NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	8/15/16, 8am-9am	**Meeting Title**	NYP PPS Executive Committee
Location	Milstein Hospital, 1HN-151 / GoTo	**Facilitator**	Betty Cheng, David Alge
Go to Meeting	https://global.gotomeeting.com/join/530564805	**Conference Line**	United States +1 (872) 240-3412 Access Code: 530-564-805

Invitees	
Betty Cheng (CBWCHC)	David Alge
Ashanti Chimurenga (NMPP)	Emilio Carrillo (Clinical Operations)
Sharen Duke (ASCNYC)	Brian Kurz (Finance)
Jay Gormley (MJHS)	Steven Kaplan & Gil Kuperman (Data/IT Governance)
Ellen Harnett (Isabella)	Anne Sperling (PAC)

Meeting Objectives	**Time**
1. Review Action Items from Last Meeting	2 mins
2. Governance Rotations	10 mins
3. NYP PPS and NYS DSRIP Updates	10 mins
4. Approval of the Population Health Strategy	10 mins
5. Presentation from the SKATE (Special Kids Achieving Their Everything) Project	30 mins
6. Identify Action Items for Next Meeting	2 mins

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Discussion with NYS around timeliness of performance data.	Isaac Kastenbaum	7/18/2016	8/15/2016	In progress
Continue NYP PPS and NYS DSRIP updates at next meeting.	Lauren Alexnander	7/18/2016	8/15/2016	In progress

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Invitees	
Betty Cheng (CBWCHC)	David Alge
Maria Moreno (NYP)	Emilio Carrillo (Clinical Operations)
Lauren Alexander (NYP)	Brian Kurz (Finance)
Jay Gormley (MJHS)	Steven Kaplan & Gil Kuperman (Data/IT Governance)
Ellen Harnett (Isabella)	Anne Sperling (PAC)
Connie Kostacos (NYP)	

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Discussion with NYS around timeliness of performance data.	Isaac Kastenbaum	7/18/2016	8/15/2016	In progress
Share governance committee rotation results with Committee	Lauren Alexander	8/15/2016	9/19/2016	In progress
Share VBP bootcamp slides	Lauren Alexander	8/15/2016	9/19/2016	In progress

Approvals:
The Population Health Management Strategy was presented for approval by Emilio Carrillo. Dr. S. Kaplan motioned to approve. E. Hartnett seconded. All were in favor.

NewYork-Presbyterian
Performing Provider System

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. Gabriel Guardarramas, MD
3. Jose Jerez, MD
4. Theodore Docu, MD

As of 8/11/2016

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.

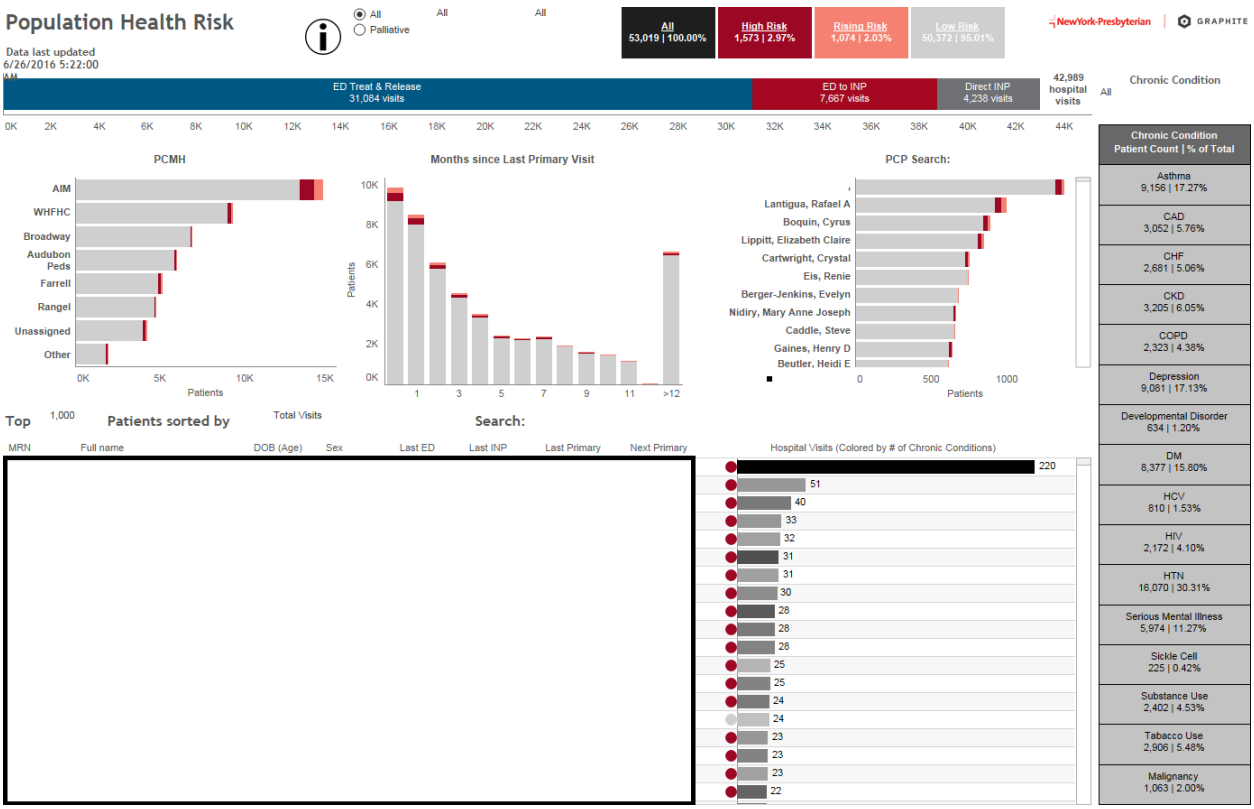
This dashboard allows teams to identify where patients are falling out of the system and connect them with the appropriate services to help prevent ED readmissions.

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 8/11/2016

NewYork-Presbyterian
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.

NYP Executive Committee Meeting

NYS & NYP PPS Updates

August 15, 2016

NewYork-Presbyterian
Performing Provider System

Agenda

- NYS Updates
  - Recent Updates / Changes
  - Quarterly Reporting
  - Midpoint Review
  - PAOP
- NYP Updates
  - Highlights
  - Recruitment Update

NYS: Recent Updates / Changes

- **NYS Medicaid Claims Data Sharing Beneficiary Opt-Out Process Complete; raw Medicaid claims data expected in early Fall**
- **Increased access (non-PHI) to DSRIP performance metrics via State's Salient Interactive Miner (as of 7/12)**
- **NYS hosting geography-specific "listening sessions" to gather feedback on PPS current plans for IS infrastructure and opportunities for DOH investment (care management, data, etc.)**

NYS: Quarterly Reporting

Quarter	Improvement Opportunity	Outcome
DSRIP Year 1, Quarter 1	…	✓
DSRIP Year 1, Quarter 2	…	✓
DSRIP Year 1, Quarter 3	…	✓
DSRIP Year 1, Quarter 4	Patient Engagement (HIV CoE*, Palliative Care**)	-
DSRIP Year 2, Quarter 1	…	(✓)

Challenge due to NYS exclusion of ADAP in reportable metric;
****Due to slow ramp up in clinical services;***

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NYS: Midpoint Assessment Overview

- Compliance with the approved DSRIP project plan, including the elements described in the project narrative;
- Compliance with the required core components for projects described in the DSRIP Strategies Menu and Metrics, including continuous quality improvement activities;
- Non-duplication of Federal funds;
- An analysis and summary of relevant data on performance on metrics and indicators to this point in time;
- The benefit of the project to the Medicaid and uninsured population and to the health outcomes of all patients served by the project (examples include number of readmissions, potentially preventable admissions, or adverse events that will be prevented by the project);
- An assessment of project governance including recommendations for how governance can be improved to ensure success. The composition of the performing provider system network from the start of the project until the midpoint will be reviewed. Adherence to required policies regarding management of lower performing providers in the network, as described in Section X of Attachment I, will be reviewed with a special focus on any action with regard to removing lower performing members prior to DYs 3, 4, and 5. (Note: Modifying coalition members requires a plan modification);
- The opportunity to continue to improve the project by applying any lessons learned or best practices that can increase the likelihood of the project advancing the three part aim; and
- Assessment of current financial viability of all lead providers participating on the DSRIP projects

NYS: Midpoint Assessment – Our Requirements

Deliverable
Project-Specific Narrative Updates (templated)
PPS Organizational Narrative Update
Request to remove providers (non-engaged, opt-out, etc.)
Requests to add network providers
PPS Lead to pass financial stability test

All information will be public.

NYS: Midpoint Assessment Timeline

Event	Date
PPS Completes DY2, Q1 Quarterly Report	July 31, 2016
Independent Assessor begins reviews of DY2, Q1 Quarterly Report and Initiates Mid-Point Assessment	August 1, 2016
Independent Assessor completes initial review of DY2, Q1 Quarterly Report; PPS 15 day remediation period begins	August 31, 2016
PPS return DY2, Q1 Quarterly Report to Independent Assessor; PPS 15 day remediation period ends	September 14, 2016
Independent Assessor finalizes results of DY2, Q1 Quarterly Report	September 29, 2016
Independent Assessor finalizes Mid-Point Assessment Recommendations	October 28, 2016
Independent Assessor Recommendations released for PPS and Public Comment	October 31, 2016
PPS Response and Recommendation period begins; Public Comment period begins	October 31, 2016
PPS Response and Recommendation period ends; Public Comment period ends	December 1, 2016
Independent Assessor compiles PPS Response and Recommendations with Public Comment	December 8, 2016
Independent Assessor submits Mid-Point Assessment Recommendations to DOH	December 12, 2016
Mid-Point Assessment Recommendations released for 30 day Public Comment Period	December 15, 2016
Mid-Point Assessment 30 day Public Comment Period Closes	January 15, 2017
Project Approval and Oversight Panel Convenes to review Mid-Point Assessment Recommendations	January 17 – 20, 2017
Project Approval and Oversight Panel Mid-Point Assessment Recommendations Submitted to Commissioner of Health	January 24, 2017
Commissioner of Health submits Mid-Point Assessment Recommendations to CMS	January 31, 2017
PPS Complete Modifications to DSRIP Project Plans	March 31, 2017

PAOP Visit

- On-site visits by 2-3 PAOP members to each PPS will be scheduled to:
  - allow greater insight into overall PPS activities
  - enable greater dialogue
  - provide more in-depth understanding of the regional and cultural context of the 25 PPS program implementations
- The meetings will be approximately 4-5 hours and will cover:
  - background information,
  - interactive discussion on implementation progress,
  - successes,
  - challenges,
  - PPS network performance and
  - meetings/visit(s) with community partner(s).

NYP PPS Update

- Continued implementation phase for projects
- Focus on collaborator engagement: outreach meetings and cross-PPS events
- Round 2 website improvements
- Continued webinar series
- Collaborator Symposium planned for September 15, 2016
- ACD rollout planned for August
- Healthix rollout continues pending final Capital contract
- Service agreements signed with 20 organizations
- Participation Agreements signed with 80 organizations (5 pending)
- Community Resource Tool Workgroup

NYP PPS: Recruitment Update*

Project	NYP + College	External
IDS	17	-
Adult Amb ICU	4	3
Peds Amb ICU	5	5
ED Care Triage	15	-
Transitions of Care	9	4
BH Integration	2	-
BH Crisis Community Stabilization	6	2
HIV CoE & Reducing Morbidity	7	10
Palliative Care	4	-
Tobacco Cessation	2	-
TOTAL	**71**	**24**

As of June 2016; may not reflect recent recruits

NewYork-Presbyterian
Performing Provider System

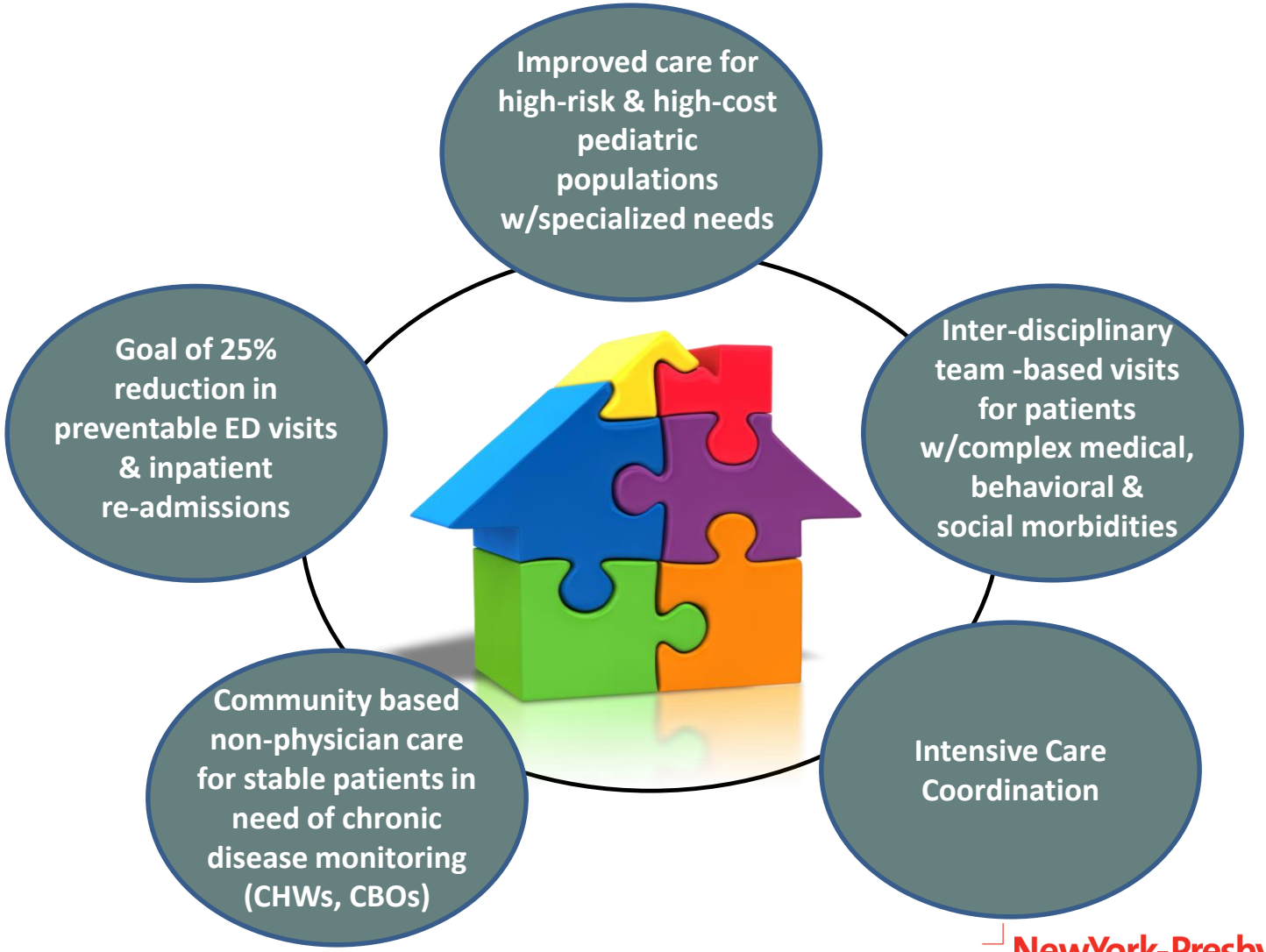
AMAZING THINGS ARE HAPPENING HERE

Special Kids Achieving Their Everything

Executive Committee Meeting 8-15-2016

NewYork-Presbyterian
Performing Provider System

Project Overview: Special Kids Achieving Their Everything (SKATE)



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Core Components

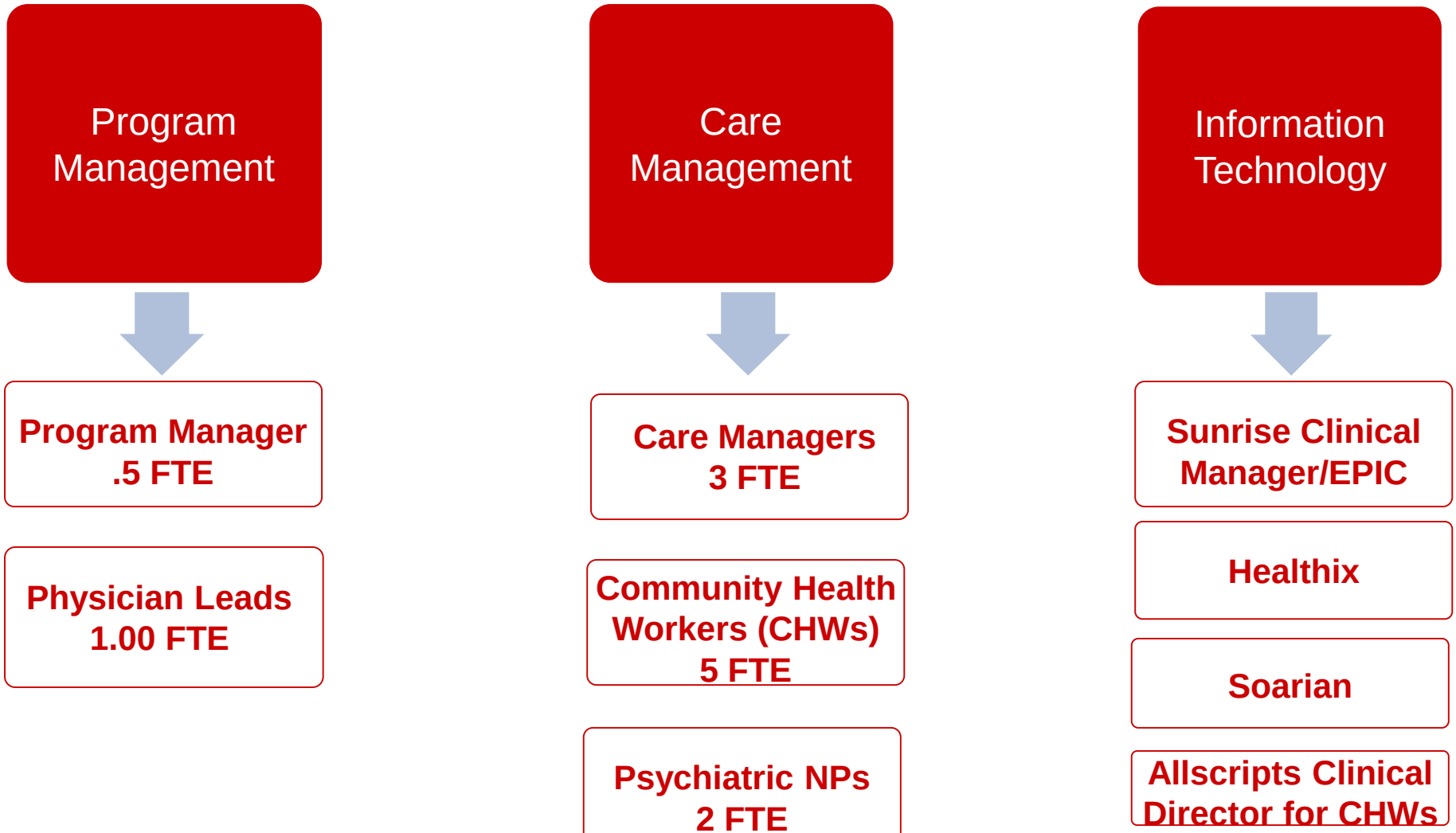
- Identification of the need for complex specialty services
- Development of specialty services (medical, behavioral, nutritional, rehab and others)
- Integration into the model of primary care physicians and practitioners
- Identification of eligible population through registries, community and Health Home referrals
- Co-locating care managers (Health Homes)
- Development of EHR and HIE connectivity
- Team based review of care planning
- Connectivity with the PCP (Patient portals)
- Expansion of service hours
- Metrics/monitoring
- Cultural competence and addressing health disparities

Proposed Metrics

- System transformation
  - Reduction in avoidable ED visits
  - Reduction in avoidable Readmissions
  - CG CAHPS measures in primary care
  - PCP NCQA /HEDIS Access/PQI

- Annual metric- 2 or more visits to Amb ICU per year

Staffing and IT Resources



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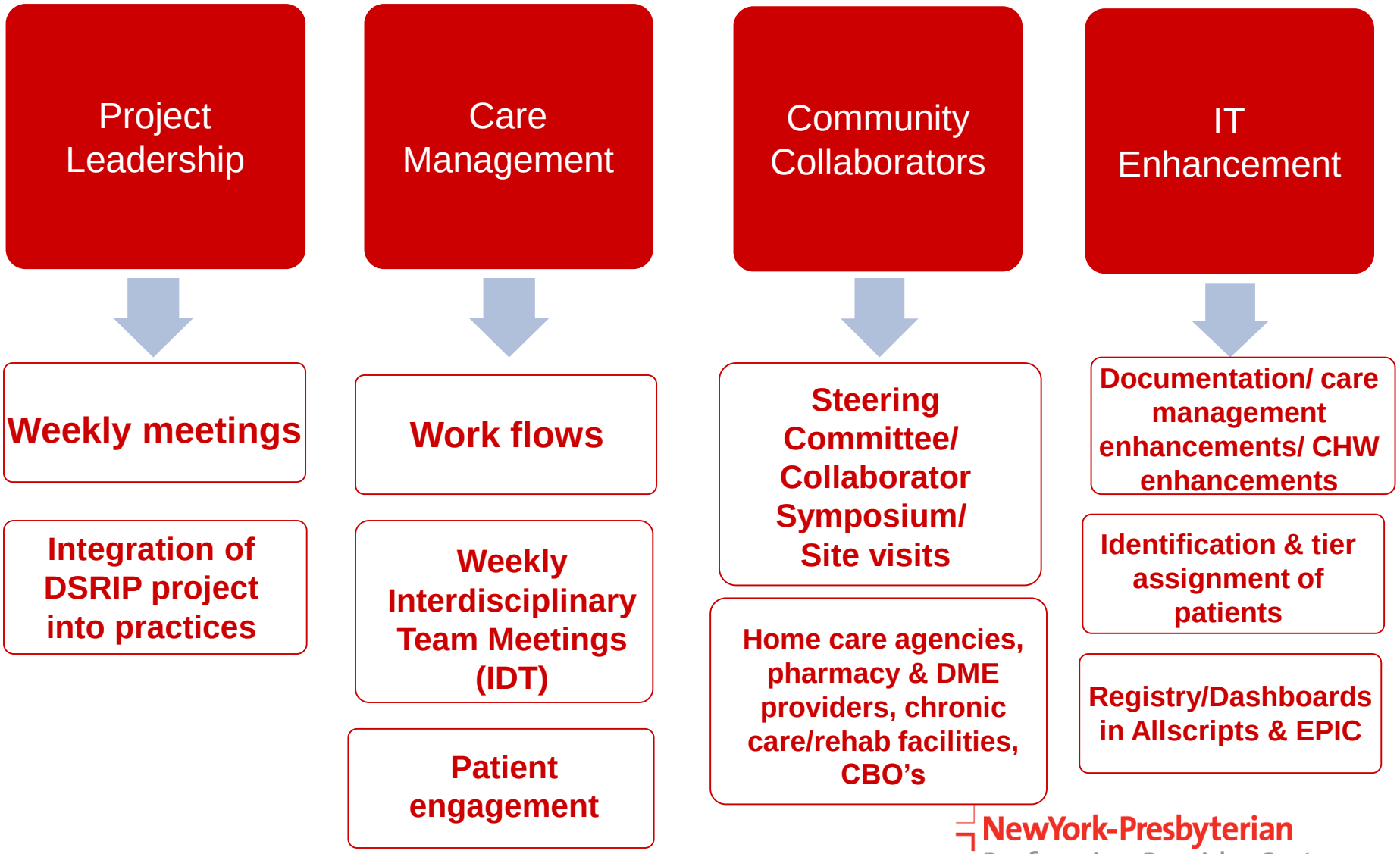
Project Areas and Structure



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Partners

- St. Mary's Children's Hospital
- Blythedale Children's Hospital
- NYLAG
- Northern Manhattan Perinatal Partnership
- Coalicion Mexicana
- Fort George Community Enrichment Center
- NY Center for Childhood Development
- City Drug
- Melbran Pharmacy
- Dominican Sisters
- Extended Home Care
- Metropolitan Center for Mental Health

Collaborator Engagement

- Steering Committee Quarterly meetings
  - 3 meetings since the summer 2015 focused on CHW program; will shift to DME suppliers/pharmacy upcoming meeting in Fall
- Collaborator Symposium
  - 90 collaborators attended; Maura Frank one of the facilitators
- Site visit to St Mary's and Blythedale facilities
  - Reciprocal visit by St Mary's to Audubon Practice and 5HT Peds
  - Creating workflows for referrals, transitions of care, orders
- CHW's based in CBO's (NMPP, Coalicion Mexicana, Fort George)
- NYLAG (Special Education team) at IDT meetings

Results (Successes)

- Hiring/onboarding
- SKATE program integration into practice
- IDTs at every practice site
- IT development: Registries
- Engagement of community collaborators
- Improved patient satisfaction
- Started Peds-IM transition process evaluation

Challenges

- IT
  - Epic development of registry (NYP-WC)
  - ED Alerts (NYP-CU)
- Healthix
- Extended hours
- Regulatory Waiver
- Peds Health Home

Long-term Considerations

- Expansion in primary care access/hours
- Pediatric psychiatry resources – limited
- Pediatric care manager resources- limited
- Access to subspecialty care for the population
- Capacity in ACN for new patients
- Health Home in Peds
- Will cost-savings occur???
- Will payers come on-board?