Hudson Valley DSRIP

Clinical & Program Planning Sub-Committee Meeting

Focus on Cancer, Cardiology, and Care Transitions DSRIP Projects

August 13, 2014
1:00 – 4:30 pm
## Agenda

<table>
<thead>
<tr>
<th>I</th>
<th>Welcome, Introductions and Meeting Agenda</th>
<th>1:00 – 1:05 pm</th>
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</thead>
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Clinical & Program Planning Sub-Committee Participation

• Behavioral Health
• Children’s Care/Pediatrics
• Counties
• Dental Care
• Eldercare
• Family and Community Services
• Health Centers
• Home Care
• Hospice

• Hospitals and Health Systems
• Labor Unions
• Mental Health Associations
• Post-Acute Care
• Primary Care
• Public Health
• Social Services Agencies
• Specialty Care
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The Hudson Valley DSRIP Initiative serves all seven counties of the Hudson Valley.

The Hudson Valley is home to an estimated 407,885 Medicaid lives.

Nearly 200 community providers are partners in the Hudson Valley DSRIP Performing Provider System (PPS).
Where We’re Headed

A Coordinated, Comprehensive Collaboration for Care Improvement

Create a system based upon integrated clinical/social management programs capable of helping patients better manage complex illnesses through the support of primary care teams that are aligned with and supported by Health Homes and specialty service providers.

Hudson Valley DSRIP Initiative Principles

- Transparent
- Culture of Continuous Learning and Improvement
- Patient and Family Focused
- Inclusive and Community Led
DSRIP Timeframe
Key Milestones and Dates

- **August 6, 2014**
  Design Grant Awards Made; Planning Application Period Begins
- **October 2014**
  Final Project Plan Application released
- **December 16, 2014**
  Detailed Project Plan Application due
- **January 2015**
  Waiver Renewal Deadline; Federal funding anticipated
- **April 2015**
  Implementation begins

NOTE: Except for public comment deadlines, timeline is in flux.
2014 DSRIP Planning Overview
July to December 2014

- Plan/conduct community needs assessment
- Assess gaps
- Analyze patient service areas / determine Hubs
- Develop project plans

- Finalize content for and write DOH Project Plan Application

- Finalize any project revisions based on needs assessments and gap analysis
- Develop implementation priorities/strategies for hubs based on local strengths and needs
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## 11 Projects Selected for the Hudson Valley DSRIP Initiative

<table>
<thead>
<tr>
<th>Domain/Project</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Domain 2: Systems Transformation Projects</strong></td>
<td></td>
</tr>
<tr>
<td>2.a.i</td>
<td>Create integrated delivery systems that are focused on evidence based medicine/population health management</td>
</tr>
<tr>
<td>2.a.iv</td>
<td>Create a Medical Village Using Existing Hospital Infrastructure</td>
</tr>
<tr>
<td>2.b.vi</td>
<td>Transitional Supportive Housing Services</td>
</tr>
<tr>
<td>2.b.viii</td>
<td>Home-Hospital Care Collaboration Solutions</td>
</tr>
<tr>
<td>2.d.vi.</td>
<td>Implementation of Patient and Community Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care</td>
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<tr>
<td><strong>Domain 3: Clinical Improvement Projects</strong></td>
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<tr>
<td>3.a.i</td>
<td>Integration of primary care services and behavioral health</td>
</tr>
<tr>
<td>3.a.ii</td>
<td>Behavioral health of community crisis stabilization services</td>
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<tr>
<td>3.b.ii.</td>
<td>Implementation of evidence based strategies in the community to address chronic disease – primary and secondary prevention strategies (adult only). (Cardiovascular)</td>
</tr>
<tr>
<td>3.f.i</td>
<td>Increase support programs for maternal and child health (including high risk pregnancies) (e.g., Nurse Family Partnership)</td>
</tr>
<tr>
<td><strong>Domain 4: Population-Wide Prevention Projects (at least 1 and up to 2)</strong></td>
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<tr>
<td>4.b.i</td>
<td>Promote tobacco cessation, especially among low SES populations and those with poor mental health.</td>
</tr>
<tr>
<td>4.b.ii</td>
<td>Increase access to high quality chronic disease preventive care and management in both clinical and community settings (focus on chronic diseases not in Domain 3.b., such as cancer)</td>
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</table>
PPS Committees and Workgroups Drive Project Planning

Project Advisory Committee (PAC)

PAC Executive Committee

Business, Operations and Finance (BOF) Sub-Committee

- Workforce Workgroup
- Payers Workgroup

Clinical & Program Planning Sub-Committee

- Behavioral Health Workgroup (Child, Integrated Care, Crisis Stabilization)
- Perinatal and Early Childhood Workgroup
- Transitions of Care Workgroup
  - (1) Hospital discharge
  - (2) PCP to Specialist Transition
- Care Management/Care Model (including Health Homes)
- Patient and Provider Engagement and Support (cancer, cardiovascular, tobacco, etc.)

- Guides/gives input on workgroup and staff development of detailed project plans
- Informs infrastructure to be developed by the Business, Operations and Finance Sub-Committee
Process for Project Plan Development

Getting from:
11 projects chosen

To:
11 detailed project plans

1. Some workgroups will directly support development of specific project plans
   - Behavioral Health
   - Perinatal and Early Childhood

2. Some workgroups will support components of multiple project plans due to crosscutting nature of project elements
   - Transitions of Care
   - Care Management/Care Model
   - Patient and Provider Engagement and Support

3. All project plans will be informed by the Community Needs Assessment (CNA)

4. All project plans will be informed by the Clinical and Program Planning Sub-Committee
Sub-Committee Participation: What to Expect

Sub-Committee Role

- Guide workgroup and staff’s development of detailed project plans
- Review program plans before submission to PAC Exec Committee and PAC
- Inform infrastructure to be developed by the Business, Operations and Finance Subcommittee
- Act in the interest of the PPS
- Actively engage in discussions and contribute expertise to decision-making processes

Timeline

- Behavioral Health Meetings
- Cancer, Cardio, Care Transitions Meeting (Aug. 13)
- Perinatal, Care Management, and Other Workgroup Meetings
- Clinical & Program Planning Sub-Committee Meeting (Oct. 9)
- Project Plan Application Development
- Project Plan Application Due (Dec. 16)

- JULY
- AUG
- PAC
- SEPT
- PAC
- OCT
- PAC
- NOV
- PAC
- DEC

PAC – Project Advisory Committee (next slide provides scope and meeting details)
Project Advisory Committee (PAC)

Project Advisory Committee
Role and Scope

• Overall DSRIP planning advisory body
• Comprised of one member per PPS partner – inclusive of all PPS partners
• Input across workstreams, Committees, and Workgroups
• Monthly meetings will provide planning updates and seek partner feedback
• Opportunity to participate in planning process in addition to Committees and Workgroups

<table>
<thead>
<tr>
<th>AUG</th>
<th>PAC Webinar</th>
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<tbody>
<tr>
<td>21</td>
<td>Planning process update</td>
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<tr>
<th>SEPT</th>
<th>PAC In-Person Meeting</th>
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<tr>
<td>24</td>
<td>Project discussion, Planning process update</td>
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<tr>
<th>OCT</th>
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<tr>
<td>27</td>
<td>CNA report out, Project Plan Application information request(s)</td>
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<th>NOV</th>
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<td>Project Plan Application update</td>
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<tr>
<th>DEC</th>
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<tr>
<td>18</td>
<td>Review final Project Plan Application (post-submission)</td>
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Initiative to Gather & Analyze Regional Data

- Plan/conduct community needs assessment
- Assess gaps
- Analyze patient service areas / determine Hubs
- Develop project plans

- Finalize content for and write DOH Project Plan Application

July | August | September | October | November | December

- Finalize any project revisions based on needs assessments and gap analysis
- Develop implementation priorities/strategies for hubs based on local strengths and needs

December 16: Project plan due
DOH Guidance on CNA Requirements

A. Description of the Health Care Resources (Including Medical and Behavioral Health) and Community Resources

B. Description Of The Community To Be Served

C. Identification Of The Main Health And Health Service Challenges Facing The Community

D. Succinct Summary Of The Assets And Resources That Can Be Mobilized

E. Summary Chart of Projects to be Implemented

F. Documentation Of The Process And Methods

Health Care Resources. For each provider, there should be an assessment of capacity, service area, Medicaid status, & any particular areas of expertise. Include data on the availability, accessibility, affordability, acceptability and quality of health services and what issues may influence utilization of services such as hours of operation, transportation, sliding fee scales, etc.

Community-based Resources. For each providers, there should be an assessment of capacity, service area, certification status, population served, gaps as well as any particular areas of expertise.

Domain 2 Metrics.
- Potentially Avoidable Services
- Provider Reimbursement
- Primary Care
- Medicaid Spending for Projects Defined Population on a PMPM basis

Demographics of Population Served. gender, race, ethnicity, age, income, disability status, mobility, educational attainment, housing status, employment status, Medicaid/insurance status, access to a regular source of care, language and health literacy, legal/illegal immigrant/migrant status, and urban/rural status.

Health Status of Population. The health status of the population and the distribution of health issues, based on the analysis of demographic factors above, with particular attention and emphasis placed on identification of issues related to health disparities and high-risk populations within the Medicaid and uninsured population.

Domain 3 and 4 Metrics.

Discussion of the contributing causes of poor health status, including the broad determinants of health including: a) Behavioral risk factors, b) Environmental risk factors, c)Socioeconomic factors, d)Basic necessity resources including housing and access to affordable food, e)Barrier free access deficiencies, f)Policy environment, g)Service gaps related to primary care and/or other specific types of service applicable to the DSRIP project or strategy, h)Factors related to access to health insurance and health services, i)Transportation barriers, j)Other unique characteristics of the community that contribute to health status.
CNA Development Process: Data Collection

A. Description of the Health Care Resources and Community Resources

**Health Care Resources.** For each provider, there should be an assessment of capacity, service area, Medicaid status, & any particular areas of expertise. Include data on the availability, accessibility, affordability, acceptability and quality of health services and what issues may influence utilization of services such as hours of operation, transportation, sliding fee scales, etc.

**Community-based Resources.** For each provider, there should be an assessment of capacity, service area, certification status, population served, gaps as well as any particular areas of expertise.

**Domain 2 Metrics.**
- Potentially Avoidable Services
- Provider Reimbursement
- Primary Care
- Medicaid Spending for Projects Defined Population on a PMPM basis

B. Description Of The Community To Be Served

**Demographics of Population Served.**
- gender, race, ethnicity, age, income
- disability status, mobility, educational attainment, housing status, employment status, Medicaid/insurance status, access to a regular source of care, language and health literacy, legal/illegal immigrant/migrant status, and urban/rural status.

**Health Status of Population.** The health status of the population and the distribution of health issues, based on the analysis of demographic factors above, with particular attention and emphasis placed on identification of issues related to health disparities and high-risk populations within the Medicaid and uninsured population.

C. Identification Of The Main Health And Health Service Challenges

**Discussion of the contributing causes of poor health status, including the broad determinants of health including:**
- Behavioral risk factors
- Environmental risk factors
- Socioeconomic factors
- Basic necessity resources including housing and access to affordable food
- Barrier free access deficiencies
- Policy environment
- Service gaps related to primary care and/or other specific types of service applicable to the DSRIP project or strategy
- Factors related to access to health insurance and health services
- Transportation barriers
- Other unique characteristics of the community that contribute to health status.
Project Selection: Cardiovascular Health
Cardiovascular Discharges (HVRHON)
Medicare-Cardiovascular Discharges
Emergency Room Repeat Visits for Cardiovascular Conditions (HVRHON)
Multiple Discharge Impact Among Medicaid Population

- Multiple Discharges Represent 10% of Individual Patient Population
- Multiple Discharges (≥2) Represent 25% of CVD Patient Occupancy
Multiple Discharge Impact Among Medicare Population

- Multiple Discharges Represent 14% of Individual Patient Population
- Multiple Discharges Represent 37% of CVD Patient Occupancy

Graphs showing the distribution of discharges and average length of stay over 5 years.
Hudson Valley View
Project Selection: Cardiovascular Health
Geo-level of Analysis: Zip Code
Geographic Profile: Raw CVD ER Rate
Geographic Profile: Raw CVD Inpatient Rate
Project Selection: Cancer Screening
Inpatient Bed Use by Population

Mid Hudson Valley Inpatient Population Use of Beds For Cancer from All Facilities

16% Recent Decline

Occupied Beds
HVRHON Population Discharges

72,000 Cancer Discharges in 5 Yrs.
HVRHON Population CA Ambulatory Surgeries Visits

Ambulatory Surgery Visits

152,000 Cancer Procedures in 5 Yrs.
Cancers Emergency Room Use by Population

90,000 ER Visits
(With & Without Admission)

9.6% Decline

Total ER Visits

Admissions from ER
<table>
<thead>
<tr>
<th>CCS Categories of Oncology</th>
<th>Discharges</th>
<th>Patient Days</th>
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<tbody>
<tr>
<td>11 Cancer of head and neck</td>
<td>1280</td>
<td>12360</td>
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<tr>
<td>12 Cancer of esophagus</td>
<td>516</td>
<td>6632</td>
</tr>
<tr>
<td>13 Cancer of stomach</td>
<td>984</td>
<td>11604</td>
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<tr>
<td><strong>14 Cancer of colon</strong></td>
<td><strong>3561</strong></td>
<td><strong>35402</strong></td>
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<tr>
<td>15 Cancer of rectum and anus</td>
<td>1363</td>
<td>14149</td>
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<tr>
<td>16 Cancer of liver and intrahepatic bile duct</td>
<td>1067</td>
<td>9851</td>
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<tr>
<td>17 Cancer of pancreas</td>
<td>1641</td>
<td>17103</td>
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<tr>
<td>18 Cancer of other GI organs; peritoneum</td>
<td>853</td>
<td>9665</td>
</tr>
<tr>
<td><strong>19 Cancer of bronchus; lung</strong></td>
<td><strong>5880</strong></td>
<td><strong>53164</strong></td>
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<tr>
<td>20 Cancer; other respiratory and intrathoracic</td>
<td>95</td>
<td>848</td>
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<tr>
<td>21 Cancer of bone and connective tissue</td>
<td>729</td>
<td>6449</td>
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<td>22 Melanomas of skin</td>
<td>203</td>
<td>986</td>
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<tr>
<td>23 Other non-epithelial cancer of skin</td>
<td>276</td>
<td>1876</td>
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<tr>
<td><strong>24 Cancer of breast</strong></td>
<td><strong>4249</strong></td>
<td><strong>16162</strong></td>
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<tr>
<td>25 Cancer of uterus</td>
<td>1426</td>
<td>7309</td>
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<tr>
<td><strong>26 Cancer of cervix</strong></td>
<td><strong>479</strong></td>
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<td>27 Cancer of ovary</td>
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<td>28 Cancer of other female genital organs</td>
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<tr>
<td>Cancer of prostate</td>
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<td>Cancer of testis</td>
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<td>Cancer of other male genital organs</td>
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<td>Cancer of bladder</td>
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<td>Cancer of kidney and renal pelvis</td>
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<td>Cancer of other urinary organs</td>
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<td>Cancer of thyroid</td>
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<td>Hodgkin`s disease</td>
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<td>Non-Hodgkin`s lymphoma</td>
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<td>Leukemias</td>
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<tr>
<td>Cancer; other and unspecified primary</td>
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<td>328</td>
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<tr>
<td>Secondary malignancies</td>
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<td>9396</td>
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<tr>
<td>Malignant neoplasm without specification of site</td>
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<td>286</td>
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<tr>
<td>Neoplasms of unspecified nature or uncertain behavior</td>
<td>44</td>
<td>2016</td>
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<td>Maintenance chemotherapy; radiotherapy</td>
<td>45</td>
<td>8024</td>
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<tr>
<td>Benign neoplasm of uterus</td>
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<td>5936</td>
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<tr>
<td>Other and unspecified benign neoplasm</td>
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<td>5438</td>
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Respiratory Cancer
(Product Line 2: Cancers)

- CCS 19: Cancer of bronchus; lung
- CCS 20: Cancer; other respiratory and intrathoracic
Lung CA: Total Hospital IP Activity in the Hudson Valley (5 Years)

- Inpatients:
  - 6,000 IP Discharges
  - 4,850 Unique Patients

- Emergency Room Visits (inc. Admits):
  - 300 ER Visits (w/o admit)
  - 280 Unique Patients
Lung CA: Admissions from Emergency Rooms (Hudson Valley)
Lung CA: Multiple Inpatient & ER Visits/Discharges

18% IP/Lung CA Patients with Multiple Visits = 34% of Patient Days

5% ER/Lung CA Patients with Multiple Visits = 10% of Visits
Breast Cancer
(Product Line 2: Cancers)

• CCS 24: Cancer of the Breast
Cancer of the Breast: Hudson Valley (5 Years)

Total Inpatient and Ambulatory Surgery

Ambulatory Surgery Activity (76%)

13,300 Am Surg Visits for 9,000 Patients
1. 32% of Patients may have second or more visits
2. Emergency Room visits insignificant.
3. Admissions from Emergency Room insignificant.
Colon Cancer
(Product Line 2: Cancers)

- CCS 14: Cancer of the Colon
Colon Cancer: Total Inpatient & Ambulatory Surgery

5700 Combined Discharges in 5 Yrs.
Colon Cancer: Hudson Valley (5 Years)

Patient Discharges

Inpatient Discharges (62%), 3,600 Disch, 3,300 Unique Pat.

Ambulatory Surgery (38%)
Multiple Admissions and Emergency Room Activity: Colon Cancer

Fewer than 10% of Patients are Re-admitted.

1. 31% of Admitted Patients come from the Emergency Room
2. Represent 41% of Patient Days with 12.9 Day ALOS
Cervical Cancer
(Product Line 2: Cancers)

• CCS 26: Cancer of the Cervix
Cancer of the Cervix: Hudson Valley (5 Years)

Total Inpatient and Ambulatory Surgery

27% Decline

Ambulatory Surgery Activity (77%)

1,600 Am Surg. Visits for 1,200 Patients
Cervical Cancer: Multiple Encounters & Emergency Room Activity

Fewer then 15% of Patients are Re-admitted.

11% of Inpatients have Emergency Room Source
Hudson Valley View
Project Selection: Cancer Screening
Geo-level of Analysis: Zip Code
Geographic Profile: Total Cancer Patients
Geographic Profile: Respiratory Cancer Patients

Respiratory Cancer Patients (per 10,000)

- 0.0 - 3.0
- 3.1 - 8.0
- 8.1 - 13.0
- 13.1 - 25.0
- 25.1 - 69.0

- Study Area Counties
- Other NYS Counties
- Other NYS Zip Codes
- Surrounding States
Geographic Profile: Breast Cancer Patients
Geographic Profile: Cervical Cancer Patients
Project Selection: Respiratory Health
Respiratory: Total Hospital IP Activity in the Hudson Valley (5 Years)
Respiratory: Total Hospital IP Activity in the Hudson Valley (5 Years)

**InPatient Discharges**
- 101,000 Discharges
- 67,700 Unique Patients: 400 Beds

**ER Visits (w/o IP Admit)**
- 351,000 ER Visits (w/o IP Admit)
- 241,000 Unique Patients
Total Emergency Room Encounters: Respiratory Conditions
Hudson Valley, Admitted Patients from ER & Other ER Visits

Highly Seasonalized
Respiratory Condition Admissions from Emergency Rooms (Hudson Valley)
Respiratory: Multiple Inpatient & ER Visits/Discharges

24% IP/Resp. Patients with Multiple Visits

29 Exceed 20 Visits

24% ER/Resp. Patients with Multiple Visits

161 Exceed 20 Visits
Respiratory Conditions: InPatient Discharges in the Hudson Valley (5 Years)

<table>
<thead>
<tr>
<th>Condition</th>
<th>2017 Discharges</th>
<th>2018 Discharges</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>122 Pneumonia (except that caused by tuberculosis or sexually transmitted)</strong></td>
<td>30441</td>
<td>188789</td>
<td>6.2</td>
</tr>
<tr>
<td>123 Influenza</td>
<td>1060</td>
<td>4475</td>
<td>4.2</td>
</tr>
<tr>
<td>124 Acute and chronic tonsillitis</td>
<td>878</td>
<td>1763</td>
<td>2.0</td>
</tr>
<tr>
<td>125 Acute bronchitis</td>
<td>4956</td>
<td>16878</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>127 COPD: Chronic obstructive pulmonary disease and bronchiectasis</strong></td>
<td>19656</td>
<td>113735</td>
<td>5.8</td>
</tr>
<tr>
<td><strong>128 Asthma</strong></td>
<td>14331</td>
<td>58282</td>
<td>4.1</td>
</tr>
<tr>
<td>129 Aspiration pneumonitis; food/vomitus</td>
<td>6264</td>
<td>57779</td>
<td>9.2</td>
</tr>
<tr>
<td>131 Respiratory failure; insufficiency; arrest (adult)</td>
<td>11198</td>
<td>112683</td>
<td>10.1</td>
</tr>
<tr>
<td>133 Other lower respiratory disease</td>
<td>4262</td>
<td>19838</td>
<td>4.7</td>
</tr>
<tr>
<td>134 Other upper respiratory disease</td>
<td>1566</td>
<td>5837</td>
<td>3.7</td>
</tr>
<tr>
<td>126 Other upper respiratory infections</td>
<td>2429</td>
<td>6794</td>
<td>2.8</td>
</tr>
<tr>
<td>130 Pleurisy; pneumothorax; pulmonary collapse</td>
<td>3677</td>
<td>27659</td>
<td>7.5</td>
</tr>
<tr>
<td>132 Lung disease due to external agents</td>
<td>185</td>
<td>1470</td>
<td>7.9</td>
</tr>
<tr>
<td>1 Tuberculosis (Prod Code 1: Inf Disease)</td>
<td>237</td>
<td>4859</td>
<td>20.5</td>
</tr>
<tr>
<td><strong>18 Cancer Bronchus or Lung (Prod Code 2: Cancer)</strong></td>
<td>853</td>
<td>9665</td>
<td>11.3</td>
</tr>
<tr>
<td><strong>19 Cancer Other Respiratory (Prod Code 2: Cancer)</strong></td>
<td>5880</td>
<td>53164</td>
<td>9.0</td>
</tr>
</tbody>
</table>
COPD

(CCS 127)
COPD: Total Hospital IP Activity in the Hudson Valley (5 Years)

Inpatient Discharges

- 19,700 IP Discharges
- 12,350 Unique Patients

Emergency Room Visits (inc. Admits)

- 37,500 Total ER Visits
- 21,500 Unique Patients
COPD: Admissions from Emergency Rooms (Hudson Valley)
COPD Multiple Inpatient & ER Visits/Discharges

27% IP/COPD Patients with Multiple Visits = 57% of Patient Days

11% ER/COPD Patients with Multiple Visits = 27% of Visits
Pneumonia
(except that caused by tuberculosis or sexually transmitted disease, CCS 122)
Pneumonia : Total Hospital IP Activity in the Hudson Valley (5 Years)

**Inpatient Discharges**

- 30,400 IP Discharges
- 26,100 Unique Patients

**Emergency Room Visits (inc. Admits)**

- 18,500 ER Visits (w/o admit)
- 17,300 Unique Patients
Pneumonia: Admissions from Emergency Rooms (Hudson Valley)
Pneumonia: Multiple Inpatient & ER Visits/Discharges

**Inpatients**

12% IP/Pneumonia Patients with Multiple Visits = 29% of Patient Days

**ER Visits (w/o Admit)**

6% ER/Pneumonia Patients with Multiple Visits = 12% of Visits
Asthma  (CCA 128)
Asthma: Total Hospital IP Activity in the Hudson Valley (5 Years)

**Inpatients**

- 14,300 IP Discharges
- 10,600 Unique Patients

**Emergency Room Visits (inc. Admits)**

- 52,400 ER Visits (w/o admit)
- 32,900 Unique Patients
Asthma: Admissions from Emergency Rooms (Hudson Valley)
Asthma: Multiple Inpatient & ER Visits/Discharges

Inpatients

18% IP/Asthma Patients with Multiple Visits = 44% of Patient Days

ER Visits (w/o Admit)

24% ER/Asthma Patients with Multiple Visits = 52% of Visits
Respiratory Cancer
(Product Line 2: Cancers)

- CCS 19: Cancer of bronchus; lung
- CCS 20: Cancer; other respiratory and intrathoracic
Lung CA: Total Hospital IP Activity in the Hudson Valley (5 Years)

**Inpatients**
- 6,000 IP Discharges
- 4,850 Unique Patients

**Emergency Room Visits** (inc. Admits)
- 300 ER Visits (w/o admit)
- 280 Unique Patients
Lung CA: Admissions from Emergency Rooms (Hudson Valley)
Lung CA: Multiple Inpatient & ER Visits/Discharges

Inpatients
18% IP/Lung CA Patients with Multiple Visits = 34% of Patient Days

ER Visits (w/o Admit)
5% ER/Lung CA Patients with Multiple Visits = 10% of Visits
Hudson Valley View
Project Selection: Respiratory Health
Geo-level of Analysis: Zip Code
Geographic Profile: Respiratory Patients
Geographic Profile: COPD Patients
Geographic Profile: Pneumonia Patients
Geographic Profile: Respiratory Cancer Patients
Geographic Profile: Asthma Patients
Next Steps

• Define Hotspots
• Gather data, information and knowledge from other sources
• Identify issues and service challenges
• Cross walk DSRIP project selection/plans with CNA findings
## Agenda

<table>
<thead>
<tr>
<th>I</th>
<th>Welcome, Introductions and Meeting Agenda</th>
<th>1:00 – 1:05 pm</th>
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<td>II</td>
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<td>VIII</td>
<td>Adjourn</td>
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Project Planning – Today’s Focus

1. Hospital – Home Care Transitions
2. Chronic Disease Preventive Strategies – Cardiovascular Health
3. Increase Access to Chronic Disease Preventive Care and Management – Cancer
4. “Medical Neighborhood” (e.g., primary to specialty care transitions)
## Hospital-Home Care Transitions – Project Goals and Key Components

### 2.b.viii Hospital-Home Care Collaboration Solutions

<table>
<thead>
<tr>
<th>NYS Toolkit defines project goal as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Implementation of INTERACT-like program in the home care setting to reduce risk of re-hospitalizations for high-risk patients”</td>
</tr>
</tbody>
</table>

### Toolkit specifies that the project must include the following key components:

- Rapid Response Teams (hospital/home care) to facilitate patients’ discharges
- Home care staff trained to identify and prevent patient risks for readmission and to support evidence-based medicine chronic care management
- Care pathways and other clinical tools for monitoring chronically ill patients
- Education of all staff on care pathways and INTERACT principles
- Advance Care Planning tools for residents and families
- Patient and family/caregiver education and engagement around care planning, including support of family/caretakers and potential for respite services
- Integration of primary care, behavioral health, pharmacy and other services within model
- Utilization of telehealth and interoperable EHRs
- Demonstration of cultural competence

---

**What are additional goals for our PPS?**

**Are there other services that may enhance the project?**
Primary and Secondary Chronic Disease Prevention Strategies (Cardio)

Project Goals and Key Components

3.b.ii Implementation of evidence based strategies in the community to address chronic disease – primary and secondary strategies (adult only)

NYS Toolkit defines project goal as:

“Improving patient self-efficacy and confidence in self-management, and engagement of the at-risk population in primary and secondary disease prevention strategies related to cardiovascular health”

Toolkit specifies that the project must include the following key components:

- Development of, or partnership with, community resources to expand availability of evidence-based self-management programs (e.g., Stanford Chronic Disease Self-Management Program)
- Development and administration of protocols for screening and referral
- Collaboration with self-management programs to monitor patient progress
- Adoption of comprehensive nutrition standards for PPS facilities
- Use of quality committee to monitor outcomes and implement improvements

What are additional goals for our PPS?
Are there other services that may enhance the project?
**Tobacco Cessation – Project Goals and Key Components**

4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health

**NYS Toolkit defines project goal as:**

“Decrease the prevalence of cigarette smoking by adults 18 and older; increase use of tobacco cessation services including NYS Smokers’ Quitline and nicotine replacement products”

**Toolkit specifies that the project must include the following key components:**

- Adoption of tobacco-free outdoor policies
- Implementation of US Public Health Services Guidelines for Treating Tobacco Use
- Use of EHRs with relevant clinical decision support (i.e., prompt for 5 A’s – Ask, Assess, Advise, Assist and Arrange)
- Facilitation of referrals to the NYS Smokers’ Quitline
- Increased Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications
- Promotion of smoking cessation benefits among Medicaid providers
- Creation of universal, consistent health insurance benefits for prescription and over-the-counter cessation medications
- Inclusion of all smokers, including people with disabilities

What are additional goals for our PPS?
Are there other services that may enhance the project?
Access to Chronic Disease Preventive Care & Management (Cancer) – Project Goals and Key Components

4.b.ii Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (targets chronic disease not included in 3.b – e.g., cancer)

NYS Toolkit defines project goal as:

“Increase the number of New Yorkers who receive evidence-based preventive care and management for chronic diseases”

Toolkit specifies that the project must include the following key components:

• Establishment or enhancement of reimbursement and incentive models to increase delivery of high-quality disease prevention and management services
• Availability of recommended clinical preventive services and pathways to community-based preventive service resources
• Incorporation of Prevention Agenda goals and objectives into Community Services Plans and coordinated implementation with community partners
• Adoption and use of EHRs, including relevant clinical decision support and registry functionality
• Adoption of medical home or team-based care models
• Creation of feedback loops to, and quality improvement incentives for, clinicians around clinical benchmarks
• Reduction or elimination of OOP costs for clinical and community preventive services

What are additional goals for our PPS?
Are there other services that may enhance the project?
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## Group Breakouts for Discussion

1. Hospital – Hospital Care Transitions
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</table>
Next Steps

- Provide input and data to DSRIP team to inform project development
- Respond to information gathering requests
- Participate in upcoming meetings (note: dates/times are subject to change)

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Meeting</th>
<th>Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 21st</td>
<td>8:30 – 10:00 am</td>
<td>Project Advisory Committee</td>
<td>Webinar</td>
</tr>
<tr>
<td>September 15th</td>
<td>TBD</td>
<td>Perinatal and Early Childhood</td>
<td>TBD</td>
</tr>
<tr>
<td>September 16th</td>
<td>3 – 5 pm</td>
<td>Care Management</td>
<td>In-Person/ Webinar</td>
</tr>
<tr>
<td>September 19th</td>
<td>TBD</td>
<td>Behavioral Health – Integrated Care</td>
<td>In-Person</td>
</tr>
<tr>
<td>September 19th</td>
<td>TBD</td>
<td>Behavioral Health – Crisis Stabilization</td>
<td>In-Person</td>
</tr>
<tr>
<td>September 24th</td>
<td>TBD</td>
<td>Project Advisory Committee</td>
<td>TBD</td>
</tr>
<tr>
<td>September 30th</td>
<td>1:30 – 3:30 pm</td>
<td>Behavioral Health Workgroup</td>
<td>In-Person</td>
</tr>
<tr>
<td>October 9th</td>
<td>All day meeting</td>
<td>CNA Report Out Clinical &amp; Program Planning Sub-Committee Meeting</td>
<td>TBD</td>
</tr>
<tr>
<td>October 27th</td>
<td>TBD</td>
<td>Project Advisory Committee</td>
<td>TBD</td>
</tr>
</tbody>
</table>
Contact Information

Clinical & Program Planning Sub-Committee
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