Nassau Queens Performing Provider System (NQP)

MidPoint Assessment Report
Action Plans
March 10, 2017

Summary: This document "NQP's MidPoint Assessment Report Action Plan" is in response to the recommendations made by the Independent Assessor (IA) and the Project Approval and Oversight Panel (PAOP) Modifications. For each recommendation, NQP has written a PPS Action Plan Narrative and included an Implementation Plan as required to projects that delineate the need for a plan. These work plans are presently being implemented to meet the requirements for DY2Q4 and captures in great detail the work that also meets and aligns to the Midpoint Assessment Recommendations. With NQP's ongoing efforts to achieve its' overall DSRIP implementation plan, this report reflects NQP's continued commitment to improving the health care delivery system for its Medicaid beneficiaries.

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8	Partner Engagement	PPS develop a strategy to increase partner engagement throughout its target area, with a specific emphasis on engaging Behavioral Health (Mental Health and Substance Abuse) and PCP partners. Behavioral health providers and integration with primary care are essential to realize the project goals of behavioral health integration and to be able to earn the high performance funds.	3-7
9	Patient Engagement	PPS develop a strategy to increase and consistently maintain patient engagement levels throughout its target area. This is another high risk area where the PPS has previously missed targets and associated DSRIP payments.	21-22
10	Organizational	Develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement. The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP. The PPS must also submit a detailed report on how the PPS will ensure successful project implementation efforts with special focus on projects identified by the IA as being at risk. These reports will be reviewed and approved by the IA with feedback from the PAOP prior to April 1, 2017.	3-7
11	Organizational	PPS submit a report that explains the functions and activities carried out at the Hub level including a description of the similarities, differences, and incentives for each of the three Hubs. The report must also describe the activities and role of the PPS.	1-2
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Nassau Queens PPS Midpoint Assessment Action Plan Narrative-Hub structure

This Narrative responds to the following Recommendation:
***Recommendation 11: Organizational* - The IA recommends that the PPS submit a report that explains the functions and activities carried out at the Hub level including a description of the similarities, differences, and incentives for each of the three Hubs. The report must also describe the activities and role of the PPS.**

This report builds upon the Governance Model in the initial PPS submission and further discussions at Enhanced Support Oversight meetings on the development of the current Nassau Queen PPS Project Management Office (NQP PMO). The Nassau Queens PPS LLC (NQP) is made up of three entities (Hubs), Long Island Jewish Medical Center (LIJ), Nassau University Medical Center (NUMC) and Catholic Health Services of Long Island (CHS). Adopting a delegated model, the Executive Committee establishes the overall direction for NQP and has designated the NQP PMO to operationalize the PPS implementation plan. To guarantee successful implementation of the DSRIP Portfolio, Hub collaboration with the NQP PMO is critical. The ongoing daily synergistic relationship that exists between NQP PMO and Hubs are what drive the strategy, vision and mission of the PPS.

NQP PMO Functions and Activities
NQP PMO administers and manages the DSRIP implementation plan. Functioning as a centralized organization, the NQP PMO shares project management resources to all three Hubs and its PPS partners. Project management resources are provided in the form of readily available subject matter expertise, templates, best practices, and DSRIP policy/guidance on the organizational work streams and 11 projects. Using a supportive framework, NQP PMO drives the direction given by the Executive Committee by sharing information across the enterprise to all the Hubs. In collaboration with the Hubs, NQP PMO's functions and activities are comprised of the following:

Centralized Clearing-house of Best-practices and Resources
PMO monitors and controls project implementation plans by continuous improvement and development of projects and deliverables within PPS workgroups. Workgroups are chaired by NQP PMO staff where resources such as evidenced best practices from partners, state and published literature are shared.

Accountability and Coordination of Hub Activities
PMO administers and manages all submissions to the state and Independent Assessor. To successfully complete submissions, PMO support staff works in partnership with Hubs' PMO support staff to drive project implementation to meet DSRIP requirements. PMO leadership holds meetings with Hub leadership to ensure ongoing progress and opportunities are administered. PMO also assists in identifying vendor resources and identifying and engaging CBOs.

Network Management and GeoMapping
PMO updates the network and performs gap analysis to determine areas of opportunities for improving patient outcomes through focused health/social services. This is done by identifying appropriate providers who can meet health and social needs of patients, while directing Hubs to contract with identified partners.

Management of DSRIP funds
Provision of accounting staff to manage awarded funds with development of funds flow model for distribution to downstream partners with Hub input.

Data Aggregation and Analytics
PMO Data team performs data analysis to satisfy performance reporting requirements and to inform performance improvement activities. PMO Data leads will lead Rapid Cycle Evaluation activities with the Hubs and will develop Hub level reports with status on contracting, funds flow, actively engaged patients, organizational and project milestones status.

Interface with State and Key Stakeholders

PMO serves as point of contact for DOH, IA, PAOP, MAPP, and PCG AST on behalf of the PPS. In addition, PMO acts as representative for PPS at consortiums and coalitions including NYC and LI Regional Planning Consortiums, HANYS, GNYHA Committees, and state/local agencies. PMO also executes PPS-wide communication strategy using a variety of communication mediums.

Hub Functions and Activities

NQP PMO shares and distributes information to Hubs where ongoing feedback is provided to drive continuous quality improvement. Similarly, Hubs are involved in the administration and operation of the PPS, but at the level of management of their facilities and the participating partners (as reported in the initial PPS Organizational Application submission). In concert with NQP PMO, Hubs are responsible for the ongoing management of their relationships with their contracted and community based partners. Below outlines the functions and activities of the Hubs:

- Implement DSRIP organizational and project requirements at their health systems, and facilities;
- Execute and establish the workforce plans as created by the PPS;
- Participate in Executive Committee, subcommittees, project workgroups, PAC, and events;
- Execute the PPS partner engagement strategy (see NQP PPS-Wide Partner Engagement Strategy White Paper) by contracting with partners to meet the DSRIP portfolio milestones/requirements;
- Work with participating partners to obtain provider level commitments and adhere to project implementation protocols, milestones and metrics (i.e. PCMH level status, RHIO connectivity, EHR and meaningful use), participation in care management and information sharing programs, data collection and reporting requirements;
- Implement appropriate, policies, clinical protocols, and processes that are PPS-wide based;
- Apply clinical oversight and performance improvement processes to the implementation of its projects;
- Share best practices across Hubs and partners;
- Provide feedback and input to NQP PMO to improve DSRIP implementation;
- Report on project status to Executive Committee;
- Pursue managed care strategy and risk contract issues with their existing relationships with key Medicaid MCOs towards value based payments; and
- Collaborate with the other Hubs and NQP PMO on an ongoing basis to successfully implement an integrated delivery system.

Funds Flow

After extensive discussion when Nassau University Medical Center, Catholic Health Services and Long Island Jewish Medical Center combined to form the Nassau Queens PPS (NQP), it was determined that the fairest way of allocating funds among the three Hubs would be equally (one third each). In addition to resolving questions about allocations by Hub, this approach had the benefit of unifying the incentives of the three Hubs to perform as well as possible on each DSRIP Project, since the PPS is judged on its performance as a whole. To maintain accountability and buy-in from each Hub, the NQP PMO, tracks critical performance areas within each Hub, in order to support the inter-connected performance that is required for the PPS to achieve its metrics and milestones, including partner engagements, PCP contracts, RHIO and EHR connectivity, PCMH certification, CBO contracts and funds flowed to partners and actively engaged achievements across all relevant projects.

Nassau Queens PPS -Midpoint Assessment Action Plan Narrative: NQP PPS-Wide Partner Engagement Strategy White Paper

This narrative responds to the following Recommendations:
***Recommendation 1:* 2ai - PPS develop strategy to increase partner engagement to support successful implementation of this project and in meeting PPS DSRIP goals.**
***Recommendation 8*: Partner Engagement -The IA recommends that the PPS develop a strategy to increase partner engagement throughout its target area, with a specific emphasis on engaging Behavioral Health (Mental Health and Substance Abuse) and PCP partners. Behavioral health providers and integration with primary care are essential to realize the project goals of behavioral health integration and to be able to earn the high performance funds.**
***Recommendation 10*: Organizational - The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement.**

Nassau Queens Performing Provider System (NQP) is committed to creating an integrated delivery system (IDS) that brings evidence-based care for Medicaid beneficiaries and the uninsured, specifically to those with complex health and social needs. NQP understands partner engagement is a critical role to successfully implement Project 2ai and to meet our PPS DSRIP goals. It is our priority to implement a comprehensive population health management strategy composed of providers across the continuum of care who are dedicated to reducing inpatient care costs, improving quality of care, and eliminating unnecessary duplication of services.

NQP has made significant strides towards increasing its' partner engagement. From the start of DSRIP implementation, NQP has utilized its' Community Needs Assessment as a resource to understand the patients' health care needs. In order to build the NQP IDS and drive our partner engagement strategy, NQP's three large health systems (Hubs), Long Island Jewish Medical Center (LIJ), Catholic Health Services of Long Island (CHS) and Nassau University Medical Center (NUMC) are solely responsible for contracting with network partners that will contribute to improving health care delivery. The strategy for contracting partners is built upon an IDS framework of patient-centered primary care, integrated population management, community of wrap around services, quality outcomes, HIE system and value-based payments.

As a first phase in Demonstration Years 1-2, partners were selected based on attribution, location, and the types of services they offered that would meet and improve patients' outcomes. Primary Care Providers (PCPs) were those identified to have high attribution and targeted early on for contracting. In collaboration with NQP PMO, Hubs established their respective contracting strategies where they targeted their providers with the highest attribution and created agreements based on delivery of services, achieving patient commitments and project requirements. To maintain partner engagements, Hubs have included incentives and/or pay for performance opportunities to those contracted. Currently, each Hub has continued their progress to strategically contract with key providers who also align with the PPS overall strategy towards value based care and sustainability. In addition, NQP's Data Team has partnered with Long Island Population Health Improvement Plan (PHIP) to hotspot regions with high density of Medicaid patients, and health care utilization to guide in identifying targeted interventions where increased contracting efforts such as Primary Care Providers, Mental Health and Substance Abuse Providers, and Community Based Organizations would best meet patients' complex needs.

NQPs contracting effort has significantly accelerated, driving the number of partner engagements up. As demonstrated below in *Table 1: NQP Partner Engagements as of January 31, 2017*, the amount of partner engagements has increased significantly since DY2Q2. From the time of the Independent Assessors evaluation in November, 2016, NQP has had a 23% increase in provider contracts. NQP continues to track additional indicators that demonstrate integration into the delivery system, including but not limited to PCMH certification, EHR interoperability, Meaningful Use, Safety Net status, and collaboration in concert with Health Homes. NQP continues to support its engaged partners' access to shared clinical information such as connection to HIE

system (RHIOs, specifically HealthIX) to foster collaboration and care management by facilitating conversations and tracking agreements between the Qualified Entity and the provider.

Table 1: NQP Partner Engagements as of January 31, 2017

Partner Category	2.a.i	2.b.ii	2.b.iv	2.b.vii	2di	3.a.i	3aii	3.b.i	3.c.i
Practitioner - Primary Care	669	94	78	0	93	658	0	480	486
Practitioner - Non-Primary Care	91	80	80	0	80	91	0	91	91
Hospital	6	5	5	4	5	2	0	1	1
Hospital - Ambulatory	0	0	0	0	0	0	0	0	0
Clinic	10	8	1	0	8	10	0	10	10
Mental Health	0	0	0	0	0	0	0	0	0
Substance Abuse	0	0	0	0	0	0	0	0	0
Case Management / Health Home	0	0	0	0	0	0	0	0	0
Health Home	0	0	0	0	0	0	0	0	0
Community Based Organization	11	0	0	0	2	4	8	0	0
Nursing Home	47	0	14	45	0	0	0	0	0
Pharmacy	0	0	0	0	0	0	0	0	0
Hospice	0	0	0	0	0	0	0	0	0
Home Care	0	0	0	0	0	0	0	0	0
All Other	11	11	11	0	11	11	0	11	11
PAM Community Navigators	163	0	0	0	163	0	0	0	0

To expand on the partner engagement strategy, NQP is actively working to improve its patient outcomes by examining its current engagements and targeting gaps/opportunities. NQP has enhanced its partner strategy into a multi-prong approach that includes the first phase of contracting with high attribution providers such as PCPs to increasing contracted partners for additional opportunities. An analysis on project opportunities across the PPS (both organizational and project level) was executed in January, 2017 where areas of need to contract additional providers (such as PCPs, Mental Health and Substance Abuse and Community Based Organizations) was recognized as critical factors to the project's success. On top of this analysis, NQP's Data Quality Team is synchronously working to improve its business intelligence and analytics to dive deeper into the available data to create focused interventions for better patient care. To learn more about the health care utilization of its patients, NQP is examining further into its hot-spotting data to identify "super-utilizers," high cost individuals in defined regions of the health care system and create a process/guide with targeted interventions. To address these "super-utilizers" NQP has adapted some of Amy Boutwell's MAX series care management process and evidenced best practices/processes.

NQP has identified initiatives it has made progress to address the IA recommendations. These initiatives coincide with DY2Q2 and Q3 milestones as well as upcoming milestones from DY2Q4. Progress towards these milestones overlap with NQP's partner engagement strategy. NQP is actively contracting with the following partner types: Mental Health/Substance Abuse (MH/SA), Tier 1 Community Based Organizations (CBO), and Primary Care Providers (PCP). As part of the strategy, NQP established relationships in early January, 2017 with two Behavioral Health IPAs: Coordinated Behavioral Care IPA (CBC), and Advanced Health Network IPA (AHN). Key focus will be placed on contracting with MH/SA providers for pay for reporting. Both IPAs will support in facilitating conversations with their existing relationships with CBOs to swiftly contract the types of services NQP

needs as outlined below in *Table 2: Project Opportunities: A Menu of Mental Health/Substance Abuse and Community Based Services*. These IPAs have large networks of providers already serving the NQP service area where they have historically provided bundles of services including clinical, rehabilitation, care coordination, housing, and peer services within their communities. To drive the success of the strategy, NQP has recently hired a Director of Behavioral Health to continue execution of its partner engagement strategy and program design across all its projects.

Table 2: Project Opportunities: A Menu of Mental Health/Substance Abuse and Community Based Services

Below is a list of identified MH and SA services and opportunities to enhance NQP's current efforts:

- ✓ **2ai: Integrated Delivery System**
  - Health Home Care Managers in hospitals to make regular rounds for psychiatric units, detox/rehab and medical units to enroll clients into health homes, improve discharge planning with linkage to community behavioral health resources
- ✓ **2bvii: Transition of Care**
  - Contract with MH and SA providers to develop mobile, interdisciplinary teams to address patents who are frequently re-admitted to hospitals following an inpatient stay in a psychiatric, detox/rehab, or medical unit
- ✓ **2di: Patient Activation**
  - MH and SA agencies for patient activation activities within their programs to engage uninsured and identify and engage low utilizers of medical services, identify patients at high medical risk
- ✓ **3ai: Behavioral Health**
  - Partnership with MH agencies to co-locate social workers and other MH/SA staff into Primary Care Practices
  - PCPs to be placed in behavioral health settings
  - Expand access to MH and SA clinical services with screenings in primary care settings
- ✓ ***3aii: Crisis***
  - Provide services to patients in crisis and report on them for patient engagements
  - Crisis Hot Lines (NYCWELL and 227TALK)
  - Mobile crisis teams
  - Crisis residence beds
- ✓ **Workforce**
  - Training workforce, community agencies (Police, first responders, schools), and the community on various behavioral health- public health issues: Mental health first aid, suicide prevention, alcohol and other substance abuse prevention and treatment, trauma, chronic medical disease and depression

NQP has existing relationships with CBOs throughout its' service area. Because of its ongoing partnerships and sponsored forums with CBOs, NQP has worked with many CBOs to inform its CCHL strategy and process, bringing great value to the PPS. With the ongoing work from the IPAs, CBOs will be contracted for additional roles as shown in *Table 3: Additional Project Opportunities for Community Based Organizations.* NQP is also working with the Health and Welfare Council of Long Island (HWCLI) and PHIP to identify agencies throughout the service area for contracting. In collaboration with HWCLI and PHIP, funding will be provided to assist CBOs in

the contracting and other business aspects of dealing with NQP. Contracts with Tier 1 CBOs in the identified NQP "Hot-Spot" areas will include public forums conducted by NQP in partnership with LIFQHC on topics such as:

- Informing community members about the goals of the NQP in terms of improving overall population health, the connection to local resources, and the need to reduce usage of emergency and inpatient services
- Inform them of the data collected by NQP regarding health outcomes and current barriers to care
- Provide resource information about accessing routine care as well as introducing the crisis diversion services. (i.e. Hotlines, Mobile Teams, etc...)
- Solicit ideas from the community regarding areas of particular need and propose concrete solutions
- NQP's financial support to assist CBOs in their ability to report data to NQP and communicate with their communities

NQP will expand the number of Community Health Workers (CHW) in its network to meet the social determinants of health of its patients. Since CBOs historically have established trusting relationships and are familiar with the communities they serve, there will be great focus on hot spot areas to hire CHWs. CHWs are key to NQP as they serve as a liaison between health/social services and the community by facilitating access to services and improve the quality and cultural competency of service delivery. For example, the role of CHWs will ensure beneficiaries get to their appointments, get access to the social determinants of health, such as food, housing, etc. Most importantly, CHWs can build on individual and community capacity by increasing health knowledge, and self-efficacy through a range of activities such as provide health coaching, outreach, community education, informal counseling, social support and advocacy. Where appropriate, CHWs will be selected because of their experience with medical chronic conditions as related to patients' needs. To support CHWs efforts, NQP will provide trainings on motivational interviewing to CHWs, evidence based practices and additional trainings as needed.

Table 3: Additional Project Opportunities for Community Based Organizations

Below is a list of identified services and opportunities CBOs are working on:

- ✓ **Social Determinants of Health**
  - Expansion of access to food, transportation, housing, etc…
  - Provide navigation to community resources and services
  - Recruiting and training Community Health Workers
- ✓ **Project Implementation**
  - PAM Surveys
  - Teach and engage the uninsured/ low Medicaid utilizers into Community based care
- ✓ **Expand and train community on CCHL Strategy**
  - CBOs to support PCP in CCHL implementation
  - CCHL training of office staff
- ✓ **Increasing consumer health knowledge and self-sufficiency**
  - Outreach and Education of specific diseases
  - Community Education such as health literary training to patients
  - Informal Counseling
  - Social Support
  - Advocacy
- ✓ **Deliver Project Focused Interventions**
  - Stanford Chronic Disease Self-Management: Provide Community tobacco cessation and cultural competency health literacy workshops
  - Care Transitions: Partnering with PCPs and providers to provide social support services

- Mental Health/Substance Abuse: Providing community access to BH support groups and resources to strengthen the MH/SA infrastructure
- HIE connectivity: Facilitating and supporting CBOs to connect to HealthIx

PCPs play a critical role to the success of NQP's IDS. Patient care services offered by MH/SA and CBOs will be coordinated with the patient's PCP. Often, PCPs do not know what services are available in their community or how to access them. Additionally, discharges from the Hospitals/ED require follow up with the PCP as well as care coordination to manage the patient's health as well as meeting their health/social needs. With increased efforts in contracting of MH/SA and CBOs, continued care coordination and communication with PCPs will drive better management of patients with complex care needs by increasing access, capacity and quality. Ongoing collaborations with PCP, MH/SA and CBOs will drive evidence based standards of care including medication management and care engagement. This allows the provisions of supportive services and care that will connect these patients with needed services and increase access to LTSS, reducing costs, but most importantly improving the quality of care.

Based upon NQP's commitment in its approved project plan, percentages for funds flow for the life of DSRIP have been established for each of the NQP Hubs for each provider type (Refer to Funds Flow Table). Within the demonstration years, financial distributions have gradually increased to partners across the network. Some partners did not require DSRIP funds as their work did not tie to DSRIP projects. Partners who did not have significant funds distributed to them, will have funds flowed to them as contracting continues. Specifically, this would apply to partner types such as PCPs, MH/SA and CBO partners. In addition, projects identified in this plan of correction will either be transitional or a newly created or expanded service which will be supported by DSRIP funds and thereafter folded into VBP contracts or funded through other government contracts such as housing funded by Office of Mental Health. As NQP implements these contracts and fulfills project requirements, it will also be reviewing quality, outcome, and other patient specific measures. In response, it is expected that services might be dropped, added, or expanded, resulting in changes to contracts and therefore to funds flow. Total five year commitments will remain in effect.

NQP will ensure successful monitoring and controlling of project implementation of partner engagements for all its projects in the DSRIP portfolio. The DSRIP portfolio is being managed with program management tools and best practices. Daily and ongoing, project milestones and tasks status reports are being reviewed and monitored for implementation where PMOs of both the NQP and Hubs meet to track progress. To manage the progress of the work, trackers are shared weekly by the NQP PMO with Hub leads. One on one meetings with Hub leads are held monthly to review progress and identify any potential at-risk projects where mitigation and contingency plans are developed to secure successful implementation. Within these meetings, best practices are shared between Hubs.

Additionally, progress will be reported at the monthly Executive Committee (Board meeting) and corresponding subcommittees and workgroups. To maintain continued accountability, NQP reports up-to-date status of the PPS performance on P4R and P4P in the form of score cards. NQP will continue to evolve its scorecards where measurements of a number of risk factors including contracting and flowing of funds to MH and SA providers will also be captured. Data on performance metrics are captured once it is made available and presented to the Board including data on Potentially Preventable Visits and Potentially Preventable Readmissions. Furthermore, a CBO Engagement Committee has been established and is co-chaired by NQP and a community-based agency to monitor CBO engagement and identify and address barriers to success to provide preventative and timely, effective care.

This narrative is in response to the following recommendation:
Recommendation 2: 2ai - The IA recommends that the PPS provide a detailed plan for how each Hub will implement its own PCMH recognition strategy for primary care physicians.

NQP is committed to supporting Primary Care Physicians (PCPs) in achieving PCMH or Advanced Primary Care (APC) recognition by end of DY3. Each Hub is responsible within its' contracting efforts for a subset of NQP's PCP network and are actively working to provide readiness assessment, work plans, care team development, training, education, coaching, and assistance with application preparation and submission towards PCMH or APC. PCPs are prioritized for contracting based on a number of variables including number of attributed lives, safety net status and practicing in hot spot locations.

Each Hub, as part of its contracting approach, offers PCPs incentives to encourage PCMH or APC recognition. These incentives vary by Hub, but include PCMH consulting services, IT support, and care management. As part of the contracting/onboarding process for all PCPs, Hubs have identified staff and dedicated resources including consultants such as HANYS to specifically work with PCPs and their staff in efforts to meet requirements related to PCMH certification. PCPs that have not started with PCMH transformation (or are having difficulties with PCMH transformation) will be assessed to determine if APC certification is a more appropriate alternative based on their practice demands.

Each Hub reports monthly to the PPS on the number of practices that are in progress and/or have achieved PCMH recognition. This is reported quarterly to the Executive Committee. Hubs vary in their numbers of PCPs achieving PCMH Level 3 Recognition. As demonstrated in *Table 1: NQP PCMH Level 3 Recognition Status By Hub as of March, 2017*, each Hub is currently working actively to implement its PCMH strategy.

Table 1: NQP PCMH Level 3 Recognition Status By Hub as of March, 2017

Hub	PCMH Level 3 Recognition	In Progress PCMH Level 3 Certification	Contracted PCPs, Not Started
Catholic Health Services Long Island (CHS)	18	54	77
Long Island Jewish Medical Center (LIJ)	131	130	234
Nassau University Medical Center/NuHealth (NUMC)	50	21	20

Hubs will provide additional support as needed to support PCPs towards PCMH or APC recognition. Care management is a key component of both PCMH, APC and the Integrated Delivery System, and Hubs are making their centralized care management services available to the participating PCPs to support PCPs in addressing the DSRIP project requirements and NCQA standards for PCMH recognition. Hub-specific care management programs may assist patients in self-management; location and coordination of appropriate medical, behavioral and social services; assistance in addressing gaps in care; and recognition and response to patients' individual care needs and preferences. Hub Care Managers can create appropriate linkages to services for high risk patients identified by participating PCPs. These programs complement and extend the care management services provided by MCOs and Health Homes.

Hubs also provide PCPs with analytic and IT support to develop and run the reports that are necessary to support PCMH transformation. Practices will receive education and support on patient engagement and quality reporting. NQP's network includes many different EHRs – each of which has different functionality – but the

Hubs are working diligently to connect providers to HealthIx and share meaningful data on their performance on quality metrics.

Each Hub has additional administrative and supportive services it offers to its PCPs. The following table below compares in detail the similarities and differences between Hubs in their strategy.

Table 2: Detailed Hub Comparison of PCMH Implementation Strategy

	Catholic Health Services Long Island (CHS)	Long Island Jewish Medical Center (LIJ)	Nassau University Medical Center/NuHealth (NUMC)
PCMH Facilitator/ Consultant	HANYS, RR Health Strategies, One PCMH Certified Content expert (another one in progress)	Northwell Health; NYC Reach; HANYS; PCDC; Four PCMH Certified Content Experts; Two CCEs dedicated to Employed practices; and Two CCEs dedicated to Community-Based Practices	HANYS
PCMH Team Facilitator Services	Works closely with the PCP office staff through a series of weekly virtual trainings and curricula to guide a practice on the path toward PCMH transformation.	Readiness assessment, work plans, care team development, training, education, coaching, and assistance with application preparation and submission.	Perform a gap analysis of the current state, review the EMR for capabilities, form/train care teams, create a work plan that fully integrates PCMH guidelines and hold regular meetings with leadership to maintain transformation of the practice.
Training and Feedback	Education and trainings provided to providers and their staff regarding PCMH recognition	Education and trainings provided to providers and their staff; Chronic disease educator provides onsite trainings on evidence based-management of cardiovascular disease and diabetes. Trainings by EHR specialist on best practices	Education and trainings provided to providers and their staff regarding PCMH recognition
EHR and RHIO Support	IT team will support PCPs in meeting EHR functionality requirements and RHIO connectivity	EHR Optimization Specialist visits each practice to assess and enhance IT workflows	IT team will support PCPs in meeting EHR functionality requirements and RHIO connectivity
Care Management Support	Care Management team will collaborate with PCPs to support linkages to community based services	Care Managers and care coordinators deployed to both employed and community based practices. Supportive services include assessment and care plan development, identifying high risk and recently discharged patients. Physician portal for referrals and Chronic Care self-management programs in community locations using Stanford Chronic Disease Model	Care Management team will collaborate with PCPs to support linkages to community based services
Performance Measurement and Quality Improvement	Using NQP Performance Reporting tools to track practices and shared data on patient engagement.	Analysis of data pulled from MAPP and provider-level dashboards on quality metrics. Practices receive support on patient engagement and quality reporting.	Using NQP Performance Reporting tools to track practices and shared data on patient engagement.
Advanced Primary Care (APC) Model	Yes, in progress for some PCPs	Yes, in progress for some PCPs	Yes, in progress for some PCPs

PCMH or APC achievements by the Hubs contributes to NQPs primary care goals of achieving a highly functioning health care delivery system, and therefore reflects the overall DSRIP goals.

This Narrative responds to the following Recommendation:
Recommendation 3 – 2di - IA recommends that the PPS detail how the new vendor IT platform will accelerate the low Partner and Patient Engagement for the project.

Since October 2016, NQP has actively worked in collaboration with CipherHealth to launch Evolve, an IT platform that would serve to address the implementation goals of Project 2di which is to engage, educate and integrate the uninsured and low/non-utilizing Medicaid population into Community Based Care. With the partnership of CipherHealth, NQP expects significant progress in managing participant surveys and supporting Health Coach activities. Using this vendor IT system, NQP has worked with CipherHealth in the past months to build out a robust and sophisticated system that will meet Health Coach activity needs while capturing reports and tracking survey responses in a useful, timely and relevant manner.

CipherHealth is a health technology company committed to improving patient outcomes and experiences through enhanced communication and care team coordination. Aligned with Project 2di's objectives, the NQP PMO staff, Hubs and Community Based Organization (CBO) Partners meet weekly to drive the direction of the IT platform. Both specifications and functionality of this IT platform are identified in ongoing meetings to ensure it is future-ready, adaptable, scaled accordingly and successful in achieving maximum efficiency for all end-users. In concert with the feedback received from the meetings, CipherHealth communicates with Insignia Health regarding the Flourish® database to ensure data is being shared between the two systems. This volume of shared data across the systems will allow for Health Coaches to share, track and review information related to patient engagement, while improving patient navigation. Specifically, CipherHealth was contracted to pull PAM® survey data from Flourish®, including PAM® score levels that will assist Health Coaches to effectively implement Coaching for Activation® (CFA). Because Flourish® did not offer these services, CipherHealth was selected to fill these gaps.

CipherHealth is planned to launch the Evolve platform for NQP on March 13th, 2017. This IT platform will pull and populate data from Flourish® every 24 hours. Health Coaches will utilize Evolve to search for beneficiary information and track beneficiary engagements to drive follow up survey efforts via patient navigation and Coaching for Activation®. CipherHealth continues to collaborate with NQP to determine process flows, appropriate data sets, field requirements, and follow-up assistance. Expanding on its functionality and resource, CipherHealth has embedded links to community resource databases, HITE and 211, and uploaded data sets into the platform, including Provider lists, CBOs, and NU/LU lists from MCOs, allowing easy access for users to provide appropriate referrals to beneficiaries.

Ongoing efforts by CipherHealth has assisted with the development of appropriate process flows in January 2017, implementations of initial User Trainings on 2/23/17 and 2/24/17, and the opening of a Sandbox Demo Platform for users to familiarize themselves with the tool until going live. Additional refresher online trainings were also provided on 3/7/17. This CipherHealth Evolve platform will offer support to NQP in the following ways:

1) Reducing Administrative Burden
   Administrative burden on Health Coaches/Patient Navigators will decrease through the provision of participant data management through dashboards and the My Agenda page to organize participant follow up. These additional views and reports will empower Health Coaches to implement more PAM® surveys and conduct coaching encounters using Coaching for Activation®.
2) Managing Participant Survey and Health Coach Activity Needs
   CipherHealth provides a mechanism for follow-up reminders and re-survey needs per patient and per individual health coach along with reportable documentation of participant survey and coaching activity.
3) Documenting Consent

Recordings of patient consent assists NQP in capturing it into the Patient's Health Information.

4) Quality Assurance and Reporting
   Quality assurance measures that will include identifying duplicate profiles based on specified beneficiary information fields allows users to identify duplicates. And improve participant outreach and management and reporting accuracy. Flexible reporting fields allow users to report data for the purpose of managing coaching follow up activity, participant status, and project reporting.
5) Improving Social Service Referrals
   Health coach access to robust online community resource databases will address beneficiary needs and increase connection to these services.

2di has experienced increased Actively Engaged (AE) numbers due to the work from its contracted CBOs (EAC Network and Planned Parenthood of Nassau County). Collaborations with representatives from all contracted CBOs, sub-Hub partners (ex. Winthrop University Hospital and St. John's Episcopal Hospital), and contracted community providers (ex. 609 Fulton Pediatrics) participate in workgroup calls to discuss quality improvement, outreach strategies, barriers, and share best practices. 2di partners have worked to support outreach staff and health coaches, working on projects like developing resources guides for utilization in the field, implementing focus group, and developing responses to beneficiaries who provide outlier survey responses. Emphasis on training outreach staff and health coaches on cultural competency and health literacy have also been implemented. These efforts led to increased AE numbers where DY1Q2, NQP engaged 22% of its AE target, but in DY2Q2, NQP met 66%. Significant improvement can also be found in AE data from DY2 alone. In DY2, NQP met 31% of the AE target in Q1, 66% in Q2, and 82% in Q3. NQP anticipates being able to meet its committed AE numbers by DY2Q4.

As NQP works to increase partner engagements to projects, it has applied its overall partner engagement strategy to Project 2di (See NQP PPS-Wide Partner Engagement Strategy). To add to the overall strategy, the following details NQP's efforts to increase actively engaged and partner engagements by September 2017:

1) Increased support of contracted CBOs
   EAC Network and PPNC, are active participants in 2di workgroups. Both provide expertise by addressing implementation concerns, sharing best practices, and providing input on NQP strategies. An emphasis has also been placed on hiring bilingual staff. NQP continues to support contracted CBOs through trainings on DSRIP, Coaching for Activation®, Flourish®, and CipherHealth Evolve. Additionally, NQP is supporting staff in implementing PAM® surveys, collaborating on outreach strategies, and tracking outreach efforts to avoid duplication of efforts.
2) Working to Contract and Engage Additional CBOs.
   Contracts are in process with the Long Island Federally Qualified Health Centers (LIFQHC) and EPIC Long Island. Staff from both CBOs will be trained to implement PAM® surveys and utilize both Flourish® and CipherHealth. In addition, NQP plans to engage more Tier 1 CBOs to implement PAM® surveys. This will improve both our actively engaged and provider commitment numbers.
3) Working on Provider Commitment Numbers
   In addition to contracting with CBOs, NQP has been working with sub-Hub groups including St. John's Episcopal Hospital and Winthrop University Hospital to train outreach and in-reach teams to implement PAM® surveys. Trainings are continuing and include Transitions of Care hospital staff and community practices.
4) Increasing community engagement and community presence with beneficiary populations in the NQP region of Nassau and Queens.
   NQP has conducted focus groups and forums with beneficiaries in hotspot areas to increase presence in the community, bring further visibility to DSRIP and the PPS' work in the region, and to learn from community members about current healthcare needs, healthcare access barriers, and the impact of DSRIP projects. NQP

continues to work collaboratively with the Long Island Population Health Improvement Program to increase PAM® activity.

NQP will ensure successful monitoring and controlling of 2di project implementation. 2di is being managed by NQP's Project Managers using project management tools and best practices. Accountability of work progress and status is daily and ongoing between NQP, Hub and participating partners. To manage the progress of the work, trackers are shared weekly by the NQP PMO with Hub leads. One on one meetings with Hub leadership with NQP are held monthly to review progress and identify any potential areas of risk where mitigation and contingency plans are developed to secure successful implementation. Project progress is reported at the monthly Executive Committee and corresponding subcommittees and workgroups. Working in concert with Performance Reporting, P4P, clinical metrics and process milestones are reported and tracked for improvement.

This Narrative responds to the following Recommendation:
Recommendation 4: 3ai - The IA recommends that the PPS and its hubs detail a "train the trainer" plan between the providers with positive experiences with this project to other physicians in the Network.

In order to create and sustain a clinical culture that integrates primary care and behavioral health together, primary care physicians within each Hub were engaged to be "champions." These individuals are positioned throughout the PPS and empowered to share their positive experiences with integrated behavioral health (IBH) with other PCPs. These physician leaders serve as a resource for the implementation of the project, including engaging physicians and assisting those practices that need extra support. PCPs who were early adopters and engaged were identified as champions to support the roll-out of integrated behavioral health.

As the PPS network continues to contract with more PCPs, these provider champions serve as a resource to share their experiences. Because of their work and being able to connect with providers, they successfully aid in reinforcing the integrated care model. Approximately 40 PCPs across the network are acting as champions and executing the "train the trainer" plan. The robustness of trainings vary across Hubs and occurs throughout the quarters based on the roll-out of the integrated care model, as well as practice-specific needs. These champions all demonstrate their leadership at an organizational, administrative and supportive level in the following ways:

Incorporated in Leadership and Contributes to the IBH Planning

- Provide feedback and insight to how to improve integrated care within various clinical settings and across the region
- Identify unmet challenges and concerns at a system and practice level, designing interventions to address physicians/staff needs
- Participate in committees and hold leadership positions to determine strategies to meet the BH needs of the beneficiaries
- Collaborate frequently with NQP to promote the IBH model across the network

Execute Trainings and share best practices

- Train other providers on how to perform a readiness assessment, effectively administer the PHQs for actively engaged reporting
- Meet with physicians with similar EHR systems and demonstrate how to input and capture data
- Share evidenced based standards of care, best practices, workflows and tools for integrating BH screenings, medication management and care engagement
- Share success stories and patient experience
- Designed trainings to meet the unique needs of individual outpatient clinics
- Present on Integrated Care in Quarterly Town halls

Function as a resource/collaborator

- Available to respond to questions and act as a support to partners
- Consultant to explain policies, core components of IBH and benefits to adoption as well as resources required for integrated care for providers interested in embedding BH providers into their practices including financial implications
- Provide independent networking to communicate with providers
- Support and strategize with providers in managing their issues, concerns and barriers to BH integration
- Share positive experiences with their colleagues and other physicians to help overcome resistance and improve actively engaged counts

IBH champions are fundamental to driving the implementation of Project 3ai. They bring significant value to NQP due to their ability to connect with providers and support providers along the way. With the "train the trainer" model, NQP's physician champions are "bought-in" to the model and continuously promoting all aspects IBH to their organization. Some examples of provider champions and their efforts are highlighted below:

- **Jacqueline Delmont, MD** owns a large multi-site practice. Currently engaged in bi-directional integration. Her practice has a PCP embedded in Catholic Charities Brooklyn Queens Rockaways location and she has a social worker embedded in her Rockaway location. Plans to embed a social worker in at least two other sites is in the works.
- **Natalie Schwartz, MD** is the lead for St. John's project implementation including their co-located primary care site to the ED. They opened with an embedded social worker in the co-location site. Dr. Schwartz will be a resource to identify and champion integrated care on the Rockaways - particularly with physician practices in St. John's Health First risk pool.
- **Marjan Tabibzadeh, MD** has been brought on as a resource to champion multiple primary care initiatives with colleagues, particularly in Nassau County. Plans are underway to embed a social worker in her practice.
- **Tarika James, MD,** and **Srikanth Challagundla,** MD, are operating clinics that have successfully added processes for behavioral health to their day-to-day operations. They have achieved this through their involvement in the MAX Series" Integrating Behavioral Health and Primary Care Services." Their success will be studied and brought to other partners within NQP, more specifically with NUMC.
- **Rajvee Vora, MD** is the Director, Ambulatory Behavioral Health and has spearheaded the integration of behavioral health practices in primary care across the LIJ employed practices and community practices attested to the LIJ Hub. Dr. Vora and her team have created an Integrated Care toolkit that describes evidence-based practices for screening, medication management, and coordination among team members. Dr. Vora and her team have educated more than 20 practices on the integrated care model, and have successfully hired behavioral health care managers to provide services in 5 practices. Dr. Vora and her team expects to be in 10 additional practice by the end of 2017.
- **JoAnne Gottridge, MD** is the Vice Chairperson, Medicine at Northwell Health and has been a true champion of behavioral health screening. Through Dr. Gottridge's advocacy, the Northwell Health ambulatory EHR was modified to include a 'Snapshot' that shows the status of all preventive screenings – including the date of the most recent PHQ. Dr. Gottridge has led by example and made behavioral health screenings an expectation for all PCPs.
- **Minu George, MD** is a Pediatrician at a very busy pediatrics practice. Dr. George was an early adopter of the integrated care model, and her practice was one of the first models of Pediatric Behavioral Health Collaborative Care. Dr. George's practice screens all adolescents for depression and anxiety, and has support from a team that includes an on-site behavioral health care manager (a licensed psychologist) and a child psychiatrist who is available for consults.

Due to the progress made with partner engagements and onboarding through trainings offered by IBH champions, actively engaged targets have successfully been achieved. Using this best practice, NQP plans to continue working toward this success and operationalizing these trainings across the network on a quarterly and as needed basis. When a PCP and/or BH provider is identified and interested in the IBH model, NQP will employ its champions to support the needs of the practice to successfully transform the clinical practice to one that aligns and practices an integrated organizational culture.

NQP will ensure successful progress of this training plan through tracking efforts made towards integration. Working concurrently with project 3ai requirements, this training plan will serve as an additional support

towards practice transformation to integration. These physician leaders are key to supporting and acting as a resource to providers interested or in the process of implementing an integrated model. Hubs will continue to report progress of the work their physician champions are doing at the site level.

This Narrative responds to the following Recommendation:
Recommendation 5: 3aii-The IA recommends that the PPS outline the specifics related to how the hub model will produce better results for this project.

NQP has developed its Crisis Intervention Strategy that will be led at the PPS-level. Its strategy will build upon established policies by OMH clinics, OASAS Clinics, Personalized Recovery Outcome-Oriented Services (PROS), and Assertive Community Treatment (ACT) teams, and OMH/OASAS Residential Programs for managing crisis calls during and after hours. The Strategy describes how the PPS will: (1) create linkages among the existing services and (2) develop and implement new programs to fill the identified gaps in prevention and community-based treatment. The goal of the Strategy is to ensure that people in crisis receive treatment in a community-based setting rather than in the emergency department or in an acute-care setting. Notably, the contracting efforts occurring at the Hub level will add significant value to the quality of care provided to NQP's attributed lives.

NQP is comprised of a large network of behavioral health and substance abuse providers with substantial expertise in treating individuals in crisis. These providers offer an array of services, including operating information and referral lines, mobile crisis teams, psychiatric acute care facilities, community crisis residences, and outpatient behavioral health care. Furthermore, NQP is working to create linkages among the existing services and provide training across the PPS to implement new programs to fill the identified gaps in prevention by September 2017. NQP is committed to increasing the use of non-emergent levels of services and providing the individual with services in the least restrictive manner. Its aim is to improve collaboration with partners that provide relevant services and data collection resources.

To achieve our goals, NQP is partnering with community-based organizations (CBO) to successfully develop and sustain an integrated delivery system. CBOs serve as frontline providers due to their vantage point within their communities and direct contact with their population. Collaboration with CBOs provides a comprehensive understanding of our population's healthcare needs within a culturally and socially competent context. Working closely with the CBOs, a feedback loop will be developed so that community health needs are shared and resources are provided. In concert with the crisis hotlines, adding the cultural competency of CBOs will ensure further outreach to this critically vulnerable population. NQP is implementing following steps to ensure CBO engagement:

1. Invite representatives from the CBOs to participate in relevant workgroup meetings.
2. Contract directly with CBOs, including Tier 1 CBOs or through the Independent Practice Associations (IPA) from Nassau County and Queens.
3. Contract with CBOs that have knowledge of the communities they serve and programs that are crucial to the goals of DSRIP behavioral health projects.

NQP is also partnering with two crisis hotline programs, that service the NQP region and provides 24/7 support, by July 2017. These include NYC Well (Queens) and 227-TALK (Nassau County). Both hotlines, provide a variety of crisis stabilization services including central triage, counseling, mobile crisis teams, and follow-up care. NQP's partnership with the crisis hotlines will promote the behavioral health and wellbeing of our attributed lives through:

- Behavioral health screening, assessment, and triage
- Centralizing information and referral within PPS network
- Data capturing of engagement activities

- Engaging in continuous improvement activities to improve the quality of existing services as well as assess the need for expansion of services.

Through contracting with the CBOs and the crisis hotlines, NQP anticipates a decrease in crisis, improvements in population health outcomes through care coordination and access to preventive services, improvements in behavioral health performance metrics, and decrease in avoidable ED visits. If gaps in services are identified, the PPS will work directly with their partners to expand access and meet the needs of the beneficiary. At this time, NQP intends to facilitate pay-for-reporting contracting with IPAs and CBOs at the Hub level by September 2017. These include:

- **OMH Clinic**
- **OASAS Clinic**
- **PROS**
- **ACT**
- **Health Home / Care Coordination**
- **OMH / OASAS Residential**
- **Mobile Residential Support**
- **Respite / Peer Respite**
- **Other Hotlines / Warm lines**

Moreover, Hubs will contract with IPAs and CBOs to develop additional Peer Respite in Nassau County as well as to develop mobile teams to bridge "high-need" clients post-discharge to the community. The contracts for these pertinent services are expected to be finalized by June 2017 and the programs are expected to be operational by September, 2017.

NQP plans to accomplish contracting with the crisis hotlines and relevant CBOs by September 30, 2017. In order to do so, we will promote awareness of the Crisis Intervention Strategy and CBOs through an educational campaign across the provider network. For example, NQP plans to develop a training webinar for the providers on the crisis intervention strategy, relevant services available at contracted CBOs, and the behavioral health protocols by September 2017. These trainings will be provided in a culturally sensitive and competent manner and will be geared toward the providers and community to educate them about local resources and ways to access them.

Based on the substantial input received from the Hubs through their participation in the Crisis Stabilization and Substance Abuse Workgroup, there is consensus on adopting the Crisis Intervention Strategy across the PPS. The Strategy and Behavioral Health Protocols will be embedded in their patient care processes thereby, enabling providers to render appropriate care to prevent crisis. As part of the Workforce Strategy, the PPS will be conducting trainings on Crisis Intervention Strategy. NQP will also conduct promotional campaigns that will facilitate dialogue between an array of provider types in the community to eliminate the silos and enable better care coordination for behavioral health services. Furthermore, at the Hub level, trainings on the Behavioral Health Protocols will be conducted within their provider sites. A designated trainer will be conducting the training and supplying training materials. NQP intends to complete the trainings by September 2017. To ensure that these trainings have occurred, NQP will be collecting a list of the scheduled trainings, meeting materials, and sign-in sheets from the Hubs.

Concurrently, at the Hub level, efforts is also being made towards crisis stabilization services. Some examples of the work that is currently being deployed is shown below:

- LIJ has contracted with four partners providing crisis stabilization services including Transitional Services Inc. NY (TSINY), Family and Children Association, Hispanic Counseling Center, and Southeast Nassau Guidance. In particular, TSINY has received additional funding to deploy the Rapid Crisis Team on the grounds of Creedmoor State Psychiatric Center due to it being the highest volume area for NYC for FDNY EMS Behavioral Health calls.

- CHS is working with Mercy Medical Center, Maryhaven and St. John's owned providers on capturing more and better AE data. CHS is also working on implementing some new services such as enhancing coding options to better capture crisis services and piloting an open access slot in the Mercy OP BH Clinic. The contracting process is underway with a number of Behavioral Health organizations such as Catholic Charities Brooklyn Queens and Catholic Charities Rockville Centre. Multiple efforts by CHS have already begun to support expanded outpatient clinic capacity and support for respite housing.
- NUMC is currently in the process of finalizing a contract with EPIC of LI to provide Crisis Stabilization through four clinic sites which would lead to expanded days and hours of operations, as well as increased capacity in the mobile crisis team.

NQP will track progress of the actions described above through the current Actively Engaged data collection process established by the Performance Reporting team. Generally, the Hubs provide updates to their contracted entities on a monthly basis. This data is then aggregated into NQP's Contracts Tracker and used to analyze the project's performance through a Performance Score Card.

This Narrative responds to the following Recommendations:

Recommendation 6: 3bi - The PPS narrative addressed challenges surrounding PCP engagement in this project and sought to mitigate this challenge by incentivizing providers to obtain PCMH certification. This is neither a requirement nor a barrier to implementing this project. As this project focuses on disease management for cardiovascular health the IA recommends that the PPS create a plan to engage the proper patient and partner types while focusing on the purpose of the project and the successful implementation of the same.

Recommendation 7: 3ci - The PPS narrative addressed challenges surrounding PCP engagement in this project and sought to mitigate this challenge by incentivizing providers to obtain PCMH certification. This is neither a requirement nor a barrier to implementing this project. As this project focuses on disease management for diabetes, the IA recommends that the PPS create a plan to engage the proper patient and partner types while focusing on the purpose of the project and the successful implementation of the same.

NQP is committed to improving the management of Diabetes and Cardiovascular disease in its clinical practices in the community and ambulatory care setting. To ensure the success of Project 3bi and 3ci, particular focus will be spent on training of providers in best clinical practices, documenting self-management goals, increased engagement of clinical leaders and development of care coordination teams. Specifically, these strategies will include increasing partner engagements, training providers in evidence based practices, improving patient engagements, improving EMR functionality and interoperability, and increasing PCMH recognition for participating partners. In unison with meeting DY2Q4 and DY3Q4 milestones, NQP believes its current activities will fulfill the IA's Midpoint Assessment recommendations. The following outlines NQP's continued efforts to engage proper patient and partners types for successful implementation as it relates to Project 3bi's and 3cis requirements.

Provider Contracting

NQP has been actively expanding its network of providers including Primary Care Physicians to more effectively reach a larger percentage of the attributed population. Primary Care Physicians are prioritized for contracting based on a number of variables including number of attributed lives, safety net status and practicing in hot spot locations. As part of each Hubs contracting approach incentives are included to encourage PCPs to meet requirements that will be critical to the success of managing these Projects 3bi and 3ci such as PCMH certification and tracking and reporting on quality metrics.

Training Providers

NQP has worked with physician leaders and subject matter experts to identify evidence based best practices to manage Diabetes and Cardiovascular diseases. As part of the contracting and onboarding process, PCPs and other members of the care team receive information and support required for implementing these projects. Providers across the continuum of care will receive training on evidence best practices and standards of care in PCMH, care management, and appropriate documentation of self-management goals.

Patient Engagement

Engaging patients to follow through on their self-management goals is important to improving their health. Members of the care team such as nurses, pharmacist, dieticians and care managers to support the patient is critical to improving their health outcomes. The care collaboration model inherent to PCMH and APC ensures that a much larger group of clinicians are engaging the patient. This includes referring to community services for both behavioral health and other social determinants of health. Presently we are using Tier 1 Community Based

Organizations to train patients on the Stanford Model Chronic Disease Self-Management Program to support patients in gaining the confidence to manage their health.

Increase EMR Functionality

NQP is working with IT teams from each of the Hubs to improve EHR functionality including making modifications to meet the project requirements. These enhancements include improving provider's ability to capture and report on self-management goals and the 5 As of smoking cessation. Major EHR's such as EPIC, eClinical Works and Allscripts are being targeted for these modifications. Additional functionality such as patient dashboards, linkages to RHIOs (HealthIx), and flags/prompts to remind providers regarding patient care will improve quality and outcomes. NQP is also actively collaborating with HealthIx to increase partners' engagement in data sharing. This is critical to support in real-time sharing of patient data. This supports improving the accuracy and timeliness of patient's medical record that is necessary in managing chronic diseases such as cardiovascular disease and diabetes.

Increase PCMH Recognition

PCMH recognition of PCPs intersects all eleven projects of NQP. Getting partners to successfully obtain PCMH will improve the care management and coordination of cardiac patients by linking them to patient registries and getting them the proper care to manage their health. Additionally, a core element of PCMH is use of care managers to help physicians manage high risk patients and referral management to ensure patients follow up with other providers in the community. At the Hub level, PCMH consultants are supporting PCPs to meet PCMH Level 3 2014 and is an ongoing process as PCP current levels vary (Refer to *2ai-PCMH Midpoint Assessment Narrative and NQP Primary Care Plan*).

NQP will ensure successful monitoring and controlling of 3bi and 3ci project implementation. 3bi and 3ci is being managed by NQP's Project Managers using project management tools and best practices. Accountability of work progress and status is daily and ongoing between NQP, Hub and participating partners. To manage the progress of the work, trackers are shared weekly by the NQP PMO with Hub leads. One on one meetings with Hub leadership with NQP are held monthly to review progress and identify any potential areas of risk where mitigation and contingency plans are developed to secure successful implementation. Project progress is reported at the monthly Executive Committee and corresponding subcommittees and workgroups. Working in concert with Performance Reporting, P4P, clinical metrics and process milestones are reported and tracked for improvement.

This Narrative responds to the following Recommendation:
Recommendation 9: Patient Engagement - The IA recommends that the PPS develop a strategy to increase and consistently maintain patient engagement levels throughout its target area. This is another high risk area where the PPS has previously missed targets and associated DSRIP payments.

Since the release of the Midpoint Assessment Recommendations in November 2016, NQP has increased its patient engagements across NQP's projects. These increases stem from ongoing efforts by NQP to contract with downstream partners across the continuum of care. Such partner engagements across NQP have allowed increased opportunities to interface with more eligible patients while working towards meeting projects' requirements and patient engagement. Performance reporting and quality improvement activities are an ongoing process throughout the life of the project, and assists contracted partners with increasing their engagement.

The combination of partner contracting and quality improvement efforts continues to assist in NQP's meeting of targets throughout DSRIP. Thus far, there have been significant improvements to the Actively Engaged (AE) patient numbers for projects 2bii, 2biv, 2bvii, 2di, 3ai, and 3ci. (Refer to Table 1: NQP Actively Engaged Patient Trends). These improvements are due to various efforts including increased contracting with Community Based Organizations (CBOs), Mental Health/Substance Abuse (MH/SA) providers, Primary Care Practices (PCPs), and additional providers that support each project. As part of the partner engagement strategy, NQP will continue to amplify its efforts to contract with additional partners that are geographical representative of the service areas as well as needs of the Medicaid beneficiaries. This will contribute to the actively engaged numbers for reporting purposes but also allow for cooperation for additional services to improve patient care (Refer to *NQP PPS-Wide Partner Strategy*).

Table 1: NQP Actively Engaged Patient Trends

	Difference in 1 year		As of January, 2017	
Projects	**DY1Q2**	**DY2Q2**	**DY2Q3**	**Meeting Targets?**
2bii: ED	99%	49%	72%	No, but increasing
2biv: Care Transitions	671%	596%	478%	**Yes, above**
2bvii: INTERACT	57%	113%	125%	**Yes, above**
2di: PAM	22%	66%	82%	No, but increasing
3ai: Co-Location	89%	140%	168%	**Yes, above**
3aii: Crisis	62%	21%	28%	No
3bi: Cardiovascular	29%	58%	48%	No
3ci: Diabetes	118%	228%	205%	**Yes, above**

To maintain the patient engagement levels, ongoing monitoring and quality improvements were implemented by the NQP's Performance Reporting Workgroup. As part of the Performance Reporting and Improvement Strategy, all contracted partners are required to undergo DSRIP project level onboarding. This includes an overview of DSRIP, review of project requirements/milestones and project specific patient engagements (as applicable). Clinical best practices and workflows tied in with quality improvement practices (PDSA cycles and CQI) are topics covered to help support partners in improving and/or maintaining their patient engagement levels. These forms of partner engagements are critical to achieving patient engagement benchmarks for the PPS. On a monthly basis, NQP collects Actively Engaged (AE) data from Hubs for each project. Actively engaged patient data is collected from partners at the Hub level and then submitted to NQP for data review and aggregation. NQP's Performance Reporting team feeds the data to the NQP AE Registry, checking the data for

integrity, quality and consistency. This data is then updated into the Patient Engagement Tracker showing year-to-date progress of actively engaged patients by project by Hub. The Patient Engagement Tracker is then shared with the Performance Reporting Workgroup as well as the Workgroups for review and discussion.

For projects that do not meet their targets, the NQP Project Manager discusses with and gathers information from respective workgroup(s) regarding reasons why targets were not met and improvement strategies to test and employ. The NQP Performance Reporting team has developed a tool for Project Managers and their workgroups to complete while conducting this analysis (see *Figure 1: Actively Engaged (AE) Improvement Strategies Tracker*). This tool is updated on an ongoing basis during workgroup discussions and submitted to the NQP Performance Reporting team quarterly. Leaning on the principles of the Institute for Healthcare Improvement's Model for Improvement[i], this tool was designed to accelerate improvement by making a way for the PM to document, for each identified barrier, improvement strategies, outcomes and results. It is the required that each project workgroup identifies barriers/risks/challenges and develops solutions/ways to mitigate/overcome them. Each intervention is tested and then assessed upon whether it has led to performance improvements. This cycle is repeated within the work groups where appropriate until the issue is removed and the strategic goals are accomplished.

Figure 1: Actively Engaged (AE) Improvement Strategies Tracker

	Current Barriers		Strategies	Sub-Strategies	Target Quarter	Outcomes	Next Steps	Last Updated (DATE)
1		1						
2		2a						
		2b						
3		3						
4		4						
5		5a						
		5b						
6		6						
7		7						

Results documented on the AE Improvement Strategies Tracker are discussed at the Performance Reporting Workgroup meetings, attended by all three Hubs and NQP. Findings are shared with the Clinical Oversight Quality Subcommittee (COQS) and Executive Committee on a quarterly basis for review and discussion. This process is designed to create a feedback loop from the Workgroups to the Performance Reporting Workgroup to COQS to the Executive Committee and cycled back again in order capture ongoing challenges and outcomes. In effect, best practices and mitigation strategies are then shared across all projects. The IT subcommittee is also included in the loop to ensure optimal use of information technology in these efforts.

[i] Institute for Healthcare Improvement's Model for Improvement - http://www.ihi.org/education/WebTraining/OnDemand/ImprovementModelIntro/Pages/default.aspx

Nassau Queens Performing Provider System

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Implementation Plan

Mid-Point Assessment Recommendation #2: The IA recommends that the PPS provide a detailed plan for how each Hub will implement its own PCMH recognition strategy for primary care physicians.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Increase PCMH 2014 Level 3 Recognition for contracted providers.	9/30/2017
Perform a needs assessment for each provider and identify the resources, and support services to get them PCMH	4/30/2017
Work with contracted PCPs towards readiness assessment, work plans, care team development, training, education, coaching and assistance with application prepration for submission.	9/1/2017
Create appropriate linkages to services for high risk patients identified by participating PCPs	9/1/2017
Work with identified PCPs interested in APC towards recognition.	9/30/2017
Mid-Point Assessment Recommendation #4: The IA recommends that the PPS and its hubs detail a "train the trainer" plan between the providers with positive experiences with this project to other physicians in the Network.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Early adopters receive training and support from Physician Leader "champions."	9/30/2017
Collaborate with physician leader "champions" on ongoing basis to provide administrative and supportive services to partners	5/1/2017
Connect physician leaders to partners working on BH integration	9/30/2017
Physician leader acts as resource and connects with physicians working on BH integration	9/30/2017
Early adopters receive support and trainings from physican leader "champions"	9/30/2017
2. Increase total of new Physician Leader "champions" across PPS network.	9/30/2017
Identify trained physicans in regions that have shortage of integration to become champions	5/1/2017
Engage identified physician leaders in supporting PPS and reinforcing the integrated model	9/30/2017
Provide trainings and supportive services to capacity build new physican leader champions	9/30/2017
Connect physician leader to partners working on BH integration	9/30/2017
Mid-Point Assessment Recommendation #6: The PPS narrative addressed challenges surrounding PCP engagement in this project and sought to mitigate this challenge by incentivizing providers to obtain PCMH certification. This is neither a requirement nor a barrier to implementing this project. As this project focuses on disease management for cardiovascular disease, the IA recommends that the PPS create a plan to engage the proper patient and partner types while focusing on the purpose of the project and the successful implementation of the same.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Increase Primary Care Physician contracts.	9/30/2017
Identify PCPs and prioritize based on attribution, safety net status and hotspot locations	5/1/2017
Contract with PCPs to deliver services that meet project requirements.	9/30/2017
2. Increase EMR Functionality	9/30/2017

Increase PCPs EMR connectivity to HealthIX	9/30/2017
3. Improve rate of actively engaged patients	9/30/2017
Support and train providers and care teams in completing self-management goals in EMR	9/30/2017
Analyze actively engaged totals for improvement	9/30/2017
Target providers and care teams for improvement in capturing patient engagements	9/30/2017

Mid-Point Assessment Recommendation #7: The PPS narrative addressed challenges surrounding PCP engagement in this project and sought to mitigate this challenge by incentivizing providers to obtain PCMH certification. This is neither a requirement nor a barrier to implementing this project. As this project focuses on disease management for diabetes, the IA recommends that the PPS create a plan to engage the proper patient and partner types while focusing on the purpose of the project and the successful implementation of the same.

PPS Defined Milestones/Tasks	*Target Completion Date*
1. Increase Primary Care Physician contracts.	9/30/2017
Identify PCPs and prioritize based on attribution, safety net status and hotspot locations	5/1/2017
Contract with PCPs to deliver services that meet project requirements.	9/30/2017
2. Increase EMR Functionality	9/30/2017
Increase PCPs EMR connectivity to HealthIX	9/30/2017
3. PCPs and care teams adoptf self-management goals into clinical workflows	9/30/2017
Support and train providers and care teams in completing self-management goals in EMR	9/30/2017

Mid-Point Assessment Recommendation #8: The IA recommends that the PPS develop a strategy to increase partner engagement throughout its target area, with a specific emphasis on engaging Behavioral Health (Mental Health and Substance Abuse) and PCP partners. Behavioral health providers and integration with primary care are essential to realize the project goals of behavioral health integration and to be able to earn the high performance funds.

PPS Defined Milestones/Tasks	*Target Completion Date*
1. Increase Primary Care Physician contracts.	9/30/2017
Identify PCPs and prioritize based on attribution, safety net status and hotspot locations	5/1/2017
Contract with PCPs to deliver services that meet project requirements.	9/30/2017
2. Contract with MH/SA providers for Pay for Reporting	9/30/2017
Finalize contracts with MH/SA Providers	6/30/2017
Providers report crisis services to NQP as part of crisis intervention strategy	6/30/2017
Provide support and resources to enhance ability to identify and report data on cardiovascular, diabetes and other quality measures	9/30/2017
3. Implement Transitions of Care teams for consumers discharged from inpatient psychiatric and substance use	9/30/2017
Work with identified hospital with volume of Behavioral Health (BH) high utilizers on BH and medical units	5/31/2017
Select provider agencies to deliver service	6/30/2017
Develop hospital and provider protocols for collaboration	7/30/2017
Implement project	8/30/2017
4. Engage CBOs in Patient Activation and engagement process	9/30/2017
Identify CBOs with large volumes of uninsured, non and low-utilizers in medical services	5/31/2017
Contract with identified CBOs	6/30/2017

Train CBO staff in PAM protocols and patient engagement	7/30/2017
Implement PAM and report to NQP	8/30/2017
5. Integrate PC and BH services (Model 1).	9/30/2017
Identify PCPs with high Medicaid utilization by region/area	5/31/2017
Match BH CBOs in those areas with identified PCPs	6/30/2017
Contract with CBOs to co-locate MH professionals in PC practices	9/30/2017
6. Integrate PC and BH services (Model 2).	9/30/2017
Identify BH CBOs with high volume of consumers who are poorly connected to routine medical care	5/31/2017
Match PCPs in those areas with identified CBOs	6/30/2017
Connect with PCPs to provide primary care services in BH settings	9/30/2017
7. Enhanced BH Crisis system.	9/30/2017
Contracts with NYC Well for Queens and 227TALK for Nassau County	7/1/2017
NYCWell and 227Talk report data on crisis calls to NQP	8/11/2017
Analyze the nature of calls and identify gaps in treatment delivery services	9/1/2017
Using analysis, partner with BH CBOs to fill gaps	9/30/2017
8. Partner with Mobile Crisis Teams.	9/30/2017
Partner with Mobile Crisis teams to report on encounters and difficulty with identifying clinical resources	7/1/2017
Using reports, identify additional providers to fill gaps	9/30/2017
9. Educate NQP Workforce, community agencies, police and first responders, and members of the community on BH related public health issues.	9/30/2017
Provide training through Hubs, BH agency and CBOs	6/1/2017
Prioritize trainings in hot spot areas	7/30/2017
Hubs, CBOs and Agencies provide training	9/30/2017
10. NQP Contract with Tier 1 CBOs in designated hotspot areas to expand social determinants of health related services	9/30/2017
Identify Tier 1 CBOs whose core services related to social determinants of health need expansion	7/30/2017
Partner with identified Tier 1 CBOs to expand those services	9/30/2017

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Partner Engagement

		Partner Engagement										
Partner Category		***2.a.i***	***2.b.ii***	***2.b.iv***	***2.b.vii***	***2di***	***3.a.i***	***3aii***	***3.b.i***	***3.c.i***	***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***
Practitioner - Primary Care		455	-	-	-	176	270	40	250	250		
Practitioner - Non-Primary Care		91	-	-	-	-	80	80	-	-		
Hospital - Inpatient/ED		3	-	-	-	3	3	-	3	3		
Hospital - Ambulatory		3	-	-	-	3	3	-	3	3		
Clinic		10	-	-	-	10	10	-	10	10		
Mental Health		350	-	253	-	-	21	349	251	251		
Substance Abuse		61	-	56	-	-	-	60	56	56		
Case Management		24	-	24	-	-	-	24	-	-		
Health Home		24	-	-	-	24	12	-	-	-		
Community Based Organization (Tier 1)		33	4	6	-	4	11	19	4	4		
Nursing Home		14	-	-	14	-	-	-	-	-		
Pharmacy		-	-	-	-	-	-	-	-	-		
Hospice		-	-	-	-	-	-	-	-	-		
Home Care		-	-	-	-	-	-	-	-	-		
Other (Define)												
Other (Define)												
Other (Define)												

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Funds Flow

Nassau Queens PPS

		Funds Flow (all funds)			
Partner Category		***Funds Flow through DY2, Q3***	***Projected Funds Flow through DY2***	***% of Earned Dollars Planned for Distribution DY3***	***% of Earned Dollars Planned for Distribution DY4 - DY5***
Practitioner - Primary Care		$ 3,188,379	$ 4,954,384	18.1%	18.1%
Practitioner - Non-Primary Care		135,803	184,091	4.1%	4.1%
Hospital - Inpatient/ED		6,479,531	6,745,280	21.0%	22.6%
Hospital - Ambulatory		-	-	5.5%	5.5%
Clinic		829,104	1,076,021	5.2%	5.2%
Mental Health		142,835	193,622	4.0%	4.0%
Substance Abuse		-	-	2.5%	2.5%
Case Management		1,082,129	1,466,902	9.1%	9.1%
Health Home		31,928	43,280	2.5%	2.5%
Community Based Organization (Tier 1)		355,831	482,354	3.3%	3.3%
Nursing Home		583,654	930,847	5.5%	6.1%
Pharmacy		-	-	0.5%	0.5%
Hospice		-	-	0.5%	0.5%
Home Care		-	-	0.5%	0.5%
Other - PMO		9,479,788	13,496,817	16.9%	14.7%
Other - Community Based Organization (Tier 2&3)		40,000	100,000	0.9%	0.9%
Total		$ 22,348,981	$ 29,673,599	100%	100%