NYP-Led Performing Provider System PAC Kickoff Meeting
MINUTES October 21, 2014

Present: D. Johansson-**ACMH**, L. Capitelli-**NY Psychiatric Institute**, K. Meyer-**Community Healthcare Network**, E. Eng-**ArchCare**, D. Lowy-**Argus Community**, A. Martin-**VNSNY**, A. Silvers-**VNSNY**, O. Mariano-**Riverdale MHA**, D. Boyian-**Realization Center**, Rev. L. Rouse-**United Methodist**, S. Marquez-**Volunteers of American-Greater NewYork**, C. Hughes-**Community Board 1**, I. Floyd-**Iris House**, F. Maselli-**Riverdale Family Practice**, B. Fajardo-**Hudson Heights IPA**, J. Meyer-Wash Heights Corner Project, J. Guzman-**Mexican Coalition**, S. Muchnick-**UMMHC**, K. Spaziani-**NYP**, J. E. Carrillo-**NYP**, D. Alge-**NYP**, C. Rosen-**NYP**, A. Nieto-**NYP**, W. Brody-**NYP**, M. Allen-**NYP**, M. Onofrieti-**NYP**, B. Hafeez-**WCMC**

1. K. Spaziani opened the meeting and reviewed the agenda for the meeting.

2. K. Spaziani reminded the group of the presentation by V. Carrillo and Z. Grinspan presented at the last PAC meeting on the preliminary results from the DSRIP Community Needs Assessment (CNA). She also reminded the group that we are very much interested in their response to the qualitative survey that was emailed to all PAC members. It was agreed at this meeting that the web-survey tool that will be sent out to all PPS partner organizations in order to collect qualitative information about the communities served by those organizations.

3. C. Rosen advised the group that the State had released its preliminary attribution and that her office would be reaching out to all partner organization with questions about the NPIs of their providers. This information will be needed in preparation for the next State attribution in November. D. Alge commented that of the 1.7 million DSRIP attributable lives, 30% had not yet been attributed. C. Rosen explained that the State would only have two more attribution cuts before the application would need to be submitted, so making sure we have all our partner NPI information is very important.

4. D. Johansson- ACMH asked if it was possible to be a part of multiple PPS groups given that many PPS groups overlap. K. Spaziani responded that you can be a part of multiple PPS groups. D. Alge also commented that there are some PPS that are require exclusivity, but not from the State.

5. K. Spaziani provided the PAC with an overview of the DSRIP application process and scoring. Approximately 20% of the application score is subjective; however, 80% is objective and will be driven by two important factors: Volume (how many patients will the programs affect) and Velocity (how quickly can the PPS get the programs up and running.) Milestones and metrics are project specific and many more IT driven. The State wants to have all projects launch in April of 2015. In years 1-2 payments will be based on a pay-for-reporting basis. In years 3-5 payments will be based on a pay-for-

performance basis. KPMG will review a mock of our application at the end of October, and will be shared with our PPS after the independent assessor reviews and scores the application.

6. K. Spaziani also reviewed with the PAC membership the NYP DSRIP application timeline. NYP plans to submit our Final DSRIP application on December 12, 2014.

7. Dr. Carrillo led the group in a discussion of the 10 DSRIP project:

    a. Domain2

        i. 2.a.i IDS
        ii. 2.b.i Ambulatory Intensive Care Units
        iii. 2.b.iii ED Care Triage
        iv. 2.b.iv Care Transitions to Reduce 30 Day Readmissions

    b. Domain 3

        i. 3.a.i Integration of Primary Care and Behavioral Health
        ii. 3.a.ii Behavioral Health Community Crisis Stabilization
        iii. 3.e.i Comprehensive Strategy to Decrease HIV/AIDS Transmission
        iv. 3.g.i Integration of Palliative Care in the PCMH

    c. Domain 4

        i. 4.b.i Promote Tobacco Cessation
        ii. 4.c.i Decrease HIV Morbidity

8. D. Alge led the group in a discussion of the NYP PPS Governance Structure. The State has put out three governance options: Collaborative Contracting, Delegated Model, and a Full Incorporated Model. We have chosen to follow the Collaborative Contracting model. D. Alge also reviewed with the PAC membership the operational governance of the PPS and the structure of key PPS committees: Executive Committee, Finance Committee, IT/Data Governance, Clinical/Operational Committee, Audit Committee, and an Ad-Hoc Committee. He also explained that the PPS organization members may be invited to be members of any of these committees, with the exception of the Executive Committee.

    Dr. Fajardo asked what happens at the end of the 5 year DSRIP period, will we have an ACO? D. Alge responded that this is still an open question and we (and other PPS around the State) would be happy we were all that successful.

9. Next Steps:

    a. Qualitative survey will be sent to all PAC and other partner organizations for their input.
    b. We would like feedback from PAC members of the various DSRIP projects and what programs PAC organization would like to collaborate with.

c. Please send your feedback on the governance model to the ppsmembership@nyp.org email address.
d. Claudia Rosen may reach out to your organizations to collected needed NPI information, please responds to these requests by 10/22/14.

10. K. Spaziani closed the meeting and reminded all PAC members that we are very interested in their feedback and questions. In order for members to provide feedback or pose questions to the NYP DSRIP program, please email: ppsmembership@nyp.org .

11. Next meeting scheduled November 24, 2014 from 9:30-11:30 at 530West 166th Street, 6th Floor, bridge line 616-371-4275.

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DSRIP Governance Model

Presentation to the Project Advisory Committee

October 21, 2014

NewYork-Presbyterian
Office of Strategy

Operational Governance Options – NYS/KPMG

A Collaborative Contracting

- Each partner remains autonomous
- Each PPS partner contracts with Lead Entity
- Lead Entity retains ultimate decision making authority
- Executive Committee role is limited to oversight of Financial, Clinical and IT activities

B Delegated Model

- Partners form a jointly owned LLC
- Key Governance responsibilities delegated to LLC
- Executive Committee is representative of all partners and directly oversees Finance, Clinical and IT activities

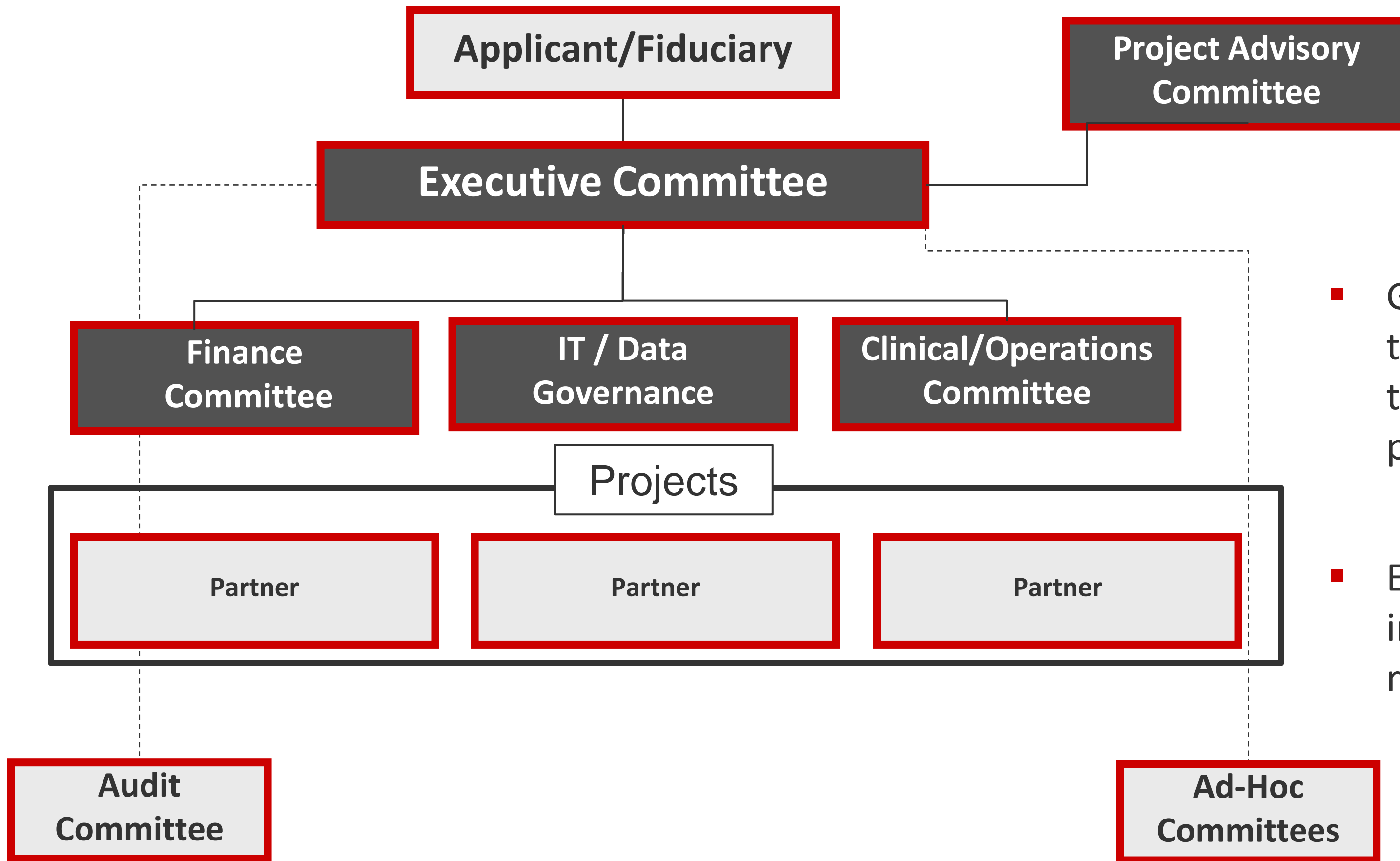
C Fully Incorporated Model

- PPS partners combined into a single legal entity
- Full ownership of the care delivery system except where contracted out to specialty providers
- Unified governance in a corporate structure
- Single management team

Governance Models – Partner Types

- PPS requires a **Lead Partner** who is responsible for fiduciary and project management control
- **Governance Partners** - members of the Executive Committee and/or sub-committees including some, but not necessarily all, members of the Finance, Clinical, or IT/Data committees
- **Participating Partners** - Partners by nature of beneficiary attribution or project contribution but are not members of the Executive Committee. These Partners may be represented on the Clinical or IT/Data Governance Committees, PAC or other advisory bodies.
- **Affiliates** who might be providers or community based organizations that do not, by themselves, attribute lives, but are otherwise important for the success of the PPS. Affiliates may be represented on the Clinical or IT/Data Governance Committees, PAC or other advisory bodies.

Operational Governance



- Governance is focused at the Program level, rather than at the individual project or local levels
- Executive Committee will include Partner representatives

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Adapted from NYS/KPMG guidance

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Governance – Clinical & Operations

Clinical Governance Committee will establish and oversee the clinical leadership within the PPS by fulfilling the following functions:

- Setting the standards of clinical care delivery (structures, processes and outcomes) which need to be met or exceeded to accomplish NY DSRIP goals
- Within the project areas selected, determining, which areas of care delivery should be the focus of improvement efforts
- Prioritizing the creation, implementation, oversight and continuous improvement of those best evidence based medical practices that will most contribute to closing the identified clinical performance gaps and improving clinical and financial results
- Developing and overseeing the creation of the infrastructure (committees and subcommittees) within the clinical component of the PPS necessary to undertake the development and implementation of these best evidence based practices

Governance – IT / Data Governance

Successful Data/IT Governance will align the IT strategy and resources with the strategy and goals of the PPS by:

- Working to ensure the interoperability of PPS partner platforms in order to share data
- Standardizing data definitions to facilitate timely, accurate, and informed clinical and business decision making
- Prioritizing allocation of IT resources and joint IT investments
- Recommending the selection of applications and IT approaches
- Providing oversight of:
  - Security and compliance
  - Data storage and usage
  - The appropriate use of data at the individual and organizational levels
  - The cost of IT and data services

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DSRIP Grant Application Overview

PAC Meeting
October 21, 2014

NewYork-Presbyterian
Office of Strategy

Agenda

- Overview of the DSRIP Application
- Project Application Overview
- Drivers of Success
- Milestones and Metrics
- Timeline

Overview of the DSRIP Application

- Organizational (30%)
  - Governance
  - Community Needs Assessment
  - Workforce Strategy
  - Data-Sharing & Reporting
  - Cultural Competency & Health Literacy
  - Budget
  - Financial Sustainability
  - Bonus Points
- Projects (70%)
  - Description & Justification
  - "Volume": Scale of Implementation
  - "Velocity": Speed of Implementation
  - Project Resource Needs

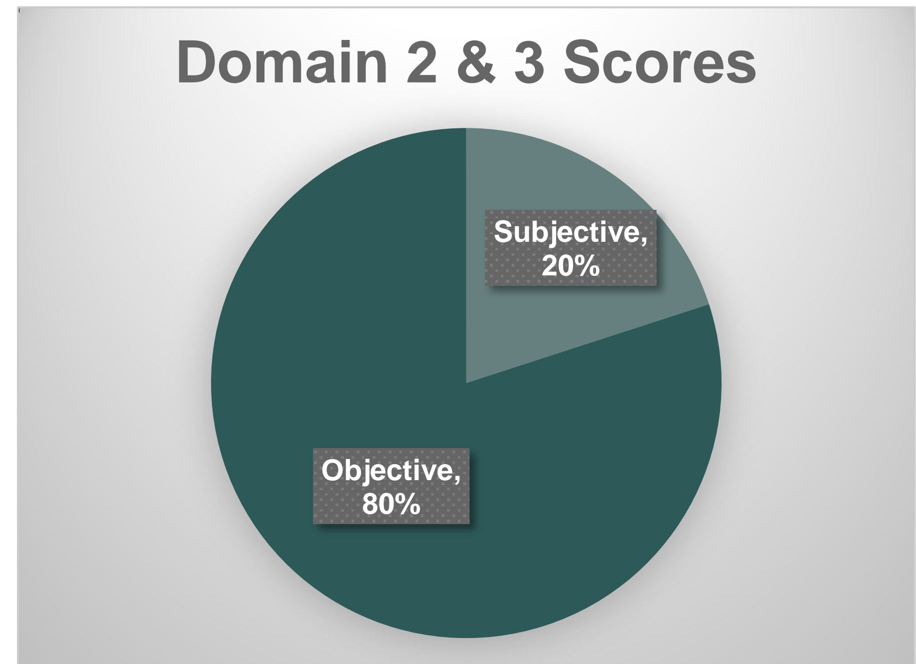
Project Application Overview

Project Requirements

Description & Justification	• "Utilizing data from the CNA..." • Current assets and anticipated challenges
Volume (Scale)	• Number [of ICUs, ED triage centers, etc.] committed • Targeted population to benefit
Velocity (Speed)	• Speed of implementation by quarter • Timeline for "active engagement" by quarter
Project Resources	• Capital budget funding needed (incl. partners) • Relevant existing Medicaid initiatives (incl. partners)

Drivers of Success

- Subjective Score (20%)
  - Project Description & Justification
- Objective Score (80%)
  - Volume
  - Velocity
- Milestones & Metrics



Notes:

- Domain 4 projects are 100% Subjective
- Capital needs do not figure into score

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Milestones and Metrics

- Domains 2 and 3 only
- Based on project-specific requirements (4 to 11 per project)
  - Some are more IT-heavy than others
- Form the basis of the detailed **Implementation Plan due April 1, 2015**
- Tracked via quarterly reports

Pay-for-Performance ≈ 50% of the overall award amount over 5 years, so be hopeful but realistic in projections

End of October: KPMG scored mock application

Timeline

S	M	T	W	T	F	S
			OCT 8: Pres.; Team Meetings	9	10: Prim/Spec Capacity Analysis Round 1 due	11
12	13: Team Meetings	14: Cultural Comp/ Health Literacy and Bonus Q1 due	15: Team Meetings; Teams Receive Round 1 of Write-up	16: Teams Receive Round 1 of Project Budgets	17: IT Completes Project Analyses 17: PC/SC Capacity Analysis Round 2 due	18
19	20	21: CNA Application Response due 21: PAC	22: Round 1 Edits due	23: Round 1 Budgets due	24: PC/SC Capacity Analysis Round 3 due	25
26	27	28: Bonus Q2 due (HR)	29: Teams Receive Round 2	30: Teams Receive Round 2 of Budgets	31: IT Completes Gap Analysis	**NOV** 1
2	3	4: Data-Sharing & Confid. due	5: Round 2 Edits due	6: Round 2 Budgets due	7: PC/SC Capacity Analysis Final Due	8
9	10: Teams Receive Final Round of Write-up	11: Workforce Strategy due	12	13: IT Completes Budget	**14: Final Team Submission Due**	15
16	17: Revisions and Team Meetings	18: Governance & Fin. Sustainability due	19: Revisions and Team Meetings	20: Revisions	21: Revisions	22
23	24: Revisions and Team Meetings 24: PAC	25: Budget & Funds Flow due	26: Revisions	**27 Thanksgiving**	28 **Thanksgiving**	29
30	**DEC** 1: Steering Committee Pres	2: Steering Committee Pres	3: Exec. Summary; Rapid Cycle Eval due	4	5: Submit Final to Steering Committee	6
7	8 – 11: Revisions and Proofreading				**12: Submit to State**	13

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DSRIP Project Summaries

Prepared for the NYP PPS PAC

October 21, 2014

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Overview

- The NYP PPS has selected 10 projects which are being developed for likely submission to the State with the DSRIP application
- Projects apply to different geographies consistent with the populations the PPS serves
- Projects are distributed across the three Domains
- Projects will continue to be tested against emerging findings of the Community Needs Assessment and may be revised accordingly

Domain 2

1) 2.a.i IDS
2) 2.b.i Ambulatory Intensive Care Units
3) 2.b.iii ED Care Triage
4) 2.b.iv Care Transitions to Reduce 30 Day Readmissions

Domain 3

5) 3.a.i Integration of Primary Care and Behavioral Health
6) 3.a.ii Behavioral Health Community Crisis Stabilization
7) 3.e.i Comprehensive Strategy to Decrease HIV/AIDS Transmission
8) 3.g.i Integration of Palliative Care in the PCMH

Domain 4

9) 4.b.i Promote Tobacco Cessation
10) 4.c.i Decrease HIV Morbidity

Geographies

- “Uptown”
  - Northern Manhattan
  - Southwest Bronx
- “East”
  - Upper East Side
  - East Harlem
  - Western Queens
- “Lower Manhattan”
  - Lower East Side
  - Chinatown
  - Referral geographies (selected Brooklyn and Queens)

Domain 2: IDS

Requirements

- …include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS…; additionally…payers and social service organizations, as necessary…
- Utilize partnering HH and ACO population health management systems and capabilities to implement the strategy...
- Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
- Ensure that all PPS safety net providers are actively sharing EHR systems with…RHIO/SHIN-NY and…among clinical partners...
- Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3...
- Perform population health management by actively using EHRs and other IT platforms, including...targeted patient registries...
- Achieve 2014 Level 3 PCMH…certification, expand access to primary care providers, and meet Meaningful Use standards...
- Contract with Medicaid MCO and other payers, as appropriate, as an integrated system and establish value-based payment...
- Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
- Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
- Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent CBOs...

Specifications

- **Geography(ies)**
  - **All**
- **Key Attribution Collaborators**
  - **FQHCs and D&Ts (Article 28)**
  - **OASAS Article 32**
  - **OMH Article 31**
  - **OPWDD Article 16**
  - **Community Physicians**
- **Key Contribution Collaborators**
  - **CHHA, LHCSA and Hospice**
  - **Subacute Rehabilitation and SNFs**
  - **Care management**
  - **Patient Navigation and Community Health Workers**

Domain 2: Ambulatory ICU

Requirements

- Ensure that all primary care providers within the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models...
- Identify a physician champion with knowledge of PCMH implementation for each primary care practice included in the project.
- Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other…practices.
- Ensure that all PPS safety net providers are actively sharing EHR systems with…RHIO/SHIN-NY and…among clinical partners...
- Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3...
- Perform population health management by actively using EHRs and other IT platforms, including...targeted patient registries...
- Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management
- Implement preventive care screening protocols including behavioral health…(PHQ-9, SBIRT) for all patients to identify unmet needs…
- Implement open access scheduling in all participating primary care practices.

Specifications

- Target Populations
  - Adults with ambulatory-sensitive conditions
  - CSHCN (Children with Special Health Care Needs)
- Geography(ies)
  - Uptown, East, Lower Manhattan
- Key Attribution Collaborators
  - FQHCs and D&Ts (Article 28)
  - OMH Article 31
  - Community Physicians
- Key Contribution Collaborators
  - Patient Navigation and Community Health Workers
  - Care Management
  - Home care and Hospice
  - SNF
  - Renal
  - Medically-tailored meals
  - Children’s Hospitals and Clinics
  - Pharmacies

Domain 2: ED Care Triage

Requirements

- Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.
  - Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards...
  - Develop process and procedures to establish connectivity between the emergency department and community primary care providers.
  - Ensure real time notification to a Health Home care manager...
- For patients presenting with minor illnesses who do not have a primary care provider:
  - Patient navigators will assist…patient to receive an immediate appointment with a primary care provider...
  - Patient navigator will assist patient with identifying and accessing needed community support resources.
  - Patient navigator will assist the member in receiving a timely appointment with that provider’s office (for patients with a PC).
- Establish protocols allowing ED and first responders…to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care (optional.)
- Use EHRs and other technical platforms to track patients engaged...

Specifications

- Target Populations
  - Frequent ED users with ambulatory-sensitive conditions
- Geography(ies)
  - Uptown, East, Lower Manhattan
- Key Attribution Collaborators
  - FQHCs and D&Ts (Article 28)
  - Community Physicians
- Key Contribution Collaborators
  - Patient Navigation and Community Health Workers
  - Renal
  - Pharmacies

Domain 2: Care Transitions to Reduce Readmissions

Requirements

- Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other…community agency.
- Engage with the Medicaid MCOs and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
- Ensure required social services participate in the project.
- Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
- Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
- Ensure that a 30-day transition of care period is established.
- Use EHRs and other technical platforms to track all patients engaged in the project.

Specifications

- Target Populations
  - High utilizers of inpatient services with multiple chronic conditions
- Geography(ies)
  - Uptown, East, Lower Manhattan
- Key Attribution Collaborators
  - FQHCs and D&Ts (Article 28)
  - Long-term Care Providers
  - Community Physicians
- Key Contribution Collaborators
  - Patient Navigation and Community Health Workers
  - SNF
  - Renal
  - Medically-tailored meals
  - Home care and hospice
  - Pharmacies

Domain 3: Integration of Primary Care and Behavioral Health

Requirements

Model 2: Behavioral Health Service Site

- Co-locate primary care services at behavioral health sites.
- Develop collaborative evidence-based standards of care including medication management and care engagement process.
- Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
- Use EHRs or other technical platforms to track all patients engaged in this project.

Specifications

- Target Populations
  - Behavioral Health patients lacking connection to, or coordination with, medical services
- Geography(ies)
  - Uptown, East
- Key Attribution Collaborators
  - FQHCs and D&Ts (Article 28)
  - OMH Article 31
- Key Contribution Collaborators
  - Patient Navigation and Community Health Workers
  - Care Management
  - Medically-tailored meals
  - Housing
  - Pharmacies

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Domain 3: Behavioral Health Community Crisis Stabilization

Requirements

- Implement a crisis intervention program that…includes outreach, mobile crisis, and intensive crisis services.
- Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.
- Establish agreements with the Medicaid MCOs…to provide coverage for the service array under this project.
- Develop written treatment protocols with consensus from participating providers and facilities.
- Include at least one hospital with specialty…and crisis-oriented psychiatric services; expansion of access to… services
- Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).
- Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.
- Ensure that all PPS safety net providers are actively sharing EHR systems with…RHIO/SHIN-NY and…among clinical partners...
- Establish central triage service with agreements among…psychiatrists, mental health, behavioral health, and substance abuse providers.
- Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality…
- Use EHRs or other technical platforms to track all patients...

Specifications

- Target Populations
  - Unstable Behavioral Health patients
- Geography(ies)
  - Uptown, East
- Key Attribution Collaborators
  - FQHCs and D&Ts (Article 28)
  - OMH Article 31
- Key Contribution Collaborators
  - Patient Navigation and Community Health Workers
  - Care Management
  - Medically-tailored meals
  - Housing
  - Pharmacies

Domain 3: Comprehensive Strategy to Decrease HIV/AIDS Transmission

Requirements

Model 2: Center of Excellence (COE) Management for HIV/AIDS (including HCV)

- Identify site location for a COE which would provide access to the population infected with HIV (and/or HCV).
- Co-locate at this site services 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.
- Co-locate care management services including Health Home care managers for those eligible for Health Homes.
- Develop a referral process and connectivity for referrals for those persons who qualify for but are not yet in a Health Home.
- Ensure understanding and compliance with evidence based guidelines for management of HIV/AIDS (and HCV).
- Ensure coordination of care between all available services preferably through a single electronic health/medical/care management record.
- Ensure that all PPS safety net providers are actively sharing EHR systems with…RHIO/SHIN-NY and…among clinical partners...
- Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3...
- Use EHRs or other IT platforms to track all patients engaged…
- Seek designation as a Center of Excellence from the NYS DOH.

Specifications

- Target Populations
  - Patients with HIV/AIDS both engaged in care and who have fallen out of care
- Geography(ies)
  - Uptown, East
- Key Attribution Collaborators
  - FQHCs and D&Ts (Article 28)
  - OMH Article 31
- Key Contribution Collaborators
  - Care Management
  - Needle Exchange
  - Housing
  - Renal
  - Home Care and LHCSA
  - SNF
  - Adult Day Care
  - Pharmacies

Domain 3: Integration of Palliative Care into the PCMH

Requirements

- Integrate Palliative Care into appropriate primary care practices that have, or will have, achieved NCQA PCMH certification.
- Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.
- Develop and adopt clinical guidelines agreed to by all partners including services and eligibility
- Engage staff in trainings to increase role-appropriate competence in palliative care skills.
- Engage with Medicaid Managed Care to address coverage of services.
- Use EHRs or other IT platforms to track all patients engaged in this project.

Specifications

- Target Populations
  - Patients with serious illnesses with significant symptoms, pain and stress, including patients at end-of-life
- Geography(ies)
  - Uptown, East, Lower Manhattan
- Key Attribution Collaborators
  - FQHCs and D&Ts (Article 28)
  - Community Physicians
- Key Contribution Collaborators
  - Home Care
  - Hospice
  - Pharmacies

Domain 4: City-wide Projects Coordinated, and with Services Provided by, DOHMH

Tobacco Cessation

- Health system change to promote comprehensive screening and treatment of all smokers including those with serious mental illness and lower income
- Media development and placement as a call to action for smokers to quit
- Changes to health benefit coverage and delivery to support barrier-free quit attempts

HIV

- PREVENT
  - Improve provider cultural competency to care for MSM/Trans population
  - Improve provider capacity to offer PEP and PrEP
- IDENTIFY
  - Expand reach of NY Knows
  - Routine HIV Testing and the Electronic Medical Record (EMR)
- LINK
  - CDC Anti-Retroviral Treatment and Access to Services (ARTAS) Training
- RETAIN
  - Care Coordination Training and Support
  - Cash Incentives for Reduced Viral Load
  - Housing Support for Improved Health Outcomes