NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	4/14/15, 1-2PM	**Meeting Title**	NYP PPS Finance Committee
Location	CB12 Conference Room 530 W 166th Street, 6th Floor	**Facilitator**	Brian Kurz, Robert Guimento
Go to Meeting	https://global.gotomeeting.com/join/858733917	**Conference Line**	Dial +1 (872) 240-3212 Access Code: 858-733-917

Invitees	
Ilana Avinari (Methodist)	Fay Pinto (Elizabeth Seton Center for Pediatrics)
Dan Del Bene (SPOP)	David Grayson (Arch Care /Calvary)
Phil Zweiger (ASCNY)	Alan Wengrofsky (Community Healthcare Network)
Jay Gormley (MJHS)	Brian Kurz (NYP)
Steve Zhou (Village Care)	Robert Guimento (NYP)
Maria Guevera (NMPP)	

Meeting Objectives	**Time**
1. Introductions (Committee Members / Project Leads	10 mins
2. New York State Updates / PPS Timeline	15 mins
3. Committee Charter & Guidelines	20 mins
4. Nominating PPS Network Co-Chair	10 mins
5. Next Steps	5 mins

Action Items				
Description	**Owner**	**Start Date**	**Due Date**	**Status**

NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	4/14/15, 1-2PM	**Meeting Title**	NYP PPS Finance Committee
Location	CB12 Conference Room 530 W 166th Street, 6th Floor	**Facilitator**	Brian Kurz, Robert Guimento
Go to Meeting	https://global.gotomeeting.com/join/858733917	**Conference Line**	Dial +1 (872) 240-3212 Access Code: 858-733-917

Invitees	
Ilana Avinari (Methodist)	Fay Pinto (Elizabeth Seton Center for Pediatrics)
Phil Zweiger (ASCNY)	David Grayson (Arch Care /Calvary)
Jay Gormley (MJHS)	Brian Kurz (NYP)
Steve Zhou (Village Care)	Robert Guimento (NYP)
Maria Guevera (NMPP)	Isaac Kastenbaum (NYP)
	David Alge (NYP)
	Claudia Rosen (NYP)

Action Items

Description	Owner	Start Date	Due Date	Status
Send out poll for PPS network member committee co-chair	Isaac Kastenbaum	4/14/15	4/28/15	Complete
Send out meeting minutes and schedule next meetings	Isaac Kastenbaum	4/14/15	4/28/15	Complete
Revise committee guidelines, as appropriate	Isaac Kastenbaum	4/14/15	4/28/15	Complete
Share Committee-specific NYS requirements	Isaac Kastenbaum	4/14/15	4/28/15	Complete

Meeting Minutes:

Meeting Minutes

- B. Kurz and R. Guimento kicked off the meeting with a welcome
- All present committee members and project leads introduced themselves
- D. Alge asked the Committee about who was participating in other PPSs
    - J. Gormley mentioned seven total PPSs
    - M. Guevara mentioned two PPSs
    - Others mentioned one-to-two PPSs
- D. Alge described the need to harmonize what is happening across the PPSs – the people who will pay will be the downstream network collaborators – they'll need to fill out the same assessment over and over for each PPS, likely several times throughout the collaboration period.

- J. Gormley mentioned that the State hasn't really augmented their assessments and other documents for non-acute providers (e.g. non hospitals or physicians). The materials/algorithms were not made for non-episodic providers like CBOs, SNFs, etc.
- R. Guimento led the group through an introduction of the projects.
- M. Guevara raised concerns about not knowing the role of CBOs across the projects (scope and relationship); R. Guimento mentioned that this will be worked out via the workflows for each project.
- B. Linder provided an example of a patient that would require significant support both from the BH practice, but also from a variety of CBOs and community-based medical providers
- D. Alge mentioned three main areas for the Finance Committee – (1) State requirements, (2) developing a financial structure around the projects, and (3) sustainability planning.
- B. Kurz took the group through the Committee charter.
    - Mentioned that this is really an exercise to prepare for the work once we find out the PMPM and final attribution.
- R. Guimento mentioned the need to focus on sustainability by year 3 (State requirement); Committee may appoint a sub-group to do this work.
- D. Grayson asked about how budgets would be handled – D. Alge responded that it would be reviewed by the Committee, but that NYP has already taken a level of conservatism (accounting for the P4P funds) in dolling out dollars to individual projects.
- J. Gormley mentioned that no other PPS has a cycle-off process, but that there wasn't any problem, but the term should be extended to 12 months.
- The group suggested we soften the language on a proxy; it's not that people cannot take vacations, but that the Committee needs people who are able to do the work and are able to speak for their organization.
- J. Gormley mentioned that the Lutheran Finance group has met 5-6 time already.
- The next steps were determined.

NYP PPS Project Descriptions

2.a.i – Integrated Delivery System

NYP Lead: David Alge (Vice President, Integrated Delivery System Strategy)

The foundation of any integrated delivery system is accessible, high-quality primary care. The PPS will work with all participating safety net providers to achieve 2014 Level 3 PCMH and Meaningful Use certification. These PCMHs will serve as the center for the PPS's population health management efforts, for example, using registries to identify and track specific patient-level outcomes and engagement.) In addition the PPS understands that to be a truly integrated system it needs to improve intra- and inter-institution care transitions. The PPS will develop a unified care management strategy that is shared across all PPS members. One area of focus is information flow from EDs to outpatient providers. The Patient Navigation program is composed of culturally competent paraprofessionals who will ensure connectivity to outpatient care is made as well as connection to community resources that can assist in the care continuum. They will work extensively with the existing social work and care management resources within the PPS to create a multi-prong approach. Finally, the PPS is implementing a Community Health Worker strategy across the projects to provide patients with culturally competent, in-home support.

2.b.i – Ambulatory ICU (Pediatric and Adult)

NYP/CU Pediatric Lead: Adriana Matiz, MD (Medical Director, NYP Washington Heights Family Health)
NYP/WC Pediatric Lead: Maura Frank, MD (Director, NYP/Weill Cornell Ambulatory Pediatrics)
Adult Lead: Elaine Fleck, MD (Medical Director, Internal Medicine, NYP Ambulatory Care Network)

The PPS will develop 9 Ambulatory ICUs in existing PCMHs; the Ambulatory ICUs will deliver comprehensive, coordinated care for complex patients using a risk-stratification methodology and a community- and practice-based interdisciplinary team. ICUs will provide intensive case management, hiring culturally competent RN Care Managers, Social Workers, Psychiatric NPs and CHWs, and maximizing relationships with CBOs. The programs will extend weekday hours and offer weekend hours to improve access. The four Adult Ambulatory ICUs, located in Northern Manhattan, will target adult patients with at least two comorbid chronic conditions including diabetes, heart failure, chronic respiratory disease, renal failure or a behavioral health diagnosis. The five Pediatric Ambulatory ICUs will target patients under the age of 21 who meet the definition of a Child with Special Healthcare Needs. These patients will present with a variety of diseases or medical conditions that require co-management by multiple subspecialists and primary care, including patients with multi-organ system involvement or patients who are technology-dependent. Specific examples include: children with uncontrolled high-risk asthma, depressed patients who are not engaged in psychiatric care, poorly controlled Type 1 diabetic patients or patients with encephalopathy who are gastrostomy-tube dependent and at risk for aspiration pneumonia.

2.b.iii – Emergency Department Care Triage

Patient Navigation Lead: Patricia Peretz, MPH (NYP Manager of Community Health & Evaluation)
NYP/CU Emergency Department Lead: Jordon Foster, MD (NYP/Milstein ED Site Director)
NYP/WC & LM Emergency Department Lead: Peter Steele, MD (NYP/Weill Cornell Attending)

To address the educational and cultural drivers of utilization, the PPS will implement an ED Care Triage Team in five Emergency Departments, consisting of culturally competent, 24/7 Patient Navigators (PN). The PN will meet with high-risk patients to understand issues with access to care and also to educate regarding resources in the community. They will schedule patients for primary care/specialty medical appointments through open access scheduling; link them to financial assistance or other social services; and connect to them to community-based resources such as home care. PNs will also offer appointment reminders and post-appointment follow-up calls. For patients without regular primary care access, PNs

will attempt to match patients with a local NCQA Level 3 PCMHs within the PPS. The ED PN program will also interface with the other projects to ensure that patients are reconnected with their normal care team.

2.b.iv – Care Transitions to Reduce 30-Day Readmissions
Project Lead: Julie Mirkin, MA, RN, NYP Vice President of Care Coordination

The PPS will strengthen continuity of care between the hospital and outpatient settings to address potentially preventable readmission rates at four campuses: NYP/CU-Milstein, NYP/CU-Allen, NYP/WC and NYP/LM. Project plans include modifying the Transitions of Care protocol among PPS collaborators, implementing RN Transitions Care Managers for the highest risk cases and integrating CBO-based Community Health Workers into the transition phase. The RN Transitions Care Managers will be trained to act as culturally competent "coaches," teaching patients (and caregivers) self-management skills during the inpatient stay and for 30 days following discharge via home visits and telephonic follow-up. The model is based on the Care Transitions Program developed by Eric Coleman, MD. The PPS will mobilize resources in our clinics and the community to provide such post-discharge care as timely primary or specialty care appointments; connections to outpatient palliative; medically tailored home meals; home care; behavioral health management and community support. For patients who lack home support, we will introduce CBO-sourced CHWs who will provide diagnosis-specific education in a linguistically and culturally appropriate manner to patients and families. They will also assess non-medical causes of readmission, such as lack of transportation or food insecurity.

3.a.i Behavioral Health and Primary Care Integration (Model B)
Project Lead: Barbara Linder, MPA, Director, NYP Behavioral Health Service Line
Project Lead: Mary Hanrahan, MSW, LCSW, Clinical Manager, NYP Behavioral Service Line
Project Lead: Dianna Dragatsi, MD, Director, NYSPI Inwood Clinic and WHCS Outpatient Services

The PPS will embed primary care within existing Behavioral Health (BH) clinics. The clinics will hire culturally competent providers to conduct preventive care screenings (medical and behavioral), improve health literacy, improve indices of care for metabolic conditions and use evidence-based standards of care to monitor patients' medical conditions. For appropriate patients, connecting with community PCPs will be the ultimate goal. We will co-locate some of PCPs with our Mobile Crisis Team to facilitate engagement. The target population is diverse, poor and immigrant adult Medicaid patients from Northern Manhattan and the Southwest Bronx. Targeted patients all carry a primary psychiatric diagnosis of chronic mental illness and co-morbid medical illness. Specifically, qualifying patients will carry psychiatric diagnoses for Schizophrenia/Schizoaffective Disorder; Bipolar Disorder; Major Depression, recurrent; or Post-Traumatic Stress Disorder in combination with any of the following medical diagnoses: Diabetes; Coronary Artery Disease, Hypertension or Congestive Heart Failure; Hyperlipidemia; or Obesity. We will prioritize care to the cohort who has not accessed traditional community primary care services and/or has had three or more medical emergency room visits or inpatient admissions in the last year.

3.a.ii – Behavioral Health Crisis Community Stabilization
Project Lead: See 3.a.i above

This project will involve two distinct interventions. Intervention #1 will embed a Psychiatric NP within the Milstein Emergency Department Triage to collaborate with CPEP psychiatrists to provide a Brief Assessment, identifying non-emergent patients and diverting them to a Urgent Care, who will provide linkage with services including CTI (see below). This triage team will coordinate with ED Patient Navigators (Project 2.b.iii) to ensure warm hand-offs.

Intervention #2 will implement a community-based, mobile Critical Time Intervention (CTI) team, linked to inpatient, outpatient and ED providers. The evidence-based CTI team is comprised of a psychiatrist, Licensed Clinical Social Worker (LCSW), RN and Peer Health Educator and will target high emergency room and inpatient utilizers. The CTI team meets patients at the point of greatest need, eliminating gaps in care. The four-person team maintains a 10:1 Patient-to-Staff ratio, and works with patients from three to nine months with the goal of linking patients to services underpinning unmet need, including mental health and substance abuse; appointments management, prescriptions adherence; connectivity to housing providers and primary care; and addressing barriers, such as lack of insurance.

3.e.i – HIV Center of Excellence
NYP/CU Project Lead: Peter Gordon, MD, Medical Director, Comprehensive HIV Program
NYP/WC Project Lead: Samuel Merrick, MD, Medical Director, Center for Special Studies

The PPS is transforming three HIV clinics into true Centers of Excellence via increased intensive care management/coordination, extending care beyond the clinics, behavioral health integration, transforming testing and adherence, implementing a Rapid HIV Consult Service in the ED and expanding hours for same-day appointments. This includes integrating more RN care managers and Practice Care Facilitators who will coordinate insurance, transportation, medications, reminders, etc, trained CBO-based CHWs to meet patients in the community, and increased coordination with CBOs for non-medical needs. The program will also integrate behavioral health staff, HCV testing, Pre-Exposure Prophylaxis, rapid HIV consultation to patients testing positive in the Emergency Department, and expanded access.

3.g.i – Integration of Palliative Care into the Patient-Centered Medical Home
Project Lead: Veronica Lestelle, LCSW, Director, NYP Palliative Care

Our program targets adults with Medicaid in the PPS service areas with a primary or secondary diagnosis of one of six conditions: Congestive Heart Failure (CHF), Kidney Failure, Dementia, Chronic Obstructive Pulmonary Disease (COPD), Stroke, Malignancy and Sickle Cell Anemia. Such patients will be flagged for primary care physicians (via the EHR) when they present at their next visit. A sub-cohort of patients will consist of those with three or more inpatient admissions for patients below age 80 and one or more inpatient admissions for patients 80 and above. These patients will be flagged as high-risk in our EHR. The PCP will then assess palliative care needs using a new, specially designed tool based on key domains such as uncontrolled pain and need for assistance with complex decisions. All PCPs will receive education on appropriate palliative care screening. The goal is to provide these patients with palliative care services over the course of their advanced illness and not merely when they are in the terminal phase.

4.b.i – Tobacco Cessation
Project Lead: David Albert, DDS, Director, Columbia College of Dental Medicine, Community Health

The PPS will use the framework established by the U.S. Public Health Service (USPHS) for evidence-based tobacco cessation. The NYP Tobacco Use Cessation Program (NYP-Quits) is a comprehensive approach that will facilitate clinician adoption of tobacco cessation via modifications to the EHR. PPS providers will receive education on tobacco cessation counseling complemented by tobacco cessation clinics that will provide individual counseling by certified tobacco cessation experts. The clinics will assist “hard core” smokers and will be of particular benefit to smokers with behavioral health disorders. In addition, populations who are vulnerable to smoking such as the elderly will be targeted through partnerships with community programs to identify tobacco users and provide referrals to NYP-Quits. The comprehensive program will result in an increase in cessation counseling available to the targeted populations and a concomitant increase in successful quit attempts by patients.

4.c.i Decrease HIV Morbidity

Project Lead: See 3.e.i above

Individuals testing positive at our Collaborator organizations—who have deep experience with testing protocols—will also be referred to CHWs for care navigation. However, we will also send CHWs into the community—to clubs, commercial sex work locations, etc.—and to Collaborators and associates of PLWH. The PPS can provide local testing, referring and navigating seropositive patients to appropriate care and providing preventive services like PrEP to uninfected individuals. Education will include health information and stress patients' right to be offered HIV testing in hospital and primary care settings.

PPS Committee Requirements (as taken from NYS Implementation Template)

Executive	Clinical Operations	Data/IT Governance	Finance	Audit / Corporate Compliance
• Target workforce state definition • Workforce transition roadmap & gap analysis • Compensation & Benefit Analysis • PMO Oversight • Governance oversight • Add / remove collaborators • Review reports to NYS • Set PPS vision • Performance reporting training	• Cultural competency strategy • Health literacy strategy • Training strategy • Performance reporting methodology • Practitioner communication, engagement, and training plan • Population health management roadmap • Clinical integration need assessment • Clinical integration strategy	• Current state assessment of IT capabilities • IT change management strategy • Interoperability roadmap • Qualifying Entity engagement plan • Data security and confidentiality plan • Performance reporting strategy	• Network financial health current state assessment • Strategy to address sustainability issues • Baseline assessment of network VBP arrangements / preferences • Plan to achieve 90% VBP by DY5 • VBP adoption plan • Funds flow budget and distribution plan	• Social Services Law 363-D Compliance Plan • Review sub-contracts