NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	6/24/16, 9-10am	**Meeting Title**	NYP PPS Clinical Operations Committee
Location	Heart Center Room 4	**Facilitator**	Dr. Emilio Carrillo, 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:** Emilio Carrillo, MD (NYP)
Alissa Wassung (God's Love We Deliver)	Tamisha McPherson (Harlem United)
Susan Wiviott (The Bridge)	Amy Shah (NYC DOHMH)
David Chan (City Drug & Surgical)	Maria Lizardo (Northern Manhattan Improvement Corporation)
Jean Marie Bradford, MD (NYPSI)	
Carol Cassell (Arch Care)	
Bill Mead (St. Mary's Hospital for Children)	

Meeting Objectives	**Time**
1. Review of action items from last meeting	2 mins
2. Meeting schedule, Sandy Merlino	5 mins
3. Community Resource Tool Workgroup, Lauren Alexander	2 mins
4. Update on the Cultural Competency/Health Literacy Workgroup/Review of the CC/HL Training Strategy, Emilio Carrillo	15 mins
5. Presentation on the Behavioral Health Projects, Julie Chipman and Brian Youngblood	30 mins
6. Identify action items for next meeting	2 mins

Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Invite P. Hernandez to next meeting to finish Healthix presentation	L. Alexander	4/22/2016	5/27/2016	Complete
Send Healthix questions in advance of P. Hernandez presentation	Committee Members	4/22/2016	6/17/2016	In progress

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Alissa Wassung (God's Love We Deliver)	
David Chan (City Drug & Surgical)	
Lauren Alexander (NYP)	
Morgan Brewton-Johnson (NYP)	
Brian Youngblood (NYP)	
Julie Chipman (NYP)	

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Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Move to a bimonthly, 2-hour meeting schedule beginning after the July meeting	L. Alexander	6/24/2016	7/22/2016	In progress
Develop monthly update to send to Committee on off-meeting months	L. Alexander/Co-Chairs	6/24/2016	8/31/2016	In progress
Submit Cultural Competency and Health Literacy Strategy to Executive Committee for approval	L. Alexander/E. Carrillo	6/24/2016	7/18/2016	Complete

Approvals:
The Cultural Competency and Health Literacy Training Strategy was presented for approval. Dr. E. Carrillo motioned to approve. S. Merlino seconded. All were in favor.

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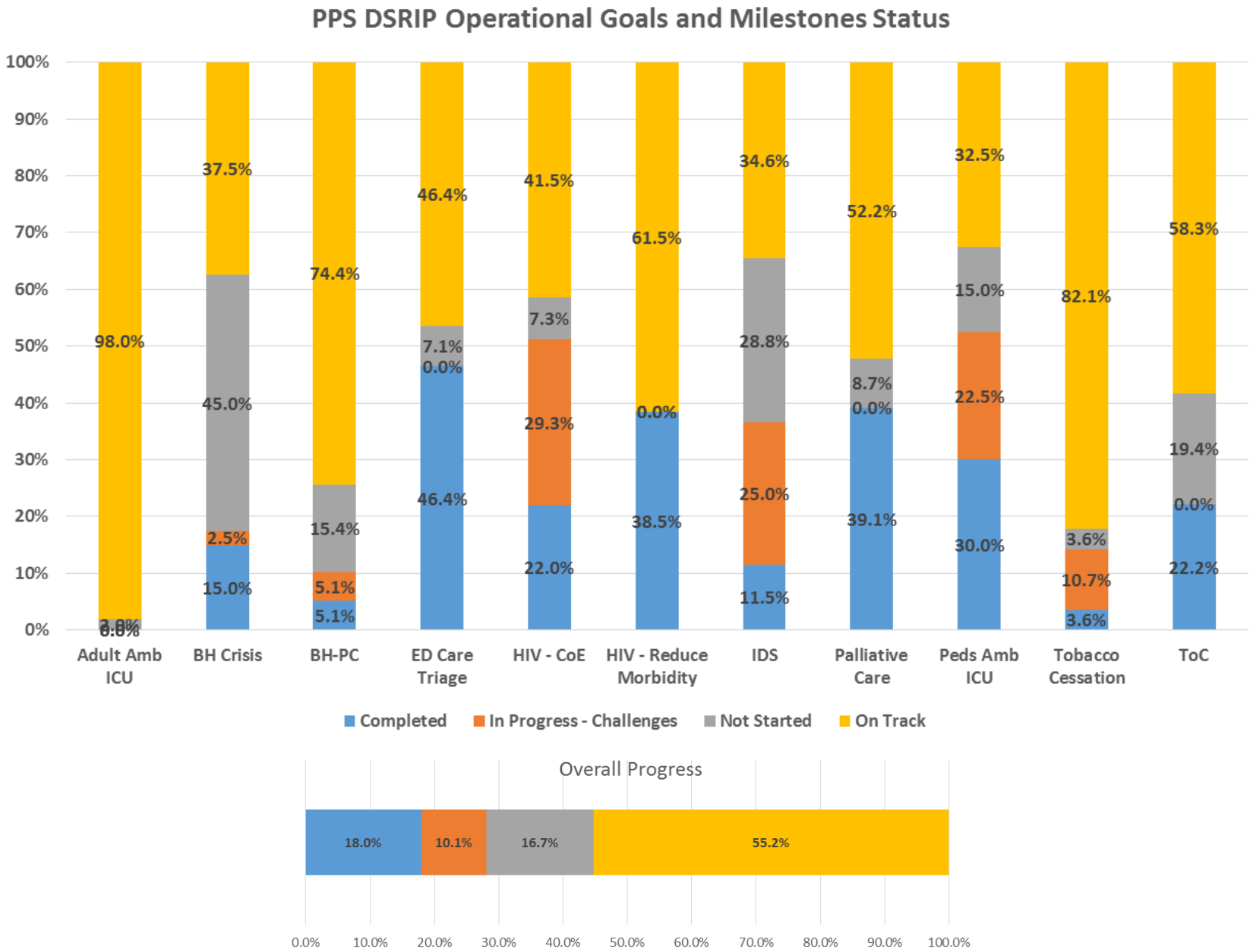
DSRIP Status Report
May 2016



Successes	Challenges
• Panel Manager Recruited [**Adult Amb ICU]** • Health Home Care Managers (Isabella) embedded into IDTs **[Adult Amb ICU]** • Paper-based referral system developed w/ Metropolitan Center **[Adult Amb ICU]** • Collaborator engagement [**HIV, Palliative Care, BH Crisis]** • Manual order implemented for Patient Navigators **[ED Care Triage]** • Completed guidelines for bedside introduction and phone visits **[ToC]** • Improved coordination with new BH leads **[BH Integration, BH Crisis]** • Recruited first CTI Team Member Case Manager **[BH Crisis]** • Successful on-boarding of Tobacco Cessation NP for West Campus ACN **[Tobacco]**	• Role definition for panel manager **[Adult Amb ICU]** • Information Systems challenges with NYSPI **[BH Integration]** • CHW Recruitment **[ToC]** • Staff Vacancy in CHW Program Manager [**BH Crisis, BH Integration, HIV]** • Health Home Referrals, hesitancy to refer to early since patients are clinically complex **[ToC]** • Turnaround time for acesss to data **[Peds Amb ICU, ED Care Triage]** • Labor transition challenges[**BH Crisis]** • Healthix rollout due to CRFP delays **[HIV]** • Clinical Space for Service Delivery **[Adult Amb ICU, Tobacco, Palliative Care]**

DSRIP Overview

Behavioral Health Projects

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NYP PPS Projects

- 2.a.i – Integrated Delivery System
- 2.b.i – Ambulatory ICU (Pediatric and Adult)
- 2.b.iii – Emergency Department Care Triage
- 2.b.iv – Care Transitions to Reduce 30-Day Readmissions
- 3.a.i Behavioral Health and Primary Care Integration (Model B)
- 3.a.ii – Behavioral Health Crisis Community Stabilization
- 3.e.i – HIV Center of Excellence
- 3.g.i – Integration of Palliative Care into the PCMH
- 4.b.i – Tobacco Cessation
- 4.c.i Decrease HIV Morbidity

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

NY State Requirements

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

Scale and Speed

Metric: The total number of patients receiving primary care services at participating mental health or substance abuse sites

Commitment: At the completion of Year 4, BH Integration will provide collocated primary care and behavioral health services to 2,258 patients annually.

Behavioral Health Projects

- **3.a.i Behavioral Health and Primary Care Integration (Model B)**
  - **Design: Where did we start and where are we now?**
  - **Population and sites: With whom and where are we working?**
  - **Collaborators: Who are our project partners?**

Behavioral Health Projects Integration– A Deeper Dive

NYSPI

- Embed two adult NPs in the NYSPI community clinics to function as part of the multidisciplinary care team
- Strengthen the workforce at the NYSPI clinics by providing their Peers training as CHWs
- Integrate routine preventive BH and PC screenings and protocols for + screens into clinic workflow
- Implement evidence-based medication management and care engagement protocols

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Behavioral Health Projects Integration– A Deeper Dive

NYP – The Ambulatory Care Network

- **Integrate SUD into the ACN's portfolio of universal preventive screens for adults and adolescents**
- **Provide access for ACN patients to SUD services at the ACNs, NYP Psychiatry Clinics, and collaborating CBOs**
- **Expand the Collaborative Care Model within the ACN**
- **Integrate routine preventive BH and PC screenings and protocols for + screens into ACN/Psychiatry clinic workflows**
- **Implement evidence-based medication management and care engagement protocols**
- **Support clinic and IT operations to facilitate changes**

Behavioral Health Crisis Stabilization (Project 3.a.ii)

NY State Requirements	
1	Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.
2	Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.
3	Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.
4	Develop written treatment protocols with consensus from participating providers and facilities.
5	Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.
6	Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).
7	Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.
8	Ensure that all PPS safety net providers are actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.
9	Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.
10	Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.
11	Use EHRs or other technical platforms to track all patients engaged in this project.

Behavioral Health Crisis Stabilization (Project 3.a.ii)

Scale and Speed
Metric: The total number of participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements. A count of crisis stabilization includes all activities for that one patient to help them back on their feet after an episode. A readmission/relapse counts as another instance for that patient.
Commitment: At the completion of Year 3, BH Crisis Stabilization will provide stabilization services to 1,300 patients annually.

Behavioral Health Crisis Stabilization (Project 3.a.ii) Current Vision

The Behavioral Health Crisis Stabilization DSRIP project will identify and divert non-emergent but in-crisis psychiatric patients (adults, children and families) from emergency, inpatient, outpatient and community-based organizations while linking them rapidly to nearby medical, social (housing, nutritional support, etc.), psychiatric, substance use and other providers as needed by the patient.

Behavioral Health Crisis Stabilization (Project 3.a.ii) How will we accomplish this?

Four Ways:

1) Create of a Behavioral Health Crisis “HUB” to provide rapid triage, assessment and risk stratification to assist providers to manage care needs of presenting patients in crisis.

2) Implement a community-based, mobile Critical Time Intervention-like (‘CTI-like’) team, linked to behavioral health access points within the hospital and community.

3) Collaborate with the NYP Ambulatory Care Network sites to discuss current crisis management procedures and invite stakeholders to form a workgroup to develop a shared, standardized protocol for assisting patients in crisis.

4) Embed resources and form partnerships with PPS Community-Based Organizations to assist patients in crisis bi-directionally and increase rapid access vital services through the PPS.

Behavioral Health Crisis Stabilization (Project 3.a.ii) Where are things today?

1) We are in the process of staffing the HUB and CTI teams; we anticipate having the right mix of staff to begin piloting the CTI team in July.

2) In July, we will be meeting with the leadership, clinicians and stakeholders in the Ambulatory Care Network site to learn about the needs of patients in crisis.

3) Our CBO relationships are a particular focus at this time with more collaborator outreach occurring in the coming months.

Q&A

Population Health Management

Milestone #1: Develop population health management roadmap

Minimum Standards of Supporting Documentation to Substantiate Successful Completion of the Milestone: The PPS must demonstrate that the roadmap has been successfully and formally established. The PPS must provider the IA:

- A copy of the PPS's population health management roadmap that addresses:
  - IT infrastructure required to support a population health management approach, such as the creation of a population health dashboard based on available data sets and registries.
  - Plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations, such as by using a learning collaborative for the necessary training and support to attain PCMH certification.
  - Identify priority target populations and define plans for addressing their health disparities by establishing goals that reflect the State of New York's Prevention Agenda.

- A list of PCMH 2014 Level 3 certified provider organizations

- Screenshot or reports from the IT system used to support the PPS's population health management roadmap.

Validation Process: As part of its oversight responsibilities, the IA will be validating the completion of Domain 1 milestones and measures. The IA will conduct a more extensive review of certain information to ensure the information submitted by the PPS is accurate and verifiable. Furthermore, the IA will:

- Review the population health management roadmap to assure that it meets the minimum standards.

- Review a random sample of the providers identified to verify their PCMG 2014 Level 3 certification.

- Review screenshots of the dashboard or output from other IT systems to ensure that IT infrastructure is sufficient to support the PPS' health management approach.

Minimum Standards of Supporting Documentation to Substantiate Ongoing Quarterly Report Updates: After the successful completion of the initial milestone, the PPS must provide the following information to the IA each quarter.

- Updates on the implementation of the population health management roadmap.

Validation Process: The IA will perform the validation process similar to the methodology described above.

Clinical Integration

Milestone #1: Perform a clinical integration 'needs assessment'

Minimum Standards of Supporting Documentation to Substantiate Successful Completion of the Milestone: The PPS must demonstrate that it has performed a clinical integration needs assessment. The PPS must provider the IA:

- A copy of a planning document that describes the clinical integration process which identifies:
  - The providers in the network who will be integrated.
  - Key data point for shared access and the key interfaces that will have an impact on clinical integration.

- List of providers who have been — or will be — integrated.

- Meeting schedules regarding the development of the Clinical Integration Needs Assessment document.
  - A template, ***"Meeting Schedule Template"*** has been developed to capture meetings, which have occurred in the past quarter. This template is mandatory and must be utilized to facilitate IA review. In completing the template, the IA is only looking for a list of meetings, dates conducted, and whether there are meeting minutes or an attendees list available. As part of random sampling the IA MAY request a list of attendees or minutes after review of the meeting template.

Validation Process: As part of its oversight responsibilities, the IA will be validating the completion of Domain 1 milestones and measures. The IA will conduct a more extensive review of certain information to ensure the information submitted by the PPS is accurate and verifiable. Furthermore, the IA will:

- Review the PPS's clinical integration 'needs assessment' to ensure that it meets minimum standards.

- The IA will contact a random sample of the providers identified to confirm their role in the PPS's clinical integration efforts.

- Review the meeting schedule and select a random sample of meeting dates and request and review the meeting agenda, sign-in sheets and meeting minutes for those dates. The ~~IA may also contact a random sample of individual listed in the meeting attendance list to verify their participation in the meetings.~~

- Ensure that technology and data components that are relevant for clinical integration are spelled out and data sharing agreements are in place.

Minimum Standards of Supporting Documentation to Substantiate Ongoing Quarterly Report Updates: After the successful completion of the initial milestone, the PPS must provide the following information to the IA each quarter.

- Updates on the clinical integration needs assessment whenever it is modified. If there have been no changes, the PPS should indicate that there have been no changes to the document.

NYP PPS Cultural Competence/Health Literacy Training Strategy

Approved by NYP PPS Cultural Competence/Health Literacy Committee, June 14, 2016

The NYP PPS Cultural Competence/Health Literacy Training Strategy is designed to help improve health and reduce disparities across the Performing Provider System. It is an important component of the overarching NYP PPS Cultural Competence/Health Literacy Strategy. Cultural competence and health literacy are necessary tools for the reduction of health disparities in vulnerable communities facing social and cultural barriers to quality health care. The National Quality Forum (NQF) has defined Cultural Competence as the ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable. Cultural Competency helps ensure that high quality care and patient safety are achieved equitably across the entire population.

An overarching Cultural Competence/Health Strategy has been formulated and ratified by the PPS (see Appendix 1). As part of that Strategy a Cultural Competency/Health Literacy Committee has been convened and this Cultural Competency/Health Literacy Training Strategy has been formulated.

The Cultural Competence/Health Literacy Committee (CCHL) is composed of content experts and front line health care providers from across the NYP PPS network. The Charter of the Committee is included as Appendix 2 and the Membership is listed under Appendix 3.

The Committee has formulated this Cultural Competence and Health Literacy Strategy in accordance with the National CLAS Standards and the NQF Comprehensive Framework for Cultural Competence as well as the findings of the Community Health Needs Assessment and the established body of knowledge and national Best Practices in Cultural Competence and Health Literacy training.

Guiding Principles of Training Strategy

The following four principles guide the training activities of the NYP PPS:

1. The trainings should adhere to standards and best practices as articulated in the federal CLAS standards and the NQF Comprehensive Framework for Cultural Competence.
2. The trainings follow a person centered cross-cultural approach that does not stereotype individuals. The trainings help distinguish between the culture of a population and the culture of the individual – the "Culture of One".
3. The trainings are informed by the findings of the NYP PPS Community Health Needs Assessment and reflect on those health disparities noted in certain populations.
4. The NYP PPS network draws from its rich diversity and wide-ranging experience when composing and selecting training curricula. A Central set of curricular resources are available for all collaborators, however collaborators may execute their own curricula in keeping with these Guiding Principles.

Implementation of Training Strategy

1. A Survey will be conducted to determine the training capacity and training needs of each collaborator.
2. The trainings will target patient facing staff, including Clinicians, Social Workers, Patient Navigators, Care Managers, Community Health Workers and Peers.
3. Collaborators will be encouraged to pursue their usual training procedures and abide by the Guiding Principles stated above.
4. Collaborators lacking training resources will be invited to participate in an annual training seminar hosted by the NYP PPS PMO and the Cultural Competence/Health Literacy Committee which will be a live, half day event, accessible on-line. The PPS will also provide online options for training, such as webinars or an online training available through the learning management platform. Collaborators may participate in external trainings conducted by GNYHA or other institutions as well.

5. The NYP PMO will track the progress of Trainings across the PPS.
6. Pre-post evaluations will be conducted before and after each training and will be reported to the NYP PMO which will track progress in the Learning System and will report as indicated to NYSDOH DSRIP.

Components of Training Strategy

- The NYP PMO will ensure that cultural competence, language access, and health literacy best practices, national standards and recommended curricular content, identified by the CCHL Committee, are shared across the PPS. NYP has gathered a collection of Cultural Competence/Health Literacy curricula and has offered educational and training programs for its staff since 2004. Each year over three hundred entering house-staff and fellows receive cultural competency training during their Orientation sessions in June and July. When the Patient Centered Medical Homes were established at NYP in 2010 a cultural competence and health literacy training was offered to ambulatory and emergency department staff. These trainings were again provided in 2013 and 2014 under the auspices of the NYS Medicaid Hospital Medical Home Demonstration Program. Similarly, all Key Personnel at NYP have received training during key personnel and the weekly Patient Safety and Experience assemblies. Three examples of such curricula are included as the Appendices 4, 5 and 6.

- Training modalities will suit the nature of the curriculum as well as the needs of intended audience. Trainings may be done live and/or remotely by Webinar.

- All trainings will be posted online in the Learning Management Platform.

- Quality Interactions, an on-line cultural resource will be provided to all collaborators. This resource provides basic skills in patient centered cross cultural communication as well as basic information on populations of interest to the NYP PPS. The QI tool also offers a Problem Based approach to cross cultural interactions which may be used as a study guide or at the time of patient care. The CCHL

Committee will host training Webinars to inform users how to maximize the benefit of this powerful tool.

- Cultural Competence trainings will include the following essential Curricular Core Elements:

a. Cultural sensitivity
b. Population based health disparities
c. Patient centered cross cultural communication
d. LEP interpretation and translation basics
e. Health literacy
f. Social, Cultural and Environmental Barriers to Health Care Access.
g. Teachback

Appendix

1. NYP PPS Cultural Competency Strategy
2. CCHL Committee Charter
3. CCHL Committee Membership
4. CLAS Standards Summary
5. Link to NQF Comprehensive Framework for Cultural Competence
6. Link to NYP PPS Community Health Needs Assessment
7. Hospital Medical Home Curriculum
8. GME Curriculum
9. PSF Culture of One Curriculum

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