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DSRIP Independent Assessor

Mid-Point Assessment Report

The New York and Presbyterian Hospital PPS

Appendix PPS Narratives

November 2016

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Prepared by the DSRIP Independent Assessor

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: The New York and Presbyterian Hospital

Project: 2.a.i

Challenges the PPS has encountered in project implementation:

The NYP PPS Integrated Delivery System (2.a.i) team has encountered a number of challenges in its implementation efforts, including: (1) CRFP funding delays have limited the ability to rollout Healthix and Allscripts Care Director (ACD) to collaborators, (2) meaningfully engaging all collaborators in the IDS and the nine clinical projects, (3) establishing the necessary legal, consent, and technical model to support care coordination across organizations employing Community Health Workers, and (4) addressing the operational challenges of expanding hours of operation at selected PCMH sites, and (5) delays in the initiation of ADT alerts to primary care providers due to privacy concerns

As it relates to the meaningful engagement of collaborators, there have been specific challenges related to: encouraging cross-collaborator engagement within the NYP PPS; streamlining referral processes; improving bi-directional communication between collaborators; and, the demands of multiple PPSs on collaborators.

Efforts to mitigate challenges identified above:

In order to mitigate the challenges identified above, the NYP PPS has:

1. CRFP Delays Effect on Healthix/ACD Rollout – the NYP PPS IS team continues to meet with collaborators to do the necessary planning prior to funding allocation. The Healthix RHIO team has been very helpful in coordinating the efforts around integration to their RHIO
2. Meaningful Collaborator Engagement - Collaborator as well as cross-PPS meetings have occurred to strengthen communication and processes between NYP and its PPS collaborators. These include a biannual collaborator symposium and one-on-one outreach meetings with minimally-engaged collaborators. The NYP PPS also continues to pursue efforts to expand the collaborators' knowledge of each other, including the identification of a vendor platform to maintain an updated inventory of community resources.
3. Technical, Legal, and Consent Framework – the NYP PPS established a subcontract model that supported the recruitment of CBO-based CHWs and peers and the rollout of the Allscripts Care Director (ACD) care management platform, develop a consent to support cross-PPS referrals, and instituted a new rollout project management plan to ensure that all necessary components were in place prior to initiation of services
4. PCMH Expansion of Hours - the PCMH teams continue to develop the necessary staffing plans, in collaboration with Union representatives, to ensure the appropriate resources are available for expanded access.

5. Demands of Multiple PPSs – wherever possible the NYP PPS has worked to align its survey efforts with those being used by other PPSs.

Implementation approaches that the PPS considers a best practice:

The NYP PPS IDS team considers the following activities a best practice:

1. Creating standardized referral processes across the PPS;
2. Developing standard risk stratification models across similar PCMH sites;
3. Developing EHR functionality to identify patients receiving multiple, often redundant services (e.g. enrollment in various disease- or initiative-based care management programs);
4. Embedding community health workers (CHWs) and peers in community-based organizations to work with the most at-risk patients across their homes, communities, and care team.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The NYP PPS Integrated Delivery System team has had success:

1. Developing EHR functionality to identify patients enrolled in multiple care management programs;
2. Streamlining referral processes across community-based organizations and providers;
3. Formed a workgroup to develop strategies to meaningfully engage all collaborators within the PPS network.
4. Integrated efforts with Health Home Administration to coordinate care management efforts, and optimize billing opportunities by referring patients through the Health Home in order to receive payments
5. Hosting biannual, PPS-wide collaborator symposia
6. Embedding Health Home care coordinators into Interdisciplinary Team meetings;
7. Creating IT enhancements such as referral orders and tracking lists to support community-based CHWs, peers, and substance use staff;
8. Standardizing Healthix consent workflow across PCMHs, creation of educational Healthix training materials for staff and patients, and training clinical and ancillary staff on Healthix consent process and overview;
9. Reviewed and implemented billing practices to ensure new DSRIP-funded programs/staff are sustained beyond the five year DSRIP program;
10. Contracted with Primary Care Development Corporation to ensure EHR systems used by independent community providers in the PPS network meet Meaningful Use and PCMH Level 3 standards;

11. Submitted application for 2014 Level 3 PCMH primary care certification for all 14? primary care provider sites within NYPH;
12. Surveyed PPS network on value-based payments, financial health, HIE and workforce;
13. Formed value-based workgroup to strategize path to sustainability;
14. Pursuing receipt of Medicaid claims data to understand network performance;
15. NYPH and ASCNYC co-investing in development of Community Empowerment Collaborative Training Center, to meet PPS and City CHW and Peer workforce needs;
16. Development of broad education for PPS network (palliative care, cultural competency, etc.)
17. Active communication through PPS website, newsletter, and outreach to non-engaged collaborators

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There have been no significant changes to populations that were proposed to be served through the project based on the community needs assessment.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: The New York and Presbyterian Hospital

Project: 2.b.i

Challenges the PPS has encountered in project implementation:
The NYP PPS Ambulatory ICU teams (separate for adults and pediatrics) have encountered the following challenges in their implementation efforts: (1) turnaround time for EHR and analytic enhancements, (2) recruitment of qualified candidates for enhanced PCMH services, (3) establishing the necessary technical, legal, and consent framework to support CBO-based community health workers, (4) increasing PCMH care team's knowledge of community-based resources, and (5) inefficiency in communication and referrals with collaborator facilities.

Efforts to mitigate challenges identified above:
The NYP PPS pursued the following activities to mitigate the Ambulatory ICU challenges identified above: 1. EHR / Analytic Development Time – the NYP PPS recruited dedicated IS and analytic staff to meet the increasing demand for new functionalities and actionable data; 2. Recruitment – The staff worked with the Human Resources team to do additional outreach to the necessary professional groups. The NYP HR team also hosted a care manager recruitment day to attract and interview qualified candidates for a variety of positions (inpatient and outpatient); 3. Technical, Legal, and Consent Framework – the NYP PPS established a subcontract model that supported the recruitment of CBO-based CHWs and peers and the rollout of the Allscripts Care Director (ACD) care management platform, developed a consent to support cross-PPS referrals, and instituted a new project management plan to ensure that all necessary components were in place prior to initiation of services; 4. PCMH Knowledge of Community-Based Resources – the Ambulatory ICU teams (Adult and Pediatric) have worked to embed health home care managers in PCMH sites (during interdisciplinary team meetings) and gain enhanced access to the various agencies' resources; developed a steering committee to guide community-based efforts; and, invited agencies to participate in interdisciplinary care team meetings. The Ambulatory ICU teams also held meetings with collaborator organizations to improve communication and streamline referrals (for example, a referral form was created and is being piloted with a community-based mental health organization) as well as bi-directional tours/ site visits.

5. To enhance the efficiency of the recruited staff, the PPS created a population health dashboard pulling information from EHR to identify last ED visit and inpatient admission for RN Care Manager follow-up.

Implementation approaches that the PPS considers a best practice:

The PPS is using several approaches considered best practices in the implementation of projects. One of these best practices includes weekly interdisciplinary team meetings to discuss high risk patients. Interdisciplinary team meetings provide an opportunity for the physician, nurse, care manager or other team members involved to enhance communication and coordination of the patient care experience. RN care managers use risk stratified registries to identify and manage the care of these patients. Another best practice used by the project is scheduling extended visits for patients identified as high-risk; these visits may include various members of the health care team besides the primary care physician such as the RN care manager, Psychiatric Nurse Practitioners, and community health workers (CHWs).

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The PPS Ambulatory ICU teams have recruited all identified staff, including two pediatric psychiatric nurse practitioners, 6.5 FTE RN care managers, two program managers, eight community health workers, one panel manager, one behavioral health care manager, and one depression care manager. The Ambulatory ICU teams (adult and pediatric) have begun to meet with collaborators to improve communication and streamline referral processes as well as engaging them in quarterly steering committee meetings. The Ambulatory ICU has also developed new workflows between PCMHs and collaborators; for example, referrals from inpatient units to post-acute providers will now include primary care physician information to ensure continued communication and coordination following an inpatient discharge.

Moreover, the PPS is in the process of testing risk stratification criteria for all NYP Ambulatory Care Network sites (already exists for pediatric population). This will allow uniform identification of children and adults that require additional care and/or care coordination.

Through the Ambulatory ICU efforts, the team has been able to identify over 6,000 children with special health care needs and over 1,600 adults with complex care needs in the PCMH sites.

Extended visits for children with special health care needs and adults with complex care needs are in the process of being fully implemented. These visits provide an opportunity for the patient to engage with their physician for an extended period of time, and have all their needs addressed by the care team as necessary.

Other IT initiatives include automated flags alerting front line staff that a patient needs extended visits, reconciling medication lists between primary care and specialty providers, and creating a population health

risk dashboard to effectively manage the patient population. A new care management note was created in the EHR to meet the needs of the pediatric population. The CHW assessments are also in the process of being built and will be ready for piloting in September.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There have not been any changes to populations that were proposed to be served through the project based on the community needs assessment.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: The New York and Presbyterian Hospital

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:

To date, five of the initial challenges the 2.b.iv project team has encountered in project implementation have been:

Patient stratification: Initially it was a challenge to identify the appropriate criteria for identifying patients at increased risk for readmission.

Prioritization of post-acute/community based organization collaboration opportunities: The PPS has a network of over eighty collaborators with various areas of expertise. Through initial implementation, it has been important to prioritize efforts with collaborators in order to focus on building meaningful relationships.

Electronic discharge paperwork transmission to next level providers: Lack of an automated solution to send discharge paperwork to post-acute collaborators, particularly primary care providers.

Access to primary care: The goal is for high risk patients to have follow-up appointments within 7-10 days of discharge. Primary care access is an ongoing challenge, particularly for patients who are not established with a primary care provider.

Program awareness within the context of a large academic medical center: The role of the transitional care nurse is relatively new, and there is an opportunity to expand awareness of the services and program benefits.

Efforts to mitigate challenges identified above:

The mitigation strategies associated with the five challenges noted above include:

Patient stratification – The project is utilizing a risk prediction tool to identify patients at highest risk for readmission. The tool includes medical factors that contribute to readmission risk – there are future plans to recalibrate to include social determinants.

Prioritization of post-acute/community based organization collaboration opportunities: The project has chosen to prioritize Health Home and Home Care collaboration initially in order to ensure appropriate patients are connected to long-term care management resources and develop standards for post discharge medication review, a critical intervention element, with home care nurses.

Electronic discharge paperwork transmission to next level providers: The project has developed a solution to electronically transmit discharge paperwork to next level providers, and the PPS is evaluating the potential to submit discharge documentation into Healthix.

Access to primary care: The project is collaborating with outpatient providers and call centers to develop an approach to expedite and streamline appointment scheduling for high-risk patients.

Program awareness within the context of large academic medical centers: The project welcomed a Physician Advisor who, as part of her role, will advocate on behalf of the program with peer groups, identify inter-professional transitional care advocates, and make recommendations on inter-professional venues across NewYork-Presbyterian to raise awareness of program services and benefits.

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Implementation approaches that the PPS considers a best practice:

The project team considers the elements below best practice for implementation:

Develop a standard workflow protocol: The project developed a transitional care protocol outlining the standard of care for patients during admission, and for thirty days post admission.

Embed transitional care nurses on the inpatient units: The project feels it is critical for the transitional care nurse to meet patients at the bedside to engage into services and build relationships.

Create/utilize patient education tools: The project provides diagnosis-specific patient education materials to reinforce red flags, disease, and self-management. Additionally, the project developed a 'Passport to Good Health' to help patients keep track of provider contact information, discharge paperwork, and follow-up appointments.

Monthly Staff Meetings: Each month, the project clinical leads and care managers have a meeting to discuss standards of care and invite guest speakers to provide in-services. Additionally, each month a care manager takes a turn presenting a case study to highlight patient demographics, social determinants, interventions, and outcomes. The case study format enables the team to learn from each other's methods and identify project barriers.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

In addition to quarterly reporting updates, the project has made strides in the areas below:

Recruitment: The project has on-boarded eight transitional care nurses across four hospitals, as well as five Community Health Workers in collaboration with three community based organizations.

Community Health Worker (CHW) model: The project has developed a CHW model to include home and follow-up appointment visits, including workflow and documentation standards. Projected implementation of the CHW model is Q3 2016.

Information Technology/Systems tools: The project developed an initial patient stratification tool that exists within the medical record, and is in process of developing an optimized version for implementation Q3 2016. The project also established an e-fax process for sending post discharge paperwork to community providers. Additionally, the project gained access to outpatient medical records systems of NewYork-Presbyterian's affiliated providers to optimize communication.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There have been no significant changes to populations that were proposed to be served through the project based on the community needs assessment.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: The New York and Presbyterian Hospital

Project: 3.a.i

Challenges the PPS has encountered in project implementation:
The Behavioral Health (BH) DSRIP team has encountered challenges in the project implementation of 3.a.i Model II. First, early BH DSRIP staff changes, including a project manager and project lead, created the need for project staff to adjust to new roles and reporting structures. Second, the contracting process between NYP PPS's primary collaborator, the community services branch of the New York State Psychiatric Institute, and the PPS has been lengthy, and recruitment and preparation of the physical space for implementation are pending contract finalization. Finally, while the NYP PPS's selection of Model 2 fits well with the NYSPI patient population and needs, updated baseline data reveal that the majority of the NYP Adult and Pediatric/Adolescent Psychiatry Clinic patients (where the majority of the attributed lives seek care) are connected to and engaged in regular primary care. The project team is implementing processes to identify and connect the small number of patients who do not have primary care; however, we are making meaningful and clinically-relevant adjustments to our model that are more in-line with Model I.
Efforts to mitigate challenges identified above:
The NYP PPS has made great efforts to mitigate the above challenges. First, the BH DSRIP project staff has worked closely with the NYP DSRIP Director on staff transitions and adjustments. Second, NYP and NYSPI have had multiple meetings involving staff and leadership to work on issues related to contracting. The BH project staff has worked with the NYSPI community services leadership to ready the clinic and staff for upcoming changes to clinic processes and culture during implementation, including starting the capital purchasing and recruitment processes prior to contract. Finally, the BH DSRIP team has completed an updated needs assessment using quantitative and qualitative data and determined ways to meet patient and community needs by integrating SBIRT and Collaborative Care into NYP primary care practices, and partnering with community-based providers to build capacity and expand community resources. The team is trying to creatively use resources to meet the existing needs while maintaining fidelity to Model 2 (due to the Domain 1 requirements) at the NYP sites. The NYP PPS has already expressed interest in applying for Model 1 in addition to Model 2 so that it can best meet patient needs.
Implementation approaches that the PPS considers a best practice:

Implementation approaches that the NYP PPS considers a best practice include: (1) Understanding the value of each collaborator to the PPS as a whole and as a network of providers and agencies. The NYP PPS makes an effort to share resources with collaborators and recognizes that, because collaborators bring significant assets to the table, bringing them together is integral to meeting patient and community needs; (2) doing sufficient due diligence to create a clinically-significant project design. All PPS must design and implement projects that meet patient and community level needs as well as DSRIP milestones and metrics; the NYP PPS encourages creativity and diligence in project planning and fosters the sharing of information and experience across projects and across PPS; and (3) Learning from pilots and PDSA cycles.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The BH DSRIP 3.a.i project has collaborated with other NYP DSRIP projects on IT/IS advances, including creating roles in the electronic health record for BH providers to self-select into so that anyone accessing a patient in the EHR will see a care banner with members of the patient care team, including the primary care provider and BH providers. The PPS BH team is working with other NYP DSRIP projects on streamlining workflows and referral processes with shared community-based organizations, including the Metropolitan Center for Mental Health and Argus Community, Inc. The PPS BH team is working to identify and engage additional CBO collaborators in Northern Manhattan and the South Bronx. Finally, at the NYSPI community clinics, three Peers were connected with a Community Health Worker training. The NYSPI is considering next steps to leverage their Peers' increased knowledge.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

As noted above, we conducted a BH-specific assessment on the primary care utilization and needs of the NYSPI community services clinic population and the NYP Adult and Child/Adolescent Psychiatry clinic populations. Our baseline data revealed that the NYSPI community services population would benefit from a Model 2 approach, though the NYP populations would better be served by an approach closer to Model 1.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: The New York and Presbyterian Hospital

Project: 3.a.ii

Challenges the PPS has encountered in project implementation:

In the midst of implementation of its originally conceived intervention, the NYP PPS received revised guidance from NYS concerning limitations on location of services rendered for the central component of the intervention - embedded staff within the CPEP to provide enhanced disposition planning and diversion from admission when possible. The NYS DOH and Account Support Team informed NYP that its current Crisis project design, as originally conceived, would not meet the requirements of the program and would not make it eligible for funding (meeting project requirements or patient scale and speed commitments). The NYS DOH/AST informed that the intervention, given its focus on reducing inpatient and ED utilization, must happen outside of the Emergency Department and CPEP. As a result, a comprehensive, rapid re-design was necessary to ensure the program met updated NYS requirements.

As mentioned above, the original recruiting for 3.a.ii staff focused on clinicians with specialized skills needed for practice within an Emergency Room setting. With the redesign of the project to be embedded in the outpatient system, the skill set of current providers had to be augmented for outpatient treatment while recruitment of future staff had to be re-evaluated to identify potential candidates who possessed the appropriate skills and community-based experience.

The 3.a.ii staff conducted interviews with patients and reviewed patient-level qualitative data to further understand the reasons for patients utilizing the emergency room. In addition to facing a dearth of available behavioral health services with immediate vacancies for patients in crisis, many patients sought ED care to alleviate acute periods of distress related to limited social supports, lack of stable and secure housing, the loss of entitlements, intoxication and safety. The diversity of patient needs and reasons for presenting the ED for assistance required a review of current staffing configuration and the recruitment of more staff to intervene across psychosocial domains in addition to acute mental health and medical care.

Efforts to mitigate challenges identified above:

Following NYS' guidance revision, the NYP PPS 3.a.ii team pulled together the program leadership, clinical staff and PPS stakeholders to review and research alternative models to provide crisis stabilization in an ambulatory setting. The team developed a continuum of care which included a centralized, telephonic triage and portable treatment component called the Behavioral Health Crisis "HUB" alongside the originally-conceived Critical Time Intervention (CTI) Team deployment. The team emphasized the need for an intermediate step between patients in crisis presenting in the NYP PPS and the use of the ED for crisis stabilization. The new model includes expedited referrals for a wide range of services, short-term crisis stabilization services, including psychotherapeutic and medication management treatment, and a community-facing CTI team which provides wrap-around services to patients who are largely disconnected from care and require the most intense level of support.

The NYP PPS 3.a.ii team spent several months ensuring that the current staff possessed the needed skills to provide crisis stabilization in outpatient and community settings. The two Nurse Practitioners who were working in the CPEP were transitioned to new roles in the NYPH Ambulatory Care Network during this period. For new staff, the recruitment process has focused on acquiring clinical and non-clinical staff that are experienced in working with a diverse patient population and flexibility to provide interventions in both outpatient and community settings.

The original project design focused heavily on prescribing clinicians (MDs and NPs) to fulfill the project requirements and deliver quality care to patients in crisis. With a greater understanding of the variety of needs presented by patients in crisis to the Emergency Department, the NYP PPS 3.a.ii team revisited this staffing model and focused more resources on meeting the unmet needs of patients in distress. The team will now comprise a smaller number of prescribing clinicians while increasing the capacity to meet acute psychosocial needs with Social Workers, Case Managers, Substance Use Disorder Clinicians and Community Health Workers. In addition, CBO collaborators have been integral in developing a safety net for critical service needs for patients in crisis. The NYP PPS 3.a.ii team continues to strengthen relationships with agencies that provide a wider range of potential service needs including housing, a continuum of substance use treatment, services for transitional age youth and HIV/AIDs treatment options.

Implementation approaches that the PPS considers a best practice:

The NYP PPS 3.a.ii project believes that the Critical Time Intervention has a strong empirical evidence base to support patients who present frequently to the ED in acute distress and provide wrap-around care to link these patients to community-based organizations. There is considerable peer-reviewed literature outlining the CTI framework and how it has been applied in a variety of settings with different configurations of clinicians and non-clinicians depending on the population-to-be-served's needs. Also, the NYP PPS 3.a.ii team is developing a novel screening and rapid assessment system to identify immediate care needs, risk stratification and level of care determination for patients who are referred to the BH Crisis HUB. While the literature is quite robust with screening and assessment tools for specific domains of need (Mental Health, Substance Use, etc.), there are limited clinical tools that put all of these concerns into a single instrument. It is our goal to develop this comprehensive determination of needs tool for use throughout the PPS. Finally, the team is researching ways to prevent crisis-level events through early identification of patients with the potential to go into crisis and develop proactive crisis intervention strategies in the form of crisis plans with outpatient recipients of services at the NYP Ambulatory Care Network.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The 3.a.ii project has recruited a wide-range of clinical and non-clinical staff to support the needs of patients in crisis. For the CTI team, we have recruited a Psychiatrist, a Social Worker, a Case Manager, a CASAC and a Community Health Worker. This in addition to the Nurse Practitioners hired in 2015. With the full complement of providers in place, efforts to operationalize and begin a pilot of the CTI intervention have accelerated dramatically with the addition of new team members.

The 3.a.ii project is nearing a go-live date in August for Allscripts Care Director, a care planning and collaboration platform, which is accessible to NYP staff and CBO collaborators to coordinate care, develop tasking for various team members and allow for communication of patient needs in real time.

The 3.a.ii team created a workgroup with the clinical staff at Project Renewal which operates the Department of Homeless Services (DHS) Fort Washington Shelter for Men which houses many shared patients receiving ED care at NYP. During collaboration over the past few months, the team has strengthened the relationship between the case management staff at Project Renewal and the clinical staff at the medical ED and CPEP to allow for on-site case conferences for patients are who are frequently presenting at the ED when indicated. In addition, the workgroup has developed new, faster processes for contacting overnight clinical staff at the Fort Washington Shelter for patients who present at the ED when the Project Renewal daytime clinical staff is not available.

The 3.a.ii project recently opened a large workroom space which will house the full team to allow for on-demand case conferences, program development and a space to receive calls from NYP PPS providers who are assisting a patient in crisis. By having the team in a centralized location, triage decisions and intervention deployment will be handled in real-time with face-to-face clinical discussions as needed.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

As stated earlier, the population to be served has largely been unchanged since the project's inception. However, the 3.a.ii clinical staff has uncovered a wider range of stressors than previously understood. As a result, the frequency of ED use metric is less valuable when viewed through a clinical lens. For example, a patient-level review of a cohort of frequent ED reveals some critical differences between each patient's underlying psychosocial and behavioral health reasons for a high frequency of ED use. This granular qualitative understanding of what drives each individual's frequent ED utilization has provided an immense amount of useful information beyond the population health-level of data. There are significant individualized needs for each patient presenting to the ED in crisis; integrating an individualized approach into project design allows for maximum flexibility to assist patients in distress is imperative to a successful crisis stabilization project.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: The New York and Presbyterian Hospital

Project: 3.e.i

Challenges the PPS has encountered in project implementation:

The NYP PPS 3.e.i project team has faced the following challenges throughout the first year of implementation: (1) due to an influx of additional resources through the acquisition of several grants, including three NYS DOH End-the-Epidemic grants, the HIV Center of Excellence (CoE) is suddenly faced with space challenges to accommodate the increasing staffing; (2) aligning new DSRIP-funded efforts with existing Medical Case Management (MCM) and other engagement-focused efforts, and (3) ensuring access to appropriate substance use treatment.

Efforts to mitigate challenges identified above:

To address the challenges identified above, the NYP PPS HIV CoE team pursued the following mitigation strategies:

1. Space - As a temporary solution the HIV CoE data management team moved into an off-site location, and is renting space from Columbia University. The HIV CoE obtained operational funding to support reconfiguration of existing space to support a revised visit flow that more efficiently uses the clinical space. Ultimately the project will depend on the final confirmation of the CRFP funding to create enough space for the expanded staff.
2. Alignment with existing initiatives – the HIV CoE went through a reorganization process, including the consolidation of the existing MCM programs and newly funded DSRIP programs under a single clinical lead.
3. Access to Substance Use Treatment – the HIV CoE team has collaborated with a community-based substance use provider (ASCNYC) to integrate a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) into the practice. DSRIP has supported a community health worker at Argus Community Inc. to ensure warm handoffs for high-risk patients in need of substance use services.

Implementation approaches that the PPS considers a best practice:

The success of the HIV CoE is dependent on sustainability and true integration of numerous CoE based grant funded programs, including DSRIP. The primary engine for integration has been through the STAR program (STAR stands for Stimulating Transformation of Technology and Team Structure to Reach PLWH). This is one of 15 demonstration projects under the "System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Healthcare Settings" initiative funded by the U.S. Health Resources and Services Administration's Special Projects of National Significance. DSRIP-funded HIV CoE initiatives are integrated through PDSA cycles that focus on enhanced panel-based clinical care teams, increased access and capacity, defined workflows, enhanced health information technology, improved care coordination, and improved integration of consumer input.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The project has successfully recruited the following staff: a program manager, data analyst, physician, adult nurse practitioner, psychiatric nurse practitioner, nurse care manager, practice care facilitator, a PrEP Coordinator and an inpatient care coordinator. Workflows have been developed to support same day access, inpatient to outpatient transitions of care (TOC), emergency department engagement in care and ambulatory retention in care. Since the start of the project, 140 patients have initiated Pre-exposure Prophylaxis (PrEP) making NYP the second largest provider of PrEP in New York City. An electronic medical record template to support TOC has gone live. Population health registries to support sexual health (including HIV/HCV/STI screening) across the New York-Presbyterian uptown Ambulatory Care Network (ACN) have been built and an institution wide HIV care cascade is nearly completed.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

Since the start of the project there has been a dramatic increase in the demand for HIV prevention services, especially Pre-exposure prophylaxis (PrEP), by communities at risk for HIV. While this is not a change in the populations in the original proposal, it is one indicator of a shift in community need and has required the project to re-allocate resources originally intended for a physician to support a PrEP Coordinator and a Nurse Practitioner dedicated to sexual health and HIV prevention to meet this increased need.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: The New York and Presbyterian Hospital

Project: 3.g.i

Challenges the PPS has encountered in project implementation:

The NewYork-Presbyterian 3.g.i project has encountered challenges due to (1) the speed at which the appropriate IS support could be developed, (2) the recruitment of staff with specialized palliative care competencies to address high-risk patients, and (3) the speed at which education can be rolled out to primary care practices that are currently involved in other DSRIP- and leadership initiatives.

The delays in IS enhancements have included documentation for the palliative care team, the creation of new clinic codes and scheduling templates for each clinician. Moreover, the project has also encountered delays in obtaining data analytics to identify potential patient population with unmet palliative care needs.

The NYP PPS also was challenged in recruiting a team (MD, NP, SW, RN Care Manager) with appropriate palliative care experience to support both direct service to the target population and the provision of education (webinars, case conferences, shadowing, etc.) to the primary care practices.

In rolling out generalist level education to the participating primary care practices, the 3.g.i project team has, as expected, also met some resistance from front line staff around their comfort level with discussing goals of care and end of life treatment with patients, as well as challenges related to merging the new education with other GME, DSRIP-funded, or practice leadership initiatives.

Efforts to mitigate challenges identified above:

To mitigate the challenges identified above, the PPS pursued the following strategies:

1. The project's documentation was fast tracked and sent to the appropriate clinical governance committee for approval. Future expansion clinic codes have been created for all outpatient facilities to prevent future delays.
2. A population health risk dashboard has been created (supporting both the 3.g.i and 2.b.i projects), which allows physicians the ability to actively engage with patients who meet the 'high risk' palliative care criteria.
3. The NYP PPS 3.g.i project has successfully recruited a full interdisciplinary team (MD, NP, SW, and RN Care Manager).
4. The PPS Palliative Care team has also made efforts to further embed themselves in provider practices to increase education about palliative care treatment, including webinars, educational sessions at interdisciplinary meetings, as well as support through tandem visits.

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Implementation approaches that the PPS considers a best practice:

The NYP PPS Palliative Care team considers the following three practices essential to ensuring success of the project to reinforce palliative care education and procedures:

1.) Monthly education across all disciplines, facilitated by palliative care experts;
2.) Concurrent/tandem visits with primary care teams to encourage generalist level palliative care;
3.) Provision of comprehensive palliative care services, by a Palliative Care specialist, for complex patients in collaboration with the primary care staff.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The NYP PPS 3.g.i project has successfully recruited a full interdisciplinary team (MD, NP, SW, and RN Care Manager). The team has created educational modules for the primary care physicians and has been providing generalist palliative care education through seminars, webinars, and during interdisciplinary team meetings (IDT). The team has also successfully integrated a palliative cares screening and risk assessment within the outpatient setting to address unmet palliative care needs. This has been done through the creation of a Population Health Risk Dashboard, which identifies patients with unmet palliative care needs based on our defined criteria. Additionally, to ensure patients have access to resources, the palliative care team engaged hospice based collaborators Metropolitan Jewish Health Center (MJHS), Visiting Nursing Service of NY (VNSNY), Calvary Hospital to develop robust guidelines for referrals.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There have been no significant changes to populations that were proposed to be served through the project based on the community needs assessment.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: The New York and Presbyterian Hospital

Project: 4.b.i

Challenges the PPS has encountered in project implementation:

The NYP PPS Tobacco Cessation team has encountered the following challenges during the first year of the project:

1. Metrics were not defined for Domain 4 projects, including tobacco cessation (4.b.i). For example, the RFP for 4.b.i. did not provide specific metrics or definitions for "poor mental health."
2. The tobacco project's goal is to establish tobacco programs in three distinct geographic areas in Manhattan, including Lower Manhattan, the Upper East Side and Washington-Heights/Inwood. However, each of these communities has distinct characteristics and community collaborators. The involvement of three hospitals (NYP/Weill Cornell Medical Center, NYP/Columbia University Medical Center & NYP/Lower Manhattan Hospital) within three ethnically diverse communities has required assessment and tailoring of tobacco cessation approaches.
3. The contractual process for recruiting Nurse Practitioners at a State-sponsored institution (New York State Psychiatric Institute) has also presented difficulties.
4. Identifying clinical space across 9 different practice locations for tobacco treatment has been another one of the project's biggest challenges.
5. Synchronization of efforts in overlapping communities is necessary for efficient interventions, coordination with community collaborators and better patient outcomes. Initially, NYC DOHMH identified itself as the facilitator for cross-collaboration between the NYC-based PPSs; however, there has been no significant activity towards achieving that goal.

Efforts to mitigate challenges identified above:

The Tobacco project has mitigated the challenges listed above through the following strategies:

1. Tobacco workflows have been aligned with other DSRIP initiatives to further collective metrics.
2. Cross-campus differences will be mitigated through bilingual staff, collaboration with local community-based organizations and culturally appropriate patient materials. The project has hired a Nurse Practitioner for the Columbia campus, who is fluent in English and Spanish. For the Lower Manhattan area, the project has been working with the Charles B. Wang Community Health Center to better understand the needs of the predominantly Asian Community and to connect patients to appropriate services. The project has also been working with New York City Treats Tobacco (NYCTT) to enable coordination of tobacco efforts in Manhattan and to enhance relationships with community collaborators. This was particularly important in building a relationship with the Charles B. Wang Community Health Center.

3. Relationships have been built with internal and collaborator stakeholders – especially those serving vulnerable populations - to collaborate on treatment efforts. This includes the creation of the Tobacco Steering Committee. The Steering Committee has addressed two areas that initially presented barriers – pharmacotherapy and mental health treatment. The Committee's efforts have enabled implementation of a pharmacy plan for administration of tobacco pharmacotherapy during provider visits and for coordination of the cessation attempt with local pharmacies. The Committee has also assisted in the engagement of mental health providers across the PPS to coordinate efforts and better align with other behavioral health efforts.
4. Space issues were mitigated by engaging practice administrators and adjusting hours of clinical operation to accommodate the new program. Additional modifications will be made as the program matures and additional clinical space becomes available.

Implementation approaches that the PPS considers a best practices

The basis for the tobacco project's efforts has been a robust assessment of current practices around tobacco treatment within the PPS. This included a gap analysis to identify barriers in practice, provider knowledge and access to resources. Analysis methods included surveys and key informant interviews of health care providers including physicians, medical residents, social workers, medial assistants, dentists and dental hygienists. The findings from the surveys and interviews enabled the development and implementation of a tobacco treatment program that is comprehensive and able to provide cessation assistance to a vulnerable population.

Provider feedback was integrated into the development of a comprehensive standard observation screen for tobacco treatment within the electronic medical record. In doing so, the project implemented an interface that is not only Meaningful Use-compliant, but one that will also facilitate the implementation of tobacco cessation into everyday practice. Integration of tobacco into existing primary care and behavioral health workflows encourages an interdisciplinary approach to cessation while mitigating the possibility treatment occurring in silos.

To build provider capacity, the project has also provided comprehensive training in tobacco treatment interventions. This one-week course enabled providers to receive evidence and science based education in tobacco cessation. The attendees of this course are now eligible to become certified tobacco cessation treatment specialists. The project has also provided tobacco cessation education to community collaborators. This aspect of the training program will expand and serve as a model resource for tobacco treatment expertise and dissemination.

All aspects of the Tobacco project have been cultivated with sustainable systems change in mind. This includes development of a long-term business plan to ensure that cessation treatment will endure well beyond DSRIP funding.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

To date, the Tobacco project has:

1. Completed a needs assessment of the NYP/Columbia University Medical Center Ambulatory Care Network practices,
2. Implemented tobacco treatment across 9 outpatient practice sites (NYP/CUMC ACN PCMHs)
3. Trained 23 clinicians to become Certified Tobacco Treatment Specialists
4. Submitted recommended modifications to EHR tobacco screens for optimal documentation of tobacco use and assistance.
5. Identified online training modules to increase provider capacity for treating tobacco use.
6. Engaged collaborators within the Tobacco Cessation Steering Committee.
7. Enabled collaborative activities on tobacco cessation across projects with the NYP PPS including Care Transitions, HIV and Behavioral Health.
8. Established tobacco training opportunities and programs for primary care providers and community collaborators.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes have been made to our proposed population.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: The New York and Presbyterian Hospital

Project: 4ci

Challenges the PPS has encountered in project implementation:
The NYP PPS 4.c.i team has encountered the following challenges to date: (1) the execution of several service agreements with PPS partners were initially on hold due to delays in DSRIP award notification and project level funding, followed by back-and-forth negotiation of contract language between NYP and PPS collaborator legal teams; (2) implementation of a shared IT platform with core PPS collaborators has been delayed by the combination of a turnover in IS staff, a lengthy stakeholder vetting process, and complicated consent considerations to facilitate cross-agency sharing of protected health information. Lastly, the use of Article 28 waiver to embed needed clinical services at PPS partners was delayed d pending PPS notification of the receipt of the waiver and the institutional vetting process for offsite activities.

Efforts to mitigate challenges identified above:
Service agreements with five out of six core PPS collaborators for the 4.c.i. project have been successfully executed, with the sixth in active negotiation. With a change in the IS leadership structure, the project specific IS work plan has been moving forward in a more coordinated and efficient manner. Workflows and draft assessments are completed in the care management tool, Allscripts Care Director (ACD), and service agreements for ACD and Healthix integration are in progress. The project leadership continue to work with registration, IT and legal to address remaining barriers to Article 28 offsite waiver implementation.

Implementation approaches that the PPS considers a best practice:
Starting in June of 2015, the project leadership established a community based shared governance structure through the formation of the REACH Collaborative (REACH stands for Ready to End AIDS and Cure Hepatitis C). The REACH Collaborative consists of senior leadership from 7 collaborators (NYP plus 6 CBOs) who have met monthly to review operations and strategy to reach DSRIP and NYS DOH End-the-Epidemic goals. DSRIP-funded REACH Collaborative staff form a cohesive cross-agency team who will use a shared IT platform to provide coordinated, patient-centered care. More recently, the REACH Collaborative has been leveraged to obtain several End-the-Epidemic and HIV testing grants which will help serve to create sustainability beyond DSRIP to continue to support meeting community-based sexual health and social service needs.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
The project has successfully recruited and trained 11 community based staff (equivalent of 7.4 FTE) including: 6 peers, 4 community health workers (CHW), and one assistant director of outreach supported through DSRIP funds. This cross-REACH integrated team have already started to support efforts in outreach, screening, linkage, and retention for needed support and clinical services as well as providing patient centered health coaching and navigation support. In addition, the NYP PPS has identified dedicated community based health home care managers to be integrated into 2 out of the 3 NYP HIV CoE sites. The PPS is also in the final stages of approving a vendor for a mobile resource mapping tool to help link clients to needed social and clinical services. With the Allscripts Care Director workflow and assessments in development, next steps are the execution of service agreements and user training prior to implementation the cross-REACH shared IT platform.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
Since the start of the project there has been a dramatic increase in the demand for HIV prevention services, especially Pre-exposure prophylaxis (PrEP), by communities at risk for HIV. While this is not a change in the populations in the original proposal, it is one indicator of a shift in community need and has required the project to re-allocate resources originally intended for a physician to support a PrEP Coordinator and a Nurse Practitioner dedicated to sexual health and HIV prevention to meet this increased need.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: The New York and Presbyterian Hospital

Project: 2.b.iii

Challenges the PPS has encountered in project implementation:

The NewYork-Presbyterian Performing Provider System (NYP PPS) ED Care Triage project team has encountered the following challenges in project implementation:

The ED Care Triage project team worked with PPS IS staff to develop specifications for needed EHR functionality, including an electronic consult order for Navigator services to connect patients presenting in the ED to primary care and other services after an ED visit. The specifications of the electronic consult order included functionality to track orders generated by tracking them in a list that was to include orders that remained unassigned. Once assigned, orders were to drop from the list. Deviations from these specifications were encountered, resulting in unassigned orders dropping from the list before they were assigned and limiting the team's ability to track and service orders for Navigator services.

Following the implementation of the electronic consult order mentioned above, analyses of referral volumes revealed higher-than-expected volumes and staff's limited ability to service all referrals made for Navigator services.

As part of the project, the team is currently working on expanding the Navigator service to NewYork-Presbyterian Lower Manhattan Hospital. A challenge the team encountered was the ability to recruit culturally competent and linguistically capable staff to meet Lower Manhattan Hospital's diverse patient population.

The ED Care Triage team has also encountered challenges in balancing the need to capture additional information on registered patients (e.g. whether or not they have a primary care physician) with placing additional burden on existing emergency department staff (e.g. nurses, social workers, registrars). This has limited the Navigator team's ability to accurately identify a target population with no PCP relationship.

Efforts to mitigate challenges identified above:

In an effort to mitigate the challenges identified above, the NYP PPS ED Care Triage project has engaged in the following activities:

First, the project team developed specifications for IT functionality in extensive detail and mitigated IT challenges by allocating time and resources to address deviations from specifications during implementation. The team engaged in a continuous and collaborative effort to troubleshoot and test the various workflows and IS system functionalities in the EHR to make sure challenges were identified, prioritized, and addressed in a timely manner. Furthermore, the team planned and prepared extensively for the rollout of the electronic consult order by generating implementation checklists, reference tools to document new processes, and best practices guidelines to set a clear vision for implementation.

Second, the team is continuously monitoring volume of referrals to identify gaps in care and missed interventions and has collaborated with IT to address the deviations from the original EHR functionality and specifications. Furthermore, the team developed a prioritization methodology to ensure high priority cases were consistently defined, identified, and prioritized.

Third, the team engaged the NewYork-Presbyterian Hospital Talent Acquisition team to secure culturally competent candidates to launch the program in the Lower Manhattan Hospital.

Lastly, the project team is collaborating and engaging clinical staff in the ED through ED clinician leadership to ensure workflows are in place to retrieve needed information for the program.

Implementation approaches that the PPS considers a best practice:

The implementation approaches that the NYP PPS ED Care Triage project team considers best practices include the following:

1. Developing specifications for IT functionality in extensive detail to ensure clarity of intended functionality and a clear description of needed capabilities.
2. Continuously testing and troubleshooting workflows and IS systems to ensure challenges are identified in a timely manner and addressed.
3. Planning and preparing for implementations by deploying implementation checklists, reference tools to document new processes, and best practices guidelines to set a clear vision for implementation.
4. Experimenting with reporting and data analytics to identify what insights and analyses are useful for the project. Once critical analyses are identified, advanced analytics resources can be deployed to automate identified analyses.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The NYP PPS ED Care Triage project reports the following details on the project implementation efforts:

First, the project has piloted various tablets to evaluate the integration of mobile technology into the ED Care Triage project workflow in the ED. The efforts explore the value of having Navigators access patient information in real time from anywhere in the ED and identified key challenges and developed tablet implementation plans.

Second, the project has successfully recruited staff for expansion of the program at NYP/Milstein Hospital, NYP/Morgan Stanley Children's Hospital of New York (MSCHONY), NYP/Allen Hospital, NYP/Weill Cornell Medical Center, and NYP/ Lower Manhattan Hospital.

Third, the project has implemented (as mentioned above) the electronic consult order for Navigator services in the emergency departments in Milstein, MSCHONY, the Allen, and Weill Cornell. The project also developed workflow and supporting EHR technology to track and prioritize referrals.

Fourth, the project developed cross-collaborator workflow to connect ED patients to outpatient HIV services on the NYP/Weill Cornell Medical Center campus, which is then responsible for outreach and getting the patient for subsequent care.

Lastly, the project is finalizing the first phase of efforts to streamline monthly reporting and analytics for the ED Care Triage program.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There have been no significant changes to populations that were proposed to be served through the project based on the community needs assessment.