As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

**Mid-Point Assessment Recommendation:**
Cultural Competency and Health Literacy: The IA recommends the PPS implement the strategies and execute the training on CCHL as articulated in its submitted plans. The execution of this strategy needs to articulate how the PPS will measure the effectiveness of its CC/HL outreach efforts to the target population.

**PPS Action Plan Narrative:**

*Background:*
In partnership with PPS collaborators, the NewYork-Presbyterian Performing Provider System (NYP PPS) developed a Cultural Competency and Health Literacy (CC/HL) Strategy that included several areas of effort:

1. Identifying key priority groups experiencing health disparities through a needs assessment;
2. Identifying factors to improve access to quality primary, behavioral and preventive care;
3. Surveying partners on their CC/HL needs so that the PPS could provide support and resources as needed;
4. Enhancing communication with the attributed population;
5. Deploying assessments and tools to assist patients with self-management;
6. Improving provider and community-based organization's (CBO's) cultural competency and health literacy strategies; and,
7. Leveraging community-based interventions to reduce health disparities and improve outcomes.

This multi-pronged strategy, while broad in its scope, was developed with a focus on developing systems and processes that could be sustained beyond the DSRIP funding.

Unfortunately, shortly after the PPS prepared and submitted its strategy, there was a change in PPS leadership (including the lead on the CC/HL efforts) and the implementation of the strategy was temporarily delayed.

Since December, the PPS has enlisted the leadership of Dr. Dodi Meyer, a Columbia University pediatrician with significant experience in developing cultural competency and health literacy training programs for providers and frontline staff; community programs where agencies are embedded in primary care practices; screening tools to identify barriers to health and quality metrics which reflect/capture disparities in the delivery of care. Dr. Meyer is a practicing

physician in one the ambulatory settings where many of the NYP PPS DSRIP-funded efforts (Ambulatory ICU, etc.) are taking place; she is well-versed in the goals of DSRIP and its intent of developing sustainable systems to improve health and healthcare.

Since assuming leadership for the CC/HL effort, Dr. Meyer and the DSRIP team have successfully implemented a number of components of the aforementioned strategy, including:

1. Establishment of a Cultural Competency and Health Literacy section of the NYP PPS website: www.nyp.org/pps

2. PPS-wide rollout of Quality Interactions Resource Center ©, a web-based platform that provides in-the-moment access to cultural competency materials for a variety of populations. Additional information is available here: http://www.qualityinteractions.com/our-solutions/qi-resource-center/

3. Conducting a PPS-wide survey of Cultural Competency and Health Literacy practices, current resources, needs, and identification of local experts available for training

4. PPS-distribution of Cultural Competency "tip sheets" to provide basic guiding principles for both the environment and the nature of interactions surrounding various issues related to provision of culturally-competent care. These are available here: http://www.nyp.org/pps/cultural-competency/training-resources

5. Scheduled PPS-wide webinars on topics covered in the "tip sheets," including: (1) Society, Culture and Race in Clinical Care, and (2) Health Literacy and Teach-Back Techniques: Overcoming Barriers to Adherence.

*Specific PPS Action and Timelines:*
Moving forward, Dr. Meyer and the PPS CC/HL Workgroup will be focusing on implementing the remainder of the PPS Cultural Competency and Health Literacy Strategy. Remaining areas of focus include:

1. Developing an annual, in-person PPS-wide training on current CC/HL best practices;

2. Developing a peer-to-peer mentor network of PPS members to support each other's cultural competency and health literacy efforts.

The following timeline provides the specific milestones and key steps to continue the implementation of the PPS-developed strategy.

**Mid-Point Assessment Recommendation #5: The IA recommends the PPS implement the strategies and execute the training on CCHL as articulated in its submitted plans. The execution of this strategy**

| **needs to articulate how the PPS will measure the effectiveness of its CC/HL outreach efforts to the target population. (Organizational, Cultural Competency & Health Literacy)** | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| **1. Identify new PPS CC/HL Lead** | 4/30/2017 |
| *Identify funding for PPS CC/HL lead* | 4/15/2017 |
| *Secure funding and time commitment of new CC/HL lead* | 4/30/2017 |
| **2. Schedule and develop first annual PPS CC/HL training event** | 9/30/2017 |
| *Review potential CC/HL topics with PPS CC/HL Workgroup* | 4/30/2017 |
| *Identify potential subject matter experts within PPS* | 5/30/2017 |
| *Identify potential subject matter experts outside of PPS (national advocacy organizations, etc.)* | 5/30/2017 |
| *Identify date, location, resources for training event* | 6/30/2017 |
| *Distribute notification of CCHL training event to PPS network* | 7/30/2017 |
| **3. Develop measures to evaluate efficacy of CC/HL efforts** | 9/30/2017 |
| *Conduct best practice review of CC/HL evaluation metrics and processes* | 4/30/2017 |
| *Review identified best practices with CC/HL workgroup; identify PPS-specific approach* | 6/30/2017 |
| *Identify DSRIP pay-for-performance metrics to evaluate for health disparities* | 6/30/2017 |
| *Develop business specifications for health disparity P4P metrics* | 7/30/2017 |
| *Implement data tools to review health disparity P4P metric data* | 9/30/2017 |
| *Implement CC/HL workgroup evaluation process* | 9/30/2017 |

*Approach to Tracking Progress:*
The Performing Provider System has developed a robust Project Management Office (PMO) that leverages best practices from Lean, PMBOK, etc. to manage its broad portfolio of efforts. To-date, this has included oversight of the ten projects, collaborator engagement efforts, State reporting, as well as the CRFP-funded IT efforts.

The above work plan will be reviewed within the NYP PPS PMO and the PPS Cultural Competency and Health Literacy Workgroup on a monthly basis.

Any challenges related to progress will reported quickly to the Director of the PPS and the PPS Executive Committee, when necessary.

*Alignment with PPS Overall Strategy*
The NYP PPS leadership recognizes that improving the cultural competency of our providers and collaborating organizations, and addressing patient health literacy, are key drivers in improving our attributed population's health outcomes. Without this focus, the PPS will be unsuccessful in the patients who most struggle with navigating their health and the healthcare system today.

As the PPS continues to pivot to focus increasingly on the pay-for-performance metrics, the clinical leads and project managers will be especially focused on ensuring CC/HL are key components of their quality improvement strategies.

**Implementation Plan:**
Please see the attached Excel template with the detailed implementation plan.

**Implementation Date:**
The PPS anticipates completing this action plan by September 30, 2017.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

**Mid-Point Assessment Recommendation:**
3.e.i: Comprehensive strategy to decrease HIV/AIDS transmission: The IA recommends that the PPS obtain long-term space for the HIV Center of Excellence (CoE) that can accommodate growth of staff and patients attributed to the program.

**PPS Action Plan Narrative:**
*Background:*
The NewYork-Presbyterian Performing Provider System (NYP PPS) originally reported the following challenge in its Mid-Point Assessment, "due to an influx of additional resources through the acquisition of several grants, including three NYS DOH End-the-Epidemic grants, the HIV Center of Excellence (CoE) is suddenly faced with space challenges to accommodate the increasing staffing."

The primary care and infectious disease clinics (NYP/Columbia University Medical Center Comprehensive Health Program (CHP) and NYP/Weill Cornell Medical Center, Center for Special Studies (CSS)) that are the primary engines for the NYP PPS HIV Center of Excellence project have been successful in increasing funding for HIV and HCV engagement by obtaining New York State, New York City, and private foundation support. This has allowed the two clinics to significantly expand their clinical and community-based services in a short period, above and beyond those resources provide through DSRIP.

To-date, the growth of the program has been accommodated by moving non-essential, administrative staff out of the practices to other administrative areas on the Hospital's campus.

As the funding portfolio (and related staffing) continues to grow, the NYP PPS will continue to seek clinical and administrative space for the expanding programs.

*Specific PPS Actions & Timeline:*
The PPS will work to secure space for the HIV CoE programs by September 30, 2017. The following timeline outlines the steps necessary to achieve this goal:

| *PPS Defined Milestones/Tasks* | *Target Completion Date* |
|---|---|
| **1. Assess HIV Center of Excellence administrative and clinical space needs** | 6/30/2017 |
| *Survey clinic and program leadership to understand existing space availability* | 4/30/2017 |

| | |
|---|---|
| *Survey clinic and program leadership to understand current and potential space needs* | 5/31/2017 |
| *Develop complete HIV CoE space needs gap analysis* | 6/30/2017 |
| **2. Identify long-term space options** | 9/30/2017 |
| *Present gap analysis to NewYork-Presbyterian Hospital facilities leadership* | 4/30/2017 |
| *Identify potential internal and community-based space options* | 5/31/2017 |
| *Rank and prioritize space options* | 6/30/2017 |
| *Conduct feasibility analysis and develop funding requirements for space build out* | 7/30/2017 |
| **3. Identify funding for space and acquire/build out space** | 9/30/2017 |
| *Identify potential funding options* | 6/30/2017 |
| *Confirm lease agreement(s) and renovation arrangements* | 7/30/2017 |
| *Finalize space and move in* | 9/30/2017 |

*Approach to Tracking Progress:*
The NYP PPS has developed a rigorous Project Management Office (PMO) that leverages best practices from Lean, PMBOK, etc. to manage its broad portfolio of efforts. To-date, this has included oversight of the ten projects, collaborator engagement efforts, State reporting, as well as the CRFP-funded IT efforts.

The above work plan will be reviewed within the NYP PPS PMO on a monthly basis as well as through the NewYork-Presbyterian Hospital Division of Community and Population Health's regular operational leadership meetings.

*Alignment with PPS Overall Strategy:*
The expansion of HIV clinical and community services, as supported by the DSRIP funds and the recent addition of non-DSRIP grant funds, is a critical component of the PPS's strategy to improve the health of its community and reduce potentially-preventable utilization. As such, the NYP PPS is committed to ensuring the success of its clinical interventions, including providing the necessary administrative, financial, facility, and information systems support to ensure impact on the attributed population.

The NYP PPS will continue to identify funding mechanisms and additional space to support this growing clinical service.

**Implementation Plan:**
Please see the attached Excel template with the detailed implementation plan.

**Implementation Date:**
The PPS anticipates completing this action plan by September 30, 2017.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

**Mid-Point Assessment Recommendation:**

3.e.i: Comprehensive strategy to decrease HIV/AIDS transmission: The PPS needs to demonstrate effective collaboration with CBOs and other resources to ensure appropriate access to substance abuse treatment.

**PPS Action Plan Narrative:**

*Background:*

The NewYork-Presbyterian Performing Provider System (NYP PPS) HIV Center of Excellence project is centered around two major clinical hubs: The Comprehensive Health Program at Columbia University Medical Center and The Center for Special Studies at Weill Cornell Medical Center:

> **The Comprehensive Health Program (CHP)** co-located services include HIV primary care, Hepatitis C treatment, infectious disease specialty care, psychiatry, social worker, nursing care management, care coordination, nutrition, prenatal care, cancer/STD screening and smoking cessation, PEP and PrEP for HIV-negative patients at risk. We have seamless connectivity to tertiary-level care, dentistry and buprenorphine maintenance providers.
>
> **The Center of Special Studies (CSS)** co-located services include HIV primary care, psychiatry, Hepatitis C treatment, gynecology and prenatal care, cancer/STD screening, smoking cessation, dentistry, dermatology, partner counseling/testing, nutrition, social work and nursing case management, coordination, education, adherence and polypharmacy management and PEP and PrEP for HIV- negative patients at risk.

Since the very beginning of the planning and implementation of the Center of Excellence project, the project teams have collaborated with a broad set of community-based providers in order to enhance the breadth of services, including substance abuse treatment, available to the PLWHA and at-risk population. With the support of DSRIP funding, the PPS has formed the REACH Collaborative (Ready to End AIDS & Cure Hepatitis C).

Working through the REACH Collaborative and leveraging DSRIP funding, NYP has executed sub-contracts with all six of the REACH core collaborators to build a team of 10 Community Health Workers (CHW) and Peers. Together the CHWs and peers form a community based health navigation team that coordinates care and linkages to the full range of support services offered across the REACH Collaborative, e.g., needle exchange, harm reduction and substance use treatment, care management, housing support, mental health, food access, money

management/vocational training, and domestic violence support and child care services. The CHW and Peers responsibilities include outreach, screening for HIV/HCV, linkage, engagement, retention and chronic disease self-care coaching. The REACH Collaborative member organizations include:

**Washington Heights Corner Project (WHCP)**
Washington Heights Corner Project is a community based organization based in the Northern Manhattan. WHCP's mission is to significantly decrease behaviors among drug users that put them at the highest risk for HIV and hepatitis transmission. WHCP works to achieve this mission by providing its participants with safer-injection and safer-sex supplies, harm reduction education and literature, as well as case management and referrals, supportive counseling, wellness evaluations, crisis intervention, and other crucial health and social services. WHCP believes that the key to achieving its mission lies in providing drug-using individuals with evidence-based education and support so that they can make healthy choices and positive changes in their lives.

- **On-going funds flow to support CHW, Peers for engagement of at-risk; HIV/HCV test kits**
- **Primary Care Clinician currently co-located to provide services**

**Dominican Women's Development Center (DWDC)**
Dominican Women's Development Center offers multicultural and holistic social services as well as the provision of educational, economic and cultural development programming. DWDC is committed to the elimination of gender inequality and the promotion of social justice.

- **On-going funds flow to support CHWs for engagement of at-risk**

**Alliance for Positive Change**
Alliance for Positive Change (formerly ASCNYC), in operation since 1990, is a multiservice community organization that carries out its mission of "helping many, one by one" by building community, connection and stability for New Yorkers living with and at risk for HIV/AIDS. The Alliance's comprehensive programs include state-of-the-art peer education and training, harm reduction, specialized women's services, HIV counseling and testing, mental health services, medical and holistic care, case management, support groups, and many other innovative programs that help New York City's most vulnerable individuals and families to survive and thrive in the face of HIV/AIDS.

- **On-going funds flow to support Peers for engagement of at-risk; CHW/Peer training resources; distribution of HIV/HCV test kits**

**Argus Community, Inc.**

Argus Community, Inc. has a long history engaging and helping disadvantaged New Yorkers, their families, and loved ones to free themselves from poverty and drug abuse. Services include health care, educational, and case management programs focused on managing addiction and chemical dependency, STD, HIV and AIDS, along with support around employment, housing, and education. NYP chose to collaborate with Argus because of their nearly 50 years of success engaging and supporting those hardest to reach and most disadvantaged individuals and their caregivers.

- **On-going funds flow to support CASAC, CHW; distribution of HIV/HCV test kits**

**Village Care**
Village Care offers unique services to adults living with HIV/ AIDS. They have many years of expertise providing case management to people with HIV needing extra support. This work has now extended into their health home. With connections to their AIDS Adult Day Health Care Program and a focus on transitioning people with HIV into older adulthood Village Care was chosen as one of the PPS's community collaborators.

- **On-going funds flow to support CHW to engage at-risk**

**Harlem United**
For 28 years, Harlem United has served as a beacon of hope to the Harlem community, providing comprehensive health care, housing and support services to underserved individuals and families in Harlem and beyond. Today, Harlem United is as a leader in building stronger communities. Through their use of a mobile healthcare unit, Harlem United is able to provide low threshold medical services.

- **On-going funds flow to support expansion of Mobile Medical Unit**

This project was identified as a "Moderate Risk" project (risk score = 3) due to partner and patient engagement issues. Organized around the REACH Collaborative, the project has active and well-maintained partner relationships; however, they were not included in part of the collaborator engagement reporting, due to data integrity (inappropriate categorization of providers) in the quarterly reports prior to the midpoint assessment. Going forward the proposed action plan is to update the quarterly report in DY3Q1 such that it appropriately catalogs the providers engaged in this project and shows evidence of their strong levels of engagement.

As for patient engagement commitments, the PPS, may continue to miss patient engagement targets, due to incorrect guidance provided during the PPS application and project planning period. Specifically, the NYP PPS made patient engagement commitments based on guidance that New York State AIDS Drug Assistance Program (ADAP) beneficiaries would be able to be included in the patient engagement efforts; however, since the implementation of the project, the PPS has received guidance that these patients are not eligible to be counted towards meeting the patient engagement commitments. This will continue to be a risk for the PPS going forward.

*Specific PPS Actions & Timeline*
The NYP PPS will seek to submit an updated collaborator engagement report by July 30, 2017 with the DY3Q1 quarterly report.

| **Mid-Point Assessment Recommendation #2: The PPS needs to demonstrate effective collaboration with CBOs and other resources to ensure appropriate access to substance abuse treatment. (Project 3.e.i)** | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| **1. Correct PPS reporting to demonstrate engagement of CBOs and SU treatment providers** | 7/30/2017 |
| *Review current PPS PIT submissions* | 5/15/2017 |
| *Catalog existing engaged collaborators in HIV CoE project* | 6/30/2017 |
| *Upload collaborator engagement data into PPS* | 7/15/2017 |

*Approach to Tracking Progress:*
The Performing Provider System has developed a robust Project Management Office (PMO) that leverages best practices from Lean, PMBOK, etc. to manage its broad portfolio of efforts. To-date, this has included oversight of the ten projects, collaborator engagement efforts, State reporting, as well as the CRFP-funded IT efforts.

The above work plan will be reviewed within the NYP PPS PMO on a monthly basis as well as included in the efforts of the team dedicated to quarterly reporting.

*Alignment with PPS Overall Strategy:*
The expansion and integration of community-based and substance use services is a critical component of the PPS's strategy to improve the health of its community and reduce potentially-preventable utilization. As such, the NewYork-Presbyterian Performing Provider System is committed to ensuring the success of its collaborations with these organizations, including providing the necessary administrative, financial, facility, and information systems support to ensure impact on the attributed population.

The PPS will continue to develop and evolve its relationships with its collaborators to ensure that access and integration of services is continuously maintained.

**Implementation Plan:**
Please see the attached Excel template with the detailed implementation plan.

**Implementation Date:**
The PPS anticipates completing this action plan by July 30, 2017.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

**Mid-Point Assessment Recommendation:**
3.g.i: Integration of palliative care into the patient centered medical home model: The IA recommends that the PPS create an action plan to increase the presence of palliative team members in primary care practices in order to increase referrals, which will further improve patient engagement.

**PPS Action Plan Narrative:**
*Background:*
At the time of the Mid-Point Assessment, the NewYork-Presbyterian Performing Provider System (NYP PPS) had successfully recruited an interdisciplinary, palliative care team (physician, nurse practitioner, social worker, and nurse care manager). The team had successfully integrated a palliative cares screening and risk assessment within the outpatient setting to address unmet palliative care needs. This was through the creation of a Population Health Risk Dashboard, which identified patients with unmet palliative care needs based on defined criteria. Additionally, to ensure patients had access to the resources, the palliative care team engaged with hospice-based collaborators Metropolitan Jewish Health Center (MJHS), Visiting Nursing Service of NY (VNSNY) and Calvary Hospital to develop robust referral guidelines and access.

While the efforts described above were well executed, they were not as successful in actively engaging the front line providers, and consequently patients, as the PPS would like. In order to address provider satisfaction and engagement, NYP PPS is now in the process of reorganizing the mechanism for delivering palliative care to the patients who would benefit from such services. This redesign effort, in addition to an enhanced focus on primary care provider engagement and education will set the NYP PPS on-track for successfully impacting the attributed patient population and achieving its patient engagement commitments.

This project was identified as a “Moderate Risk” project (risk score = 3) due to partner and patient engagement issues. The NYP PPS’s relationships and engagement with collaborators are active and well-maintained; however, they were not included in part of the collaborator engagement reporting, due to data integrity (inappropriate categorization of providers) in the quarterly reports prior to the midpoint assessment. The PPS will update the quarterly report in DY2Q4 to appropriately catalog the providers and collaborators engaged in this project.

As for patient engagement commitments, the PPS, since the Mid-Point Assessment, has improved its capacity to capture the palliative care-related activities of its frontline clinical staff and is well-positioned to meet its patient engagement commitments going forward.

*Specific PPS Actions & Timeline:*
The following action plan outlines the efforts to redesign and enhance the access to palliative care staff within the targeted primary care practices. The patient and partner engagement numbers will be addressed through changes in regular quarterly reporting.

| **Mid-Point Assessment Recommendation #3: The IA recommends that the PPS create an action plan to increase the presence of palliative team members in primary care practices in order to increase referrals, which will further improve patient engagement. (Project 3.g.i)** | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| **1. Assess Internal Medicine practice specific palliative care service and educational needs** | 7/30/2017 |
| *Develop interview questions for Internal Medicine (IM) practice interviews* | 4/30/2017 |
| *Schedule interviews with Internal Medicine practice leadership* | 5/30/2017 |
| *Summarize interview feedback for review with PPS and project leadership* | 6/30/2017 |
| **2. Develop palliative care service model and rollout timeline** | 9/30/2017 |
| *Develop a palliative care clinical services model in response to collected feedback* | 4/30/2017 |
| *Develop rollout/implementation plan and review with key Internal Medicine stakeholders* | 5/31/2017 |
| *Implement clinical services aligned with Internal Medicine practices' needs* | 6/30/2017 |
| *Implement communication strategy to notify Internal Medicine providers of new services* | 7/30/2017 |

*Approach to Tracking Progress:*
The Performing Provider System has developed a robust Project Management Office (PMO) that leverages best practices from Lean, PMBOK, etc. to manage its broad portfolio of efforts. To-date, this has included oversight of the ten projects, collaborator engagement efforts, State reporting, as well as the CRFP-funded IT efforts.

The above work plan will be reviewed monthly within the NYP PPS PMO and the NYP PPS Adult Medicine project group which oversees the integration of Palliative Care, Tobacco Cessation, Behavioral Health, etc. into the Internal Medicine clinics.

*Alignment with PPS Overall Strategy:*
The NYP PPS is committed to making generalist and specialist-level palliative care efforts available to its attributed population and addressing the unmet needs that are likely drivers of potentially-avoidable utilization. Access to these services will require the continued engagement of identified PPS collaborators and providers, which the PPS is well-positioned to sustain.

**Implementation Plan:**
Please see the attached Excel template with the detailed implementation plan.

**Implementation Date:**

The PPS anticipates completing this action plan by September 30, 2017.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

**Mid-Point Assessment Recommendation:**

3.g.i: Integration of palliative care into the patient centered medical home model: The IA recommends that the PPS develop a plan to increase outreach and education materials to partners with respect to end of life care. The plan should include ongoing support and resources with educational updates for partners and their staff.

**PPS Action Plan Narrative:**

*Background:*

The NewYork-Presbyterian Performing Provider System (NYP PPS) has been committed to rolling out education and access to specialty palliative care services since the planning and implementation of the DSRIP process. However, in rolling out generalist level education to the participating primary care practices, the project team has, as expected, met some resistance from front line staff around their comfort level with discussing goals of care and end of life treatment with patients, as well as challenges related to merging the new education with other GME, DSRIP-funded, or practice leadership initiatives. This specific challenge was identified by NYP PPS in its Mid-Point self-assessment in August 2016.

The PPS is planning a renewed approach to engaging the frontline clinical staff in targeted clinics by better understanding their current practice, their comfort with expanding that practice, and their preferred modality for enhancing their knowledge.

Whereas in the past, the NYP PPS leveraged internal Palliative Care expertise only, the NYP PPS is now looking to enhance those training resources with those from national Palliative Care advocacy organizations and/or local Palliative Care providers with significant experience in education. These decisions will be tailored over the upcoming months as the results of the assessment becomes available.

*Specific PPS Actions & Timeline:*

The NYP PPS will focus on expanding education and outreach materials to its collaborators and providers by September 30, 2017. This will include both a revised assessment of provider needs and the development of a new education plan to support generalist knowledge of primary care.

| **Mid-Point Assessment Recommendation #4: The IA recommends that the PPS develop a plan to increase outreach and education materials to partners with respect to end of life care. The plan should include ongoing support and resources with educational updates for partners and their staff. (Project 3.g.i)** | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| **1. Assess Internal Medicine practice specific palliative care service and educational needs** | 7/30/2017 |
| *Develop interview questions for Internal Medicine practice interviews* | 4/30/2017 |
| *Schedule interviews with Internal Medicine practice leadership* | 5/30/2017 |
| *Summarize interview feedback for review with PPS and project leadership* | 6/30/2017 |
| **2. Develop and rollout Palliative Care educational plan** | 9/30/2017 |
| *Pull together Internal Medicine and Palliative Care experts (Hospital and community-based) to develop palliative care curriculum* | 4/30/2017 |
| *Finalize first draft of palliative care curriculum* | 5/31/2017 |
| *Review palliative care curriculum with Internal Medicine provider community* | 6/30/2017 |
| *Launch and complete training on generalist level Palliative Care training* | 9/30/2017 |

*Approach to Tracking Progress:*
The Performing Provider System has developed a robust Project Management Office (PMO) that leverages best practices from Lean, PMBOK, etc. to manage its broad portfolio of efforts. To-date, this has included oversight of the ten projects, collaborator engagement efforts, State reporting, as well as the CRFP-funded IT efforts. The above work plan will be reviewed within the NYP PPS PMO and the PPS Adult Medicine project group (which oversees integration of Palliative Care, Tobacco Cessation, Behavioral Health, etc. into Internal Medicine clinics) on a monthly basis.

*Alignment with PPS Overall Strategy:*
The enhancement of primary care provider knowledge and comfort with addressing Palliative Care and end of life treatment is an imperative in the PPS's strategy to improve the health of its community and reduce potentially-preventable utilization. Many of the most complex PPS-attributed patients will directly benefit from this effort to increase our primary care workforce's knowledge and comfort with providing generalist level Palliative Care.

This educational effort will also be supported by the team that is focused on PPS Workforce / Training Development to ensure that it is well-aligned with, and supported by, the PPS's other training efforts.

**Implementation Plan:**
Please see the attached Excel template with the detailed implementation plan.

**Implementation Date:**

The PPS anticipates completing this action plan by September 30, 2017.

**State of New York**
**Department of Health**
**Delivery System Reform Incentive Payment (DSRIP) Program**
**Mid-Point Assessment Action Plan - Implementation Plan**
**The New York and Presbyterian Hospital Performing Provider System (NYP PPS)**

| **Mid-Point Assessment Recommendation #1: The IA recommends that the PPS obtain long-term space for the HIV Center of Excellence (CoE) that can accommodate growth of staff and patients attributed to the program. (Project 3.e.i)** | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| **1. Assess HIV Center of Excellence administrative and clinical space needs** | 6/30/2017 |
| *Survey clinic and program leadership to undesrtand existing space availability* | 4/30/2017 |
| *Survey clinic and program leadership to undesrtand current and potential space needs* | 5/31/2017 |
| *Develop complete HIV CoE space needs gap analysis* | 6/30/2017 |
| **2. Identify longterm space options** | 9/30/2017 |
| *Present gap analysis to NewYork-Presbyterian Hospital facilities leadership* | 4/30/2017 |
| *Identify potential internal and community-based space options* | 5/31/2017 |
| *Rank and prioritize space options* | 6/30/2017 |
| *Conduct feasibility analysis and develop funding requirements for space build out* | 7/30/2017 |
| **3. Identify funding for space and acquire/build out space** | 3/31/2018 |
| *Identify potential funding options* | 6/30/2017 |
| *Confirm lease agreement(s) and rennovation arrangements* | 7/30/2017 |
| *Finalize space and move in* | 9/30/2017 |

| **Mid-Point Assessment Recommendation #2: The PPS needs to demonstrate effective collaboration with CBOs and other resources to ensure appropriate access to substance abuse treatment. (Project 3.e.i)** | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| **1. Correct PPS reporting to demonstrate engagement of CBOs and SU treatment providers** | 7/30/2017 |
| *Review current PPS PIT submissions* | 5/15/2017 |
| *Catalog existing engaged collaborators in HIV CoE project* | 6/30/2017 |
| *Upload collaborator engagement data into PPS* | 7/15/2017 |

| **Mid-Point Assessment Recommendation #3: The IA recommends that the PPS create an action plan to increase the presence of palliative team members in primary care practices in order to increase referrals, which will further improve patient engagement. (Project 3.g.i)** | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| **1. Assess Internal Medicine practice specific palliative care service and educational needs** | 7/30/2017 |
| *Develop interview questions for Internal Medicine (IM) practice interviews* | 4/30/2017 |
| *Schedule interviews with Internal Medicine practice leadership* | 5/30/2017 |
| *Summarize interview feedback for review with PPS and project leadership* | 6/30/2017 |
| **2. Develop palliative care service model and rollout timeline** | 9/30/2017 |
| *Develop palliative care clinical services model in response to collected feedback* | 4/30/2017 |
| *Develop rollout/implmentation plan and review with key Internal Medicine stakeholders* | 5/31/2017 |
| *Implement clinical services to meet Internal Medicine practices needs* | 6/30/2017 |
| *Implement communication strategy to notify Internal Medicine providers of new services* | 7/30/2017 |

| **Mid-Point Assessment Recommendation #4: The IA recommends that the PPS develop a plan to increase outreach and education materials to partners with respect to end of life care. The plan should include ongoing support and resources with educational updates for partners and their staff. (Project 3.g.i)** | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| **1. Assess Internal Medicine practice specific palliative care service and educational needs** | 7/30/2017 |
| *Develop interview questions for Internal Medicine practice interviews* | 4/30/2017 |
| *Schedule interviews with Internal Medicine practice leadership* | 5/30/2017 |
| *Summarize interview feedback for review with PPS and project leadership* | 6/30/2017 |
| **2. Develop and rollout Palliative Care educational plan** | 9/30/2017 |
| *Pull together Internal Medicine and Palliative Care experts (Hospital and community-based) to develop palliative care curriculum* | 4/30/2017 |
| *Finalize first draft of palliative care curriculum* | 5/31/2017 |
| *Review palliative care curriculum with Internal Medicine provider community* | 6/30/2017 |
| *Launch and complete training on generalist level Palliative Care training* | 9/30/2017 |

| **Mid-Point Assessment Recommendation #5: The IA recommends the PPS implement the strategies and execute the training on CCHL as articulated in its submitted plans. The execution of this strategy needs to articulate how the PPS will measure the effectiveness of its CC/HL outreach efforts to the target population. (Organizational, Cultural Competency & Health Literacy)** | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |

| | |
|---|---|
| **1. Identify new PPS CC/HL Lead** | 4/30/2017 |
| *Identify funding for PPS CC/HL lead* | 4/15/2017 |
| *Secure funding and time commitment of new CC/HL lead* | 4/30/2017 |
| **2. Schedule and develop first annual PPS CC/HL training event** | 9/30/2017 |
| *Review potential CC/HL topics with PPS CC/HL Workgroup* | 4/30/2017 |
| *Identify potential subject matter experts within PPS* | 5/30/2017 |
| *Identify potential subject matter experts outside of PPS (national advocacy organizations, etc.)* | 5/30/2017 |
| *Identify date, location, resources for training event* | 6/30/2017 |
| *Distribute notification of CCHL training event to PPS network* | 7/30/2017 |
| **3. Develop measures to evaluate efficacy of CC/HL efforts** | 9/30/2017 |
| *Conduct best practice review of CC/HL evaluation metrics and processes* | 4/30/2017 |
| *Review identified best practices with CC/HL workgroup; identify PPS-specific approach* | 6/30/2017 |
| *Identify DSRIP pay-for-performance metrics to evaluate for health disparities* | 6/30/2017 |
| *Develop business specifications for health disparity P4P metrics* | 7/30/2017 |
| *Implement data tools to review health disparity P4P metric data* | 9/30/2017 |
| *Implement CC/HL workgroup evaluation process* | 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.i*** | ***2.b.iii*** | ***2.b.iv*** | ***3.a.i*** | ***3.a.ii*** | ***3.e.i*** | ***3.g.i*** | ***4.b.i*** | ***4.c.i*** | |
| Practitioner - Primary Care | | | | | | | | | | | | |
| Practitioner - Non-Primary Care | | | | | | | | | | | | |
| Hospital - Inpatient/ED | | | | | | | | | | | | |
| Hospital - Ambulatory | | | | | | | | | | | | |
| Clinic | | | | | | | | | | | | |
| Mental Health | | | | | | | | | | | | |
| Substance Abuse | | | | | | | | | | | | |
| Case Management | | | | | | | | | | | | |
| Health Home | | | | | | | | | | | | |
| Community Based Organization (Tier 1) | | | | | | | | | | | | |
| Nursing Home | | | | | | | | | | | | |
| Pharmacy | | | | | | | | | | | | |
| Hospice | | | | | | | | | | | | |
| Home Care | | | | | | | | | | | | |
| Other (Define) | | | | | | | | | | | | |
| Other (Define) | | | | | | | | | | | | |
| Other (Define) | | | | | | | | | | | | |

**State of New York**
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**Mid-Point Assessment Action Plan - Funds Flow**

| | | 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 | | | | | |
| Practitioner - Non-Primary Care | | | | | |
| Hospital - Inpatient/ED | | | | | |
| Hospital - Ambulatory | | | | | |
| Clinic | | | | | |
| Mental Health | | | | | |
| Substance Abuse | | | | | |
| Case Management | | | | | |
| Health Home | | | | | |
| Community Based Organization (Tier 1) | | | | | |
| Nursing Home | | | | | |
| Pharmacy | | | | | |
| Hospice | | | | | |
| Home Care | | | | | |
| Other (Define) | | | | | |
| Other (Define) | | | | | |
| Other (Define) | | | | | |
| **Total** | | $ - | $ - | | |