



**Department  
of Health**

# DSRIP Independent Assessor Mid-Point Assessment Report

NYU Lutheran Medical Center PPS

Appendix PPS Narratives

November 2016

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Prepared by the DSRIP  
Independent Assessor



# Department of Health

## DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting the overall organizational efforts to date.

**PPS Name:** NYU Lutheran Medical Center

### Highlights and successes of the efforts:

The NYU Lutheran PPS has made immense progress as it relates to data connectivity, security, and technological solutions. The PPS has worked with our partner QE, Healthix, to connect key PPS partners to their system, with 84% of our attributed population now covered by a Healthix-connected partner. We have completed the IT Security Workbooks and instituted the corresponding controls. We are currently working to implement a Salesforce customer relationship management solution to enhance PPS management, data sharing, as well as further strengthen communications with our partners. NYU Lutheran has also worked to implement Epic as our new electronic medical record system, which is scheduled for go-live on August 28<sup>th</sup>, 2016.

The NYU Lutheran PPS is driving towards a long-term, sustainable strategy to provide highly integrated care, reduce unnecessary inpatient and emergency department utilization, and expedite the collective move towards Value Based Payment (“VBP”) arrangements. To achieve these goals, we have focused our efforts on establishing the mechanism that will allow for risk contracting on behalf of our PPS, through the creation of a new Medicaid-focused, Independent Practice Association (“IPA”)-based clinically integrated network. The immediate focus will include enhancing information technology connectivity, developing clinical protocols focused on improving quality while reducing unnecessary spend and dedicating resources to provide highly coordinated care to our patients. Over the past few months, NYU Lutheran PPS has created a new legal entity and has begun to enroll PPS partners, with the initial focus on the enrollment of Federally Qualified Health Centers (“FQHCs”) and other providers whose primary focus is the care of Medicaid beneficiaries.

With the creation of the IPA, we are preparing to transition existing Fee for Service (“FFS”) contracts to Level 1 or Level 2 arrangements, and to work with existing Managed Care payors with VBP contracts in place to move towards a higher risk level. To prepare for these VBP arrangements, significant activities are underway, including: partner assessments to understand the readiness to move towards risk, building the infrastructure to support VBP arrangements, engaging payors in discussions on moving to VBP, using powerful analytical capabilities to understand the population and total cost of care, and developing patient-centered interventions to ensure patients are receiving the highest quality care in the appropriate setting.

To date, the NYU Lutheran PPS has completed a variety of Domain 1 milestones and will continue to strive towards the completion of milestones across all Domains as the DSRIP Program continues.



## DSRIP Mid-Point Assessment - Project Narratives

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

**PPS Name:** NYU Lutheran Medical Center

**Project:** 2.a.i

### Challenges the PPS has encountered in project implementation:

The NYU Lutheran PPS has encountered several challenges with Project 2.a.i (Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management) relative to the following areas: PCMH Status, IT Connectivity, MCO Contracting, Patient Engagement, Provider Engagement and receiving timely, accurate, valid and meaningful data. Each respective field has its own challenges.

- With PCMH Status, significant funding and efforts are required to support partners' meeting PCMH NCQA 2014 Level 3 status. Partner buy-in and compliance will be essential in moving forward to achieve the appropriate levels of PCMH statuses.
- Whereas in IT connectivity, significant money and expertise is required to meet EHR, data sharing and HIE connectivity requirements.
- MCO contracting is complex and has considerable legal structural impediments. The Collaborative Contracting Model requires that each partner remain autonomous.
- Patient Engagement involves the difficulty of engaging hard to reach patients, many of whom may have little familiarity with the health care system.
- Provider Engagement consists of challenges to engage some providers to follow IDS care coordination protocols, use standardized interventions/tools and participate in performance management programs.
- There is a significant risk with the State not transmitting timely, accurate, valid and meaningful current patient-specific data on our attributable population required for population health management.



## Efforts to mitigate challenges identified above:

The NYU Lutheran PPS has noted the following efforts to mitigate the challenges identified in the section above.

- **PCMH Status:** PPS is making considerable efforts to help partners achieve or maintain their PCMH statuses. To date, approximately 150 PPS providers have achieved or maintained a PCMH status designation. The PPS has conducted a current state assessment to identify the PCMH statuses of our PPS partners and will continue to make efforts in this area as the DSRIP Program continues.
- **IT Connectivity:** PPS has conducted a current state assessment to help develop a gap analysis. This strategy informs which PPS partners to prioritize when expending resources and timing to support partner's EHR/HIE connectivity implementation. PPS will continue to leverage NYU's HIE platform that already connects 26 different EHRs from various institutions, provides technical assistance to partners without existing EHRs, and help establish connectivity to HIE and the RHIO.
- **MCO Contracting:** PPS has been meeting with MCOs to better coordinate population health efforts and looking to develop shared savings models and other risk-bearing structures. Additionally, the PPS is working with partners to enter into risk-based contracts.
- **Patient Engagement:** PPS has been meeting actively engaged targets throughout DY1 and DY2, Q1 and will continue its efforts in this area through coordinating, training, equipping and deploying Community Health Workers as a key element of the community-based patient navigation strategy, partner with CBOs to support outreach and navigation activities that are culturally competent and accessible, and develop multilingual patient outreach and education materials.
- **Provider Engagement:** PPS has identified clinical project leaders to serve as project champions and build support across the network leading to move towards an optimally integrated network. The PPS will continue to attempt to actively engage providers as this will be crucial as the DSRIP Program continues.
- **Data:** PPS will try to make best use of data provided by the State.

## Implementation approaches that the PPS considers a best practice:

NYU Lutheran PPS is currently researching implementation approaches and best practices in creating an Integrated Delivery System that is focused on evidence-based medicine and population health management. In the coming months and DSRIP quarters, the PPS intends on working closely with partners, CBOs and other PPSs to effectively collaborate and collectively move towards achieving the goals of the DSRIP Program.



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

At this time, the PPS is actively moving and working towards creating an Integrated Delivery System that is focused on evidence-based medicine and population health management. Focus areas will include, but are not limited to: PCMH Status, IT Connectivity, MCO Contracting, Patient and Provider Engagement, and using data to achieve improved quality and performance within the system.

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

The population that is proposed to be served remains fairly consistent with what was initially identified through the CNA (Community Needs Assessment). The PPS will continue to focus on efforts in the community, focus on improved quality measures, meeting DSRIP deliverables, and moving towards population health management.



## DSRIP Mid-Point Assessment - Project Narratives

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

**PPS Name:** NYU Lutheran Medical Center

**Project:** 2.b.iii

### Challenges the PPS has encountered in project implementation:

- Ensuring patients have access to Primary Care Providers in the community with extended hours.
- Populations with a pattern of high ED utilization are resistant to changing their care patterns. Cultural barriers are also tied to resistant to change behavior. A survey conducted in the NYU Lutheran ED showed that a number of large percentage of patients utilize the ED as a Primary Care office.
- IT infrastructure and timing limitations - interconnectivity is key to closing the coordination of care gap that exists today in the healthcare community.
- Inconsistent funds flow to the PPS at the beginning of DY1 impacted the ability to launch resource intensive interventions.

### Efforts to mitigate challenges identified above:

- To address care patterns of high ED utilizers –a Community Health Worker (CHW) program will be implemented as a part of the Patient Navigation Center. This model has been used by University of Pennsylvania and shown to be effective in reducing avoidable ED visits and re-admissions. High utilization is linked to behavioral health, substance use, as well as social issues that impact impoverished communities. These factors affect the patient’s ability to effectively self-manage his or her medical conditions. The CHWs will help patients make and maintain connections to essential medical, behavioral health, and social services in order to improve the patient’s ability to care for him or herself. This will be done by assessing needs, creating a transitional plan, and by providing a “hands-on” intensive 30 day follow after the patient leaves the ED. If a patient requires ongoing support beyond the 30 days the CHWs will provide a warm handoff to the next level of care management services (e.g.- New York State’s Health Home program). Through the Patient Navigation Center referrals to appropriate medical, behavioral health, and social services during the 30 day follow the program will drive down ED usage by patients struggling with behavioral health, substance use, and complex medical conditions.



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- Community Health Workers that are culturally sensitive will be hired to help address resistance to change due to cultural barriers. In effort to mitigate this challenge Community Health Workers will receive cultural competency training as part of their on-boarding process. To impact patients' perceptions and use of the ED for convenient comprehensive care, the PPS will promote the benefits of primary care provider engagement and the downside of unnecessary testing. We will coordinate our efforts with local Community Based Organizations that can reinforce the message in a culturally appropriate manner in the community.
- NYU Lutheran PPS works closely with Healthix to connect our partners to the RHIO to ensure continuity of care through DSRIP and beyond. Information technology is key to improving the population's health through reduction of variation in processes across providers.

## Implementation approaches that the PPS considers a best practice:

- Implementing a Community Health Worker (CHW) program within Lutheran Hospital and Emergency Department will allow the PPS to identify frequent utilizers and the highest risk patients. The intensive 30 day follow by CHW will provide the best opportunity to fully understand the patient's needs and ensure that they are connected to a the primary care physician and other community based supports including behavioral health services, Health Homes, and other community based programs addressing social determinants of health.
- In addition to the CHW program the Lutheran PPS will be creating positions to address specific non-clinical patient needs such as Housing and Health Care Benefits. Focusing on these key non-clinical areas will address "upstream" social determinants that impact our patients' ability to tend to their physical and mental health care.

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

- NYU Lutheran care coordination model includes the two focus areas detailed above as well as a proactive telephonic care coordination program staffed by LPNs and LCSWs. The staff will provide telephonic care management services to high risk patients who do not qualify for New York State's Health Home program and will target patients for support before they visit the ED or end up in the hospital. This combination of services will enable us to identify high risk patients within our PPS population, support their transitions across the continuum of care, and connect them with local physicians and community based organizations to address health, mental health, and social determinants that will ultimately reduce unnecessary that impact hospital & ED utilization.

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



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- There were no changes identified in the community needs assessments and therefore, there are no changes to the populations that were proposed to be served through the project.





## DSRIP Mid-Point Assessment - Project Narratives

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

**PPS Name:** NYU Lutheran Medical Center

**Project:** 2.b.ix

### Challenges the PPS has encountered in project implementation:

- Observation Unit Staffing – Speed and Scale required hiring and training of additional physicians, physician assistants, nurses, case managers and social workers and meeting implementation goals.
- Supporting Services – Aligning key clinical and non-clinical support services with the operational needs (ie. prioritization and availability) of an Observation Unit, which previously were not required.
- EHR – Lack of an integrated EHR across inpatient and outpatient system-wide platforms to allow seamless and rapid availability of clinical data

### Efforts to mitigate challenges identified above:

- Observation Unit Staffing – Interim staffing unit solution implemented to bridge during the period of onboarding permanent clinical staff
- Supporting Services – Established new strategic relationships and workflows with key clinical and non-clinical support services to support efficient and effective resourcing of the Observation Unit
- EHR – Interim documentation templates created to bridge period of existing EHR(Vista) until implementation of Epic, a single system-wide EHR

### Implementation approaches that the PPS considers a best practice:

- Operate a dedicated, protocol-driven Observation Unit with specialized staff and leadership is the best practice model for delivering observation services, which previously did not exist at NYU Lutheran Medical Center
  - Based on the experience at NYU Langone Medical Center with the delivery of observation services in a dedicated observation unit, a similar best practice model is being implemented at NYU Lutheran Medical Center, under the guidance of system-wide leadership.



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

- The Department of Emergency Medicine will assume the responsibility of delivering and administering observation services as of August 1<sup>st</sup>, 2016
- The go-live date for Epic implementation at NYU Lutheran is August 28<sup>th</sup>, 2016
- Strategic relationships with key clinical and non-clinical services at NYU Lutheran continue to be forged to support the operation goals of the observation unit

Year, Quarter		DY1,Q4 (DSRIP Year 1 Total)	DY2, Q1
<b>PPS Reported</b>	Baseline Commitment	131	46
	Quarterly Update	<b>234</b>	<b>92</b>

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

- There were no changes identified in the community needs assessments and therefore, there are no changes to the populations that were proposed to be served through the project.



## DSRIP Mid-Point Assessment - Project Narratives

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**PPS Name:** NYU Lutheran Medical Center

**Project:** 2.c.i

### Challenges the PPS has encountered in project implementation:

The Patient Navigation Center (PNC) has a broad mandate, encompassing many functions and roles, as well as serving as an integrator across projects, sites and partners. Designing the project has required close alignment with other projects and some dependence on the timeliness of those projects. As a result, the PNC was the last of the clinical projects to officially form.

Given the range of services and supports that will be delivered by the navigation center it took time to prioritize which services to roll out and when. Both “hands on” direct service supports as well as technological solutions had to be considered when thinking about maximizing impact of community based health navigation services. Evaluating the numerous vendors in the market providing population management solutions and considering how these systems interface with existing electronic health records and the PPS has proven to be a challenge.

### Efforts to mitigate challenges identified above:

The core planning group, consisting of Care Management, IT, and Project Management, with others invited as necessary, has been meeting weekly to finalize the PNC design and create a phased in approach. Since then regular calls and updates between the core planning group have remained constant.

Throughout 2015 a variety of technology companies were evaluated to explore fit with PNC. Companies reviewed provided automated phone/text support (care transitions/disease management/gaps in care), community resource guides, and care management platforms. The PPS has made some initial selections laying the framework for partner connectivity. The PPS and PNC team continues to review additional technological platforms for expanding navigation support beyond the first phase of services that will be delivered by the PNC.



## Implementation approaches that the PPS considers a best practice:

We will use Community Navigators in both clinical and non-clinical roles to support the PPS. Implementing a Community Health Worker (CHW) program within Lutheran Hospital and Emergency Department will allow the PPS to identify frequent utilizers and the highest risk patients. The intensive 30 day follow by CHW will provide the best opportunity to fully understand the patient’s needs and ensure that they are connected to a primary care physician and other community based supports including behavioral health services, Health Homes, and other community based programs addressing social determinants of health.

In addition to the CHW program the Lutheran PPS will be creating Community Navigator positions to address specific non-clinical patient needs such as Housing and entitlements. Focusing on these key non-clinical areas will address “upstream” social determinants that impact our patients’ ability to tend to their physical and mental health care.

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

The PNC will be a hub and spoke model designed to encompass both clinical and non-clinical services that will permit the provision of services both telephonically and in-person in the community. Our care coordination model includes the two focus areas detailed above as well as a telephonic care coordination program staffed by nurses and social workers. The team will provide telephonic care management services to high risk patients who do not qualify for New York State’s Health Home program. This combination of services will enable us to identify high risk patients within our PPS population, support their transitions across the continuum of care, and connect them with local physicians and community based organizations to, address health, mental health, and social determinants that will ultimately reduce unnecessary hospital & ED utilization.

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

Based on the community needs assessment we determined that having dedicated staff to support non-clinical needs such as care transitions from ED to home, addressing connectivity to primary care, behavioral health care, and other services (E.g.- housing, benefits, and other social determinant factors that impact health) would not only provide key services to patients, but allow staff such as doctors, therapist, nurses, to spend more of their time addressing specific health and mental health needs and thereby operate at the top of their licenses.



## DSRIP Mid-Point Assessment - Project Narratives

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**PPS Name:** NYU Lutheran Medical Center

**Project:** 3.a.i

### Challenges the PPS has encountered in project implementation:

- Budget constraints – limitation of not having 2 billable services in one-single day. A “warm hand-off” is a mechanism by which the primary care provider introduces the behavioral health provider at the time of the medical visit in order to establish an initial face-to-face contact between the patient and the behavioral health provider. It has been proven that “warm hand-offs” increase the likelihood that patients will keep their appointments. FQHCs cannot bill the majority of managed care plans additionally for a behavioral health service that occurs the same day as another service which creates a sustainability challenge as efforts to increase behavioral health services grow.
- Space/capacity issues for Behavioral Health providers in Primary Care - physical layout of the space for practices implementing behavioral health integration an important consideration. Finding physical space in a primary care setting that can accommodate behavioral health is a challenge. For example, a primary care practice bringing on a behavioral health provider will need to have an office for the behavioral health provider to see patients.
- Recruitment of culturally appropriate Behavioral Health staff – the diverse populations served by NYU Lutheran PPS creates challenges in terms of hiring LCSWs who speak other languages, in particular: Yiddish and Spanish.

### Efforts to mitigate challenges identified above:

- To mitigate the challenge of funding required resources to implement integrated behavioral health services in a primary care setting there has been an added focus on analyzing the business case as it relates to a number of visits per day required to sustain a Social Worker’s salary.
- Working with organizational leadership to find creative solutions to manage existing space among all specialties. Busy primary care settings do not have extra rooms for behavioral health. Some possible solutions would include the following:
  - Rotating offices for behavioral health staff in the primary care setting
  - Behavioral health providers working a later shift
- Partnering with local Social Work educational programs to train and recruit Behavioral Health staff appropriate for Primary Care and specific needs of the community.
- The promotion and integration of policies and procedures are being updated across the network to support an increase towards all levels of integrating behavioral health into a primary care setting.



## Implementation approaches that the PPS considers a best practice:

- Enhanced collaboration between Primary Care Providers and Behavioral Health staff through:
  - Implementation of warm-handoffs
  - Weekly provider meetings with behavioral health staff
  - Daily morning huddles including behavioral health staff
  - Consulting psychiatrist educating primary care providers on anti-depressant medication use
- Enhanced collaboration between Primary Care Providers and Behavioral Health staff through collaborative discharge planning. Prior to graduating patient from short term mental health treatment, the behavioral health provider and primary care physician shall discuss patient’s progress. i.e., although depression may be down, the primary care provider may request to extend mental health treatment to get diabetes under control.
- Established ‘open access scheduling’ for Behavioral Health staff to allow for timely access to care for warm handoffs.

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

### Participation in the MAX Series Program:

- NYU Lutheran PPS is participating in the Department of Health offered Medicaid Accelerated eXchange (MAX) Series Program. MAX is an 8-month intensive learning experience designed as a multidisciplinary collaboration that empowers clinicians to lead change, apply leading practices and learn from leading topic experts and each other. It is focused at a local level (Adult Medicine Clinic from NYU Lutheran) to generate grass-roots level change and act as an enabler to impact overall DSRIP measures, as well as local improvement measures. The program builds skills and capacity for process improvement at a local level that can be scaled and shared across the broader PPS. Program approach includes three phases – an assessment and preparation phase, followed by three full-day Workshops and intermediary improvement cycles, concluding with a reporting period.
- Impact of action plans implemented through piloting the MAX Series program:

	<b>Before Implementation</b>	<b>After Implementation</b>	<b>Target</b>
Screening Rates	28% avg/month	89% avg/month	90% avg/month
Warm Handoffs	1 avg/month	11 avg/month	40 avg/month
Discharge Coordination	0 avg/month	2.5 avg/month	TBD with further observation
Confirmation Appointments for Behavioral Health Staff	16.5% no show rate	10.1% no show rate	5% no show rate



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- There were no changes identified in the community needs assessments and therefore, there are no changes to the populations that were proposed to be served through the project.



## DSRIP Mid-Point Assessment - Project Narratives

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**PPS Name:** NYU Lutheran Medical Center

**Project:** 3.c.i

### Challenges the PPS has encountered in project implementation:

- Inconsistent funds flow to the PPS at the beginning of DY1 impacted the ability to launch resource intensive interventions.
- NYU Lutheran Family Health Center's transition to Epic has a large impact on operations, limiting time and resources of clinical leads and others with clinical responsibilities for the rollout of new initiatives and training of providers.

#### Data

- Lack of timely and granular performance data to support performance monitoring and targeting of interventions.

#### Care gaps

- Limited availability and long wait times for eye exams, which impacts performance on the Comprehensive Diabetes Screening performance measure.
- Limited availability of diabetes educators and specialties for nutrition and endocrinology, which can support the closing of care gaps.
- Standardization of care managers and providers' workflow after adoption of best practice guidelines.
- EHR limitations of some partners, such as the lack of usable order sets, which impact the ability to ensure that all proper diabetic protocols are met.

### Efforts to mitigate challenges identified above:

#### Data

- Use of alternative data sources, such as EHR reports and MCO data, to prioritize project implementation activities.

#### Care gaps

- Assess and monitor partners' performance on each component of the diabetes care composite and flu shot measures to identify best opportunities for improvement.
- Develop and implement telemedicine pilot using fundoscopic cameras to increase availability of eye exams.
- Coordinate with the Patient Navigation Center to provide care coordination services for high-risk patients with diabetes, with a specific focus on those with short-term complication due to diabetes.
- Explore the expansion of the Patient Navigation Center to deploy Community Health Workers for case management of high risk patients.
- Utilizing Salesforce to engage CBOs system wide, which will provide a single access point for partners to access protocols, guidelines, and track referrals.





- Explore new partnerships with CBOs to provide the Stanford Diabetes Self-Management Program.
- Adopt methodology to stratify high-risk patients.

### Implementation approaches that the PPS considers a best practice:

- Creation of reports that are provider specific and giving regular feedback regarding performance.
- Regular review of performance data at workgroup meetings to guide project implementation activities.
- Alignment of DSRIP measures with other quality improvement initiatives. Emphasizing the alignment of measures helps with engagement of providers as there are other ongoing initiatives that can take attention from the project.
- NYU Lutheran Family Health Center provides point of care testing to close care gaps and provide current information for providers. Also supports achievement of patient engagement targets.
- Ezra Medical Center offers “one-stop shopping” by co-locating primary care providers, vision care, and podiatrists to reduce access barriers for patients with diabetes.
- Partner-based action teams that implement best practices at their local sites. Each partner has experiences that are shared at work group meetings which are used to identify best practices. Partners are then able to apply what they learned to their own sites.

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

- NYU Lutheran Family Health Center uses clinical software, Azara, to identify patients at risk for readmissions. NYUPN, the clinically integrated network of NYU Lutheran Medical Center and the University Physicians Network IPA, assist diabetic patients in obtaining preventive health services. Through a combination of claims and clinical data, nurses work from EMR-based patient registries to conduct outreach and assessment. The PPS will leverage all this knowledge and experience to adopt a risk stratification model.
- NYU Lutheran Family Health Center monitors and incentivizes providers via report cards; the PPS will expand this program to support achievement of DSRIP performance measures.

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

- There were no changes identified in the community needs assessments and therefore, there are no changes to the populations that were proposed to be served through the project.



**DSRIP Mid-Point Assessment - Project Narratives**  
PPS must submit a narrative in each section for every project the PPS is implementing

**PPS Name:** NYU Lutheran Medical Center

**Project:** 3.d.ii

**Challenges the PPS has encountered in project implementation:**

- Inconsistent funds flow to the PPS at the beginning of DY1 impacted the ability to launch resource intensive interventions.
- NYU Lutheran Family Health Center’s transition to Epic has a large impact on operations, limiting time and resources of clinical leads and others with clinical responsibilities for the rollout of new initiatives and training of providers.

Home visit intervention

- Home visit interventions are resource intensive and must be developed in a sustainable manner. Time was needed to assess options and negotiate with vendors to determine how home visits would integrate into existing infrastructure.
- General reluctance to home assessments from parents. This barrier is also complicated by the fear of government repercussions among first generation immigrant families. Additionally, cultural competency considerations must be taken. For instance, orthodox Jewish communities are reluctant to have strangers enter their homes.

Diagnosis and treatment of asthma

- Inconsistent diagnosis of asthma severity and treatment for asthma, which impacts care on an individual level and risk stratification activities on a population health level.
- Cultural resistance to asthma diagnosis and use of controller medications.

Data

- Lack of timely performance data to support performance monitoring and targeting of interventions.

**Efforts to mitigate challenges identified above:**

- Development and implementation of a provider training specific to standardizing diagnosis and treatment for asthma.
- Use of alternative data sources, such as EHR reports and MCO data, to prioritize project implementation activities. When asthma diagnosis is miscoded, data sources such as medical record or medication review are also utilized.

Home visit intervention

- Explore the expansion of the Patient Navigation Center to deploy Community Health Workers for home assessments of high risk patients with asthma.

Diagnosis and treatment of asthma

- Development of provider training specific to standardizing diagnosis and treatment for asthma.
- Assess and monitor partners’ performance on Asthma Medication Ratio measure.



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- Adopt methodology to stratify high-risk patients so that an appropriate level of intervention is provided.
- Provide patient education materials at point of care (e.g., asthma action plans).

## Data

- Establish a registry to track performance, stratify risk and coordinate care.
- Use of alternative data sources, such as EHR reports and MCO data, to prioritize project implementation activities.

## Implementation approaches that the PPS considers a best practice:

- Apply a continuous quality improvement approach toward development of the provider training curriculum. Pilot trainings are being conducted at smaller sites to identify opportunities for improvement based on participant feedback and pre/post-test outcomes.
- Cultural competency considerations are integrated into the provider training curriculum.
- Adopt a decentralized model where partners implement best practices learned from one another. For example, ODA Primary Health Care Network is participating in the development of the provider training curriculum as they have also identified inconsistent diagnosis of asthma severity as a challenge. However, their model of provider training focuses on smaller group or individual settings. When the curriculum is complete, it will be shared with primary care partners across the PPS who adapt the training to fit their needs.
- NYU Lutheran employs pre-discharge protocols to provide patient education on care plans, medication management, and prescription-filling services by leveraging existing relationships with local pharmacies, for asthma patients presenting in the emergency department as inpatients.

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

- A pilot home visit intervention was funded through an MCO for their high risk patients. An asthma educator worked in conjunction with a pulmonologist to provide home visits and asthma education to high risk patients. Patients were referred to the educator by a primary care physician or pulmonologist. Patients were also identified by a report from emergency department discharges related to asthma. Lessons learned from this pilot are being used to inform how to best develop a sustainable home visit program and to engage other MCOs to support home visits.
- The Adult Medicine site at NYU Lutheran is conducting shared medical appointments for patients with asthma. These are group visits where 8-10 patients can work with the care team and receive in-depth education on asthma (covering topics such as medication and symptoms) as well as a one on one visit with a pulmonologist. The lessons learned from this initiative being applied to the development of shared medical appointments for pediatric patients.
- Discussions are underway with various MCOs on strategies to manage and stratify an asthma population in preparation for risk-based contracts.
- The go-live date for Epic implementation at NYU Lutheran is August 28th, 2016.



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- There were no changes identified in the community needs assessments and therefore, there are no changes to the populations that were proposed to be served through the project.



## DSRIP Mid-Point Assessment - Project Narratives

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

**PPS Name:** NYU Lutheran Medical Center

**Project:** 4.b.i

### Challenges the PPS has encountered in project implementation:

- Inconsistent funds flow to the PPS at the beginning of DY1 impacted the ability to launch resource intensive interventions.
- NYU Lutheran Family Health Center’s transition to Epic has a large impact on operations, limiting time and resources for the rollout of new initiatives and training of providers.

#### Cessation counselling

- Inconsistent counselling given by providers to patients who are smokers.

#### Special populations

- High smoking rates among certain patient populations: homeless; people with severe mental illness.
- Cultural norms for high rates of tobacco use among the Chinese and Arab communities in Sunset Park.
- Lack of coverage for Nicotine Replacement Therapy for people without health insurance.

### Efforts to mitigate challenges identified above:

#### Cessation counselling

- Partner with NYC Treats Tobacco (NYCTT) project to implement the 5A protocols. ODA Primary Health Care Network has been working with NYCTT to them since the end of 2014.
- Explore partnerships with PFIZER for education of providers and patients on tobacco cessation, with special focus on 5As.
- ODA is a member of the Center of Excellence for Health Systems Improvement for a Tobacco-Free New York eClinicalWorks IT Workgroup. The workgroup is developing a new Smartform in eCW to reflect new recommendations for tobacco screenings and cessation counseling, which would then be applied to ODA’s EHR.

#### Special populations

- Provide trainings regarding behavioral health and tobacco cessation. For example, ODA has conducted these trainings for their staff.
- To address cultural norms within the Chinese community that make tobacco cessation particularly challenging, the PPS will repurpose NYU Lutheran Medical Center’s culturally competent outreach and education materials developed for the Chinese community and employ their peer navigator model to provide education and link smokers to treatment. The model may also be expanded to other communities with ingrained cultural norms around tobacco use, such as the Arab community.
- Work with CBOs to provide community based education and media campaign (2015).
- Repurpose Department of Health and Mental Hygiene’s media materials and leverage its expertise in



public health approaches to tobacco control.

- Explore partnerships with PFIZER for Nicotine Replacement Therapy resources for the uninsured population.

## Implementation approaches that the PPS considers a best practice:

- Established policies and procedures to screen every patient for tobacco use and if positive, provide tobacco cessation counseling and cessation resources (e.g., medication, nicotine replacement therapy). Patients are also referred to the New York State Smokers' Quitline.
- Incorporation of tobacco cessation into quality improvement activities. Tracking of smoking screening and cessation performance helps with engagement of providers as there are other ongoing initiatives that can take attention from the project.

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

- Development of a pilot tobacco cessation project as part of SAMHSA grant to identify chronic illnesses and teach medical self-management within the mental health clinic. An evidence-based, culturally appropriately curriculum was developed where people with mental health conditions can participate in in a tobacco cessation group. The goal is to show reduced CO levels for participants over the course of 12 months in the project, and to train other staff to learn the skills to support tobacco cessation among their patients.

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

- There were no changes identified in the community needs assessments and therefore, there are no changes to the populations that were proposed to be served through the project.



## DSRIP Mid-Point Assessment - Project Narratives

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

**PPS Name:** NYU Lutheran Medical Center

**Project:** 4.c.ii

### Challenges the PPS has encountered in project implementation:

- Inconsistent funds flow at the beginning of DY1 impacted the ability to launch resource intensive interventions.
- Slow ramp up time for Cross-PPS HIV Coalition. Given the complex nature of PPSs, the process of developing the Coalition by-laws and Memorandum of Understanding was extensive as the legal requirements of seven PPSs had to be satisfied. These governance structures needed to be in place before project implementation could occur.

#### Staffing

- Transition of three HIV providers, including the HIV Medical Director, out of NYU Lutheran.

#### PrEP (Pre-Exposure Prophylaxis) and PEP (Post-Exposure Prophylaxis)

- Low knowledge of PrEP and PEP among patients.
- Low enrollment of high-risk negatives in PrEP.

#### Data

- Data inconsistencies within the HIV Registry from EHR extracts, leading to a time intensive manual transcription and validation process to address inconsistencies.

### Efforts to mitigate challenges identified above:

- Participation in Cross-PPS Collaborative convened by NYC DOHMH , with specific interest in the Models for Care Viral Load Suppression and PrEP Implementation Standing Committees as they align with the PPS's current priority areas.

#### Staffing

- Active recruitment underway for HIV providers. The new HIV Medical Director has been recruited and will start in mid-September, who will provide clinical leadership in project implementation.

#### PrEP (Pre-Exposure Prophylaxis) and PEP (Post-Exposure Prophylaxis)

- Use of patient navigators to identify high-risk negatives for enrollment into PrEP. This approach is patient navigator driven and would provide an opportunity for a more in-depth discussion regarding PrEP than what could occur in a medical visit. High risk negatives would be engaged through HIV testing. If the risk assessment indicates the patient is a good candidate for PrEP, the patient navigator would provide PrEP education and appropriate linkages to services.
- A multi-pronged approach to address low knowledge of PrEP and PEP includes:
  - Integration of PrEP and PEP counseling as part of routine HIV testing
  - Development of an education campaign to educate the community and staff about PrEP and PEP. More than ten-thousand campaign materials are to be distributed at community events



and partner sites. Materials include fliers, posters, and condom kits. The materials direct people to call a hotline staffed by a patient navigator who can provide HIV testing, linkage to care, or answer questions.

## Data

- NYU EPIC programmers are working with HIV Network staff to ensure EPIC's structured fields reliably captures data needed to implement an HIV program.

## **Implementation approaches that the PPS considers a best practice:**

- Integrate HIV testing, Medical Case Management (for HIV-positive patients), and PrEP to cover the spectrum of HIV prevention and treatment.
- A focus on patient engagement through the use of patient navigators as part of the HIV care team. Patient navigators have the skills and time needed to have an in-depth discussion with high-risk negatives to assess their suitability for PrEP. Patient navigators also provide key case management services, such as appointment follow-up and enrollment into medication assistance programs. Patient navigators also receive special training on PrEP counseling best practices, motivational interviewing, and LGBT sensitivity.
- Systematic HIV testing as part of primary care. HIV testing is tracked as quality indicator to support continuous quality improvement across the primary care network.
- Established relationships with CBOs for community-based services, such as legal assistance for immigration issues, HIV testing and counseling, and support groups.

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

- Viral load suppression (VLS) is achieved through intensive case management for HIV-positive patients through NYU Lutheran's Medical Case Management (MCM) Program. MCM provides support to newly diagnosed patients such as housing assistance, appointment reminders, and medication adherence (through directly observed therapy). VLS is recognized as part of the "graduation" of patients from the MCM program. The rate of VLS in the MCM Program is 90%.

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

- There were no changes identified in the community needs assessments and therefore, there are no changes to the populations that were proposed to be served through the project.