NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	4/24/15, 9-10AM	**Meeting Title**	NYP PPS Finance Committee
Location	530 W 166th Street, CB12 Conference Room	**Facilitator**	Dr. Emilio Carrillo
Go to Meeting	https://global.gotomeeting.com/join/256656797	**Conference Line**	Dial +1 (646) 749-3112 Access Code: 256-656-797

Invitees	
Ilana Avinari (Methodist)	Tamisha McPherson (Harlem United)
Angela Martin (VNSNY)	Mediha Gega (NYC DOHMH)
Alissa Wassung (God's Love We Deliver)	Maria Lizardo (Northern Manhattan Improvement Corporation)
David Pomeranz (Hebrew Home)	Susan Wiviott (The Bridge)
David Chan (City Drug & Surgical)	Emilio Carrillo, MD (NYP)
Jean Marie Bradford, MD (NYPSI)	
Eva Eng (Arch Care)	
Jonah Cardillo (St. Mary's Hospital for Children)	

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

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**

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Share Meeting Minutes	Isaac Kastenbaum	4/24/15	4/30/15	
Share Invite to Nominate/Volunteer Co-Chair	Isaac Kastenbaum	4/24/15	4/30/15	
Share Meeting Materials	Isaac Kastenbaum	4/24/15	4/30/15	
Schedule Committee Meeting Series	Isaac Kastenbaum	4/24/15	4/30/15	

Meeting Minutes:

1. E. Carrillo welcomed everyone to the first Clinical Operations Committee Meeting
   a. Mentioned many people in the room have a history of collaboration and this new DSRIP effort only builds upon those close ties
2. E. Carrillo facilitated Committee Member and Project Lead Representatives
   a. Committee Members introduced themselves and provided a broad overview of the services that they provide.
3. I. Kastenbaum provided an update on the NYS external and NYP PPS internal timelines
   a. NYS's date to release the final Valuation Attribution (# of lives) and maximum 5-year funding value has been delayed to May 7th. This is largely due to the recent potential breakup of the Advocate Community Partners PPS – if their breakup is successful, it would release a significant (200K+) members back into the attribution pool.
   b. The roster of attributed patients should be released in mid-May; we've already had a few internal conversations about how we would go about identifying the attributed beneficiaries, within technical and legal limits

   c. The PPS Domain 1 Implementation Plan is now due June 1st (back from May 1st); there will be a second implementation plan due on July 1st that relates specifically to projects.
   d. NYP PPS Project Leads are working on first draft workflows and implementation plans – will then turn to collaborating with key network providers to flesh out details of cross-network collaborations
4. E. Carrillo provided an overview of the PPS's 10 projects
   a. 2.a.i (IDS) – this is the foundation for every project – really the infrastructure for how the PPS will coordinate and connect care across the network
   b. 2.b.i (Amb ICU) – this is the "PCMH on steroids" for both peds and adults
   c. 2.b.iii (ED Care Triage) – this builds off of an NYP proven patient navigator model; uses navigators in the ED to reconnect patients with their primary care physician or to help establish a new PCP relationship
   d. 2.b.iv (Care Transitions) – J. Mirkin and C. Beck described how this builds upon the Hospital's care management model and applies additional resources to the at-risk Medicaid population
   e. 3.a.i and 3.a.ii (BH Integration and BH Crisis Stabilization) – M. Hanrahan provides an overview of the two projects – both really focus on integrating the appropriate care for the BH population. One will bring primary care physicians and NPs to BH clinics; the other will bring a Critical Time Intervention (CTI) team to support those patients in-need.
   f. 3.e.i and 4.c.i (HIV Center of Excellence and HIV Reducing Morbidity) – S. Merrick provided an overview of their focus on increasing identification of PLWHA and improving retention in care
   g. 3.g.i (Palliative Care) – E. Carrillo provided a quick overview of how this project brings palliative care consults to the PCMH
   h. 4.b.i (Tobacco Cessation) – E. Carrillo provided a quick overview of how this project will provide Cessation training in PCMHs and setup Cessation clinics for the high-risk smoking population
   i. J. Cardillo asked how these projects would translate into work with the PPS network collaborators. E. Carrillo mentioned that this would be worked through the implementation planning and workflow conversations
   j. A. Wassung described services that God's Love We Deliver was working on, including a UAS survey that could be broadly used across the PPS.
5. E. Carrillo reviewed the Committee Charter and Guidelines
   a. Several group members asked whether the Committee was the venue for discussions of project-level details
   b. E. Carrillo responded that the Committee would address high-level strategies, but that each Project Lead would work with the PPS Network collaborators to flesh out the details at a project level. Also, the Clinical Operations Committee would work closely with the Data/IT Governance Committee to ensure the projects are appropriately supported by IT tools.
6. E. Carrillo reviewed the PPS Network Co-Chair nomination/volunteer process. I. Kastenbaum will send out a follow-up email requesting volunteers or nominations. If there is a run-off, that will be facilitated offline between meetings.
7. E. Carrillo closed the meeting, stating the need for us to meet on an on-going basis going forward and that there was a lot of work to do in this Committee and the others.

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

New York and Presbyterian Hospital PPS
Clinical Operations Committee Guidelines

Co-Chair: Dr. J. Emilio Carrillo, VP of Community Health, NewYork-Presbyterian Hospital
PPS Network Co-Chair: TBD

Charter:

The Clinical Operations Committee will provide recommendations for the New York and Presbyterian Hospital Performing Provider System's clinical and programmatic standards. The committee will be comprised of leaders with clinical and programmatic experience with representation from a variety of provider-types across the entire PPS.

The committee will ultimately be responsible for:

1. Establishing the necessary clinical and programmatic strategies to succeed in the performance period
2. Establishing standard care protocols for transitions of care
3. Communication plans to Collaborators, community stakeholders and Medicaid beneficiaries
4. Establishing standard performance measures and feedback mechanisms
5. Reviewing the progress of projects and individual PPS Network members and making recommendations to the Executive Committee for programmatic/membership changes

The Committee may, at times, form small workgroups to complete specific tasks that include (as outlined in the NYS DSRIP Implementation Plan):

1. Perform a clinical integration 'needs assessment'
2. Develop a Clinical Integration Strategy
3. Finalize cultural competency / health literacy strategy
4. Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material)
5. Develop practitioner communication and engagement plan
6. Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda
7. Oversee transition of safety net providers to meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
8. Oversee that all PPS providers are included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.
9. Develop plans to leverage partnering HH and ACO population health management systems and capabilities to implement the strategy towards evolving into an IDS.

Membership

1. Committee will be comprised of 11 members – with two chairpersons

2. Committee membership will be rotated in 12 month terms; at the completion of a term, 3 members will be rotated off (through a random-selection process in the 7th month of the term). Committee members will serve, at a maximum, thirty 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; the PPS Network collaborator will be chosen based on a vote at the first meeting of each term. Collaborator Chairpersons will rotate every ten months.
5. Committee members that miss 3 consecutive meetings will be removed and replaced

Co-Chair Responsibilities:

Clinical Operations Committee Co-Chairs will be responsible for: (1) preparing for meetings, (2) preparing/reviewing meeting agendas and notes, (3) working offline with Committee Members to push Committee efforts forward, (4) reviewing Committee deliverables, and (5) presenting to Executive Committee, when appropriate. Co-Chairs will serve a 12-month term.

Focus:

1. Committee will be responsible for advising the Executive Committee
2. Committee will be required to draft recommendations to be presented to the Executive Board monthly by the Chairperson(s)

Operations:

1. A majority of the members of the Committee shall constitute a quorum for the transaction of business. The vote of a majority of the members present at a meeting at the time of such vote, if a quorum is then present or the unanimous written consent of all members thereof, shall be the act of the Committee.
2. Committee will be required to submit minutes and attendance to the NYP PPS Project Management Office (PMO)
3. Committee meetings will be hosted in-person at NYP or Collaborator locations - a GoToMeeting/telephone option will also be offered.
4. NYP will provide a staff person to support the committee