

Blueprint

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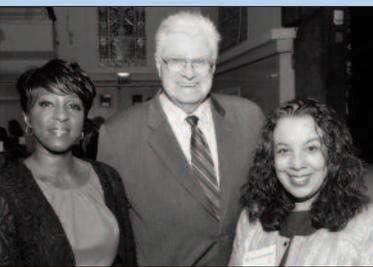
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"Together on Diabetes" Making Real Difference in Seniors' Health

In just three years, Together on Diabetes-NYC—the community partnership developed by the United Hospital Fund to help seniors manage their diabetes and improve their quality of life—is proving its worth. It's not only having a positive impact on the lives of its active enrollees but also demonstrating a promising approach to managing other chronic diseases.

The model program, based in Washington Heights, has forged key connections among local health care and social services organizations, developed an array of educational and support services at multiple locations, and enrolled more than 1,600 seniors.

Data document its positive impact. Participants report feeling better, having more confidence in their diabetes-management skills, and doing more to take care of themselves. And now an unprecedented new agreement on insurance reimbursement for select program services is additional testimony to the initiative's success.

BUILDING SUSTAINABLE PARTNERSHIPS

While initial funding for the program—a three-year, \$2.8 million grant from the Bristol-Myers Squibb Foundation—has recently ended, Together on Diabetes-NYC (ToD-NYC) will continue its work, with community anchor Isabella Geriatric Center managing day-to-day operations. That kind of transition is integral to the Fund's efforts.

"Together on Diabetes-NYC is a good example of our approach to shaping positive change," says Fund President Jim Tallon. "We work with partners to target a problem or a community need; we develop innovative strategies for improvement, and test them; and then, if successful, we help move



Diabetes educator Nancy Aponte, RN, discusses medications with ToD-NYC participants at Riverstone Senior Life Services.

the program into the hands of our partners to take the reins and move forward."

For ToD-NYC, effective partnerships—among local social service organizations, health care providers, and other resources, and with New York City's Department of Health and Mental Hygiene and Department for the Aging—have been the key.

"We chose Washington Heights because, in addition to its high diabetes rate, it has broad social service capability that allowed us to start in the community rather than in the clinical setting. Our approach was to build upon that while creating new and stronger connections between partners," says Fredda Vladeck, director of the Fund's Aging in Place initiative. "And from day one, we were thinking about how to strategically channel resources and about long-term sustainability."

In addition to Isabella, three other senior-serving organizations—ARC XVI Fort Washington, Riverstone Senior Life Services, and the YM&YWHA of Washington Heights and Inwood—offer ToD-NYC's core services, which include diabetes education, support groups, and individual coaching; exercise programs; foot health instruction and screenings by podiatrists; and diabetes-friendly

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Together on Diabetes *(continued from page 1)*

cooking and nutrition activities led by City Harvest.

An important element of ToD-NYC is its management information system, which captures data on seniors' participation in the program, self-care behaviors, and views about their overall health and quality of life. Reassessments of 1,190 seniors found significant improvements in behaviors essential to diabetes management, including monitoring blood sugar, adhering to medication regimens, and following diet and exercise guidelines. As important, these changes are being sustained over time. Among the first 317 seniors eligible to be assessed a third time based on length of participation in the program, 89 percent report testing blood sugar daily as recommended, up from 68 percent; 94 percent said they are following a healthy diet, up from 83 percent; and 77 percent said they exercise three or more days a week, up from 64 percent. Those gains are matched by equally significant improvements in seniors' self-reported health status and confidence in their ability to manage their illness.

Another strength of the project has been its ability to change its approach quickly when needed. Early on, when doctors'-office-based referral strategies weren't gaining traction, the program tried a more personal and interactive approach, working with a local grass-roots organization to deploy "street marketing teams" wearing bright tee-shirts to promote ToD-NYC at popular senior destinations in the neighborhood. Within weeks, enrollment soared.

The program has also prompted changes at the City administration level. Spurred by the positive data, the Department for the Aging has changed its service definitions to allow staff at the four senior centers to report hours spent on specific ToD-NYC activities as "accountable time" that helps meet contractual requirements.

COVERAGE VALIDATES APPROACH

The project's combination of high enrollment and early positive outcomes has piqued the attention of the managed care community—a group "we always

knew must be at the table, especially to ensure the project's long-term sustainability," says Ms. Vladeck.

Beginning in the summer of 2015, Healthfirst, the insurer sponsored by public and nonprofit hospitals throughout the city, will reimburse for selected Together on Diabetes-NYC services provided to its health plan members.

"This is an exciting development that supports and validates the program's approach and certainly increases the potential to drive real change in this community," says Isabella's CEO Mark Kator.

Healthfirst also sees the new agreement as a great opportunity, as well as an example of the types of community partnerships that could be forged throughout the health care system. "We know that seniors with diabetes need ongoing education and a web of community support to reinforce instructions from their doctors, help prevent unnecessary

"This program has helped me change how I live. Now I feel healthier and more in charge."



hospital visits, and help them manage their disease and feel better overall," says Healthfirst Vice President and Medical Director Susan Beane, MD. "This is the mission of Together on Diabetes-NYC, and we hope that additional insurers will come on board."

In the coming months, data—on changes in blood sugar levels, blood pressure, and other clinical measures, and on diabetes-related emergency department use and hospital admissions among participants—are expected from project partner NewYork-Presbyterian Hospital. "Continued positive results will certainly indicate real progress for our participants," says Fredda Vladeck. "And it will also boost the community partnership approach as a promising model for improving the health of other groups with chronic diseases."

Blueprint

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The United Hospital Fund is a health services research and philanthropic organization whose primary mission is to shape positive change in health care for the people of New York.

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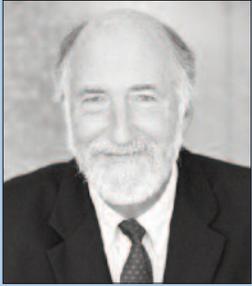
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“Convenient Care,” a Growing Trend in Ambulatory Care



Urgent care centers and retail clinics—collectively known as “convenient care”—are a major development in ambulatory care, offering potential

benefits and risks for both individual patients and the health care system. A new Fund report examines the trend, its pros and cons, and policy options for consumer and public health protections. Greg Burke, one of the report’s authors, highlights some of the issues.

Urgent care centers seem to be popping up everywhere. Why, and why now?

It’s mainly a response to consumer demand. Being unable to see your doctor without losing time at work is frustrating and, for many people, costly. With their extended hours—including evenings and weekends—urgent care centers speak to that. An additional factor is out-of-pocket costs—for an urgent but not life-threatening situation, these are often far less expensive to the consumer than an emergency room visit. For a well-defined set of services—minor traumas, acute episodic illness, like a bad cough—these providers can see you when you have the time, in your community. So the growth nationally has been pretty stunning—New York is actually a little behind the rest of the country.

Do retail clinics fill the same role?

Urgent care centers, by design, offer episodic care, with no real expectation of a long-term relationship. Retail clinics, which are located in pharmacies and big-box stores, tend to emphasize prevention and wellness—immunizations, simple medical conditions that have an over-the-counter or

prescription drug fix right at hand, or, increasingly, a focus on managing chronic conditions. In general, they explicitly want return business, a real relationship.

Your report notes concerns about fragmentation of care...

Convenient care has different utility and risks for different types of patients. For people who are basically in good to excellent health, without an underlying medical problem, urgent care centers may be a good option for treating specific, limited problems. But if you’re prescribing a drug that might interfere with a patient’s other meds you need to connect with some system that sends up a flag. If there’s something that might foreshadow a medical problem—where a primary care doctor might say “it looks like this but in this patient it’s probably that”—then that usual source of care needs to know about it.

What about quality and services?

Consumers and regulators must know what these different kinds of providers can and can’t do, particularly because there can be so much variety in the services offered. One light-touch approach might be to require a listing of services and capabilities, and some minimum reporting. In terms of quality, the little literature that exists indicates that convenient care is generally in the same ballpark as traditional private practice—which is how these centers are typically licensed, actually. But there is still a lot we don’t know about quality in these settings.

Is pediatric care a special case?

The vast majority of pediatric patients have established relationships; convenient care for them is just about after-hours and weekend visits, or maybe quicker care than

in emergency rooms. So for kids there’s a particular need for documenting what the urgent care center is doing, and connecting back with the primary care doctor. The other issue is the provider’s skill set: kids present differently, they need different treatments and dosages. So there’s a question of the extent to which internists, who are often staffing these centers, are appropriately handling pediatric urgent issues other than, say, a finger laceration that needs stitching. There’s a strong argument to be made that there ought to be some clear declaration about whether or not there’s somebody on site with pediatric training.

What about people without their own doctor?

One of the real takeaways of our report, data from one large urgent care chain, is that 40-60 percent of its patients do not have a primary care physician. For those who want a relationship, many urgent care centers will make specific efforts to connect them with primary care doctors in the community. But for many of these people, it seems convenient care is the provider of choice. A lot of them are “young invincibles,” who may not think they need a doctor, but there are others, too, who don’t seek a primary care relationship. Not everyone wants a medical home, and many may be satisfied with this option instead. It also relieves demand on what is currently an oversubscribed primary care system, so doctors can deal with patients who most need their time and attention.

Convenient Care: Retail Clinics and Urgent Care Centers in New York State is available at <http://www.uhfnyc.org>.

GRANTMAKING

Home Health’s “Eyes and Ears” Test Tools for Better Care

“For years, we in the health care community have said that home care aides are our eyes and ears when it comes to the everyday status of our clients,” says Carol Rodat, the New York policy director for PHI, formerly the Paraprofessional Healthcare Institute. “If they’re our eyes and ears, though, the big question is ‘Do we have a good way to capture what they’re observing?’”

The answer is crucial, given the growing demand for home care—and the increasingly complex health conditions and disabilities of home care clients. Effective monitoring and coordinated, high-quality care are essential to enabling clients to remain safely at home, and to preventing avoidable trips to the hospital.

With grant support from the United Hospital Fund, PHI is coordinating a pilot project to determine whether the use of telehealth technology by home care aides can improve patient care, prevent avoidable hospitalizations and thus reduce costs, and enhance aides’ job satisfaction and integration into the clinical care team.

MORE EFFECTIVE COMMUNICATION

The project’s fundamental goal is to ensure that the care management team, including registered nurses and social workers, is fully aware of a client’s condition, and changes in it, so needed interventions can be made without delay. Currently, that’s often challenging. An aide who is concerned about a client typically must report to the home care agency supervisor, who cannot pass along those concerns until determining which provider or managed care plan—and which nurse at

that organization—is responsible for the client.

“It’s basically a formula for failure to intervene in a timely way when a client’s condition worsens,” says Ms. Rodat.

As part of the pilot program, two teams—both consisting of a home care agency and a managed long-term care plan—have each trained a group of aides to use a telehealth system to relay information and alerts on clients’ health status directly to the assigned care management team.

Aides working with some of the primarily elderly clients of Jewish Home Lifecare and its plan partner Healthfirst tested the e-Caring tablet, which is largely icon-based and can collect information on indicators selected from more than 120 options—vital signs, adherence to medication regimen, mood, and more. Aides from Cooperative Home Care Associates, partnering with Independence Care System, used tablets loaded with Care at Hand software for their clients, many of whom are nonelderly adults with disabilities; that system prompts users to ask broad yes/no questions about the client’s health, including medication compliance and wound condition.

Early feedback is already encouraging. “The tablet gave me exactly the right words to ask my clients how they are feeling, and they seemed more willing to answer these questions,” says Awilda Gonzalez Medina, an aide with Cooperative Home Care Associates. “I feel like the whole project has made everybody more focused on the patient’s needs.” Initial data also indicate



Telehealth technology may give home care aides the ability to provide valuable, timely information on clients’ changing health status.

that the number of calls from nurses to aides has risen, and that wound care has improved in response to better reporting of wound condition.

Evaluation of the projects, to be completed later this spring, will include interviews with clients and aides, a comparison of data on hospitalizations, primary care visits, and RN visits for patients in the two test groups and in control groups, and a report on the relative impact and efficiency of the two systems.

FURTHER EFFORTS WIN SUPPORT

Equally important, the pilot project is expected to reveal where enhancements—in both the training of aides and in the technologies themselves—should be made. And those are insights that will be valuable as PHI builds on these first efforts. In fact the knowledge gained during this pilot, says Ms. Rodat, “absolutely” helped PHI secure a \$1.9 million grant from the New York State Department of Health to expand the use of home- and community-based care using strategies including telehealth.

“This pilot project reflects the Fund’s longtime interest in improving patient-centered care, better care coordination, and the meaningful use of innovative technology to bring those about,” says Deborah Halper, vice president for education and program initiatives.

New Quality Fellows Prepare for Leadership Roles

Bringing a wealth of clinical experience to the table—and eager to develop strong health care quality improvement and leadership skills—the seventh class of the United Hospital Fund/Greater New York Hospital Association Clinical Quality Fellowship Program began its 15-month training in January.

At a two-day retreat that introduced the intensive curriculum ahead, the 16 doctors and 4 nurses heard from expert faculty and program alumni on topics including the role of quality improvement in health reform, the regulatory environment, managing change, teamwork, and making a success of the CQFP experience—notably the signature “capstone” project that each participant will

develop and lead in his or her hospital.

This year’s class includes Fellows from four hospitals new to the program—Bronx-Lebanon, Mount Sinai Queens, New York Methodist, and New York-Presbyterian Lower Manhattan—and from clinical specialties including ambulatory care, hospital medicine, emergency medicine, ob/gyn, geriatrics, critical care, women’s health and HIV services, and nursing professional practice; for the first time a certified nurse midwife is participating. This brings to 127 the number of current and past Fellows; many alumni have already gone on to quality improvement or medical leadership positions.

2015–16 Clinical Quality Fellows

Bronx-Lebanon Hospital Maria Teresa Timoney, CNM
 Hackensack University Medical Center Lisa Tank, MD, FACP
 Lutheran HealthCare Nada Abou-Fayssal, MD; Karen DeLorenzo, MSN, RN, CHCR
 Maimonides Medical Center Fouad Atallah, MD
 Memorial Sloan Kettering Cancer Center Chhavi Kumar, MD
 Mount Sinai Beth Israel Robert Freeman, MSN, RN-BC; Glenn Kashan, MD
 Mount Sinai Hospital Hyung (Harry) Cho, MD
 Mount Sinai Hospital Queens Amrita Gupte, MD, MPH
 Mount Sinai St. Luke’s Hospital Jeffrey Rabrich, DO, FACEP
 New York Hospital Queens Roxana Lazarescu, MD; Jean Versace, RN, CCM
 New York Methodist Hospital Barbara Gatton, MD
 New York-Presbyterian Lower Manhattan Hospital Daniel Crossman, MD
 New York-Presbyterian Morgan Stanley Children’s Hospital John Babineau, MD
 NYU Langone Medical Center Yasir Al-qaaq, MD; Raghad Said, MD
 North Shore University Hospital Kenneth Feldhamer, MD
 SBH Health System Daniel Lombardi, DO, FACEP

NEWS BRIEFS

Spreading Advanced Primary Care

throughout New York City is the goal of a new Fund partnership with the New York City Department of Health and Mental Hygiene (DOHMH), the Fund for Public Health in New York, and the New York Academy of Medicine, launching later this spring. The partnership will convene health care providers, payers, consumers, public health officials, and other stakeholders, with the aim of collecting data and identifying strategies for expanding the Advanced Primary Care model, in which high-performing practices offer comprehensive, patient-centered

care, especially for those with complex needs. The Fund for Public Health in New York, DOHMH’s nonprofit partner, is one of 11 Population Health Improvement Programs (PHIPs) statewide—organizations charged with conducting regional planning for programs to improve population health.

Plans are underway for an **initiative on antibiotic management strategies**, to be co-led by the Fund and the Greater New York Hospital Association (GNYHA). Among the new initiative’s anticipated elements are assessments of current practices and antibiotic usage, and assistance with implementation of antimicrobial stewardship programs. The

initiative follows on a 2009–10 Fund/GNYHA initiative that helped health care institutions implement programs guiding the use—and preventing misuse—of antibiotics.

Planning for long-term care gained additional national notice when Carol Levine, director of the Fund’s Families and



Carol Levine

Health Care Project, was a guest on the “Today” show this winter, pointing out that 80 percent of long-term care in the United States is provided by family caregivers.

Honoring Hospital Volunteers and Auxilians

Celebrating 84 volunteers and auxilians from 60 hospitals and hospital divisions throughout the city and close-by suburbs, the Fund hosted its 22nd annual Hospital Auxilian and Volunteer Achievement Awards ceremony on March 13, filling the ballroom of the Waldorf-Astoria.

“This annual tribute spotlights the extraordinary dedication and contributions of caring volunteers, who share their time and talents to support patients and their families and provide valuable extensions of hospital services,” Fund President Jim

Tallon told the 680 guests. Selected from thousands of volunteers providing millions of hours of service annually, this year’s honorees range in age from the 20s through the 90s, come from all walks of life, and have given an average of more than 10 years of service each, noted Board member Susana Morales, MD, who helped Mr. Tallon acknowledge the volunteers.

Their contributions are as diverse as they are. One volunteer coordinates “Musicians on Call,” bringing live music directly to patients’ bedsides. Another phones older adults who have been discharged to home, to make sure they are keeping follow-up appointments. A graduate student provides special assistance to geriatric patients in the emergency department. Another volunteer assists with activities to help children with special needs become more independent.



NY1 News anchor Cheryl Wills (left) and Fund board member Susana Morales, MD, with Jim Tallon.

And a young man who began volunteering as a high school freshman continues to do so ten years later, tutoring on a child and adolescent psychiatric unit.

Yet they all have something in common, summed up guest speaker Cheryl Wills, anchor of NY1 News: “a very special commitment to helping patients and their families when they feel most vulnerable.”

New Caregiver Guide on Medical Equipment Rules

Picking the right medical equipment, learning how to use it, and getting reimbursed for it are some of the trickier issues when a family member needs help with walking, or certain medications, or even breathing. A new Fund guide for family caregivers now addresses those challenges, explaining what “durable medical equipment”—wheelchairs, IV tubes, oxygen tanks, and many other types of medically necessary equipment or supplies—is and is not, who can prescribe it, how to select it, and the applicable rules of Medicare and other insurance.

Available on the Fund’s Next Step in Care website, www.nextstepincare.org, the guide is the latest addition to the site’s more than two dozen guides and checklists helping family caregivers navigate the complexities of the health care system and their caregiving tasks.

Cary Kravet, Business Leader, Elected to Fund Board



Cary A. Kravet

Cary A. Kravet, a leader in the New York and international decorative home furnishing industry and a longtime hospital trustee, has been elected to the Fund’s board of directors. Mr. Kravet is the president and chief executive officer of Kravet Inc., a fifth-generation family business that is a global leader in decorative fabrics and home furnishings.

Since 2000 Mr. Kravet has been a trustee of the North Shore-LIJ Health System. He currently serves on its Executive Committee and chairs its Committee on Quality; previously, he chaired its Committee on Community Health. He also serves on the board of directors of Huntington Hospital.

Mr. Kravet graduated from Emory University and received his JD from Harvard Law School; he also studied at the Wharton School of Business.

“Twenty years ago I decided to devote my charitable time and attention to a field I knew little but cared much about,” says Mr. Kravet. “I became involved with our local community hospital, and the more I participated the more I learned. I was drawn to the issues of quality and humanism in the delivery of care.” That focus, notes Fund President Jim Tallon, “combined with his business savvy and legal expertise, makes him an invaluable addition to our board.”

Small Group Insurance Market Changes May Affect Premiums

New national rules slated to take effect January 1, 2016, will extend the small group insurance market, now made up of companies with 1-50 employees, to include groups of 1-100 employees, and will affect how health plans set premiums for small firms. At the crux of the matter for states is how best to implement this provision of the Affordable Care Act. A new Fund report analyzes the potential effect on premiums and examines options available to New York regulators and policymakers carrying out the federal rule.

“The straightforward definitional change of ‘small employer’ quickly becomes complicated because different rules govern

how rates are set for firms of this size,” says Peter Newell, director of the Fund’s Health Insurance Project and author of the report. For groups with 51-100 employees, age, gender, type of business, and claims experience are used to set premiums, a practice known as “experience rating.” These larger small businesses will now be subject to “community rating”—the methodology now used for groups with 50 and fewer workers—which takes into account only family size and region.

The effective merger of the two market segments could stabilize premiums in the current 1-to-50-employee small group market, but create “winners and

losers” within the 51-to-100-employee segment: for some lower-risk firms, premiums might rise under community rating, while for higher-risk firms, with older workers or more women, premiums might decline.

Policymakers and regulators do have some discretion about when and how to implement the change—whether to phase it in gradually, attempt to delay it further, or meet the January deadline. The Fund report, *Larger Small Groups*, lays out various policy options for them.

Whatever path is chosen by New York officials, says Mr. Newell, the new definition will have bottom-line implications for the 1.3 million “covered lives” of the state’s 1-to-50-employee small businesses and the 676,000 employees and dependents of 51-to-100-employee “larger small groups.”

RECENT GRANTS

In February 2015, the Fund awarded grants totaling \$464,000.

CHILDREN’S DENTAL HEALTH PROJECT (\$95,000)

To address the widespread problem of early childhood caries—severe tooth decay caused by a bacterial infection—among low-income preschoolers by adapting a dental education mobile app, now used by health workers, for families’ use with smartphones, to help parents identify risk levels and set and monitor daily prevention goals. The project will also explore Medicaid-allowable payment options to support oral health education services.

CITY UNIVERSITY OF NEW YORK SCHOOL OF PUBLIC HEALTH (\$100,000 OVER 18 MONTHS)

To address untreated depression among CUNY students by developing and pilot testing a student awareness campaign and resources, and using student “health ambassadors” to provide outreach and information at three Bronx campuses. CUNY will also strengthen campus mental health services and review current linkages to community mental health providers.

ISABELLA GERIATRIC CENTER / TOGETHER ON DIABETES-NYC (\$60,000 OVER 6 MONTHS)

To bridge operational costs of Together on Diabetes-NYC—the Fund’s model community-based program to help seniors manage

their diabetes—borne by the initiative’s community anchor Isabella Geriatric Center, until a pending reimbursement agreement between Isabella and insurer Healthfirst is completed and implemented, so the program can be self-sustaining.

MEMORIAL SLOAN KETTERING CANCER CENTER IMMIGRANT HEALTH AND CANCER DISPARITIES SERVICE (\$65,000)

To help people newly insured through New York State of Health, particularly those with limited English or low health literacy, access their insurance benefits and engage with a primary care provider, by developing and testing new educational materials and strategies for facilitating those connections.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (\$144,000 OVER 6 MONTHS)

To improve and expand access to care for uninsured populations—especially patients with chronic health conditions requiring coordinated, frequent care—through HHC Options, the Corporation’s financial assistance program, by identifying redesign possibilities and aligning the program’s design with other health system changes.

Additional information on each of these grants is available at www.uhfnyc.org/grants.



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CALENDAR

MAY 11

The annual Tribute to Hospital Trustees luncheon and awards ceremony. The Waldorf-Astoria

JULY 16

“Medicaid in New York: Transforming the Delivery

System,” the Fund’s annual Medicaid conference, with keynote by Jason Helgerson, New York State Medicaid director and Office of Health Insurance Programs deputy director. New York Academy of Medicine

OCTOBER 5

United Hospital Fund Gala, Presenting the Health Care Leadership and Distinguished Community Service Awards, and a special tribute. The Waldorf-Astoria

OFF
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PRESS

Convenient Care: Retail Clinics and Urgent Care Centers in New York State presents a national overview of these new providers of ambulatory care; examines their presence in New York State and potential impact on two special populations, children and the medically underserved; discusses their relationship to broader health system restructuring; and offers policy options for consumer and public health protections.

Performing Provider System Projects: Tackling the Health Needs of Communities provides a snapshot of the projects selected by 25 emerging PPSs that have applied to participate in New York’s DSRIP (Delivery System Reform Incentive Payment) program, and shows the scope of their proposed efforts to better coordinate care and improve the health outcomes of some six million beneficiaries.

Larger Small Groups: Implementing the New ACA Small Employer Definition in New York explains the logistics of implementing the Affordable Care Act provision that redefines the small group market as 1–100 employees instead of 1–50, and explores the implications for policymakers and affected small businesses.

These and other Fund reports are available at www.uhfnyc.org.

WWW.UHFNYC.ORG

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