NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	8/12/16, 3:00-4:00PM	**Meeting Title**	NYP PPS Finance Committee
Location	Milstein Hospital Building, 177 Fort Washington Avenue, Heart Center Room 4	**Facilitators**	Jay Gormley, Brian Kurz
Go to Meeting	https://global.gotomeeting.com/join/557555301	**Conference Line**	United States +1 (872) 240-3311 Access Code: 557-555-301

Invitees	
Ilana Avinari (Methodist)	Alan Wengrofsky (Community Healthcare Network)
Dan Del Bene (SPOP)	Diomedes Carrasco (NMPP)
Steve Zhou (Village Care)	Co-Chair: Jay Gormley (MJHS)
Daniel Johansson (ACMH)	NYP Co-Chair: Brian Kurz
Fay Pinto (Elizabeth Seton Center for Pediatrics)	Judy Hederman (ASCNYC)
David Grayson (ArchCare/Calvary)	

Meeting Objectives	**Time**
1. Review action items from last meeting	2 mins
2. Governance Committee Rotations	5 mins
3. Updates:	10 mins
• Financial Health Assessment Update	
• Value-Based Payment Assessment Update	
4. DY2, Q1 Budget Review	10 mins
5. HIV Projects Finance Presentation	30 mins
6. Identify Action Items	2 mins

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
F/U on whether current Year 1 surplus is in line with anticipated carry forward	I. Kastenbaum	5/13/2016	7/8/2016	In Progress

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Invitees	
Steve Zhou (Village Care)	Sam Merrick (NYP)
Daniel Johansson (ACMH)	Rachel Naiukow (NYP)
David Grayson (ArchCare/Calvary)	
NYP Co-Chair: Brian Kurz	
Lauren Alexander (NYP)	
Steve Chang (NYP)	

Meeting Objectives	**Time**
1. Review action items from last meeting	2 mins
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3. Updates:	10 mins
• Financial Health Assessment Update	
• Value-Based Payment Assessment Update	
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5. HIV Projects Finance Presentation	30 mins
6. Identify Action Items	2 mins

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Show DY2, Q1 budget broken out at project-level and that accounts for year 1 carry forward	I. Kastenbaum	8/12/2016	9/9/2016	In Progress
Share governance committee rotation results	L. Alexander	8/12/2016	9/9/2016	In Progress
Share materials from meeting	L. Alexander	8/12/2016	9/9/2016	In Progress

AMAZING THINGS ARE HAPPENING HERE

3.e.i HIV Center of Excellence
4.c.i Decrease HIV Morbidity

Finance Committee Review
12 Aug 2016

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Agenda

1. Milestone Highlights
2. NYS Domain 3.e.i. and 4.c.i. Milestones Progress
3. FTE Update
4. Project Patient Engagement Metric Progress (YTD)
5. NYS Domain 3, 4 Performance Metric Progress
6. Next Steps

Milestone Highlights

- **Engaged 6 Core PPS Partners**
  - **REACH** Collaborative (**R**eady to **E**nd **A**IDS and **C**ure **H**epatitis C) 14 monthly meetings with senior leadership (June 2016 – Present)
  - 5 executed service agreements: staff + testing supplies, 6th in progress
  - Article 28 waiver (reg. code & site visit completed), pending approval
- **Recruited 19 DSRIP funded positions (FTE slides)**
  - 10 Community based
  - 9 NYP based
- **Integration into ACN through Practice Transformation**
  - Clinical Care Teams
  - CHP Quality Improvement
  - CHP Data Management

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Milestone Highlights

- **Information Systems**
  - Population Health Registries:
    - West ACN Primary → added STI/HIV/HCV fields → ACN Tableau Dashboard in development
    - NYP HIV Care Cascade → completed → accepted abstract at 2016 Ryan White Conference (Randi Scott to present)
  - Documentation
    - CHP Transitions of Care Note in SCM completed
    - PrEP Note in SCM completed
    - REACH Collaborative Notes in development in ACD
- **Workflow development**
  - Inpatient → outpatient
  - ED → outpatient
  - Access → CHP
  - CSS retention
  - ACD workflow

NYS Domain 3 Milestone Progress (3.e.i)

#	Milestone	Status
1	Identify site location for a Center of Excellence (COE) which would provide access to the population infected with HIV (and/or HCV)	On-Track
2	Co-located at this site service generally needed for this population including primary care, specialty care, dental care, behavioral health services, dietary services, high risk prenatal care and buprenorphine maintenance treatment.	On-Track
3	Co-locate care management services including Health Home care managers for those eligible for Health Homes	In-Progress, Challenges
4	Develop a referral process and connectivity for referrals of people who qualify but are not yet in a Health Home.	In-Progress, Challenges
5	Ensure understanding and compliance with evidence-based guidelines for management of HIV/AIDS (and HCV)	On-Track
6	Ensure coordination of care between all available services preferably through a single electronic health/medical/care management record.	On-Track
7	Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners including directed exchange (secure messaging), alerts and patient record look ups, by the end of DY 3.	In-Progress, Challenges
8	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of DY3.	On-Track
9	Use EHRs and other technical platforms to track all patients engaged in the project, including collecting community data and Health Home referrals	Not Started
10	Seek designation as center of excellence from New York State Department of Health	On-Track

NYS Domain 4 Milestone Progress (4.c.i)

#	Milestone	Status
1	Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care	On-Track
2	Increase peer-led interventions around HIV care navigation, testing, and other services	On-Track
4	Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration, and mental health	On-Track
5	Assure cultural competency training for providers	On-Track
7	Empower PLWHA to help themselves and others around issues related to prevention and care	On-Track
8	Educate patients to know their right to be offered HIV testing in hospital and primary care settings	On-Track
9	Promote delivery of HIV/STD Partner Services to at risk individuals and their partners	On-Track

FTE Update (3.e.i.)

Position Title	Number of FTEs	Status / Date Started
Inpatient Care Coordinator	1.0	May 2015
Program Manager	0.2	June 2015
ID Attending	0.6	June 2015
Practice Care Facilitator	1.0	August 2015
RN Care Manager	1.0	August 2015
Adult Nurse Practitioner	1.0	September 2015
Psychiatric Nurse Practitioner	1.0	February 2016
Adult Nurse Practitioner	1.0	Accepted offer

FTE Update (4.c.i.)

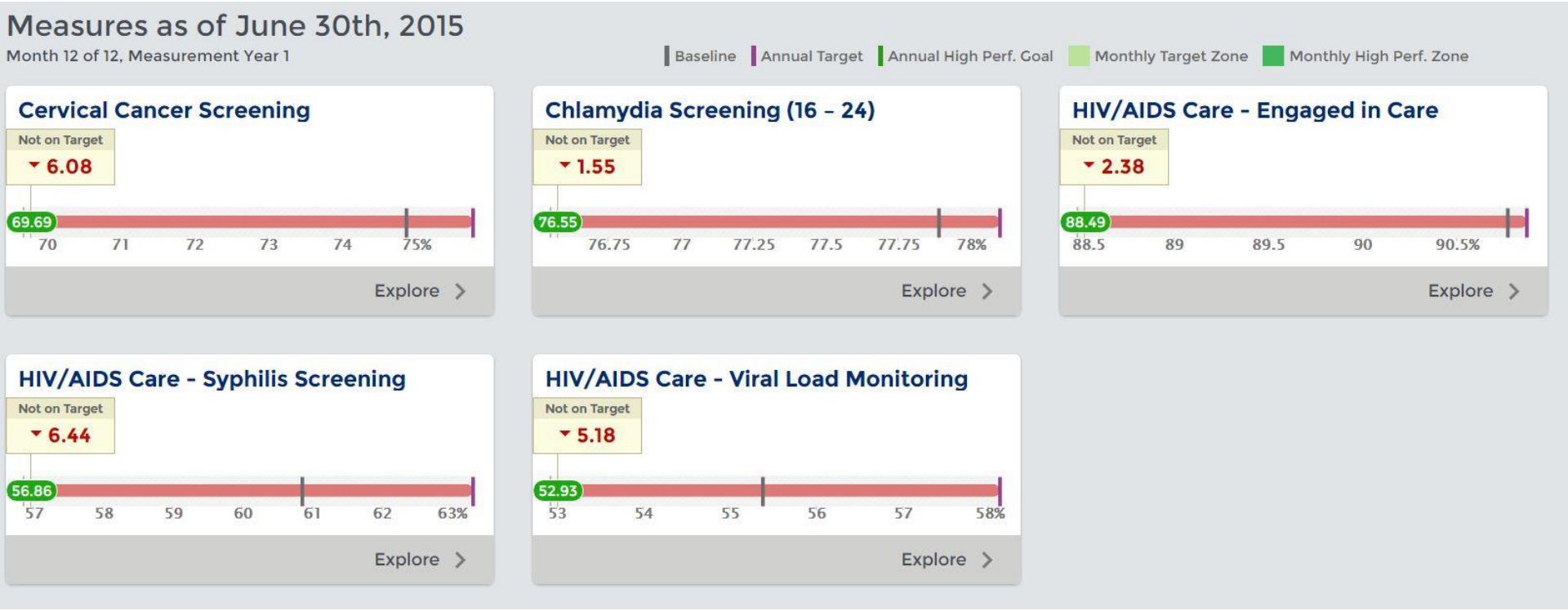
Position Title	Number of FTEs	Status / Date Started
Program Manager	0.8	June 2015
Data Coordinator	1.0	July 2015
Community Health Worker (Argus)	1.0	April 2016 (terminated August 2016) Actively recruiting
Assistant Director of Outreach	0.4	May 2016
Peers (ASCNYC)	4.0	May 2016
Community Health Worker (WHCP)	1.0	July 2015
Peer (WHCP)	0.5	July 2015
Community Health Navigator (DWDC)	0.5	August 2015
Community Health Worker (DWDC)	1.0	Actively recruiting

NYS Patient Engagement Progress

NYS Engagement Definition: *A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.*

Metric	DY1Q4	DY2Q1	DY2Q2	DY3Q3
Commitment	3,445	867	1,941	2,600
Cross-PPS Reduction	N/A	N/A	N/A	N/A
80% Goal	2,756	694	1,553	2,080
Actual Achievement	2404	694	-	-

NYS Performance Metric Update



Working to gain better understanding of performance metrics

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Next Steps

- CCHN Program Manager on-boarding (Y2, Q2)
- Onboard Adult Nurse Practitioner to support sexual health / HIV prevention (PrEP/PEP) (Y2, Q3)
- ACD go-live as cross REACH Collaborative care coordination system (Y2, Q3)
- Execute subcontract with Harlem United to support increased hours of operation and joint staffing on mobile medical van (Y2, Q4)
- Healthify go-live as resource map to support REACH Collaborative (Y2, Q4?)
- Finalize ACN Sexual Health and NYP HIV Care Cascade dashboards to support targeted population health interventions (Y2, Q4)
- Finalize establishment of Article 28 activity at Washington Heights Corner Project (Y2, Q4)