



**Department
of Health**

DSRIP Independent Assessor

Mid-Point Assessment Report

The New York-Presbyterian/Queens PPS

Appendix PPS Narratives

November 2016

www.health.ny.gov

Prepared by the DSRIP
Independent Assessor

DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: NewYork-Presbyterian/Queens

Highlights and successes of the efforts:**Organizational Section: Funds Flow / Financial Sustainability / Budget****Successes to Date:**

The PPS continues to meet the expectations associated to the financial aspects of the PPS. This mid-point assessment narrative will address (1) Funds Flow, (2) Financial Sustainability, and (3) Budget.

○ Overall –

- A Financial Analyst was recruited to the PMO and currently is focused to developing monthly financial tools to include budget, actual spend, forecasting, and variance explanations. This team member will work in partnership with the Finance Committee and executive leadership to consistently track and trend financials as well as complete finance deliverables.
- Additional recruitment is underway for numerous positions to include both clinical & non-clinical positions to support operations as well as clinical integration.

○ Funds Flow –

- Quarterly partner distributions continue with a schedule of March & September to align with the NYS DSRIP payments to include payments for incentives, cost of implementation, and revenue loss.
- PIT Updates in MAPP include payments made to partners based on actual checks cut in quarter being reported.
- CBO payments are included in the incentive funding and will be reviewed monthly to ensure compliance with the 95% / 5% safety-net provider ruling.
- The NYP/Q PPS Executive Leadership is working with the NYP Managed Care team to complete the contracting for the EIP/ EPP funding. One contract has been signed and a second contract is in final phases of signatures.

○ Financial Sustainability –

- The financial sustainability partner analysis was completed and two partners were identified as potential risks within the network. The Financial Analyst is working to complete the follow-up action items that are identified in the PPS Financial Sustainability plan.
- The PPS Executive Leadership is partnering with the NYP PPS to align strategies of Value Based Payment transition of the lead hospital as well as partners.

○ **Budget –**

- Actual spend has met expectations outlined with the DSRIP application to include: 5% Contingency, 2% Workforce, 30% Administrative Overhead, 5% Non-Covered Services, 10% Revenue Loss, 18% Cost of Implementation, and 30% Incentives.
- Expense forecasting is underway to ensure availability of funds pending the EIP/EPP Contracting.

Challenges:

The PPS has identified the following challenges related to performance reporting:

- **Funds Flow: 95% / 5% Safety Net Limitation** – A number of the clinical programs require a direct connection to CBO’s for engagement and education and the organizations are not safety-net providers.
- **Financial Sustainability: Value Based Payment Adoption** – The NYP/Q PPS is a collaborative model approach which has no accountability of MCO contracting for engaged partners. Along with no direct-accountability, the PPS is also limited to assisting with negotiation and planning due to federal regulatory compliance limitations.
- **Funds Flow: Delayed EIP / EPP Contracting** – The NYP/Q organization depends on the NYP organization to complete all MCO negotiations and contracting. The leadership at NYP is working on behalf of both NYP & NYP/Q PPS in order to complete the EIP/EPP contracting as a system strategy.
- **Transition of the Funds Flow Model to Performance Based** – The existing PPS funds flow model was built to encourage engagement, project requirements, and engaged patient volume. In order to meet the quality based outcomes for performance the model will need to evolve into a true pay-for-performance model blended with other indicators which will ensure engagement, productivity, and quality.

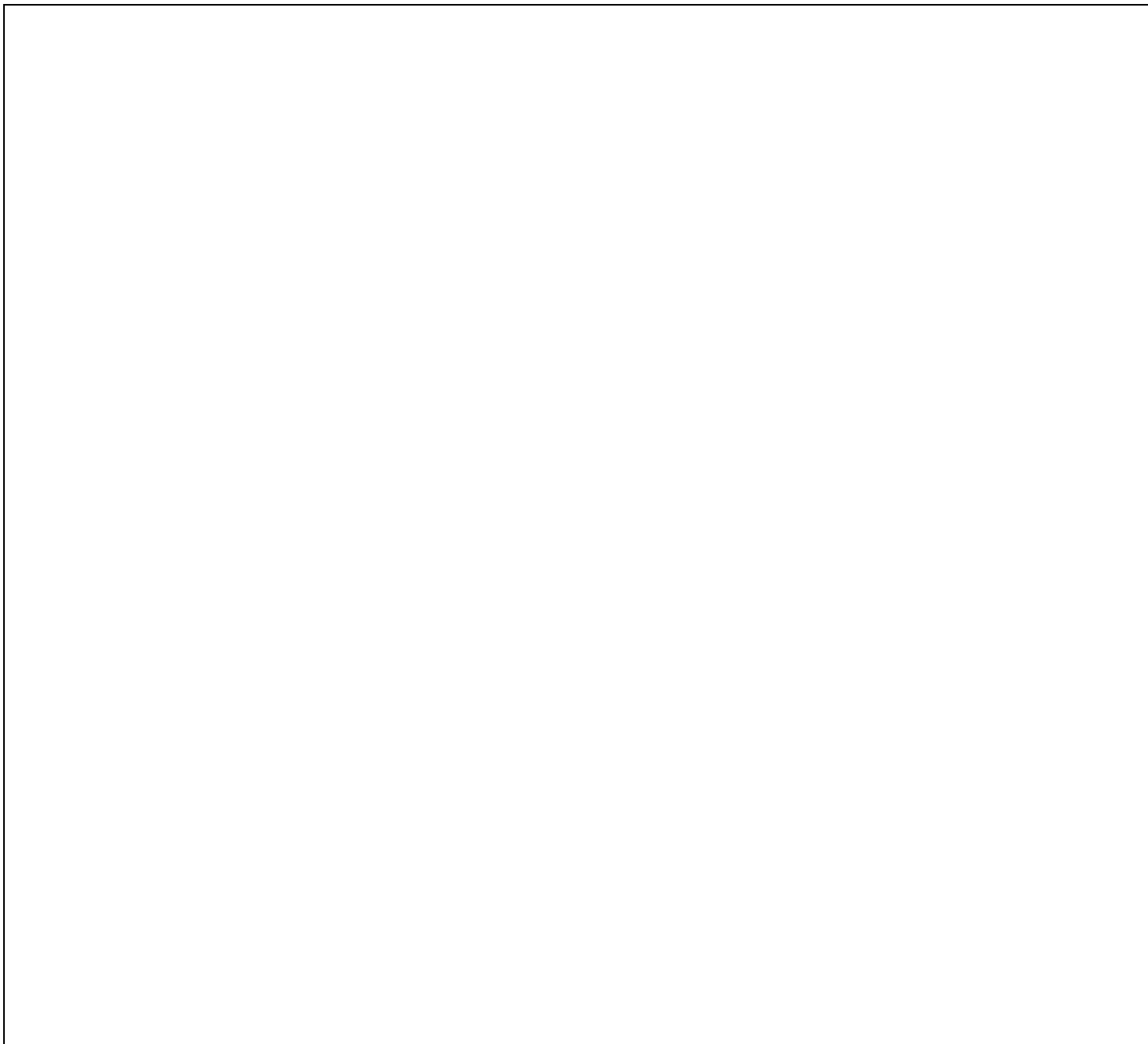
Mitigations:

The PPS has identified mitigation strategies to the challenges:

- **Funds Flow: 95% / 5% Safety Net Limitation** – The PPS is working with partnering organizations in order to identify potential sub-contractor relationships with CBO’s in order to ensure engagement for education and engagement.
- **Financial Sustainability: Value Based Payment Adoption** – The PMO team is partnering with the NYP PPS to build an educational program focused to value based payment conversion. The models will provide educational materials as well as financial modeling tools for partners in order to internally prepare for MCO negotiations and contracting.
- **Funds Flow: Delayed EIP / EPP Contracting** – Both NYP & NYP/Q PPS’s are working closely with the NYP managed care operations executives to complete the contracting in a timely manner. The PMO teams are providing financial analytics and input into the negotiating processes to ensure full understanding of drafted contracts.



- **Transition of the Funds Flow Model to Performance Based** – The Financial Analyst and PMO leadership are working on modeling additional phases of the funds flow models focused to engagement as well as outcomes. It is anticipated to have models presented to the Finance Committee late 2016.





DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: NewYork-Presbyterian/Queens

Highlights and successes of the efforts:

Organizational Section: Cultural Competency & Health Literacy

Successes to Date:

The NYP/Q PPS successfully completed both the Cultural Competency and Health Literacy strategy and training strategy. The PPS has built both the organizational structure and clinical projects with CCHL as the foundational principle. The PPS has built the strategies on national best practices including the NQF CLAS standards, Teach Back, and AskMe3. The PPS is leveraging the expertise of partners who has historically done trainings for the community on health literacy to determine the best ways to educate the community.

Challenges:

The PPS has identified three primary challenges to ensuring the success of the CCHL work.

- **CC/HL Leadership** – The CC/HL committee is comprised of a diverse group of PPS partners with expertise in patient experience, cultural competency, health literacy, and training and the committee is chaired by PMO leadership. The PPS is in the process of contracting with 1199TEF to provider subject matter expertise in the execution of the CC/HL strategy and training plan for the partner network.
- **Training Competencies** – The PPS has created a comprehensive training plan which includes the CCHL trainings. The PPS will be using an e-learning platform for the majority of the trainings. There are currently no national standards for competencies for CCHL. The PPS will include pre- and post-tests in the training to ensure that participates are going through the modules and can track the change in the results. The PPS would like to include additional competencies to ensure that the trainings are comprehended as opposed to being another item that staff click through but do not make any changes to their processes.
- **Cultural Shift for the Workforce** – The PPS will be providing training to the partner network workforce through both in person trainings and e-learning platforms. The PPS will monitor training and the embedded tests to track the changes in competency for the CCHL trainings. The PPS is aware that completing training does not necessarily result in a paradigm shift for the workforce in how they interact with the patients and present information about healthcare and self-management.

Mitigations:

The PPS has identified mitigation strategies to the challenges to the success of the workforce work stream.

- **CC/HL Leadership** – The PPS is in the process of engaging 1199TEF for the workforce related deliverables for the PPS. The PPS aims to have 1199TEF act as a subject matter expert for the CC/HL committee to assist with the execution of the strategy and training plan including vetting vendors and best practices related to training.
- **Training Competencies** – The PPS will include embedded pre- and post-tests for staff in the eLearning platform and provide questionnaires for in person trainings to monitor the success of the training. The PPS will continue to monitor updates from NQF on competencies on CCHL to incorporate into the trainings and evaluation processes.
- **Cultural Shift for the Workforce** – The PPS will provide training for the workforce and track the progress of the embedded competencies. The PPS will continue to work with partners to ensure that CCHL is embedded as a philosophy within the organization beginning at the leadership level. The PPS will strive to engage partners and partner leadership to incorporate the NQF principles in the workflows of the organization and begin to encourage the cultural shift that accompanies this workstream.



DSRIP Mid-Point Assessment Clinical Integration Organizational Narrative

PPS Name:NewYork-Presbyterian/Queens

Highlights and successes of the efforts:

The NYP/Queens PPS has been working towards the creation of an integrated clinical network through the DSRIP program. The PPS, through its organizational committees, project committees, and partner engagement and outreach initiatives, has determined the fundamental needs of a sustainable integrated network. The robust and effective structure of the Clinical Integration committee, which is responsible for the Clinical Integration and Population Health workflows in addition to ensuring clinical quality and oversight of the project committees, engaged both internal stakeholders and PPS partners in the identification of gaps in integration.

As the oversight committee for clinical quality, the Clinical Integration Committee in NYP/Queens PPS is also responsible for approving best practices, evidence based standards, and protocols that have been recommended by the project committees and/or are deemed necessary by the Clinical Integration Committee. To date, the Clinical Integration Committee has reviewed and approved over 15 best practices for the PPS. NYP/Queens PPS continues to work with partners in vetting out evidence based best practices for various clinical processes.

It is necessary to analyze gaps in clinical and operational workflows at the same time as the PPS practices the ongoing approval of best practices. Therefore, NYP/Queens PPS is continuing their search for recruitment for population health nurse who in collaboration with PMO team will work extensively on PDSA (Plan, Do, Study, Act) cycles. The NYP/Queens PPS will also establish a Rapid Cycle Evaluation (RCE) unit in DSRIP DY 2 to utilize performance data reported by partners as well as data available in MAPP (Salient) and other tools for quality improvement efforts.

In order to succeed as PPS and to effectively impact the population health, NYP/Queens PPS understands the value of data-driven process improvement efforts. As part of that, NYP/Queens PPS has started utilization of MAPP dashboard data in project committees. In June 2016, a metrics review and planning day was organized as well within the group, the objective of which was to review, educate and begin process improvement for metrics overall and those out of compliance with goals. Moreover, the PPS has decided to produce quarterly quality based outcome dashboards for all project workgroups. The dashboards will encompass summaries of metric data pulled from MAPP, Salient, and PPS claims data housed on the secure sever. Each dashboard will be unique to the clinical projects and will be shared with the project workgroups for further analysis and process improvement planning. The dashboards will also provide tools to the Rapid Cycle Evaluation Unit team to identify trends and risks associated with quality based outcomes.

Another big highlight of the NYP/Queens PPS in the Clinical Integration organizational project is the establishment of Root Cause Analysis (RCA) workgroup. The long term care project workgroups have



established a process of analyzing an actual patient encounter recommended by a partner based on the goal of reducing hospital admissions, readmissions, or emergency department utilization. The patient information and facility information is blinded and the encounter from beginning to end is discussed and analyzed to identify opportunities for process improvement. The Root Cause Analysis is completed in a workgroup where the team reviews items such as pre-condition/admission indicators, clinical indications, facility processes, communication among facility partners, access to electronic health records, etc. in order to improve outcomes for future patients. The teams are using the RCA lessons learned to make local performance improvement changes to clinical operations in order to avoid ED utilization, admissions and re-admissions. The RCA will also become an integral part of the Rapid Cycle Evaluation Unit to allow team input for process improvement efforts.

Furthermore, as learned in the June 21, 2016 DOH Conference in Albany, the PPS also plans to utilize Lean concepts and create effective workflows with minimal waste in the process. The PPS leadership and PMO team are in discussion for potential identification of such initiatives.

But all these successes and efforts happened after overcoming multiple challenges, some of which the PPS still continues to face. The next few bullet points outline some of many challenges NYP/Queens has been facing and how we tried to resolve them.

Challenge 1: Non-current data and limited tools and resources for data analytics

Timing of project implementation with the MY/DY spread of metrics is a challenge to ensure process improvement that will result in quality outcomes. The PPS has received several DSRIP data feeds, including the member roster and the MAPP performance dashboards. While this information is a necessary start to the quality data process, there continues to be limited availability of data to the PPS and at the partner level. The member roster contains minimal information while the MAPP dashboards have limited access. This data is necessary both as claim based feeds from DOH, but also has real time information to enable rapid cycle improvement in the PPS.

Moreover, due to some movement of employees in the PMO team since the beginning of DSRIP project, the new staff members who are responsible for data analysis and trending do not have access to Salient as they were never present when the initial training was first offered to all PPSs. No upcoming Salient trainings are offered as well. Despite the PPS' interest to be active participant in the Salient Interact Miner workgroup and utilize the data efficiently and meaningfully, the limited tools, staff, and available data for this continues to pose a risk to integration.

Mitigation strategy by NYP/Queens PPS: The PPS is continuing their efforts in working with DOH and Salient contacts who can possibly manage to offer additional Salient training to the new staff in PMO office. In addition, the PPS is working best to use the data that is currently made available to us and create dashboards and summary to be presented to project committees and possibly utilize for further analysis by RCE unit.

Challenge 2: Challenging to get buy-in from partners

It is very difficult to get buy in from partners and perform up to the par and follow the approved best practices without any robust incentive payment model.



Department of Health

Mitigation strategy by NYP/Queens PPS: The PPS is trying to be creative as always and is in the process of formulating an updated incentive plan which will revolve around partners meeting the quality outcome based measures. This will not only make effective use of the limited funding and create a robust incentive plan, but will also serve as a good buy-in strategy for partners to comply with requirements and adopt best practices as needed.

DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: NewYork-Presbyterian/Queens

Highlights and successes of the efforts:**Organizational Section: Funds Flow / Financial Sustainability / Budget****Successes to Date:**

The PPS continues to meet the expectations associated to the financial aspects of the PPS. This mid-point assessment narrative will address (1) Funds Flow, (2) Financial Sustainability, and (3) Budget.

- **Overall –**

- A Financial Analyst was recruited to the PMO and currently is focused to developing monthly financial tools to include budget, actual spend, forecasting, and variance explanations. This team member will work in partnership with the Finance Committee and executive leadership to consistently track and trend financials as well as complete finance deliverables.
- Additional recruitment is underway for numerous positions to include both clinical & non-clinical positions to support operations as well as clinical integration.

- **Funds Flow –**

- Quarterly partner distributions continue with a schedule of March & September to align with the NYS DSRIP payments to include payments for incentives, cost of implementation, and revenue loss.
- PIT Updates in MAPP include payments made to partners based on actual checks cut in quarter being reported.
- CBO payments are included in the incentive funding and will be reviewed monthly to ensure compliance with the 95% / 5% safety-net provider ruling.
- The NYP/Q PPS Executive Leadership is working with the NYP Managed Care team to complete the contracting for the EIP/ EPP funding. One contract has been signed and a second contract is in final phases of signatures.

- **Financial Sustainability –**

- The financial sustainability partner analysis was completed and two partners were identified as potential risks within the network. The Financial Analyst is working to complete the follow-up action items that are identified in the PPS Financial Sustainability plan.
- The PPS Executive Leadership is partnering with the NYP PPS to align strategies of Value Based Payment transition of the lead hospital as well as partners.

○ **Budget –**

- Actual spend has met expectations outlined with the DSRIP application to include: 5% Contingency, 2% Workforce, 30% Administrative Overhead, 5% Non-Covered Services, 10% Revenue Loss, 18% Cost of Implementation, and 30% Incentives.
- Expense forecasting is underway to ensure availability of funds pending the EIP/EPP Contracting.

Challenges:

The PPS has identified the following challenges related to performance reporting:

- **Funds Flow: 95% / 5% Safety Net Limitation** – A number of the clinical programs require a direct connection to CBO’s for engagement and education and the organizations are not safety-net providers.
- **Financial Sustainability: Value Based Payment Adoption** – The NYP/Q PPS is a collaborative model approach which has no accountability of MCO contracting for engaged partners. Along with no direct-accountability, the PPS is also limited to assisting with negotiation and planning due to federal regulatory compliance limitations.
- **Funds Flow: Delayed EIP / EPP Contracting** – The NYP/Q organization depends on the NYP organization to complete all MCO negotiations and contracting. The leadership at NYP is working on behalf of both NYP & NYP/Q PPS in order to complete the EIP/EPP contracting as a system strategy.
- **Transition of the Funds Flow Model to Performance Based** – The existing PPS funds flow model was built to encourage engagement, project requirements, and engaged patient volume. In order to meet the quality based outcomes for performance the model will need to evolve into a true pay-for-performance model blended with other indicators which will ensure engagement, productivity, and quality.

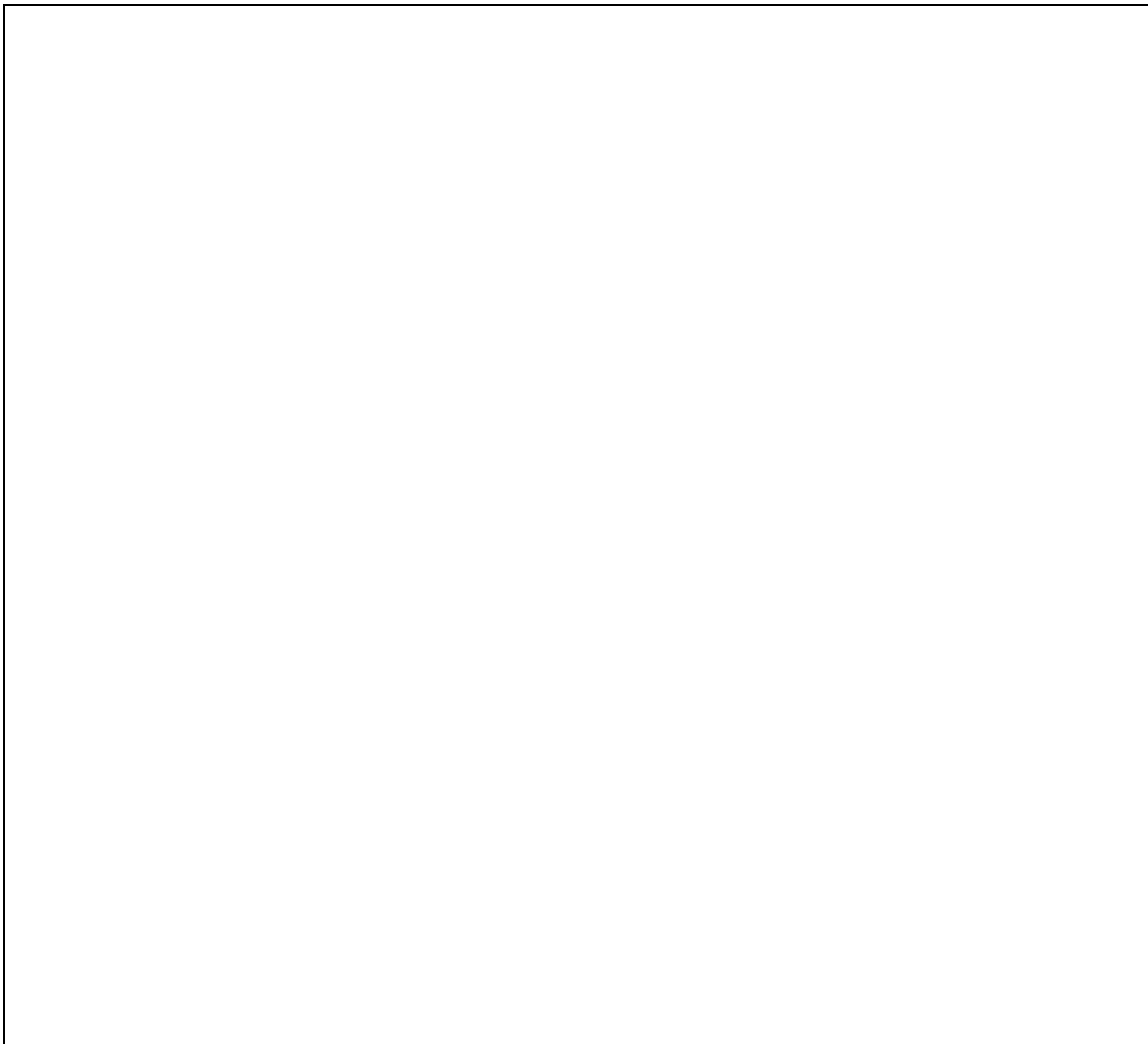
Mitigations:

The PPS has identified mitigation strategies to the challenges:

- **Funds Flow: 95% / 5% Safety Net Limitation** – The PPS is working with partnering organizations in order to identify potential sub-contractor relationships with CBO’s in order to ensure engagement for education and engagement.
- **Financial Sustainability: Value Based Payment Adoption** – The PMO team is partnering with the NYP PPS to build an educational program focused to value based payment conversion. The models will provide educational materials as well as financial modeling tools for partners in order to internally prepare for MCO negotiations and contracting.
- **Funds Flow: Delayed EIP / EPP Contracting** – Both NYP & NYP/Q PPS’s are working closely with the NYP managed care operations executives to complete the contracting in a timely manner. The PMO teams are providing financial analytics and input into the negotiating processes to ensure full understanding of drafted contracts.



- **Transition of the Funds Flow Model to Performance Based** – The Financial Analyst and PMO leadership are working on modeling additional phases of the funds flow models focused to engagement as well as outcomes. It is anticipated to have models presented to the Finance Committee late 2016.



DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: NewYork-Presbyterian/Queens

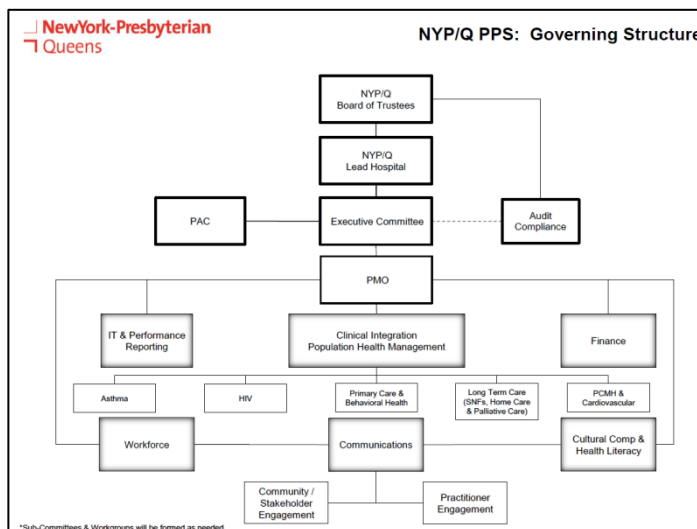
Highlights and successes of the efforts:

Organizational Section: Governance

Successes to Date:

The NYP/Q PPS created a successful collaborative contracting model for the PPS governance structure. The PPS Executive Committee is comprised of members from the PPS lead, NYP/Q, as well as partners from LTC, Behavioral health, Home Care, and a community member. The executive committee oversees the progress and partner engagement for the PPS. Additionally, the PPS has built a PMO team which includes a Director, Program Coordinator, Data Analyst, Financial Analyst, and IT staff. The PMO is continuing to recruit for clinical staff (rapid cycle, chronic disease, and behavioral health) and an additional data analyst. The PMO team works with the NYP PPS PMO to ensure collaboration and consistency across some areas of DSRIP such as VBP and IT resources. This collaborative relationship between the PPSs ensures the appropriate leveraging of resources and tools across both PPSs when available and knowledge sharing for the successes and challenges of DSRIP.

The PPS has created an organizational structure for the projects to be grouped based on deliverables and partner engagement for each. The projects are bucketed into 5 groups – Asthma (3.d.ii), HIV (4.c.ii), Primary Care/Behavioral Health (3.a.i), Long Term Care (2.b.v, 2.b.vii, 2.b.viii, 3.g.ii), PCMH & Cardiovascular (2.a.ii, 3.b.i). The clinical workgroups report into the Clinical Integration and Population Health Management Committee, which is comprised of the chairs from the clinical projects, IT committee chair, and a representative from the RHIO Healthix. The grouping of these projects ensures efficiency for partners by grouping the deliverables to make the scope of the projects more manageable where possible.



The PPS holds bi-annual town hall meetings to promote staff and community engagement and provide a forum for educational sessions and communication on the DSRIP initiatives. Previous town hall meetings have included presentations on DSRIP 101, DSRIP funds flow, pediatric asthma and PCMH. The PPS has been featured in local media from the town hall meetings.



The China Press 03
14 16.pdf

The PPS has executed 45 contracts to date and flowed funds to 49 partner sites¹. A robust communication and engagement plan has been approved by the PPS and outlines the communication process for partners, CBOs, and public agencies for the PPS.

Challenges:

The PPS has identified

- **95%/5% Funding Rule** – Per the STCs of the DSRIP waiver, the PPS is only permitted to flow 5% of fund to non-safety net providers. As the PPS engages non-safety net partners, specifically CBOs, in the DSRIP projects, the ability to incentivize these organizations is limited by this requirement.
- **Value Based Payment** – The NYP/Q PPS is a collaborative model approach which has no accountability of MCO contracting for engaged partners. Along with no direct-accountability, the PPS is also limited to assisting with negotiation and planning due to federal regulatory compliance limitations.

Mitigations:

- **95%/5% Funding Rule** – The PPS is working on engaging CBO partners through project participation and educational opportunities for the PPS. The PPS is also working with partners to identify potential sub-contracting opportunities for CBOs and external revenue sources, such as grant funding. DOH is currently in the process of requesting an extension of the safety net definition to any provider who sees a minimum of 25 Medicaid patients. If this is approved, the PPS will have more flexibility with incentive funding as additional providers in the PPS will be eligible for the 95%.
- **Value Based Payment** – The PMO team is partnering with the NYP PPS to build an educational program focused to value based payment conversion. The models will provide educational materials as well as financial modeling tools for partners in order to internally prepare for MCO negotiations and contracting.

¹ Partners are contracted at an organizational level and funds are flowed by DOH categorization, therefore the PPS may contract with an FQHC that has 3 sites. This results in 1 contract but 3 funds flow to each of the sites within the FQHC.



DSRIP Mid-Point Assessment Information Technology Organizational Narrative

PPS Name: NewYork-Presbyterian/Queens

Highlights and successes of the efforts:

RHIO Connectivity and EHR Implementation Strategy

To date, the NYP/Queens PPS has successfully identified and implemented various strategies, policies and tools to support a fully integrated DSRIP health system. Surveys were initially the main tools used to assess downstream partners for their current capabilities across various IT tools, systems and security resources. Based on the results of the surveys and subsequent revalidation of the data, the PPS was able to complete a gap analysis to identify priority areas including partners and tools.

Therefore, the PPS identified Healthix and NYCREACH as the two main partners to help close the gaps on RHIO connectivity and EHR adoption (MU Stage 2 compliance), respectively. Additionally, to facilitate partner engagement for RHIO connectivity the PPS implemented a pilot which was created based on partners who share a similar EHR system. As part of the pilot, the PPS assigned an implementation specialist to work with the vendor and the partners to help gather requirement and provision the work needed. The role of NYCREACH is to helping the PPS to engage and educate PPS partners without EHRs, how to adopt, implement and attest for Meaningful Use. Partners who are identified as not meeting MU Stage 2 or not having EHR systems are being invited to NYCREACH/NYP-Queens, hosted seminars to participate and learn about their options.

Information Security

The NYP/Queens PPS has successfully completed a full scale security assessment of our DSRIP partners. The security assessments were completed using partners' surveys. The objective of assessment was to determine if partners have implemented appropriate policies and tools to help maintain the privacy and security of patient health data. Additionally, the PPS has created recommended policies to address security & confidentiality. The standardized recommendations are in alignment with current policies of the healthcare organization, NYP/Queens. Language in the security and confidentiality document provides guidance regarding policies and tools to address Administrative, Technical and Physical Safeguards, being recommended to the PPS partners.

Information Security – Server

The PPS has also completed the SSP workbooks and have been receiving and storing claims data for DSRIP data analytics and population health management. Some of the elements and steps included into the claims data file and includes the following;

- Server is Separated From the Hospital Domain
- Virtualized



- Encrypted Server
- Limited Admin Access, Limited Users (2 each)
- Contained Environment Virtual Session
- Data
- Secure File Transfer Protocol New York State
- Medicaid Data – Encrypted NYP/Q Key
- Two-Factor Authentication (2 authorized users)
- Open Source Data Tool (Libre Office)
- Old data destroyed as per NYS request – DOD DeGuasse Standard
- Data Exchange Application & Agreement
- Keith Weiner, NYP/Q Security Officer completed the SSP work books.

DSRIP IT Tools

The PPS has identified and implemented tools such as a RHIO consent Model, Allscripts Care Director, eMolst and Cureatr to support appropriate DSRIP projects.

RHIO Consent Model

A RHIO consent model was implemented within the Eagle registration system to facilitate the capturing and communication with the RHIO (Healthix). RHIO consent is a critical component of the project. Therefore it is important that the PPS establishes a specific strategy for collecting the appropriate consent for all attributed lives.



Allscripts Care Director (ACD)

The PPS has recently completed a phase 1 rollout of the population health system Allscripts Care Director. The system was configured with the appropriate access levels for DSRIP users, relevant care plans, assessments, attribution plans and reporting features. Phase 1 was based on an internal roll-out to the internal staff to provide a centralized system where attributed patients will be managed and tracked. The phase 2 configuration and implementation of the system is in progress and will be set-up to consume Clients Event Notifications (Alerts) from the RHIO. Additionally the system is also in process of being configured to finalize the attributed patients and to extend access to identified PPS partners who are not using a similar platform.

Cureatr & eMOLST

The PPS is also collaborating with the secure messaging technology vendor Cureatr, to support data exchange, client event notifications, tracking 30-day readmissions and other care coordination initiatives. The vendor has an existing ADT feed in the PPS, which is currently being leveraged to support care transitions and patient tracking. The system design for Cureatr to support data exchange of engaged patient counts across the PPS and to facilitate provider secure text messaging options are being finalized. An IT workflow to support the system design has been completed and the project will kick-off after validation from the clinical leads. In addition to the work which has been completed to implement the ACD Cureatr, the PPS has also piloted and implemented the Electronic Medical Orders for Life-Sustaining Treatment (eMOLST). The implementation and access to this state registry was completed to support the PPS palliative group. Staff trainings and introduction to the system was supported by the PPS leads, IT and eMOLST partner. Plan to engage our partners about adopting and implementing EMOLST is in progress.

Some Challenges:

- No clearly identified Data Analytics tool
- RHIO consent model that supports the entire PPS
- Lack of IT resources at partner sites to support integration
- Slow adoption of partners RHIO connectivity
- Integration Issues across disparate systems.
- No Telemedicine/Telehealth identified resources.
- Patient Enrollment into the PPS designated population Health System
- Data Exchange tools and guidance.

Mitigation Strategies: The PPS and the IT team will continue outreach to the State and collaborate with other PPSs who are experiencing similar issues. The PPS will also continue to let the clinical workflows defined by the clinical leads who can determine the appropriate tools and strategies to implement.



DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: NewYork-Presbyterian/Queens

Highlights and successes of the efforts:

Organizational Section: Population Health Management

Successes to Date:

The PPS has initiated conversations with project workgroups to outline a roadmap strategy for population health management. The roadmap will align with the nine projects and will select a focused patient base to manage with the existing tools to be implemented by the IT team to include Allscripts Care Director, Cureator, and an analytical tool to be announced. The following steps will be the focus of the PMO & clinical leads to outline this strategy:

- **Recruitment of a Population Health Manager (RN preferred)** – The PMO leadership currently has a vacant position for a PH Manager and will continue to interview to fill as soon as possible. This position will be accountable for building the Rapid Cycle Evaluation Unit while partnering with the clinical leads to implement the PHM strategy.
- **Population Analytics** – The PHM strategy will identify a select patient set to manage as the PPS funding limits the ability to manage the entire population. NYP/Q chose project 2.a.ii versus 2.a.i and will not create an integrated delivery system to align with a PHM strategy. The focused PMH strategy will align with the selected projects such as the PCMH integration in order to address gaps in care, care coordination, patient tracking, provider identification & engagement, etc. The PMO data analytics team will work with the existing data elements to identify a select population to maximize the benefit of implementing a PHM strategy. The data will be categorized and prioritized to include utilization, chronic conditions, access, and gaps in care and will be presented to the Clinical Integration Committee for final prioritizations and decisions.
- **Alignment of Focused Patient Base to Projects** – The analytics completed above will then be aligned with complimenting projects to outline process workflows, plans to ensure proper provider engagement, and address any gaps in care focused to care coordination & quality improvements.
- **Completion of the PHM Strategy** – Upon final analytics and vetting among partners and clinical leads, the PMO team will finalize a strategy roadmap to outline the PPS strategy to include processes, partners, and IT tools for the focused patient base.
- **Clinical Workgroup, Clinical Integration & PAC Presentation** – A complete PHM strategy roadmap will be reviewed by multiple partner outlets to include clinical workgroups and PAC. The final PHM strategy will be reviewed & approved by the Clinical Integration and Executive Committees.

Challenges:

The PPS has identified the following challenges related to population health management:

- **Limited Funding for a Complete PHM Strategy** – The available funding for the NYP/Q PPS is limited and will be consumed by the clinical integration of the nine projects. A strategy of population health for the entire attributed network would require more funding to ensure complete processes and tools are implemented (ex: Care coordination, data analytics, etc.)
- **Manual Processes for IT Tool Registration** – The PMO IT team has identified tools needed to implement the PHM strategy which requires a large amount of workforce time to manually register patients for tracking.

Mitigations:

The PPS has identified mitigation strategies to the challenges:

- **Limited Funding for a Complete PHM Strategy** – The PMO team is working to identify a select group of patients to build a PHM strategy focused to quality improvements. The population that will be identified during the ‘population analytics’ process on page one of this document will focus to the most relevant patient population based on need and opportunities for improvements in order to maximize the return of investment for processes and tools.
- **Manual Processes for IT Tool Registration** – The PMO IT team is working with the IT vendors in order to identify additional batch methods for the registration of the attributed lives for the NYP/Q PPS. The complexity of this task is to ensure no duplication of records when we receive a monthly performance attributed patient registry from NYS.



DSRIP Mid-Point Assessment Practitioner Engagement Organizational Narrative

PPS Name:NewYork-Presbyterian/Queens

Highlights and successes of the efforts:

The NYP/Queens PPS has made enormous efforts to date to build a sense of efficiency and community among PPS practitioners, partners, and leaders by sharing regular, organized communications. We also continue to encourage transparency among practitioners and partners in order to instill public trust in the changes being proposed and community belief in the potential for successful outcomes.

The NYP/Queens PPS is organized as a collaborative contracting model. It is made up of dozens of healthcare, mental health and community service providers in the region. These community partners, agencies, patients, and providers participate in 15 subcommittees that function under an Executive Committee that reports in to New York-Presbyterian/Queens and its Board of Trustees. One of these subcommittees is a Communications Committee. Community partners also participate in a Project Advisory Council (PAC) that oversees development of the NYP/Queens DSRIP's nine (9) approved community projects as well as a bi-annual Town Hall meeting that focuses on PPS function and project updates to the community at large.

To date, the internal NYP/Queens internal practitioners participate in the project workgroups, executive committee and professional group meetings. The monthly / quarterly project workgroups are focused to (1) Primary Care & Behavioral Health, (2) Cardiovascular, (3) Long Term Care, (4) Palliative Care, (5) Asthma, and (6) HIV. Executive committee meetings occur monthly which are focused to PPS development, approvals, risks, and financials. The numerous Professional Group meetings occur based on the scheduling of each organization. Agenda items include general topics, DSRIP specific items, and related professional topics.

Additionally, the PPS is working on rolling out multiple IT tools for project management, population health management, event notifications etc. With that, the PPS also recognizes that it is critical that communications and roll-out for our network is efficient and effective to ensure partner and practitioner engagement and use of products developed. The PMO management team will continue to perform continuous outreach to partners for feedback on the process, tools, reports, and data for ongoing updates.

In order to ensure active and meaningful practitioner engagement, the NYP/Queens PPS has arranged several trainings which encourage the practitioner to be subject matter expert or champion and educate others at their respective sites. Examples include trainings to recruit Physician champions for PCMH, Palliative Care champions and INTERACT champions for the long term projects.

For the sites who are undergoing the PCMH transformation and for those that have completed the transformation, the PPS is appointing a physician champion at each site. Physician champion training is provided to selected practitioners. The training is focused on NCQA's 2014 PCMH standards, True practice



Department of Health

transformation, role of change management, role of HIT, and lessons learned. Then, the physician champion is expected to be engaged in various ways. They will partner with HANYS PCMH Advisory Services to ensure buy-in from the team and effective roll out of processes. They will serve as the liaison between CMO and other physicians. In addition, they will be the go to person for escalations and reinforcement with other providers. They will partner with Project Manager and PCMH team to educate clinicians and staff on goals and standards. Moreover, they will also report monthly updates to appropriate parties.

Besides PCMH training, the PPS will provide training to the long-term care providers participating in the INTERACT and home care project. The PPS aims to implement a train-the-trainer model by having the facility champions trained and then having the champions act as the trainers and experts at their own facilities.

In collaboration with GNYHA, the NYP/Queens PPS has hosted an all-day training session on June 15, 2016 for care coordinators in the PPS. Care coordinators are those who would play a coordination role in the continuum of care for patient. There was a very good turnout to this training. The assigned care coordinators from each partner site were very engaged. This specific training was intended to specifically educate the coordinators about the fundamental, evidence-based concepts for building an effective care coordination process to achieve improved outcomes and understands roles, responsibilities and best practices within their individual sites.

Another way of encouraging practitioner engagement that the PPS has adopted is through building training modules and requiring partners/ practitioners to comply by watching the modules and testing their knowledge in it. The NYP/Queens PPS aims to train the PPS partner's workforce on DSRIP through DSRIP 101 training, which includes what DSRIP is, the goals of the program, the specifics of the NYP/Queens PPS, how to participate, and the funds flow incentive model. Similar to the DSRIP 101 training, the PPS has also undertaken training specific to each of the projects for the partners participating in each. These project specific trainings are aimed at providing baseline knowledge of the goals and requirements of each project and provide a platform for in depth project specific training. These baseline trainings have taken place at committee meetings with participating providers/partners and at town hall meetings for the PPS. The PPS will continue to engage partners in these forums and through individual encounters to ensure any new participants/practitioners in DSRIP have a thorough understanding of the projects that have been selected.

The PPS also educates partners/practitioners on various policies, procedures and approved documents and best practices. For instance, Performance Reporting Strategy is an approved document crafted by the PPS that includes policies, processes, and procedures to ensure confidential data exchange and effective communications for quality and operational data between the PPS and its provider network. Partners/Practitioners will be educated on the Performance Reporting Strategy as well.

Given the hundreds of partners that the NYP/Queens PPS has, the liaison role that partners play is a critical one to ensure success, overall and in specific projects. The goal is to have partner organizations take ownership of PPS projects by developing knowledge and enthusiasm.

Below are a variety of communications vehicles and engagement methods that are already implemented or will be in near future to stimulate partners' active participation, helping them to lead and manage potential issues:

Web site: A microsite has already been created for use by all stakeholders, including PPS partners. This is a



common work environment that provides plans, schedules, materials, and links to other content and engagement tools of various types. The website will be continually updated based on the development of the PPS.

Message track: This outlines key messages to be used in discussing programs. It includes citations for data used to support those programs, as well as messaging around the Community Needs Assessment that details the needs around which those programs were created.

Elevator speech: A one-page document that describes DSRIP, what the PPS is doing and the route to success. Partner leaders and team members should customize this speech and use it to talk about DSRIP with external stakeholders and their own staff.

Frequently Asked Questions (FAQs): Responses to commonly asked questions collected from leaders, employees and physicians. It provides answers directly from the DSRIP project team.

Glossary of Terms: A common list of terms that people may hear during the DSRIP rollout – terms they may not be familiar with or understand.

Master deck: A collection of slides that tells the story of DSRIP. It will include a healthy dose of visuals and infographics suitable for varying audiences. The deck is not meant to be used in its entirety; partner leaders will be encouraged to pull out necessary slides and graphics to suite their purposes.

Community Needs Assessment 101: A brief on the highlights of fall 2014 findings and what they mean to the community.

Templates for Milestone Announcements: Models of *ads*, *press releases*, *media advisories* and *letters* will be provided for partner use in communicating with their external stakeholders. Other items will be developed if needed as programs roll out.

Link to possible Introductory Video: If feasible from budget perspective, a video will be produced to introduce Partner leadership, their employees and physicians to the DSRIP project. It will include description of DSRIP projects, why the projects are being developed and what it means for individual stakeholder organizations.

Project List, Descriptions, Timeline and Site-Specific Involvement: Timeline of when major project milestones will occur and what it means for partners. The timeline will change as projects progress.

Archive and Links: Relevant content, as well as tools on other web sites, including NY State Department of Health.

Mini-White paper, “What does Transformation look like”? This will be provided to PPS partners for use within their organization and with external stakeholders.

Performance Logic: A project management software, will be rolled out to all engaged partners to track project progress and action items for proper PPS quarterly reporting.

Function and Project Committees and Sub-Committees: All partners were surveyed as to their interest in all function and project committees and sub-committees, based on the projects committed or subject matter expertise. Committee rosters are maintained and partners are encouraged to add additional members based on the evolution of each group. (All meetings allow in person and call in options with occasional webinars)

Project Advisory Council (PAC): All external partners hold a seat on the PAC and are invited to engage quarterly.

Town Hall: Meetings allow external stakeholders to participate and / or present as a subject matter expert to the community, based on the topic being covered.



Department of Health

MAX Series: Identified engaged partners that align with the NYS MAX series topics are given the opportunity to participate and receive additional funds flow based on the approved PPS funds flow model.

TOM Series: IT focused committee that allows for partner engagement to collaborate on information technology scenarios and how they relate to a project to anticipate the PPS need for operational changes to improve IT and patient care. This is an additional item that links to the funds flow model approved.

NYS All PPS Meetings: The PPS leadership reviews all PPS meeting agendas to identify partner attendance to allow access to all state PPS meetings.

As PPS project implementation accelerates, regularly scheduled Partner/team conference calls will be instituted to provide updates, identify issues as they develop, answer questions, and share ongoing communications guidance



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

PPS Name: NewYork-Presbyterian/Queens

Project: 2.a.ii

Challenges the PPS has encountered in project implementation:

The PPS has identified several challenges specific to the implementation of the PCMH project. These challenges include

- Care Coordination Resources – Approximately 1/3 of partners that are undergoing PCMH transformation are small practices, which may only include a physician and a medical assistant. The PCMH practices, especially these small sites, have limited resources to provide care coordination and generally do not have the capacity to hire a new employee specific to care coordination.
EHR/IT Requirements – NYP/Q is currently undergoing a change in EHR systems for the ambulatory clinics from eCW to Athena Health. The PCMH transformation and application process requires that clinics have reports, population health management, and an EHR. In order to provide this information, the sites are required to have an EHR system that is utilized. The transition from eCW to Athena Health has required a delay for the NYP/Q sites to complete the application and certification process.
Transformation Process – The transformation process for PCMH is a both a time consuming and resource intensive process. Many practitioners have identified this as the largest hurdle to participating in this project.

Efforts to mitigate challenges identified above:

Based on the identified challenges for the project, the PPS has identified the following mitigation strategies:

- Care Coordination Resources – The PPS has partnered with GNYHA to provide care coordination training to PPS partners. The PPS hosted the 1st session in June 2016 and had 27 attendees from across the partner network. The PPS aims to continue supporting these in person sessions and will consider including a refresher course on the eLearning platform.
EHR/IT Requirements – NYP/Q sites completed the transition to Athena Health in July 2016. The HANYS Solutions team is in the process of reengaging the NYP/Q sites to complete the application process. NYP/Q sites are on schedule to submit the PCMH 2014 Level 3 application in the fall/winter of 2016.

- **Transformation Process** – The PPS has engaged HANYS Solutions to assist practices with the transformation process across the partner network. As of DY2, Q2 4 practices (20 practitioners) have completed the PCMH process and received their 2014 Level 3 certification. The PPS is continuing to work with an additional 6 practices (16 practitioners) to complete the certification process by the end of DY3 per the project requirement. Currently, all practices are on track to meet the requirements for certification.

Site Name	# of Practitioners	PCMH Transformation Status
Brightpoint Health	3	Certified 2014 Level 3
Community Health Network	14	Certified 2014 Level 3
Advanced Pediatrics	2	Certified 2014 Level 3
Ma Jesus Calagos, M.D.	1	Certified 2014 Level 3
Jackson Heights	4	In Progress
TLCC	6	In Progress
ACC	3	In Progress
Jose Quiwa, M.D.	1	In Progress
Rite Care	1	In Progress
Dr. T	1	In Progress
TOTAL	36	

Implementation approaches that the PPS considers a best practice:

The PPS has approved several best practices for the PCMH project:

- **Roles & Responsibilities – Care Coordination & Physician** – The project committee has created an outline of the roles and responsibilities for care coordinators and physician champions in the PCMH project.



Care Coordinator
Role and Responsibility



Physician Champion
Role and Responsibility

- **PCMH Roadmap** – The PPS, in collaboration with HANYS Solutions, created a roadmap for completing the PCMH process and built a training outline including a timeline and protocols.



PCMH Roadmap 11
30 15.pdf



PCMH Training
Protocols & Timeline C

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

All scale & speed expectations for this project are forecasted to be met based on those partners committed to the project.



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

There are no current proposals for changes to the populations served by the patient centered medical home project.



DSRIP Mid-Point Assessment SNF Care Transition Project Narrative

PPS Name:NewYork-Presbyterian/Queens

Project:2.b.v

Challenges the PPS has encountered in project implementation:

The NYP/Queens PPS selected this project and bundled it with two other projects INTERACT and Hospital Home care as the objectives and deliverables align well together. One of the main objectives of this specific project is to ensure SNF staffs have access to hospital patient records and hospital staff prior to patient discharge; therefore, Information Technology is an integral key to success.

The NYP/Queens PPS IT survey revealed that most partner nursing homes have EHR systems. However, there is a lack of interoperability among partners. Currently, SNFs are not eligible for Meaningful Use and therefore minimal incentives to have a certified EHR (as required by DSRIP) and connect to a RHIO. However, as part of mitigation strategy, the PPS has implemented a RHIO pilot to provide resources and a small financial incentive for partners who participate (to be described in the section below).

Also, in implementing several milestones for this project, the PPS has been encountering numerous challenges. A common barrier for an improvement effort such as this is enabling time for project team participation and for the training required to support implementation. Nursing home leaders are requested to support team participation and training as part of, not in addition to, their day to day job responsibilities. Successful implementation require funding in the project budget to allow for training participation without causing understaffing at the bedside. As the smallest PPS, and with minimal funding, this becomes a challenge for NYP/Queens PPS.

Efforts to mitigate challenges identified above:

To incentivize partners to both adopt an EHR and connect to the RHIO, the PPS has adopted bilateral strategies, (1) NYCReach and (2) RHIO Pilot. The PPS partnered with NYC Reach, an organization that assists practices with selecting, adopting, and implementing EHR systems. This service is offered to partners that are currently utilizing a paper based clinical documentation system as part of their participation in the NYP/Q PPS DSRIP efforts. Additionally, the PPS selected 'Infrastructure spending related to SHIN-NY / RHIO' as an EIP (Equity Infrastructure Payment) measure. As the PPS will receive incentive payments for accomplishing this through the EIP/EPP program, the PPS has incorporated incentive funding for participation into the funds flow model. Participants in the RHIO pilot program currently receive \$2,500 for participating in the pilot and connecting to the Healthix RHIO.

In order to make sure the SNFs and home care facilities can have INTERACT training for all staff members and at the same time keep the operations uninterrupted, the PPS adopted the idea of having facility champions from each partner organization. Facility champions are in the process of being identified at sites.



The PPS aims to implement a train-the-trainer model by having the facility champions trained and then having the champions act as the trainers and experts at their own facilities.

To date, the INTERACT is close to finalization and budget for the training is drafted as well. The PPS projects to have the training sessions with the 27 SNFs and 8 home care facilities potentially in September 2016.

Implementation approaches that the PPS considers a best practice:

The NYP/Queens PPS has undertaken several approaches that we are proud to consider as best practice and below bullet points highlight the efforts to accomplish that.

- **Development of Advance Care Planning Tools**

The PPS is encouraging partners to utilize the eMOLST tool for participation in the long-term care bundled projects. eMOLST optimizes the clinicians workflows and helps them to determine the level of appropriate care for terminally ill patients. The PPS has engaged Dr. Patricia Bomba, MD, FACP with Excellus BlueCross BlueShield to provide training to PPS partners on how to utilize the tool most efficiently. This training will be provided based on demand by the PPS partners.

- **INTERACT Implementation checklist shared with the partner facilities**

This checklist is intended to assist organizations in determining the degree to which the INTERACT Quality Improvement Program is being implemented. INTERACT implementation requires all the key components in the checklist, not just using selected INTERACT tools.

- **Population Health Management and Event Notification Tools**

The PPS has selected vendors for population health management (Allscripts) and event notifications (Cureatr) to contract with on behalf of PPS partners.

The Allscripts Care Director (ACD) tool is in the process of an internal roll out at NYP/Queens with the PMO and clinical leads. The goal is to include all engaged patients in the tool and utilize the reporting and care plan functions to improve care coordination and generate required reports for the quarterly reporting process to DOH and the IA. After a successful implementation at the PMO, the PPS plans to roll out the tool to partners to continue to load patients requiring care plans and patients that meet the actively engaged definitions for the participating projects. The PPS will complete a phased roll out of the tool beginning with the NYP/Q hospital during DY2, Q2.

Cureatr is an event notification tool which provides user notifications of patients registered who have had an admission or discharge to the hospital. NYP/Queens currently utilizes the tool with the case management care coordinators and the PPS aims to roll out the tool to select partners. The PPS aims to roll this tool out to primary care and home care providers in the PPS to ensure timely follow-up on any inpatient or ED admissions. The PPS is in the process of validating need of the tool based on the services provided by partners, but it is likely that the PCMH and home care partners will be provided access to enable enhanced coordination of care.

- **Project Performance Metrics:**

In order to succeed as PPS and to effectively impact the population health, NYP/Queens PPS understands the value of data-driven process improvement efforts. As part of that, NYP/Queens PPS has started



utilization of MAPP dashboard data in the SNF/INTERACT project committee. Moreover, the PPS has decided to produce quarterly quality based outcome dashboards for the project workgroup. The dashboards will encompass summaries of metric data pulled from MAPP, Salient, and PPS claims data housed on the secure sever. The dashboard will be shared with the project workgroups for further analysis and process improvement planning. The dashboards will also provide tools to the Rapid Cycle Evaluation Unit team to identify trends and risks associated with quality based outcomes.

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

All scale & speed expectations for this project are forecasting to be met based on those partners committed to the project.

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

There are no current proposals for changes to the populations served with our Care Transitions Intervention for Skilled Nursing Facility (SNF) residents' project, as our clinical integration of the project align with the needs outlined in our community needs assessment.



DSRIP Mid-Point Assessment INTERACT Project Narrative

PPS Name:NewYork-Presbyterian/Queens

Project:2.b.vii

Challenges the PPS has encountered in project implementation:

The NYP/Queens PPS has selected the INTERACT program as one of the 9 clinical projects as we think this is a best practice for reducing avoidable readmissions from nursing facilities. The PPS intends to support partner sites implementing this program and utilize lessons learned from partners that have already adopted the program to ensure a successful implementation across participating sites.

However, in implementing several milestones for this project, the PPS has been encountering numerous challenges. A common barrier for an improvement effort such as this is enabling time for project team participation and for the training required to support implementation. Nursing home leaders are requested to support team participation and training as part of, not in addition to, their day to day job responsibilities. Successful implementation require funding in the project budget to allow for training participation without causing understaffing at the bedside. As the smallest PPS, and with minimal funding, this becomes a challenge for NYP/Queens PPS.

Moreover, in order to build better coordination system and meet the multiple project requirements, the partner organizations needs to have eMR and be connected to RHIO. Currently, SNFs are not eligible for Meaningful Use and therefore minimal incentives to have a certified EHR (as required by DSRIP) and connect to a RHIO. However, as part of mitigation strategy, the PPS has implemented a RHIO pilot to provide resources and a small financial incentive for partners who participate (to be described in the section below).

Efforts to mitigate challenges identified above:

The NYP/Queens PPS conducted a survey of participating nursing homes to assess if the INTERACT program had been adopted and the degree of adoption. One facility reported the adoption of seven of the tools designed for nursing homes and was advanced in its practice of INTERACT principles. This entity proved to be a great resource for the quality improvement collaborative. During the assessment, nursing homes were also asked to complete the Interact Version 3.0 Nursing Home Capabilities List to strengthen the match between SNF selection and patient needs at hospital discharge. This is a first step towards the adoption of the INTERACT program and therefore the implementation has begun.

In order to make sure the SNFs and home care facilities can have INTERACT training for all staff members and at the same time keep the operations undisrupted, the PPS adopted the idea of having facility champions from each partner organization. Facility champions are in the process of being identified at sites. The PPS aims to implement a train-the-trainer model by having the facility champions trained and then



having the champions act as the trainers and experts at their own facilities.

To date, the INTERACT is close to finalization and budget for the training is drafted as well. The PPS projects to have the training sessions with the 27 SNFs and 8 home care facilities potentially in September 2016.

To incentivize partners to both adopt an EHR and connect to the RHIO, the PPS has adopted bilateral strategies, (1) NYCReach and (2) RHIO Pilot. The PPS partnered with NYC Reach, an organization that assists practices with selecting, adopting, and implementing EHR systems. This service is offered to partners that are currently utilizing a paper based clinical documentation system as part of their participation in the NYP/Q PPS DSRIP efforts. Additionally, the PPS selected 'Infrastructure spending related to SHIN-NY / RHIO' as an EIP (Equity Infrastructure Payment) measure. As the PPS will receive incentive payments for accomplishing this through the EIP/EPP program, the PPS has incorporated incentive funding for participation into the funds flow model. Participants in the RHIO pilot program currently receive \$2,500 for participating in the pilot and connecting to the Healthix RHIO.

Implementation approaches that the PPS considers a best practice:

The NYP/Queens PPS has undertaken several approaches that we are proud to consider as best practice and below bullet points highlight the efforts to accomplish that.

- **Development of Advance Care Planning Tools**

The PPS is encouraging partners to utilize the eMOLST tool for participation in the long-term care bundled projects. eMOLST optimizes the clinicians workflows and helps them to determine the level of appropriate care for terminally ill, patients. The PPS has engaged Dr. Patricia Bomba, MD, FACP with Excellus BlueCross BlueShield to provide training to PPS partners on how to utilize the tool most efficiently. This training will be provided based on demand by the PPS partners.

- **INTERACT Implementation checklist shared with the partner facilities**

This checklist is intended to assist organizations in determining the degree to which the INTERACT Quality Improvement Program is being implemented. INTERACT implementation requires all the key components in the checklist, not just using selected INTERACT tools.

- **Population Health Management and Event Notification Tools**

The PPS has selected vendors for population health management (Allscripts) and event notifications (Cureatr) to contract with on behalf of PPS partners.

The Allscripts Care Director (ACD) tool is in the process of an internal roll out at NYP/Queens with the PMO and clinical leads. The goal is to include all engaged patients in the tool and utilize the reporting and care plan functions to improve care coordination and generate required reports for the quarterly reporting process to DOH and the IA. After a successful implementation at the PMO, the PPS plans to roll out the tool to partners to continue to load patients requiring care plans and patients that meet the actively engaged definitions for the participating projects. The PPS will complete a phased roll out of the tool beginning with the NYP/Q hospital during DY2, Q2.

Cureatr is an event notification tool which provides user notifications of patients registered who have had an admission or discharge to the hospital. NYP/Queens currently utilizes the tool with the case management



care coordinators and the PPS aims to roll out the tool to select partners. The PPS aims to roll this tool out to primary care and home care providers in the PPS to ensure timely follow-up on any inpatient or ED admissions. The PPS is in the process of validating need of the tool based on the services provided by partners, but it is likely that the PCMH and home care partners will be provided access to enable enhanced coordination of care.

- **Project Performance Metrics:**

In order to succeed as PPS and to effectively impact the population health, NYP/Queens PPS understands the value of data-driven process improvement efforts. As part of that, NYP/Queens PPS has started utilization of MAPP dashboard data in the SNF/INTERACT project committee. Moreover, the PPS has decided to produce quarterly quality based outcome dashboards for the project workgroup. The dashboards will encompass summaries of metric data pulled from MAPP, Salient, and PPS claims data housed on the secure sever. The dashboard will be shared with the project workgroups for further analysis and process improvement planning. The dashboards will also provide tools to the Rapid Cycle Evaluation Unit team to identify trends and risks associated with quality based outcomes.

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

All scale & speed expectations for this project are forecasting to be met based on those partners committed to the project.

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

There are no current proposals for changes to the populations served with our INTERACT project as our clinical integration of the project align with the needs outlined in our community needs assessment.



**DSRIP Mid-Point Assessment
Hospital Home Care Project Narrative**

PPS Name:NewYork-Presbyterian/Queens

Project:2.b.viii

Challenges the PPS has encountered in project implementation:

The NYP/Queens PPS has identified Hospital Home Care project, alongside Care Transitions in SNF and INTERACT project, as a vital project to make impact to its community based on the community needs assessment. For patients identified as high risk for readmission, transitions from hospital to home are expected to be managed using an interdisciplinary, multi-agency discharge team including patient and family, hospital, PCMH, home care, DME, social services and specialty services as needed. A transition care coordinator is expected to ensure timely patient follow-up with their PCP, that the plan of care is communicated to all involved, and that guidelines and criteria are in place for early identification and treatment of worsening patient conditions.

As one of the resources and tools that can be used by home care agencies, the PPS chose the INTERACT Program as it offers a comprehensive implementation package which is compatible with EHR and paper based systems. The NYP/Queens PPS is supporting the adoption and implementation of the INTERACT tools by the home care agencies. This project is well suited to using a quality improvement collaborative model (“learning system that brings together teams to seek improvement in a focused topic area”) to implement the INTERACT program and are used by the NYP/Queens PPS. Since the INTERACT processes and materials are already developed and available, the home health agencies can focus collectively on the systematic implementation of the tools while learning from each other, leveraging common resources such as physician and staff training, and support each other throughout the process. The early adopter in the group can share lessons learned with others just starting. However, in implementing that came some barriers as well. A common barrier for an improvement effort such as this is enabling time for project team participation and for the training required to support implementation. Nursing home leaders are requested to support team participation and training as part of, not in addition to, their day to day job responsibilities. Successful implementation require funding in the project budget to allow for training participation without causing understaffing at the bedside. As the smallest PPS, and with minimal funding, this becomes a challenge for NYP/Queens PPS.

As stated in DSRIP application for this project, partner home care agencies will adopt Healthix (RHIO) for real-time exchange of information and the PPS will provide technology guidance through this process. Currently, home care agencies are not eligible for Meaningful Use and therefore minimal incentives to have a certified EHR (as required by DSRIP) and connect to a RHIO. However, as part of mitigation strategy, the PPS has implemented a RHIO pilot to provide resources and a small financial incentive for partners who participate (to be described in the section below).



Efforts to mitigate challenges identified above:

In order to make sure home care facilities and SNFs can have INTERACT training for all staff members and at the same time keep the operations undisrupted, the PPS adopted the idea of having facility champions from each partner organization. Facility champions are in the process of being identified at sites. The PPS aims to implement a train-the-trainer model by having the facility champions trained and then having the champions act as the trainers and experts at their own facilities.

To date, the INTERACT is close to finalization and budget for the training is drafted as well. The PPS projects to have the training sessions with the 27 SNFs and 8 home care facilities potentially in September 2016.

To incentivize partners to both adopt an EHR and connect to the RHIO, the PPS has adopted bilateral strategies, (1) NYCReach and (2) RHIO Pilot. The PPS partnered with NYC Reach, an organization that assists practices with selecting, adopting, and implementing EHR systems. This service is offered to partners that are currently utilizing a paper based clinical documentation system as part of their participation in the NYP/Q PPS DSRIP efforts. Additionally, the PPS selected 'Infrastructure spending related to SHIN-NY / RHIO' as an EIP (Equity Infrastructure Payment) measure. As the PPS will receive incentive payments for accomplishing this through the EIP/EPP program, the PPS has incorporated incentive funding for participation into the funds flow model. Participants in the RHIO pilot program currently receive \$2,500 for participating in the pilot and connecting to the Healthix RHIO.

Implementation approaches that the PPS considers a best practice:

The NYP/Queens PPS has undertaken several approaches that we are proud to consider as best practice and below bullet points highlight the efforts to accomplish that:

- **Root Cause Analysis Workgroups:**

The long term care project workgroups have established a process of analyzing an actual patient encounter recommended by a partner based on the goal of reducing hospital admissions, readmissions, or emergency department utilization. The patient information and facility information is blinded and the encounter from beginning to end is discussed and analyzed to identify opportunities for process improvement. The Root Cause Analysis is completed in a workgroup where the team reviews items such as pre-condition/admission indicators, clinical indications, facility processes, communication among facility partners, access to electronic health records, etc. in order to improve outcomes for future patients. The teams are using the RCA lessons learned to make local performance improvement changes to clinical operations in order to avoid ED utilization, admissions and re-admissions. The RCA will also become an integral part of the Rapid Cycle Evaluation Unit to allow team input for process improvement efforts.

- **Population Health Management and Event Notification Tools**

The PPS has selected vendors for population health management (Allscripts) and event notifications (Cureatr) to contract with on behalf of PPS partners.

The Allscripts Care Director (ACD) tool is in the process of an internal roll out at NYP/Queens with the PMO and clinical leads. The goal is to include all engaged patients in the tool and utilize the reporting and care plan functions to improve care coordination and generate required reports for the quarterly reporting



process to DOH and the IA. After a successful implementation at the PMO, the PPS plans to roll out the tool to partners to continue to load patients requiring care plans and patients that meet the actively engaged definitions for the participating projects. The PPS will complete a phased roll out of the tool beginning with the NYP/Q hospital during DY2, Q2.

Cureatr is an event notification tool which provides user notifications of patients registered who have had an admission or discharge to the hospital. NYP/Queens currently utilizes the tool with the case management care coordinators and the PPS aims to roll out the tool to select partners. The PPS aims to roll this tool out to primary care and home care providers in the PPS to ensure timely follow-up on any inpatient or ED admissions. The PPS is in the process of validating need of the tool based on the services provided by partners, but it is likely that the PCMH and home care partners will be provided access to enable enhanced coordination of care.

- **Project Performance Metrics:**

In order to succeed as PPS and to effectively impact the population health, NYP/Queens PPS understands the value of data-driven process improvement efforts. As part of that, NYP/Queens PPS has started utilization of MAPP dashboard data in the Hospital Home Care project committee. Moreover, the PPS has decided to produce quarterly quality based outcome dashboards for the project workgroup. The dashboards will encompass summaries of metric data pulled from MAPP, Salient, and PPS claims data housed on the secure sever. The dashboard will be shared with the project workgroups for further analysis and process improvement planning. The dashboards will also provide tools to the Rapid Cycle Evaluation Unit team to identify trends and risks associated with quality based outcomes.

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

All scale & speed expectations for this project are forecasting to be met based on those partners committed to the project.

The PPS is actively exploring different options for telehealth and mobile health technology. Options will be evaluated and best tools will be implemented to best meet the needs of the beneficiary population.

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

There are no current proposals for changes to the populations served with our Hospital Home Care project as our clinical integration of the project align with the needs outlined in our community needs assessment.



DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: NewYork-Presbyterian/Queens

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

The PPS has identified challenges specific to the integration of primary care and behavioral health and the implementation of the requirements for the project.

- **Behavioral Health Workforce Recruitment** – NYS has a shortage of behavioral health practitioners, including NPs, Case Managers, and physicians. The PPS has also identified a shortage of behavioral health providers, which has been compounded by the closing of several behavioral health clinics in the past several years.
- **EHR Interoperability** – The project requires EHR interoperability between the primary care and behavioral health providers as a requirement of both Models 1 and 2. Based on this, the PPS will need to navigate the regulatory limits of sharing data related to behavioral health between the practitioners to ensure continued compliance.
- **Capital Funding** – The PPS committed to integrating care at 3 sites within PPS; additionally, the PPS committed to purchasing a population health management tool for use by the entire partner network. Both of these are commitments that require capital funding. The PPS applied for CRFP funds from the state but was not awarded any of the submitted application. The PPS therefore has to ensure the success of these commitments on a limited DSRIP valuation and without CRFP funding.
- **Cultural Stigma** – Through the PPS CNA qualitative data compilation, many stakeholders identified significant cultural and/or religious barriers to seeking behavioral health care. The sites that will be integrating services will have a challenge engaging patients in care due to this cultural barrier.

Efforts to mitigate challenges identified above:

The PPS has identified several strategies for mitigating the identified challenges for the PPS.

- **Behavioral Health Workforce Recruitment** – The PPS is committed to connecting partners to resources to assist with the recruitment of behavioral health providers, such as Mental Health Corps. The PPS will continue to work to identify opportunities for partners to assist in recruiting behavioral health providers and connecting with resources within the partner network.
- **EHR Interoperability** – The project committee is collaborating with the IT committee, legal counsel, and Healthix to ensure that all regulations are met in the course of implementing the co-location process.
- **Capital Funding** – One PPS partner, Brightpoint Health, was awarded CRFP funding for the integration of primary care and behavioral health project. Brightpoint Health is one of the partners in the network that will be integrating services. The other partners that will be integrating services are Child Center of NY, Mental Health Providers of Western Queens (MHPWQ), and NYP/Q. These partners who did not receive CRFP funding are looking at their internal budgets to ensure that they can fund the requirements for integration.
- **Cultural Stigma** – The PPS is working with partner organizations to provide education and information on behavioral health. The PPS will utilize platforms such as the e-learning to provide training to practitioners and staff, and the bi-annual town hall meeting for community members. Additionally, the PPS will leverage community engagement events that are held by partner organizations.

Implementation approaches that the PPS considers a best practice:

The PPS has approved best practices related to preventative health screenings, including the PHQ-2/9, SBIRT, lipid screenings, and others.



Preventative Care Screenings 11 30 15.p

Additionally, the PPS is in the process of determining tools that can be provided to partners on administering primary screenings at the behavioral health sites and behavioral health at the primary care sites.

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

All scale & speed expectations for this project are forecasted to be met based on those partners committed to the project.

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



There are no current proposals for changes to the populations served by the integration of primary care and behavioral health.



DSRIP Mid-Point Assessment Cardio Project Narrative

PPS Name:NewYork-Presbyterian/Queens

Project:3.b.i

Challenges the PPS has encountered in project implementation:

Cardiovascular disease has the highest prevalence and utilization rates of any disease state in the NYP/Queens PPS community. Improving the health status of persons with cardiovascular disease, and thereby decreasing preventable utilization for cardiovascular disease, will inherently decrease overall preventable utilization. This project was selected as one of the clinical projects with the intention that the PPS would work with high risk patients to address any barriers to managing their cardiovascular disease.

However, as the PPS approached in implementing different strategies to meet milestones for the project, we encountered multiple challenges, some of which are outlined below:

➤ **Defining true care coordination team**

As one of the requirements for this project, the PPS needs to develop care coordination teams including use of RN staff, pharmacists, dieticians & community health workers to address lifestyle changes, medication adherence, health literacy issues, & patient self-efficacy and confidence in self-management. Currently the definition for care coordination team is very vague and does not specify if the members in the care coordination team have to be located in same site or can work together remotely, etc. It is important to know this piece of information in order to build the appropriate care coordination team that will meet the patient's needs and at the same time be operationally feasible.

➤ **Non-current data available to the PPS**

Timing of project implementation with the MY/DY spread of metrics is a challenge to ensure process improvement that will result in quality outcomes. The PPS has received several DSRIP data feeds, including the member roster and the MAPP performance dashboards. While this information is a necessary start to the quality data process, there continues to be limited availability of data to the PPS and at the partner level. The member roster contains minimal information while the MAPP dashboards have limited access. This data is necessary both as claim based feeds from DOH, but also has real time information to enable rapid cycle improvement in the PPS.

Efforts to mitigate challenges identified above:

In order to mitigate the challenges identified above, the NYP/Queens PPS have undertaken multiple efforts and implemented some effective strategies, all of which are briefly summarized below:

- For this 3bi project, the PPS has formed a Cardio committee that meet monthly to discuss deliverables, workflows, best practices and partner feedback. The committee also reports out to



Clinical Integration Committee. As the oversight committee for clinical quality, the Clinical Integration Committee in NYP/Queens PPS is responsible for approving best practices, evidence based standards, and protocols that have been recommended by the project committees and/or are deemed necessary by the Clinical Integration Committee. To date, the Cardio Committee and the Clinical Integration Committee have reviewed and approved over several best practices for the PPS. NYP/Queens PPS continues to work with partners in vetting out evidence based best practices for various clinical processes.

- In collaboration with GNYHA, the NYP/Queens PPS has hosted an all-day training session on June 15, 2016 for care coordinators in the PPS. Care coordinators are those who would play a coordination role in the continuum of care for patient. There was a very good turnout to this training. The assigned care coordinators from each partner site were very engaged. This specific training was intended to specifically educate the coordinators about the fundamental, evidence-based concepts for building an effective care coordination process to achieve improved outcomes and understands roles, responsibilities and best practices within their individual sites.
- Also, to target the medication management piece for care coordination team development concept, the NYP/Queens PPS is currently in discussion to work with a partner. The given partner has best practices in medication management and the PPS plans to roll that out for whole network as part of developing care coordination interdisciplinary team.
- The PPS is continuing their efforts in working with DOH and Salient contacts who can possibly manage to offer additional Salient training to the new staff in PMO office. In addition, the PPS is working best to use the data that is currently made available to us and create dashboards and summary to be presented to project committees and possibly utilize for further analysis by RCE unit.



Implementation approaches that the PPS considers a best practice:

The NYP/Queens PPS has implemented several best practices and undertaken approaches that we consider to be best practices and also highlight our successes to date. The PPS is providing materials related to the Million Hearts Campaign, hypertension diagnosis and medication management, blood pressure check and tobacco cessation referrals for partners.

➤ **Million Hearts Campaign**

The Million Hearts Campaign, <http://millionhearts.hhs.gov/>, provides resources and protocols on hypertension and tobacco-smoking cessation. These protocols have been provided to participating sites for implementation by the clinical director. The PPS will offer an in service, as needed, with partners and participating sites on how to use the tools and protocols for improving patient care.

➤ **Blood Pressure Competency**

The PPS has approved the competency checklist for both the manual and automatic blood pressure check. Partners will ensure that the BP competency is incorporated into their annual competency check process and provide copies of the completed certification of competency to the PPS.

The PPS will request random audits and documentation of the partner blood pressure competency and utilization of the million hearts campaign. The PPS will use these samples as part of the documentation submission process for the IA quarterly reports.

➤ **NYS Smokers Quit line Provider Education Resources**

In order to make sure providers are comfortable speaking with patients, who are identified as smokers, about the smoking quitting referral, the PPS has provided the partners/providers with education resources from NYS Smokers Quit line program.

- Collaborative call- Sep 7, 2016

<http://nysmokefree.com/HCP/HCPSubpage.aspx?p=70&p1=7050>

- Continuing Medical Education- online module <http://nysmokefree.com/cme/>

- More tools and resources for Provider & Partners

<http://nysmokefree.com/HCP/HCPSubpage.aspx?p=70&p1=70280>



Department of Health

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

All scale & speed expectations for this project are forecasting to be met based on those partners committed to the project.

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

There are no current proposals for changes to the populations served with our cardio project as our clinical integration of the project align with the needs outlined in our community needs assessment.



DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: NewYork-Presbyterian/Queens

Project: 3.d.ii

Challenges the PPS has encountered in project implementation:

Challenges related to the Asthma Home Based Care project relate directly to funding availability, the ability to influence socio-economic factors within the patient’s home, and the ability to directly improve quality based indicators that cover a broader range of patient outside of a pediatric population. Challenges are detailed below with mitigation strategies outlined in the second section of this file:

- **Asthma Resource Center (ARC)** – The application process originating before the financial valuation created a misalignment of funding and the plans for clinical integration of new service line offerings. Initially in the application, the team planned to develop an Asthma Resource Center (ARC) that would provide care coordination, provider education, and other resources for the provider and patient community.
- **95% / 5% STC Funding Rule** – Understanding that the DSRIP program is focused to maximize efforts and utilization at our safety-net partners, the asthma program has benefits to expanding our relationships with CBO’s and non-clinical providers in order to increase education & access points to the pediatric population. The current 95%/5% rule within the STC limits our ability to incentivize our non-clinical/non-safety net partners to expand the program services.
- **Home Access & Change** – Home access to asthmatic pediatric population has been identified as a challenge as the socio-economic factors of each patient is unique along with the family structure and support system. Gaining access to the home is the initial struggle while influencing changes in the home setting to include behavioral changes of family members is an additional challenge that our program will face.
- **NYS Assigned Non-Pediatric Quality Metrics** – The focus of the Asthma partner network within our PPS is to improve quality outcomes in order to maximize the improvement to our community and partners. The clinical workgroup aligns clinical integration planning with metrics as best as possible but the metrics outlined by the NYS DOH for this project have a wider range of patients that our specific pediatric project. Our application was submitted to serve those 18 years and younger while only two of the five metrics focus to pediatrics (PQI #14 & PQI #15). Three quality indicators cover ages 5-64 (medication management ratio, 50% treatment days covered, and 75% of treatment days covered).

Efforts to mitigate challenges identified above:

The process of risk identification & mitigation planning is an ongoing process of the clinical teams. The clinical workgroup structure allow for proper identification and planning of risks as clinical integration tasks are completed at all partner types. The above risks have been vetted utilizing the clinical workgroup structure and include the following mitigation strategies:

- **Asthma Resource Center (ARC)** – The clinical workgroup has identified an alternative to the Asthma Resource Center (ARC) and has created a plan to develop a CBO based process that will focus to provider education based on the access points of patient activity (ED, Inpatient Hospitalizations, School Based Clinics, Clinical & Non-Clinical providers). The CBO based program will also include a patient navigation / coordination effort to ensure connectivity to home-based care. The program dynamic will ensure education of patients and providers based on the access points and the connectivity to home-based care providers based on the need of the patient or family. The CBO contract with The Asthma Coalition of Western Queens has been executed and the PMO team is working to outline a full scope of the agreement to align incentives based on clinical integration and quality based outcomes for a partner that is non-billable.
- **95% / 5% STC Funding Rule** – The above contract with the Asthma Coalition is being forecasted to maintain the 95%/5% ruling, but the team is finding the incentive funding potential limiting as the NYP/Q PPS has limited revenue potential and 5% is limited. The clinical teams are working internally with safety-net partners to identify additional contracting strategies with CBO's and other safety net providers in order to maximize incentives to critical non-safety net or non-clinical providers. Such contracting strategies include third-party contracting with safety net providers based on existing relationships.
- **Home Access & Change** – The clinical workgroup, which includes community based organizations, clinical partners, behavioral health partners, and non-clinical partners, understands the dynamics associated with such a challenging process of behavior changes for those surrounding the pediatric asthmatic patient and is building an education based model with multiple access points to help influence change. An example of educational opportunities include school based clinic trainings. The partnership with the Asthma Coalition and Mental Health Providers of Western Queens has provided opportunities for education of the staff within the clinic to identify triggers of asthma patients, refer patients to home-based care, and to help educate family members on the processes available to manage this chronic condition.
- **NYS Assigned Non-Pediatric Quality Metrics** – Understanding that we have no ability to change the indicators for our project, our team is aligning our pediatric asthma project with our PCMH project to increase access and care coordination for this chronic condition. Along with project coordination, the PPS will align the Rapid Cycle Evaluation (RCE) Unit to include provider quality analytics in order to outline process improvement opportunities which will include asthma patient populations up to the age of 65. The expertise in the clinical workgroup will be leveraged during the process improvement processes in an effort to increase awareness, communication, and education to our provider network.

Implementation approaches that the PPS considers a best practice:

The Asthma clinical workgroup has adopted numerous national best practices for this patient population and are being used as a clinical integration tool with all partners committed to this project. Along with the national best practices, our PPS has identified the following as internal PPS best practices to date:

- ***School Based Clinic Education Program*** – The clinical team outlined an education program for school based clinic staff that focus to asthma basics, environmental triggers, home-based care opportunities, referrals for home-based care and clinical providers, and other items. This education is an amazing opportunity to access pediatrics patients where they spend most of their time, in school, and helps the clinical staff to decrease absenteeism and potentially reduce emergency department utilization and hospital admissions through multiple access points for education & coordination.

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

All scale & speed expectations for this project are forecasting to be met based on those partners committed to the project.

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

There are no current proposals for changes to the populations served with our pediatric asthma project as our clinical integration of the project align with the needs outlined in our community needs assessment.

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: NewYork-Presbyterian/Queens

Project: 3.g.ii

Challenges the PPS has encountered in project implementation:

The PPS has identified challenges specific to the implementation of the Palliative Care in Skilled Nursing Facilities (SNF) project. These challenges include the cultural/religious stigma of palliative care, MOLST/eMOLST tools, and Funding/MCO reimbursement rates for services. Challenges are detailed below with mitigation strategies outlined in the second section of this file:

- **Cultural/Religious Stigma** – Queens County Medicaid Beneficiaries are inclusive of a diverse group of people from various ethnic, racial, religious, and cultural backgrounds. Patients/care givers/ family members in the past have been reluctant to participate in end of life and/or palliative care discussions. The PPS has a large lift to engage the community in these efforts and provide information and education on the importance of the integration of palliative care.
- **MOLST/eMOLST Tools** – The PPS has committed to utilizing the MOLST/eMOLST tool for the project. The PPS is encouraging partners to adopt the eMOLST tool but there is resistance amongst clinicians as the tool takes a significant amount of time to complete compared to the paper version (approximately 45 minutes).
- **MCO Reimbursement for Services**– The project partners has indicated that the MCO reimbursements for palliative care services are insufficient or nonexistent specific to consultations and education for the patient/family/care giver. The PPS has a deliverable to engage MCOs in this discussion as partners move into VBP based contracts.

Efforts to mitigate challenges identified above:

Based on the identified challenges, the PPS has formulated mitigation strategies to ensure the success of the project. These strategies are detailed below:

- **Cultural/Religious Stigma** – The PPS has begun a training program for practitioners on palliative care from the EPEC (Education in Palliative and End-of-Life Care) program. The training program includes modules on communication and how to address patients/families/care givers on this topic. Additionally, the practitioners will be provided education from the CC/HL workgroup on cultural competency and health literacy. The PPS also aims to inform patients and the community on palliative and end-of-life care and will use the biannual town hall meeting as a forum for presentations and discussion on the topic.

- **MOLST/eMOLST Tools** – The PPS is providing support to partners as they adopt the MOLST or eMOLST forms. The PPS is partnering with Dr. Bomba from Excellus BCBS to provide training on the eMOLST tool to help providers better understand how to navigate and document in the tool and provide tips on how to reduce the time burden for completing the eMOLST.
- **MCO Reimbursement for Services** – The PPS is committed to providing partners with aggregate data on partner survey responses for uncovered services and patient outcome data to use when partners begin the VBP process with MCOs. Additionally, the PPS is providing incentives to partners outside of direct DSRIP funding, such as EPEC certification and CME credits for participation in training.

Implementation approaches that the PPS considers a best practice:

The Palliative Care committee has adopted several best practices which have been presented to and approved by the Clinical Integration Committee.

- **EPEC** – The training program has been adopted as a best practice for the PPS. The trainings are held bi-monthly and cover two modules per session. The trainings rotate between partner sites and practitioners that attend are eligible to receive CME credits. Additionally, practitioners that attend all of the sessions can receive their certification in EPEC.



EPEC Training
Schedule v3.pdf

- **CAPC**— The PPS is engaged with CAPC (Center for Advanced Palliative Care) as an educational resource for partners. Membership with CAPC has been made available to the partner network at a discounted DSRIP rate. In addition to educational opportunities, CAPC offers information on policy, clinical quality data, networking, and news updates.

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

All scale & speed expectations for this project are forecasted to be met based on those partners committed to the project.

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

There are no current proposals for changes to the populations served with our palliative care project.



DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: NewYork-Presbyterian/Queens

Project: 4.c.ii

Challenges the PPS has encountered in project implementation:

Challenges related to the project focused to increasing early access, and retention in, HIV care have been discussed in detail with the project workgroup and are described as follows:

- **Lack of Dedicated Funding for Non-Covered Medicaid Services** – Outreach and education are critical elements of this program and the project workgroup has identified an outreach strategy that will require additional contractual relationships with non-clinical (CBO) partners to expand existing programs & service areas that focus to outreach & education based on the needs of the patient base.
- **Connectivity of Medical Records for Partner Use** – The PPS is focused to RHIO connectivity with a rigorous processes and training for the patient consent process, but the HIV population is a select group of patients, similar to behavioral health and pediatrics that has limitations on access.
- **95%/5% Safety Net Funding NYS DOH Ruling** – The HIV project will rely heavily on relationships/contracts with CBO's in order to expand access to outreach and educational opportunities. The CBO partners identified are not considered safety net providers due to the fact that they are not billable Medicaid providers yet our project will depend on funding to this partner base.
- **Lack of Quality Based Outcome Data / Partner Specific** – The workgroup is currently focused to hot-spotting patient activity in order to identify unmet patient needs for outreach, HIV testing, education, and access to care. The current data compilation is being derived from public data that is dated and the team would benefit from actual PPS partner data to have more timely data specific to the need of the population we serve.

Efforts to mitigate challenges identified above:

- **Lack of Dedicated Funding for Non-Covered Medicaid Services** – The NYP/Q PPS has built a funds flow model that is a group practice method where all projects are considered priority and receive the same formula for an overall resource of revenue received from performance. The HIV project has incentives outlined focused to performance of project requirements, engagement in state level activity, etc. and has educated all partners on the potential to maximize incentives based on their engagement in the project.
- **Connectivity of Medical Records for Partner Use** – The NYP/Q PMO IT team is working with Healthix to identify potential processes for patient consent for this patient population. The team is also working with all partners on the RHIO Connectivity pilot project which is aligned with incentive funding to ensure connectivity.
- **95%/5% Safety Net Funding NYS DOH Ruling** – Partner relationships are being established or expanded for safety-net providers in order to sub-contract with non-safety net providers who are critical to the success of the project. The sub-contractor model is not ideal to ensure timeliness of implementation but will allow partners to maximize return & build on existing relationships with CBO's.
- **Lack of Quality Based Outcome Data / Partner Specific** – The PPS has been informed that there will eventually be access to this patient level information and the workgroup will complete the hot-spotting activity at that time to continue to identify needs of the community based on geography or partner activity.

Implementation approaches that the PPS considers a best practice:

The PPS partners to include clinical providers, pharmacies, CBO's, etc. have identified an outreach strategy that aligns with the patient need based on unconventional access points for outreach, education, and testing. The outreach strategy is attached to outline the current approach and will be used to continue to evolve based on the need of the patients and partners.



NYPQ HIV Outreach
Strategy Final.pdf

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

The PPS continues to engage in NYS HIV collaboration workgroups to maximize efforts of 6 PPS's and ensure consistency among partners involved. The collaborative recently identified additional sub-committees focused to topics and the NYP/Q PPS is working with engaged partners to assign members to each workgroup and will work with executive leaders to include in the funds flow method in order to provide incentives to partners for engaging.



Department of Health

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

At this time, there has been no changes to populations of patients or network partners that affect the clinical implementation of the HIV project. The PMO team will continue to monitor the patient base and partner network to identify additional changes or trends.

DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: NewYork-Presbyterian/Queens

Highlights and successes of the efforts:**Organizational Section: Workforce****Successes to Date:**

The NYP/Q PPS has completed 2 workforce milestones, target state and compensation & benefits analysis; in addition the PPS has successfully achieved the DY1 committed workforce spend and anticipates meeting the commitments for DY2-DY5. Additionally, the PPS completed a workforce communication and training plan that details the workforce needs for each DSRIP organizational work stream and clinical project.

Challenges:

The PPS has identified two primary challenges for completing the workforce milestones.

- **Tracking and Reporting of Staff Impact** – The PPS currently has limited infrastructure across the partner network to track and report on staff impact for all of the required categories. This information is currently housed by some HR systems but is not tracked by workforce category (recruitment, redeployment, retraining, and reduction) nor by job title and organization type.
- **Limited Funding** – The PPS has limited revenue to support the partner network including providing vendor and/or in person training sessions, providing IT solutions for tracking and reporting the workforce staff impact, and recruitment of new practitioners needed to address the safety net gap identified in the CNA.

Mitigations:

The PPS has identified mitigation strategies to the challenges to the success of the workforce work stream.

- **Tracking and Reporting of Staff Impact** – The PPS is in the process of creating a manual process to collect data from partners on staff impact by organization type, job title, and workforce impact category. The PPS will continue to look for IT solutions to provide to the partner network to ensure that the staff impact process can be streamlined if possible.
- **Limited Funding** – The PPS is contracting with a vendor to provide an e-platform for training across the partner network. This will enable the PPS to provide training required for the organizational work streams and clinical projects to the partner network; this includes the ability to complete training from the office and for the PPS to track the training that has been completed at the PPS



level across partner organizations for reporting. Additionally, the PPS is connecting partners to outside resources to assist with funding for recruitment such as the Mental Health Service Corps.