NewYork-Presbyterian

NYP PPS - Project Advisory Committee [PAC] meeting

107 East 70th Street, (btw Park/Lexington Avenues)

VNSNY Auditorium, 1st Floor

Dial-in 212-305-9039

Monday, March 9, 2015

9:30 a.m.-11:30 a.m.

AGENDA

1. **Latest Developments in the NYP PPS**
2. **IT Update**
3. **Population Health and Workforce**
4. **NYC Primary Care Information Program (Anname Phann)**

Next PAC meeting: Monday June 15th 9:30am – 11:30am

Place TBD

HIE, RHIOs, SHIN-NY and DSRIP

Gilad J. Kuperman, MD, PhD

NewYork-Presbyterian Hospital – Information Systems

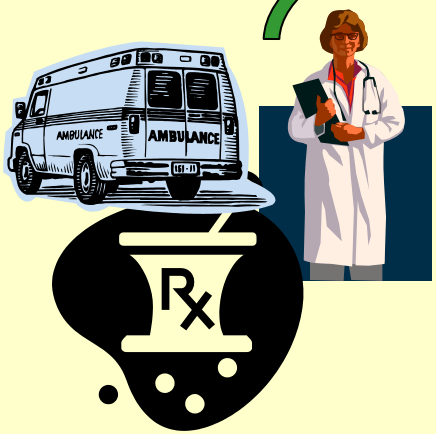
3/9/2015

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Outline

- Health information exchange
  - Needs and challenges
- RHIOs
  - Why do we have RHIOs
  - Healthix
  - Getting data in and out of RHIOs
  - Privacy policies
  - Participant obligations
- “Directed exchange”
- SHIN-NY
- HIE and DSRIP

Health information exchange



Place where data was generated

Place where data is needed

Today

- Copies of paper records
  - The patient
  - United States Postal Service
- Fax machines
- CDs of images / film themselves
- Or, do without

Vision

- “Electronic” data exchange
- Data should be available where it is needed not just where it is collected

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Need for HIE

- In primary care[1]
  - Clinical information missing in 13% of visits
  - Data present in an outside system 52% of time
  - Missing data at least somewhat likely to affect care 44% of time
- In emergency setting[2]
  - Information gaps present in 32% of visits
    - More common in sicker patients
  - "Essential to care" 48% of time
- Necessary to support new models of care of care delivery[3]

1 – Smith, JAMA, 2005, 2 – Stiell, CMAJ, 2003
3 – McClellan, Health Affairs, 2010

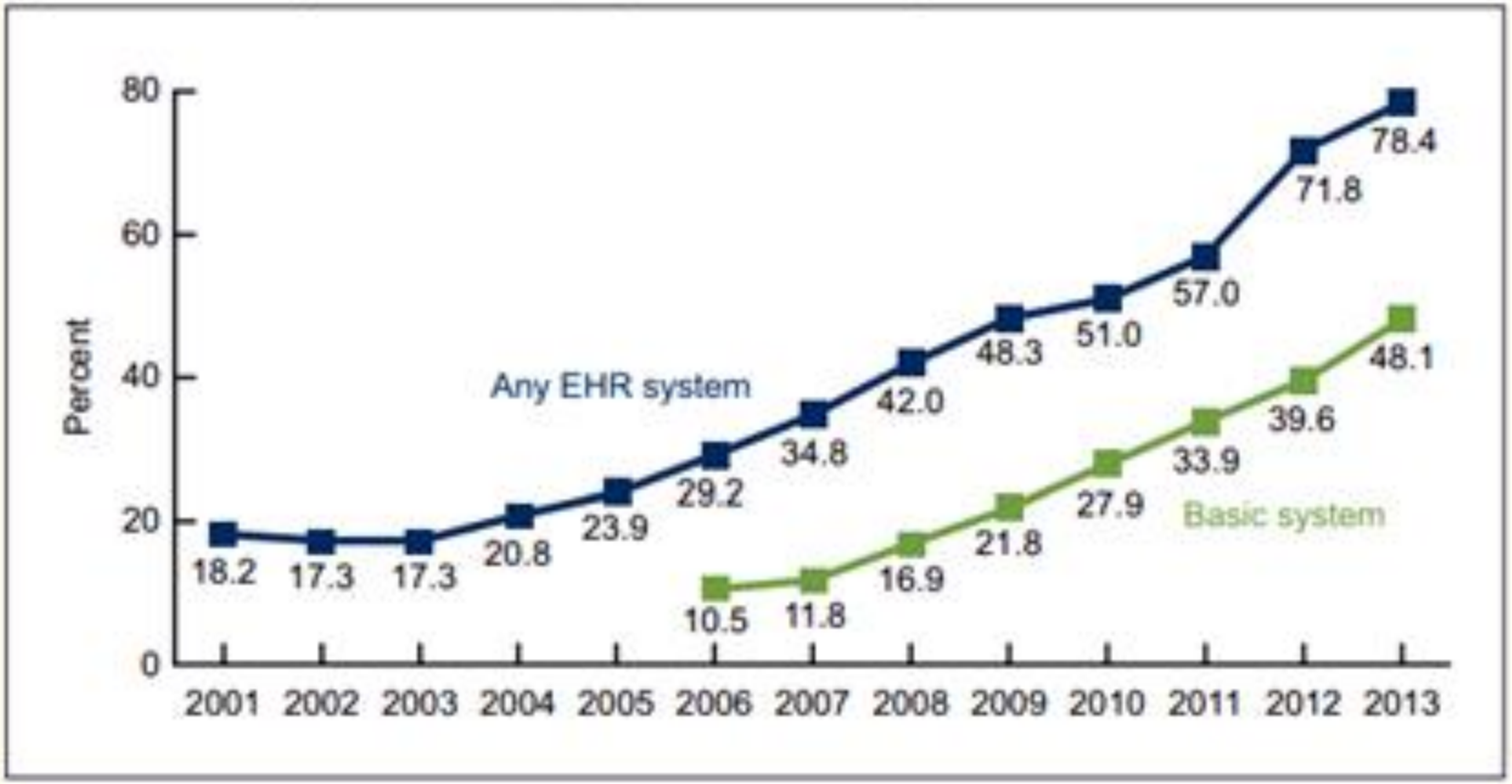
Challenges to HIE

- Until recently, EHRs not commonly available (see next slide)
- Leadership / organizational models
  - Who's responsible for getting this to happen?
  - What is the structure for governing and managing exchange?
- Privacy
  - Just because the data can move, should it?
  - How do the patient's wishes fit in?
- Technology -- data interfaces, networks
- Patient matching
  - How do we know that the "Gilad J. Kuperman" who went to NYU for care is the same as "Gil Kuperman" who went to NYPH for care
- Structuring / coding of the clinical data
  - Assuring that the various data types (meds, problems, allergies, etc.) coming from various sources can be combined for best care and analysis
- Vendor-related challenges
- Financial sustainability
  - What is the mechanism to pay for the technology and operations?

- <u>As a result of all of the above, electronic information exchange currently occurring infrequently.</u>

Adoption of basic EHR systems by office-based physicians increased 21% between 2012 and 2013.

Figure 1. Percentage of office-based physicians with EHR systems: United States, 2001–2013



NCHS Data Brief ■ No. 143 ■ January 2014

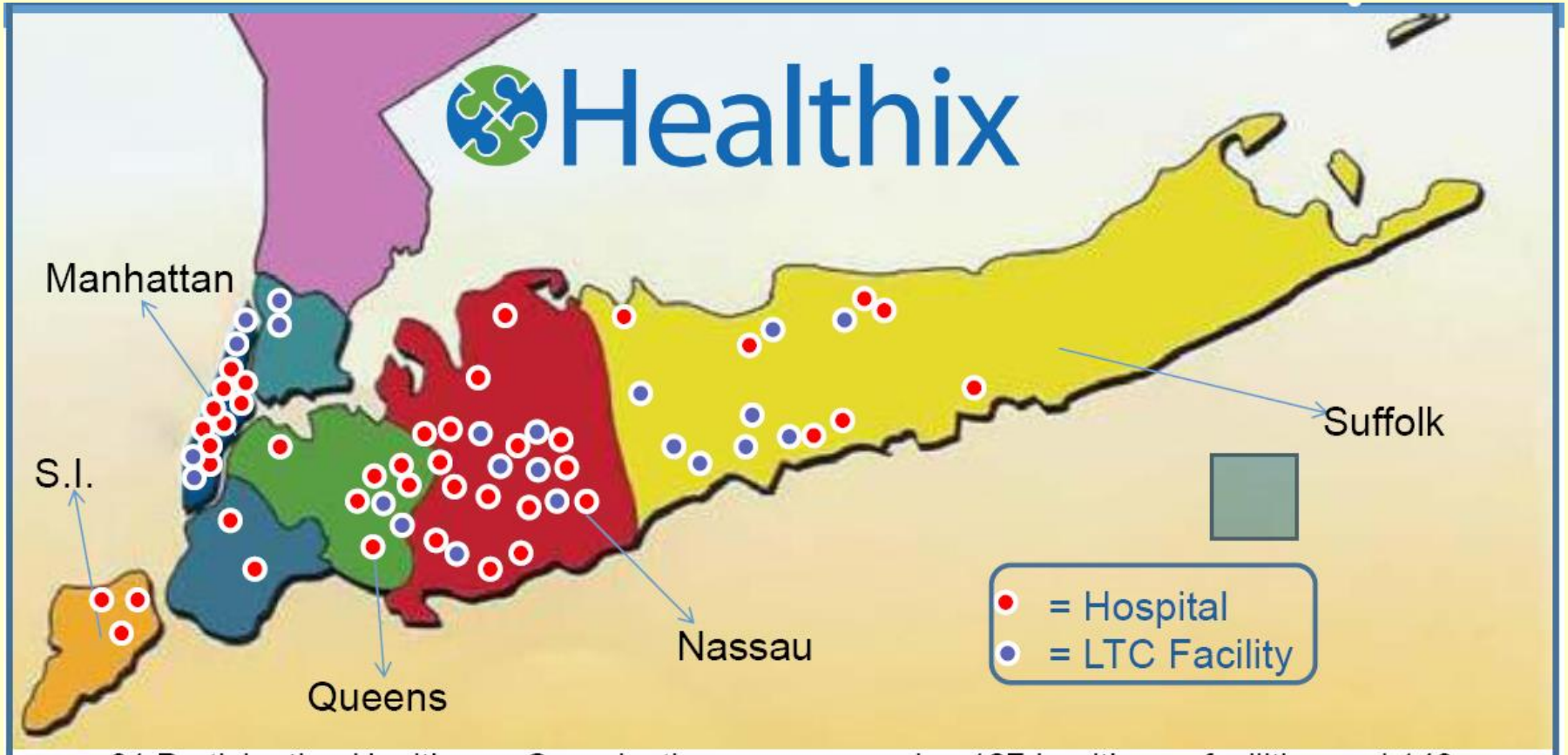
Regional health information organization (RHIO)

- Idea promoted in mid-2000s
- Premise: Since most of the benefit would be local, providers in a region should organize to tackle the challenges
- As of 2010, ~200 RHIOs nationwide
- NY State invested heavily in RHIO model

HEAL-NY

- Starting in 2006, used HEAL to advance a “21st century health information infrastructure to support the delivery of high quality care”
- Advanced RHIOs
  - Also, supported deployment of EHRs
- Four phases
  1. 2006 -- Demonstrate interoperability (established RHIOs)
  2. 2008 – 1st attempt at state-wide architecture
  3. 2009 -- Support for patient centered medical home
  4. 2010 -- Support for chronic disease with a mental health comorbidity
- Lessons
  - More complex than first thought, especially state-wide exchange
- Still, a substantial infrastructure was established
  - ~10 RHIOs in NY State

Example of a RHIO

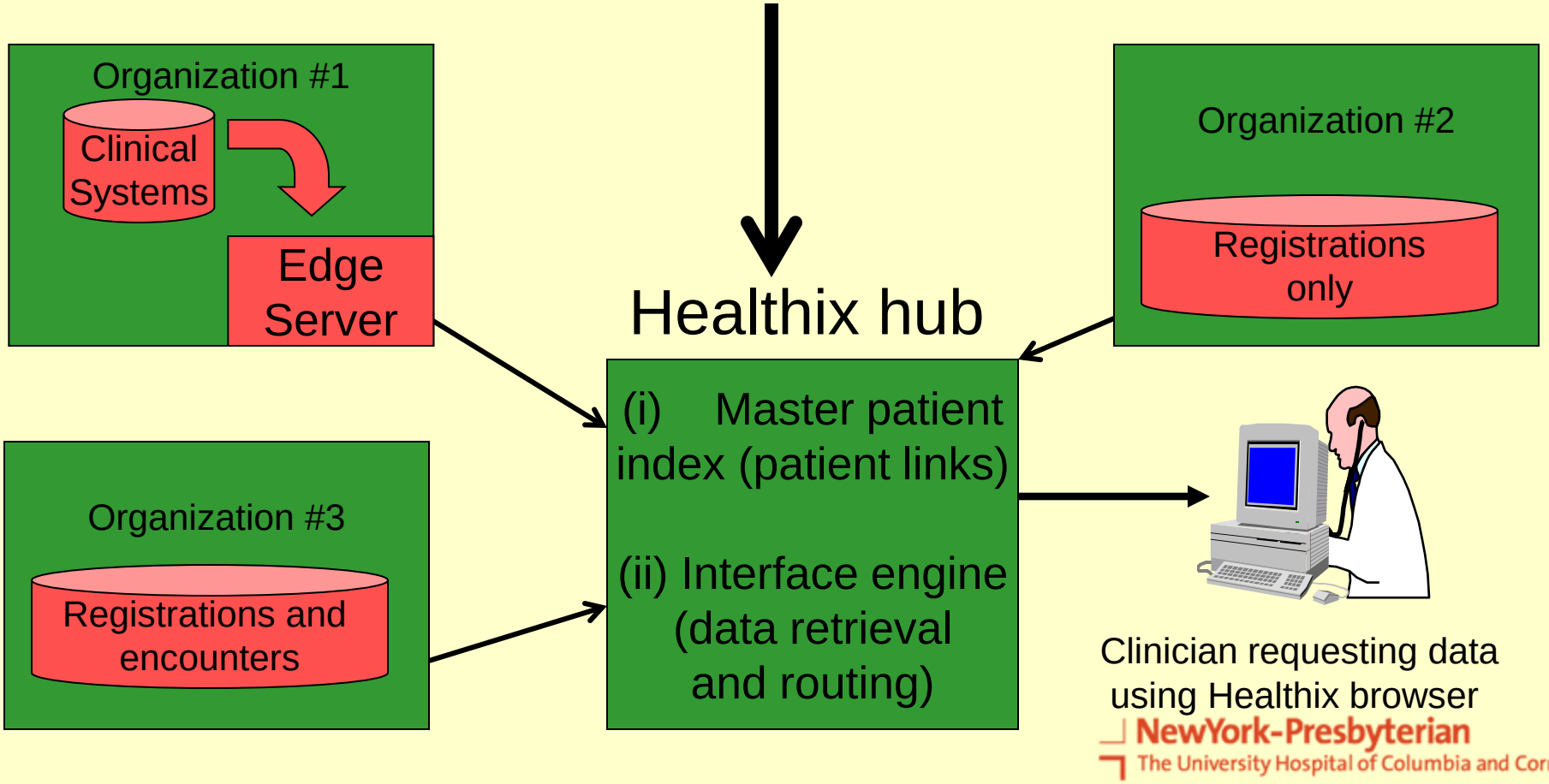


- 61 Participating Healthcare Organizations encompassing 127 healthcare facilities and 149 ambulatory medical sites:
  - 45 Hospitals (shown above)
  - 23 Long Term Care Organizations (shown above)
  - 59 Home Care, CBO, BHO, Radiology, etc.

- 5,778 clinicians are registered to use Healthix.
- Each quarter: 1,600 clinicians conducted 21,600 searches of patient data.
  8,000 automatic event notifications are delivered to clinicians.

Healthix technology

- Master patient index links patients
  - Statistical matching techniques applied to patient demographics
- "Interface engine"
  - Retrieves data from participant sites when needed



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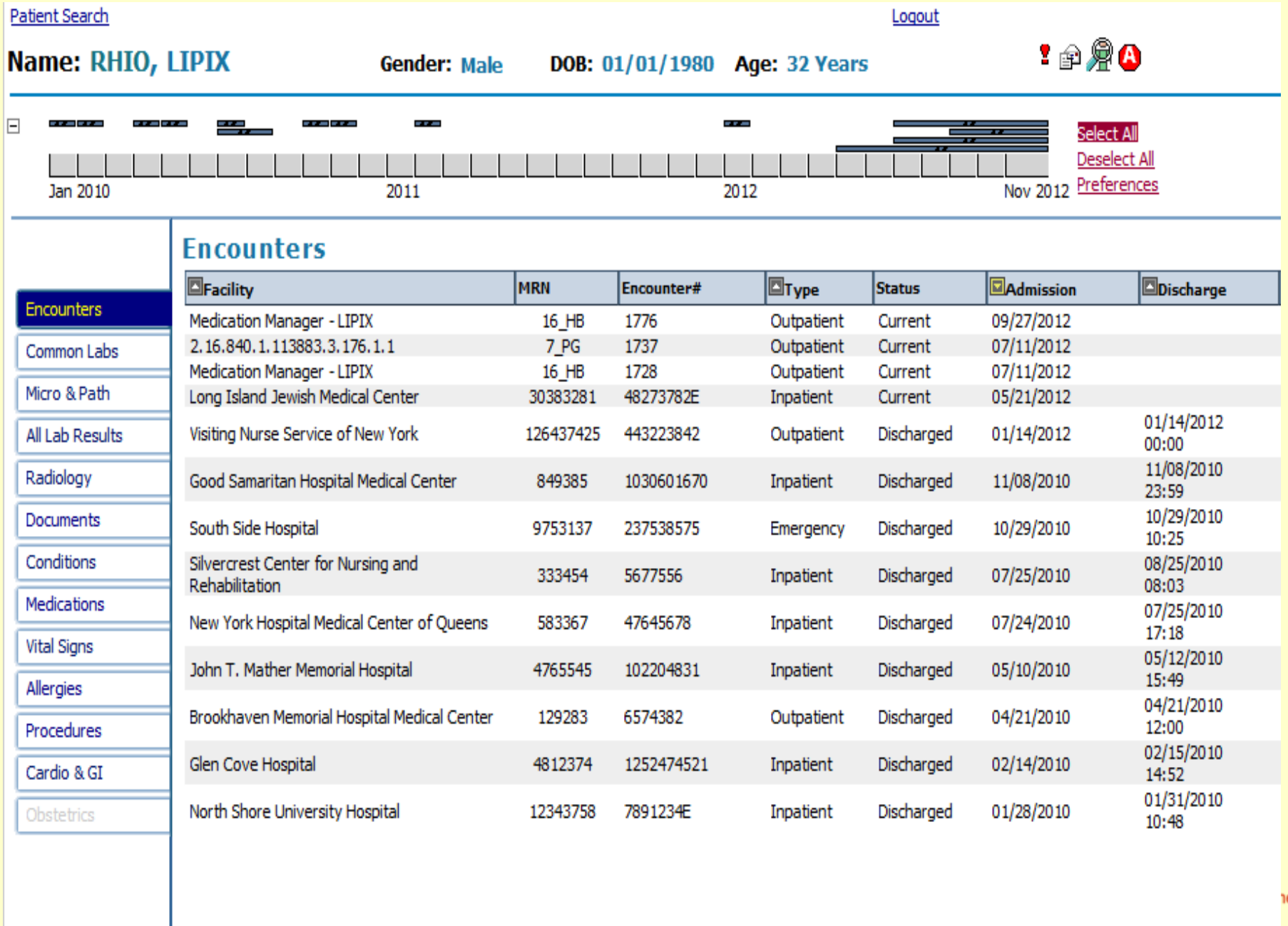
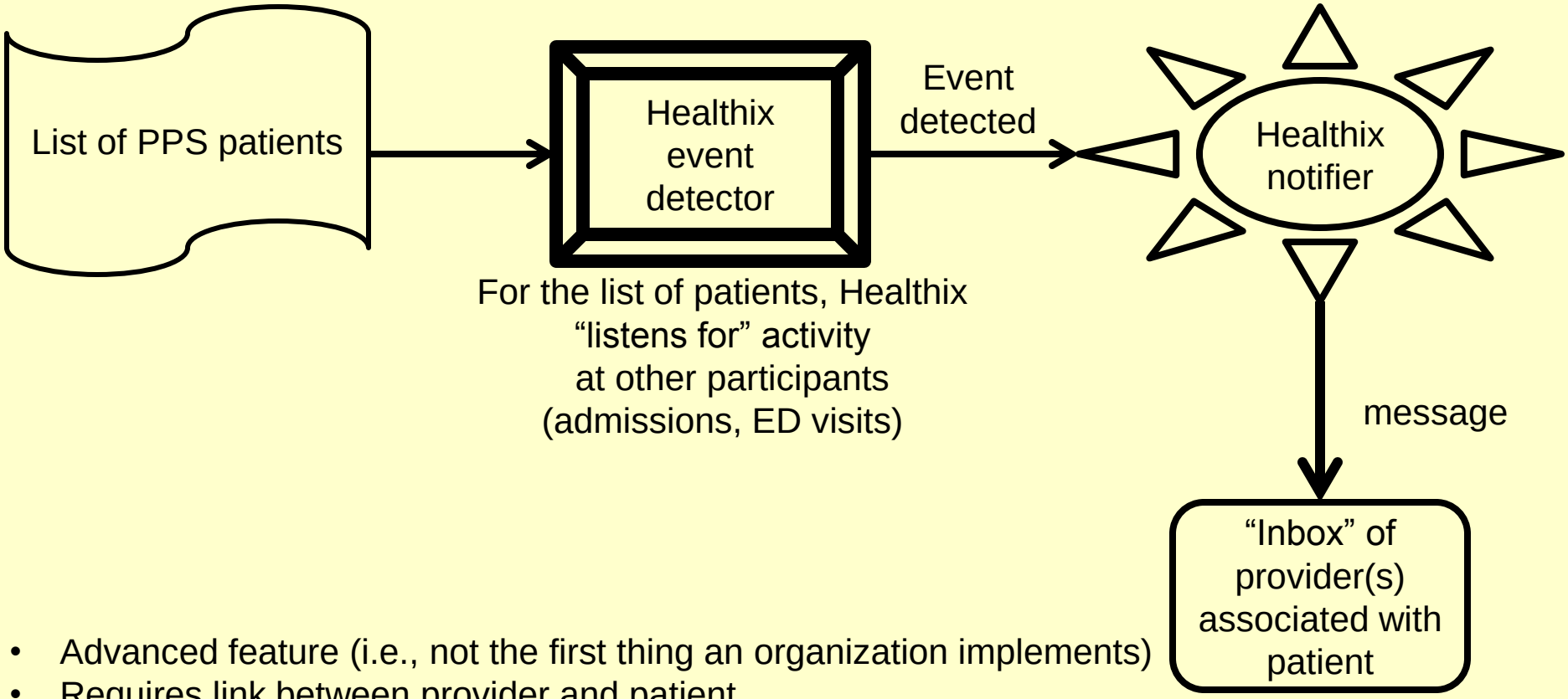
Healthix results review screen



Another way to get information from Healthix: notifications



- Advanced feature (i.e., not the first thing an organization implements)
- Requires link between provider and patient
- Requires some method to get message to provider
- Receiving messages requires the patient's consent

Healthix Privacy Policy

- Consent -- patient must give each site written consent to access data
- Provider commitments
  - Authorized users
  - Appropriate use
  - Accept responsibility for breaches
  - Will audit compliance w/ these commitments
- Healthix commitments
  - Oversees the auditing process

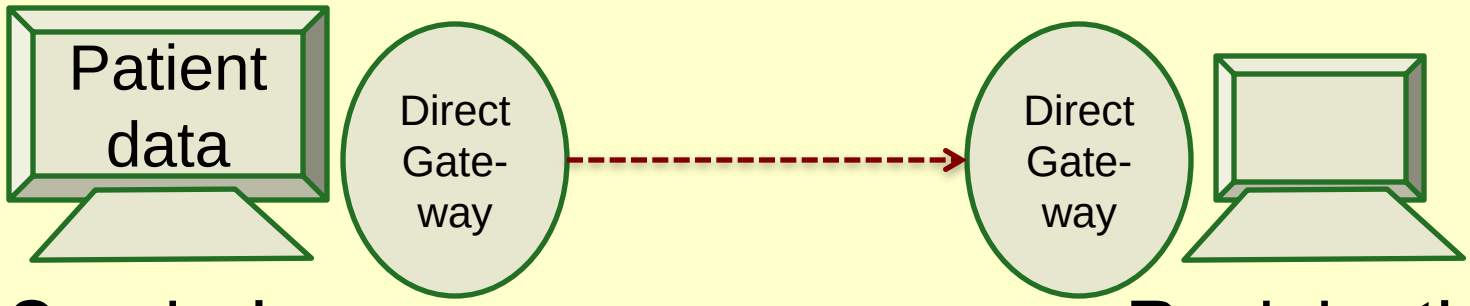
Healthix participant obligations

- Leadership engagement
- Integrate Healthix into workflow
  - ★ Implement processes to capture patient consent
  - ★ Implement workflows to leverage data
  - – Negotiate workflows with partner organizations
  - – Integrate with other information technologies
- Point person for project management
- Legal and compliance obligations
  - – Participant agreement; legal relationship w/ Healthix
  - – Compliance with Healthix privacy policies

NYP involvement in Healthix

- Healthix Board
  - Aurelia Boyer (NYP CIO)
- Healthix Clinical Committee
  - Gil Kuperman, MD (IT)
  - Peter Gordon, MD (HIV)
- Healthix Privacy and Security Committee
  - Gil Kuperman, MD (IT)
  - Peter Grabowski (Security)
  - Cheryl Parham (Legal)
  - Debora Marsden (Privacy Officer)

Directed exchange
"Push" of data from A to B



Sender's system

Recipient's system

Example scenarios include:
-Referral
-Visit / discharge summary
-Lab results
-Radiology report
-Etc.

Could be:
-Ambulatory provider
-Nursing home
-Public health agency
-PHR
-Etc.

Notes

- ***Direct does not require the RHIO***
  - ***However, RHIOs can help***
- ***"Systems" can be EHRs but don't have to be***

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Directed exchange

- Still relatively new
- Less complex than RHIO
  - Fewer interfaces needed
  - Less need for complex governance
  - Privacy model much simpler; consent not needed
- Complements RHIO model
- Useful when know where you want to send data
- Requires
  - Participants to have an “address”
  - Provider directories
  - An “inbox” – could be an EHR but could be a web application provided by Healthix
  - Workflows for handling messages

★ Partners need to mutually decide when they can / want to use Direct

SHIN-NY

- SHIN-NY will provide ability to exchange data across RHIOs
- Currently, Healthix can only pull from its members
  - Excludes HHC, Bronx, rest of the State
- SHIN-NY capabilities scheduled to be available in the 2nd half of 2015
  - Might be an ambitious timeline…

HIE and DSRIP

- Goal of DSRIP is to make effective use of all available services and to keep patients from needing ED visits and admissions
- Requires collaborative care models and IT-enabled workflows, including HIE
- NYP PPS has multi-layered HIE strategy
  - Some partners will be using Allscripts Care Director
  - Many PPS partners will become Healthix members
  - Direct messaging
- Challenges
  - Designing the workflows that best use HIE and then implementing those workflows
  - Staging / phasing

Summary

- Several challenges to HIE
- RHIOs are an important infrastructure that enable HIE
  - A RHIO provides the technology, privacy and governance infrastructure for HIE
  - RHIO participants can contribute registration, encounter, or clinical data
  - RHIO participants have obligations
- “Direct” is an emerging approach to HIE that complements the RHIOs
  - Workflows that use Direct need to be worked out between the partners that will use it
- The SHIN-NY will provide data exchange capabilities across RHIOs where that is needed
- HIE is an important (but not the only) enabler of DSRIP’s goals

NYP PPS PAC Meeting: Integrating three roles

Community Health Worker
Care Manager
Patient Navigator
March 9, 2015

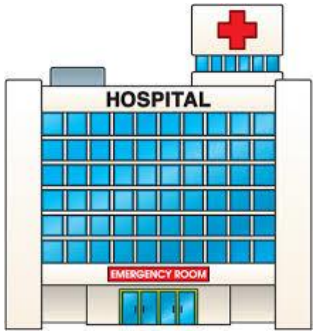
NewYork-Presbyterian
Ambulatory Care Network

Working Together to Provide Patient-Centered Care Across the Continuum

Home

Community Health Workers

Hospital (ED)



Patient Navigators

Patient

Community and Ambulatory Based

Care Managers

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Ambulatory Care Network

Community Health Workers

Who are they?

- Bilingual, peer supporters
- Community based
- Members of the health care team
- Support patients to better manage their chronic disease

CBOs working together with NYP since 2005

- Integrated into PCMH 2011

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Community Health Workers

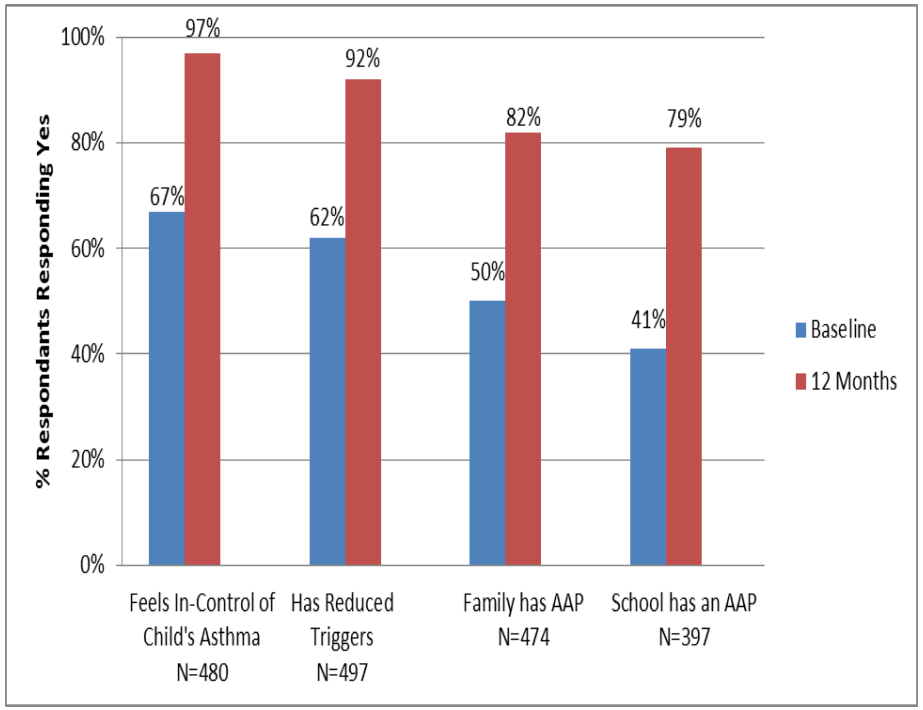
What do they do?

- Support patients in the home, PCMH, hospital, and Community Based Organizations
- Conduct home visits and make referrals for community based resources
- Apply non-clinical, peer-based approach to reinforce key health messages
- Help patients understand diagnoses and address disease management challenges
- Key member of interdisciplinary team

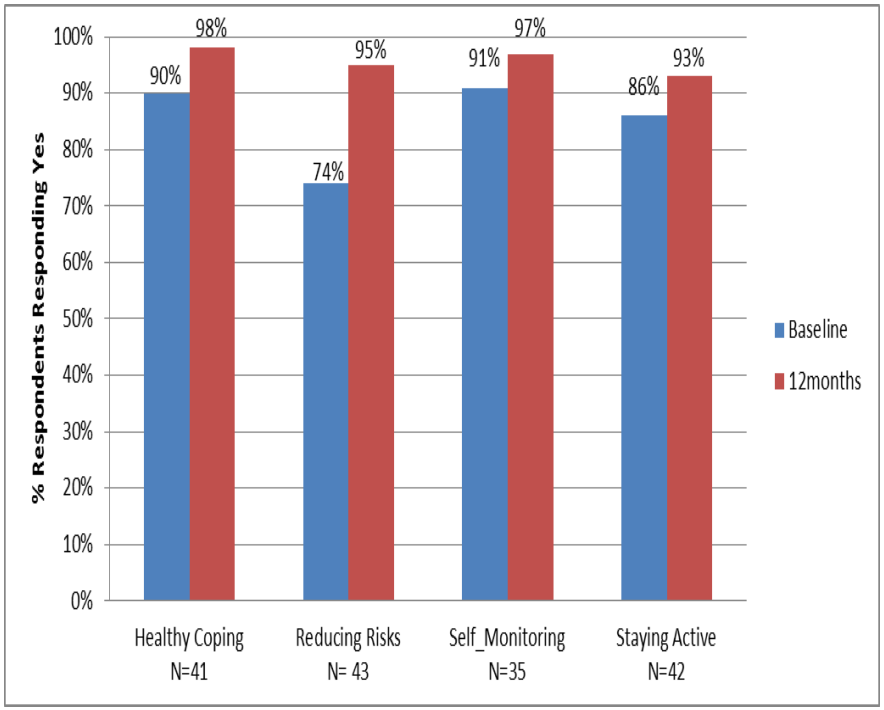
Community Health Workers

What are the outcomes?

Asthma



Diabetes



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Care Managers

Who we they?

Both community based and imbedded within the NYP Patient Centered Medical Home

Depending on the agency: various models

- Outreach staff
- Non-clinician Care Coordinators (e.g., ASC)
- Nurse Care Managers (RN)
- Behavioral Health Care Managers (LCSW)
- For NYP Health Home: both Community and NYP based Care Managers work within a common IT platform → Allscripts Care Director

Care Managers

What do they do:

- Target medically and psychosocially complex patients with multiple co-morbidities and a recent history of high inpatient and emergency room utilization.
- For Health Home: identified by the NYS.
- The interventions lasts from a few months to several years

To have greatest impact and sustainability:
Assessment and Care Plans are designed to address both clinical and social determinants of health in the following domains:

- Access and Coordination
- Medication Management
- Behavioral Health
- Functional Status
- Socioeconomic
- Social Network
- Self Efficacy
- Self Care

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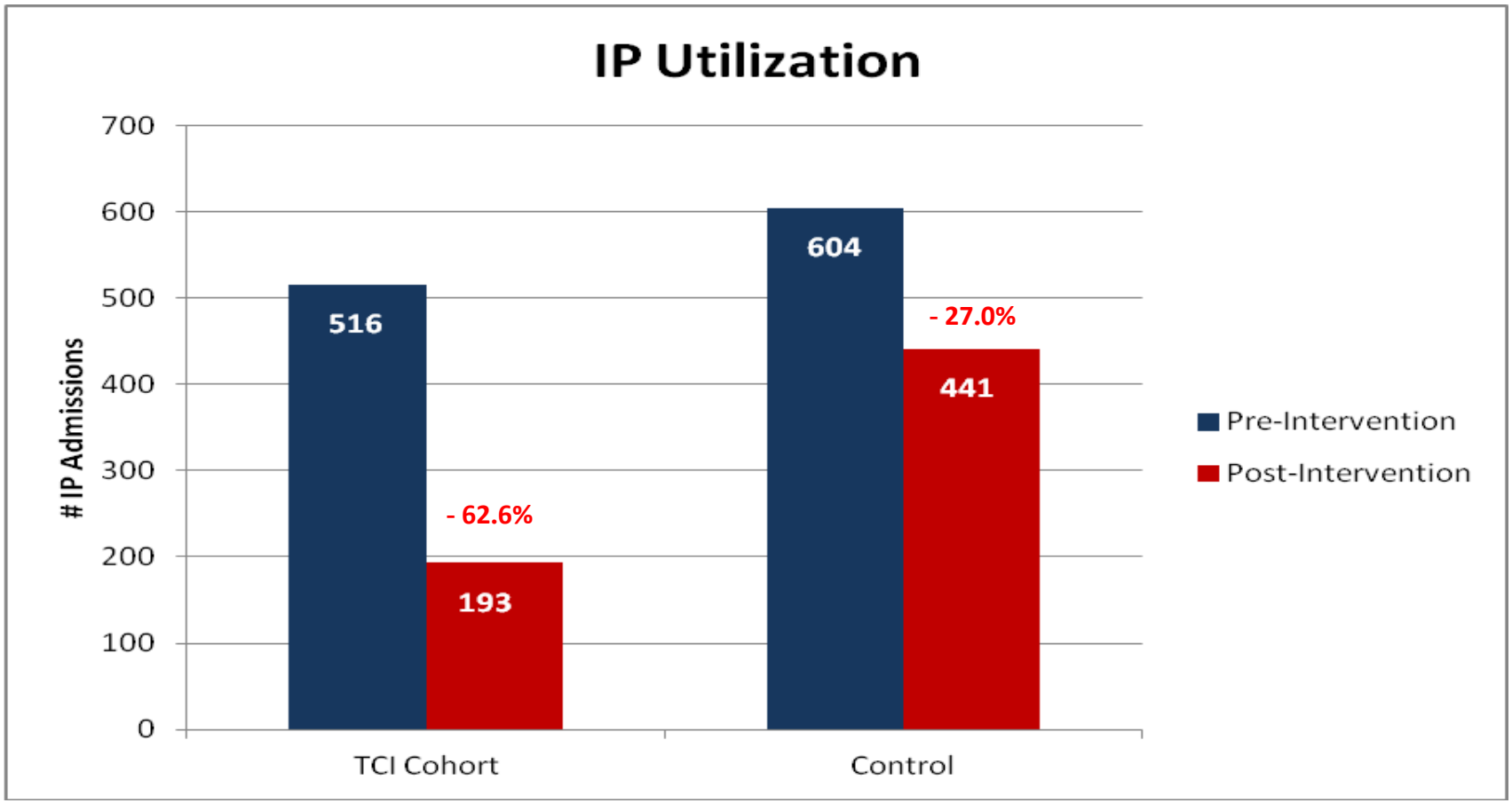
Care Managers

What are the outcomes?



** Represents a statistically significant risk reduction between the TCI Cohort and the Control Cases (p-value=0.02)*

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Patient Navigators

Who are they?

Implemented in 2008 @ NYP

Serve three EDs: Milstein, Allen & MSCHONY

- Patient Navigators: Bilingual, multicultural & have experience working for and with the local community
- Provide services to patients of all ages who are treated and released from the Emergency Department (ED)
- Collaborate with ACN and Community Providers
- Support, educate and empower patients to effectively navigate the healthcare system and maximize available resources.

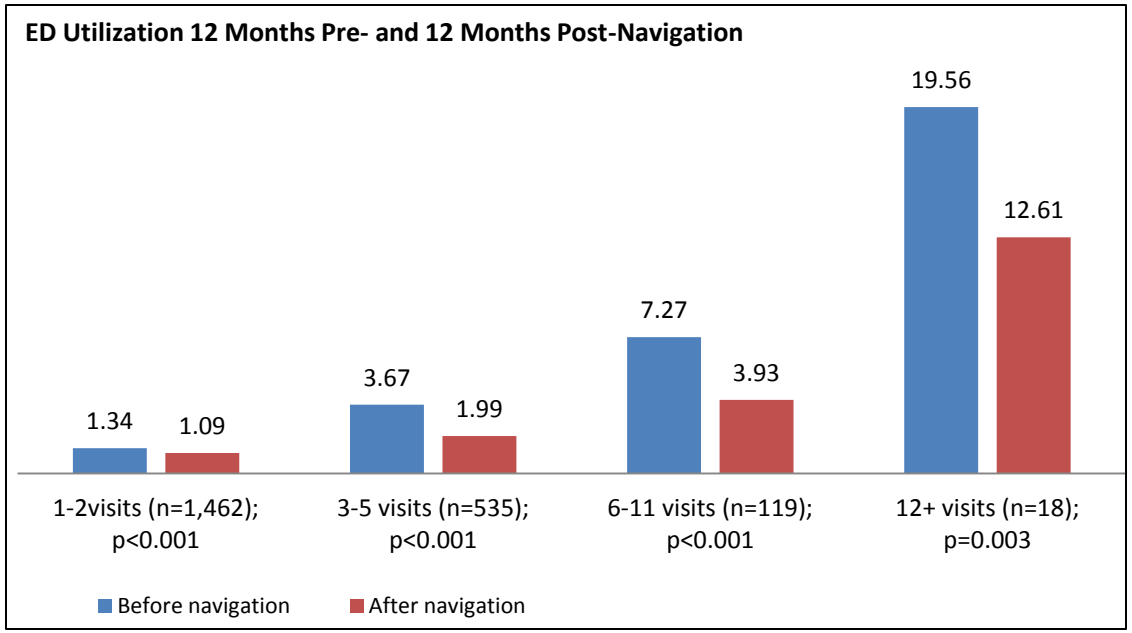
Patient Navigators

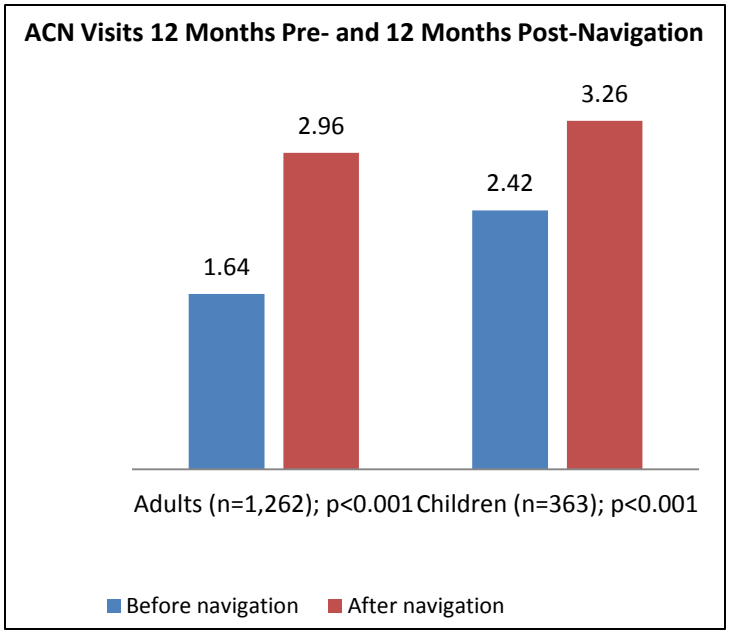
What do they do?

- Provide referrals to connect to health insurance
- Educate patients on having and utilizing a Primary Care Provider
- Educate patients on the importance of keeping medical appointments
- Schedule appointments as necessary (whether Primary Care, Specialty or both)
- Follow-up with patients to verify appointment adherence

Patient Navigators

What are the outcomes?





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Shared experience across the PPS

Open discussion and questions?

- What are best practices or lessons learned with these three roles across the PPS?
- How might this experience best inform integration of these three roles into the DSRIP projects to achieve our goals?
- Other Q & A?

Health IT & Practice Transformation in PCIP Practices

Anname Phann, MPH, Senior Manager, Partnerships

Primary Care Information Project
NYC Department of Health & Mental Hygiene

March 9, 2015

PCIP Overview

The Primary Care Information Project (PCIP) is a NYC DOHMH bureau in the division of Prevention and Primary Care.

Mission:

Improve population health using health IT with a focus on clinical preventive services in the ambulatory setting.

Provider Network:

18,000+ primary care and specialist providers including **1,000+** small practices

Funding:

PCIP is funded by federal, state, and private grants to provide practice transformation and quality improvement services.

PCIP Overview

EHR Adoption & Meaningful Use

- Provider Recruitment
- Technical Assistance for EHR Optimization
- Resources and Trainings for Providers

Quality Improvement

- On-site
- Dashboards
- PCMH
- Pay for Quality
- Patient engagement
- Community Projects

Interoperability

- Health Information Exchange
- Interfaces
- Accountable Care Organizations

Public Health Monitoring

- Disease Surveillance and Management
- Diabetes Registry
- Query Health
- Clinical Data

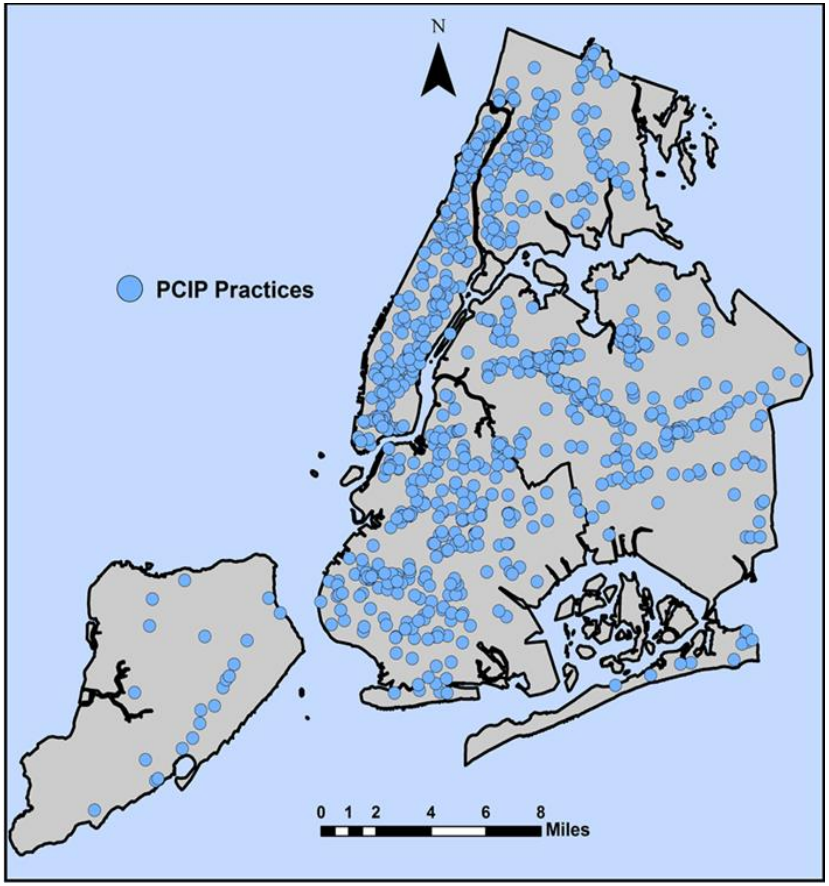
Actionable Information in NYC

PCIP Successes:

- **3,200** PCPs implemented prevention-oriented EHR
- **6,000** behavioral health providers on qualifying EHR and care coordination software

Practice Transformation Results:

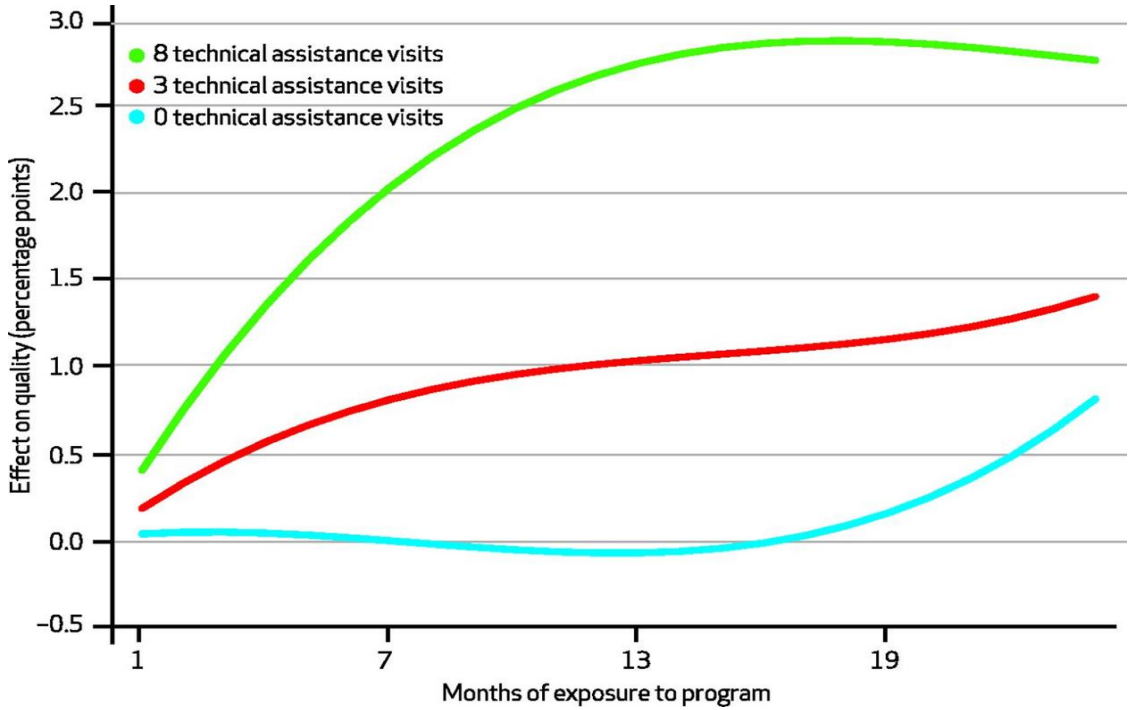
- **4,200** providers achieved Meaningful Use
- **$250,000,000** earned MU incentives
- **400** practices supported with PCMH



Health IT + Technical Assistance = Quality Improvement

Practices receiving customized technical assistance from PCIP saw more improvement at a faster rate.

Estimated Effect Of The Primary Care Information Project On Quality For Electronic Health Record (EHR)–Sensitive Measures, By Level Of Technical Assistance.



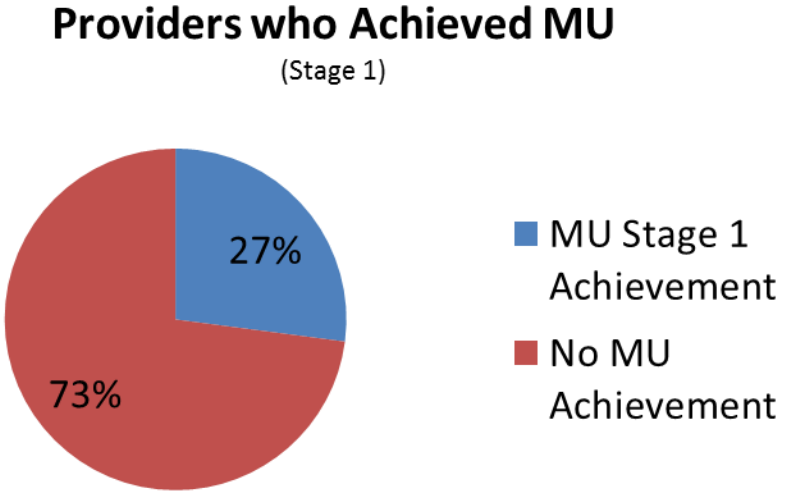
Ryan A M et al. Health Aff 2013;32:53-62

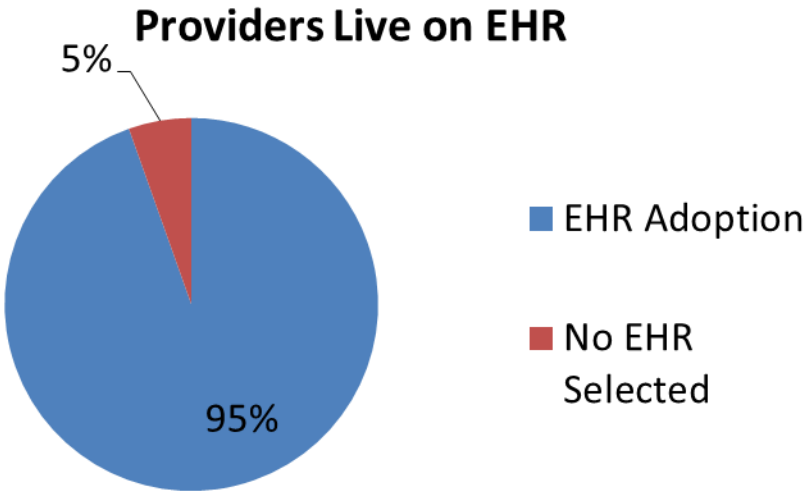
HealthAffairs

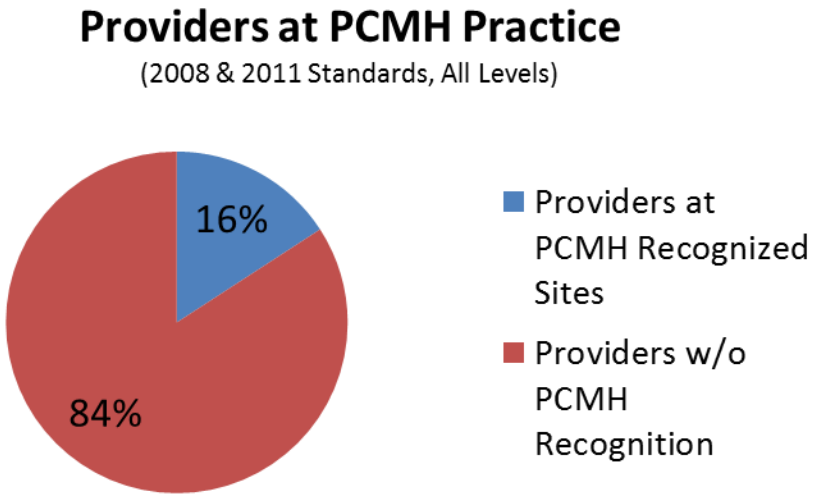
PCIP Data On Practice Transformation Status

Lesson Learned:

- Providers need 1-2 years for EHR adoption
- Engaging providers requires multiple touches
- Ambulatory practices overwhelmed & need more than MU technical assistance

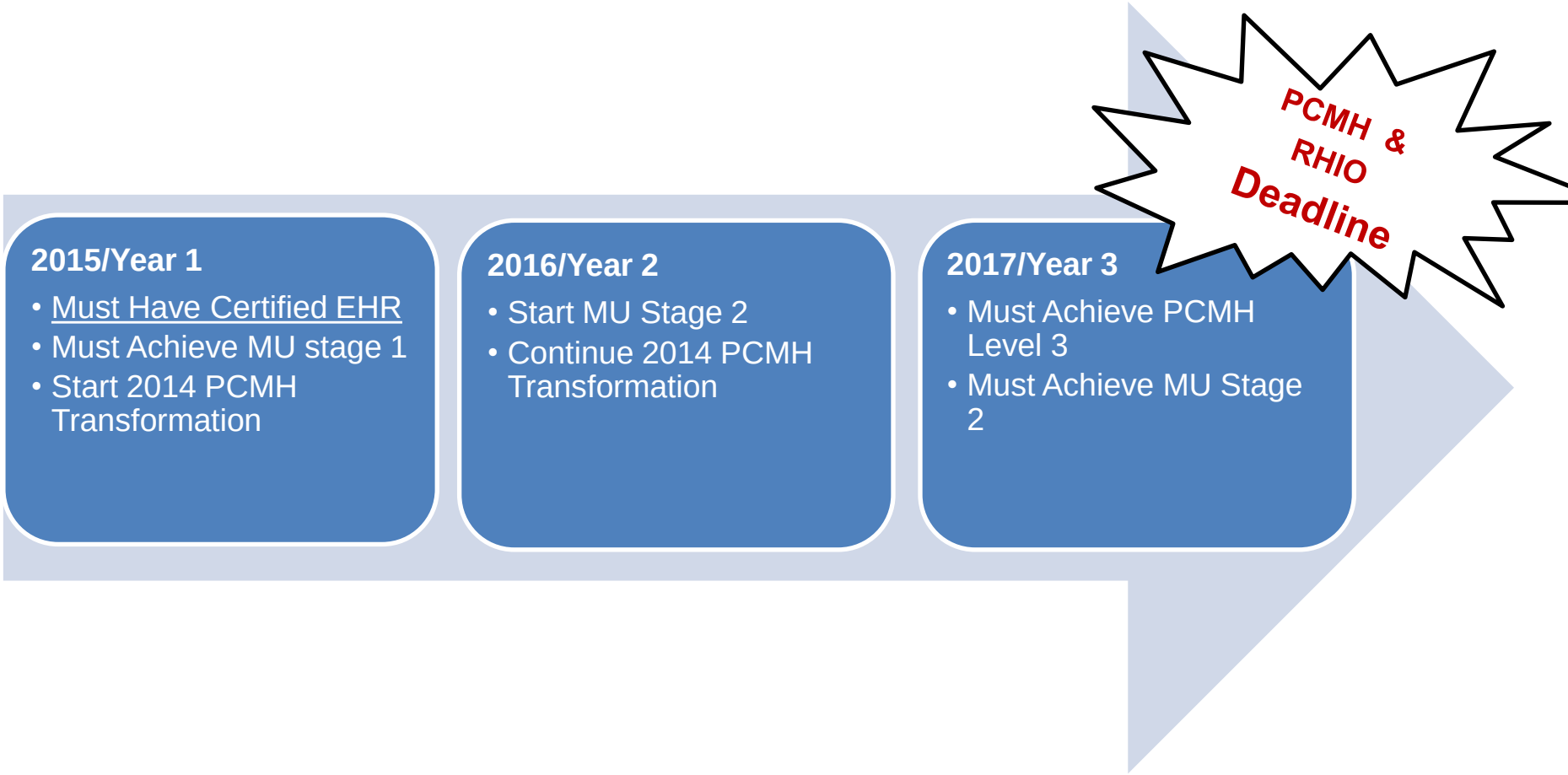




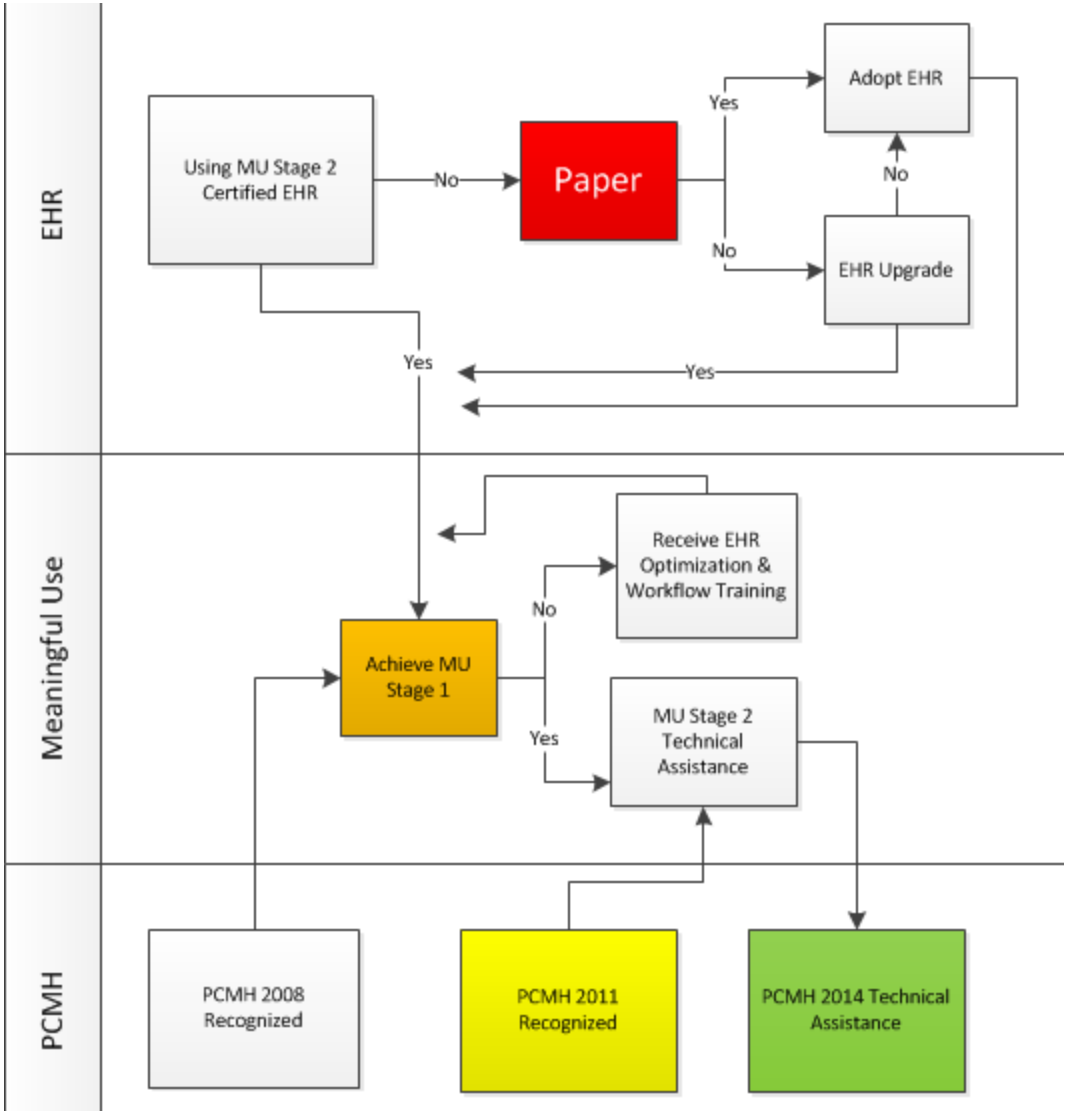


Practice Transformation Timeline

DSRIP PPS practices should start transformation now.



Practice Transformation Workflow



Meaningful Use is the foundation for Quality Improvement

Meaningful Use EHR Program:

- Federally funded incentive program to increase EHR adoption and standardized documentation
- Providers receive up to $64,000 in Medicaid MU Incentives

Program Components

- Use of certified EHRs
- Consistent documentation for easier reporting
- Patient engagement
- Increased patient safety
- Care coordination

SUBSIDIZED TECHNICAL ASSISTANCE
for Medicaid participating
PCPs & Specialists until 2016

NYS Medicaid PCMH Incentive Payments

Additional reimbursement helps practices coordinate care

Managed Care	NCQA Level 2 2014 Standards	NCQA Level 3 2014 Standards
Per Member Per Month	$6.00	$8.00

Fee for Service Add On Per Visit	NCQA Level 2 2014 Standards	NCQA Level 3 2014 Standards
Article 28 clinic	$23.25	$25.25
Office-Based Provider	$20.50	$29.00

http://www.health.ny.gov/health_care/medicaid/program/update/2015/feb15_mu.pdf

HIE Incentive Program

RHIO connectivity required by DSRIP Year 3

NYS incentives available for EHR RHIO fees (interface & first year of maintenance)

Requirements	Incentive
Sign RHIO Agreement and attest to contribute clinical data for 1 year	**$ 2,000**
Attest to connection “Go-Live” date & contribute 5 of 7 clinical data elements	**$8,000**
Attest on behalf of EPs (max 40 providers)	**$500 per provider** (max $20,000**)**

Contact Information

For questions or more information:

Email: pcip@health.nyc.gov
Phone: 347-396-4888

VNSNY Homecare
Risk for Re-Hospitalization

NYP PPS PAC Meeting

March 9th 2015

Regina Hawkey, MPA, RN, NE-BC

Reducing Re-Hospitalizations --- The Age-Old Problem

DSRIP - The New Opportunity

The Good News About Hospitalization Reduction

- ED Diversion
- “Take Heart”
- Risk Stratification Drives Care Planning

VNSNY Transitional Care

- Rosati risk stratification embedded in the Comprehensive Assessment

"Development and Testing of an Analytic Model to Identify Home Healthcare Patients at Risk for a Hospitalization Within the First 60 Days of Care"

Robert J. Rosati, PhD

Liping Huang, MA

Available online at http://hhc.haworthpress.com

doi:10.1300/J027v26n04_03 21

(M1032) Risk for Hospitalization

Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply)

1 - Recent decline in mental, emotional, or behavioral status

2 - Multiple hospitalizations (2 or more) in the past 12 months

3 - History of falls (2 or more) in the past 12 months

4 - Taking five or more medications

5 - Frailty indicators e.g. weight loss, self-reported exhaustion

6 - Other

7 - None of the above

Other Risk Factors for Hospitalization/Emergent Care

- HIV/AIDS
- CHF
- Diabetes
- End Stage Renal Disease
- Chronic skin ulcers
- Neoplasm as primary diagnosis
- COPD
- "New" diagnosis/problem
- 9 or more medications
- More than two secondary diagnoses
- Low socioeconomic status or financial concerns
- Lives alone
- Help with managing medications needed
- Confusion (any level)
- Short life expectancy
- Poor prognosis
- Dyspnea (any level)
- Urinary catheter
- Open wound (stasis, pressure, diabetic ulcer; open surgical wound)
- None of the above

From Assessment to Intervention

- Triggers for referral to other members of the Team
  - Home Health Aide
  - Physical Therapist / Occupational Therapist / Speech Language Pathologist
  - Social Worker
  - Palliative Care Consult
  - Behavioral Health Program
- Frequency and intensity of contact
  - In person
  - Telephonic
  - Remote Monitoring

From Assessment to Intervention

- Triggers for referral to community programs:
  - Nutrition Programs
  - Housing Based Supportive Services
  - Transportation Providers

- The Assessment Findings and Pt Stated Goal(s) inform:
  - “My Action Plan”
  - Personal Health Record
  - Red Flags
  - Communication with the PCP (SBAR)

Visiting Nurse Service of New York

Patients by Predicted Risk of Rehospitalization Level

Run Date: 09/14/2012

Patients Referred From: NY PRESB HOSP CPMC

Risk Score Calculation Date Range: 09/02/2012 - 09/15/2012

VNSNY Patients at High Risk of Rehospitalization (moderate-high to very-high)

Risk Score*	First Name	Last Name	Address	City	State	Zip	Phone	DOB	Date of Admission to VNSNY Home Care	Primary VNSNY Home Care Diagnosis	Primary Payer	
Very High									08/29/2012	ANEMIA NOS		
Very High									08/31/2012	MALIG NEO CORPUS UTERI		
Very High									08/31/2012	AFTERCARE FOLLOW ORGAN TRA		
High									08/26/2012	AFTERCARE FOLL EXPLANT OF JT P		
High									08/29/2012	CHF UNSPECIFIED		
High									08/30/2012	MALIGN NEOPL PROSTATE		
Moderate-High									08/31/2012	HYPERTENSION NOS		
Moderate-High									08/28/2012	AFTRCRE SURG ORAL/DIGE SYS		
Moderate-High									08/29/2012	COMPL LIVER TRANSPLANT		

VNSNY Patients at Medium Risk of Rehospitalization (low-moderate to moderate)

Risk Score*	First Name	Last Name	Address	City	State	Zip	Phone	DOB	Date of Admission to VNSNY Home Care	Primary VNSNY Home Care Diagnosis	Primary Payer	
Moderate									08/31/2012	PRIM CARDIOMYOPATHY NEC		
Low-Moderate									08/30/2012	CHF UNSPECIFIED		
Low-Moderate									08/26/2012	AFT SURG CIRCSYST NC		

** Predicted Risk of Rehospitalization in seven levels: very low, low, low-moderate, moderate moderate-high, high, very high.*
Based on: Rosati RJ, Huang L. Development and Testing of an Analytic Model to Identify Home Healthcare Patients at Risk for a Hospitalization within the First 60 Days of Care. Home Health Care Services Quarterly. 2007 .26: 21-36

Discussion

- What best practices for Transitional Care and Risk Stratification exist across the PPS?
- How should we look at integrating best practices to best serve the PPS?
- Other Q & A?