders as active and most importantly visible sponsors of transformational changes. Senior leaders from every corner of the network have a presence on the PPS governing committees and many project-level steering committees. Additionally, the PPS has recruited the support of middle managers and frontline supervisors as advocates of these changes. Many of these individuals serve as Project Leads for the ten DSRIP projects and other highly aligned programs. Effective and timely communications are another cornerstone of the PPS's change management strategy.

Through these channels, the PPS is able to communicate the need for change, the impact on clinical teams and the benefits to the clinical teams.

Conclusion

Through its investments in workforce development and technology for care transitions management, the NYP PPS has shown a commitment to improving the current state of clinical integration and reducing 30-day readmissions. To help guide its work, the PPS will also continue to evolve its project governance structures, including a shift from a project-centric (siloed) model focused on pay-for-reporting metrics and operations to a population-centric model prioritizing rapid-cycle workflow redesign, quality improvement interventions and pay-for-performance metrics. It is expected that such changes will lead to discussions about the DSRIP projects as collaborative quality improvement efforts rather than independently managed DSRIP requirements.

The Executive Committee and the Clinical Operations Committee will play central roles in leading any change. Any new governance model will focus on standardizing approaches, terminology and reporting requirements in addition to exploring options for distribution of performance funds to encourage performance. The PPS is also considering identifying a dedicated clinical leader to spearhead clinical integration and practice redesign efforts across the collaborator network.

Next Steps

Next, the PPS will reduce the identified risks to successful clinical integration by aligning: (1) transitions of care management and change management skills training plans with those already developed for practitioner engagement and workforce skills training; and (2) technology infrastructure implementation plans with those already developed for population health management and clinical data sharing.

Appendix

Appendix A: List of Providers in NYP PPS by Provider Type

Primary Care Providers and Other Specialty Providers (*Health Home downstream provider)

1. Access CHC
2. AJS Medical Practice
3. Andres Pereira, MD/Inwood D&T Center
4. Charles B. Wang Community Health Center
5. Columbia University Medical Center
6. Community Healthcare Network
7. Elizabeth Seton Pediatric Center / Children's Rehab Center
8. Gabriel Guardarramas, MD
9. Harlem United / Upper Room AIDS Ministry
10. Jose Jerez, MD
11. New York City Department of Health and Mental Hygiene
12. NewYork-Presbyterian Hospital
13. Theodore C. Docu, MD, PC
14. Weill Cornell Medical College

Post-Acute Care Providers (*Health Home downstream provider)

1. Amsterdam Nursing Home
2. Blythedale Children's Hospital
3. Calvary Hospital
4. Dominican Sisters Family Health Service
5. ElderPlan, Inc. (MJHS)
6. Empire State Home Care Services
7. Extraordinary Home Care
8. HomeFirst LHCSA, Inc.
9. Isabella Geriatric Center*
10. Mary Manning Walsh Residence
11. Menorah Home and Hospital for the Aged and Infirm
12. Methodist Home for Nursing and Rehabilitation
13. MJHS
14. Riverdale Mental Health Association
15. St. Mary's Center – Harlem
16. St. Mary's Hospital for Children
17. St. Vincent de Paul Residence
18. Schervier Nursing Home
19. Terrence Cardinal Cooke Health Care Center
20. Village Care*
21. Visiting Nurse Service of New York

Pharmacy Providers (*Health Home downstream provider)

1. QuickRx - Audubon
2. QuickRx - Lexington
3. AIDS Healthcare Foundation
4. Boan Drug, Inc.
5. C&C Drug, Inc.
6. CityDrug & Surgical, Inc.
7. Heights Pharmacy, Inc.
8. Island Care Pharmacy
9. Melbran Pharmacy
10. Metrocare Pharmacy, Inc.
11. Nature's Cure Pharmacy

Community-Based Organizations (*Health Home downstream provider)

1. 1199 Training Fund
2. AIDS Service Center NYC (ASCNYC)*
3. Argus*
4. Association to Benefit Children

5. Catholic Resources, Inc.
6. City Meals on Wheels
7. City-Pro Group, Inc. / ABI
8. Coalicion Mexicana
9. Community League of the Heights
10. Dominican Women's Development Center
11. Fort George Community Enrichment Center
12. God's Love We Deliver
13. Hamilton-Madison House
14. Inwood Community Services
15. Iris House
16. Lenox Hill Neighborhood House
17. NAMI - NYC Metro
18. New York Legal Assistance Group
19. Northern Manhattan Improvement Corporation
20. Northern Manhattan Perinatal Partnership
21. Northside Center for Child Development
22. Riverstone Senior Life Services
23. Union Settlement Association

Mental Health & Substance Use Providers (*Health Home downstream provider)

1. ACMH*
2. Cornerstone Treatment Facilities
3. Create, Inc.
4. Fountain House
5. Karen Horney Clinic
6. Metropolitan Center for Mental Health
7. New York State Psychiatric Institute (NYSPI)
8. Project Renewal, Inc.
9. Realization Center, Inc.
10. Service Program for Older People
11. St. Christopher's Inn
12. The Bridge*
13. Upper Manhattan Mental Health Center, Inc.*
14. Washington Heights CORNER Project

Community Provider Quality Improvement Population Line Lead Responsibilities:

The Community Provider Quality Improvement Population Line Lead will be responsible for overseeing the discovery and implementation planning for interventions that improve the NewYork-Presbyterian Hospital Performance Provider System's performance on the DSRIP pay-for-performance metrics (list below), specifically working with the following providers:

1. Federally Qualified Health Centers
    a. Community Healthcare Network / Community League Health Center
    b. Community Healthcare Network / Catherine Abate Essex Street Health Center
    c. Charles B. Wang Community Health Center (Chinatown)
    d. Harlem United / Upper Room AIDS Ministry
    e. Access Community Health Center
2. Independent Community Physicians
    a. Jose Jerez, MD
    b. Andres Pereira, MD
    c. Gabriel Guadarramas, MD
    d. Theodore Docu, MD
3. Other behavioral health organizations as identified for related quality improvement opportunities

Collaborate with local practice leadership from the entities listed above to:

- Plan quality improvement interventions that are best practice/evidenced-based to show improvement on pay-for-performance metrics
- Develop workflows and care plans, as appropriate
- Advise on analytics and information systems processes to support quality improvement initiatives
- Meet with collaborators to troubleshoot operational challenges related to achieving the P4P metrics
- Review primary-care focused performance measurement data in order to drive initiatives
- Develop a funds flow process to support community providers in achieving pay for performance
- Establish a governance structure to engage community providers in collective quality improvement efforts
- Manage and guide practices' achievement of 2014 PCMH status
- Coordinate efforts with other Population Lines (especially Transitions and Community Providers)
- Leverage project management staff to organize, manage and prioritize efforts

Measure Name
Adherence to Antipsychotic Medications for People with Schizophrenia
Adults w/ Preventive or Ambulatory Care Visit in Last Year - 20 to 44 years
Adults w/ Preventive or Ambulatory Care Visit in Last Year - 45 to 64 years
Adults w/ Preventive or Ambulatory Care Visit in Last Year - 65 and older
Antidepressant Medication Management - Effective Acute Phase Treatment
Antidepressant Medication Management - Effective Continuation Phase Treatment

CAHPS - Getting Timely Appointments, Care and Information (Q6, 8, 10, and 12)
CAHPS - Length of Primary Care Relationship >/= One Year (Q3)
CAHPS - Provider is Usual Source of PCP Care (Q2)
CAHPS - Provider Up-to-Date about Care Received from Other Providers (Care Coordination)
Cardiovascular Monitoring (LDL-C Test) for People with Cardiovascular Disease and Schizophrenia
Cervical Cancer Screening
Chlamydia Screening (16 - 24 Years)
Diabetes Monitoring (Both LDL-C Test & HbA1c Test) for People with Diabetes and Schizophrenia
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication
Medical Assistance with Smoking and Tobacco Use Cessation - Advised to Quit
Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Medication
Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Strategies
Potentially Avoidable Emergency Room Visits
Potentially Avoidable Readmissions
Potentially Preventable Admissions - Adults (PQI 90)
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis)
Screening for Clinical Depression and Follow-Up Plan