NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	2/3/17, 9-10:30am	**Meeting Title**	NYP PPS Clinical Operations Committee
Location	Visiting Nurse Service of New York / 1250 Broadway, Room 7A (at 32nd Street and Broadway)	**Facilitator**	Dr. Steven Kaplan, Sandy Merlino
Go to Meeting	https://global.gotomeeting.com/join/676507237	**Conference Line**	Dial +1 (408) 650-3123 Access Code: 676-507-237

Invitees	
Chair: Sandy Merlino (VNSNY)	**Chair:** Steven Kaplan, MD (NYP)
Alissa Wassung (God's Love We Deliver)	Terri Udolf (St. Christopher's Inn)
Susan Wiviott (The Bridge)	Amy Shah (NYC DOHMH)
David Chan (City Drug & Surgical)	Maria Lizardo (Northern Manhattan Improvement Corporation)
Jean Marie Bradford, MD (NYPSI)	Catherine Thurston (SPOP)
Genevieve Castillo (Methodist)	
Dan Johansson (ACMH, Inc.)	

Meeting Objectives	**Time**
1. Review of Action Items from Last Meeting (Lauren Alexander)	5 mins
2. Cultural Competency and Health Literacy Update (Rachel Naiukow)	5 mins
3. Overview of the NYP Health Home (Tiffany Sturdivant-Morrison)	20 mins
4. Shift to Focus on Performance Metrics (Andrew Missel)	15 mins
5. Review of Monthly Status Report (Andrew Missel)	10 mins
6. Clinical Integration Needs Assessment and Strategy (Andrew Missel)	10 mins
7. Community Provider Quality Improvement Lead (Lauren Alexander)	10 mins
8. Co-Chair Position (Lauren Alexander)	5 mins
9. Open Discussion (Steven Kaplan/Sandy Merlino)	10 mins

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Explore alignment between Clinical Operations and IT/Data Governance Committees	L. Alexander, S. Merlino, S. Kaplan	12/2/2016	Ongoing	In progress
Invite Healthix and Patricia Hernandez to future Clinical Operations Meeting	L. Alexander	12/2/2016	3/31/2016	In progress
Follow-up on CRFP funding questions and provide status update at next meeting	S. Kaplan	12/2/2016	2/3/2016	Complete
Provide project descriptions and current status updates at next meeting (send project descriptions document in advance of meeting)	A. Missel	12/2/2016	2/3/2016	Complete
Share slides from meeting with Committee	L. Alexander	12/2/2016	12/30/2016	Complete
Share final Clinical Integration Needs Assessment/Strategy document with Committee	L. Alexander	12/2/2016	12/30/2016	Complete
Revise meeting schedule and send updates Outlook invites	L. Alexander	12/20/2016	12/30/2016	Complete

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Alissa Wassung (God's Love We Deliver)	Terri Udolf (St. Christopher's Inn)
Susan Wiviott (The Bridge)	Catherine Thurston (SPOP)
David Chan (City Drug & Surgical)	Andrew Missel (NYP)
Jean Marie Bradford, MD (NYPSI)	Alpa Prashar (NYP)
Genevieve Castillo (Methodist)	Tiffany Sturdivant-Morrison (NYP)
Lauren Alexander (NYP)	Rachel Nauikow (NYP)

Meeting Objectives	**Time**
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Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Inform L. Alexander if you or your organization would like to participate in cultural competency and health literacy efforts	Committee	2/3/2017	Ongoing	In progress
Share Health Home FAQs and referral form with Committee	L. Alexander	2/3/2017	2/17/2017	Not started
Review metrics at next meeting	L. Alexander/ A. Missel	2/3/2017	3/17/2017	Not started
Schedule conference call to discuss shift to performance metrics in more depth	L. Alexander/ A. Missel	2/3/2017	3/3/2018	In progress
Review remaining agenda items at next meeting or via e-mail	L. Alexander	2/3/2017	3/10/2017	Not started

AMAZING THINGS ARE HAPPENING HERE

NewYork-Presbyterian Health Home

Overview

Tiffany Sturdivant-Morrison, MPH

Program Administrator, NYP Health Home

AMAZING THINGS ARE HAPPENING HERE

What is a Health Home?

- Not a residence……..
- Section 2703 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) adds a new section 1945 to the Social Security Act. This section allows States to amend their State Medicaid Plans to provide "Health Homes" to enrollees with chronic conditions, including mental health conditions, substance abuse disorders, asthma, diabetes, heart disease and being overweight(BMT > 25).

http://www.health.nygov/health_care/medicaid/program/medicaid_health_homes/

What is a Health Home?

- The health home model of service delivery expands on the traditional medical home model to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, *with the main focus on the needs of persons with multiple chronic illnesses.*

- NYSDOH has identified high risk/high cost population groups and has designated a **care management program**, Health Home, to care manage these individuals.

- Health Homes provide comprehensive care coordination and care management services for people with complex medical and behavioral conditions.

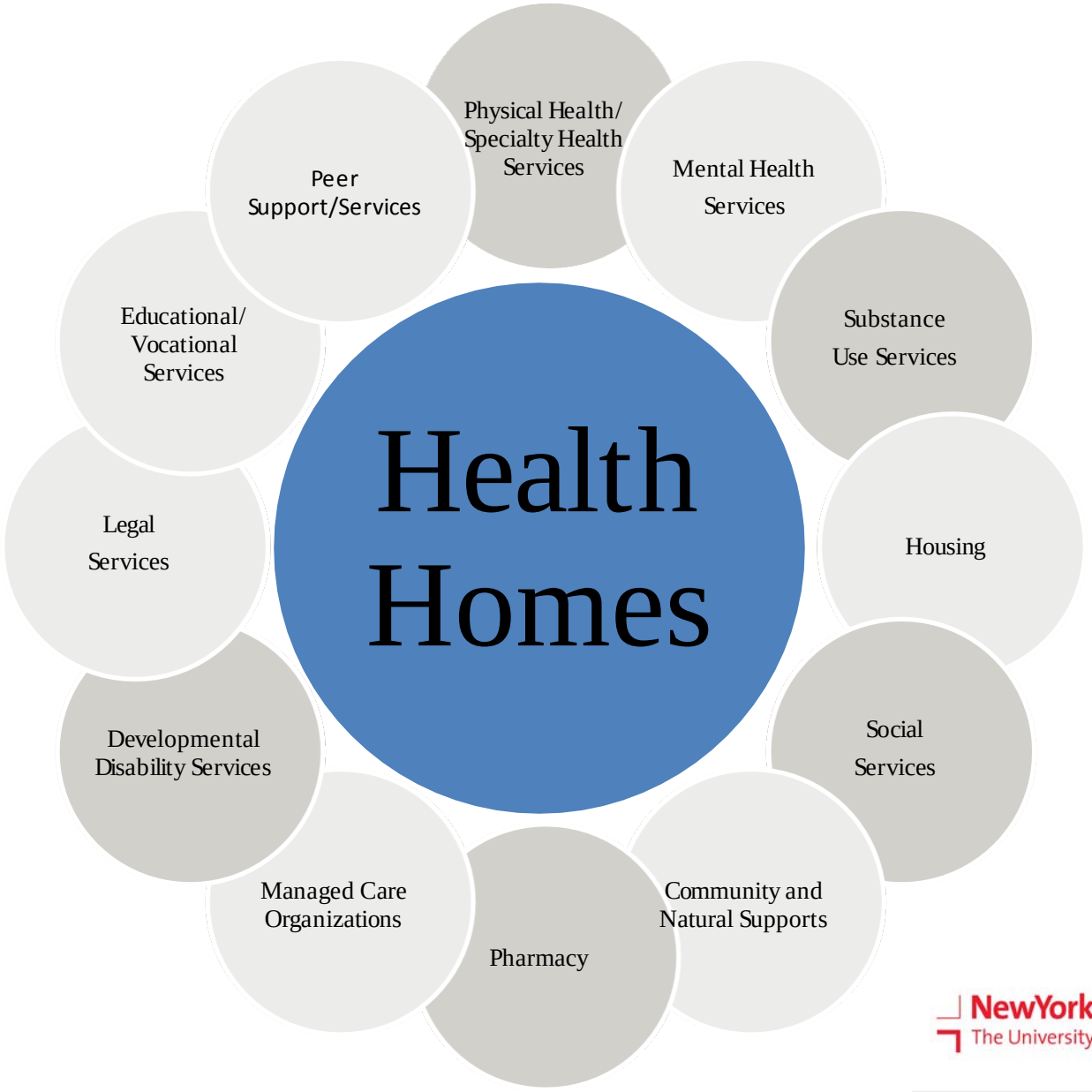
- Members are assigned **dedicated care managers** to help them navigate the complex medical, behavioral, and social service systems across the continuum of care.

What is a Health Home?

- Health home services include:
  - comprehensive care management
  - care coordination
  - health promotion
  - comprehensive transitional care, including appropriate follow-up from inpatient to other settings
  - patient and family support
  - referral to community and social support services, and
  - use of health information technology to link services

- GOAL: Expect that use of the health home service delivery model will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual.

What makes up a Health Home?



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Health Home Eligibility

Patients who qualify to be part of the Health Home meet these criteria:

Medicaid Coverage

- Medicaid eligible / Active Medicaid
- Medicare/Medicaid dual enrolled

Chronic Conditions

- Two Chronic Conditions **OR**
- HIV/AIDS **OR**
- Serious Mental Illness (Schizophrenia, Schizoaffective, Bipolar Disorder, Major Depression

Social Determinants

- Have significant behavioral, medical, or social risk factors
  - Lack of social /family support
  - Non adherence to treatments and / or medications
  - Recent release from an inpatient setting
  - Homeless
  - Learning / cognition issues

AMAZING THINGS ARE HAPPENING HERE

Top Down Assignment by DOH/MCO

- DOH and Managed Care Organizations (MCOs) review Medicaid claims data to identify high cost individuals considered “at risk” of hospitalization due to lack of engagement and meet the HH eligibility criteria
- Individual loyalty is considered (what ER they frequent, where treatment services are provided, etc.)
- Both DOH and MCOs then assign patients to the NYP Health Home

Top Down Assignment by DOH/MCO

- The NYP Health Home will assign a Care Management Agency (CMA) to provide outreach to the member within 3 calendar months
- The patient must consent to care management services and to be part of the Health Home

Bottom (Ground) Up Referrals

- Patients that are not assigned by the State can still be assigned to a health home.
- These referrals are know as bottom (ground) up or community referrals.
- These referral are made directly to the Lead Health Home.

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NYP Health Home Referral Form

Check all that apply

Step 1: Health Home Eligibility

☐ Patient/Client has **ACTIVE** Medicaid- Medicaid Number_____

Patient/Clients meets the diagnostic eligibility criteria:

☐ TWO chronic conditions (mark all that apply)

- ❑ Mental Health Condition
- ❑ Substance Use Disorder
- ❑ Asthma/COPD
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Other(specify)_____

AND/OR

☐ A Severe Mental Illness (specify) :_____

AND/OR

☐ HIV/AIDS :

☐ Additional Indicators (mark all that apply)

- ❑ Probable risk for an adverse event (i.e. death, disability, inpatient admission
- ❑ Lack of adequate social/family support or housing support
- ❑ Lack of adequate connectivity to the healthcare system
- ❑ Non-adherence to treatment or medications or difficult managing medications
- ❑ Recent release from incarceration or psychiatric hospitalization
- ❑ Deficits of activities of daily living
- ❑ Learning or cognition issues

☐ Patient/Client resides in one of the following boroughs: ❑ Manhattan ❑ Bronx ❑ Brooklyn

☐ Patient/Client has utilized services at New York Presbyterian Hospital (i.e. ED, inpatient, ambulatory, or specialty)

Step 2: Demographic Information

NYP MRN (if known):_____

Last Name: _____First Name:_____ DOB:_____

Phone Numbers:_____

Home Address:_____

Has referral been discussed with patient _____

If making a referral from an inpatient unit, what is the anticipated discharge date and disposition plan?

_____

_____

_____

Referrer Contact:

Name:_____

Unit/Clinic/Agency:_____ Phone:_____

Email:_____

Please fax form to Yelena Kaplan at 212.342.0598 or Email to yek9017@nyp.org
Questions? Call 212-342-0015

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NYP's Care Management Agencies

Collaborators	Housing Instability & Quality	Food Insecurity	Utility Needs	Interpersonal Violence	Transportation Needs	Family & Social Support	Education	Employment & Income	Health Behaviors	Smoking Cessation
ACMH	▲	▲	▲	▲		▲			▲	▲
Argus	▲	▲	▲		▲	▲	▲	▲	▲	
ASCNYC	▲	▲		▲	▲	▲	▲	▲	▲	
Create, Inc	▲	▲							▲	▲
Hebrew Home	▲					▲				
Isabella Geriatric Center	▲	▲			▲					
Riverstone Senior Life Services	▲	▲	▲			▲				
The Bridge	▲					▲		▲	▲	▲
Upper Manhattan Mental Health Center, Inc		▲								
VillageCare	▲					▲			▲	

Health Home Next Steps

- Policy and Procedure Development
- Training and Education Opportunities
  - Care Management Agencies
  - Internal and external referral sources
- Staffing
- Care Coordination Strategy Development
  - Explore opportunities for Care Coordination types to effectively work together to meet the needs of our patients

Questions?

Contact:
Tiffany Morrison,
Health Home Program Administrator
tis9034@nyp.org

NYP Health Home Frequently Asked Questions

What is a Health Home?

A Health Home is not a physical space. It is a group of health and community agencies who have agreed to work together to provide care management support to Medicaid members with complex medical and behavioral healthcare needs. Each Health Home member will have a designated care manager to help them coordinate their care. The role of the care manager is inclusive, but not limited to: health promotion, provision of individual and family support, and care coordination and referral management to community and support resources.

Who is eligible for the NYP Health Home?

Anyone who is has active Medicaid **and** has:

- Two chronic diseases such as diabetes, asthma, heart disease, high blood pressure, substance abuse or obesity, OR
- HIV/AIDS, OR
- A chronic mental illness

A list of eligible chronic conditions and other state guidelines may be found at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf.

When in doubt, please complete the Health Home Referral form and we will let you know of the patient's eligibility.

What insurances are accepted by the NYP Health Home?

We accept patients who have:

- Affinity Health Plan
- EmblemHealth-HIP (Health Ins. Plan of GTR NY)
- Fidelis (NYS Catholic Health Plan)
- Healthfirst NY
- United Healthcare Community Plan
- VNSNY Choice
- Medicaid FFS
- Dual eligible Medicaid/Medicare
- Medicaid/ADAP (Spendown must be met)

Patients enrolled in a MLTC are eligible for the NYP Health Home. Currently, we do not have contracts with Managed Long Term Care (MLTC) Plans can still be billed for HH servicer. If patients with MLTC coverage are referred to the NYP HH, NYP HH will process referral accordingly and link to CMA if eligible.

NYP Health Home Frequently Asked Questions

MCO Contact info

Healthfirst
Ara Hodge, Program Manager, ahodge@healthfirst.org, 646-767-5771
Samantha Danko, Program Coordinator, sdanko@healthfirst.org, 646-677-3614

VNS
Alan Rice, Pop Health Specialist, alan.rice@vnsny.org, 212-609-5671

Emblem
Christiana Duodu, Lead Specialist – cduodu@emblemhealth.com, 646-447-5943, fax – 212-510-3197
Healthhomememberinquiry@emblemhealth.com

Fidelis
Elizabeth Apeadu, Long Term Care Provider Specialist, EApeadu@fideliscare.org, 718-685-5279
HARP/HCBS/POC documents can be sent via: Secure Fax: 347-868-6427; E-mail –QHCMHARPBH@fideliscare.org

UHC
Sanrose Russell, Managing Director of Health Homes, sanrose_russell@uhc.com, 866-361-9709

Beacon
Linda Nelli, HARP/QMP Care Manager, linda.nelli@beaconhealthoptions.com, Office: 646-927-4132

Who are NYP's Health Home Partners? And what are their geographic service areas?

ACMH: 02187204 (Direct Biller) HARP
Kristina Garcia-212-543-0592 ext. 302- kgarcia@acmhnyc.org (capacity)
Senior Director for Care Management Services
Racquel Reid-212-543-0592 ext. 308- rreid@acmhnyc.org (capacity, referrals)
Director, Care Management Services
Patrick M. O'Quinn- 212-274-8558 ext. 230- POQuinn@acmhnyc.org
Senior vice President for Care Management and Program Development
Boroughs Served: Manhattan
Address: 254 W. 31st Street, 9th Floor, New York, NY, 10001
Specialty: Behavioral Health, Substance Use

Argus: 01370850 (Direct Biller)
Ed Perez-718-401-5731- eperez@arguscommunity.org (capacity, referrals)
Care Manager Supervisor
Celestino Fuentes – 718-401-5407, cfuentes@arguscommunity.org (capacity, referrals)
Charise Brody- cbrody@arguscommunity.org
Patient Navigator Administrator
Address: 402 E 156th St, Bronx, NY, 10455
Boroughs Served: Manhattan, Bronx, Brooklyn, Queens
Specialty: Behavioral Health, Substance Use, HIV

NYP Health Home Frequently Asked Questions

ASC: 01484019 (Direct Biller) HARP
Marcy Thompson, Director 212-645-0875 ext.307- marcy@ascnyc.org (capacity, status reports)
Lindsay Hayek, Asst. Director 212-645-0875 ext.359- Lindsay@ascnyc.org (capacity, enrolled)
Cesar Dechoudens, Care Manager Supervisor, 212-645-0875 ext. 748 – cesar@ascnyc.org (capacity, referrals)
Omar Almanzar, Outreach Manager-212-645-0875 ext. 426 (referrals, outreach)- omar@ascny.org
Annette Williams (Referrals, Outreach) annette@ascnyc.org
Jamila Allen, Assistant Director of Outreach and Linkage to Care - 212-645-0875 Jamila@ascny.org
Address: 64 W 35th St, 3rd Floor New York, NY 10001
Boroughs Served: Manhattan, Bronx, Brooklyn **(11222, 11211, 11201, 11231, 11205)**
Specialty: Behavioral Health, Substance Use, HIV

Bridge: 02997620 (Direct Biller) HARP
Lakeida Alford, Director-212-678-7188 ext. 2008- lalford@thebridgeny.org (referrals, capacity)
Sheryl Silver, Sr. VP-646-739-8117- ssilver@thebridgeny.org (capacity)
Damaris Spivey-212-678-7188 ext. 2017- Dspivey@thebridgeny.org
Address: 248 W 108th St, New York, NY, 10025
Boroughs Served: Manhattan, Bronx
Specialty: Behavioral Health, Substance Use

Isabella: 02942450 HARP
Vonalis Pina-212-342-9514- vpina@isabella.org (capacity, referrals)
Awilda- acepeda@isabella.org
Address: 515 Audobon Ave, New York, NY, 10040
Boroughs Served: Manhattan, Bronx
Specialty: Chronic Illness, Behavioral Health

NYP CMA: 00243178
Claudia Beck-212-342-0274
Boroughs Served: ACN population/ Manhattan/ Bronx
Specialty: Chronic Illness, Behavioral Health

Upper Manhattan: 02993800 (Direct Biller)
Max Calderon-212-694-3500 ext. 12- mcalderon@bowencsc.org (capacity, referrals)
Steve Muchnick-212-694-3500 ext. 11- smuchnick@bowencsc.org (capacity, referrals
Michael Rosenberg- Biller
Address: 120 Broadway Suite 2840 New York, NY, 1027
Boroughs Served: Manhattan, Bronx (455,456,467)
Specialty: Behavioral Health, Substance Use

Village Care: 01539335 (Direct Biller) HARP
Hira Ruskin-212-337-5887- hiram@villagecare.org (capacity, referrals)
Jacqueline Prince-212-337-5638 jacquelinep@villagecare.org (capacity, referrals)
Carissa Ruiz – 212-402-2338 carissar@villagecare.org (capacity, referrals)

NYP Health Home Frequently Asked Questions

hhrefer@villagecare.org
Boroughs Served: Manhattan, Bronx, Queens, Brooklyn
Specialty: Behavioral Health, Substance Use, HIV

Newest Providers:

CREATE, Inc.
Address: 73 Lenox Ave, New York, NY 10026
Specialty: Substance Use, Housing
Boroughs Served: Manhattan

Riverstone
Address: 99 Fort Washington Avenue, basement, New York, NY 10032

What is the referral process?

1. Email the Health Home referral form completely filled out to nyphealthhome@nyp.org.
2. Within 2 - 3 business days someone from the Health Home team will contact you:
    a. If the patient is eligible for the NYP Health Home, the Health Home team will assign the patient to one of our partners.
    b. If the patient is not eligible for the NYP Health Home and / or the patient is already engaged with another Health Home, the Program Administrator will reach out to another lead Health Home to connect you.
3. Follow up with the Health Home partner within 5 business days to review case to ensure connection was made.

If the patient is not eligible for the NYP Health Home, who are our preferred Lead Health Home contacts?

The Program Administrator will work with you to refer patients to another Lead Health Home. In the event you would like to reach out directly, below is a list of the counties they serve and their general information phone numbers:

- **Bronx Lebanon**

  Yanica Polanco- Ypolanco@bronxleb.org – 718-466-7270

- **Community Care Management Partners (CCMP), LLC**

  Counties: Bronx, Manhattan
  Member Referral Number: 888-682-1377
  Stephanie Garcia- Stephanie.garcia@ccmphealthhome.org,

- **Coordinated Behavioral Care dba Pathways to Wellness**

  Counties: Brooklyn, Manhattan, Staten Island
  Member Referral Number: 866-899-0152
  Jeanette Wilson- Jwilson@cbcare.org – 646-930-8833

- **Community Healthcare Network**

  Counties: Bronx, Brooklyn

NYP Health Home Frequently Asked Questions

Member Referral Number: 855-CHN-HHCC (246-4422)
Allen Warnock-awarnock@chnnyc.org- CHN

☐ **Hudson River Healthcare, Inc. dba CommunityHealth Care Collaborative**

Counties: Columbia, Dutchess, Greene, Orange, Nassau, Putnam, Rockland, Suffolk, Sullivan, Westchester
Member Referral Number: 1-888-980-8410

☐ **Montefiore Medical Center**
855-680-2273 (CARE)
917-803-5015
omontoya@mhhc.org

☐ **Brightpoint Health (CMA)**
Cdasilva@brightpointhealth.org
855-681-8700

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NYP Health Home Referral Form

Please complete all fields. Incomplete forms will result in delays.

Please email your completed form to nyphealthhome@nyp.org

Questions? Please call 212.342.0542

Date of Referral: _____ **Referral Type:** ■Bottom Up ☐MCP Referral ☐Lead Referral

Demographics

NYP MRN (if known):_____

Last Name: _____ **First Name**: _____ **DOB**: _____

Home Phone Number: _____ Cell **Phone Number**: _____

Home Address: _____

Has referral been discussed with patient? ■Yes ❑No

Patient/Client resides in one of the following boroughs: ■Manhattan ❑Bronx ❑Brooklyn ❑Queens ❑Staten Island

Currently the NYP Health Home does not accept patients who live in Staten Island but will assist in referring another Health Home

Referrer Contact:

Name: _____ **Unit/Clinic/Agency**: _____

Phone: _____ **Email**: _____

Health Home Eligibility

■ Patient/Client has **ACTIVE** Medicaid- Medicaid Number_____

Patient/Clients meets the diagnostic eligibility criteria:

■ TWO chronic conditions (mark all that apply)

- ❑ Mental Health Condition
- ❑ Substance Use Disorder
- ❑Asthma/COPD
- ❑Diabetes
- ❑Heart Disease
- ❑ Other (specify):_____

AND/OR

☐ A Severe Mental Illness (specify):_____

AND/OR

☐ HIV/AIDS

FOR NYP CMA ONLY: Assign to self?

No

FOR HEALTH HOME USE ONLY

Review Date: _____

MCO: _____

HARP: ❑**Yes** ■**No**

Assigned to: _____

Comments:_____

_____

_____

_____

_____

Services Needed: (Check all that apply)

☐	Chronically Ill	☐	Appointment Reminders
☐	Dental Care / Vision Care	☐	Housing advocacy and support
☐	Discharge Planning (Recent release from incarceration/hospitalization) Anticipated Discharge Date:_____	☐	Legal Services/specify: _____
☐	Entitlements Assistance	☐	Mental Health/Counseling
☐	Family Therapy	☐	Substance Use Treatment
☐	GYN Care	☐	TB Testing and Follow-up
☐	Harm Reduction Referrals	☐	Treatment Adherence / Education
☐	In Home Services (Home Health Aide)	☐	Transportation
☐	Linkage to Care / Healthcare System	☐	Food and Nutrition Services
☐	Support Groups/specify type: _____	☐	Other; Specify: _____

General Comments:

Thank you for your referral to the NYP Health Home.

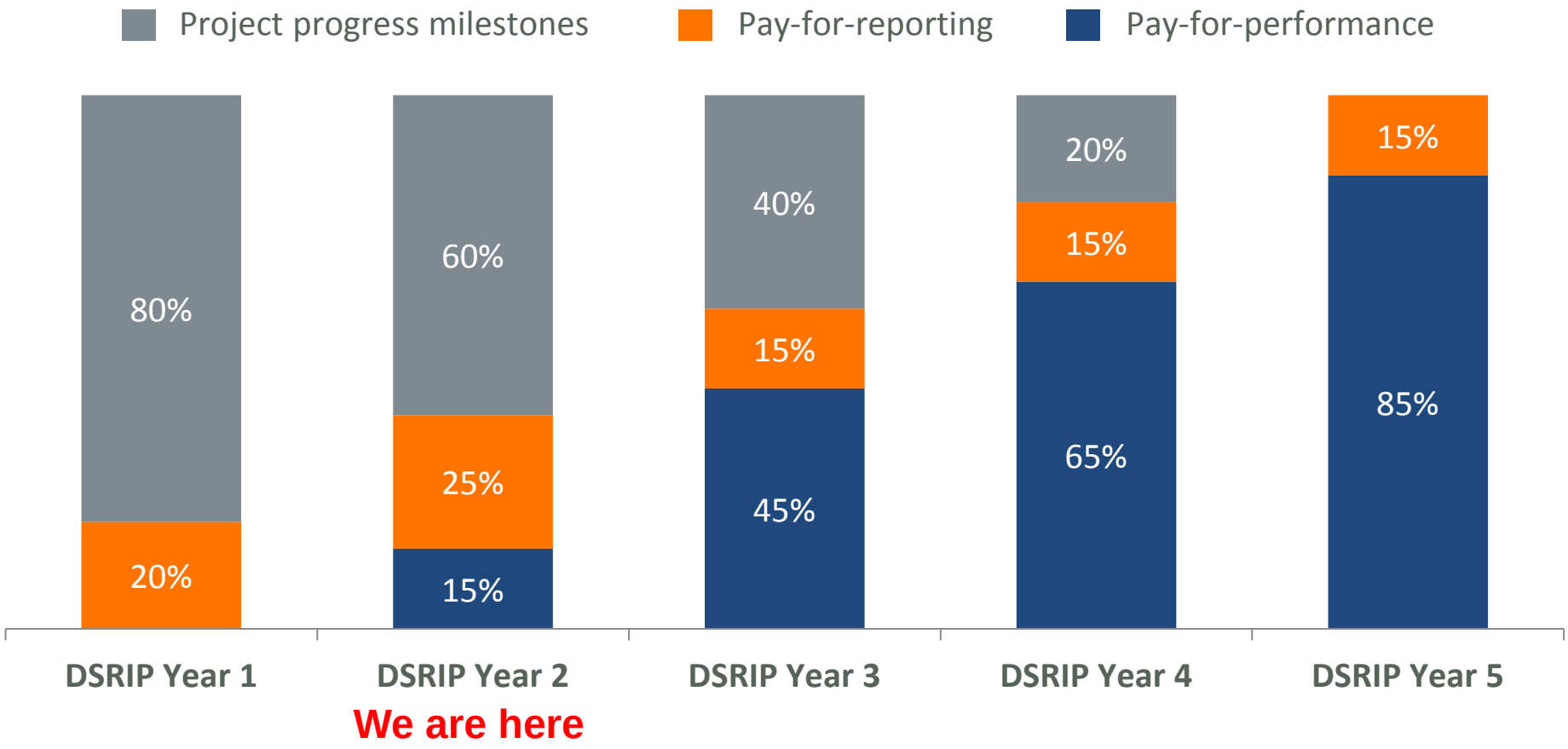
AMAZING THINGS ARE HAPPENING HERE

Transition to P4P

Clinical Operations Committee
February 3, 2017

NewYork-Presbyterian
Performing Provider System

Shift from P4R to P4P Throughout DSRIP



Note: As part of a December 2015 waiver amendment request to the federal Centers for Medicare and Medicaid Services, New York is seeking to slightly modify these percentages.

Source: New York State Department of Health, Attachment I—NY DSRIP Program Funding and Mechanics Protocol, April 2014.

NewYork-Presbyterian
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P4P Dollars Become Increasingly Important

PPS budgeted at $79M over five years; only $60M is likely guaranteed. We must focus on closing the $20M gap by achieving the pay-for-performance gaps.

Evaluation Level	Funding Source	5-Year Max Value	Portion (%)
PPS	Pay-for-Performance Performance Metrics	$26,012,419	26.6%
PPS	Equity Infrastructure Program – investments in foundational efforts of PPS	$23,628,005	24.2%
PPS	Pay-for-Reporting Performance Metrics	$19,705,156	20.2%
PPS	PPS Organizational Milestones	$9,657,160	9.9%
PPS	Pay-for-Performance High-Performance Fund	$9,500,000	9.7%
Project	Project Implementation Plan Approval (1 time)	$4,632,393	4.7%
Project	Project Budget Reporting	$2,414,290	2.5%
Project	Project Patient Engagement Speed	$1,585,839	1.6%
Project	Project Requirement Achievement	$502,659	0.5%
TOTAL		**$97,637,921**	**100%**

DSRIP Year 1-1.5: It has all been about the projects

Current State (10 projects):

- Budgeting and expenses managed **through projects**
- Clinical leadership and project management organized **by projects**
- Governance Committees have provided guidance **for projects**
- Information technology has been developed **for projects**
- Collaborators have been engaged **in projects**
- PPS communication has been centered **on projects**

DSRIP Years 1.5 – 5: It's all about performance

Pay for Performance Metrics:

- Are evaluated on the **full 90K attributed beneficiaries**
- Are focused on **various provider types**
- Will require work **across the care continuum**
- Will focus **on the patient**
- Will require distribution of **data to providers**

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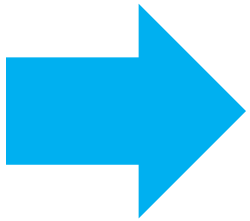
Proposed PPS Pivot: Transition to P4P

Project-Centric Governance

PPS Governance Committees

- Integrated Delivery System
- Ambulatory ICU
- ED Care Triage
- 30-Day Care Transitions
- BH – Primary Care Integration
- BH Crisis Stabilization
- HIV Center of Excellence
- Palliative Care in PCMHs
- Tobacco Cessation
- Reduce HIV Morbidity



Performance-Driven Governance

PPS Governance Committees

- Adult Medicine @ NYP
- Pediatrics @ NYP
- Sexual Health
- Community Providers
- Transitions / High Utilizers
- CBO/Social Determinants

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Performing Provider System

Proposed PPS Pivot: Population Lines

Population Line	Scope / P4P Metrics (not exhaustive)
Adult Medicine @ NYP	Screenings, tobacco cessation, reduced potentially avoidable utilization, timely appointments, primary care access
Pediatrics @ NYP	Screenings, tobacco cessation, reduced potentially avoidable utilization, timely appointments, primary care access, ADHD treatment
Sexual Health	HIV, STI, HCV screening, referral, engagement
Community Providers (PC/BH)	Screenings, tobacco cessation, reduced potentially avoidable utilization, timely appointments, primary care access, PCMH achievement, **[FQHCs, Community Providers, BH Providers]**
Transitions / High Utilizers	Potentially preventable utilization, follow-up for BH hospitalizations, transitions to/from ED and inpatient
CBO/Social Determinants	Navigation of community-based psychosocial services, standardized screening and referral, housing, legal aid, nutrition support, substance use access, Healthix and Healthify rollout

Proposed PPS Pivot: Population Lines

Anticipated Challenges

- Performance data
  - 1+ year lag (directional)
  - Not directly attributed to single provider/organization
  - Few data sources are identifiable / actionable
- NYS reporting will remain project-centric

Anticipated Opportunities

- Align funding to performance
- Reorganizing away from project silos
- Resource QI in community
- Enhanced engagement across network
- Revamp PPS governance to be performance-oriented

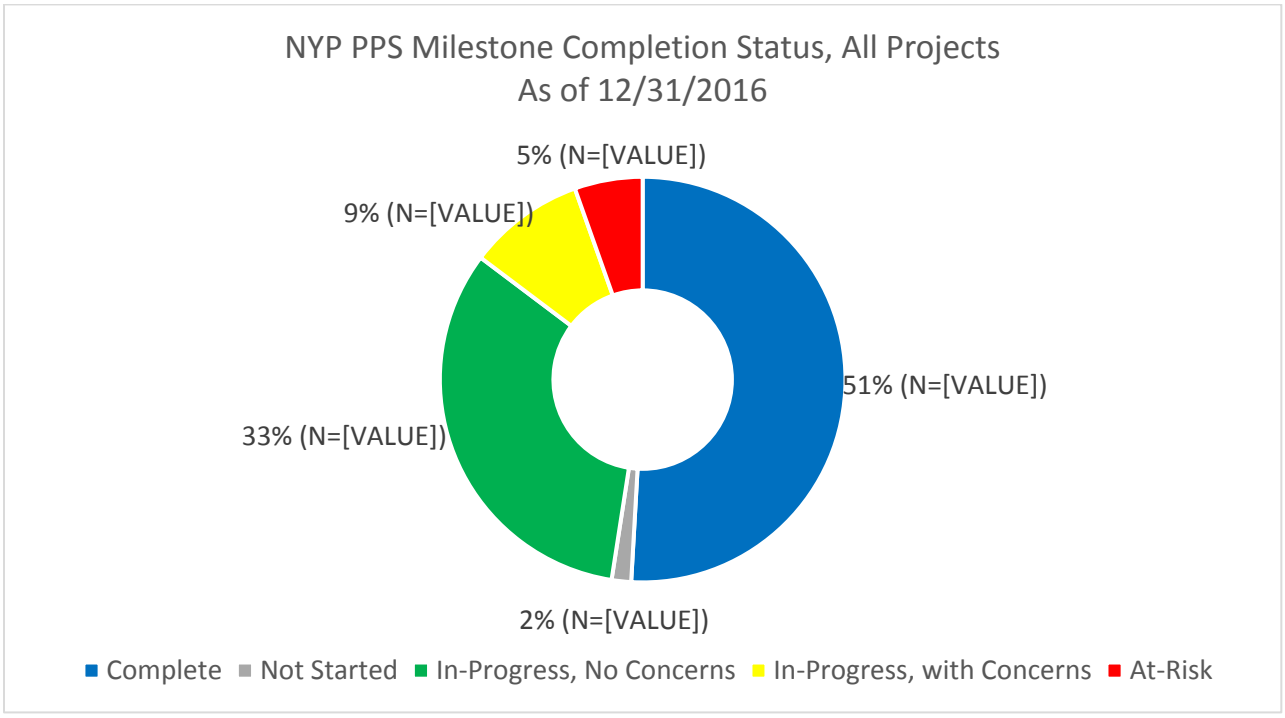
Immediate Focus: Assessing Quality Improvement Opportunities

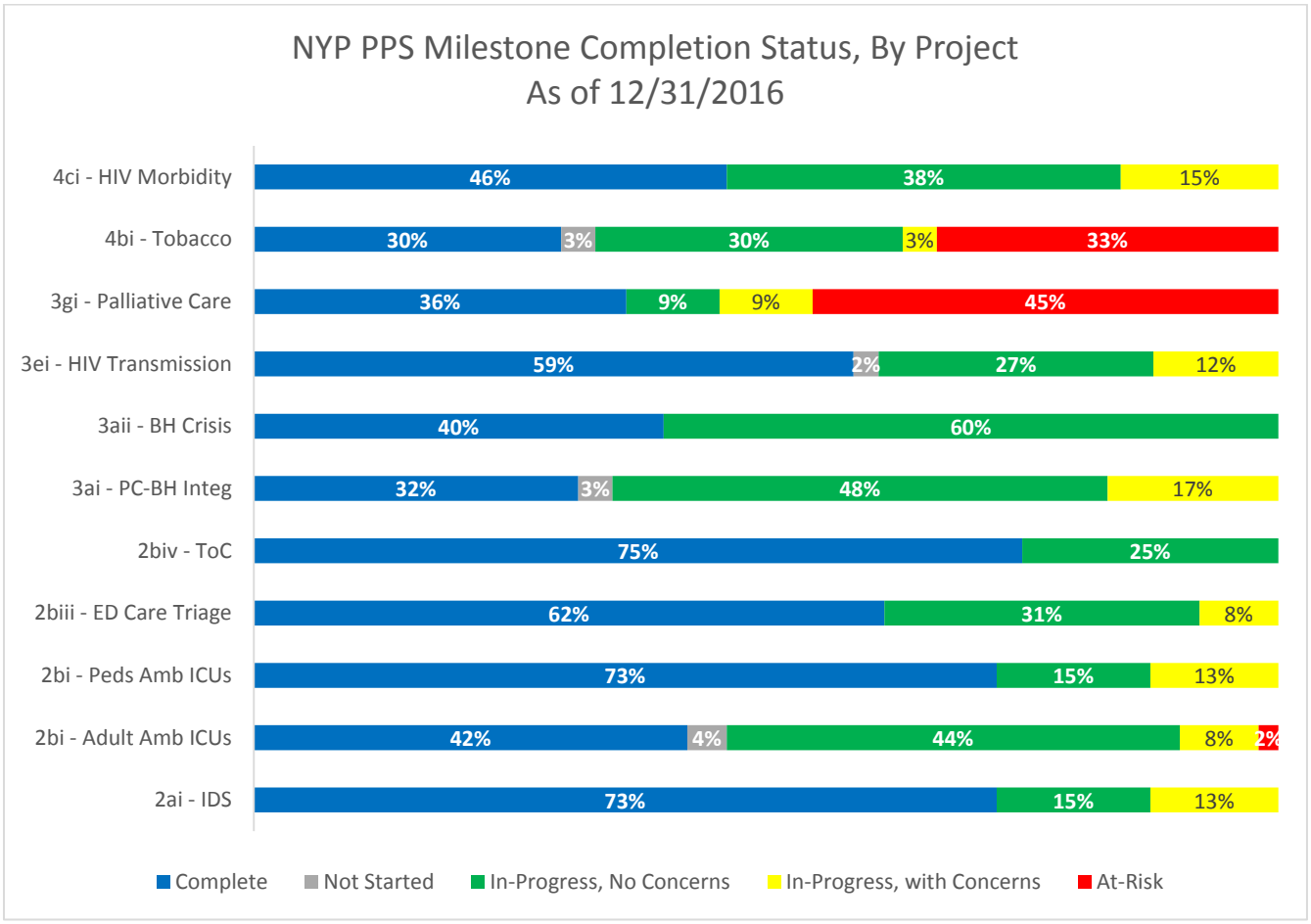
PPS Pivot: Where PMO needs help today

- **What data are a priority to provide to community providers?**
- **What type of quality improvement support is valuable in the community?**
- **How much can be done in collaboratives (e.g. all primary care providers) vs. independently?**
- **How can/should the PPS governance structure evolve?**

Project Milestone Completion Report

NYP PPS Clinical Operations Committee, 2/3/2017





PPS Overall	
Wins	**Challenges**
Completed final draft of Clinical Integration Milestone	Physical space for DSRIP-funded staff at NYP campuses
Meeting with NYC Dept. of Homeless Services to discuss potential collaboration opportunities	Spread of interventions across NYP campuses & collaborators
Held Part 2 of *Tobacco Cessation* webinar series	Delays in PPS Healthix implementation
Held *Welcome to the Era of Patient Experience* webinar	Delays in roster of attributed DSRIP patients from NYS
Successful discussions re: project "ramp-down" transitions	Managing scope of work in new Population Lines
Ongoing development & refinement of P4P metrics	Consistent use of cross-collaborator care management platform (ACD)
NYS approval to receive attributed member claims data	Human resource changes delaying rollout of Healthify

NewYork-Presbyterian
Performing Provider System

NewYork-Presbyterian Performing Provider System (NYP PPS)

Clinical Integration Needs Assessment & Strategic Plan

NewYork-Presbyterian
Performing Provider System

Table of Contents

NewYork-Presbyterian
Performing Provider System

Part I: Clinical Integration (CI) Needs Assessment

Objective

The NewYork-Presbyterian Performing Provider System (NYP PPS) defines "clinical integration" as a continuous effort to align the comprehensive continuum of services, conditions, providers and settings. The ultimate goal of clinical integration is to achieve alignment across these factors to deliver care that is safe, timely, effective, equitable and patient-focused.

The NYP PPS is committed to creating an accessible, integrated delivery system for the patients and communities it serves. The PPS has identified, through a needs assessment process conducted in consultation with its organizational committees, project teams and the PPS Clinical Operations Committee, three strategic focus areas for improving clinical integration across the network. Part I of this document details a Clinical Integration Needs Assessment which has identified specific risks and gaps in each of these strategic focus areas and presents mitigation strategies to address them. Part II of this document presents strategies to capture the opportunities and mitigate the risks with each strategic focus area.

The strategic focus areas are:

1. Care Transitions Management;
2. Technology Infrastructure;
3. Training & Change Management.

NYP PPS Overview of Integrated In-Network Providers

The NYP PPS is a network of 83 diverse providers and community collaborators (see Table 1) jointly committed to improving the health and wellbeing of patient populations while addressing unnecessary hospital and emergency department utilization and the social determinants of health. Of these, seven providers are also health home downstream partners. NewYork-Presbyterian Hospital (NYPH) is the anchor institution for this collaboration, which delivers acute care across six campuses and primary care through its Ambulatory Care Network (ACN).

The NYP PPS has classified network collaborators by five service types (Primary Care & Other Specialty, Post-Acute, Pharmacy, Community-Based and Mental Health & Substance Use, with further indication if an organization is also a downstream Health Home partner).

Table 1: Number of Providers in NYP PPS by Provider Type

Provider Type	Count in Network
Primary Care & Other Specialty	14
Post-Acute	21
Pharmacy	11
Community-Based	24
Mental Health & Substance Use	13

Please refer to Appendix A for the comprehensive list of collaborators which the PPS will engage in its Clinical Integration Strategy. The PPS collaborates with this network of providers to implement the 10 DSRIP projects. Projects such as Ambulatory ICU, ED Care Triage, Integrated Delivery System and Transitions of Care help the PPS to better assess the current state of clinical integration and are vehicles for leading change within the provider network. In combination with the steering committees from each of these projects, the PPS actively engages its organizational committees and the PPS Clinical Operations Committee to discuss, plan, implement and monitor integration efforts.

Care Transitions Management Needs Assessment

Current State

In order to accomplish the mutual goal of managing patient transitions of care, the NYP PPS actively cultivates relationships between four NYP hospitals, in-network community collaborators, NYP Transitions of Care Managers (TCMs) and Ambulatory Care Network (ACN) RN Care Managers.

The PPS Transitions of Care Project on-boarded six Community Health Workers (CHWs) who are employed by the Northern Manhattan Improvement Corporation, Hamilton-Madison House and Lenox Hill Neighborhood House. The key functions of the CHW role include:

1. Home visits and assessment of non-medical causes of readmission, such as lack of transportation or food insecurity;
2. Accompanying patients to post-discharge follow-up appointments with primary care provider(s);
3. Addressing patient pharmaceutical challenges through pursuit of a Pharmacist resource for medication reconciliation and direct patient education;
4. Using electronic health records and IT systems to share patient information, facilitate the transmission of care plans to subsequent care settings and send hospital discharge paperwork to next-level providers.

The Project also developed a training/orientation shadowing protocol to facilitate the partnership between TCMs and CHWs and successfully launched the CHW model as of October 2016. Specialized CHW assessments and follow-up notes have been created in AllScripts Care Director, the vehicle for CHW documentation. Additionally, the Transitions of Care team holds bi-weekly calls with the CHW program and the Health Home to improve collaboration and address real-time challenges. Currently, the team is in the process of evaluating an electronic referral mechanism to both entities.

Transitions of Care is also collaborating with home care agencies to expand transitional care workflows and implement a transportation aide program from hospital-to-home and home-to-subsequent care settings throughout the 30-day post-discharge period.

Gaps & Risks

Within the PPS, staff and resources which impact care transitions are fragmented across inpatient, ambulatory, community and post-acute providers. Historically, transformation efforts have resulted in care plans which are not shared across practice areas, have created protocols which subject patients to

redundant outreach by PPS staff and care pathways that fragment and complicate care for patients. All of these realities serve only to widen gaps in care, rather than close them.

Risks to the PPS from such a misalignment manifest themselves in multiple ways. First, front line clinical teams receive redundant, incomplete or even conflicting guidance for activities which are critically important to successful clinical integration, such as risk stratification and prioritization, staff roles and chronic condition management. Second, referral workflows and care pathways between inpatient, ambulatory and post-acute providers, CBOs and health homes vary greatly by practice setting, placing patients at increased risk of adverse events when transitioning between practice settings.

Technology Infrastructure Needs Assessment

Current State

Effective clinical integration will require the sharing of clinical and other relevant information with network providers and be readily accessible for all providers across the patient care spectrum. The PPS envisions a connected care environment where a single patient's care can be collaboratively managed by providers in hospitals, ambulatory clinics, Community Based Organizations, (CBOs) and elsewhere. Collaborative management will consist of agreed upon workflows that are supported by various information technology capabilities.

IT systems infrastructure is a significant investment for the PPS and for participating network members. In order to support quality improvement, the PPS leverages multiple documentation and data systems, including the Healthix RHIO, NYS Medicaid Analytics Performance Portal, the Salient Interactive Miner, NYP's EHRs, the Healthify tool for community resource referral management, future distributions of NYS Medicaid claims data and the collaborators' documentation systems.

Gaps & Risks

The PPS network is currently pursuing an enhanced IT infrastructure through a variety of mechanisms for its collaborators. For some providers, this meant becoming PCMH-certified or enhancing their level of certification or joining the RHIO. For others, it meant learning and utilizing Allscripts Care Director and tracking and monitoring registries of Medicaid beneficiaries participating in the PPS. A fragmented IT infrastructure leads to challenges in developing new tools to support collaborative workflows and in analytic tools to support rapid-cycle improvement.

Training & Change Management Needs Assessment

Current State

Optimizing Collaborative Clinical Governance, Clinical Programs and IT Infrastructure are central activities to the PPS's success and also represent transformational changes to the way care is delivered and evaluated. As with all transformational changes (particularly those carried out across diverse organizational cultures), individual participants have experienced the changes in different ways and at

different rates. On one extreme, some participants have welcomed change with open arms, while conversely others have offered pointed resistance. The sources of resistance have been diverse.

Gaps & Risks

Unmanaged, resistance to change has the potential to significantly delay the clinical quality, patient experience and utilization improvements sought by the DSRIP program. The PPS also does not operate in a vacuum. Clinical teams and administrative leaders alike face pressures from state and federal regulators and from participation in other value-based reimbursement models (PCMH, MSSP ACO, etc.).

Conclusion

The NYP PPS, with guidance from the PPS Clinical Operations Committee, completed an in-depth analysis of the current state of clinical integration and identified associated risks. The NYP PPS is committed to leveraging all available resources to ensure that each risk is managed appropriately and that both network collaborators and patients realize tangible benefits from the DSRIP projects. This plan will guide the clinical integration strategic planning process for the PPS and will continue to evolve as collaborator and organizational needs change throughout the DSRIP initiative's life-cycle.

Next Steps

To take action on the Clinical Integration Needs Assessment the PPS will recommended appropriate mitigation strategies including technology infrastructure for adoption and, through collaborative clinical governance bodies, expand its support of integrated transitions of care planning and training opportunities which support both the DSRIP goals and those of providers across the network.

Part II: Clinical Integration (CI) Strategy

Providers to Be Integrated

The NYP PPS is committed to deepening its understanding of in-network provider activities. As the PPS begins to discuss rapid-cycle workflow and quality improvement efforts at the provider level, early activities to advance the current state of clinical integration could include:

- Mapping each network provider and their requirements for clinical integration (including IT systems use, referral patterns and/or treatment protocols);
- Stratifying collaborators into phases of PPS-supported technology infrastructure roll-out;
- Surveying collaborators to better understand gaps in clinical and operations skills development.

Care Transitions Management Mitigation Strategy

The primary focus areas of this strategy is to strengthen continuity of care between inpatient care, primary care and subsequent post-acute settings in order to reduce the risk of avoidable readmissions within 30 days. The target population is patients who have an increased likelihood of readmission or who are deemed at-risk by their care team (psychosocial and medical determinants). Particular focus is given to patients with three or more inpatient admissions in the past twelve months and/or patients who have challenging medication regimens.

The PPS has already launched or committed to participating in clinical programs that target major opportunities in care improvement. These include:

1. Embedding RN Transitional Care Managers (TCMs) on inpatient medicine and cardiac units who work with patients and interdisciplinary care teams for 30 days post-discharge in order to:
    a. Educate patients and caregivers on disease and self-management;
    b. Facilitate timely follow-up with primary care provider(s);
    c. Coordinate medical and social service needs to overcome barriers to safe transitions.
2. Identification and management of high-risk patients (such as those with multiple chronic conditions, severe mental illness or HIV/AIDS) through newly created patient stratification tools, discussion at daily Interdisciplinary Rounds (IDR) meetings and direct provider referral;
3. Enhancing care transitions services and collaboration with next-level of care providers through workflows, structured hand-offs and case conferences with home care agencies, ambulatory clinics, the NYP Health Home and community-based organizations employing Community Health Workers (CHWs). The project employs CHWs who collaborate with TCMs to facilitate and reinforce disease-focused education in a linguistically and culturally-appropriate manner to patients and caregivers.

Technology Infrastructure Mitigation Strategy

The IT infrastructure for the PPS has eight main components covering key data points for shared access and the key interfaces that will have an impact on clinical integration.

Key Data Points

1. Patient ADT feed
2. Assigned PCP with contact information
3. Assigned Care Manager with contact information
4. Medication list
5. Care plan notes for discharge instructions, follow-up appointments and crisis stabilization plan

Key Interfaces to Impact Clinical Integration

1. Workflow 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 manage registries of patients; track 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. This application is also used by the NYP Health Home.

2. EHR Enhancements

   The inpatient and outpatient EHRs 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. 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. The PPS will also work with its collaborators to enhance their documentation platforms, as appropriate and necessary.

3. Support for Community Health Workers (CHWs), Peers and other Field-Based Staff

   Culturally competent CHWs, Peers and field-based staff (e.g. CASACs) serve as a link between patients and medical/social services. The CHWs 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 were selected, the application was implemented and CHWs have been trained in the use of the hardware and application.

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 twenty-three (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 Enterprise Master Patient Indices 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 the 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 Medical Center PPS has already contracted with Healthify so there is precedence for using this platform in a PPS Network.

Training & Change Management Mitigation Strategy

Training opportunities have already been provided in several areas to address needs in the areas of care coordination across settings, clinical documentation tools and communication for coordination and operations staff. Examples of such trainings include:

- "Transitional Care Protocol" – Review of the 10-day care transitions workflow;
- "AllScripts Care Director (ACD) Application Training" – Use of the ACD tool for DSRIP project teams;
- "Care Management and the Health Home;"
- Three-day intensive Care Management training;
- "Bridges to Better Health and Wellness" – CHW and Care Managers in community mental health settings;
- "DSRIP CHW and Patient Navigator Events" – self-care workshop, change management training, managing patient with asthma and COPD.

Please reference the Training Template for a complete list of relevant trainings conducted to-date.

In addition to ensuring that training opportunities of these types remain available to NYPH and in-network staff, the PPS will also continue to use a structured change management approach, partnering with NYPH and the collaborators' institutional change management resources. The PPS believes that being able to manage change is a core skill for any leader in the network. Over time, stakeholders will receive training in methods for addressing resistance and managing change throughout a project lifecycle, and in how to identify the root causes of resistance to change. Upon delivery of these trainings, the PPS expects to realize improvements in the time-to-completion of key deliverables and participation in governance meetings.

To date, the PPS has engaged senior leaders as active and most importantly visible sponsors of transformational changes. Senior leaders from every corner of the network have a presence on the PPS governing committees and many project-level steering committees. Additionally, the PPS has recruited the support of middle managers and frontline supervisors as advocates of these changes. Many of these individuals serve as Project Leads for the ten DSRIP projects and other highly aligned programs. Effective and timely communications are another cornerstone of the PPS's change management strategy. Through these channels, the PPS is able to communicate the need for change, the impact on clinical teams and the benefits to the clinical teams.

Conclusion

Through its investments in workforce development and technology for care transitions management, the NYP PPS has shown a commitment to improving the current state of clinical integration and reducing 30-day readmissions. To help guide its work, the PPS will also continue to evolve its project governance structures, including a shift from a project-centric (siloed) model focused on pay-for-reporting metrics and operations to a population-centric model prioritizing rapid-cycle workflow redesign, quality improvement interventions and pay-for-performance metrics. It is expected that such changes will lead to discussions about the DSRIP projects as collaborative quality improvement efforts rather than independently managed DSRIP requirements.

The Executive Committee and the Clinical Operations Committee will play central roles in leading any change. Any new governance model will focus on standardizing approaches, terminology and reporting requirements in addition to exploring options for distribution of performance funds to encourage performance. The PPS is also considering identifying a dedicated clinical leader to spearhead clinical integration and practice redesign efforts across the collaborator network.

Next Steps

Next, the PPS will reduce the identified risks to successful clinical integration by aligning: (1) transitions of care management and change management skills training plans with those already developed for practitioner engagement and workforce skills training; and (2) technology infrastructure implementation plans with those already developed for population health management and clinical data sharing.

Appendix

Appendix A: List of Providers in NYP PPS by Provider Type

Primary Care Providers and Other Specialty Providers (*Health Home downstream provider)

1. Access CHC
2. AJS Medical Practice
3. Andres Pereira, MD/Inwood D&T Center
4. Charles B. Wang Community Health Center
5. Columbia University Medical Center
6. Community Healthcare Network
7. Elizabeth Seton Pediatric Center / Children's Rehab Center
8. Gabriel Guardarramas, MD
9. Harlem United / Upper Room AIDS Ministry
10. Jose Jerez, MD
11. New York City Department of Health and Mental Hygiene
12. NewYork-Presbyterian Hospital
13. Theodore C. Docu, MD, PC
14. Weill Cornell Medical College

Post-Acute Care Providers (*Health Home downstream provider)

1. Amsterdam Nursing Home
2. Blythedale Children's Hospital
3. Calvary Hospital
4. Dominican Sisters Family Health Service
5. ElderPlan, Inc. (MJHS)
6. Empire State Home Care Services
7. Extraordinary Home Care
8. HomeFirst LHCSA, Inc.
9. Isabella Geriatric Center*
10. Mary Manning Walsh Residence
11. Menorah Home and Hospital for the Aged and Infirm
12. Methodist Home for Nursing and Rehabilitation
13. MJHS
14. Riverdale Mental Health Association
15. St. Mary's Center – Harlem
16. St. Mary's Hospital for Children
17. St. Vincent de Paul Residence
18. Schervier Nursing Home
19. Terrence Cardinal Cooke Health Care Center
20. Village Care*
21. Visiting Nurse Service of New York

Pharmacy Providers (*Health Home downstream provider)

1. QuickRx - Audubon
2. QuickRx - Lexington
3. AIDS Healthcare Foundation
4. Boan Drug, Inc.
5. C&C Drug, Inc.
6. CityDrug & Surgical, Inc.
7. Heights Pharmacy, Inc.
8. Island Care Pharmacy
9. Melbran Pharmacy
10. Metrocare Pharmacy, Inc.
11. Nature's Cure Pharmacy

Community-Based Organizations (*Health Home downstream provider)

1. 1199 Training Fund
2. AIDS Service Center NYC (ASCNYC)*
3. Argus*
4. Association to Benefit Children

5. Catholic Resources, Inc.
6. City Meals on Wheels
7. City-Pro Group, Inc. / ABI
8. Coalicion Mexicana
9. Community League of the Heights
10. Dominican Women's Development Center
11. Fort George Community Enrichment Center
12. God's Love We Deliver
13. Hamilton-Madison House
14. Inwood Community Services
15. Iris House
16. Lenox Hill Neighborhood House
17. NAMI - NYC Metro
18. New York Legal Assistance Group
19. Northern Manhattan Improvement Corporation
20. Northern Manhattan Perinatal Partnership
21. Northside Center for Child Development
22. Riverstone Senior Life Services
23. Service Program for Older People
24. Union Settlement Association

Mental Health & Substance Use Providers (*Health Home downstream provider)

1. ACMH*
2. Cornerstone Treatment Facilities
3. Create, Inc.
4. Fountain House
5. Karen Horney Clinic
6. Metropolitan Center for Mental Health
7. New York State Psychiatric Institute (NYSPI)
8. Project Renewal, Inc.
9. Realization Center, Inc.
10. St. Christopher's Inn
11. The Bridge*
12. Upper Manhattan Mental Health Center, Inc.*
13. Washington Heights CORNER Project

NewYork-Presbyterian
Performing Provider System

PROGRAM OVERVIEW

About DSRIP

The Delivery System Reform Incentive Payment (DSRIP) Program is the main mechanism by which New York State will implement the Medicaid Redesign Team (MRT) plans. DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. Up to $7.4 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health.

Through DSRIP, organizations work together to form Performing Provider Systems (PPSs) – either coming together under a single new entity or forming a tighter collaborative – to accept responsibility for the health of a Medicaid population in their service area. These PPSs are then responsible for selecting between 5-10 projects based on a Community Needs Assessment, which includes the feedback of their community leaders, collaborators, and beneficiaries.

NYP PPS Overview

The NewYork-Presbyterian Performing Provider System (NYP PPS) is a network of 80+ hospitals, providers and community collaborators jointly committed to improving the health and wellbeing and addressing the unnecessary hospital and emergency department use of the community that it serves.

The PPS will collaborate with the New York State Department of Health Medicaid Program to develop a sustainable DSRIP **Integrated Delivery System**, which will include:

- Integration of New York State Health Homes to provide community-based care coordination
- Warm handoffs between care settings
- Connections across local health information exchanges and use of other Health Information Technology tools to facilitate sharing of information
- Use of a culturally competent workforce
- Collaboration with safety net community-based organizations
- Adoption of a PPS-wide Patient Centered Medical Home model to address the health needs of our patient population
- Identification of a path to financial sustainability using Value-Based Payment Method

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

What do we hope to accomplish?

- Improve care and health outcomes for high-risk and high-cost adult and pediatric populations with complex care needs

Who is our target population?

- *Adult:* Patients seen in the last 12 months who have at least two or more chronic conditions with 4 or more emergency room visits or inpatient visits or a combination of both
- *Pediatric:* Patients under the age of 21 who are high risk and cost with specialized needs. (e.g. children with uncontrolled seizures, depression, autism)

How will we do it?

- Establish nine Ambulatory ICUs in existing Patient Centered Medical Homes that will:
    - Deliver comprehensive, coordinated team-based care for complex patients using a patient-centered approach
    - Deploy a population health strategy that identifies high-risk patients and provides services based on medical complexity, stability and level of need
    - Embed culturally competent and family-centered Nurse Care Managers, Social Workers, Psychiatric Nurse Practitioners and Community Healthcare Workers to coordinate care
    - Ensure the Ambulatory ICU collaborates with a network of providers and community based organizations, including medical, behavioral health, nutritional, rehabilitation, care management and other necessary provider specialties to meet the needs of the population
    - Extend weekday hours and offer weekend hours to improve access
    - Provide specialized education to providers and patients to promote chronic disease management
    - Utilize technical platforms to support provider, patient and care team communication

NewYork-Presbyterian
Performing Provider System

Emergency Department Care Triage (Project 2.b.iii)

What do we hope to accomplish?

- Reduce avoidable emergency department use by connecting patients to primary care and addressing the educational and cultural drivers of emergency department utilization

Who is our target population?

- Patients presenting at the emergency department who would benefit from follow-up with primary care, specialty care and other outpatient specialty services

How will we do it?

- Integrate culturally competent Patient Navigators into five NYP emergency department care teams who will ensure that obstacles to patient adherence are addressed and follow-up care is initiated. Activities include:
    - Meeting with high-risk patients to understand their issues with access to care and educating them regarding how best to utilize the health care system
    - Sharing updates with the health care team to inform the health care plan
    - Scheduling patients for primary care/specialty medical appointments through open access scheduling
    - Linking patients to financial assistance or other social services
    - Providing appointment reminders
    - Conducting post-appointment follow-up calls
    - Matching patients without regular primary care providers to local Patient Centered Medical Homes within the Performing Provider System
    - Making referrals to Community Healthcare Workers, Social Workers and Care Managers to address complex, multidisciplinary medical needs

NewYork-Presbyterian
Performing Provider System

Care Transitions to Reduce 30-Day Readmissions (Project 2.b.iv)

What do we hope to accomplish?

- Strengthen continuity of care between NewYork-Presbyterian Hospital inpatient care and subsequent settings in order to reduce the risk of avoidable readmissions within 30 days

Who is our target population?

- Adult patients admitted to NYP hospitals who are readmitted, have a high readmission risk score or are deemed at-risk by their care team (psychosocial and medical determinants)

How will we do it?

- Enhance care transitions services and collaboration with next level of care providers
- Identify patients at high risk for readmission
- Embed Transitions of Care Managers (RNs) who will work with patients and interdisciplinary care teams during inpatient stays and for 30 days post-discharge in order to:
    - Educate patients and caregivers on disease and self-management
    - Facilitate timely follow-up with primary care provider(s)
    - Coordinate medical and social service needs to overcome barriers to safe transitions
- Employ Community Healthcare Workers who:
    - Collaborate with Transitions of Care Managers to facilitate and reinforce disease-focused education in a linguistically and culturally appropriate manner to patients and caregivers
    - Accompany patients to post-discharge follow-up appointments with primary care provider(s)
    - Assess non-medical causes of readmission, such as lack of transportation or food insecurity
- Engage pharmacy supports to address patient pharmaceutical challenges
- Utilize electronic health records and IT systems to share patient information and facilitate the transmission of care transitions plans to subsequent care settings

Behavioral Health Primary Care Integration (Project 3.a.i)

What do we hope to accomplish?

- Ensure that NewYork-Presbyterian and New York State Psychiatric Institute (NYSPI) outpatient behavioral health patients receive timely, coordinated and appropriate primary care services

Who is our target population?

- Adults and children who utilize known behavioral health clinics and are not regularly receiving primary care services

How will we do it?

- Identify behavioral health patients who are not receiving comprehensive care
- Embed primary care resources within behavioral health practices to provide engagement, prevention and continuity of care
- Educate and encourage providers to take a holistic approach to treatment in behavioral health practices
- Develop and implement practices that will encourage the patients' primary care, community and psychiatry teams to communicate and coordinate services
- Connect patients to Community Healthcare Workers
- Build and maintain strong relationships with community organizations

Crisis Community Stabilization
(Project 3.a.ii)

What do we hope to accomplish?

- To reduce avoidable emergency room use by patients in behavioral health crisis through the development, expansion and implementation of comprehensive, coordinated and ongoing safety net services which address the underlying clinical needs by patients who seek non-emergent care in an emergency room setting.

Who is the target population?

- Adults and youth in behavioral health crisis who present in acute distress with complex needs and would be better served with ongoing care and a full spectrum of services.

How will we do it?

- Create and implement a Behavioral Health Crisis HUB to conduct rapid triage by identifying non-emergent, emergent and chronic users and connecting these patients with embedded and/or community-based clinical services which will provide patients in crisis with novel interventions, enhanced discharge planning, expedited care planning and follow-up in real-time.
- Utilize a Critical Time Intervention Team (CTI) model to implement cross-disciplinary psychiatric teams to target patients in potentially destabilizing periods of transition and provide intensive, wrap-around community-based services.
- Link patients to services underpinning unmet needs, including but not limited to:
    - Substance abuse services
    - Primary care services
    - Appointments management assistance
    - Prescription adherence support
    - Housing providers
    - Health insurance assistance
    - Navigation, Peer Services and community-based assistance and treatment
- Build and maintain strong relationships with community organizations

HIV Center of Excellence / Reducing HIV Morbidity (Project 3.e.i and 4.c.i)

What do we hope to accomplish?

- Transform three HIV practices into true Centers of Excellence (CoE) where all services for People Living with HIV and/or HCV or those at risk for HIV are integrated into one practice. These services include prevention services, increasing primary care, HIV/HCV consultation and treatment, dental care, specialty care, behavioral health care, prenatal care, nutritional services and substance abuse services.
- Develop a network of collaborators that engages people who are at risk for HIV or who are newly diagnosed or living with HIV and/or HCV who are not engaged in care or lost-to-follow-up.

Who is our target population?

- People Living with HIV and/or HCV and persons at risk for HIV

How will we do it?

- Develop a Steering Committee that engages a group of community-based providers and collaborators to design collaborative workflows and advance the goals of DSRIP and the New York State Department of Health initiative to End the AIDS Epidemic
- Integrate a team of Community Health Workers and Peers into both collaborators and on-site at CoE to increase outreach, screening, linkage and retention to needed social and clinical services through education, advocacy and motivational interviewing
- Identify and link those at risk for HIV or living with HIV and/or HCV and not engaged in care to preventive services (e.g., PrEP/PEP) or clinical care (e.g., HIV or HCV treatment) as well as link them to community-based services to address psychosocial needs that may impact on engagement and/or retention in clinical care
- Expand the nature and number of clinical services provided at three NYP HIV ambulatory sites to better meet the emerging DSRIP standards for a CoE
- Enhance and integrate co-located behavioral health services including both mental health (with the addition of a Psychiatric NP) and substance use services (through a co-located Credentialed Alcoholism and Substance Abuse Counselor (CASAC)) into the CoE to meet this under-met need
- Provide more alternatives for pharmacy intervention and support to increase access and adherence to HIV prevention or treatment
- Enhance care coordination and care management services to connect people at risk for or living with HIV and/or HCV to the CoE to ensure patients are receiving appropriate preventative services, engaging in care and transitioning to appropriate settings when leaving the Emergency Department or hospital

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Integration of Palliative Care into the Patient-Centered Medical Home (Project 3.g.i)

What do we hope to accomplish?

- Enhance Primary Care Physicians' competencies to integrate generalist-level palliative care in the NYP Ambulatory Care Network and community-based practices as standard of care
- Develop a new capacity to provide specialized palliative care services by expert teams in the NYP Ambulatory Care Network
- Develop model of care to include care management oversight and collaboration with external providers

Who is our target population?

- Patients facing advance illnesses who have unmet palliative care needs or avoidable utilization with a diagnosis of one of six conditions: Congestive Heart Failure (CHF), Kidney Failure, Dementia, Chronic Obstructive Pulmonary Disease (COPD), Stroke, Malignancy and Sickle Cell Anemia

How will we do it?

- Enhance Primary Care Physicians' knowledge of palliative care for further incorporation into their practice through integrated educational interventions
- Integrate palliative care screening and risk assessment within the NYP PPS to address unmet palliative care needs
- Implement a specialized palliative care team to collaborate with providers throughout the PPS and provide care management services, including:
    - Employing RN Care Managers who will coordinate with other team members to conduct palliative care assessments and provide palliative care expertise to interdisciplinary teams
    - Utilizing Community Healthcare Workers to enhance support to patient and families in the community through home visits and additional education
- Collaborate with PPS network members to develop referral processes for palliative care

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Tobacco Cessation (Project 4.b.i)

What do we hope to accomplish?

- Integrate evidence-based, sustainable tobacco use treatment into health services across our PPS

Who is our target population?

- Current tobacco users with low socioeconomic status, co-morbidities and poor mental health status

How will we do it?

- Create an interdisciplinary team approach to addressing tobacco use with our patients
- Establish dedicated clinical services that will provide comprehensive tobacco treatment to patients across all NYP campuses
- Increase provider capacity to effectively engage patients in cessation by:
    - Assessing current provider practices for development opportunities
    - Enhancing the electronic medical record to include comprehensive documentation on cessation assistance as well as referrals to tobacco clinical services
    - Providing tailored, evidence-based education to providers on how to prescribe medications and dialogue with patients
    - Implementing clinical decision support systems that will facilitate appropriate provider intervention
    - Integrating electronic referrals to NY State Quitline
    - Establishing compliant, consistent and accurate tobacco cessation billing practices to ensure sustainability of care
- Promote patient education on cessation resources through the creation of culturally-appropriate patient education materials to support tobacco cessation
- Sustain a tobacco-free hospital environment for our patients
- Work closely with community-based organizations to ensure cessation treatment is culturally appropriate

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For Additional Information:

- How to get involved with the projects: Please send an e-mail to ppsmembership@nyp.org outlining how you would like to engage in the PPS projects and a member of our Project Management Office will get back to you.
- Visit the NYP PPS web site: www.nyp.org/pps
- Visit the NYSDOH DSRIP web site, where you can also find a copy of the NYP PPS's design grant application: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/
- Visit the DSRIP Program Group on LinkedIn – "New York State Delivery System Reform Incentive Payment (DSRIP) Program Group"
- Email: ppsmembership@nyp.org