NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	October 7, 2015, 9:00-11:00am	**Meeting Title**	NYP PPS Project Advisory Committee
Location	MSCHONY 12th Floor, Klienman Conf Rm. 12-45	**Facilitator**	Kate Spaziani
GoToMeeting	none	**Conference Line**	Dial In: 855-640-8271 Passcode: 24545434

Invitees	
Project Advisory Committee Membership	

Meeting Agenda	**Time**
1. Welcome (Kate Spaziani) 2. NYP PPS Updates (Isaac Kastenbaum) 3. Center for Community Health Navigation (Patricia Peretz and Dr. Adriana Matiz) 4. Community Engagement Plan (Kate Spaziani)	

Action Items				
Description	**Owner**	**Start Date**	**Due Date**	**Status**

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Go to Meeting	None	**Conference Line**	Dial In: 855-640-8271 Passcode: 24545434

Attendees	
Agnes Peterson (NYP)	Kenneth Meyer (Community Healthcare Network)
Alessia Daniele (NYP)	Lauren Alexander (NYP)
Angela Martin (VNSNY)	Luz A. Matiz-Zanoni (NYP)
Anne Sperling (NYP)	Marci Allen (NYP)
Bradley Moore (Lenox Hill Neighborhood House)	Eliana Leve (ASCNYC)
Daniel Johansson (ACMH)	Maria Lizardo (Northern Manhattan Improvement Corporation)
Daniel Lowy (Argus)	Maria Perez (Methodist Home for Nursing and Rehabilitation)
David Alge (NYP)	Michael Andrews (1199 SEIU)
Deborah Katznelson (YWHA of Washington Heights)	Patricia Peretz (NYP)
Eric Carr (NYP)	Stacie Williams (NYP)
Eva Eng (ArchCare)	Victor Carrillo (NYP)
Isaac Kastenbaum (NYP	Yaffa Ungar (Isabella)
Jenna Tina (Washington Heights CORNER Project)	Ana Garcia (NYCDOHMH)
Jonah Cardillo (St. Mary's Health System)	Fern Hertzberg (ARC XVI Ft. Washington, Inc.)
Kate Spaziani (NYP	Rob Batiste (Metropolitan Center for Mental Health)
Jay Gormley (MJHS)	

Meeting Objectives	**Time**
1. Welcome (Kate Spaziani) 2. NYP PPS Updates (Isaac Kastenbaum) 3. Center for Community Health Navigation (Patricia Peretz and Dr. Adriana Matiz) 4. Community Engagement Plan (Kate Spaziani)	

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
K. Spaziani, L. Alexander and I. Kastenbaum will meet to review and implement suggestions from the community engagement discussion. Will come back to the group with concrete next steps.	K. Spaziani, L. Alexander	10/7/2015	12/16/2015	Complete
Partners should send additional ideas for community engagement to K. Spaziani or L. Alexander	Partners	10/7/2015	Ongoing	In progress
Partners should let us know if they are interested in having us speak to one of their groups	Partners	10/7/2015	Ongoing	In progress

Partner organizations should let us know if they are interested in hosting a future PAC meeting	Partners	10/7/2015	Ongoing	In progress
Recirculate Heat Maps outlining our geographic area	K. Spaziani, L. Alexander	10/7/2015	11/7/2015	Not started

Minutes:

- K. Spaziani opened the meeting.
- K. Spanziani introduced L. Alexander, new Manager for DSRIP Community Relations.
- I. Kastenbaum provided an update on the NYP PPS, which included an overview of the following:
    - NYS Updates:
        - NYS Learning Collaborative (Sept 17 – 18)
        - DSRIP Quarterly Reports (Q1, Q2)
        - Safety Net Equity Payment
        - CRFP
        - Updated Domain 1 Minimum Reporting Requirements
    - NYP PPS Updates:
        - Recruitment
        - Collaborator Engagement
        - Project Implementation
        - Information Technology
    - Next Steps
        - Continue sub-contract development with collaborators
        - Continue to achieve Organizational Milestones via Committees
        - Operationalize projects by November 2015
- A. Martin asked a question about patient engagement activity and how the PPS is tracking this.
- An update was provided on the work of the committees.
    - With regards to the Finance Committee, D. Lowy asked if the Committee had determined concrete ways in which partners would be measured. J. Gormley reported that the committee had been focused on ensuring the funds were flowing correctly to the budgets and would be turning to this shortly.
- P. Peretz and Dr. A. Matiz presented on the work of the Center for Community Health Navigation, which encompasses both the Patient Navigator and Community Health Worker programs at NYP. The presentation provided an overview of the Community Health Worker and Patient Navigator models and how these models are being integrated across DSRIP projects.
    - D. Lowy asked who provides the training for the Community Health Workers, whether there was a minimum level of education required and if partners can access the training for their own staff. P. Peretz indicated that there is no degree requirement and that the training is a combination of a core set of competencies with additional training in specific areas (i.e. case management). Many of the Center's partners have been involved in the training and there is a role for DSRIP partners to share their expertise as well.
    - A. Garcia and D. Lowy asked about the training center that is under development, including what the focus will be and its capacity. Dr. A. Matiz and P. Peretz noted that they are open to partner participation in the development of the training center.
    - E. Leve raised the topic of a new service category called Home and Community-Based Services (HCBS) that is reimbursed by Medicaid, noting the overlap with Community Healthcare Workers and Patient Navigators. She also noted the Health and Recovery Plan. Both programs could potentially offer opportunity for sustainability beyond DSRIP. A. Nieto suggested that perhaps our community partners can inform us more in these areas and that this topic could be revisited in future conversations.
    - Y. Ungar asked how Community Healthcare Workers interface with Skilled Nursing Facilities.
    - F. Hertzberg asked about the outreach to CBOs and how this is conducted. A. Nieto underscored the important role that partners play in such community work and that we are open and interested in working with partners in this area. M. Lizardo agreed, noting that open and honest conversation and relationship-building between NYP and CBOs has been key in making this work successful.
    - A. Garcia inquired about how many Community Healthcare Workers will be hired in total across DSRIP projects.
    - E. Leve inquired about whether the Community Healthcare Workers and Patient Navigators are mostly full-time or part-time.
    - E. Leve asked how screening and compliance issues such as exclusion checks and background checks are handled for Community Healthcare Workers and Patient Navigators that are placed at partner

organizations. P. Peretz responded that these staff participate in a credentialing process and undergo standard clearance, background checks and new staff orientation.

- K. Spaziani led a discussion around the development of the PPS's community engagement plan. State requirements of the community engagement plan were reviewed and feedback was solicited in the following areas:
  - Identifying key stakeholders – Are there other stakeholders we should be engaging that we haven't already?
    - A. Martin asked if Community Advisory Boards have been included in the PAC.
    - D. Johansson and A. Martin suggested that we reach out to community boards. A. Garcia endorsed this idea. Suggestion that we visit community boards of all campuses.
    - D. Lowy asked about the geographic area for our PPS. K. Spaziani said she would recirculate Heat Maps.
    - D. Lowy suggested that we reach out Harlem United and Bailey House if we haven't already. He also suggested that we reach out to the faith-based community, including the Muslim community.
    - B. Moore suggested that we reach out to programs such as Head Start.
    - F. Hertzberg recommended looking at Harlem Congregations for Community Improvement.
    - D. Lowy and E. Leve raised the importance of engaging patients and community members.
    - A. Martin and D. Lowy were interested in discussing further the role of managed care organizations.
  - How to engage stakeholders – What other methods can we use to engage stakeholders?
    - D. Johannson suggested that webinars on specific topics could be of particular use to partners, i.e. illness 101, best practices for diabetes care. P. Peretz and Dr. A. Matiz indicated that they would be happy to share information about the community workshops that they offer with the PAC and other PPS members.
    - K. Meyer offered to provide a training on health literacy to PAC members.
    - There was discussion related to the need for more clarification around health program literacy, i.e. HARP, FIDA, etc. Perhaps consider a NYS Health Plans 101 training as a way to engage partners. The Managed Care Technical Assistance Web site might be of use.
  - Role of the PAC member – What is the best way to meaningfully engage the PAC?
    - K. Spaziani suggested that this could be a forum to revisit the community needs assessment and solicit feedback from members in order to ensure that the evolving needs of the community are represented in the DSRIP projects.
  - Including the patient perspective – How can the PAC better understand patient issues and needs?
- K. Spaziani reviewed next steps and closed the meeting.
  - K. Spaziani, L. Alexander and I. Kastenbaum will meet to review and implement suggestions from the community engagement discussion. We will come back to the group with some concrete steps.
  - K. Spaziani requested that organizations let us know if they are willing to host future PAC meeting.
  - K. Spaziani announced that we are willing to present to colleague organizations and to please let us know if partners are interested in having DSRIP staff speak to one of their groups.
  - K. Spaziani asked that members please send additional ideas regarding community engagement to herself or L. Alexander.

AMAZING THINGS ARE HAPPENING HERE

NYP PPS Update

October 7, 2015

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NYS DSRIP Update

Domain	Update
NYS Learning Collaborative (Sept 17 – 18)	• High-level overview of value-based payment, advanced primary care model, insights on various projects • ***Presentations from ASCNYC re Peers/CHWs (S. Duke) and NYP CHW Team (P. Peretz, A. Matiz)***
DSRIP Quarterly Reports (Q1, Q2)	• **Q1:** Received limited feedback/guidance from NYS; re-submitted in September • **Q2:** Reports due 10/30; introduces new sections on workforce, patient engagement activity, etc.
Safety Net Equity Payment	• PPSs anticipate receiving next payment in October • Webinar TODAY to provide update
CRFP	• No update
Updated Domain 1 Minimum Reporting Requirements	• Introduced new specificity on Organizational and Project-Specific Deliverables • New burden introduced on tracking every meeting, training, training materials, etc.

NYP PPS Update

Domain	Update
Recruitment	• 53 of 97 FTEs recruited, started by January 1st • 8 Managers (PMO) fully staffed
Collaborator Engagement	• Monthly meetings hosted for Executive, Clinical Ops, Finance, and IT / Data Governance Committees • Sub-Contracts beginning to flow for CBOs and NYSPI • Scopes of work for CHWs are being drafted • PPS Participation Agreement to be released this week • Several projects launched 'steering committees; others engaging CBOs one-by-one
Project Implementation	• ED Care Triage (Patient Navigators) likely running in November at Weill Cornell campus • HIV Center of Excellence beginning to develop care cascade
Information Technology	• Beginning to discuss rollout of Allscripts Care Director and Healthix to collaborators

Next Steps

- Continue sub-contract development with collaborators
- Continue to achieve Organizational Milestones via Committees
  - Cultural Competency Strategy
  - Rapid Cycle Evaluation
  - Workforce Deliverables
  - IT Current State Assessment
  - Provider Engagement
- Operationalize projects by November 2015

Center for Community Health Navigation

Patricia Peretz, MPH
Manager, Community Health and Evaluation
NewYork Presbyterian Hospital

Adriana Matiz , MD
Associate Professor of Pediatrics
Columbia University Medical Center

NewYork-Presbyterian

COMMUNITY HEALTH WORKER MODEL

- Implemented in 2005
- Hospital-Academic-Community Partnership
- Community Health Workers
  - Community-based
  - Bilingual
  - Peer support & education reinforcement
  - Members of health care team

Peretz P, Matiz LA, et al. Community Health Workers as Drivers of a Successful Community-Based Disease Management Initiative. American Journal of Public Health: August 2012, Vol. 102, No. 8, pp. 1443-1446

PROGRAM STAGES

Stage 1 Months 1 - 3	**Stage 2** Months 4 - 6	**Stages 3** Months 7 - 12
Comprehensive Education	Monthly Check-In	Bi-Monthly Check-In
Home Environmental Assessment	Home Visit	Home Visit
Goal Setting & Service Referrals	Goals Check-in	Service Referrals
Provider-Led Asthma/Diabetes Workshops	Service Referrals	12 Month Follow-up
Baseline Survey	6 Month Follow-up	Graduation

*Frequency of check-ins and intensity of services determined by participant needs

PCMH SUPPORT AND EDUCATION

Implemented: February 2011

CHWs:

- Apply non-clinical, peer-based approach to reinforce key health messages
- Help patients understand diagnoses and uncover disease management obstacles
- Participate in multidisciplinary meetings and rounding

Impact: 5421 patients have received practice-based support & education since February 2011.

Matiz LA. et al. The Impact of Integrating Community Health Workers into the Patient Centered Medical Home. *J Prim Care Community Health*. 2014 Oct;5(4):271-4.

PROGRAM OUTCOMES

Asthma:

- 1104 patients enrolled in year-long program
- Retention at 6 months: 77%, at 12 months: 65%
- ED visits and hospitalizations decreased by more than 65% among graduates
- Nearly 100% of graduates stated that they feel in control of child's asthma

Diabetes:

- 343 patients enrolled in year-long program
- Retention at 6 months: 90%, at 12 months: 81%
- Nearly 60% of graduates improved their A1C levels
- Nearly 100% of graduates stated that they are able to cope and reduce their risk

PATIENT NAVIGATOR MODEL

- Implemented in 2008
- ACN-ED Partnership
- Based in 5 NYP EDs
- Patient Navigators
  - Bilingual
  - ED-Based
  - Peer support & education reinforcement
  - Members of health care team

ED-BASED SUPPORT AND EDUCATION

Patient Navigators:

- Help patients understand how best to access and utilize health care system
- Connect patients to on-site insurance resource
- Schedule follow up appointment(s) for patients
- Remind patients of upcoming appointment(s) and follow up to find out if they attended scheduled appointment(s)
- Support patients and their families to achieve the most successful plan for continuity of care

PROGRAM OUTCOMES

Cumulative to date:

- 52,000 patients served since 2009
- 91% of patients without PCP had new PCP appointment upon discharge
- 77% of patients with a scheduled follow-up appointment attended the appointment

Sub-sample:

- Emergency departments visits decreased by 36% among high utilizers post-navigation
- ACN Primary care visits increased by 80% for adults and 35% for children post-navigation

LESSONS LEARNED

- CHWs from the local community are uniquely positioned to build trusting partnerships
- CHWs can move fluidly between community and health care settings
- CHWs can be the “voice” of the community in clinical settings and bridge gaps in care
- Community partner involvement in all aspects of the program development and evaluation is critical to program success
- Theses models are transferable to other disease areas and other populations
- It is important to develop a sustainability plan early and to revisit it often

DSRIP REQUIREMENTS

- The DSRIP program will promote "community-level" collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years.
- Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.
- Employ qualified candidates for community health workers who meet criteria such as cultural competence, communication, and appropriate experience and training.
- Work with paraprofessionals, including peer counselors, lay health advisors, and community health workers to reinforce health education, healthcare service utilization, and enhance social support to high-risk pregnant women.

NYP PPS PROJECTS

Project	Key Features
Integrated Delivery System	• Integrated governance structure • Standardized clinical protocols and referral mechanisms • Integrated IT and reporting infrastructure • Level III PCMH
ED Care Triage	• Enhanced Patient Navigators embedded in ED (WC, CU, LM) • Connections to PCPs for <30 day follow-up visits • Warm handoffs to CBOs
Ambulatory ICU (ped and adult)	• Enhanced care coordination for high-risk patients (WC, CU) • Multi-disciplinary care teams, including specialists • CHW home visits
Care Transitions to Reduce 30-Day Readmissions	• Targeted RN care coordinators for most at-risk(WC, CU, LM) • Warm handoffs to post-acute providers and PCPs • Embedded pharmacy support • Follow-up phone calls • CHW home visits

NYP PPS PROJECTS

Project	Key Features
Behavioral Health and Primary Care Integration	• Integrated primary care teams into NYSPI and NYP clinics • Additional NPs for expanded capacity (CU)
Behavioral Health Crisis Stabilization	• Embedded care teams in CPEP, mobile crisis (CU) • CHW home visits
HIV Center of Excellence	• Enhanced care coordination for high-risk patients (WC, CU) • Enhanced relationships with pharmacies and CBOs • CHW home visits
Integration of Palliative Care into PCMHs	• Palliative care teams integrated into PCMH (CU) • Additional palliative care training for ACN and community PCPs • CHW home visits
Promote Tobacco Use Cessation	• Outreach through CBO with CHWs to reconnect (WC, CU, LM) individuals with primary care and smoking cessation treatment

NEXT STEPS

1. Launch the Center for Community Health Navigation
2. Expand models to Cornell & Lower Manhattan
3. Expand support to new populations
4. Expand and enhance training curriculum

CONTACT INFORMATION

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Community Engagement Plan

Project Advisory Committee
Wednesday, Oct 7, 2015
9am-11am

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State Requirements of the Community Engagement Plan

- The Community Engagement Plan must:
  - Clearly identify the stakeholders the PPS intends to engage
  - Outline the methods that will be used (i.e. in person, web-based, etc.)
  - Note how often the community will be engaged
  - Articulate the role of community stakeholders and if/how they will be involved in shaping the decisions and priorities of the PPS

Identify the Stakeholders

- **Current stakeholders: PPS partners, labor unions, government agencies, community members**
- **Who else do we want to engage? What voices are important to have around the table?**
  - **i.e. schools, churches, homeless services, housing providers and law enforcement agencies**
  - **PAC suggestions?**

Engaging Stakeholders

- Current model: quarterly PAC meetings, website, newsletter
- Other ideas:
  - Town Halls?
  - Workgroups to address particular issues facing the PPS?
  - Webinars?

Role of the PAC Member

- **Current role: to stay informed of PPS developments and provide feedback**
- **Other roles:**
  - **Inform PPS on the evolving needs of the community?**
  - **Recommendations for best practices?**
  - **Dedicated role for CBOs?**

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Patient Perspective

- **How can the PAC address and better understand patient issues and needs?**

Next Steps for the Community Engagement Plan

- **Share your suggestions for how to meaningfully utilize the PAC**
- **What topics would you like for us to cover in the future?**
  - **Updates from the State?**
  - **Information on projects?**
  - **Others?**