NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Montefiore Hudson Valley Collaborative PPS

Appendix PPS Narratives

November 2016 **www.health.ny.gov** **Prepared by the DSRIP Independent Assessor**

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DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Montefiore Medical Center

Highlights and successes of the efforts:

Executive Summary:

The Montefiore Hudson Valley Collaborative (MHVC) has already made lasting connections and changes to healthcare in the Hudson Valley. We have made exciting progress towards our initial goals, as submitted to New York State Department of Health, on December 22, 2014:

Goal: Develop a more integrated system, better able to take on risk and deliver value

- MHVC is committed to Value Based Payment arrangements and has actively worked in the creation and lift of a Hudson Valley Independent Practice Association (IPA) to serve the network after the life of DSRIP
- Completed network financial sustainability assessment and planned VBP readiness assessment to position network on a path to sustainability
- Created Population Health Workgroup charged with defining standardized services that will be provided centrally or delegated among network partners

Goal: Pursue a more sustainable system, with care delivered locally in the right care setting

- MHVC is committed to a fully Integrated Delivery System (IDS) that allows Hudson Valley providers to practice the type of care their patients need
- MHVC developed a formal governance structure (Steering Committee, subcommittees, workgroups) with representation from diverse providers representing the entire network geography to ensure local voice in the creation of communities of care
- Adopted a focus on patients, partners and communities of care that values and resources the innovative care being delivered in the Hudson Valley

Goal: Create a more patient-centered system, with access to services tailored to community needs

- MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners
- MHVC is committed to the Patient Centered Medical Home model that reaches patients and their families where they are
- Leading design, strategic planning, and implementation of Medical Villages that create regional communities of care that take into account unique needs of populations and geographies

Goal: Align the workforce with the evolving needs of a rapidly changing delivery system

- MHVC is committed to workforce training and top of license practice methods to prepare for the future state of the Hudson Valley delivery system
- Completed full network workforce assessments and analysis in order to continue the successful path towards workforce transformation

Today, the Montefiore Hudson Valley Collaborative (MHVC) is a partnership of more than 250 organizations representing a

diverse group of stakeholders including hospitals, Federally Qualified Health Centers (FQHC) and Behavioral health organizations, to community-based organizations and public sector agencies that address the social determinants of health. Together, we aim to redesign the healthcare delivery system in the Hudson Valley, and collaboratively transform into an integrated system that seamlessly delivers the right care in the right place at the right time. Successful transformation is dependent upon strong relationships between diverse stakeholders, development of Information Technology (IT) systems that can talk to one another, and practitioners that are willing to use these shared systems to communicate, to listen and to learn from each other to collaboratively care for our Hudson Valley community.

At MHVC we are committed to our patients, to our partners and to developing strong communities of care. Our team recognizes that each stakeholder group has the potential to become a critical piece of our network. As we mature our network and plan for the transition to Value Based Payment (VBP) arrangements, building a culture of transparency, accountability, and shared decision-making is a core strategy of our MHVC partner engagement plans.

Our team has worked hard to develop processes that ensure diverse stakeholders and geographies are represented within our governing body (steering committee, subcommittees and workgroups). We also continuously strive to incorporate various stakeholder perspectives and strengths into our planning and project design. Our team regularly elicits and incorporates partner feedback into our work as part of our shared decision making strategy for project design, funds flow strategies and even development of contracting metrics. And that work is regularly reported back to the network as part of MHVC's rigorous formal reporting structure.

All of these efforts have put MHVC and its partners on a path to sustainability built on better care delivered by an integrated system of providers, better health for the people of the Hudson Valley and lower costs for providers, plans and the State.

Governance:

We believe the governance structure implemented to date ensures comprehensive governance and management of the DSRIP program. When we instituted our original governance structure, we aligned on a set of guiding principles to inform overall strategy and decision-making. We said we would:

- Ground decisions in data, robust analytics, and evidence-based practices
- Approach decisions collaboratively, transparently and with input from multiple perspectives (including stakeholders beyond MHVC);
- Adopt approaches that are centered around the voice and needs of our patients
- Have a shared MHVC vision
- Promote local ownership of regional transformation
- Focus on DSRIP requirements and long-term financial sustainability of integrated systems of care

Over the course of DSRIP Year 1, Quarter 2 the MHVC worked diligently with our network partners to create a governance structure that carefully considered their regional footprint, and the attributed lives for which MHVC is responsible. At the same time MHVC approved a set of governance by-laws and subcommittee specific charters, after multiple rounds of revisions and partner review, to ensure a transparent oversight of the MHVC network.

Creating this structure at an early stage in the DSRIP process required MHVC to more fully engage its partner network and think strategically about the organization and the partners that would play key roles. Challenges arose from making sure that subcommittees maintained active membership representing all the pieces of the MHVC network. Further, certain partners were insistent on representation and roles on certain committees.

In response to those challenges, MHVC leadership worked over a number of weeks to craft a system that ensured the best representation and structure for our governance committees. In particular, the use of an organizing matrix, broken out by provider type and geography allowed MHVC to carefully monitor the creation of subcommittees and ensure the participation of a diverse set of partners. This model also allowed MHVC to easily present the rosters to interested partners and governing bodies

for approval. The model showed that membership was based on the need of the subcommittee and network.

MHVC's successful completion of this milestone and its continued successful implementation is a source of pride for the network. Many partners have taken the opportunity to speak publicly among their colleagues about the success of the governance structure and all it has accomplished in a short time. MHVC has also carefully monitored the structure; adapting and evolving when appropriate, to ensure responsibilities of the network are being met.

Overall, MHVC has set up a structure that gathers valuable input and guidance from its network and is positioned to succeed over the life of the program.

Governance Reporting

MHVC has established a thorough, multi-directional reporting and governance monitoring process. Utilizing the following structures and procedures, MHVC has ensured appropriate oversight and transparency:

1. Formal Governance Structure with a bi-directional reporting created within committee by-laws and charters. All by-laws and charters were approved by MHVC Steering Committee after a series of presentations, sessions and revisions that culminated in agreement on final documents. The Steering Committee and Subcommittees create monthly minutes and presentations to document discussions and decisions.
    - The Steering Committee comprised of 19 MHVC members representing multiple stakeholders and seven-county geographic footprint.
    - Formal Subcommittees comprised of 10-12 MHVC members representing multiple stakeholders (inclusive of the following provider types: Primary Care Provider, Federally Qualified Health Center, Hospital, Skilled Nursing Facilities, Developmentally Disabled, Behavioral Health, Substance Use, Health Homes, Public Sector Agencies and Community Based Organizations) and seven-county geographic footprint:
        - Finance and Sustainability
        - Workforce
        - Information Technology
        - Clinical Quality
        - Legal and Compliance
    - More than 20 Ad Hoc/Standing workgroups all reporting up through a governance subcommittee
    - Workgroups inclusive of the above mentioned provider types but also including local representation such as patient voice and law enforcement.
2. Monthly reports by MHVC staff to Steering Committee regarding Subcommittee and Workgroup updates
3. Monthly reports by MHVC staff to formal Subcommittees regarding the work of other subcommittees as well as the overall work of the MHVC
4. Standardized weekly reporting among MHVC staff on Implementation Plan monitoring and progress and subcommittee updates to identify risks and opportunity for integration
5. Creation of Implementation Plan-based metrics identified by the Clinical Quality and Data Analytics teams to ensure completion of Implementation Plan milestones and drive reporting and performance for the network
    - Network engagement and information metrics to support the first MHVC contracted flow of funds to ensure partner level contacts for purposes of reporting and performance
6. Purchase and deployment of Performance Logic, a partner performance and implementation plan organizational tool and Salesforce, a partner tracking and resource tool with partner access to Governance materials (i.e., Steering Committee and Subcommittee meeting materials) to allow for bi-directional communication and reporting between MHVC and partners
7. Digital storage of relevant reporting and governance documents in shared drives, available to all MHVC staff, to be transitioned to Performance Logic for MAPP submission.

Value Based Payment (VBP)

MHVC, working with its extensive and innovative network, is well positioned to continue to move towards Value Based Payment

(VBP) arrangements. The Montefiore Health System has been on the forefront of VBP arrangements for more than two decades and has become a national leader in the drive for value over volume. MHVC has leveraged the extensive knowledge base of our Care Management Organization (CMO) and their strong MCO relationships to lay groundwork for a VBP future for Westchester and the Hudson Valley.

The following activities are underway to support transition of the MHVC network towards VBP arrangements:

Partner Education Plan

1. MHVC is developing an education and communication plan and materials for partners to enhance their understanding of value based arrangements including:
   a) risk sharing
   b) contracting options
   c) estimates of total opportunity

Survey Network to Determine Needs

1. MHVC has performed a financial health and sustainability current state assessment to understand and begin to address key sustainability issues.
2. MHVC defined an approach for monitoring financially fragile partners, including an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio
3. MHVC administered the survey utilizing a third party “black box” method in order to avoid the improper sharing of competitively sensitive market information. The third party consultant disseminated the assessments, compiled responses and rolled up data for use by MHVC
4. By DY2 Q2 MHVC will conduct a survey of partners' existing readiness to participate in VBP and the level of their current involvement in VBP utilizing the same “black box” method.
5. The third party will compile survey results into a baseline assessment of our partners’ value based arrangements, and develop recommendations in concert with the MHVC Finance and Sustainability subcommittee for approaches to improve the readiness of partners to participate effectively in VBP.

Define VBP Strategy

1. Using results from the VBP survey MHVC will develop detailed baseline assessments of network revenue linked to value-based payment as well as preferred compensation modalities for partners as part of a larger strategy to leverage MCO relationships.
2. Survey outputs will include an overview of partner readiness; opportunities for training and programmatic enhancements to partner infrastructure to support VBP; estimate of potential VBP revenues by source, and an overview of the current MCO landscape to the MHVC Finance and Sustainability Subcommittee and MHVC Steering Committee.
3. Building off of Montefiore's existing experience with VBP and the findings of the survey of partners, estimate the potential VBP revenues by source and utilize in the creation / refinement of an outreach strategy to the MCO's in the region.
4. Engage MHVC Finance and Sustainability Subcommittee and MHVC Steering Committee to develop the roles and responsibilities of the MHVC lead in coordinating the transition to value-based payments.
5. Obtain Finance and Sustainability Subcommittee and MHVC Steering Committee recommendations for their central role in coordination.
6. Continue meetings with MCO's and engage in development of MCO strategy framework for MHVC.
7. Work closely with MHVC Population Health Management workgroup to standardize centralized services and network refinement that will be impactful in achievement of quality metrics and transition to VBP through DSRIP and the HV IPA.

Engage with VBP QIP Process

1. MHVC plays a central role in the VBP QIP program as the central administrator for five hospitals participating in the program.
2. The administrator role allows MHVC to further strengthen MCO relationships on behalf of key members of the MHVC network and leverage those relationships and the learning from the program down to other network partners.
3. MHVC will work closely with each facility to ensure completion of milestones and standard metrics that alight VBP regional strategy.
4. MHVC organizes monthly Internal Steering Committee meetings with VBP QIP participants followed by regular meetings with QIP participants and the MCOs.

Participate in Hudson Valley IPA

1. MHVC is a key player in standing up of the Hudson Valley Integrated Provider Association (IPA) as a vehicle for VBP participation. The legal entity has been created and governance structures are formed.

2. MHVC has engaged in extensive Montefiore internal planning committees on HV IPA formation.
3. On 12/15/15 Montefiore formerly launched the governance structure of the HV IPA with a meeting of membership organization leadership
4. Since the 12/15/15 launch regular meetings and network recruitment have continued.
5. The overlap between HV IPA and MHVC membership has allowed for critical collaboration that will ensure the work of MHVC will integrate seamlessly with the HV IPA in the out years of DSRIP.

By taking these steps MHVC will transition its network and partners on to a path for sustainability in the Hudson Valley.

IT Systems and Processes

MHVC's is working to create an information technology architecture which helps transform health care delivery from a process which generates data, to a process which utilizes information to achieve improved clinical performance outcomes and reduced cost.

This will be achieved through individuals, partners, and other organizations providing patient-centered care to the Medicaid members served by the DSRIP Program. To achieve these goals, MHVC is developing processes to:

- Ensure timely, easy, and secure access to appropriate and accurate information in the pursuit of their patient care activities
- Provide information that enables outcomes improvement
- Increase collaboration and information sharing among care providers to enhance patient care

MHVC's IT infrastructure and strategy is interconnected with all other organizational workstreams, and serves as the foundation of a clinically integrated healthcare delivery system. With our partners at differing levels of IT capabilities and using differing platforms, we will pursue a realistic approach to achieving an integrated delivery system by focusing efforts on:

- Leveraging existing infrastructure (i.e. Use of People, Process, Technology)
- Adopting an incremental approach to developing the technology landscape
- Educate/Inform/Engage – ensure participation is understood and embraced
- Developing technology solutions that are flexible and sustainable enough to support other strategic initiatives with similar requirements
- Use a requirements driven approach – let priorities drive focus

Over the past several months MHVC has accomplished the following:

- MHVC has completed the IT Current State Assessment, identifying both capabilities and gaps across our network, including readiness for data sharing and the implementation of interoperable IT platform(s). The results of the assessment have given MHVC critical knowledge of the network and clear next steps for IT integration. These elements will be key to MHVC's ability to properly rollout a Population Health Roadmap and a Clinical Integration Strategy in the coming months.

- MHVC has partnered with the Primary Care Development Corporation (PCDC) to implement our PCMH strategy. They are in the field assessing practices readiness for transformation and bucketing practices according to their readiness level so that we can provide targeted technical assistance support for EHR, RHIO PCMH transformation and project alignment activities. Our PCDC scope of work offers different types of support, from telephonic assistance to onsite intense coordination for practices that need it. Offering different levels of support will be essential in our work to transform small community based practices.

- MHVC is working collaboratively with our QE, HealthlinkNY. The collective goal is to evaluate the current state of RHIO adoption in the Hudson Valley. There is also a strong focus on discussing the scope of services that the QE may provide to support MHVC deliverables and facilitating a plan to prioritize partner RHIO adoption and appropriate types of connectivity. To help encourage organizations to start the connection process, MHVC has been promoting state funded programs such the Data Exchange Incentive Program, to help cover the costs of the initial process. The promotion of this

information has been done via PPS webinars, monthly newsletters and one-on-one conversations

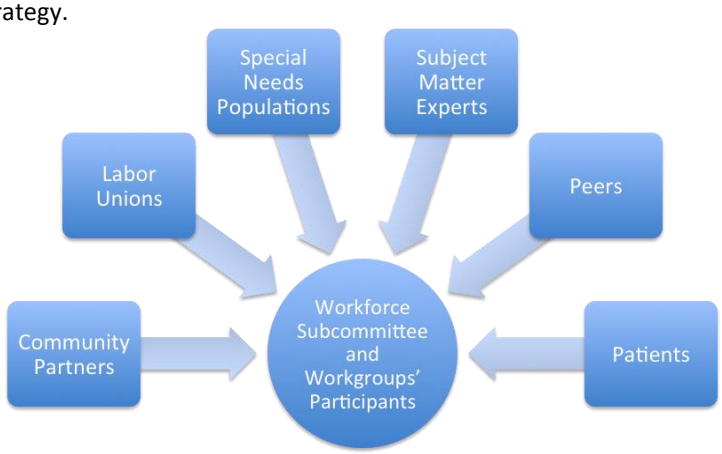
- MHVC has a Data Exchange Application & Agreement (DEAA) in place with the State and all 18 System Security Plan (SSP) workbooks have been completed and submitted to the State, making MHVC one of the first networks able to pull down and utilize state claims data. In addition, MHVC has created a secure infrastructure to support the exchange of clinical data with its Partners and has Business Associate Agreements (BAA's) in place with its contracted partners

- MHVC is working with provider groups that have no EHR in place to promote EHR adoption through the use of a vetted EMR solution, Medgen, currently in place for Montefiore's community physician groups that are members of the Montefiore ACO. Medgen is a certified MU Stage 2 EHR.

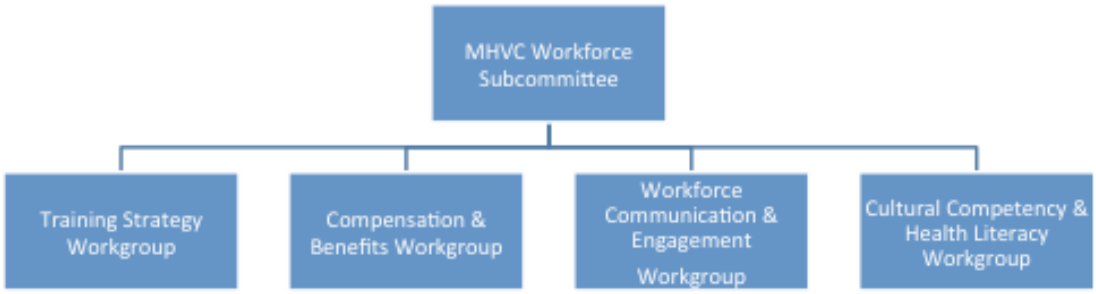
In the coming months MHVC, along with the IT Subcommittee, will be developing and overseeing the implementation of the IT change management strategy, clinical data sharing and interoperable systems roadmap, engagement of attributed members in qualifying entities and the population health roadmap. The network has made great progress on IT integration and will continue that work in the quarters to come.

Overview of Workforce Accomplishments & Governance Structure

MHVC, with the help of a strong workforce governing body, is actively working on a workforce transformation strategy and has successfully completed the five workforce milestones and one governance milestone defined by the state, including: target workforce state, transition roadmap, detailed gap analysis, compensation and benefits analysis, training strategy, and workforce communication and engagement strategy.



The Workforce Transformation Subcommittee and supporting workgroups are made up of diverse groups of partners to ensure necessary stakeholders and facility types are represented. The above chart depicts the key stakeholders that are participating in our workforce transformation: community partners, labor unions, special needs populations, subject matter experts, peers, and patients. The Workforce Transformation Subcommittee is responsible for advising MHVC on a comprehensive workforce development and management strategy to support MHVC projects and network partners. As subject matter experts, the Subcommittee members contributed to the workforce assessment, gap analysis, and planning necessary for understanding future workforce needs. The Subcommittee provides guidance on worker retention, redeployment, and/or hiring to promote successful project implementation. The four workgroups that are actively engaged in workforce transformation include: Workforce Training Strategy, Workforce Communication and Engagement, Workforce Compensation and Benefits, Cultural Competency and Health Literacy (CCHL).



In our DSRIP project plan application MHVC made initial annual commitments to workforce strategy spending which our workforce team is using to implement workforce transformation. We revised our baseline table to reflect the 25% discount factor for DY1 that was granted by DOH and we reallocated funds from "Retraining" to "Other" to support the initial planning work associated with workforce strategy. Our budget baseline commitments hold true to our overall spending commitments for our total workforce budget.

Workforce Milestone Completion

Over the past year we have worked with our Workforce Transformation Subcommittee and MHVC network partners to complete the five prescribed workforce milestones:

- Target Workforce State
- Transition Roadmap
- Current State Gap Analysis
- Compensation & Benefits Analysis
- Training Strategy

Successful implementation of MHVC projects requires the involvement of a variety of provider and facility types, as well as identification of multiple workforce positions with varying functions and qualifications. The convergence of multiple provider types to execute each project was a key consideration in the workforce planning efforts. We used focus groups and online working sessions with our key stakeholders, which allowed us to assess the differences in the functions, skills, and education levels of job roles across many work environments, such as long-term care, acute care, and ambulatory settings. These working sessions were an integral component of our target state forecasting, gap analysis, and transition roadmap and training strategy. The Director of Workforce Development and Management at MHVC has worked with other PPS workforce leads on our approach to completing the workforce milestones and has been active in PPS wide workforce meetings. In addition, our workforce lead participated in the Department of Health (DOH) Compensation and Benefits workgroup, led by Peggy Chan, to provide input to the reporting requirements and to better understand how MHVC network partners will be able to use the results from the compensation and benefits analysis report. The MHVC Workforce Transformation Subcommittee determined that a joint approach with Westchester Medical Center for the compensation and benefits survey would reduce the survey completion requirements for our shared partners and allow for richer data collection. Gallagher Integrated was selected as the vendor for the compensation and benefits analysis survey.

MHVC understands that to transform our workforce we must value communication as a tool to foster advocacy for change. As such, we have worked with our Workforce Transformation Subcommittee, our Workforce Communication and Engagement Workgroup, and our network partners to define our workforce communication and engagement strategy. We began this effort by identifying key themes from our initial data collection and engaging our network partners and various clinical and workforce committees and workgroups. In addition to interview sessions focused on workforce communication methods at the network partner level, we researched best practices in workforce communication, change management, labor management strategies, and organizational development trends.

We also conducted a series of meetings with clinical and workforce workgroups, being sure to include representatives from the various stakeholders/facility types involved in our Integrated Delivery System projects to identify audience segments, appropriate marketing and communication channels, tools/resources, and gaps and opportunities. Feedback from these workgroups directed us toward a communication model focused on workforce engagement and aligned with our communications plan and the priorities that are critical to the partner's successful implementation of MHVC projects.

Our detailed approach to each workforce milestone is included in the appendix.

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Overview Cultural Competency Health Literacy (CCHL) Strategy

The CCHL Strategy was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners. Upon completion of a community needs assessment, findings from this assessment were categorized in three stages: Stage 1 – Identifying Need Domains, Stage 2 – Identifying Theoretical Constructs, and Stage 3 – Researching Resources in the Community.

Using the assessment and evaluative findings, MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners. This strategy is divided into two major sections: the provider organizations and MHVC CCHL Workgroup.

Each section is sub-divided into three areas of effort: data collection, organizational activity, and community engagement. See diagram in appendix.

In DY1 Q4 we hosted a webinar on our CCHL Strategy that was attended by 152 individuals from our partner organizations. Our CCHL workgroup continues to actively meet to discuss the implementation of the CCHL strategy and the development of our CCHL training strategy. Our workgroup continues to collect CCHL materials for our CCHL repository, and we launched our CCHL assessment in mid February. For the past several months, we have been working with a cross sector workgroup to develop a full-day workforce training initiative on advancing health equity. In March, we modified our Cultural Competency and Health Literacy (CCHL) Strategy to include Key Factors to Improve Access to Quality Healthcare.
MHVC is implementing organization-wide and project specific activities to ensure cultural competency and health literacy remain priorities at each level of care delivery (e.g. from the partners to clerical staff). The following are current, on-going and/or planned activities that are key factors to improving access to quality healthcare.
Cross Cutting/MHVC Wide Initiatives to Improve Patient Access to Care

- Engaging partners to work together by conducting individual site visits and regional meetings. The purpose of these meetings is to learn about available services, linkages between partners, and needs assessment. These meetings are opportunities to provide education and resources regarding best practices for improving access to care.
- Inviting members of the CCHL workgroup (who are also members of clinical project workgroups) to attend and take part in ongoing project implementation planning as well as development of specific tasks (more details listed below).
- Providing patients with additional means of transportation to ensure they can reach healthcare partners.
- Opening additional primary and behavioral healthcare services in areas with gaps.
- Using telemedicine to provide primary, preventive and behavioral healthcare services to areas with gaps.
- Expanding hours of service and open access scheduling to make scheduling easier and more readily available.
- Co-locating services to create “one-stop-shops” for patients to receive their behavioral and primary care needs (through the Integrated Primary and Behavioral Health (3.a.i.) and Medical Village (2.a.iv) projects).
- Doing Outreach to community based organizations, schools, and other non-healthcare settings to make information more accessible to the community through public health campaigns.
- Creating pathways for communication and sharing of patient information between different services partners to promote integrated and seamless delivery of care.
- Training in structural competency for staff involved with patient care (Structural competency material can be found in the Resource Repository).

Training outcomes and practice transformation initiatives will be assessed through use of the Plan, Do, Study, Act (PDSA) model of process improvement to test changes and assess their impact on patient engagement and outcomes. This model is also being used to aid in the development of health literate educational materials for patients and staff.

Key accomplishments of the CCHL workgroup include:

- Creating a resource repository link in the CCHL section of the MHVC Partner website.
- Developing a Provider Organization CCHL Plan
- Conducting a Provider/Staff Capacity Survey
- Conducting focus groups and in-depth interviews with partners and patients
- Collaborating on a full day training initiative on Advancing Health Equity and Community Action Poverty Simulation Training
- Completing the CCHL Training Strategy

Going forward our CCHL workgroup will be focused on implementing our CCHL strategy and training strategy. An overview of CCHL Training Strategy is included in the appendix.

Approach to Funds Flow:

Over the course of DY1, MHVC worked closely with partners (including the Finance and Sustainability Subcommittee and ad hoc partner workgroups) to develop a funds flow methodology that supports DSRIP success.

MHVC is committed to a funds flow model that is a careful steward of state and federal dollars and distributes funds in a thoughtful, fair, and equitable manner. At the same time this model recognizes critical MHVC partners and supports the development of an Integrated Delivery System infrastructure to ensure a financially stable future for MHVC partners in the Hudson Valley.

The funds flow process is highly iterative and will continue to be revised as DSRIP and the MHVC network matures. In late 2015, MHVC contracted with partners via a Phase 1 funds flow focused on network development. In Phase I of contracting, MHVC focused on the MHVC partners that represented more than 90% of our network attribution. This group of 50 partners was eligible to receive $5M in partner payments. In early July 2016, MHVC's Phase II contracts will be released with a focus on roles and responsibilities for program implementation and clinical outcomes. More detail on both phases can be found below. Phase II contracts will take MHVC's targeted partner list from 50 to 69 and will increase the allocated partner funding from $5 million in Phase I to $7.2 million in Phase II, Performance Period I. Further, the evolving structure of contracting will now have 75% of funds earned via successful completion of Project Milestones and 25% of funds earned via the MHVC's ability to successfully meet clinical outcomes set and measured by New York State. As of August 5th MHVC has flowed $154,425 to partners that have executed their Phase II contracts.

Funds Flow Guiding Principles

Context of DSRIP funding

The overall goal of DSRIP is to catalyze the transition from a fee-for-service system to a value-based system. DSRIP funds can cover a portion of the costs necessary to transition to a value-based system. However, MHVC recognizes that there are additional drivers of transformation that are necessary to ensure a financially viable health care system. . Partners that chose to participate in the MHVC network will be expected to carry some of the financial responsibility for funding their organizational transformation realizing that the path to financial sustainability will include sources of value beyond DSRIP incentives including:

- Increased revenue from out-patient and primary care
- Reduced migration of patients to partners outside of MHVC and the region
- Operational efficiency due to greater scale
- Reduced fixed cost and variable cost savings
- Value-based contracts

High-level allocation of funding

The MHVC budget and funds flow methodology aligns with definitions set forth in the MHVC Implementation Plan and are aligned with the budget projections reported in the December 2014 MHVC Lead Agency DSRIP application. Funds are allocated to the following budget categories:

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MHVC 5-Year Funds Flow Average by Bucket

Budget Category	%
Cost of Project Implementation	45%
- Administrative costs including network management, DSRIP program office administrative support for PPS operations, legal support, PPS compliance - Centralized services will support creating shared infrastructure of the PPS and will include costs of shared IT infrastructure (to support performance reporting and data sharing), care management functions, central training and workforce development. Costs of implementation will be higher in the initial years to reflect the financial needs to set up DSRIP infrastructure (mirroring process and reporting metrics)	
Revenue Loss	10%
- Some partners will experience revenue decline in Medicaid population, as well as in Medicare and commercial populations Designed with the aim to help providers overcome the initial period of set-up costs and lost revenues while focusing on the right metrics as they grow and transform their services - To qualify for revenue loss compensations, partners will need to meet both progress and performance benchmarks and demonstrate ability to shift to sustainable system	
Internal PPS Provider Bonus Payments	40%
- Support project implementation and continued care delivery transformation - Provide reimbursement for services not currently covered under existing FFS contracts - Reward partners for outperforming on target milestones - The gradual shift from process to outcome measures aims to mirror the DSRIP incentive structure - Building on existing ACO experience, distribution of funds will be based on attribution, case mix and partners' performance against project milestones & performance measures	
Other (Contingency and Innovation)	5%
- Funds dedicated for continuous innovation and piloting new clinical programs - Discretionary funding to account for unforeseen expenses or underperformance	
Total	100%

Considerations for funds flow to partners

We have designed the MHVC funds flow methodology to closely mirror the DOH methodology. Funding will be tied directly to stakeholders' role in projects and outcomes and will be distributed to partners by assessing the patient population impacted by the projects. As the needs of each partner may be slightly different, partners will have autonomy and will maintain control over individual budgets and implementation plans (in close collaboration with the MHVC office). We expect partners to provide regular status updates to ensure DOH milestones and requirements are met. Reflecting how MHVC will earn incentive payments from the DOH, partner funds will be increasingly tied to performance over the course of DSRIP.

MHVC's Phase I of funding (October – December 2015) was allocated to partners based on provider type, network development needs and member attribution. Phase II funding will cover the 18 month period July 2016 – December 2017 and is organized in three 6-month contract periods. Each contract period will reflect the most current data available from DOH related to member attribution and a partner's claims history as well as a partners role in Project Milestones, their use of shared services, and regional needs. Additionally funds flow will continue to adhere strictly to the "95/5" safety net rule that ensures that 95% of partner payments are distributed to safety net entities. MHVC will ensure that the roles of CBOs are valued in the funds flow methodology by recognizing their critical role in regional communities of care and a value based future.

MHVC Funds Flow Key Compliance Principles

- No payments will be made to partners before MHVC receives payment
- No payments will be made to partners without executed contracts
- Funds Flow methodologies are created through a collaborative process with the MHVC Finance and Sustainability Subcommittee and submitted to the MHVC Steering Committee for review and feedback

Funds Flow Endnotes in accordance with NYS DOH Request

Cash Flow

Through DY2, Q1, MHVC has experienced some programmatic challenges related to cash flow and funds flow reporting. Initially, MHVC experienced cash flow delays caused by the change in payment method from the planned Safety Net Equity Payment transition to the EIP and EPP programs. The subsequent need to contract with MCOs created temporary cash flow issues that led to a delay in the release of MHVCs partner payments for Phase I contracted partners. To mitigate this challenge, MHVC created an active line of communication with the MCOs, DOH, and trade organizations to speed up contract negotiations.

Reporting

MHVC also encountered some early challenges with funds flow reporting when we discovered no state defined category for MHVC spending as a provider type. This caused early reports to not accurately reflect the type of funds flowing from MHVC, as spending done on behalf of the network through MHVC was recommended to be categorized as "hospital". MHVC identified the issue to the State and Independent Assessor to advocate for more transparent categorization and a new category (PPS PMO) was added to the future reports to accurately reflect the type of funds flow on a go forward basis.

Internal Audit

MHVC under Montefiore Health System's leadership sought out an independent Internal Audit conducted by KPMG. We had strengths identified in the following categories: partner contracting, partner disbursement, cash management, financial management, budgeting, forecasting, expenditure authorization, and DSRIP program compliance. This was an opportunity to improve upon existing controls and KPMG assisted MHVC by providing several recommendations to improve business practices, processes, and internal controls to help mitigate operational risk. MHVC considers this a best practice.

Practitioner Engagement – Best Practices:

We have found that the majority of our MHVC practitioners, regardless of stakeholder type, share a common goal with the MHVC team: we are all committed to improving quality care for our patients. Below we outline several unique strategies our MHVC team has incorporated to collaboratively engage practitioners in our work.

- **Culture of Transparency, Accountability, and Shared Decision Making:** At MHVC we are committed to ensuring our partners are kept aware of the challenges and opportunities that exist in developing and growing the MHVC network, and the level of administrative oversight required to ensure DSRIP deliverables are on track. Our partners have a unique "boots on the ground" perspective of implementation opportunities and needs as well as expertise in project and systems design and clinical guidelines. MHVC values this expertise and seeks to appropriately incorporate it into our project development and implementation planning.

- **"Patient Voice":** First launched in Sweden, the "Esther Project" uses a patient persona (Esther) to engage diverse stakeholder groups around systems redesign. Clinical/Quality workgroup members are encouraged to incorporate Esther's perspective into the redesign process by continually asking themselves . . . "What does Esther need?" and "what does Esther want?" Since many of our MHVC practitioners, regardless of stakeholder type, are deeply committed to their patients and to improving the quality of care they receive, we identified this unifying commitment to quality care as a strategic engagement opportunity. To this end, we collaboratively developed MHVC "Esther" personas for each DSRIP projects and challenge our partners to keep the patients voice and perspective in mind as we plan for systems and practice redesign that aims to improve patient flow, experience and quality.

- **Incorporating the Spirit of Motivational Interviewing (MI) into our engagement work:** Motivational Interviewing is an evidence-based skill set that partners can use to guide patients toward "change". "The spirit of MI" (Compassion, Acceptance, Partnership and Evocation) forms the foundation of MI and adherence to MI spirit is associated with movement toward change. In contrast, when people are told what to do, they are more likely to resist change. DSRIP initiatives are all about making major changes across systems, including roles and responsibilities, workflows, IT infrastructure, job descriptions, and care delivery system processes. These represent just some of the changes that practitioners will need to make as we transition to an integrated delivery system that serves as the foundation for our VBP future. Recognizing that any change is hard, our MHVC team is committed to modeling Motivational Interviewing

with partners to collaboratively develop strategies to help move systems toward change. For example, aligned with the "Spirit of MI," our subcommittees and workgroups collaboratively developed "Rules of Engagement" that define standards of how our workgroup members will work together (see Appendix). These are reviewed at the start of each workgroup meeting with emphasis on the opportunity for modifications and additions to be made.

- **Sustainability Strategy:** MHVC is committed to the long term financial sustainability of the Hudson Valley network and community of care. A fundamental goal of MHVC's DSRIP work has been, and will continue to be, the drive towards a successful Value Based Payment (VBP) arrangement future for our partners. The clinical innovations our partners already practice, and those they have committed to making, will be the foundation of that sustainable future. Close collaboration with our network ensures that the resources that lead to quality care and that drive VBP payments will be in reach for partners throughout the Hudson Valley. MHVC, building off of Montefiore Health System's decades of VBP experience, is uniquely positioned to turn high quality care into value based reimbursement for our partners. To this end MHVC is a close partner in the creation and setup of the Hudson Valley IPA (HVIPA) which will be both the vehicle for the continuation of our DSRIP progress and the way in which our network will earn the value it creates over the life of the DSRIP program.

Community Based Organization (CBO) Engagement

MHVC is putting relationship building first and foremost in our approach to developing a diverse, active, connected network of community based partners. We connected to CBOs by conducting one-to-one meetings, attending regional meetings and events, producing informational webinars (including some created and led by CBOs), distributing a monthly newsletter, and inviting CBOs to participate in workgroups & subcommittees. Now that we see a high level of engagement by our CBO partners, we can focus on assisting them with needs they have related to managed care readiness. To that end, MHVC is partnering with New York Association of Psychiatric Rehabilitation Services (NYAPRS) to provide targeted technical assistance on topics ranging from VBP arrangements and sustainability to board relations and networking. NYAPRS is a statewide coalition with expertise in community based care and organizational structure with an emphasis on valuing difference and promoting cultural competence in all aspects of their work. The MHVC partnership with NYAPRS reflects our commitment to support CBO partners to develop the practices, knowledge and skills needed to thrive in a managed care environment.

Through DY2 Q1 MHVC has reached out to engage our community based partners through in-person visits to obtain their input including: needs, linkages, concerns, capacities, and feedback on our communication/engagement efforts. Our listening tour included: 3 regional meetings throughout the Hudson Valley in June 2015 with nearly 500 participants, coalition meetings in 3 counties, meetings with county government officials and partners in 7 counties, and one-on-one meetings with executive leaderships of over 35 individual organizations. We also worked closely with CBOs to ensure they understand the timing, scope, resource and training needs of our MHVC projects as they related to their work.

Below is a summary of the stakeholder involvement to date:

- **Introductory Meetings---** Face-to-face site visits introduced MHVC to community based partners, thanking them for their participation, learning about their capacities and concerns, and providing an update on MHVC development.
- **Workgroup & Subcommittee Engagement---**Based on MHVC engagement work, the MHVC has recruited representatives from our CBO partners to provide valuable expertise and perspective to MHVC's subcommittees and workgroups.
- **"3rd Friday Webinars"--** The MHVC listening tour identified CBOs who offer a wealth of knowledge, innovative practices and expertise, which MHVC has been featuring in the "3rd Friday" webinar series – a standing monthly webinar attended by hundreds of partners and members of the community . CBOs have created content and led some of these webinars.
- **Establishing a Presence in the MHVC Region—**MHVC is maintaining a presence at regional provider and coalition meetings, conferences and events as well as setting up regional offices to ensure close contact with the region.

- **CBO Technical Assistance Program with NYAPRS---** MHVC will launch our first round of technical assistance for CBO's with a group of 30 organizations that are reflective of our geography that covers 7 counties. The scope of training will include technical assistance, VBP training, board relations and networking guidance and will follow the existing relationships (links) between hospital and primary care partners and CBOs.

Future phases of CBO engagement will include but are not limited to:

- Review of the MHVC governance structure to ensure appropriate network representation, including CBOs, and inclusive of organization requests to join
- Mapping CBO relationships to MHVC contracted organizations in order to understand existing local practice patterns and key CBO roles
- Launching a network resource directory
- Promoting RHIO connectivity assessment and technical assistance
- Expanding our funds flow model with our contracted entities to value the work of CBOs in support of the Integrated Delivery System

MHVC's commitment to CBO engagement has given the network a critical perspective on these organizations role in the success of DSRIP and the future of care in the Hudson Valley. Our continuing work with CBOs will allow us to ensure their value as the network heads towards a value based and sustainable future.

EPP/High Performance Metrics Strategy

As part of our culture of transparency, accountability and shared decision making, MHVC strategized to be inclusive in the decision making process for selecting our six EPP metrics. We convened an ad hoc Metrics Workgroup to leverage partner experience to guide MHVC's Quality Improvement strategy for EPP metrics selection. In doing this work the group brought their knowledge and consideration of the High Performance metrics and gave feedback on development of MHVC partner dashboards. Additionally, MHVC and its partners participated in a cross-PPS Hudson Region DSRIP (HRD) Clinical Council to strategize around the high performance metrics. The cross-PPS HRD Clinical Council includes diverse stakeholders such as hospitals, behavioral health providers and MCOs convening to review available state data and understand numerator and denominator requirements for high performance metrics. Collaboratively, we are working to develop guidance documents which will include clinical and technical specification, evidence to support high performance metrics and workflow guidance to improve care and ultimately impact regional performance on high performance metrics.

NEW YORK STATE | Department of Health

APPENDIX

This appendix contains additional valuable information on MHVC's workforce and cultural competency efforts:

Overview Cultural Competency Health Literacy (CCHL) Strategy:

The CCHL Strategy was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners. Upon completion of a community needs assessment, findings from this assessment were categorized in three stages: Stage 1 – Identifying Need Domains, Stage 2 – Identifying Theoretical Constructs, and Stage 3 – Researching Resources in the Community.

Using the assessment and evaluative findings the MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners. This strategy is divided into two major sections: the provider organizations and MHVC CCHL Workgroup.

Each section is sub-divided into three areas of effort: data collection, organizational activity, and community engagement. See diagram in appendix.

Key accomplishments of the CCHL workgroup include:

- Creating a resource repository link in the CCHL section of the MHVC Partner website.
- Developing a Provider Organization CCHL Plan
- Conducting a Provider/Staff Capacity Survey
- Conducting focus groups at the JMHCA in Newburgh and Family Ties of Westchester, as well as in-depth interviews at HOPE House (Human Development Services of Westchester) and St. Luke's Hospital at Newburgh Emergency Department
- Collaborating on a full day training initiative on Advancing Health Equity and Community Action Poverty Simulation Training
- Completing the CCHL training Strategy

Going forward our CCHL workgroup will be focused on implementing our CCHL strategy and training strategy.

Our detailed approach to the CCHL milestones is included in the appendix.

Workforce Appendix:

Define Target Workforce State

Over the past year we have worked with our workforce transformation subcommittee and MHVC network partners to define our Target Workforce State. We began this effort by conducting a comprehensive workforce survey of our network partners. In addition to specific workforce data, the survey included questions on PCMH readiness, IT transformation, quality improvement, training offered, and training capacity. We also conducted a series of focus groups with our network partners, being sure to include representatives from the various stakeholders/facility types involved in our MHVC projects. These focus groups helped us to build out our target workforce staffing model and identify skills, competencies, licensure requirements, and redeployment and training opportunities. Our approach included an analysis of the impact on future workforce demand of the known path, as well as alternative futures, using a combination of demand forecasting techniques. We anticipate changes in the workforce needs once our projects are fully implemented. By analyzing the impact of the alternative futures, we will be able to respond quickly to rapid changes from the known path to the alternative future. Multiple scenarios were analyzed to allow MHVC to move above and below the known path for the number of staff and mix of capabilities required. Forecasting techniques were used to enable MHVC to assess the likelihood, consequence, and mitigation strategy for each alternative future identified. We also worked closely with the MHVC project leads to understand the timing, scope, and resource and training needs of MHVC projects. On March 15, 2016, our workforce transformation subcommittee/governance body approved our Target Workforce State.

Successful implementation of MHVC projects involves a variety of provider and facility types, as well as multiple workforce positions with varying functions and qualifications. The convergence of multiple provider types to execute each project was a key consideration in the workforce planning efforts. Assessing the differences in the functions, skills, and education levels of job roles across many work environments, such as long-term care, acute care, and ambulatory settings, was also an integral component of our target state forecasting process.

Listed below is an outline of the process steps:

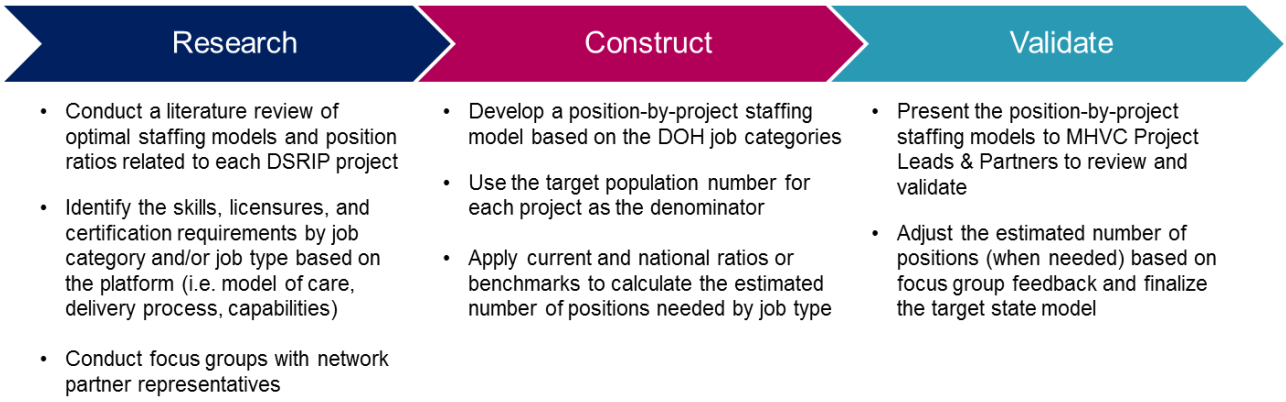
Analyzed MHVC Project Plan and Services:

- Evaluated the MHVC project plan and the services included within each project, including reviews of process maps, operations manuals, staffing models, etc.
- Conducted a thorough review of the requirements for each project and the specific services to be provided to each target population
- Determined the workforce implications and impacts of each project requirement.

Segmented the Workforce for Each Project:

- Outlined the specific job functions and job types available within each of our network partner organizations (based on the DOH Job Categories)
- Identified the job types and/or job titles needed for each project
- Cataloged the job types/job titles by partner organization, including emerging roles
- Collected required qualifications for each job category and job type
- Obtained the required position ratios (caseloads, panel sizes, etc. - when applicable) for each partner organization
- Determined which projects would use new and/or current positions
- Estimated the number of positions (by job type) that are needed to support each project now and in the future

The graphic below outlines our target state analysis approach.



Transition Roadmap

The MHVC workforce team worked with our Workforce Transformation Subcommittee and network partners to define our transition roadmap. The objective of our Workforce Transition Roadmap is to assess, understand, and act on the implications of strategic change for its future workforce.

As the healthcare landscape changes across the state of New York and within the Mid-Hudson Valley region, workforce development plays the pivotal role in the success of the transformation. Our workforce must be prepared to accommodate and manage an extraordinary amount of change within the healthcare arena. MHVC's workforce development and planning efforts focused on assessing the numerical gaps that exist between our current supply and future demand, identifying and articulating skills and competency gaps, anticipating trends that may impact the workforce in the future and analyzing the ways in which positions will need to change.

The transition roadmap initial steps to close gaps within our workforce include:

- Working collaboratively with our network partners to evaluate and close numerical gaps across various job categories.
- Training and equipping personnel with the knowledge, skills and competencies to perform all new business and clinical system and process tasks required in support of our MHVC projects.
- Increasing the skillset of the current workforce with workflow processes, job aids, evidenced-based guidelines, and real-

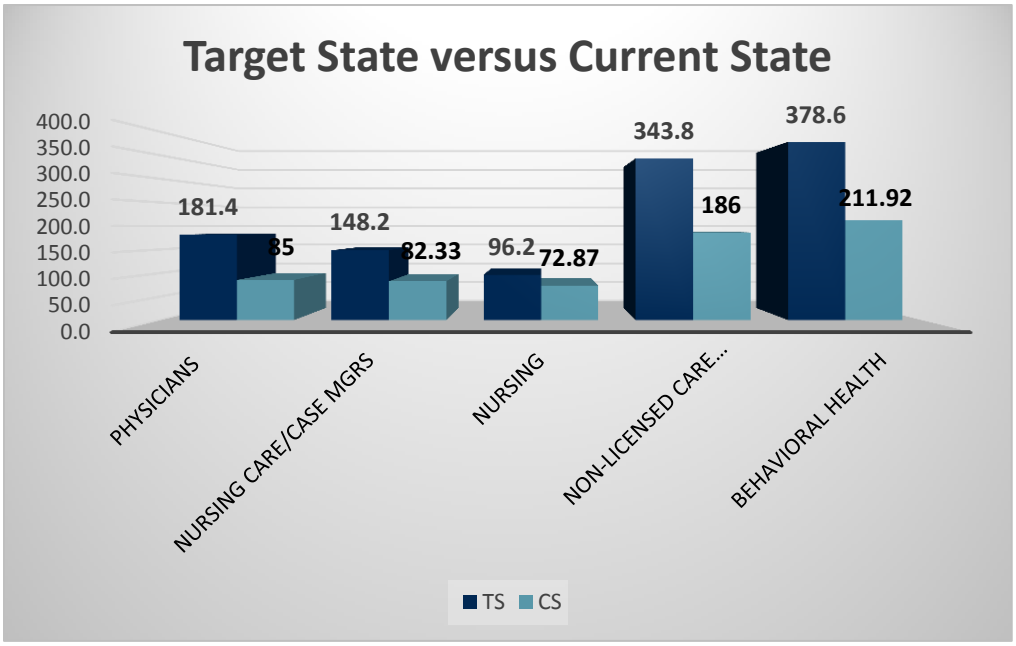
time information about patient experience.

- Reducing the time that it takes personnel to fully adopt new workflow processes, thereby reducing costs of initial lost productivity and ongoing support.
- Implementing change management processes to reduce anxiety staff may experience when workforce changes are implemented.

Our Transition Roadmap for achieving our defined target workforce state includes the following key elements:

- Detailed plans to address the recruitment, training and redeployment needs of network partners on an ongoing basis.
- A projected timeline with realistic target dates for accomplishing all steps to close workforce gaps.
- Defined goals, objectives and strategies outlining the ways in which we plan to close identified gaps so as to meet the needs of MHVC and our network partners.

MHVC identified and analyzed both quantitative and qualitative gaps within our workforce. To accurately analyze the workforce numerical gap, we collected data from our network partners regarding the actual current state workforce allocation to each project, as opposed to a pure headcount. This information provided a more finite number from which to calculate a gap. A comparison of our target state projections by project and current state workforce allocation yielded a quantitative gap of **613.78** (FTE).



MHVC Workforce Totals

Target State Projection: **1470.25**
Current State Allocation: **856.49**
Numerical Gap: **613.78**

We held a series of workforce planning sessions with our key network partners to discuss the workforce gaps and asked our partners to provide projections for New Hires, Redeployments, Retraining, and Other approaches they are planning to leverage to close the identified gaps.

The MHVC Workforce Transition Roadmap describes the gaps within our workforce and describes priority strategies and activities that we are initiating to help achieve gap closure including:

<u>Training & Education</u>

Our data has indicated that training and education are primary tactics currently being used by our network partners to prepare and transition the workforce. Subsequently, we recognize the need to apply quality improvement tools and processes to our training and education efforts, as we do with our clinical and business practices. It is imperative that training is both effective and accessible across our network. It is also important that our training content areas target knowledge requirements for both clinical and administrative workers. As such, our gap closing training and education strategy contains the following:

- Blended learning methods
  - That includes training through both classroom-based instruction and technology-driven content delivery.
- Train-the-Trainer programs
  - Which enables select staff members to learn techniques to deliver end user training, work with the training

materials effectively, schedule end users for training and manage attendance and assess and certify end users as appropriate.

- Quality Improvement
  - That offers protocols and methods aimed at enhancing training activities, as well as providing network partners with literature and best practice guidelines that support the methods and provide examples of the application of training and evaluation techniques.
- On-going training needs assessment
  - Which assesses staff training needs to identify gaps in skills and capabilities along with a curricula plan to identify types of learning opportunities to fill gaps.
  - And enhances our Training Plan to expand the audience groups, training methods and development process, roles and responsibilities, review and measurement processes.

Recruitment & Retention

We recognize that our network partners may need technical assistance in assessing, adapting and refining their recruiting and retention approaches. Our goal is to work collaboratively with and support the efforts currently underway. We also recognize the need to address the broader systemic issues of training & education, compensation and marketing which are crucial to improving recruitment and retention.

These are the focus areas for our Recruitment & Retention Strategy:

- Job Board / Clearing House
  - Establishing a clearinghouse of job listings that aims to create unified platform and one-stop shopping for both network partners and healthcare workers.
- Career Ladders/Succession Planning
  - Implementing Career Ladders and Lattices. These tools will help professional research career pathways and outline the experience and skills they should acquire in order to progress through various roles and fields.
- Workforce Diversity initiatives
  - Promoting efforts to create and maintain a diverse, results-oriented and high-performing workforce. We will provide technical assistance to our partners in identifying new talent pools and organizing employee resource and affinity groups.
- Recruitment and selection processes
  - Sharing best practice techniques to find and hire the talent required to provide outstanding patient care. Outlining tactics for interviewing for cultural fit, setting goals, and providing employees with feedback and advancing employee's careers through educational programs.

Retraining & Redeployment

MHVC and its network partners believe that employees displaced should be viewed as assets, not liabilities, and managed accordingly — otherwise valuable human capital will be lost which could otherwise be utilized to create value and offset future recruitment and training costs. Closing gaps through redeployment of displaced employees through retraining, internal recruitment and flexible working options is a sensitive and complex issue that requires careful management. Our approach is to play an active role, where possible and appropriate, in employee redeployment.

These are the focus areas for our Retraining & Redeployment Strategy:

- Structural Mapping
  - Providing partner organizations with a process that provides a clearer view of where job opportunities exist and where vacancies could be filled within an existing talent pool.
- Analysis & Review of Alternative Roles
  - Using job evaluation frameworks and job descriptions as essential tools to assess suitable alternative roles for affected staff. We will encourage the up-skilling of staff that could be trained to serve in vacant roles.
- Forecasting & Phased Reductions
  - Offering support to network partners with workforce forecasting and planning for restructuring and reductions. We will assist with developing solutions to close workforce gaps including outlining a phased earlier release of staff or temporary resourcing.
- Support Processes for Impacted Staff
  - Providing a technology resource to ensure relevant vacancies are shared with impacted staff so that there is an immediate proactive list of relevant options for them to consider. We will encourage line managers to hold

regular one-on-one meetings with impacted staff and review vacancy options with them.

Organizational Development

Closing our workforce gaps is a collaborative initiative with our network partners and stakeholders. One of the key ways we plan to collaborate is by aligning our efforts to expand the knowledge and effectiveness of the workforce to promote a more successful transformation. Organizational change and development will be a challenge for all of our network partners; however, by working collaboratively, we can connect various types of providers, share techniques for redeploying and retaining workers, and identifying promising practices in a range of areas.

These are the focus areas for our Organizational Development Strategy:

- Organizational Culture Change
  - We will foster organizational culture changes that ensure new practices that staff will learn through training and will be adopted into organization-wide practice.
- Change Risk and Readiness
  - Our goal is to help partners understand the potential risks and use the findings to provide mitigation recommendations as well as to drive change management planning.
- Communication and Engagement
  - Our communication and engagement strategy will assess current communication methods, targets, and plans to determine best practices and ways to improve on opportunities to proactively address areas of ongoing resistance across all partners and communities related to workforce.
- Cultural Competency & Health Literacy
  - We will leverage data from our workforce survey to create and offer training programs focused on non-discrimination, race/ethnicity, cultural awareness/sensitivity, health literacy and the effective use of interpreters across the network partner sites. Our goal is to close workforce skills and competency gaps in each of these areas.

On June 28, 2016, our workforce subcommittee/governance body approved our transition roadmap.

Gap Analysis

The MHVC workforce team worked with the Workforce Transformation Subcommittee and network partners to define the current workforce state and gap analysis. We began this effort by conducting a comprehensive workforce survey of our network partners. In addition to specific workforce data, the survey included questions on PCMH readiness, IT transformation, quality improvement, and training capacity.

Survey Administration

To gather self-reported workforce data and meet the workforce assessment criteria outlined by the NYS DOH, we developed and distributed a comprehensive, electronic workforce survey. Data were collected through a web-based questionnaire that was emailed to our network partners. The survey was administered in one release and the process included: a pre-notification email letter, the main survey email, and a number of reminder emails and phone contacts by MHVC workforce staff to network partners.

The survey was distributed to partner organizations representing the following facility types:

- Primary Care Practices
- Hospitals
- Skilled Nursing Facilities (SNFs)
- Community Based Organizations
- Federally Qualified Health Centers (FQHC's)
- Health Homes
- Behavioral Health
- Substance Abuse
- Developmental Disabilities Services

Survey Questionnaire

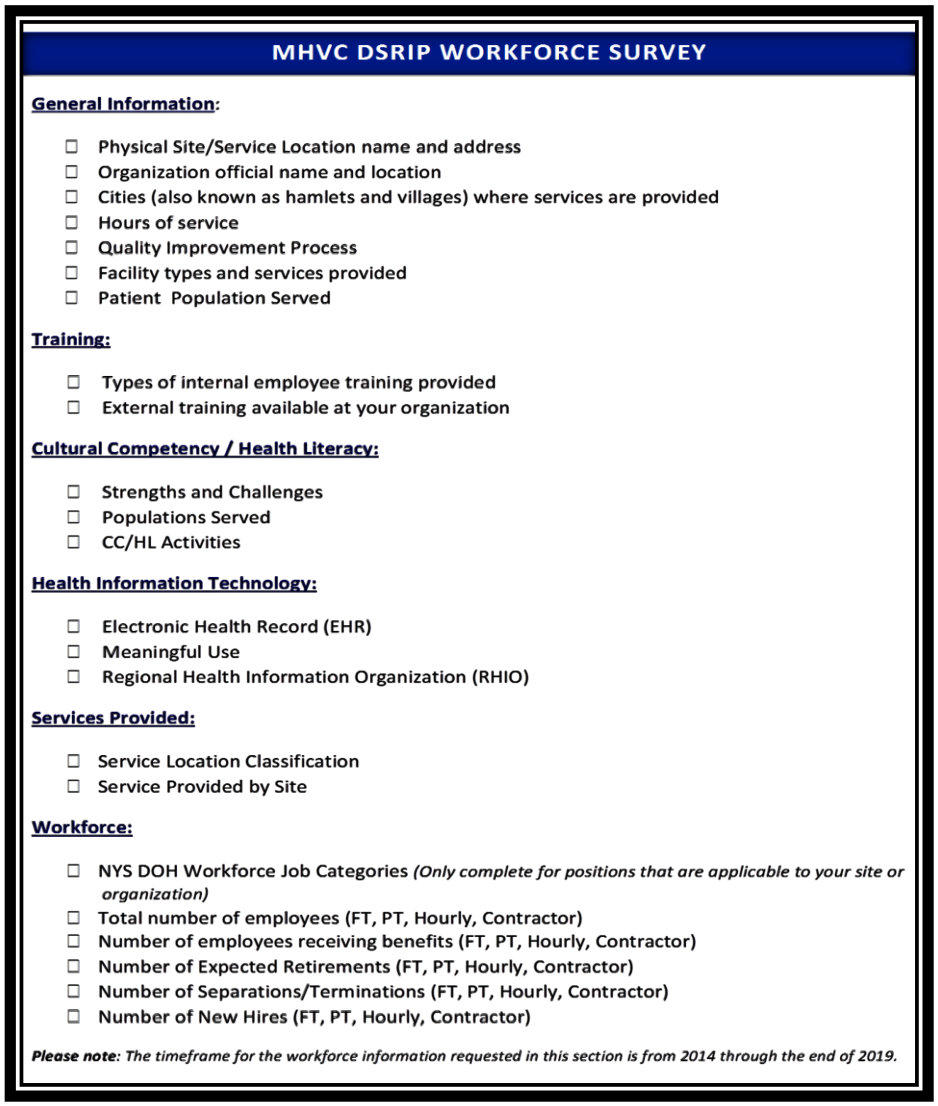
A core group of MHVC staff members, including the Medical Director, IT Transformation Director, Workforce Director and our workforce transformation subcommittee collaborated with our workforce vendor to develop the survey questions. The survey

questions were applicable to multiple provider groups and were based on the DSRIP project requirements, the populations to be served, and the workforce positions needed to obtain the desired care management outcomes. The survey questionnaire included six sections: 1) General Information, 2) Training, 3) Cultural Competency/Health Literacy, 4) Health Information Technology, 5) Services Provided, and 4) Workforce Metrics.

The objectives of the MHVC Current State Workforce Survey were to:

- Determine current workforce supply at the organizational level, and where possible, at the site level for various job categories.
- Quantify distinct headcounts and attrition rates of the existing workforce at the position level.
- Develop a quantitative model of various job families/job types including Incumbents-Ready Now, Redeploys-Ready Now, Redeploy-Retrains, and New Hire & Retrains by Project.

The graphic below highlights the sections and contents included in our Workforce Survey.



MHVC DSRIP WORKFORCE SURVEY

General Information:

- ☐ Physical Site/Service Location name and address
- ☐ Organization official name and location
- ☐ Cities (also known as hamlets and villages) where services are provided
- ☐ Hours of service
- ☐ Quality Improvement Process
- ☐ Facility types and services provided
- ☐ Patient Population Served

Training:

- ☐ Types of internal employee training provided
- ☐ External training available at your organization

Cultural Competency / Health Literacy:

- ☐ Strengths and Challenges
- ☐ Populations Served
- ☐ CC/HL Activities

Health Information Technology:

- ☐ Electronic Health Record (EHR)
- ☐ Meaningful Use
- ☐ Regional Health Information Organization (RHIO)

Services Provided:

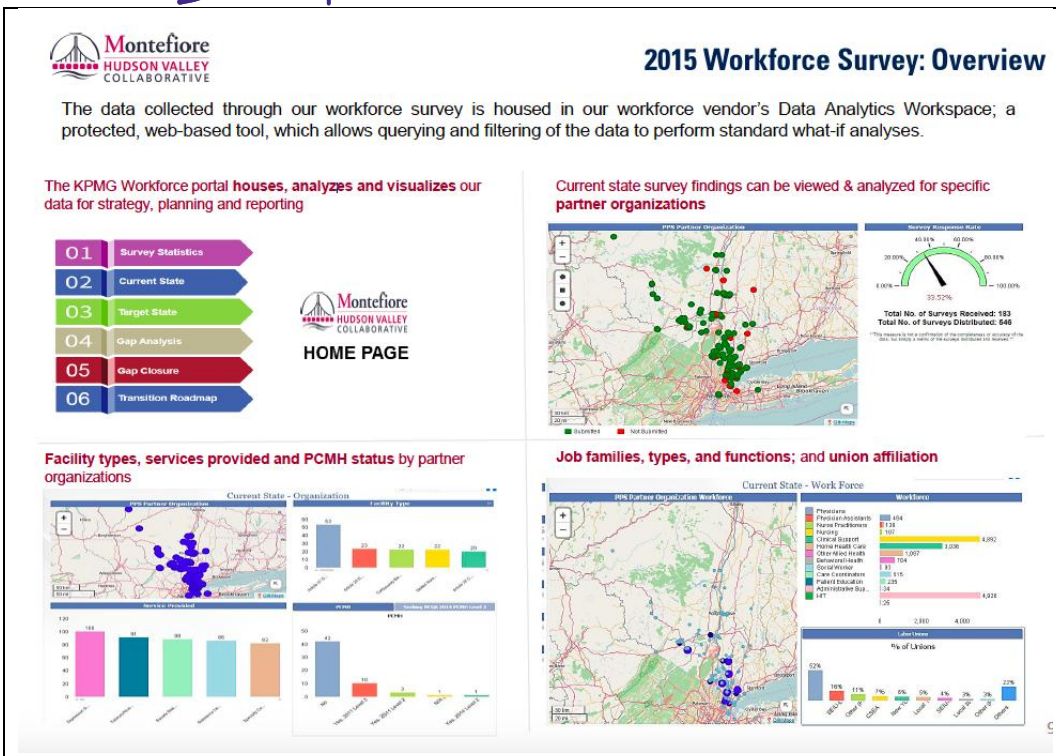
- ☐ Service Location Classification
- ☐ Service Provided by Site

Workforce:

- ☐ NYS DOH Workforce Job Categories *(Only complete for positions that are applicable to your site or organization)*
- ☐ Total number of employees (FT, PT, Hourly, Contractor)
- ☐ Number of employees receiving benefits (FT, PT, Hourly, Contractor)
- ☐ Number of Expected Retirements (FT, PT, Hourly, Contractor)
- ☐ Number of Separations/Terminations (FT, PT, Hourly, Contractor)
- ☐ Number of New Hires (FT, PT, Hourly, Contractor)

***Please note**: The timeframe for the workforce information requested in this section is from 2014 through the end of 2019.*

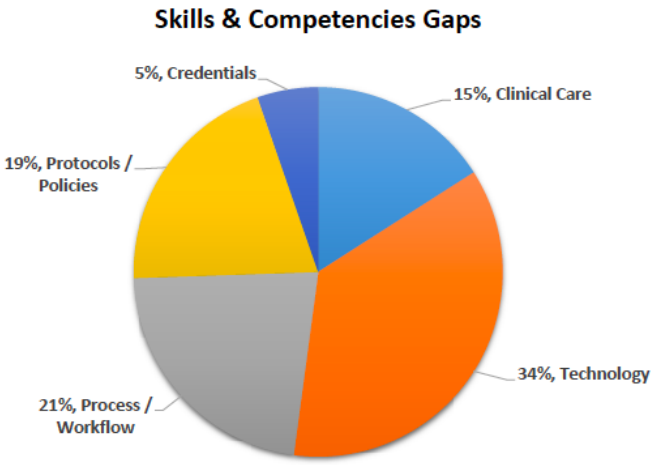
The overall workforce survey response rate for our contracted network partners exceeded 90%. The data collected was uploaded to our MHVC Workforce Portal, a visualization tool for strategy, planning, and reporting. Other features include sorting data elements by, but not limited to, partner organization, facility type, services provided, job families, and union affiliation.



Our current state workforce analysis revealed both qualitative and quantitative gaps. A comparison of our target state projections and current state workforce supply yielded a quantitative gap of 613.78. Our analysis reviewed current supply versus the future demand for the top 5 workforce job categories: non-licensed care coordinators, behavioral health, nursing care/case managers, physicians, and nursing.

Analyzing the skills and competencies currently possessed by the network partners' workforce identified qualitative gaps and those needed in the future state to support the MHVC projects. Qualitative gaps were evaluated using the five focus areas:

- Clinical Care
  - The training and skills needed to provide high-quality, coordinated care specific to the patient's clinical needs and circumstances.
- Technology
  - The knowledge & ability to utilize new technology systems, such as EHRs and Care Management Systems in the delivery of DSRIP services.
- Process/Workflow
  - The knowledge and understanding of new and/or updated processes and clinical workflows related to the DSRIP projects.
- Protocol/Policies
  - The knowledge and understanding of new and/or updated evidenced-based guidelines and standards of care policies based on the care delivery models.
- Credentials
  - A license, certification, qualification and/or achievement required for specific DSRIP projects.



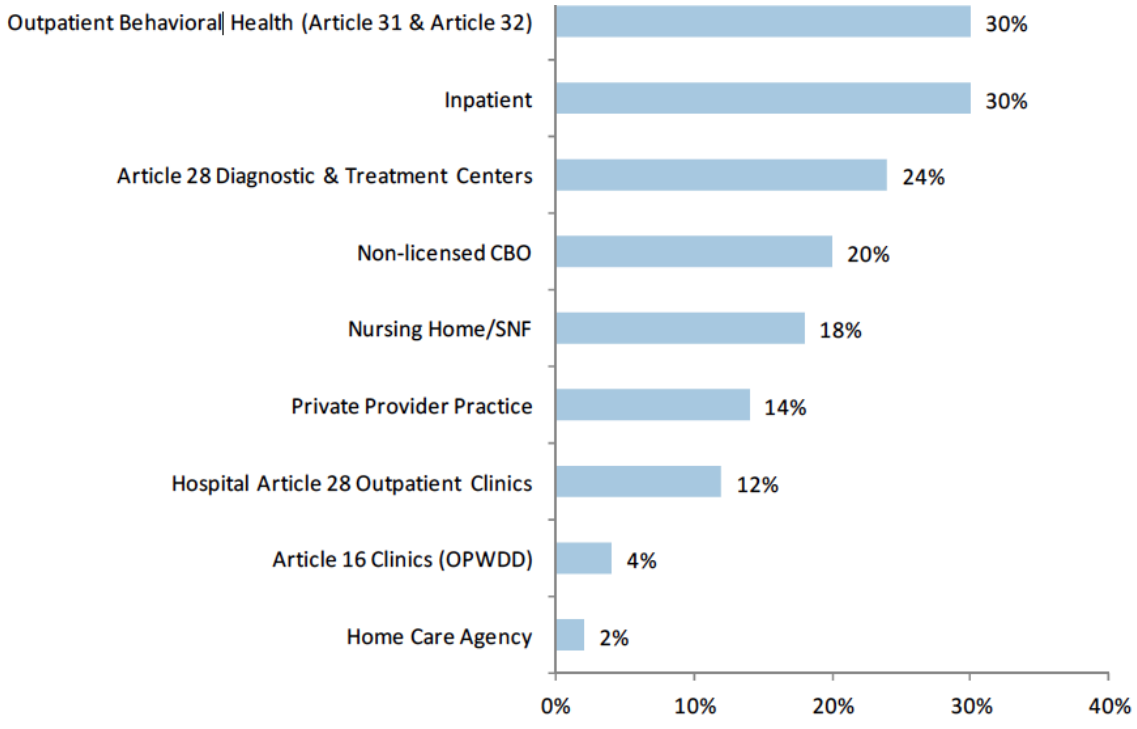
On June 28, 2016, our workforce subcommittee/governance body approved our current state and gap analysis.

Compensation & Benefits Analysis:

The Director of Workforce Development and Management participated in the Department of Health (DOH) Compensation and Benefits workgroup, led by Peggy Chan, to provide input to the reporting requirements and to better understand how MHVC network partners will be able to use the results from the compensation and benefits analysis report. The activities of the DOH workgroup were shared with our workforce transformation subcommittee, and our internal MHVC workforce team reviewed vendors that could assist with this reporting requirement and safeguard the data to prevent any potential antitrust violations. The workforce transformation subcommittee determined that a joint approach with Westchester Medical Center MHVC for the compensation and benefits survey would reduce the survey completion requirements for our shared partners and allow for richer data collection. Gallagher Integrated was selected as the vendor for the compensation and benefits analysis survey.

The workforce subcommittee and our workforce compensation and benefits workgroup reviewed the requirements for the analysis and provided input into the survey tool. The survey was administered in April 2016. We received a response rate of 81%. The results from the survey were presented to, and approved by, the workforce subcommittee/governance body on June 28, 2016.

The distribution of facility types that completed the compensation and benefits survey is shown below; organizations were able to choose more than one facility classification.



The members from the subcommittee and compensation and benefits workgroup have already begun to use the data for reviewing and setting salaries within their organizations. They shared with MHVC that the data is valuable to them, since it is specific to the Hudson Valley and does not include New York City salaries.

Impact on Retrained, Redeployed Staff, and New Hires

In understanding the impact on retrained, redeployed and new hires, we reviewed our current state, target state, and gap closing strategy. Our analysis indicated that our partners plan to close staffing gaps from MHVC projects, primarily with new hires. Only a few partners indicated that they would be retraining and redeploying staff to fill positions targeted for the MHVC network projects. The workforce subcommittee discussed this data finding and thinks that this may change as our network partners begin to operationalize the projects. We will reassess redeployment and retraining numbers as projects begin to be fully operationalized.

We also reviewed the positions with the highest vacancy rates; since our partners may wish to adjust compensation rates for these positions to attract needed candidates.

The top five positions with the highest vacancy rate, with a range of 42.4% to 25.5% average vacancy rate, are as follows:

- RN - Level 1
- Substance Abuse Counselor (Degreed)
- Pharmacy Technician I
- Peer Support Worker
- Nurse Practitioner – Psychiatric

Lastly, we considered the impact of compensation on the top roles that were identified in our target state projections. The chart below shows the minimum and maximum median pay rates for these targeted positions.

DOH Job Category	Position Type/Job Title	Target State (in FTE)	Median Pay Min	Median Pay Max
Non-licensed Care Coordination / Case Mgmt / Care Mgmt / Patient Navigators / Community Health Workers	Care / Patient Navigator	75.55	$17.15	$23.20
	Community Health Worker / Community Outreach Worker	82.25	$18.84	$21.36
	Referral Coordinator (Care Navigator)	137.25	$17.15	$23.20
	Peer Support Specialist / Peer Educators	83.35	$14.65	$16.00
Behavioral Health	Addictions Counselor	103.00	$20.62	$25.48
	Licensed Clinical Social Worker	33.60	$27.63	$34.68
	Licensed Social Worker	70.80	$25.73	$34.90
	Mental Health Therapist / Behavioral Health Specialist / Milieu Counselor / Therapeutic Aide	35.30	$24.84	$34.92
	Peer Support Specialist (BH)	45.00	$14.65	$16.00
	Psychiatrist	40.80	$90.00	$114.26
	Substance Use Counselor (CASAC / CASAC-T)	15.30	$19.50	$21.98

Gallagher Integrated, on behalf of MHVC, completed three separate detailed compensation and benefits reports:

1. 2016 DSRIP Survey Report – All (report includes MHVC and Westchester Medical Center network partner data)

2. 2016 DSRIP Survey Report – Montefiore (report includes MHVC network partner data)
3. 2016 DSRIP Survey Report – Montefiore Participant (report includes only Montefiore network partner data and is designed to be shared with partners who completed the survey)

Network Partners who completed the compensation and benefits survey will receive the Montefiore participant summary report.

Training Strategy

The Montefiore Hudson Valley Collaborative (MHVC) and its network partners prepared to embark on a workforce training effort to support the Integrated Delivery System (IDS) projects through the development of the Workforce Training Strategy. The overarching goal of this strategy is to enhance and introduce learning concepts to its network partners in topics, which include: population health, value-based healthcare, care management and cost-effective care coordination that meets or exceed defined quality standards.

Under the leadership of the MHVC Workforce Transformation Subcommittee and input from MHVC network partners, the Workforce Training Strategy was created to address training needs for identified staff impacted by the IDS initiative. The Workforce Training Strategy includes: clinical staff training related to population and care management, non-clinical staff training required support skills needed to reinforce the new care model, and opportunities to leverage learning institutions /educational programs and existing partner learning practices to fulfill its overarching goal.

The development of the training strategy was a collaborative effort of network partners (represented via committees), MHVC leadership, PMO staff, and consulting support (xG Health Solutions, and Health Literacy Partners). The strategy consists of the current state (based on data collected from MHVC partners via a workforce survey conducted in December 2015) and future state (collected from project applications, project requirements, and implementation plans) of training.

Current state findings influential to the development of the training strategy were to:

- Leverage MHVC partners that have training in place to address training needs.
- Address training gaps in areas of behavioral change, self-management support, patient-centered communication skills training /engagement.
- Develop a robust training for new positions in the outpatient setting that focus on care navigation and coordination.
- Address budget constraints by partners who expressed challenges in certain staff training topics.

The Workforce Training Strategy framework consists of the following four components:

- **Who** needs to be trained?
  - Identify new positions and existing clinical / operational staff needing training.
- **What** are the top training areas?
  - Identify general, project specific, and foundational / cross-project topics that need to be included in development of training.
- **How** should the training operating model look?
  - Identify the need to coordinate the oversight of training programs and utilize existing network partners or vendors for training.
- **When** should training be rolled out?
  - Identify the timeframe for “when” training should occur.

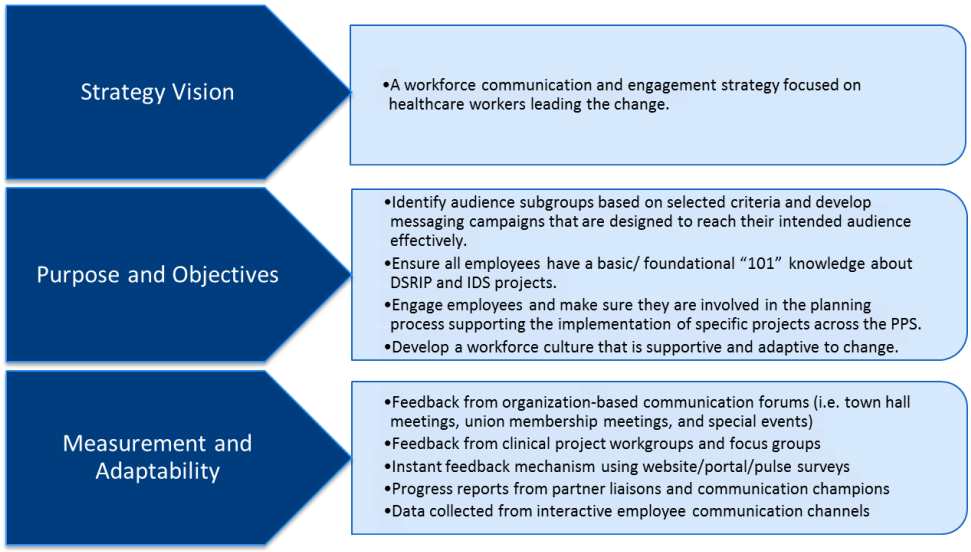
On June 28, 2016, the MHVC Workforce Transformation Subcommittee approved this training strategy.

Communication and Engagement

Montefiore Hudson Valley Collaborative (MHVC) values communication as a tool to foster advocacy for change. As such, we have worked with our Workforce Transformation Subcommittee, our Workforce Communication and Engagement Workgroup, and our network partners to define our workforce communication and engagement strategy. We began this effort by identifying key themes from our initial data collection and engaging our network partners and various clinical and workforce committees and workgroups. In addition to interview sessions focused on workforce communication methods at the network partner level, we researched best practices in workforce communication, change management, labor management strategies, and organizational development trends.

MHVC conducted a series of meetings with clinical and workforce workgroups, being sure to include representatives from the various stakeholders/facility types involved in our Integrated Delivery System projects to identify audience segments, appropriate marketing and communication channels, tools/resources, and gaps and opportunities. Feedback from these workgroups directed us toward a communication model focused on workforce engagement and aligned our communications plan with the priorities that are critical to the partner’s successful implementation of MHVC projects.

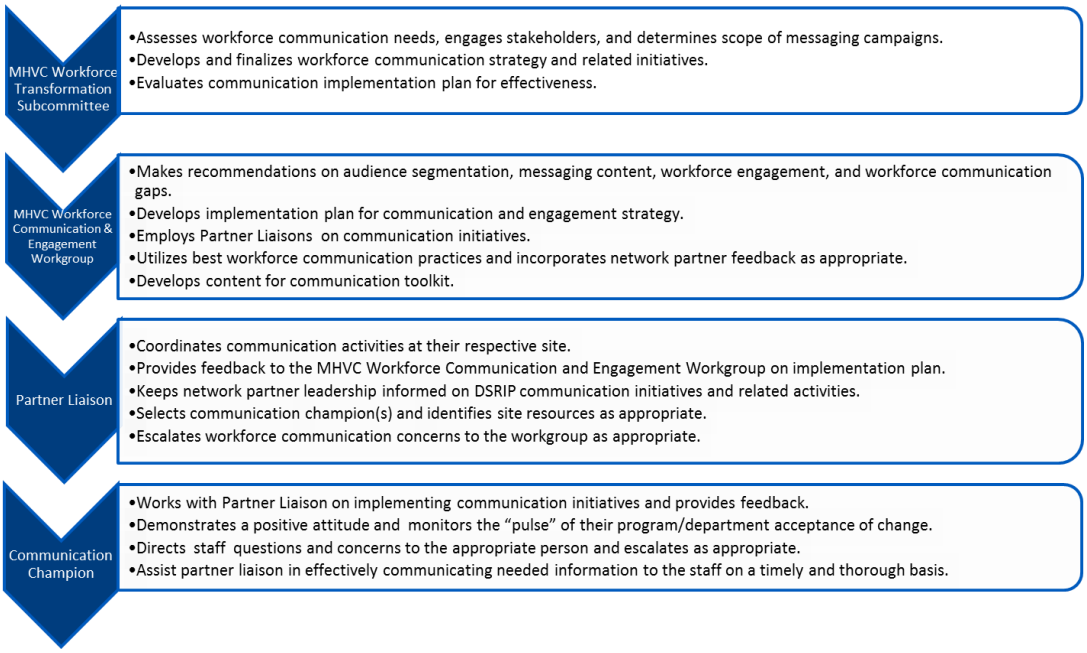
A Proposed Model for Workforce Communication and Engagement



Leveraging resources within the network partners, providing communication tools, and sharing best practices were key needs acknowledged during our interviews. Thus we included the following essentials into our strategy:

- The newly created roles of *Network Partner Liaison* and *Communication Champion,* who are defined as the team within the network partner site, that will work with the Workforce Communication and Engagement Workgroup on the successful implementation of communication initiatives.
- A communication toolkit that will provide talking points, how-to guides, templates, and a repository of best practices and resources for our partners to communicate with their staff about their participation in the Integrated Delivery System projects. The toolkit will grow with network partner communication needs, target specific audience groups, engage local key stakeholders, and adapt to workforce communication behaviors and media use.

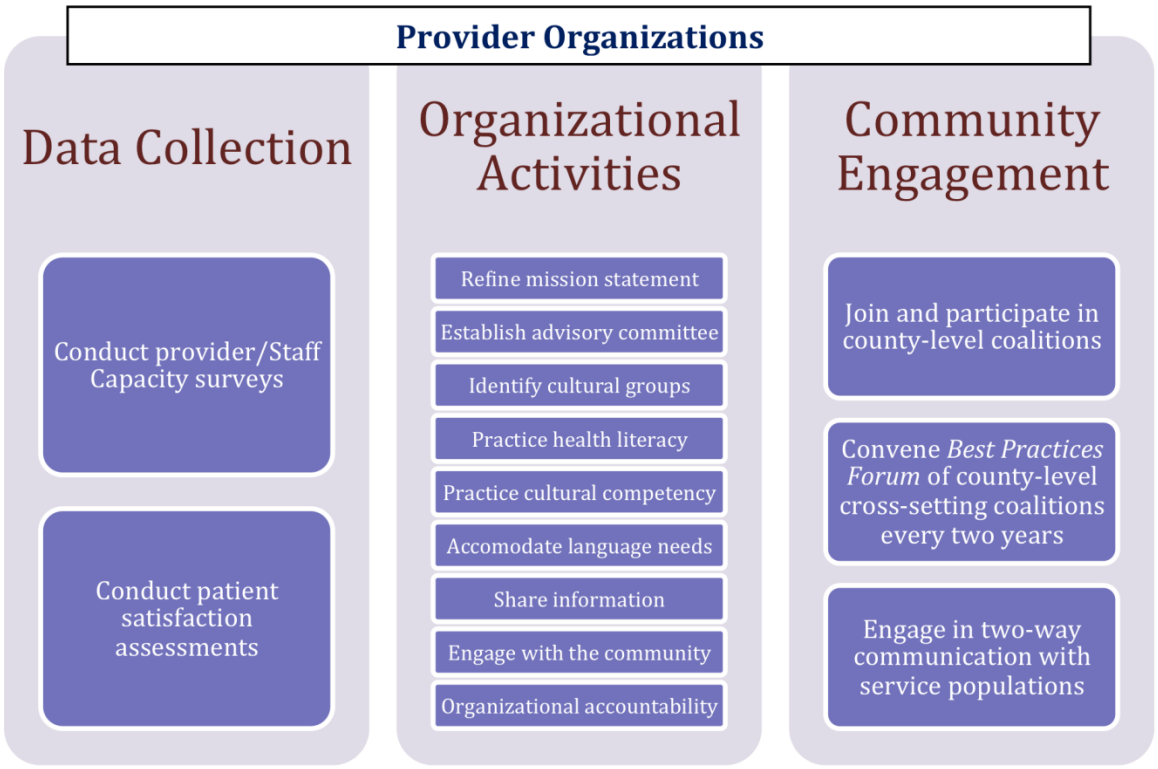
MHVC Workforce Communication and Engagement Strategy Staffing Resources

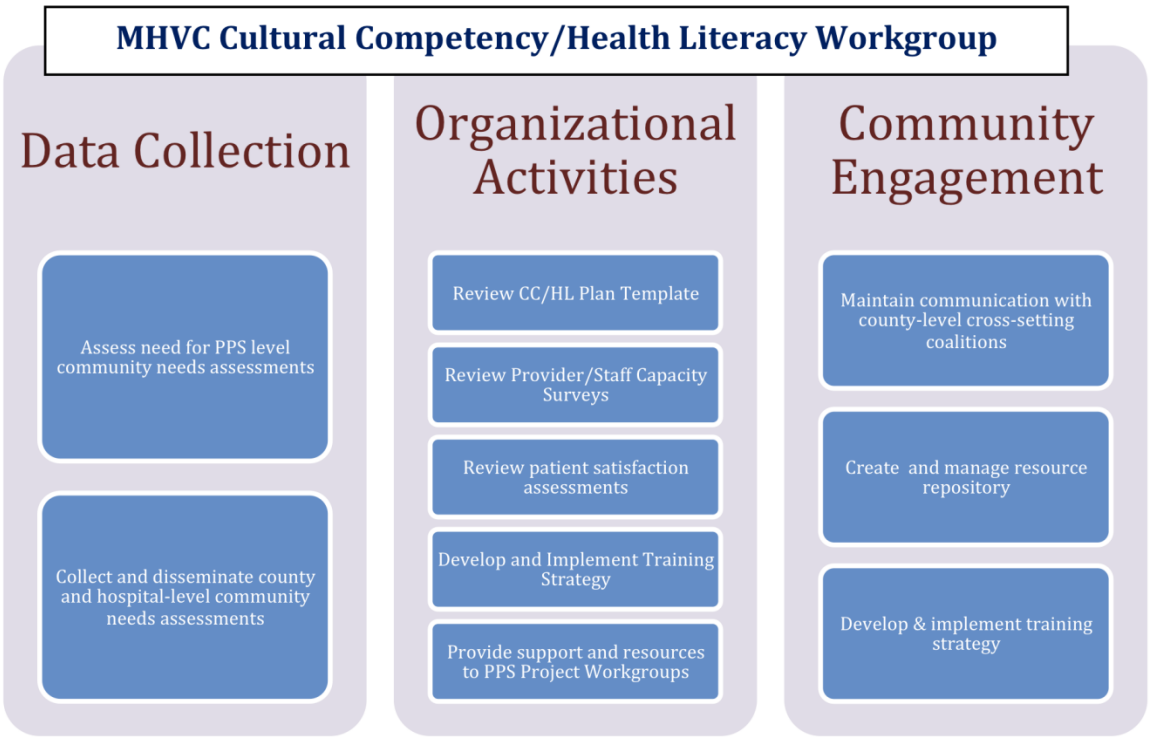


On June 28, 2016, our Workforce Transformation Subcommittee (governance body) approved our workforce communication and

engagement strategy.

Cultural Competency Health Literacy Appendix
Cultural Competency and Health Literacy Training Strategy





Cultural Competency and Health Literacy Training Strategy

The MHVC CCHL Workgroup in collaboration with network partners created the CCHL Training Strategy. The overarching perspectives of this strategy consist of:

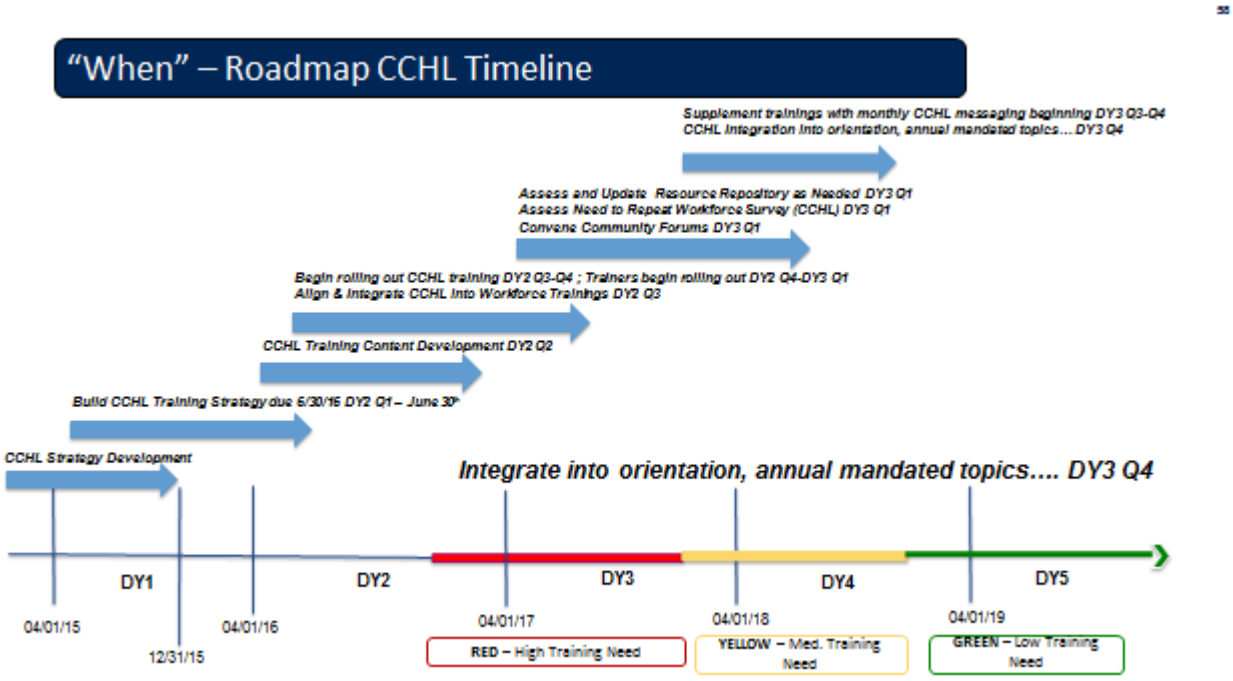
- Alignment of the strategy to the population MHVC network partners serves.
- Prioritization and implementation of various learning modalities to address health disparities among population served by clinical and non-clinical staff.
- Integration of CCHL training into existing workforce training.

Current state findings (as reported by the December 2015 Workforce survey) influential to the development of the CCHL training strategy include:

- Leveraging resources from network partners that currently provide some form of cultural competency training.
- Developing consistency in mandated and non-mandated training practice.

The CCHL strategy also includes the "universal precautions approach" to health literacy that builds opportunities to strengthen the foundation for the provision of equitable health care, recognizes the importance of participant/client/member safety, and drives outcomes and cost efficiency. The "universal precautions approach" is part of the Department of Health and Human Services Health Literate Care Model that teaches a systems approach to improving patient's engagement in care.
The following organizational framework assisted MHVC network partners in addressing the CCHL training to engage organizations, communities, professionals, individuals and families in a multi-sector effort to promote culturally and linguistically appropriate care in context:

- Who – Defined targeted partner employees and network staff that would need training.
- What – Provided a breakdown of training into three categories: CCHL Integration Level, Basic/Foundational "101" Level, and Intermediate / Advanced Level.
- How – Provided a "centralized training" approach due to need to integrate various key functions and provide ongoing support to MHVC network partners.
- When – Provided information on implementation of training delivery that coincide with project implementation and identified partner engagement rollout. The timeline is displayed in the chart below.



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

PPS Name: Montefiore Hudson Valley Collaborative

Project: 2aiii HH at Risk

Challenges the PPS has encountered in project implementation:

Challenges the Montefiore Hudson Valley Collaborative (MHVC) has encountered and planned mitigation strategies related to implementation of the Health Home at Risk project fall into several categories as outlined below:

Finance and Sustainability Challenges:

1. Financial Sustainability Modeling: The primary challenge encountered for this project is related to financial sustainability modeling for the care management of a large population of patients who may not yet be "expensive" to a health system. Our primary care partners have raised concerns about the short and long term funding for the care management services required for their Health Home at Risk patients.

Mitigation: Short term solutions have focused on **encouraging our partners to use DSRIP funds to support the hiring and redistribution of resources necessary to provide the needed care management services**. Facility participation in Value Based Payment (VBP) arrangements will further support short and long term financial health for participating providers. For more information on MHVC VBP planning see the organizational narrative and 2.a.i. project narrative.

Challenges in reporting Actively Engaged Patients

2. Ambitious speed and scale targets for this project would put a strain on central resources necessary to provide quality care management services. MHVC committed to the project targets articulated in our DSRIP application, without a clear understanding of what type of Care Plan would be required. When additional guidance was released regarding the alignment of the HH at Risk Care Plan with the Health Home Care Plan, MHVC realized that providing that level of Care Management to an at risk population would be cost prohibitive.

Mitigation: MHVC and our partners agree that this project lives in the primary care PCMH. MHVC made a conscious decision to approach this project in a meaningful way that aligns with other projects and quality improvement efforts. MHVC also agreed to align with regional initiatives target towards standardizing care plans and the means for which this data is shared.

The advantages of these decisions are below:

- Allowing practices to phase in a care management strategy spearheaded by PCMH care team members for a manageable population of focus**.** If pilot work demonstrates improved outcomes using this model, then this may support VBP contracting models to support care management of this population. At that point, or when individual practices build up their care management capacity within the level 3 2014 NCQA PCMH, partners can expand the population of focus for the project to other chronic diseases at risk.
- Ensuring that care management infrastructure and tools are aligned with developing regional standards to support interoperability and sustainability.

3. The delay in the receipt of claims data

The phased rollout of the NY State managed resources portal, Medicaid Analytics Performance Portal (MAPP) hindered our ability to stratify our population and identify targeted patients for this project. As articulated above, MHVCs commitments for this project assumed real time access to claims data.

Mitigation: In the absence of claims data, and in response to the resource challenge detailed above, the project workgroup agreed that partners should initially focus this project on a defined sub-population of patients who meet the HH at risk eligibility requirements. This sub-population can align with other projects population of focus. For example, a partner who is participating in the cardiovascular Evidence Based Guidelines project can select a target population that includes Hypertensive patients participating in a treat to target Hypertension program. This would enable project alignment since the same nurse managing the patients HTN can do the care plan and link the patient to needed social services.

IT Challenges

4. Lack of a standardized Care plan

Mitigation: To support MHVC's clinical integration efforts care transition projects and management of care plans data will need to be securely exchanged between members' care providers. Since there are no standards defined yet for the exchange of care management data, MHVC and its partners will define a MHVC Care Management Data Interface Specification that will be used to create and exchange files of data extracted from partner care management systems.

MHVC has worked with GNYHA to:

- Identify and recommend set of core care plan data elements
- Recommend nomenclature and structural conventions for care plan organization
- Develop guidelines for supplemental care plan data elements and applications

We plan to utilize QE functionality for Care Plan exchange. This can be achieved through direct messaging, QE secure messaging and care plan upload as a static document or structured data/Consolidated Clinical Document Architecture (CCDA) to the HIE.

5. Success of this project will depend on IT readiness of partners for integrated care plans and interactions / transitions among partners.

Mitigations: To ensure partners are ready, we have focused on the following (1) Ensuring that easily implementable integration strategies are in place, such as increasing EHR and RHIO adoption; and (2) longer-term solutions, including building a more uniform and sustainable IT infrastructure with a common IT platform and common care-management tools. Varying levels of provider readiness pose a risk to this project. To that end we have assessed our network and developed a strategy to provide additional assistance if key providers are struggling to implement IT systems and offer interim strategies for smaller providers who are slower to adopt IT. Building upon the Accountable Care Organization work of the Montefiore Care Management Organization we have identified a potential IT EHR solution for those practices that do not yet have an EHR. Medgen is a certified meaningful use stage 2 EHR. In the interim, the MHVC team is working with these practices to potentially develop workarounds until practices have adopted EHRs. We will need a way to identify or build a robust EHR implementation tracking and support team. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative.

6. High cost of HIE connections

Mitigation: MHVC has Inventoried current EHR systems in place within the Network and will identify opportunities

leverage scale to get volume based discounts and variable pricing. We will also encourage providers to leverage funding from the NYS Data Incentive program and the Medicaid Meaningful Use program. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative.

7. Attaining PCMH will be difficult for providers without EHRs:

Attainment of 2014 standards of PCMH level 3 and meeting MU requirements are foundational requirements for practices participating in this project. We have identified practices that wish to participate in this project that may be unable to meet the EHR requirements in early years.

Mitigation: We have partnered with the Primary Care Development Corporation (PCDC) to implement our PCMH strategy. They are in the field assessing practices readiness for transformation and bucketing practices according to their readiness level. Those practices without EHR's fall into a low readiness bucket. We have developed a strategy to offer these practices access to a low cost EHR, Medgen, which meets meaningful use stage 2 requirements.

8. Risk that partner organizations, MCOs and Health Homes may be too overwhelmed, understaffed, or uninterested to partner with us on this project. We will need to find ways to work with other PPSs to reduce the burden of implementation on partners so they can fully engage and support this project.

Mitigation: We have a multipronged approach to address this risk and ease the burden of participation in multiple projects and transformation efforts.

1. The Cross PPS Hudson Region DRSIP Clinical Council ,convened by the Public Health Information Program (PHIP), is committed to easing the burden of DSRIP reporting by aligning reporting requirements for shared partners participating in multiple PPSs, and collaborating on project design and our Cross PPS high performance metrics strategy.

2. MHVC's PCMH vendor is working collaboratively with our internal DSRIP team to align PCMH quality improvement work needed for PCMH transformation with our other DSRIP projects including the three projects that live in the primary care space (3bi, 3di, and 3ai, 2biii)

3. MHVC will make critical elements of protocols consistent across providers (critical elements will be determined by a committee of subject matter experts), but allow providers to keep existing protocols if they contain all critical elements.

4. MHVC will have routine discussions with providers, working with the partner engagement team, to segment stakeholders and develop a tailored communication/engagement strategy for each segment (including CBOs).

5. The network will add key quality improvements to VBP clinical guidelines in order to demonstrate the value of these interventions.

9. Delay in the receipt of claims data in regards to Performance Improvement

Claims data became available June 2, 2016 and the recent date of release of this data remains an important limitation to MHVC's ability to implement projects. In addition, the data has a lag of 12+ months, limiting the use for clinical purposes. The lag means that by the time MHVC or partners receive that data the time period for impacting the metric has ended. Therefore, the data primarily can be used for reporting to providers on their prior year performance. In addition, while the data is now available, and is being utilized, there is a time of approximately three months of testing, validation and understanding the data feed in order to develop usable claims based data. In addition, security requirements add a layer of complexity to MHVC's ability to share information both internally and with partners.

Mitigation: The claims data validation and preliminary analysis of the claims data distributed in June 2016 is progressing. We are in the process of developing initial cuts of data for key metrics and validating those counts

against either Salient or MAPP. We are using substitutes for the redacted cost data that most claims data includes, but the DOH claims data does not yet include. We have two additional mitigation strategies for analyzing clinically relevant data: 1) the MAPP snapshot tool provides very recent data and is used to track key metrics by provider and patient with an opportunity to intervene to improve outcomes and 2) Montefiore is exploring the opportunity to work with data vendors that will utilize provider data as the primary source of data and this would virtually eliminate the issue of claims lag and permit MHVC to communicate information that can improve patient outcomes to providers on a real time basis.

Efforts to mitigate challenges identified above:

Please see mitigation strategies as outlined above.

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Implementation approaches that the PPS considers a best practice:

Best Practices (Details below)

- Aligning the project with other projects and quality improvement work.
- Defining standards of care plan that a PCP is responsible for documenting
- Partner Engagement Strategies
- Process Mapping to Inform development of partner contracting milestones
- Toolkits
- Aligning Clinical, Workforce and IT work streams
- Including representation from CBO's and organizations that serve people with developmental

Alignment of Project with Other Projects and Quality Improvement Work

Recognizing that many of our MHVC projects live in the primary care space including the HH at risk project, Cardiovascular EBG, Asthma EBG, BH integration, and PCMH transformation, MHVC has aligned the projects whenever possible to ease the burden of project implementation for our partners.

Specific to Health Home at Risk, MHVC has worked to align this project with PCMH transformation requirements for certification including the required patient risk stratification process. To that end we have been providing training, coaching and technical support to practices working toward their certification as part of the Integrated Delivery System (IDS) project requirements. We will also provide education to our partners about how these services can be packaged and compensated under a Value Based Payment (VBP) arrangement. As articulated in the IDS narrative, our approach to contracting breaks down these steps into metrics which must be completed in order for partners to earn eligible funding.

For example, our partner contracting milestones for this project also aligns with PCMH requirements

i.e. Contracting Milestone: Develop a process to identify Health Home At-Risk patients as determined by MHVC minimum criteria, is aligned with the following PCMH Standards required to achieve 2014 PCMH level 3 recognition.

PCMH Standard 4B - Care Planning and Self-Care Support

- *4.B.1. Care team and patient collaborate to develop and update an individual care plan for 75% of high risk patients, incorporating patient preferences and functional/lifestyle goals*

- *4.B.2. Care team and patient collaborate to develop and update an individual care plan for 75% of high-risk patients, incorporating identification of treatment goals*

Strategies were developed to ease the implementation burden for practices participating in multiple primary care based projects. They include:

- **Ensuring Flexibility and Alignment:** Our project implementation plan guidance outlines the necessary care management responsibilities while allowing flexibility for how practices accomplish this including:
  - hiring a care manager;
  - sharing the responsibilities among different members of their care team; or
  - contracting with an external care management agency

- We have also **incorporated flexibility** for partners **in how they define their "At-Risk" patient definition when identifying a population of focus for this project.** While any patient with one chronic condition and

accompanying medical or social risk factors may be eligible for the Health Home at Risk program, we are asking participating primary care providers to:

- Select **one targeted condition** as the initial population of focus for this project from a list of priority conditions selected by our project workgroup.
- This will allow providers to initially **narrow their focus to a condition that is relevant to their patient population** and aligned with available community resources and supports.
- Additionally many of our targeted conditions are linked to our Domain 3 Clinical Improvement projects (3.a.i Integrated Primary Care and Behavioral Health, 3.b.i Cardiovascular, and 3.d.ii Asthma) which allow for aligned project implementation.

- In addition, for the HH at risk project, we are suggesting that initially **partners focus this project on a defined sub-population of patients who meet the HH at risk eligibility requirements**. This sub- population can align with other projects population of focus. For example, a partner who is participating in the cardiovascular EBG project can select a target population of focus that includes Hypertensive patients participating in a treat to target HTN program. This would enable project alignment since the same nurse managing the patients HTN can do the care plan and link the patient to needed social services.

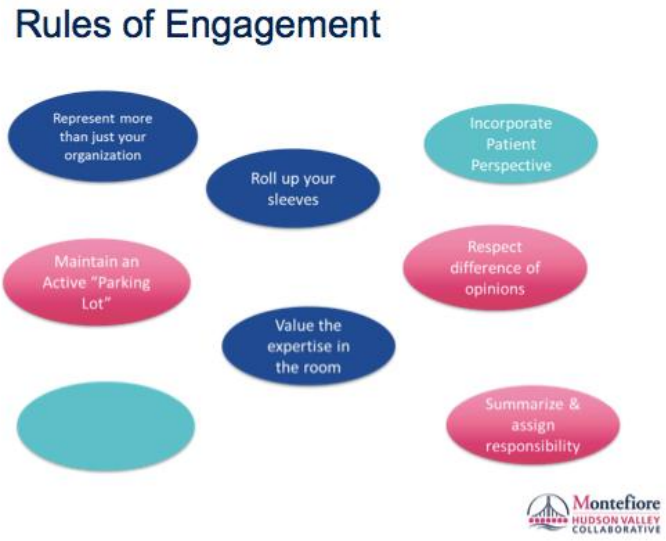
Defining standards of care plan that a PCP is responsible for documenting

As referenced in the challenges section, the lack of a standardized care plan poses a risk to facilitating adoption across the Network. To this end, the project workgroups collaborated to evaluate existing care plan templates, in use in partner organizations and to define interim minimum criteria to support standardization patient activation reporting. MHVC has also been engaged in the GNYHA association work to standardize both the elements of the care plan as well as the strategy for developing broad capacity to share this information on the HIE.

Practitioner Engagement Strategies

At MHVC we strive to **engage our partners** in project implementation work **in a way that is meaningful, values and integrates their expertise and incorporates a patient-centered lens.** Below we outline several best practices that have helped us effectively engage our partners in project design and implementation and incorporating the patient voice into our work.

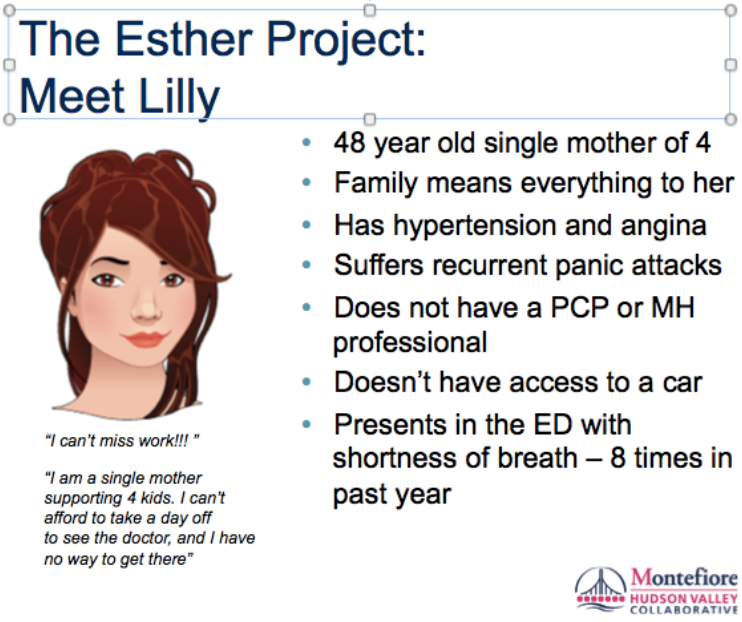
- **Workgroup "Rules of Engagement":** With the goal of establishing a non-competitive collaborative spirit that fosters a high degree of active participation within our project workgroups, MHVC facilitated the development of **"Rules of Engagement"** that defined the way workgroup members agreed to work together. (See Practitioner Engagement Plan Appendix).



- **Incorporating partner feedback into our work:** Because we value each partners voice related to program implementation, we routinely survey our partners after each workgroup meeting to ensure that members feel engaged. Feedback is reported back to our workgroups and Clinical Quality Subcommittee and incorporated into workgroup processes

- I**nstilling the patient voice** into our project design using evidence based strategies including the "Esther Project" **has helped to convene and engage diverse stakeholder groups with a common goal of providing quality care** for their patients.

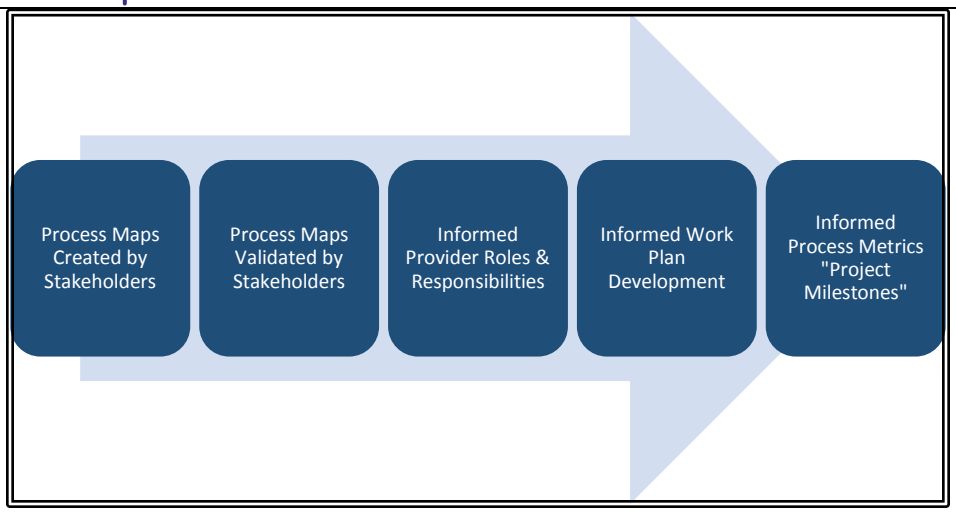
First implemented in Sweden, the "Esther Project" uses "patient personas" ("Esther's") for each project, co-created within our project workgroups, to challenge partners to consider the patient perspective during every aspect of project design. **By continually asking . . . *"What does Esther want?"* and *"How will this new process feel for Esther?"* diverse partner stakeholders are challenged to consider the patients perspective, needs and wants above their own organizational goals.**



- **Process Maps Informed MHVCs Contracting Strategy:**

Through a collaborative process MHVC engaged diverse stakeholder groups, in a facilitated activity that led to the creation of a series of process maps illustrating the patient journey through the care continuum for each project. Swim lane diagrams highlighted the roles and responsibilities attributed to each provider type involved. The process maps note linkages between different provider types and points of intersection with other clinical projects.

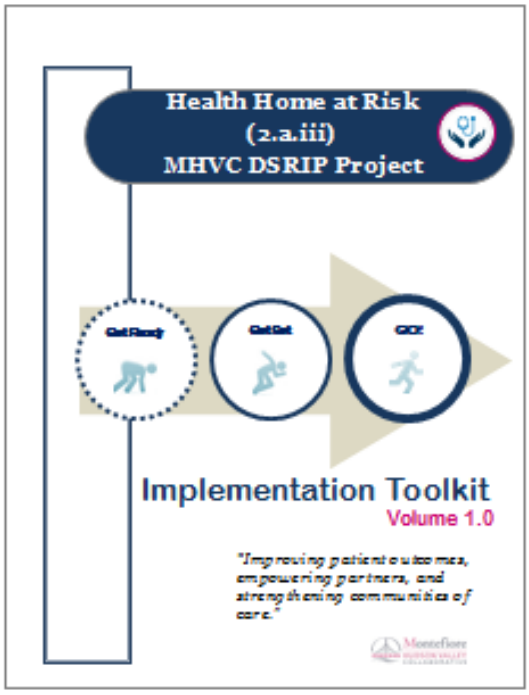
After validating these process maps by diverse stakeholders in the field, they were used to inform the development of project specific roles and responsibilities as well as a project work plan. In turn these materials guided the development of foundational process metrics that will help move our projects forward. These process metrics ("Project Milestones") are project and provider type specific and form the foundation of MHVC's MHVC's dynamic contracting strategy. We will continue to use this model, creating project milestones in six-month cycles, to ensure active feedback on project success and provide opportunities to realign our approach as necessary.



- **Toolkit Development**

In support of Phase II Contracting, MHVC developed webinars on each project, outlining the partner milestones and introducing the forthcoming project toolkit. The **project toolkits** detail on a granular level what partners must do to satisfy milestones, lay the groundwork for successful project implementation, and receive compensation.

MHVC developed a series of dynamic interactive Project Toolkits to support partners in their implementation journey. The toolkits are living documents that are constantly growing and will become more robust over time as partners contribute best practices, workflows, policies and procedures, training resources and materials and share successful quality improvement PDSAs. Toolkit's will guide partners to identify appropriate project team members, complete readiness assessments, develop project plans, and collect baseline and follow up data to support quality improvement efforts.



Aligning Clinical, Workforce and IT work streams

Recognizing the importance of collaboration between work streams, our MHVC Clinical team has worked closely with our workforce and IT work stream counterparts to ensure a unified approach to project planning and implementation. Our Medical

Director and Directors of Workforce and IT have participated in subcommittee meetings from the other workstreams as subject matter experts to ensure that subcommittee members of each workstream are kept updated about areas where collaboration across work streams will improve efficiencies and outcomes. In addition we have internal and external workgroups that cross work streams including:

- MHVC Population Health Workgroup
- MHVC Strategic Reporting, Planning and Oversight Workgroup Meeting
- Cultural Competency and Health Literacy Workgroup
- MHVC High Performance Metrics Workgroup
- Analytics Workgroup
- Integrated Delivery System (IDS) Workgroup
- Workforce Training Workgroup
- Workforce Communication and Engagement Workgroup

CBO's and organizations that serve people with developmental disabilities represented on project workgroups

Vast opportunities for self-management support exist in the community. While patients may see a doctor three times a year, they may go to church every Sunday and may visit a food pantry in a community center weekly. Recognizing that CBO's offer evidence based Self-Management Support programs (The Stanford Model, Asthma Educators, and peer programing) that provide an important way to engage patients with chronic disease within their communities, as well as community based services ability to address the social determinants of health, MHVC expanded workgroup representation to include CBOs. Along the same lines, we included representation from organizations that serve people with developmental disabilities and/or mental illness to ensure that the voice of patients that fall into these populations are represented on our workgroups.

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

The Montefiore Hudson Valley Collaborative (MHVC) and its network partners are prepared to embark on a workforce training effort to support the Integrated Delivery System (IDS) projects through the development of the Workforce Training Strategy. The overarching goal of this strategy is to enhance and introduce learning concepts to its network partners on topics which include: population health, value-based healthcare, care management and cost-effective care coordination that meets or exceeds defined quality standards.

Under the leadership of the MHVC Workforce Transformation Subcommittee and input from MHVC network partners, the Workforce Training Strategy was created to address training needs for identified staff impacted by the IDS initiative. The Workforce Training Strategy includes: clinical staff training related to population and care management, non-clinical staff training required support skills needed to reinforce the new care model, and opportunities to leverage learning institutions /educational programs and existing partner learning practices to fulfill its overarching goal.

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

With Phase 2 contracting well underway and clinical projects kicking off, the full impact to populations is still being assessed. However, through collaborative efforts, a solid plan has been developed to address community needs, combat health disparities, and the gaps in service originally referenced in our application and project implementation plans.

MHVC project workgroups keep these issues at the forefront of their work to create and implement each project. Initial plans for this work began with the formal creation of the CCHL (Cultural Competency & Health Literacy) Strategy, which was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners.

Using the assessment and evaluative findings the MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners. In March, 2016, we modified our CCHL Strategy to include Key Factors to Improve Access to Quality Healthcare. Further, projects have begun to be actively implemented and rolled out to partners.

MHVC is responsible for implementing organization-wide and project specific activities to ensure cultural competency and health literacy remain priorities at each level of care delivery (e.g. from the partners to clerical staff). The following are current, on-going and/or planned activities that are key factors to improving access to quality healthcare and address social determinants of health.

Cross Cutting/MHVC Wide Initiatives to Improve Patient Access to Care

1. Engaging partners to work together by conducting individual site visits and regional meetings. The purpose of these meetings is to learn about available services, linkages between partners, and needs assessment. These meetings are opportunities to provide education and resources regarding best practices for improving access to care.
2. Inviting members of the CCHL workgroup (who are also members of clinical project workgroups) to attend and take part in ongoing project implementation planning as well as development of specific tasks (more details listed below).
3. Providing patients with additional means of transportation to ensure they can reach healthcare partners.
4. Opening additional primary and behavioral healthcare services in areas with gaps.
5. Using telemedicine to provide primary, preventive and behavioral healthcare services to areas with gaps.
6. Expanding hours of service and open access scheduling to make scheduling easier and more readily available.
7. Co-locating services to create “one-stop-shops” for patients to receive their behavioral and primary care needs (through the Integrated Primary and Behavioral Health (3.a.i.) and Medical Village (2.a.iv) projects).
8. Doing Outreach to community based organizations, schools, and other non-healthcare settings to make information more accessible to the community through public health campaigns.
9. Creating pathways for communication and sharing of patient information between different services partners to promote integrated and seamless delivery of care.
10. Training in structural competency for staff involved with patient care (Structural competency material can be found in the Resource Repository).

Programmatic outcomes and practice transformation initiatives will be assessed through use of the Plan, Do, Study, Act (PDSA) model of process improvement to test changes and assess their impact on patient engagement and outcomes. This model is also being used to aid in the development of health literate educational materials for patients and staff

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Montefiore Medical Center

Project: 2.a.iv

Challenges the PPS has encountered in project implementation:

MHVC is establishing seven medical villages in the Hudson Valley: Montefiore New Rochelle (MNR), Montefiore Mount Vernon (MMV), St. Luke's Cornwall Hospital—Newburgh, St. Luke's Cornwall Hospital—Cornwall, Nyack Hospital, St. John's Riverside Hospital and St. Joseph's Medical Center—Yonkers.

We aim to meet two identified gaps in care with our medical village project:

1) Address excess capacity leading to inefficient health care resource usage; and
2) Meet unmet community needs, including: improving access, providing integrated primary and behavioral health care, ensuring an even distribution of urgent care access points, providing care management and coordination, and address shortages in community-based resources such as crisis beds.

To meet these gaps, we are designing our medical villages using an iterative four-pronged process:

a) Engaging partner hospitals to co-create a future-state vision for facilities providing an integrated care experience tailored to the need of the local communities;
b) Conducting facility surveys to assess suitability of space for potential uses and estimate required capital;
c) Engaging local communities to seek input on the services to be provided in villages; and
d) Ensuring financial sustainability by providing services capable of generating alternative revenue streams while maximizing additional sources of capital, including philanthropy.

Our PPS is uniquely positioned to carry out this strategy given the breadth of our network, with more than 15 hospital campuses that serve patients from all 7 counties. This breadth will allow our partners to work together to strategically adapt care delivery, taking into consideration both demand as well as quality of care, so as to achieve the maximal savings from the removal of unnecessary capacity. Similarly, creation of multiple villages at our partners will allow us to coordinate the services to be provided at these sites to best meet community needs

Our approach is embodied by the bold vision of our partners. For example, St. John's Riverside Hospital envisions a medical village that will increase the total number of treatment areas (including urgent care, resuscitation and behavioral health) and introducing a Rapid Assessment Zone that will enable

more effective ED triage.

Project Implementation:

Risk: Challenges in project implementation are due to the fast-paced nature of health care in the Hudson Valley. Even as MHVC analyzes service line financials, utilization trends and community needs, these aspects of the landscape evolve continually, sometimes rendering our conclusions moot.

Mitigation: To mitigate this challenge, MHVC remains open to the possibility that some initial recommendations may not make the final cut of strategic planning and project implementation and will require alternate solutions.

Risk: Ensuring appropriate community engagement related to the implementation of Medical Village sites.

Mitigation: MHVC, has begun to engage Medical Village sites to assess their individual community engagement practices and gaps. MHVC has also formed a community engagement steering committee made up of facility specific representatives and community engagement staff within the Montefiore Health System to craft a meaningful and effective strategy. This strategy will ensure that MHVC benefits from the perspective and expertise of the local community as the project progresses.

Risk: There is risk associated with obtaining the necessary permits and the associate risk of potential construction cost overruns.

Mitigation: MHVC will leverage Montefiore Health System's decades of experience in managing construction projects to guide each host Medical Village has in its respective community.

Financial Sustainability:

Risk: The timing and availability of capital funds will impact the PPS project implementation and performance, as certain projects may require up-front capital investments that may not be covered by DSRIP funds (e.g., 2.a.iv - medical village development is capital intensive yet simultaneously key to achieving Domain 2 milestones in DSRIP years 1-3). Capital Restructuring Financing Program (CRFP) dollars from the state were significantly delayed and 3 MHVC Medical Village sites were not funded through CRFP. This lack of funding puts quality outcomes at risk as well as the level of hospital and community transformation envisioned over the life of the DSRIP program. Further, the timing of funds flows may create cash flow risks, especially with at-risk partners.

Mitigation: MHVC worked tirelessly with network partners to attain state provided CRFP funding for some of the Medical Village capital needs – receiving $121,551,831 in eligible funds (including facility match). Additionally, MHVC has an allocated revenue loss budget to offset the potential funding shortages for providers that may arise from Medical Village implementation. The parameters and process for allocating revenue loss dollars is in active development with the MHVC Finance Subcommittee and MHVC Steering Committee. At the same time our network continues to seek and advocate for other funding streams that could offset the costs of Medical Village implementation. Facility participation in Value Based Payment (VBP) arrangements will further support short and long term financial health for participating providers. For

more information on MHVC VBP planning see the organizational narrative and 2.a.i. project narrative.

Risk: There is risk in balancing the short-term financial health of our at-risk partners that may arise from some of the immediate implementation steps of Medical Village with the long term DSRIP plan.

Mitigation: MHVC has an allocated revenue loss budget to offset a portion of the expected financial losses for providers that may arise from successful project implementation. These dollars will be used to support initiatives that aid Medical Village transition. The parameters and process for allocating revenue loss dollars is in active development with the MHVC Finance Subcommittee and MHVC Steering Committee.

Risk: Participating partners may not be able to transition their planning to reflect value-based concepts

Mitigation: Phase II of MHVC contracts have added quality outcome metrics for our network to give network partners early experience in this integral part of Value Based Payment arrangements. Facility participation in VBP arrangements will support short and long term financial health for participating providers. For more information on MHVC VBP planning see the organizational narrative and 2.a.i. project narrative. Further, During DSRIP year 1, in consultation with Montefiore CMO, MHVC stood up the Population Health Workgroup. This multi-disciplinary team comprised of partner organizations and Montefiore CMO subject matter experts is charged with identifying target populations and the interventions that should be delivered to improve care. The workgroup is co-facilitated by Montefiore CMO and MHVC and was built to provide a transparent, collaborative process to define what services are standardized, centralized and/or delegated for the MHVC network. Representatives of Medical Village providers sit on the workgroup to ensure our resource planning for the population health strategy considers their needs and project development timing.

Challenges encountered, and efforts to mitigate challenges identified above:

See Above

Implementation approaches that the PPS considers a best practice:

We believe our approach to strategic planning for the medical villages is a best practice. There are three parts to the process: Strategic Planning, Business Planning and Implementation Planning. In the Strategic Planning phase, we analyze the hospital strategy and financials; conduct market and communities needs assessments; and prioritize services lines that we then develop into strategic initiative hypotheses that are tested in the Business Planning phase. From there MHVC project activities will support Medical Village implementation through integration with other DSRIP projects and access to project management resources.

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

MHVC has taken a phased approach to Medical Village implementation. By rolling out site implementation in waves each facility can receive the focus of MHVC and Montefiore Health System as they progress through each milestone. Below is a summary of sites and planning for implementation:

We have completed the strategic planning process for Montefiore New Rochelle (MNR) and have moved that facility along to next steps of implementation.

We have completed the strategic planning process for Montefiore Mount Vernon (MMV) and are evaluating options. We expect the strategic plan for MMV to be completed by 9/30/16.

We have determined service line priorities for Nyack Hospital and St. Luke's Cornwall Hospital in order to stabilize these two institutions. In the second half of this year, we will develop business plans for the services to be provided in the medical villages. We expect the strategic plan for these two institutions to be completed by 12/31/16.

Beginning in 2017, we will turn our attention to the final two medical villages at St. John's Riverside Hospital and St. Joseph's Medical Center. We expect the strategic plan for these two institutions to be completed by 12/31/17.

Milestone 1, Metric 1
We are committed to the transformation of health care delivery in the Hudson Valley and to the goal of bringing more advanced care closer to home. As stated above, MNR is the first facility to move past the strategic plan and those steps are outlined below. This is informative of the steps that will be taken for subsequent sites.

We have developed a Strategic Plan for MNR that will:

- Improve the financial position and sustainability of the institution;
- Better meet the needs of its community;
- Integrate the aims of DSRIP to improve population health transition toward value-based care;
- Transform the healthcare delivery system; and
- Integrate MNR more fully into MHS.

The Community Health Needs Assessment conducted by MHVC suggested the need to provide more primary and ambulatory care services in locations and times that are more convenient and accessible to patients. MNR's strategic plan will expand primary care capacity in the Hospital's service area, reduce avoidable hospital use and benefit the large number of Medicaid and uninsured community members.

In the future state, MNR will be a high-quality, 232-bed community hospital with integrated outpatient care designed to provide access to the hospital's underserved community and eliminate inappropriate inpatient and ED utilization. MNR will have a reimagined and expanded ED, including a pediatric ED, emergency behavioral health services, radiology and an extended-hours urgent care center.

These services will be connected to a Community Health Center offering integrated primary, specialty, oral

and behavioral health care accessible via patient navigators as well as a Healthcare Education and Training Institute for workforce, patient and community education. MNR and Facilities Management are already in the process of developing these programs.

In addition, MNR will offer flagship services to the entire community, including an orthopedic center of excellence, a vascular care program, a center for digestive health and a culturally competent birthing center.

Milestone 1, Metric 2
In each of four existing planning processes, we are working closely with our partner hospitals to co-create the future state vision.

Our analyses include facility surveys, baseline service line financial analyses, community health needs assessments, population demographics, disease burden information, market share and utilization trends. In addition, we have analyzed the physician market surrounding the partner hospital.

Each partner hospital submitted applications for CRFP and VAPAP funding in 2015. For hospitals that received CRFP funding, projects are currently in the CON stage.

We created an analytics template for each member of the PPS to determine the targets for reduction in the Medicaid population of both inpatient and ED utilization. The inpatient target is based on decreasing admissions for Ambulatory Sensitive Conditions; the ED target is based on reducing avoidable visits.

Milestone 2, Metric 1
As indicated above, we are in the process of developing strategic plans for each of the medical villages. We seek to encourage a regional planning approach to ensure we meet the needs of our communities and avoid redundancy. Detailed timelines for bed reduction and transfer will be finalized after all medical village projects are completed.

Milestone 7, Metric 1
We are in the process of developing a regional plan that is taking into consideration community needs as well as the market landscape. The regional plan will make recommendations on consolidating services and services lines, as clinically and geographically appropriate. We expect to present such recommendations by the end of 2016.

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

With Phase 2 contracting well underway and clinical projects kicking off, the full impact to populations is still being assessed. However, through collaborative efforts, a solid plan has been developed to address community needs, combat health disparities, and the gaps in service originally referenced in our application and project implementation plans.

MHVC project workgroups keep these issues at the forefront of their work to create and implement each project. Initial plans for this work began with the formal creation of the CCHL (Cultural Competency & Health Literacy) Strategy which was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs

assessment was completed to capture broad concerns of communities served by MHVC network partners.

Using the assessment and evaluative findings the MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners. In March, 2016, we modified our CCHL Strategy to include Key Factors to Improve Access to Quality Healthcare. Further, projects have begun to be actively implemented and rolled out to partners.

MHVC is responsible for implementing organization-wide and project specific activities to ensure cultural competency and health literacy remain priorities at each level of care delivery (e.g. from the partners to clerical staff). The following are current, on-going and/or planned activities that are key factors to improving access to quality healthcare and address social determinants of health.

Cross Cutting/MHVC Wide Initiatives to Improve Patient Access to Care

1. Engaging partners to work together by conducting individual site visits and regional meetings. The purpose of these meetings is to learn about available services, linkages between partners, and needs assessment. These meetings are opportunities to provide education and resources regarding best practices for improving access to care.
2. Inviting members of the CCHL workgroup (who are also members of clinical project workgroups) to attend and take part in ongoing project implementation planning as well as development of specific tasks (more details listed below).
3. Providing patients with additional means of transportation to ensure they can reach healthcare partners.
4. Opening additional primary and behavioral healthcare services in areas with gaps.
5. Using telemedicine to provide primary, preventive and behavioral healthcare services to areas with gaps.
6. Expanding hours of service and open access scheduling to make scheduling easier and more readily available.
7. Co-locating services to create “one-stop-shops” for patients to receive their behavioral and primary care needs (through the Integrated Primary and Behavioral Health (3.a.i.) and Medical Village (2.a.iv) projects).
8. Doing Outreach to community based organizations, schools, and other non-healthcare settings to make information more accessible to the community through public health campaigns.
9. Creating pathways for communication and sharing of patient information between different services partners to promote integrated and seamless delivery of care.
10. Training in structural competency for staff involved with patient care (Structural competency material can be found in the Resource Repository).

Programmatic outcomes and practice transformation initiatives will be assessed through use of the Plan, Do, Study, Act (PDSA) model of process improvement to test changes and assess their impact on patient engagement and outcomes. This model is also being used to aid in the development of health literate educational materials for patients and staff.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Montefiore Hudson Valley Collaborative

Project: 2biii ED Care Triage

Challenges the PPS has encountered in project implementation:

Challenges the Montefiore Hudson Valley Collaborative (MHVC) has encountered and planned mitigation strategies related to implementation of the ED Care Triage project fall into several categories as outlined below:

Financial Sustainability:

1. There is risk in balancing the short-term financial health of our at-risk partners with the long term DSRIP plan.

Mitigation: MHVC has an allocated revenue loss budget to offset the expected financial losses for providers that may arise from successful project implementation. The parameters and process for allocating revenue loss dollars is in active development with the MHVC Finance Subcommittee and MHVC Steering Committee. Facility participation in Value Based Payment (VBP) arrangements will further support long term financial health for participating providers. For more information on MHVC VBP planning see the organizational narrative and 2.a.i. project narrative.

2. **Payment Models do not support diversion:** Paramedics are not paid if patient is not transported to ED.

Mitigation:

There is a helpful example in Rockland County that calls out the importance of recognizing the value of diversion: In Rockland county, a Behavioral Health (BH) crisis team travels together with the county paramedics. The team has demonstrated success diverting hospital ED visits for patients in crisis by establishing timely linkages to BH providers in the community. We envision we will learn a lot as this model grows that that will be applicable to this project and will inform clinical guidelines in future VBP arrangements.

Resource Challenges:

3. **Shortage of community resources to address social determinants of health needs.** Another challenge that has been encountered by our early project implementers is a lack of community resources sufficient to address the social determinants of health impacting their "high utilizing" patients. Homelessness or lack of stable housing and family stressors have been identified as common concerns among the "high utilizing" patients, and hospitals have experienced a lack of needed resources such as shelters, supportive and low income housing, as well as challenges accessing behavioral health programing.

Mitigation: We are working to address this through linkages to our Integrated Primary Care and Behavioral Health, and Crisis Stabilization project participants, who are working to expand access to needed Behavioral Health services. We also intend to leverage resource and referral directories that are being developed through other clinical projects as a source of information to aid hospitals in making the linkages necessary to address the underlying issues and drive down ED usage. Given that housing shortages represent common risk theme in the Hudson Valley, MHVC intends to leverage best practices from the Bronx Health and Housing Coalition. Further, through MHVCs Medical Village projects, partners will come together with their neighborhoods to foster communities of care that support whole health activities, including social determinants of health.

4. Care Management Capacity within current ED workforce. Workgroup members have expressed concerns about workforce, specifically how hospitals will be able to provide the appropriate staffing to complete the care management services necessary to understand and address the social risk factors and other drivers of inappropriate ED utilization.

Mitigation: We have addressed this concern by creating a flexible implementation model that outlines the roles and responsibilities that are to be completed and allows each organization to determine how best to accomplish these tasks, either by hiring new staff members, dividing the tasks up amongst current staff, or some combination thereof. Additionally we are working closely with the Montefiore Care Management Organization team that designed and successfully implemented the ED care triage project at 3 Montefiore Hospitals in the Bronx to better understand staffing model needs including staffing ratios. Our MHVC workforce team is also participating in this effort.

5. Risk that partner organizations, MCOs and Health Homes may be too overwhelmed, understaffed, or uninterested to partner with us on this project. We will need to find ways to work with other PPSs to reduce the burden of implementation on partners so they can fully engage and support this project.

Mitigation: We have a multipronged approach to address this risk and ease the burden of participation in multiple projects and transformation efforts.

1. The Cross PPS Hudson Region DRSIP Clinical Council ,convened by the Public Health Information Program (PHIP), is committed to easing the burden of DSRIP reporting by aligning reporting requirements for shared partners participating in multiple PPSs, and collaborating on project design and our Cross PPS high performance metrics strategy.

2. MHVC's PCMH vendor is working collaboratively with our internal DSRIP team to align PCMH quality improvement work needed for PCMH transformation with our other DSRIP projects including the three projects that live in the primary care space (3bi, 3di, and 3ai, 2biii)

3. MHVC will make critical elements of protocols consistent across providers (critical elements will be determined by a committee of subject matter experts), but allow providers to keep existing protocols if they contain all critical elements.

4. MHVC will have routine discussions with providers, working with the partner engagement team, to segment stakeholders and develop a tailored communication/engagement strategy for each segment (including CBOs).

5. The network will add key quality improvements to VBP clinical guidelines in order to demonstrate the value of these interventions.

IT Challenges:

6. Inability of some partners to meet the EHR and HIE requirements in early years: These include the need for alerts / secure messaging, ER navigator access to PSYCKES and access to the RHIO for information sharing.

Mitigation: To address this risk MHVC has begun to work with partners to (1) provide technical assistance, in partnership with local CBOs or relevant organizations, and (2) Develop interim workarounds until practices have adopted EHRs. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative.

7. HIGH Cost of HIE connections to migrate data or create interfaces.

Mitigation: MHVC has inventoried EHR systems in use within our Network and will leverage scale to get volume based discounts and variable pricing. We will also encourage providers to leverage funding from the NYS Data Incentive program and the Medicaid Meaningful Use program. And are working with the IT workstream on setting up the patient registry. We have also been working with the HealthLink NY our local QA to facilitate provider trainings and build awareness of the value of an Integrated Delivery System (IDS) in managing care. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative.

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Federal Restrictions Limiting our ability to implement "optional" Milestone #4

8. EMTALA: Within our implementation plan (State Defined Project Milestone #4), MHVC considered the possibility of implementing ED diversion protocols as part of our ED care triage project. During our collaborative process mapping sessions (workgroup meetings that define the scope and roles of DSRIP projects) for this project, it became clear that multiple MHVC partners strongly feel that EMTALA represents a large challenge here, which ultimately precludes the development of diversion processes at this time.

Mitigation: Respecting our partners strong feelings about EMTALA regulations we have elected not to focus on this optional milestone at this time. We are committed to continuing to monitor the regulatory environment that impacts the ability to implement this milestone and will continue to critically consider the feasibility of implementing diversion protocols in the future. We have included our paramedic partners on this workgroup as a lens into needed reforms.

Changing provider behavior is challenging:

9. Shifting physician culture away from sending patients to the ED as a default and toward shifting members to outpatient settings presents challenges.

Mitigation: We have identified two strategies to address this risk:

- We will dedicate efforts towards engaging physicians to help them understand not only the transition to VBP but also the financial incentives for meeting outcome metrics including reduction in ED use for ambulatory sensitive conditions.
- The MHVC team plans to apply the spirit of Motivational Interviewing as a communication strategy in order to engage clinicians in this work. This entails evoking from our physician partners the benefits of culture changes and workflow changes. By evoking the benefits of the system change from our providers we anticipate that it will be easier to engage them to actively participate and change their behaviors.

Actively Engaged Patient Definitions:

10. While we are on track to meet our patient engagement speed for this project, we have encountered several challenges related to the definition of "Active engagement" for this project.

- First, partners have voiced concerns that **a follow up appointment may not be an appropriate next step for every patient** who visits the ED with an ambulatory care sensitive condition. For example, a patient seen in the ED for strep throat, who is already engaged in care, would not require a follow up appointment unless he/she continues to feel unwell. Partners rightly feel, that requiring an in person appointment to satisfy the definition of "active engagement" for this process, in cases where a phone triage would be a more efficient strategy for identifying those patients who actually need a timely follow up with their PCP could lead to a waste of a scarce access resource.
- Secondly, partners have shared concerns about the need for a PCP follow up appointment to demonstrate "active engagement" in this project when a follow up appointment with a BH provider may be a more appropriate next step. For example, it is more important for a patient seen in the ED with an acute BH or substance abuse issue to establish care with a BH/SA provider rather than a PCP. Once the BH issues are stabilized a referral to primary care is more likely to be fruitful.

Mitigation: We have developed clear guidance for partners on reporting "Actively Engaged Patient" included in our clinical and technical specifications manual. We will continue to message partner concerns about patient engagement definitions to the state and update our manual as needed if state guidance changes.

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Efforts to mitigate challenges identified above:

Please see mitigation strategies as outlined above.

Implementation approaches that the PPS considers a best practice:

Best Practices (Details below)

- Flexibility in Project Planning
- Participation in the MAX series
- Partner Engagement Strategies
- Process Mapping to Inform development of partner contracting milestones
- Toolkits
- Aligning Clinical, Workforce and IT work streams
- Including representation from CBO's and organizations that serve people with developmental disabilities on project workgroups

Flexibility in Project Planning

The goals of the ED care triage project can be achieved through two strategies, corresponding to our Contracting Milestones (See diagram below). The two strategies build on each other and are both foundational to the success of the ED care triage project.

Recognizing the scope of work required to plan for project implementation across multiple projects, we have allowed some flexibility for partners in our guidance related to strategies to achieve Partner Implementation Milestones. For example, related to the ED care triage project, partners can select to focus their initial efforts around Medicaid Accelerated eXchange (MAX) series activities related to identifying high utilizers, and then shift focus to Partner Implementation Milestones (PIMs) related to developing a project plan for implementation efforts of the ED care triage project or visa versa.

Step 1: Develop an organizational High Utilizer definition and identification process*

** Hospitals participating in the MAX series may report on their High Utilizer cohort to satisfy this milestone*

Step 2: Develop a process for linking identified patients to a PCP or HH Care Manager.

Patients leave the ED with an appointment to see their PCP, are connected with a Care Manager, and/or linkages to Community Based Organizations.

MAX Series Participation:

MHVC is participating in the Medicaid Accelerated eXchange (MAX) series, a quality improvement initiative and intensive 8 month learning collaborative, aligned with the ED Care Triage project.

MHVC is represented by **two multidisciplinary "Action Teams"**;

St. Luke's Cornwall Hospital (SLCH) team: comprised of hospital staff and representation from their community partners with shared patients, Cornerstone Family HealthCare, Access Supports for Living and Horizon Health Center.

St. Joseph's Medical Center (SJMC) team: comprised of staff from across several departments and programs within the medical center's campus.

Both teams have reached significant achievements since they began working with the program in early 2016, and their **experiences have directly contributed to the larger project design and implementation efforts, including the development of selection criteria for high utilizer definitions**, **and process steps for how high utilizing patients will be identified and treated in the ED**. Additional MAX achievements include:

- The **development and launch of brief screening tools aimed at understanding patients' social risk factors, challenges accessing care, and needed supportive services.**
- An introductory **Motivational Interviewing and patient engagement training** was held for SLCH staff and two members of the SJMC team to support their use of the new screening tools.
- **Collaboration between SJMC and a community dialysis treatment center to develop improved patient pathways between the sites that will reduce ED visits and inpatient admissions**, and will also strengthen communication and the sharing of patient information between sites. This pilot has great potential as an emerging best practice and MHVC is exploring how it can be replicated in other sites across our network.

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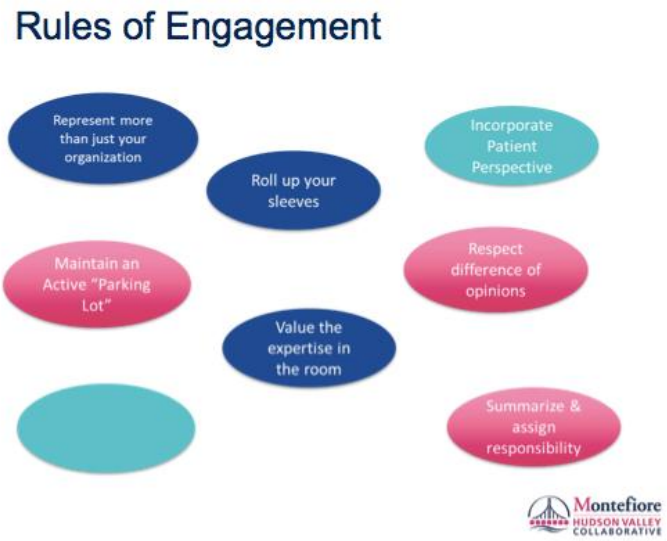
Partner Engagement Strategies

At MHVC we strive to **engage our partners** in project implementation work **in a way that is meaningful, values and integrates their expertise and incorporates a patient-centered lens.** Below we outline several best practices that have helped us effectively engage our partners in project design and implementation and incorporating the patient voice into our work.

- **Workgroup "Rules of Engagement":** With the goal of establishing a non-competitive collaborative spirit that fosters a high degree of active participation within our project workgroups, MHVC facilitated the development of **"Rules of Engagement"** that defined the way workgroup members agreed to work together. (See Practitioner Engagement Plan Appendix).



- **Incorporating partner feedback into our work:** Because we value each partners voice related to program implementation, we routinely survey our partners after each workgroup meeting to ensure that members feel engaged. Feedback is reported back to our workgroups and Clinical Quality Subcommittee and incorporated into workgroup processes

- I**nstilling the patient voice** into our project design using evidence based strategies including the "Esther Project" **has helped to convene and engage diverse stakeholder groups with a common goal of providing quality care** for their patients.

First implemented in Sweden, the "Esther Project" uses "patient personas" ("Esther's") for each project, co-created within our project workgroups, to challenge partners to consider the patient perspective during every aspect of project design. **By continually asking . . . *"What does Esther want?"* and *"How will this new process feel for Esther?"* diverse partner stakeholders are challenged to consider the patients perspective, needs and wants above their own organizational goals.**

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The Esther Project: Meet Lilly

"I can't miss work!!! "

"I am a single mother supporting 4 kids. I can't afford to take a day off to see the doctor, and I have no way to get there"

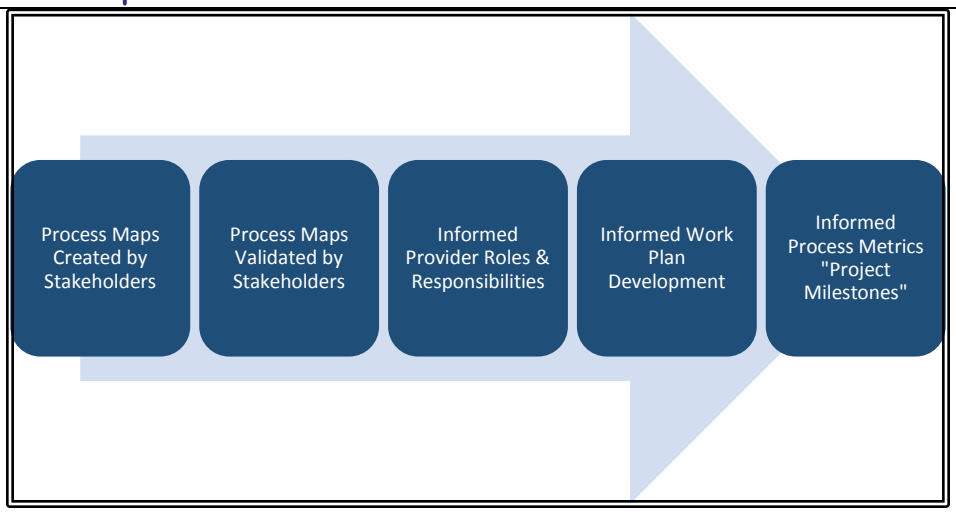
- 48 year old single mother of 4
- Family means everything to her
- Has hypertension and angina
- Suffers recurrent panic attacks
- Does not have a PCP or MH professional
- Doesn't have access to a car
- Presents in the ED with shortness of breath – 8 times in past year

Montefiore HUDSON VALLEY COLLABORATIVE

Process Maps Informed MHVCs Project Design and Contracting Model:

Through a collaborative process MHVC engaged diverse stakeholder groups, in a facilitated activity that led to the creation of a series of process maps illustrating the patient journey through the care continuum for each project. Swim lane diagrams highlighted the roles and responsibilities attributed to each provider type involved. The process maps note linkages between different provider types and points of intersection with other clinical projects.

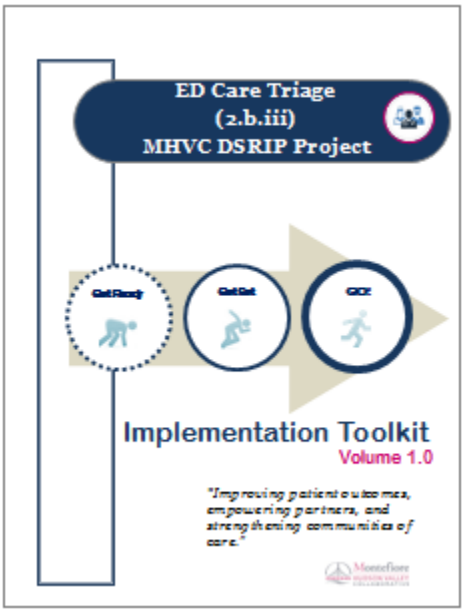
After validating these process maps by diverse stakeholders in the field, they were used to inform the development of project specific roles and responsibilities as well as a project work plan. In turn these materials guided the development of foundational process metrics that will help move our projects forward. These process metrics ("Project Milestones") are project and provider type specific and form the foundation of MHVC's dynamic contracting strategy. We will continue to use this model, creating project milestones in six-month cycles, to ensure active feedback on project success and provide opportunities to realign our approach as necessary.



Toolkit Development

In support of Phase II Contracting, MHVC developed webinars on each project, outlining the partner milestones and introducing the forthcoming project toolkit. The **project toolkits** detail, on a granular level, what partners must do to satisfy milestones, lay the groundwork for successful project implementation, and receive compensation.

MHVC developed a series of dynamic interactive Project Toolkits to support partners in their implementation journey. The toolkits are living documents that are constantly growing and will become more robust over time as partners contribute best practices, workflows, policies and procedures, training resources and materials and share successful quality improvement PDSAs. Toolkit's will guide partners to identify appropriate project team members, complete readiness assessments, develop project plans, and collect baseline and follow up data to support quality improvement efforts.



<u>Aligning Clinical, Workforce and IT work streams</u>

Recognizing the importance of collaboration between work streams, our MHVC Clinical team has worked closely with our workforce and IT work stream counterparts to ensure a unified approach to project planning and implementation. Our Medical

Director and Directors of Workforce and IT have participated in subcommittee meetings from the other workstreams as subject matter experts to ensure that subcommittee members of each workstream are kept updated about areas where collaboration across work streams will improve efficiencies and outcomes. In addition we have internal and external workgroups that cross work streams including:

- MHVC Population Health Workgroup
- MHVC Strategic Reporting, Planning and Oversight Workgroup Meeting
- Cultural Competency and Health Literacy Workgroup
- MHVC High Performance Metrics Workgroup
- Analytics Workgroup
- Integrated Delivery System (IDS) Workgroup
- Workforce Training Workgroup
- Workforce Communication and Engagement Workgroup

CBO's and organizations that serve people with developmental disabilities represented on project workgroups

Vast opportunities for self-management support exist in the community. While patients may see a doctor three times a year, they may go to church every Sunday and may visit a food pantry in a community center weekly. Recognizing that CBO's offer evidence based Self-Management Support programs (The Stanford Model, Asthma Educators, and peer programing) that provide an important way to engage patients with chronic disease within their communities, as well as community based services ability to address the social determinants of health, MHVC expanded workgroup representation to include CBOs. Along the same lines, we included representation from organizations that serve people with developmental disabilities and/or mental illness to ensure that the voice of patients that fall into these populations are represented on our workgroups.

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

The Montefiore Hudson Valley Collaborative (MHVC) and its network partners are prepared to embark on a workforce training effort to support the Integrated Delivery System (IDS) projects through the development of the Workforce Training Strategy. The overarching goal of this strategy is to enhance and introduce learning concepts to its network partners on topics which include: population health, value-based healthcare, care management and cost-effective care coordination that meets or exceeds defined quality standards.

Under the leadership of the MHVC Workforce Transformation Subcommittee and input from MHVC network partners, the Workforce Training Strategy was created to address training needs for identified staff impacted by the IDS initiative. The Workforce Training Strategy includes: clinical staff training related to population and care management, non-clinical staff training required support skills needed to reinforce the new care model, and opportunities to leverage learning institutions /educational programs and existing partner learning practices to fulfill its overarching goal.

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

With Phase 2 contracting well underway and clinical projects kicking off, the full impact to populations is still being assessed. However, through collaborative efforts, a solid plan has been developed to address community needs, combat health disparities, and the gaps in service originally referenced in our application and project implementation plans.

MHVC project workgroups keep these issues at the forefront of their work to create and implement each project. Initial plans for this work began with the formal creation of the CCHL (Cultural Competency & Health Literacy) Strategy which was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners.

Using the assessment and evaluative findings the MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners. In March, 2016, we modified our CCHL Strategy to include Key Factors to Improve Access to Quality Healthcare. Further, projects have begun to be actively implemented and rolled out to partners.

MHVC is responsible for implementing organization-wide and project specific activities to ensure cultural competency and health literacy remain priorities at each level of care delivery (e.g. from the partners to clerical staff). The following are current, on-going and/or planned activities that are key factors to improving access to quality healthcare and address social determinants of health.

<u>Cross Cutting/MHVC Wide Initiatives to Improve Patient Access to Care</u>

1. Engaging partners to work together by conducting individual site visits and regional meetings. The purpose of these meetings is to learn about available services, linkages between partners, and needs assessment. These meetings are opportunities to provide education and resources regarding best practices for improving access to care.
2. Inviting members of the CCHL workgroup (who are also members of clinical project workgroups) to attend and take part in ongoing project implementation planning as well as development of specific tasks (more details listed below).
3. Providing patients with additional means of transportation to ensure they can reach healthcare partners.
4. Opening additional primary and behavioral healthcare services in areas with gaps.
5. Using telemedicine to provide primary, preventive and behavioral healthcare services to areas with gaps.
6. Expanding hours of service and open access scheduling to make scheduling easier and more readily available.
7. Co-locating services to create “one-stop-shops” for patients to receive their behavioral and primary care needs (through the Integrated Primary and Behavioral Health (3.a.i.) and Medical Village (2.a.iv) projects).
8. Doing Outreach to community based organizations, schools, and other non-healthcare settings to make information more accessible to the community through public health campaigns.
9. Creating pathways for communication and sharing of patient information between different services partners to promote integrated and seamless delivery of care.

10. Training in structural competency for staff involved with patient care (Structural competency material can be found in the Resource Repository).

Programmatic outcomes and practice transformation initiatives will be assessed through use of the Plan, Do, Study, Act (PDSA) model of process improvement to test changes and assess their impact on patient engagement and outcomes. This model is also being used to aid in the development of health literate educational materials for patients and staff.

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DSRIP Mid-Point Assessment - Project Narratives
PPS must submit a narrative in each

PPS Name: Montefiore Medical Center

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

Challenges the Montefiore Hudson Valley Collaborative (MHVC) has encountered and planned mitigation strategies related to implementation of the Behavioral Health Integration project fall into several categories as outlined below:

Financial Sustainability

1. Financial Viability Concerns: Partners, particularly Article 31 sites, are concerned with the sustainability of integration programs.

Mitigation:
Five MHVC sites representing three of our FQHC partners (Cornerstone (1 site), Middletown Community Health Center (1 site), and Hudson River Healthcare (3 sites)) are participating in the New York state IMPACT model funding pilot project. Under the pilot, sites are eligible for a monthly care management fee for each patient enrolled in the IMPACT model if all model requirements are met. This fee makes the model sustainable. We have advocated for the state funding pilot to be expanded to additional sites due to interest from multiple partners in pursuing the Model. MHVC was pleased to receive a recent communication from the state that this is a possibility. If the pilot demonstrates improved outcomes, it will provide evidence to support our MCO VBP discussions.

We also have a Model 2 team participating in the BH Medicaid Accelerated Exchange (MAX) series. Access Supports for Living (Access) has partnered with Hudson River Healthcare to supply a nurse practitioner to one of their BH clinics. In support of this project, Access recently received regulatory relief that will allow them to expand substance abuse services to support Model 2 sustainability. In this patient centered integrated care model the Access behavioral health site serves as a "one stop shop" (primary care, mental health, and substance abuse treatment) for patient's with serious mental illness and substance abuse.

In order to ensure shared learning is taking place between practices implementing BH integrations, we linked our MHVC partners piloting Models 2 and 3 to Montefiore leadership, including Dr. Henry Chung, a nationally recognized expert in the field of BH integration, to share best practices in coding and billing, level set expectations, and align for joint advocacy around payment reform to support these models.

Facility participation in Value Based Payment (VBP) arrangements will further support short and long term financial health for participating providers. For more information on MHVC VBP planning see the organizational narrative and 2.a.i. project narrative.

2. Medicaid billing requirements and limitations Social Work (LMSW/LCSW) supervision requirements: Some clinical services must be supervised by LCSW in order to bill for those services.

Mitigation: The MHVC workforce team conducted a workforce gap assessment with partners and identified key staffing shortages and challenges. As we build out the project and begin to create and enhance linkages between programs and providers, we are actively seeking opportunities to develop group and inter-agency supervision for LMSWs. We are working with the Montefiore Medical Center Corporate Compliance team to explore options for contracts that would permit the sharing of patient information. This would have the added benefit of promoting staff engagement and retention and further integrating patient care by sharing information and intervention strategies across providers.

Resource Challenges:

3. Lack of behavioral health providers (particularly in rural counties): Workforce members and partners piloting programs have discussed the inadequate number of behavioral health providers particularly in less densely populated areas.

Mitigation: One successful strategy we hope to spread is the use of telepsychiatry. For example, a psychiatrist in New York City is

working with an Orange County facility remotely. Another approach will be to "broker" shared services across facilities. Additionally the workforce team conducted a workforce gap assessment with partners and identified key staffing shortages and challenges. Closing our workforce gaps is a collaborative initiative with our network partners and stakeholders. One of the key ways we plan to collaborate is by aligning our efforts to expand the knowledge and effectiveness of the workforce to promote a more successful transformation. Organizational change and development will be a challenge for all of our network partners; however, by working collaboratively, we can connect various types of providers, share techniques for redeploying and retaining workers, and identify promising practices in a range of areas. We are building tools to support:

- **Structural Mapping** - provide partner organizations with a process that provides a clearer view of where job opportunities exist and where vacancies can be filled within an existing talent pool.
- **Analysis & Review of Alternative Roles** – examine the role of providers like Nurse Practitioners to provide certain low-access services and encourage the up-skilling of staff who could be trained to serve in vacant roles.
- **Forecasting & Phased Reductions** - offer support to network partners with workforce forecasting and planning for restructuring and reductions. We will assist with developing solutions to close workforce gaps including outlining a phased earlier release of staff or temporary resourcing.
- **Support Processes for Impacted Staff** – provide a technology resource to ensure relevant vacancies are shared with impacted staff so that there is an immediate proactive list of relevant options for them to consider throughout the network.
- **Jobs Clearing House** – provide a centralized recruitment marketing resource for all network partners to share open positions. It will include best practice tools for candidates in transition.

IT Challenges

4. Electronic Health Record Integration: Behavioral health and primary care facilities typically utilize different EHRs. This poses a challenge related to sharing patients' records between primary care and BH providers.

Mitigation: To date, several partners have identified temporary workflows to help circumvent this challenge. These are labor-intensive workarounds and include:

1. Patients signing mutual consent forms when two agencies (albeit co-located) care for the same patient.
2. Cross-training key staff on their counter-part EHR systems.
   Printing lab results, care plans and other important documents from one EHR and scanning them into the second EHR system.

More elegant solutions are needed. In addition to continuing to emphasize the importance of in person and telephonic case discussions and warm handoffs, MHVC hopes to utilize the RHIO to share care plans and is exploring the use of text and email messaging solutions. We will use the results of our IT readiness assessment survey to help guide solutions and the creation of best practice guidance. **We are also contracting with the University of Washington in order to give partners participating in BH integration Models 1 & 3 access to a "bell's and whistles" registry to guide integrated care case review discussions.** For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative.

PCMH and Meaningful Use

5. Attaining PCMH will be difficult for providers without EHRs:
Attainment of 2014 standards of PCMH level 3 and meeting MU requirements are foundational requirements for practices participating in this project. We have identified practices that wish to participate in this project that may be unable to meet the EHR requirements in early years.

Mitigation: We have partnered with the Primary Care Development Corporation (PCDC) to implement our PCMH strategy. They are in the field assessing practices readiness for transformation and bucketing practices according to their readiness level. Those practices without EHR's fall into a low readiness bucket. We have developed a strategy to offer these practices access to a low cost EHR, Medgen that meets meaningful use stage 2 requirements. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative.

Regulatory Challenges

6. Regulatory Relief: Some of MHVC's partners have already begun their integration process and one of the identified hurdles is the

need for regulatory relief. Partners felt encumbered by the regulatory process and, when applicable, the related physical changes that needed to be completed.

Mitigation: Montefiore Medical Center's legal team continues to work with partners and New York State governmental agencies on needed regulatory relief for DSRIP implementation. MHVC created an ad-hoc Regulatory Relief workgroup comprised of MHVC project staff, legal council and partners to support partners as additional need for guidance and advocacy arises.

7. Delay in the receipt of claims data

Claims data became available June 2, 2016 and the recent date of release of this data remains an important limitation to MHVC's ability to implement projects. In addition, the data has a lag of 12+ months, limiting the use for clinical purposes. The lag means that by the time MHVC or partners receive that data the time period for impacting the metric has ended. Therefore, the data primarily can be used for reporting to providers on their prior year performance. In addition, while the data is now available, and is being utilized, there is a time of approximately three months of testing, validation and understanding the data feed in order to develop usable claims based data. In addition, security requirements add a layer of complexity to MHVC's ability to share information both internally and with partners.

Mitigation: The claims data validation and preliminary analysis of the claims data distributed in June 2016 is progressing. We are in the process of developing initial cuts of data for key metrics and validating those counts against either Salient or MAPP. We are using substitutes for the redacted cost data that most claims data includes, but the DOH claims data does not yet include. We have two additional mitigation strategies for analyzing clinically relevant data: 1) the MAPP snapshot tool provides very recent data and is used to track key metrics by provider and patient with an opportunity to intervene to improve outcomes and 2) Montefiore is exploring the opportunity to work with data vendors that will utilize provider data as the primary source of data and this would virtually eliminate the issue of claims lag and permit MHVC to communicate information that can improve patient outcomes to providers on a real time basis.

Training Challenges:

8. Staff Training in Evidence Based Guidelines: We need to ensure that primary care providers and staff are adequately trained on evidence-based strategies for screening and treatment of depression, anxiety, substance abuse and other behavioral health disorders

Mitigation: We have been working closely with our workforce work stream to collaboratively determine training needs and develop a training strategy that will leverage expertise and resources within our PPS. For more information on MHVC Workforce strategy see the organizational narrative and 2.a.i. project narrative.

9. Staff Training in Self Management Support Communication Skills

Successful implementation of this project is in large part contingent on the ability to develop a workforce skilled in self-management support skills. A large number of staff will need to be trained to have competency in self-management support strategies, motivational interviewing, and strategies to improve health literacy and shared decision making.

Mitigation: MHVC is committed to developing staff skills in Self-Management Support principles including Brief Action Planning (BAP) for patient centered goal setting, and Motivational Interviewing. Using a Train-the-trainer model we aim to develop a highly skilled group of trainers embedded within our partner organizations. This will enable organizations to train their staff and clinicians within their organizations on an ongoing basis. To this end, we have contracted with the Centre for Collaboration, Motivation and Innovation (www.CentreCMI.ca) to administer two Train-the-Trainer programs (Brief Action Planning, Motivational Interviewing) thereby building capacity and skills across our network partners. These trainers will then be able to train staff and clinicians within their organizations using the Centre's curriculum.
For more information on MHVC Workforce strategy see the organizational narrative and 2.a.i. project narrative.

10. Risk that partner organizations, MCOs and Health Homes may be too overwhelmed, understaffed, or uninterested to partner with us on this project. We will need to find ways to work with other PPSs to reduce the burden of implementation on partners so they can fully engage and support this project.

Mitigation: We have a multipronged approach to address this risk and ease the burden of participation in multiple projects and transformation efforts.

1. The Cross PPS Hudson Region DRSIP Clinical Council ,convened by the Public Health Information Program (PHIP), is committed to easing the burden of DSRIP reporting by aligning reporting requirements for shared partners participating in multiple PPSs, and collaborating on project design and our Cross PPS high performance metrics strategy.

2. MHVC's PCMH vendor is working collaboratively with our internal DSRIP team to align PCMH quality improvement work needed for PCMH transformation with our other DSRIP projects including the three projects that live in the primary care space (3bi, 3di, and 3ai, 2biii)

3. MHVC will make critical elements of protocols consistent across providers (critical elements will be determined by a committee of subject matter experts), but allow providers to keep existing protocols if they contain all critical elements.

4. MHVC will have routine discussions with providers, working with the partner engagement team, to segment stakeholders and develop a tailored communication/engagement strategy for each segment (including CBOs).

5. The network will add key quality improvements to VBP clinical guidelines in order to demonstrate the value of these interventions.

Efforts to mitigate challenges identified above:

Please see mitigation strategies as outlined above.

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Implementation approaches that the PPS considers a best practice:

Best Practices (Details below)

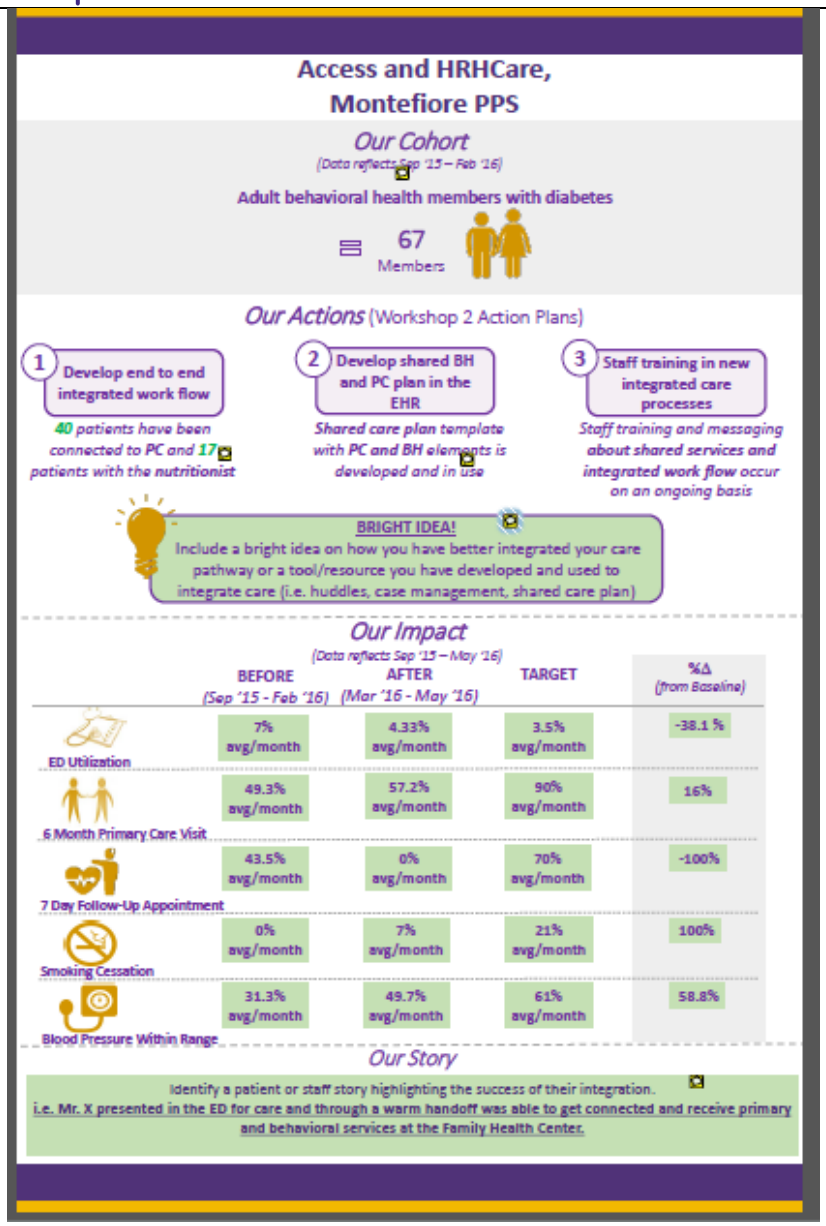
- Participation in MAX Series
- Behavioral Health Integration Readiness Assessment based on United Hospital Fund Behavioral Health Integration Continuum Framework
- Partner Engagement Strategies
- Project Design and Funds Flow: Process Mapping to Inform development of partner contracting milestones
- Toolkits
- Aligning Clinical, Workforce and IT work streams
- Including representation from CBO's and organizations that serve people with developmental

MAX Series Participation: MHVC is participating in the Medicaid Accelerated eXchange (MAX) series, a quality improvement initiative and intensive 8 month learning collaborative, aligned with the Behavioral Health Integration Project.

MHVC is represented by **ACCESS: Supports for Living** and **Hudson River HealthCare**, a behavioral health care site and primary care provider, respectively, to integrate primary care into a behavioral health facility (Model 2).

The project team identified a cohort of patients with mental health diagnoses and co-morbid diabetes. The BH site embedded a nurse practitioner and nutritionist to engage the identified cohort in primary care.
Key accomplishments and performance improvement to date include:

- Completed physical space renovations to accommodate a primary care office within the BH facility.
- The team created and is implementing a Shared Care Plan template to be shared between behavioral health and primary care providers.
- During the first 6 weeks of having an embedded primary care Nurse Practitioner, over 60 patient visits occurred. This has resulted in:
  - 61% of patients with blood pressure within range, **a 58% increase from the baseline.**
  - **A 31% drop in Emergency Department use.** It is hypothesized that this is due to having the nurse practitioner onsite so that patients can "drop in" with problems before they escalate.



BH Integration Readiness Assessment using the UHF BH Integration Continuum Framework:

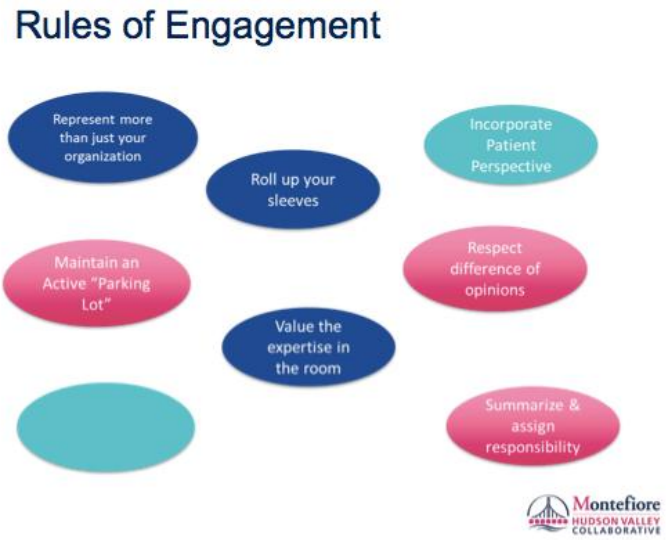
The UHF recently published a white paper entitled "Enhancing Integration of Behavioral Health Into Primary Care: A Continuum Based Framework" that describes an eight domain framework for integrated BH and primary care. MHVC was highlighted in the UHF publication as a best practice case study demonstrating the use of the framework in New Yorks Reform Efforts.

- Dr. Chung, one of the frameworks authors, guided our MHVC team to develop a site level readiness survey aligned with the 8 framework domains. An instructional webinar describing the framework and providing guidance on how to collaboratively assess level of integration across 8 domains was created.
- We anticipate survey results will help us map investments provider practices need to make in time, training, workforce and resources to successfully integrate BH as well as inform the development of targeted site specific learning plans within our learning collaborative.
- We plan to administer the survey at various times during the course of the collaborative to track sites progress toward integrated BH. By tying completion of the survey to partner funds flow as a contracting Project Implementation Milestone (see reference to Contracting Model and Strategy below) we anticipate a robust response rate.

Partner Engagement: At MHVC we strive to **engage our partners** in project implementation work **in a way that is meaningful,**

values and integrates their expertise and incorporates a patient-centered lens. Below we outline several best practices that have helped us effectively engage our partners in project design and implementation and incorporating the patient voice into our work.

- **Workgroup "Rules of Engagement":** We elicited Rules of Engagement from each workgroup to ensure that every partner's voice is heard in the discussion and in program implementation.



- **Incorporating partner feedback into our work:** Because we value each partners voice related to program implementation, we routinely survey our partners after each workgroup meeting to ensure that members feel engaged. Feedback is reported back to our workgroups and Clinical Quality Subcommittee and incorporated into workgroup processes.

- I**nstilling the patient voice** into our project design using evidence based strategies including the "Esther Project" **has helped to convene and engage diverse stakeholder groups with a common goal of providing quality care** for their patients. The patient voice is also "heard" through the participation of CBOs including Peer organizations.

First implemented in Sweden, the "Esther Project" uses "patient personas" ("Esther's") for each project, co-created within our project workgroups, to challenge partners to consider the patient perspective during every aspect of project design. **By continually asking . . . *"What does Esther want?"* and *"How will this new process feel for Esther?"* diverse partner stakeholders are challenged to consider the patient's perspective, needs and wants above their own organizational goals.**

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The Esther Project: Meet Lilly

"I can't miss work!!! "

"I am a single mother supporting 4 kids. I can't afford to take a day off to see the doctor, and I have no way to get there"

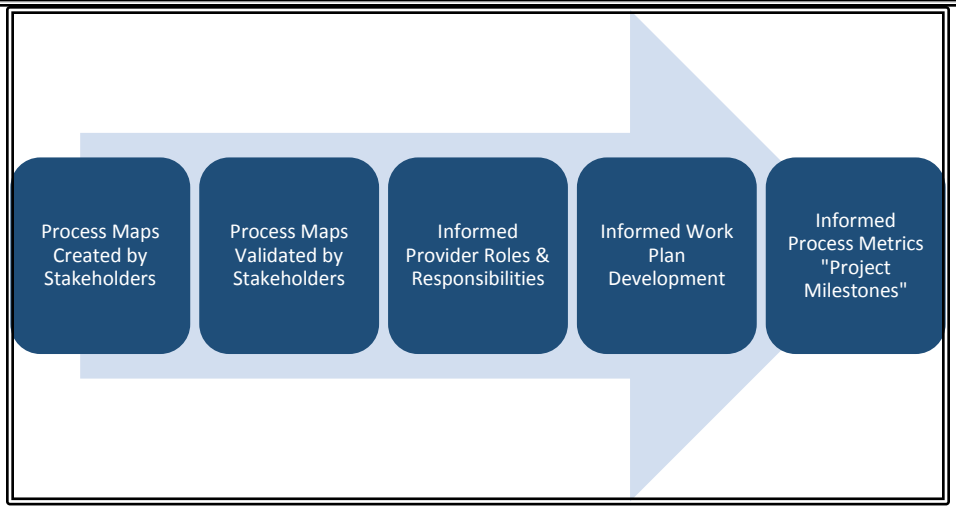
- 48 year old single mother of 4
- Family means everything to her
- Has hypertension and angina
- Suffers recurrent panic attacks
- Does not have a PCP or MH professional
- Doesn't have access to a car
- Presents in the ED with shortness of breath – 8 times in past year

Montefiore HUDSON VALLEY COLLABORATIVE

Process Maps Informed MHVCs Project Design and Contracting Model:

Through a collaborative process MHVC engaged diverse stakeholder groups in a facilitated activity that led to the creation of a series of process maps illustrating the patient journey through the care continuum for each project. Swim lane diagrams highlighted the roles and responsibilities attributed to each provider type involved. The process maps note linkages between different provider types and points of intersection with other clinical projects.

After validating these process maps by diverse stakeholders in the field, they were used to inform the development of project specific roles and responsibilities as well as a project work plan. In turn these materials guided the development of foundational process metrics that will help move our projects forward. These process metrics ("Project Milestones") are project and provider type specific and form the foundation of MHVC's dynamic contracting strategy. We will continue to use this model, creating project milestones in six month cycles, to ensure active feedback on project success and provide opportunities for realignment of our approach as necessary.



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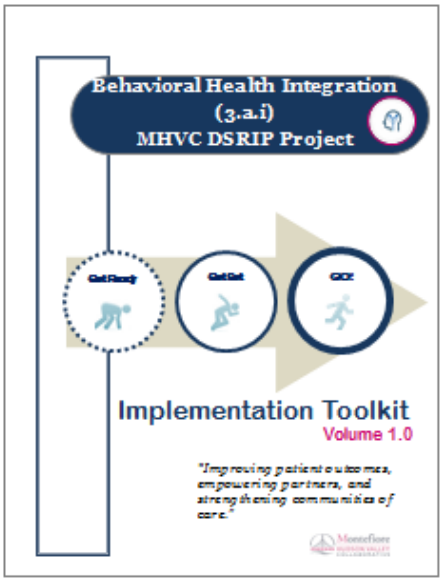
Project Toolkit Development

MHVC developed a series of dynamic interactive Project Toolkits to support partners in their implementation journey. The toolkits are living documents that are constantly growing and will become more robust over time as partners contribute best practices, workflows, evidence-based guidelines, policies and procedures, training resources and materials and share successful quality improvement PDSAs. Toolkit's will guide partners to identify appropriate project team members, complete readiness assessments, develop project plans, and collect baseline and follow up data to support quality improvement efforts.



Aligning Clinical, Workforce and IT work streams

Recognizing the importance of collaboration between work streams, our MHVC Clinical team has worked closely with our workforce and IT work stream counterparts to ensure a unified approach to project planning and implementation. Our Medical Director and Directors of Workforce and IT have participated in subcommittee meetings from the other workstreams as subject matter experts to ensure that subcommittee members of each workstream are kept updated about areas where collaboration across work streams will improve efficiencies and outcomes. In addition we have internal and external workgroups that cross work streams including:

- MHVC Population Health Workgroup
- MHVC Strategic Reporting, Planning and Oversight Workgroup Meeting
- Cultural Competency and Health Literacy Workgroup
- MHVC High Performance Metrics Workgroup
- Analytics Workgroup
- Integrated Delivery System (IDS) Workgroup
- Workforce Training Workgroup
- Workforce Communication and Engagement Workgroup

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CBO's and organizations that serve people with developmental disabilities represented on project workgroups

Vast opportunities for self-management support exist in the community. While patients may see a doctor three times a year, they may go to church every Sunday and may visit a food pantry in a community center weekly. Recognizing that CBO's offer evidence based Self-Management Support programs (The Stanford Model, Asthma Educators, and peer programing) that provide an important way to engage patients with chronic disease within their communities, as well as community based services ability to address the social determinants of health, MHVC expanded workgroup representation to include CBOs. Along the same lines, we included representation from organizations that serve people with developmental disabilities and/or mental illness to ensure that the voice of patients that fall into these populations are represented on our workgroups.

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

MHVC will work closely with a nationally recognized expert in the field of BH integration, Dr. Henry Chung (Chief Medical Officer, Montefiore Care Management Organization (CMO)), to design, launch and co-lead together with our medical director, Dr. Damara Gutnick, a BH Integration learning collaborative. Dr. Chung's team will provide technical assistance and coaching to sites to guide site level implementation efforts. Project toolkits will supplement the learning sessions and draw upon the experience of existing co-location pilot programs.

MHVC is collaborating with our fellow PPS, One City Health, on the creation of a web based interactive training module that can be used to educate collaborative care team members including primary care providers, care managers, psychiatrists and care managers.

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

With Phase 2 contracting well underway and clinical projects kicking off, the full impact to populations is still being assessed. However, through collaborative efforts, a solid plan has been developed to address community needs, combat health disparities, and the gaps in service originally referenced in our application and project implementation plans.

MHVC project workgroups keep these issues at the forefront of their work to create and implement each project. Initial plans for this work began with the formal creation of the CCHL (Cultural Competency & Health Literacy) Strategy which was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners.

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Cross Cutting/MHVC Wide Initiatives to Improve Patient Access to Care

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2. Inviting members of the CCHL workgroup (who are also members of clinical project workgroups) to attend and take part in ongoing project implementation planning as well as development of specific tasks (more details listed below).
3. Providing patients with additional means of transportation to ensure they can reach healthcare partners.
4. Opening additional primary and behavioral healthcare services in areas with gaps.
5. Using telemedicine to provide primary, preventive and behavioral healthcare services to areas with gaps.
6. Expanding hours of service and open access scheduling to make scheduling easier and more readily available.
7. Co-locating services to create “one-stop-shops” for patients to receive their behavioral and primary care needs (through the Integrated Primary and Behavioral Health (3.a.i.) and Medical Village (2.a.iv) projects).
8. Doing Outreach to community based organizations, schools, and other non-healthcare settings to make information more accessible to the community through public health campaigns.
9. Creating pathways for communication and sharing of patient information between different services partners to promote integrated and seamless delivery of care.
10. Training in structural competency for staff involved with patient care (Structural competency material can be found in the Resource Repository).

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Montefiore Medical Center

Project: 3.a.ii

Challenges the PPS has encountered in project implementation:

Challenges the Montefiore Hudson Valley Collaborative (MHVC) has encountered and planned mitigation strategies related to implementation of the Behavior Health Community Crisis Stabilization Services project fall into several categories as outlined below:

Financial Sustainability:

1. Payment Models do not support diversion: Paramedics are only reimbursed if they actually transport the person

Mitigation: There is a helpful example in Rockland County that calls out the importance of recognizing the value of diversion: In Rockland county, a Behavioral Health (BH) crisis team travels together with the county paramedics. The team has demonstrated success diverting hospital ED visits for patients in crisis by establishing timely linkages to BH providers in the community. We envision we will learn a lot as this model grows that that will be applicable to this project and will inform clinical guidelines in future VBP arrangements.

2. Payment Models do not support care management for patients who do not meet Health Home or HARP requirements

Mitigation: Care Management resources to guide the linkage of patients in crisis to downstream providers is an important component of this project, however these services are not covered for patients who are not Health Home or HARP eligible. Partner participation in Value Based Payment (VBP) arrangements will further support short and long term financial health for participating providers. We will develop case based business models to support the transition to VBP arrangement for crisis services. For more information on MHVC VBP planning see the organizational narrative and 2.a.i. project narrative.

3. Medicaid billing requirements and limitations Social Work (LMSW/LCSW) supervision requirements: Some clinical services must be supervised by LCSW in order to bill for those services.

Mitigation: The MHVC workforce team conducted a workforce gap assessment with partners and identified key staffing shortages and challenges.

Closing the network's workforce gaps is a collaborative initiative with among our partners and stakeholders. One of the key ways we plan to collaborate is by aligning our efforts to expand the knowledge and effectiveness of the Hudson Valley workforce to promote a more successful transformation. Organizational change and development will be a challenge for all of our network partners; however, by working collaboratively, we can connect various types of providers, share techniques for redeploying and retaining workers, and identify promising practices in a range of areas. We are building tools to support:

- **Structural Mapping** - provide partner organizations with a process that provides a clearer view of where job opportunities exist and where vacancies can be filled within an existing talent pool.
- **Analysis & Review of Alternative Roles** – examine the role of providers like Nurse Practitioners to provide certain low-access services and encourage the up-skilling of staff who could be trained to serve in vacant roles.

- **Forecasting & Phased Reductions** - offer support to network partners with workforce forecasting and planning for restructuring and reductions. We will assist with developing solutions to close workforce gaps including outlining a phased earlier release of staff or temporary resourcing.
- **Support Processes for Impacted Staff** – provide a technology resource to ensure relevant vacancies are shared with impacted staff so that there is an immediate proactive list of relevant options for them to consider throughout the network.
- **Jobs Clearing House** – provide a centralized recruitment marketing resource for all network partners to share open positions. It will include best practice tools for candidates in transition.

Additionally, as we build out the project and begin to create and enhance linkages between programs and providers, we are actively seeking opportunities to develop group and inter-agency supervision for Licensed Masters Social Worker's (LMSWs.) We are working with the Montefiore Medical Center Corporate Compliance team to explore options for contracts that would permit the sharing of patient information. This would have the added benefit of promoting staff engagement and retention and further integrating patient care by sharing information and intervention strategies across providers.

IT Challenges:

4. Inability of some partners to meet the EHR and HIE requirements in early years: These include the need for alerts / secure messaging, ED navigator access to PSYCKES, and access to the QE for information sharing.

Mitigation: To address this we will work with the MHVC IT team to (1) provide technical assistance in partnership with local CBOs or relevant organizations, and (2) potentially develop workarounds until practices have adopted EHRs. We will need a way to identify or build a robust EHR implementation tracking and support team. We are also likely to encounter insufficient funding for HIE connections given the exorbitant prices vendors may charge to migrate data or create interfaces. Here, we will leverage scale to get volume based discounts and variable pricing. We will also encourage providers to leverage funding from the NYS Data Exchange Incentive Program and the Medicaid Meaningful Use Program. In conjunction with the IT team, we will establish patient registries. HealthlinkNY has also been critical in helping to facilitate provider trainings and build awareness of the value of an IDS in managing crisis care. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative

Resource Challenges

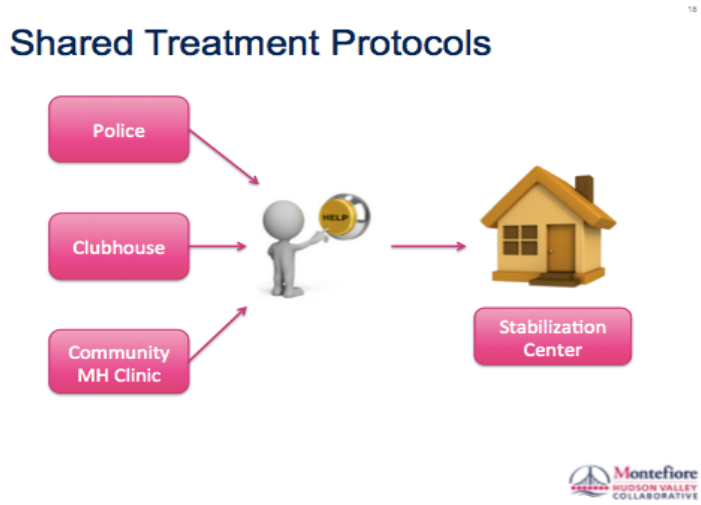
5. Access to urgent behavioral care appointments: One of the challenges associated with this project is the difficulty of obtaining urgent behavioral care appointments. This is highlighted by the absence of ambulatory detox services in that region and in part due to the difficulty in hiring psychiatrists.

Mitigation: We will mitigate this risk by having providers expand hours of operation and accept walk-in and urgent care appointments and also work with partners to develop a model for dynamic scheduling of crisis staff to optimize hours of operation. To further address this risk, MHVC will encourage some partners in our network to seek ambulatory detox licensure. We are also creating a centralized job board, assisting partners with recruitment best practices and are exploring alternative roles, such as psychiatric nurse practitioners to fill the need for behavioral health providers in the region.

6. Lack of Behavioral Health Services: A single provider does not have the capacity to offer a complete range of crisis stabilization services as defined by the project requirements.

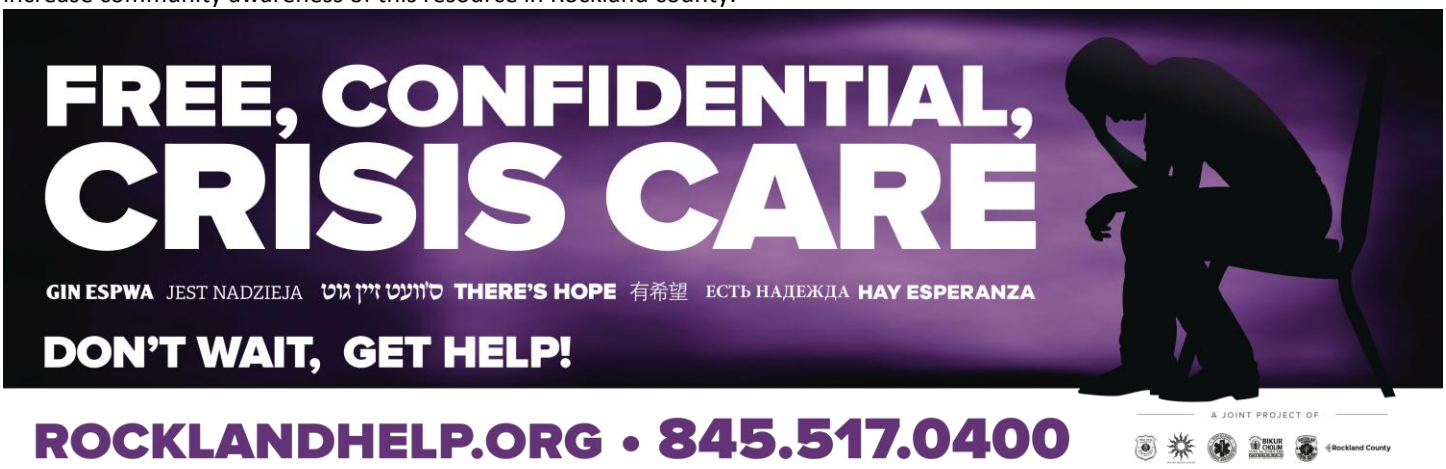
Mitigation: We are collaborating on this project with our neighboring PPSs, Westchester Medical Center and Refuah. To align efforts we established the "Crisis Leadership Group," comprised of leadership and project leads from the three PPSs.

Ensuring seamless links to care allows patients to access the necessary services needed to continue along their path to wellness. To this end, each PPS is working collaboratively as well as with our respective workgroups, to build consensus on treatment protocols and best practices. This will have the added benefit of easing the burden of reporting actively engaged patients for shared partners. (for more information please see best practices section below)



7. **Limited Services (mobile crisis and respite):** There is risk associated with the limited mobile crisis and crisis respite services in the Hudson Valley region.

Mitigation: In order to mitigate this risk, we are coordinating with our partner PPSs, public sector agencies and our network partners to understand current behavioral health and crisis services in our region and identify service gaps and opportunities to fill them. For example, Refuah PPS is sponsoring the expansion of the Rockland County Behavioral Health Response Team (BHRT). This is an innovative integrated program spearheaded by paramedic providers in the MHVC network. They have also promoted a culturally competent marketing campaign that included a multilingual billboard representing the most common languages in the county to increase community awareness of this resource in Rockland county.



Practitioner Engagement:

8. Diverse stakeholders need to be engaged: The project will require different stakeholders to work together, including community resources and traditional medical teams.

Mitigation: To ensure this collaboration is effective, we will:

- Develop a robust change management strategy to ensure all stakeholders understand the rationale behind the collaboration and the importance of working together effectively.
- Bring stakeholders together to develop consensus around care guidelines where possible (see Process Mapping Session reference below)
- Work within the practitioner engagement work stream to educate providers about rationale behind the crisis stabilization requirements.
- Join efforts with the workforce team to allow us to identify providers who will need additional assistance/training on the guidelines and include this in our training strategy.

9. Practitioner reluctance to adapt clinical guidelines and treatment protocols: There is a risk that providers will resist adopting clinical guidelines and treatment protocols.

Mitigations: To address this, we are ensuring that standards and protocols are developed collaboratively and that partner input is incorporated throughout the process. Our first joint PPS process mapping session for the crisis project recently occurred in Orange County. The output of this session was consensus on service categories and definitions and agreement on minimum standards for providing and accessing Crisis services, including identifying the information programs needed in order to make and accept effective, appropriate and timely referrals.

In order to create a successful network, we are working together to develop a set of shared practices and principles- the lens through which we will provide care. These lenses, were identified by our crisis workgroup members, and are consistent with national standards. (See diagram).

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Cross PPS Collaborative Process Mapping session- August 3, 2016 in Orange County

10. Increasing an organization's comfort and capacity to manage behavioral health crises internally and the challenge of changing organizational behaviors to reflexively direct patients to the ED.

Mitigation: During our recent crisis process mapping session (see photos above), we did an initial examination of the acceptable "level of risk" across many domains including suicidality, harm to others, self-harm or self-injury, neglect to others, and self-neglect, that crisis services have or should have the capacity to manage internally. We explored how the PPSs could support organizations in developing staff skills and policies to increase capacity and comfort to address and manage behavioral health crises internally. The group also examined opportunities to develop protocols and linkages that facilitate direct, warm handoffs to programs that have the capacity and are the appropriate level of care for higher risk patients, rather than reflexively directing patients to the ED.

11. Risk that partner organizations, MCOs and Health Homes may be too overwhelmed, understaffed, or uninterested to partner with us on this project. We will need to find ways to work with other PPSs to reduce the burden of implementation on partners so they can fully engage and support this project.

Mitigation: We have a multipronged approach to address this risk and ease the burden of participation in multiple projects and transformation efforts.

1. The Cross PPS Hudson Region DRSIP Clinical Council ,convened by the Public Health Information Program (PHIP), is committed to easing the burden of DSRIP reporting by aligning reporting requirements for shared partners participating in multiple PPSs, and collaborating on project design and our Cross PPS high performance metrics strategy.
2. MHVC's PCMH vendor is working collaboratively with our internal DSRIP team to align PCMH quality improvement work needed for PCMH transformation with our other DSRIP projects including the three projects that live in the primary care space (3bi, 3di, and 3ai, 2biii)
3. MHVC will make critical elements of protocols consistent across providers (critical elements will be determined by a committee of subject matter experts), but allow providers to keep existing protocols if they contain all critical elements.
4. MHVC will have routine discussions with providers, working with the partner engagement team, to segment stakeholders and develop a tailored communication/engagement strategy for each segment (including CBOs).
5. The network will add key quality improvements to VBP clinical guidelines in order to demonstrate the value of these interventions.

<u>Regulatory Challenges:</u>

12. Electronic Health Record Integration: The CFR 42.2 regulations impact the ability for providers to seamlessly share patients' records.

Mitigation: To date, several partners have identified temporary workflows to help circumvent this challenge. These are labor-intensive workarounds and include:

1. Patients signing mutual consent forms when two agencies care for the same patient.

2. Cross-training key staff on their counter-part EHR systems.

3. Printing lab results, care plans, and other important documents from one EHR and scanning them into the second EHR system.

More elegant solutions are needed. In addition to continuing to emphasize the importance of in person and telephonic case discussions and warm handoffs, MHVC hopes to utilize the QE to share care plans and is exploring the use of text and email messaging solutions. We will use the results of our IT Current State Assessment survey to help guide solutions and the creation of best practice guidance. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative

13. Additional Regulatory Challenges Include:

- **Ambulance services can only divert crisis to an article 28 and 31 facility.**
- **OMH licensed out-patient clinics limits on multiple visits per recipient per day**

Mitigation: Montefiore Medical Center's legal team continues to work with partners and New York State governmental agencies. MHVC created an ad-hoc Regulatory Relief workgroup comprised of MHVC project staff, legal counsel, and partners to support partners as additional need for regulatory relief arises.

14. Actively Engaged Patient Definitions:

This project contains broad service categories that are subject to interpretation and require consensus building within our network and across the region. Our partners have expressed the desire to include a range of supportive services within the continuum of crisis services, for example, housing advocacy, peer support, and walk in appointments, and medication refills.

Mitigation

We have addressed this by developing clarification to our Actively Engaged Patient definition which provides a range of expanded service examples. Within our workgroup we have also developed a brief series of Qualifying Questions. Four of our partner organizations have agreed to pilot this questionnaire. By using the questionnaire, partners are able to screen interventions that have helped to prevent and avoid the development of a crisis or have helped someone remain stable in the days or weeks following a crisis. We believe the results of this pilot will help to identify a range of critical interventions that should be included within our continuum of crisis services. Additionally, we are collaborating with our neighboring PPSs and bringing together our respective workgroups to build consensus on service definitions across the region and its providers.

Claims Data

15. Delay in the receipt of claims data

Claims data became available June 2, 2016 and the recent date of release of this data remains an important limitation to MHVC's ability to implement projects. In addition, the data has a lag of 12+ months, limiting the use for clinical purposes. The lag means that by the time MHVC or partners receive that data the time period for impacting the metric has ended. Therefore, the data primarily can be used for reporting to providers on their prior year performance. In addition, while the data is now available, and is being utilized, there is a time of approximately three months of testing, validation and understanding the data feed in order to develop usable claims based data. In addition, security requirements add a layer of complexity to MHVC's ability to share information both internally and with partners.

Mitigation: The claims data validation and preliminary analysis of the claims data distributed in June 2016 is progressing. We are in the process of developing initial cuts of data for key metrics and validating those counts against either Salient or MAPP. We are using substitutes for the redacted cost data that most claims data includes, but the DOH claims data does not yet include. We have

two additional mitigation strategies for analyzing clinically relevant data: 1) the MAPP snapshot tool provides very recent data and is used to track key metrics by provider and patient with an opportunity to intervene to improve outcomes and 2) Montefiore is exploring the opportunity to work with data vendors that will utilize provider data as the primary source of data and this would virtually eliminate the issue of claims lag and permit MHVC to communicate information that can improve patient outcomes to providers on a real time basis.

Efforts to mitigate challenges identified above:

Please see mitigation strategies as outlined above.

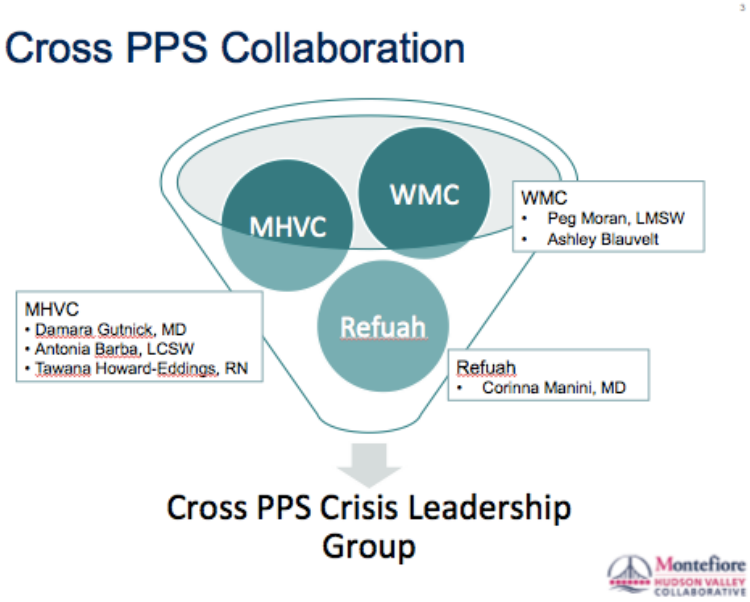
Implementation approaches that the PPS considers a best practice:

Best Practices (Details below)

- Cross PPS Collaboration
- Partner Engagement Strategies
- Project Design and Funds Flow: Process Mapping to Inform development of partner contracting milestones
- Toolkits

Cross PPS Collaboration:

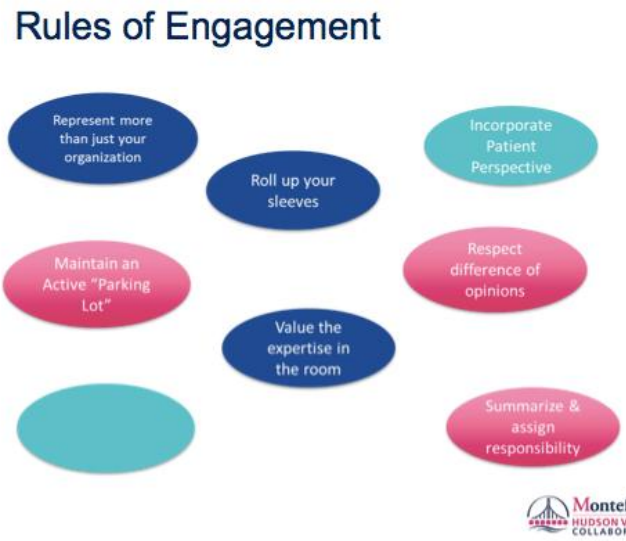
We established the cross PPS **Crisis Leadership Group**, comprised of PPS and project leadership to facilitate work across the region with our providers and our Local Government Units, and ensure that our project implementation efforts are aligned. This will allow us to leverage existing systems of care and best practices, ease the burden of reporting for shared partners, and also ensure that patients across the region receive seamless continuum of care regardless of where or with whom they access services.



Partner Engagement Strategies:

At Montefiore Hudson Valley Collaborative (MHVC) we strive to **engage our partners** in project implementation work **in a way that is meaningful, values and integrates their expertise, and incorporates a patient-centered lens.** Below we outline several best practices that have helped us effectively engage our partners in project design and implementation and incorporating the patient voice into our work.

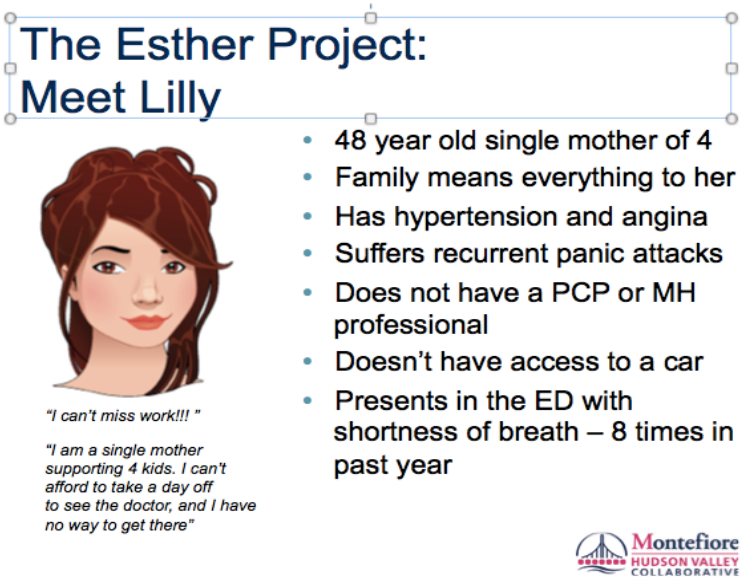
- **Workgroup "Rules of Engagement":** We elicited Rules of Engagement from each workgroup to ensure that every partner's voice is heard in the discussion and in program implementation.



- **Incorporating partner feedback into our work:** Because we value each partners voice related to program implementation, we routinely survey our partners after each workgroup meeting to ensure that members feel engaged. Feedback is reported back to our workgroups and Clinical Quality Subcommittee and incorporated into workgroup processes.

- **Instilling the patient voice** into our project design using evidence based strategies including the "Esther Project", **has helped to convene and engage diverse stakeholder groups with a common goal of providing quality care** for their patients. The patient voice is also "heard" through the participation of CBOs including Peer run organizations.

First implemented in Sweden, the "Esther Project" uses "patient personas" ("Esther's") for each project, co-created within our project workgroups, to challenge partners to consider the patient perspective during every aspect of project design. **By continually asking . . . *"What does Esther want?"* and *"How will this new process feel for Esther?"* diverse partner stakeholders are challenged to consider the patient's perspective, needs and wants above their own organizational goals.**



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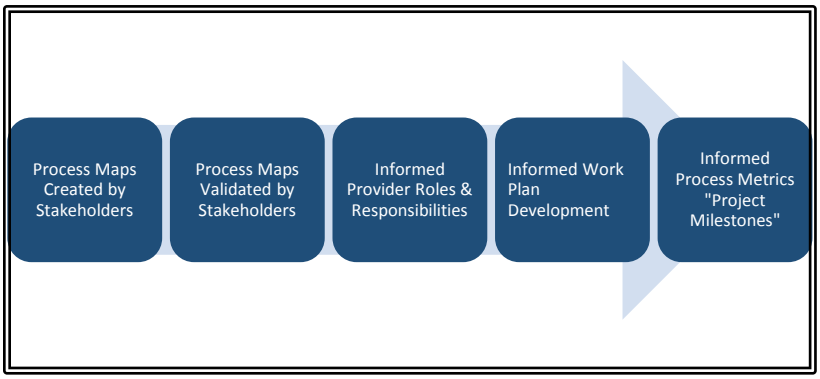
Project Design and Funds Flow:

Process Maps Informed MHVC's Project Design and Contracting Model:

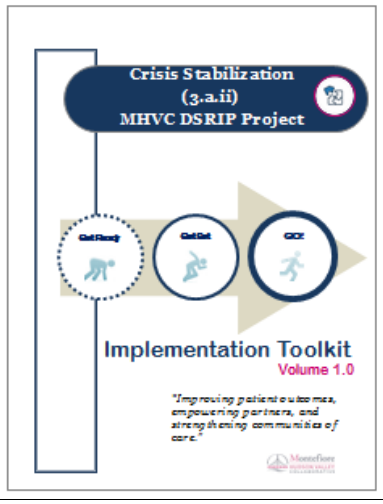
Through a collaborative process, MHVC engaged diverse stakeholder groups, in a facilitated activity that led to the creation of a series of process maps illustrating the patient journey through the care continuum for each project. Swim lane diagrams highlighted the roles and responsibilities attributed to each provider type involved. The process maps note linkages between different provider types and points of intersection with other clinical projects.

After validating these process maps by diverse stakeholders in the field, they were used to inform the development of project specific roles and responsibilities as well as a project work plan. In turn these materials guided the development of foundational process metrics that will help move our projects forward. These process metrics ("Project Milestones") are project and provider type specific and form the foundation of MHVC's contracting strategy. We will continue to use the contract model, creating project milestones in six month contract model, creating project milestones in six month cycles, to ensure active feedback on project success and realigning project approach as necessary.

Due to the complexities of this project, process mapping sessions will be convened regionally and in collaboration with our neighboring PPSs. The first session will concentrate in Orange County and is scheduled in early August. The goal of these sessions are to determine ED and hospital diversion protocols, linkages between Health Homes, hospitals and other key service providers, provider linkages to central triage services, and processes for expanding access to specialty psychiatric and crisis-oriented services, including observation units and respite beds.



Project Implementation: Toolkit Development



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MHVC developed a series of dynamic interactive Project Toolkits to support partners in their implementation journey. The toolkits are living documents that are constantly growing and will become more robust over time as partners contribute best practices, workflows, evidence-based guidelines, policies and procedures, training resources and materials and share successful quality improvement PDSAs. Toolkits will guide partners to identify appropriate project team members, complete readiness assessments, develop project plans, and collect baseline and follow up data to support quality improvement efforts.

Aligning Clinical, Workforce and IT work streams

Recognizing the importance of collaboration between work streams, our MHVC Clinical team has worked closely with our workforce and IT work stream counterparts to ensure a unified approach to project planning and implementation. Our Medical Director and Directors of Workforce and IT have participated in subcommittee meetings from the other workstreams as subject matter experts to ensure that subcommittee members of each workstream are kept updated about areas where collaboration across work streams will improve efficiencies and outcomes. In addition we have internal and external workgroups that cross work streams including:

- MHVC Population Health Workgroup
- MHVC Strategic Reporting, Planning and Oversight Workgroup Meeting
- Cultural Competency and Health Literacy Workgroup
- MHVC High Performance Metrics Workgroup
- Analytics Workgroup
- Integrated Delivery System (IDS) Workgroup
- Workforce Training Workgroup
- Workforce Communication and Engagement Workgroup

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

Cross PPS Crisis Leadership:

MHVC has taken a multi-pronged approach to this project by establishing both the cross PPS Crisis Leadership Group and the MHVC Crisis Stabilization Project Workgroup. To date, the Crisis Leadership group has outreached and begun to collaborate with our county Local Government Units to assess current crisis services, identify service gaps, and leverage best practices. We are also developing a structure for cross PPS workgroup meetings, and have begun to roll out a series of joint process mapping sessions beginning with Orange County. The agenda of these meetings aligns with state milestones with focus on the finalization of crisis service definitions, the development of shared written treatment protocols and best practices, and identification of process steps for project implementation and expanded access to services. The joint workgroups also represent the desire of our partner organizations to collaborate and streamline our efforts.

Work to date has focused on a review of currently available crisis services, a gaps analysis, and the identification of the needs and best practices for specialized populations including LGBTQ individuals, and individuals with Intellectual and Developmental Disabilities (IDD).

MHVC has developed a webinar, outlining our partner milestones and introducing the forthcoming Crisis Services Assessment Survey, designed to gather further information about organizational access to specialty crisis and psychiatric services and treatment protocols.

Lastly, MHVC has engaged Kristin Woodlock, former acting commissioner of NYS OMH, as a subject matter expert with extensive depth of knowledge in crisis services to help guide our strategy and help gain consensus around a model in the 7 counties.

Training Strategy:

The Montefiore Hudson Valley Collaborative (MHVC) and its network partners are prepared to embark on a workforce training effort to support the Integrated Delivery System (IDS) projects through the development of the Workforce Training Strategy. The overarching goal of this strategy is to enhance and introduce learning concepts to its network partners on topics which include: population health, value-based healthcare, care management and cost-effective care coordination that meets or exceeds defined

quality standards.

Under the leadership of the MHVC Workforce Transformation Subcommittee and input from MHVC network partners, the Workforce Training Strategy was created to address training needs for identified staff impacted by the IDS initiative. The Workforce Training Strategy includes: clinical staff training related to population and care management, non-clinical staff training required support skills needed to reinforce the new care model, and opportunities to leverage learning institutions/educational programs and existing partner learning practices to fulfill its overarching goal.

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

With Phase 2 contracting well underway and clinical projects kicking off, the full impact to populations is still being assessed. However, through collaborative efforts, a solid plan has been developed to address community needs, combat health disparities, and the gaps in service originally referenced in our application and project implementation plans.
MHVC project workgroups keep these issues at the forefront of their work to create and implement each project. Initial plans for this work began with the formal creation of the CCHL (Cultural Competency & Health Literacy) Strategy which was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners.

Using the assessment and evaluative findings the MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners. In March, 2016, we modified our CCHL Strategy to include Key Factors to Improve Access to Quality Healthcare. Further, projects have begun to be actively implemented and rolled out to partners.

MHVC is responsible for implementing organization-wide and project specific activities to ensure cultural competency and health literacy remain priorities at each level of care delivery (e.g. from the partners to clerical staff). The following are current, on-going and/or planned activities that are key factors to improving access to quality healthcare and address social determinants of health.

Cross Cutting/MHVC Wide Initiatives to Improve Patient Access to Care

1. Engaging partners to work together by conducting individual site visits and regional meetings. The purpose of these meetings is to learn about available services, linkages between partners, and needs assessment. These meetings are opportunities to provide education and resources regarding best practices for improving access to care.
2. Inviting members of the CCHL workgroup (who are also members of clinical project workgroups) to attend and take part in ongoing project implementation planning as well as development of specific tasks (more details listed below).
3. Providing patients with additional means of transportation to ensure they can reach healthcare partners.
4. Opening additional primary and behavioral healthcare services in areas with gaps.
5. Using telemedicine to provide primary, preventive and behavioral healthcare services to areas with gaps.
6. Expanding hours of service and open access scheduling to make scheduling easier and more readily available.
7. Co-locating services to create “one-stop-shops” for patients to receive their behavioral and primary care needs (through the Integrated Primary and Behavioral Health (3.a.i.) and Medical Village (2.a.iv) projects).
8. Doing Outreach to community based organizations, schools, and other non-healthcare settings to make information more accessible to the community through public health campaigns.
9. Creating pathways for communication and sharing of patient information between different services partners to promote integrated and seamless delivery of care.
10. Training in structural competency for staff involved with patient care (Structural competency material can be found in the Resource Repository).

Programmatic outcomes and practice transformation initiatives will be assessed through use of the Plan, Do, Study, Act (PDSA) model of process improvement to test changes and assess their impact on patient engagement and outcomes. This model is also being used to aid in the development of health literate educational materials for patients and staff.

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

PPS Name: Montefiore Medical Center

Project: 3.b.i

Challenges the PPS has encountered in project implementation:

Challenges the Montefiore Hudson Valley Collaborative (MHVC) has encountered and planned mitigation strategies related to implementation of the Cardiovascular project (3bi) fall into several categories as outlined below:

Financial Sustainability

1. Limited Coverage for Self-Management Support Services, Home Blood Pressure Monitoring and Care Coordination Services

- **Limited Medicaid MCO Coverage of CBO Services**: Community based organizations (CBOs) provide educational and self-management services to patients with chronic diseases. Medicaid Managed Care Organizations (MCOs) have varying coverage policies for Home Health services and other community based resources. Identifying mechanisms to value the essential role CBOs and providers in the region who provide services such as the Stanford Self Management Support Program can potentially play in population health management is a foundational DSRIP goal.

- **Limited Medicaid MCO Coverage for Care Coordination and Home Blood Pressure Monitoring**: Provider contracts with MCO's may also not permit follow-up Blood Pressure checks without a copay. Routine waivers of contractually required cost-sharing obligations are problematic, and generally are not permitted under Medicaid, Medicare, or commercial insurance...

Mitigation: Partner participation in Value Based Payment (VBP) arrangements will further support short and long term financial health for participating providers. For more information on MHVC VBP planning see the organizational narrative and 2.a.i. project narrative. We are developing case based business models to support the value of alternative payment models for these services and will work with other PPS's and the State DOH to determine an appropriate statewide strategy, as needed. Partner participation in Value Based Payment (VBP) arrangements will further support short and long term financial health for participating providers. For more information on MHVC VBP planning see the organizational narrative and 2.a.i. project narrative.

Regulatory Relief

2. **Blood pressure checks without copays:** If benefit design calls for payment of a cost-sharing amount for each such visit, this project requirement could potentially present contractual and regulatory issues.

Mitigation: We will need to clarify the legality of suggesting waived co-pays and potentially explore other alternatives, including sliding scale co-pays for repeat blood pressure checks, having the co-pay be waived only for patients who are compliant with medications, encouraging providers to leverage mid-levels to perform the blood pressure checks as level 1 E/M visits, and exploring the use of home blood pressure monitoring to accomplish the blood

Access to Care

3. Access to Specialty Care: One of the prominent challenges Medicaid beneficiaries face in the Hudson Valley is access to providers, particularly specialists.

Mitigation: Our MHVC Clinical team has been working closely with our workforce and IT work streams to understand and address this barrier. Together we are analyzing our network and identifying needs for specialists. We are exploring creative solutions to

placing specialists within our primary care sites (Asthma, Cardiovascular and Behavioral Health specialists) possibly through the incorporation of telemedicine. A telemedicine strategy will leverage existing best practices from prominent organizations, such as the International Society for Telemedicine and e-Health and the American Telemedicine Association, and follow developing State legal and regulatory parameters. Additionally, we plan to utilize alternative roles to increase access (i.e. Nurse Practitioners and Physician Assistants). MHVC will also engage providers and MCOs to address notable barriers, including remote provider hospital privileges and MCO reimbursement policies with telemedicine providers.

4. **Delay in the receipt of claims data**:
Claims data became available June 2, 2016 and the recent date of release of this data remains an important limitation to MHVC's ability to implement projects. In addition, the data has a lag of 12+ months, limiting the use for clinical purposes. The lag means that by the time MHVC or partners receive that data the time period for impacting the metric has ended. Therefore, the data primarily can be used for reporting to providers on their prior year performance. In addition, while the data is now available, and is being utilized, there is a time of approximately three months of testing, validation and understanding the data feed in order to develop usable claims based data. In addition, security requirements add a layer of complexity to MHVC's ability to share information both internally and with partners.

Mitigation: The claims data validation and preliminary analysis of the claims data distributed in June 2016 is progressing. We are in the process of developing initial cuts of data for key metrics and validating those counts against either Salient or MAPP. We are using substitutes for the redacted cost data that most claims data includes, but the DOH claims data does not yet include. We have two additional mitigation strategies for analyzing clinically relevant data: 1) the MAPP snapshot tool provides very recent data and is used to track key metrics by provider and patient with an opportunity to intervene to improve outcomes and 2) Montefiore is exploring the opportunity to work with data vendors that will utilize provider data as the primary source of data and this would virtually eliminate the issue of claims lag and permit MHVC to communicate information that can improve patient outcomes to providers on a real time basis.

IT Challenges:

5. Attaining PCMH will be difficult for providers without EHRs:
Attainment of 2014 standards of PCMH level 3 and meeting MU requirements are foundational requirements for practices participating in this project. We have identified practices that wish to participate in this project that may be unable to meet the EHR requirements in early years.

Mitigation: We have partnered with the Primary Care Development Corporation (PCDC) to implement our PCMH strategy. They are in the field assessing practices readiness for transformation and bucketing practices according to their readiness level. Those practices without EHR's fall into a low readiness bucket. We have developed a strategy to offer these practices access to a low cost EHR (Medgen) that meets meaningful use requirements. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative.

6. Electronic Health Record Integration: MHVC is assisting eligible partners to become PCMH Level 3 certified by March 2018. This project requires PCMH partners and partners with electronic health records (EHR) to imbed evidence based guidelines (EBGs) and project-specific patient alerts, such as the need for an AAP, into their systems. This requires significant IT resources and provider education for many of our partners

Mitigation: To most efficiently and effectively support our partners, MHVC is both engaging its IT Subcommittee and contracting with a vendor to conduct readiness assessment. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative.

7. Tracking Self-Management Goals in the EHR: Currently many electronic health records do not have the capacity to track self-management goals since these goals are often added as free-text. Without this functionality, it is impossible to query the system to obtain a report and more vitally, it is hard for providers to see what goals patients committed to on previous appointments and follow-up on them.

Mitigation: Some partners have created this functionality within their systems and we will leverage their experience to guide the development of practical IT solutions for partner organizations. Standardized documentation, provider education and sharing best practices is paramount to our being able to capture work that is already being done to satisfy our reporting efforts. MHVC

has a strategy in place to emphasize the importance of PCPs documenting their work in appropriate template fields to ease reporting and capture of work.

8. Systems Integration: Practices may not have the ability to integrate electronic home blood pressure data into their EHR system.

Mitigation: To address this risk we may need to consider alternative ways to capture the data from home blood pressure monitoring (e.g., structured fields manually entered or use of patient portals to communicate blood pressure scores with the practice). We will work with the IT workstream and New York eHealth Collaborative (NYEC) team to determine whether state-wide vendors could provide a solution to this problem. We will also develop a strategy to ensure quality of home blood pressure monitoring, including patient education.

Training Challenges:

9. Staff Training in Evidence Based Guidelines: We need to ensure that clinicians and staff are adequately trained on evidence-based strategies for cardiovascular disease prevention and management.

Mitigation: We have been working closely with our workforce work stream to collaboratively determine training needs and develop a training strategy which will leverage expertise and resources within our PPS. For more information on MHVC Workforce strategy see the organizational narrative and 2.a.i. project narrative.

10. Staff Training in Self-Management Support Communication Skills

Successful implementation of this project is in large part contingent on the ability to develop a workforce skilled in self-management support skills. A large number of staff will need to be trained to have competency in self-management support strategies, motivational interviewing, and strategies to improve health literacy and shared decision making.

Mitigation: MHVC is committed to developing staff skills in Self-Management Support principles including Brief Action Planning (BAP) for patient centered goal setting, and Motivational Interviewing. Using a Train-the-trainer model we aim to develop a highly skilled group of trainers embedded within our partner organizations. This will enable organizations to train their staff and clinicians within their organizations on an ongoing basis. To this end, we have contracted with the Centre for Collaboration, Motivation and Innovation (www.CentreCMI.ca) to administer two Train-the-Trainer programs (Brief Action Planning, Motivational Interviewing) thereby building capacity and skills across our network partners. These trainers will then be able to train staff and clinicians within their organizations using the Centre's curriculum.
For more information on MHVC Workforce strategy see the organizational narrative and 2.a.i. project narrative.

11. Engaging Practitioners and Practices to Adopt Standard Guidelines

Variation in the Guidelines: Given the frequency of new guidelines (e.g. hypertension and aspirin use) it is not surprising that partners adhere to different protocols and that PCP's may lack buy-in and be reluctant to change their practice guidelines.

Mitigation: The project workgroup collaboratively reviewed current evidence-based guidelines and consensus was reached to adapt JNC-8 as the standard MHVC project 3bi guideline. The workgroup agreed to emphasize the importance of two additional elements:

1. The inclusion of self-management goals as a foundational element; and
2. Emphasis on the use of once-daily regimens or fixed-dose combination pills when appropriate.

These recommendations were adapted as minimum standards for the 3bi project. In collaboration with the workforce work stream we have developed a training strategy to support this project.

12. Meeting Project Scale Requirements: Challenge: This project requires us to engage 80% of PCPs. Engaging small practices to commit to necessary transformational activities is challenging due to limited resources, and reluctance to change, competing priorities.

Mitigation: Through field-work, we have learned and are continuing to learn about our partner's barriers and fears. MHVC has tiered partners based on current state and is working to create targeted messaging and tools that educate partners on how various initiatives are aligned, what role we as a PPS will play in supporting them and how to navigate and identify additional funding opportunities that support DSRIP objectives. Opportunities also exist to align messaging around benefits of PCMH and VBP contracts with the messaging campaigns around MACRA transformation being conducted by national medical societies

including ACP.

13. Risk that partner organizations, MCOs and Health Homes may be too overwhelmed, understaffed, or uninterested to partner with us on this project. We will need to find ways to work with other PPSs to reduce the burden of implementation on partners so they can fully engage and support this project.

Mitigation: We have a multipronged approach to address this risk and ease the burden of participation in multiple projects and transformation efforts.

1. The Cross PPS Hudson Region DRSIP Clinical Council ,convened by the Public Health Information Program (PHIP), is committed to easing the burden of DSRIP reporting by aligning reporting requirements for shared partners participating in multiple PPSs, and collaborating on project design and our Cross PPS high performance metrics strategy.
2. MHVC's PCMH vendor is working collaboratively with our internal DSRIP team to align PCMH quality improvement work needed for PCMH transformation with our other DSRIP projects including the three projects that live in the primary care space (3bi, 3di, and 3ai, 2biii)
3. MHVC will make critical elements of protocols consistent across providers (critical elements will be determined by a committee of subject matter experts), but allow providers to keep existing protocols if they contain all critical elements.
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5. The network will add key quality improvements to VBP clinical guidelines in order to demonstrate the value of these interventions.

Efforts to mitigate challenges identified above:

Please see mitigation strategies as outlined above.

Implementation approaches that the PPS considers a best practice:

Best Practices (Details below)

- Incorporating partner feedback into project design
- Aligning the project with other projects and quality improvement work to ease implementation burden
- Partner Engagement Strategies
- Process Mapping to Inform development of partner contracting milestones
- Toolkits
- Aligning Clinical, Workforce and IT work streams
- Including representation from CBO's and organizations that serve people with developmental disabilities on project workgroups

Incorporating partner feedback into project design and ensuring alignment between projects and PCMH transformation:

Our MHVC **Project Workgroups were actively engaged in collaboratively planning project implementation design work.**

- Workgroup members participated in process mapping sessions for this project and
- Feedback was elicited throughout the design phase.

Project Alignment with PCMH Transformation and Between Projects to Ease Implementation Burden on Primary Care Practices

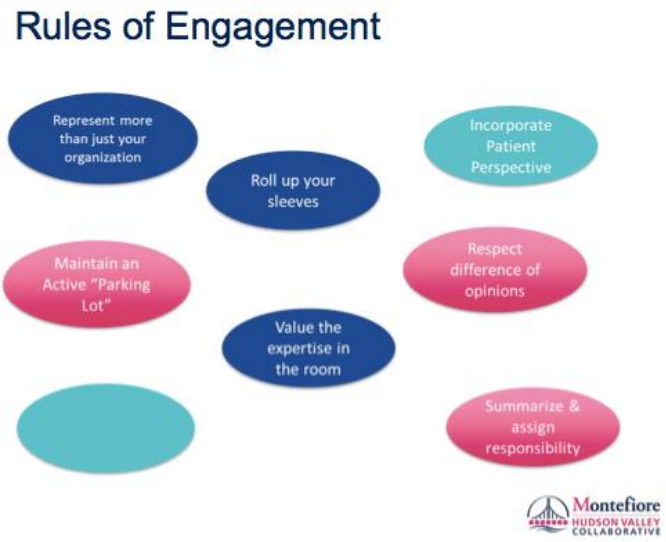
Given that many of our MHVC projects live primarily in primary care, we are keenly aware of the implementation burden for these PCP practices. To this end, we have:

- Attempted to align this project with our other primary care focused projects and
- Ensured alignment of PCMH transformation efforts between projects.

Partner Engagement Strategies:

At MHVC we strive to **engage our partners** in project implementation work **in a way that is meaningful, values and integrates their expertise and incorporates a patient-centered lens.** Below we outline several best practices that have helped us effectively engage our partners in project design and implementation and incorporating the patient voice into our work.

- **Workgroup "Rules of Engagement":** We elicited Rules of Engagement from each workgroup to ensure that every partner's voice is heard in the discussion and in program implementation.



- **Incorporating partner feedback into our work:** Because we value each partners voice related to program implementation, we routinely survey our partners after each workgroup meeting to ensure that members feel engaged. Feedback is reported back to our workgroups and Clinical Quality Subcommittee and incorporated into workgroup processes
- I**nstilling the patient voice** into our project design using evidence based strategies including the "Esther Project" **has helped to convene and engage diverse stakeholder groups with a common goal of providing quality care** for their patients. The patient voice is also "heard" through the participation of CBOs.

First implemented in Sweden, the "Esther Project" uses "patient personas" ("Esther's") for each project, co-created within our project workgroups, to challenge partners to consider the patient perspective during every aspect of project design. **By continually asking . . . *"What does Esther want?"* and *"How will this new process feel for Esther?"* diverse partner stakeholders are challenged to consider the patient's perspective, needs and wants above their own organizational goals.**

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The Esther Project: Meet Lilly

"I can't miss work!!! "

"I am a single mother supporting 4 kids. I can't afford to take a day off to see the doctor, and I have no way to get there"

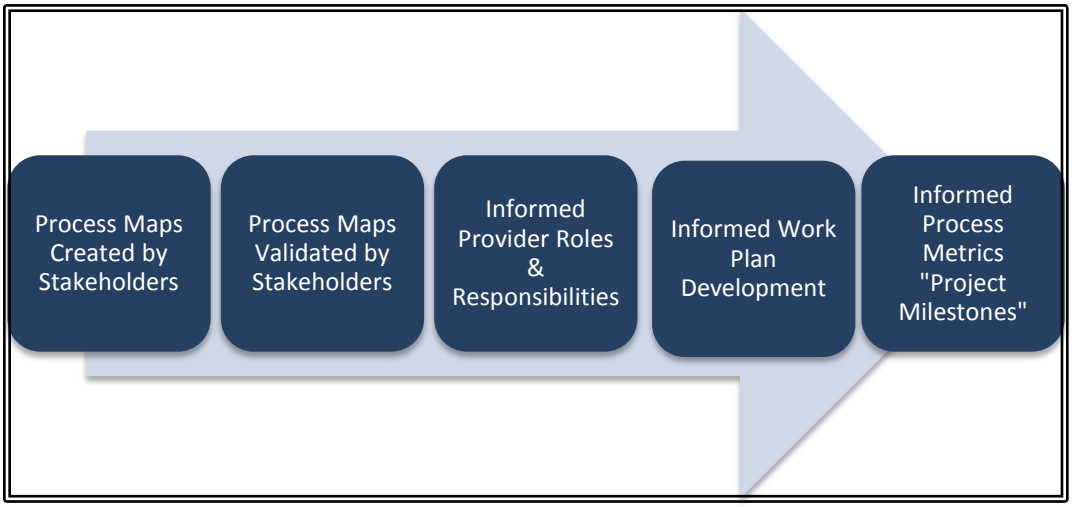
- 48 year old single mother of 4
- Family means everything to her
- Has hypertension and angina
- Suffers recurrent panic attacks
- Does not have a PCP or MH professional
- Doesn't have access to a car
- Presents in the ED with shortness of breath – 8 times in past year

Montefiore HUDSON VALLEY COLLABORATIVE

Process Maps Informed MHVCs Project Design and Contracting Model:

Through a collaborative process MHVC engaged diverse stakeholder groups, in a facilitated activity that led to the creation of a series of process maps illustrating the patient journey through the care continuum for each project. Swim lane diagrams highlighted the roles and responsibilities attributed to each provider type involved. The process maps note linkages between different provider types and points of intersection with other clinical projects.

After validating these process maps by diverse stakeholders in the field, they were used to inform the development of project specific roles and responsibilities as well as a project work plan. In turn these materials guided the development of foundational process metrics that will help move our projects forward. These process metrics ("Project Milestones") are project and provider type specific and form the foundation of MHVC's dynamic contracting strategy. We will continue to use this model, creating project milestones in six month cycles, to ensure active feedback on project success and provide opportunities for realignment of our approach as necessary.



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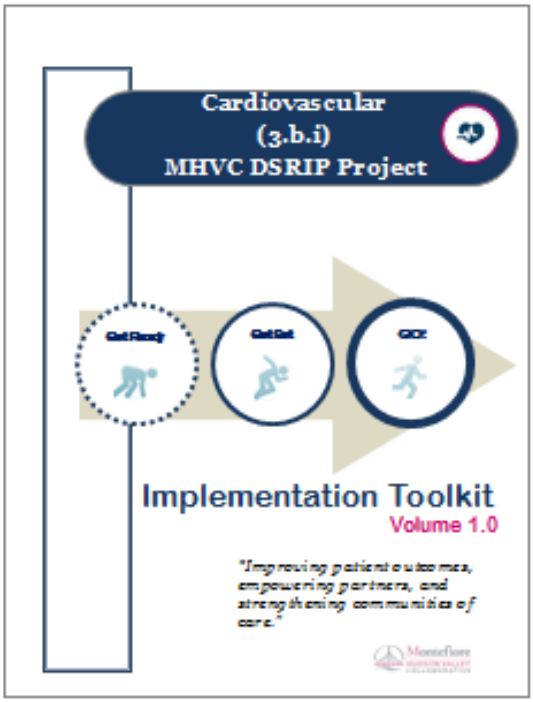
Toolkit Development

MHVC developed a series of dynamic interactive Project Toolkits to support partners in their implementation journey. The toolkits are living documents that are constantly growing and will become more robust over time as partners contribute best practices, workflows, evidence-based guidelines, policies and procedures, training resources and materials and share successful quality improvement PDSAs. Toolkit's will guide partners to identify appropriate project team members, complete readiness assessments, develop project plans, and collect baseline and follow up data to support quality improvement efforts.



Aligning Clinical, Workforce and IT work streams

Recognizing the importance of collaboration between work streams, our MHVC Clinical team has worked closely with our workforce and IT work stream counterparts to ensure a unified approach to project planning and implementation. Our Medical Director and Directors of Workforce and IT have participated in subcommittee meetings from the other workstreams as subject matter experts to ensure that subcommittee members of each workstream are kept updated about areas where collaboration across work streams will improve efficiencies and outcomes. In addition we have internal and external workgroups that cross work streams including:

- MHVC Population Health Workgroup
- MHVC Strategic Reporting, Planning and Oversight Workgroup Meeting
- Cultural Competency and Health Literacy Workgroup
- MHVC High Performance Metrics Workgroup
- Analytics Workgroup
- Integrated Delivery System (IDS) Workgroup
- Workforce Training Workgroup
- Workforce Communication and Engagement Workgroup

CBO's and organizations that serve people with developmental disabilities represented on project workgroups

Vast opportunities for self-management support exist in the community. While patients may see a doctor three times a year, they may go to church every Sunday and may visit a food pantry in a community center weekly. Recognizing that CBO's offer evidence

based Self-Management Support programs (The Stanford Model, Asthma Educators, and peer programing) that provide an important way to engage patients with chronic disease within their communities, as well as community based services ability to address the social determinants of health, MHVC expanded workgroup representation to include CBOs. Along the same lines, we included representation from organizations that serve people with developmental disabilities and/or mental illness to ensure that the voice of patients that fall into these populations are represented on our workgroups.

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

Patients with Cardiovascular Disease and Co-morbid Depression:

The primary cause of death for patients with Serious Mental Illness (SMI) is cardiovascular disease and patients with SMI are 2-3 times more likely to die a cardiovascular disease death than the general population. MHVC is therefore focusing a lens on patients with behavioral health diagnosis and comorbid depression.

We have a multipronged approach to address this population.

- We are performing data analyses to identify this population and will use what we learn to develop provider chase lists.
- We will educate providers (BH and PCPs) on the value of health home referrals to help manage and coordinate care for this population of patients
- As part of our cross PPS High Performance Metrics strategy we are working with Community Based Behavioral Health Providers, Care Management Agencies, Hospitals, Health Homes, MCO's and FQHCs to develop strategies to ensure that patients with cardiovascular disease and comorbid behavioral health diagnosis receive appropriate cholesterol and diabetes screening and management.
- We are participating in project 3ai, Model 2 (reverse BH integration) through which primary care providers are embedded within BH practices to engage patients with SMI in preventive care.
    - We will develop and share materials and best practices to ensure that EBG are implemented within these collocated practices
    - The case below exemplifies successful engagement of a patient with SMI in chronic disease management by the NP at a new Model 2 BH Integration pilot site participating in the MAX series.

The patient was previously reluctant to engage with a new "unknown" medical provider and past medical providers were uncomfortable providing care because of the patient's aggressive posturing.

The primary care nurse practitioner embedded within the BH facility became a familiar face and the patient felt comfortable with her measuring his blood pressure. The NP PCP discovered that it was high enough to warrant hospitalization. The NP worked with the patient's care manager who accompanied him to subsequent appointments and assisted him in filling and taking his medication. Several weeks later the patient's blood pressure was better controlled and he felt comfortable enough to attend appointments himself.

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

With Phase 2 contracting well underway and clinical projects kicking off, the full impact to populations is still being assessed. However, through collaborative efforts, a solid plan has been developed to address community needs, combat health disparities, and the gaps in service originally referenced in our application and project implementation plans.

MHVC project workgroups keep these issues at the forefront of their work to create and implement each project. Initial plans for this work began with the formal creation of the CCHL (Cultural Competency & Health Literacy) Strategy which was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners.

Using the assessment and evaluative findings the MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners. In March, 2016, we modified our CCHL Strategy to include Key Factors to Improve Access to Quality Healthcare. Further, projects have begun to be actively implemented and rolled out to partners.

MHVC is responsible for implementing organization-wide and project specific activities to ensure cultural competency and health literacy remain priorities at each level of care delivery (e.g. from the partners to clerical staff). The following are current, on-going and/or planned activities that are key factors to improving access to quality healthcare and address social determinants of health.

Cross Cutting/MHVC Wide Initiatives to Improve Patient Access to Care

1. Engaging partners to work together by conducting individual site visits and regional meetings. The purpose of these meetings is to learn about available services, linkages between partners, and needs assessment. These meetings are opportunities to provide education and resources regarding best practices for improving access to care.
2. Inviting members of the CCHL workgroup (who are also members of clinical project workgroups) to attend and take part in ongoing project implementation planning as well as development of specific tasks (more details listed below).
3. Providing patients with additional means of transportation to ensure they can reach healthcare partners.
4. Opening additional primary and behavioral healthcare services in areas with gaps.
5. Using telemedicine to provide primary, preventive and behavioral healthcare services to areas with gaps.
6. Expanding hours of service and open access scheduling to make scheduling easier and more readily available.
7. Co-locating services to create “one-stop-shops” for patients to receive their behavioral and primary care needs (through the Integrated Primary and Behavioral Health (3.a.i.) and Medical Village (2.a.iv) projects).
8. Doing Outreach to community based organizations, schools, and other non-healthcare settings to make information more accessible to the community through public health campaigns.
9. Creating pathways for communication and sharing of patient information between different services partners to promote integrated and seamless delivery of care.
10. Training in structural competency for staff involved with patient care (Structural competency material can be found in the Resource Repository).

Programmatic outcomes and practice transformation initiatives will be assessed through use of the Plan, Do, Study, Act (PDSA) model of process improvement to test changes and assess their impact on patient engagement and outcomes. This model is also being used to aid in the development of health literate educational materials for patients and staff.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Montefiore Medical Center

Project: 3.d.iii

Challenges the PPS has encountered in project implementation:

Challenges the Montefiore Hudson Valley Collaborative (MHVC) has encountered and planned mitigation strategies related to implementation of the Asthma Management project fall into several categories as outlined below:

Financial Sustainability

1. Coverage for Self-Management Support Services and Medications

- **Limited Medicaid MCO Coverage of CBO Services**: Community based organizations (CBOs) perform essential environmental assessments for asthma triggers and provide educational and self-management services to patients with chronic diseases. Medicaid Managed Care Organizations (MCOs) have varying coverage policies for Home Health services and other community based resources. Identifying mechanisms to value the essential role CBOs and providers in the region who provide services such as the Stanford Self-Management Support Program can potentially play in population health management is a foundational DSRIP goal.

- **Prescription Limits for asthma inhalers**: Members face a challenge in obtaining appropriate medication supplies. For instance, patients may need multiple inhalers in a given month: one for home and another for school. Unfortunately, many MCOs only cover a single inhaler per prescription per month.

Mitigation: We are developing case based business models to support the value of alternative payment models for these services and will work with other PPS's and the State DOH to determine an appropriate statewide strategy, as needed. Partner participation in Value Based Payment (VBP) arrangements will further support short and long term financial health for participating providers. For more information on MHVC VBP planning see the organizational narrative and 2.a.i. project narrative.

Access to Care

2. Access to Specialty Care: One of the prominent challenges Medicaid beneficiaries face in the Hudson Valley is access to providers, particularly specialists.

Mitigation: Our MHVC Clinical team has been working closely with our workforce and IT workstreams to understand and address this barrier. Together we are analyzing our network and identifying needs for specialists. We are exploring creative solutions to placing specialists within our primary care sites (Asthma, Cardiovascular and Behavioral Health specialists) possibly through the incorporation of telemedicine. A telemedicine strategy will leverage existing best practices from prominent organizations, such as the International Society for Telemedicine and e-Health and the American Telemedicine Association, and follow developing State legal and regulatory parameters. Additionally, we plan to utilize alternative roles to increase access (i.e. Nurse Practitioners and Physician Assistants). MHVC will also engage providers and MCOs to address notable barriers, including remote provider hospital privileges and MCO reimbursement policies with telemedicine providers.

3. **Delay in the receipt of claims data**

Claims data became available June 2, 2016 and the recent date of release of this data remains an important limitation to MHVC's ability to implement projects. In addition, the data has a lag of 12+ months, limiting the use for clinical purposes. The lag means that by the time MHVC or partners receive that data the time period for impacting the metric has ended. Therefore, the data

rimarily can be used for reporting to providers on their prior year performance. In addition, while the data is now available, and is being utilized, there is a time of approximately three months of testing, validation and understanding the data feed in order to develop usable claims based data. In addition, security requirements add a layer of complexity to MHVC's ability to share information both internally and with partners.

Mitigation: The claims data validation and preliminary analysis of the claims data distributed in June 2016 is progressing. We are in the process of developing initial cuts of data for key metrics and validating those counts against either Salient or MAPP. We are using substitutes for the redacted cost data that most claims data includes, but the DOH claims data does not yet include. We have two additional mitigation strategies for analyzing clinically relevant data: 1) the MAPP snapshot tool provides very recent data and is used to track key metrics by provider and patient with an opportunity to intervene to improve outcomes and 2) Montefiore is exploring the opportunity to work with data vendors that will utilize provider data as the primary source of data and this would virtually eliminate the issue of claims lag and permit MHVC to communicate information that can improve patient outcomes to providers on a real time basis.

IT Challenges

4. Attaining PCMH will be difficult for providers without EHRs:
Attainment of 2014 standards of PCMH level 3 and meeting MU requirements are foundational requirements for practices participating in this project. We have identified practices that wish to participate in this project that may be unable to meet the EHR requirements in early years.

Mitigation: We have partnered with the Primary Care Development Corporation (PCDC) to implement our PCMH strategy. They are in the field assessing practices readiness for transformation and bucketing practices according to their readiness level. Those practices without EHR's fall into a low readiness bucket. We have developed a strategy to offer these practices access to a low cost EHR, Medgen that meets meaningful use stage 2 requirements. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative.

5. Electronic Health Record Integration: MHVC is assisting eligible partners to become PCMH Level 3 certified by March 2018. This project requires PCMH partners and partners with electronic health records (EHR) to imbed evidence based guidelines (EBGs) and project-specific patient alerts, such as the need for an AAP, into their systems. This requires significant IT resources and provider education for many of our partners

Mitigation: To most efficiently and effectively support our partners, MHVC is both engaging its IT Subcommittee and contracting with a vendor to conduct readiness assessment. For more information on MHVC IT planning see the organizational narrative and 2.a.i. project narrative.

6. Tracking Asthma Action Plans in EHRs: Currently many electronic health records do not have the capacity to track self-management goals or asthma action plans in EHR's. These since these goals and plans are often added as free-text. Without this functionality, it is impossible to query the system to obtain a report and more vitally, it is hard for providers to see what goals patients committed to on previous appointments and follow-up on them.

Mitigation: Some partners have created this functionality within their systems and we will leverage their experience to guide the development of practical IT solutions for partner organizations. At the same time we are encouraging providers to collect information on asthma action plans manually as a temporary, labor intensive work around. More elegant solutions are needed.

Training Challenges:

7. Staff Training in Evidence Based Guidelines: We need to ensure that clinicians and staff are adequately trained on evidence-based strategies for asthma diagnosis and management.

Mitigation: We have been working closely with our workforce work stream to collaboratively determine training needs and develop a training strategy which will leverage expertise and resources within our PPS. For more information on MHVC Workforce strategy see the organizational narrative and 2.a.i. project narrative.

8. Staff Training in Self-Management Support Communication Skills

Successful implementation of this project is in large part contingent on the ability to develop a workforce skilled in self-management support skills. A large number of staff will need to be trained to have competency in self-management support strategies, motivational interviewing, and strategies to improve health literacy and shared decision making.

Mitigation: MHVC is committed to developing staff skills in Self-Management Support principles including Brief Action Planning (BAP) for patient centered goal setting, and Motivational Interviewing. Using a Train-the-trainer model we aim to develop a highly skilled group of trainers embedded within our partner organizations. This will enable organizations to train their staff and clinicians within their organizations on an ongoing basis. To this end, we have contracted with the Centre for Collaboration, Motivation and Innovation (www.CentreCMI.ca) to administer two Train-the-Trainer programs (Brief Action Planning, Motivational Interviewing) thereby building capacity and skills across our network partners. These trainers will then be able to train staff and clinicians within their organizations using the Centre's curriculum. For more information on MHVC Workforce strategy see the organizational narrative and 2.a.i. project narrative.

9. **Risk that partner organizations, MCOs and Health Homes may be too overwhelmed, understaffed, or uninterested to partner with us on this project**. We will need to find ways to work with other PPSs to reduce the burden of implementation on partners so they can fully engage and support this project.

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5. The network will add key quality improvements to VBP clinical guidelines in order to demonstrate the value of these interventions.

10. **Unwanted variation in implementation across partners (although some local adaptation will be encouraged to ensure the projects meet the needs of the communities and are culturally/linguistically appropriate**).

Mitigation: To address this, we will need to build local capacity in each region to assess implementation fidelity. Further, our partner support team will work with various partners to periodically conduct gap assessments using a standard instrument, to better detect inappropriate variation. We will also leverage the NYS Regional Asthma Coalition to assist with the implementation of consistent evidence based guidelines and protocols.

Efforts to mitigate challenges identified above:

Please see mitigation strategies as outlined above.

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Implementation approaches that the PPS considers a best practice:

Best Practices (Details below)

- Incorporating partner feedback into project design
- Aligning the project with other projects and quality improvement work to ease implementation burden
- Partner Engagement Strategies
- Identifying Effective Asthma Management Models
- Development of a Best Practice Universal Asthma Action Plan template
- Process Mapping to Inform development of partner contracting milestones
- Toolkits
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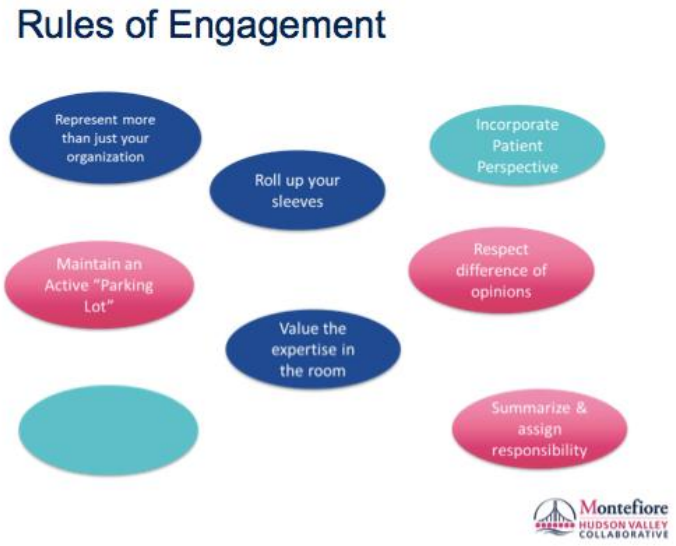

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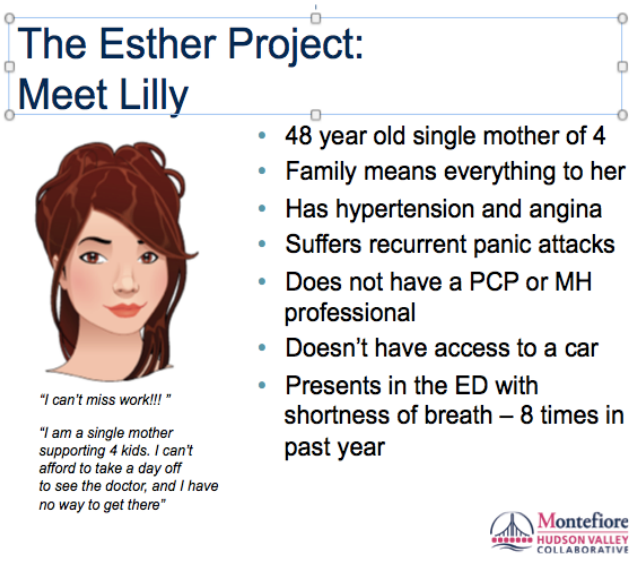

Identifying Effective Asthma Management Models: MHVC evaluated existing high-performing asthma management programs to learn from as we commence asthma engagement activities. The Hudson Valley Asthma Coalition (HVAC) offers a successful model to reduce asthma morbidity and mortality, enhance the quality of life for individuals with asthma, and reduce ED visits and hospitalizations. MHVC's workforce team is leveraging HVAC's expertise to execute asthma-specific trainings for partners on integrating EBGs into day-to-day patient engagement.

Development of a Best Practice Universal Asthma Action Plan template

MHVC's asthma workgroup is comprised of passionate and driven stakeholders. This group offers a valuable and diverse perspective on asthma treatment. The Universal Asthma Action Plan (AAP) was created as a best practice for MHVC network partners participating in project 3diii; Together, though a robust collaborative engagement effort, the workgroup:

- carefully reviewed and analyzed existing asthma guidance and AAPs

endorsed ideal elements to include in the Universal AAP

- agree upon a more user-friendly and visual AAP (for adult and pediatric patients alike)

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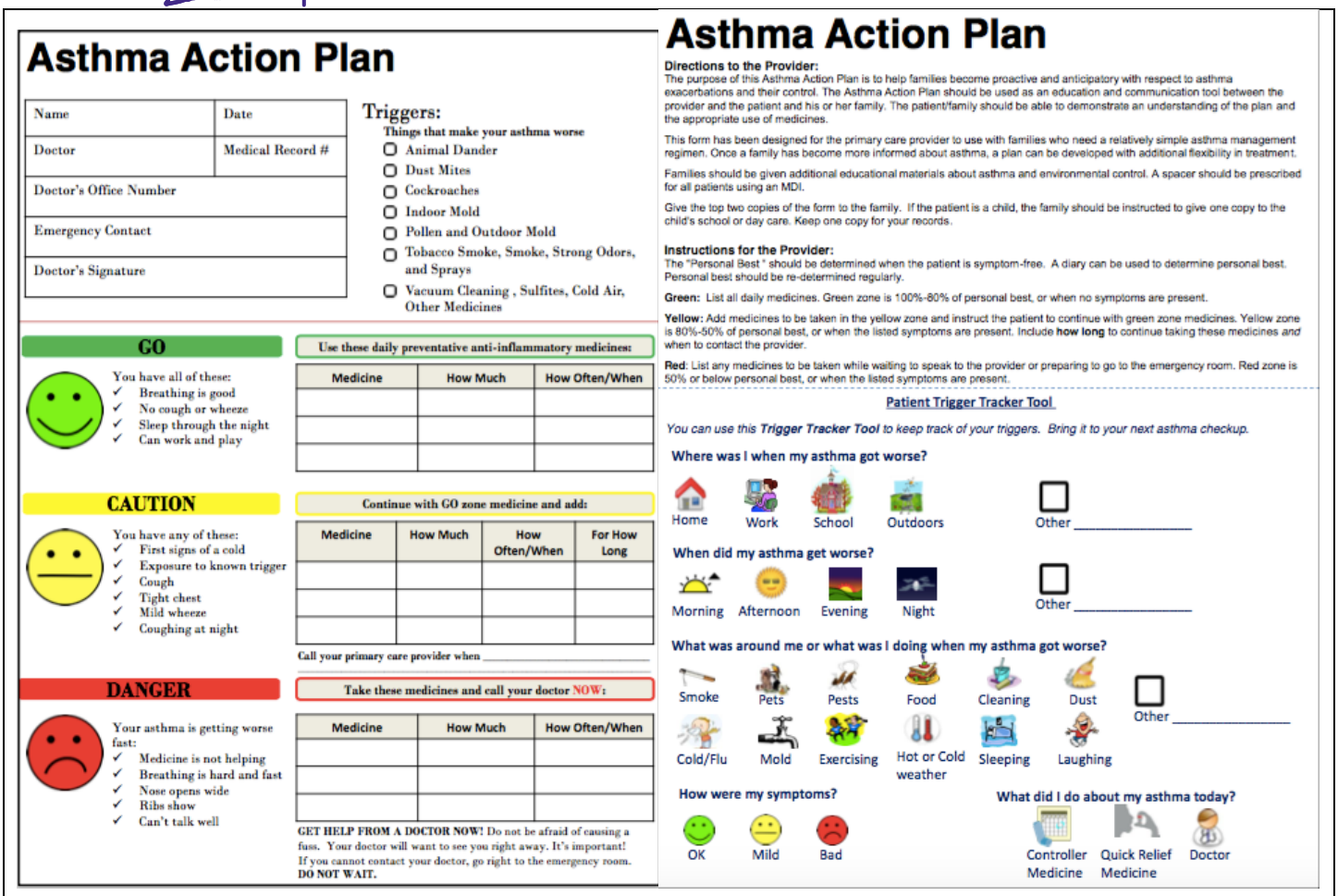


Asthma Action Plan

Name	Date
Doctor	Medical Record #
Doctor's Office Number	
Emergency Contact	
Doctor's Signature	

Triggers:
Things that make your asthma worse
- ☐ Animal Dander
- ☐ Dust Mites
- ☐ Cockroaches
- ☐ Indoor Mold
- ☐ Pollen and Outdoor Mold
- ☐ Tobacco Smoke, Smoke, Strong Odors, and Sprays
- ☐ Vacuum Cleaning , Sulfites, Cold Air, Other Medicines

GO

You have all of these:
- ✓ Breathing is good
- ✓ No cough or wheeze
- ✓ Sleep through the night
- ✓ Can work and play

Use these daily preventative anti-inflammatory medicines:

Medicine	How Much	How Often/When

CAUTION

You have any of these:
- ✓ First signs of a cold
- ✓ Exposure to known trigger
- ✓ Cough
- ✓ Tight chest
- ✓ Mild wheeze
- ✓ Coughing at night

Continue with GO zone medicine and add:

Medicine	How Much	How Often/When	For How Long

Call your primary care provider when _____

DANGER

Your asthma is getting worse fast:
- ✓ Medicine is not helping
- ✓ Breathing is hard and fast
- ✓ Nose opens wide
- ✓ Ribs show
- ✓ Can't talk well

Take these medicines and call your doctor NOW:

Medicine	How Much	How Often/When

GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go right to the emergency room. **DO NOT WAIT.**

Asthma Action Plan

Directions to the Provider:
The purpose of this Asthma Action Plan is to help families become proactive and anticipatory with respect to asthma exacerbations and their control. The Asthma Action Plan should be used as an education and communication tool between the provider and the patient and his or her family. The patient/family should be able to demonstrate an understanding of the plan and the appropriate use of medicines.

This form has been designed for the primary care provider to use with families who need a relatively simple asthma management regimen. Once a family has become more informed about asthma, a plan can be developed with additional flexibility in treatment.

Families should be given additional educational materials about asthma and environmental control. A spacer should be prescribed for all patients using an MDI.

Give the top two copies of the form to the family. If the patient is a child, the family should be instructed to give one copy to the child's school or day care. Keep one copy for your records.

Instructions for the Provider:
The "Personal Best " should be determined when the patient is symptom-free. A diary can be used to determine personal best. Personal best should be re-determined regularly.

Green: List all daily medicines. Green zone is 100%-80% of personal best, or when no symptoms are present.

Yellow: Add medicines to be taken in the yellow zone and instruct the patient to continue with green zone medicines. Yellow zone is 80%-50% of personal best, or when the listed symptoms are present. Include **how long** to continue taking these medicines *and* when to contact the provider.

Red: List any medicines to be taken while waiting to speak to the provider or preparing to go to the emergency room. Red zone is 50% or below personal best, or when the listed symptoms are present.

Patient Trigger Tracker Tool

*You can use this **Trigger Tracker Tool** to keep track of your triggers. Bring it to your next asthma checkup.*

Where was I when my asthma got worse?
Home | Work | School | Outdoors | ☐ Other _____

When did my asthma get worse?
Morning | Afternoon | Evening | Night | ☐ Other _____

What was around me or what was I doing when my asthma got worse?
Smoke | Pets | Pests | Food | Cleaning | Dust | ☐ Other _____
Cold/Flu | Mold | Exercising | Hot or Cold weather | Sleeping | Laughing

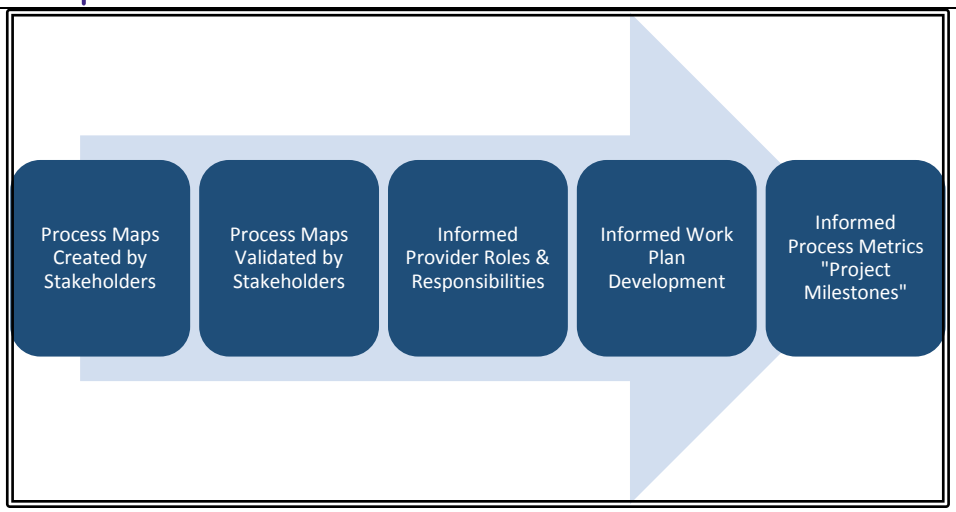
How were my symptoms?
OK | Mild | Bad

What did I do about my asthma today?
Controller Medicine | Quick Relief Medicine | Doctor

Process Maps Informed MHVCs Project Design and Contracting Model:

MHVC engaged diverse stakeholders and facilitated a collaborative activity to create a series of process maps illustrating the patient journey through the care continuum for each project. Swim lane diagrams highlight the roles and responsibilities attributed to each provider type involved. The process maps note linkages between different provider types and points of intersection with other clinical projects.

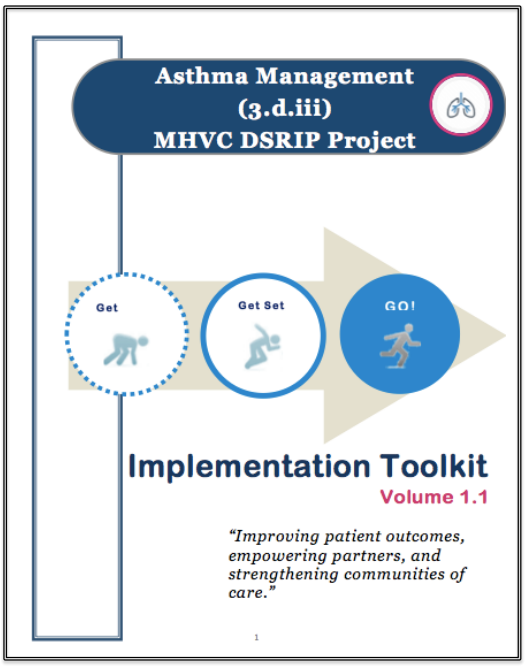
After validating these process maps by diverse stakeholders in the field, they were used to inform the development of project specific roles and responsibilities as well as a project work plan. In turn these materials guided the development of foundational process metrics that will help move our projects forward. These process metrics ("Project Milestones") are project and provider type specific and form the foundation of MHVC's dynamic contracting strategy. We will continue to use this model, creating project milestones in six-month cycles, to ensure active feedback on project success and provide opportunities to realign our approach as necessary.



Toolkit Development:

In support of Phase II Contracting, MHVC developed webinars on each project, outlining the partner implementation milestones and introducing the forthcoming project toolkit. The **project toolkits**, detail on a granular level what partners must do to satisfy milestones, lay the groundwork for successful project implementation, and receive compensation.

MHVC developed a series of dynamic interactive Project Toolkits to support partners in their implementation journey. The toolkits are living documents that are constantly growing and will mature as partners contribute best practices, workflows, evidence-based guidelines, policies and procedures, training resources and materials, and share successful quality improvement Plan/Do/Study/Act (PDSA) plans. The toolkits will help partners identify appropriate project team members, complete readiness assessments, develop project plans, and collect baseline and follow up data to support quality improvement efforts.



Aligning Clinical, Workforce and IT work streams

Recognizing the importance of collaboration between workstreams, our MHVC Clinical team has worked closely with our workforce and IT workstream counterparts to ensure a unified approach to project planning and implementation. Our Medical Director and Directors of Workforce and IT have participated in subcommittee meetings from the other workstreams as subject matter experts to ensure that subcommittee members of each workstream are kept updated about areas where collaboration across workstreams will improve efficiencies and outcomes. In addition we have internal and external workgroups that cross workstreams including:

- MHVC Population Health Workgroup
- MHVC Strategic Reporting, Planning and Oversight Workgroup Meeting
- Cultural Competency and Health Literacy Workgroup
- MHVC High Performance Metrics Workgroup
- Analytics Workgroup
- IDS Workgroup
- Workforce Training Workgroup
- Workforce Communication and Engagement Workgroup

CBO's and organizations that serve people with developmental disabilities represented on project workgroups

Vast opportunities for self-management support exist in the community. While patients may see a doctor three times a year, they may go to church every Sunday and may visit a food pantry in a community center weekly. Recognizing that CBO's offer evidence based Self-Management Support programs (The Stanford Model, Asthma Educators, and peer programing) that provide an important way to engage patients with chronic disease within their communities, as well as community based services ability to address the social determinants of health, MHVC expanded workgroup representation to include CBOs. Along the same lines, we included representation from organizations that serve people with developmental disabilities and/or mental illness to ensure that the voice of patients that fall into these populations are represented on our workgroups.

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

Innovative App to Support Asthma Self-Management

MHVC is partnering with the Montefiore Medical Center Asthma Clinic's Dr. Sunit Jariwala to integrate new, Montefiore-designed mobile technology (currently for iPads) into patient education efforts. **This mobile application, known as the Algorithmic Software Tool to Help Manage Asthma (ASTHMA)-Educator, is an application for providers and patients to learn about the asthma triggers in a patient's home or environment.** The ASTHMA-Educator aims to address the problems of critical time constraints and deliver asthma education in the primary care, ED, and specialty clinic settings. By fall 2016, Dr. Jariwala hopes to make the ASTHMA-Educator available to patients on their mobile phones (IOS and Android smartphones) so they may also use it in their home settings. In addition to focusing on education awareness, the ASTHMA-Education will include real-time alerts, such as asthma-triggering weather conditions. Furthermore, although currently designed for only English-speaking adult patients, the ASTHMA-Educator will target pediatric and Spanish-speaking patients as well.

Workgroup Selection Process

MHVC kicked off its projects by soliciting nominations from partners for participation in our **clinical workgroups**. From the nominations, MHVC underwent a rigorous evaluation and selection process to ensure representation across a range of provider types, geographical representation, and CBOs located throughout our region.

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

With Phase 2 contracting well underway and clinical projects kicking off, the full impact to populations is still being assessed. However, through collaborative efforts, a solid plan has been developed to address community needs, combat health disparities, and the gaps in service originally referenced in our application and project implementation plans.

MHVC project workgroups keep these issues at the forefront of their work to create and implement each project. Initial plans for this work began with the formal creation of the CCHL (Cultural Competency & Health Literacy) Strategy which was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners.

Using the assessment and evaluative findings the MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners. In March, 2016, we modified our CCHL Strategy to include Key Factors to Improve Access to Quality Healthcare. Further, projects have begun to be actively implemented and rolled out to partners.

MHVC is responsible for implementing organization-wide and project specific activities to ensure cultural competency and health literacy remain priorities at each level of care delivery (e.g. from the partners to clerical staff). The following are current, on-going and/or planned activities that are key factors to improving access to quality healthcare and address social determinants of health.

Cross Cutting/MHVC Wide Initiatives to Improve Patient Access to Care

1. Engaging partners to work together by conducting individual site visits and regional meetings. The purpose of these meetings is to learn about available services, linkages between partners, and needs assessment. These meetings are opportunities to provide education and resources regarding best practices for improving access to care.
2. Inviting members of the CCHL workgroup (who are also members of clinical project workgroups) to attend and take part in ongoing project implementation planning as well as development of specific tasks (more details listed below).
3. Providing patients with additional means of transportation to ensure they can reach healthcare partners.
4. Opening additional primary and behavioral healthcare services in areas with gaps.
5. Using telemedicine to provide primary, preventive and behavioral healthcare services to areas with gaps.
6. Expanding hours of service and open access scheduling to make scheduling easier and more readily available.
7. Co-locating services to create “one-stop-shops” for patients to receive their behavioral and primary care needs (through the Integrated Primary and Behavioral Health (3.a.i.) and Medical Village (2.a.iv) projects).
8. Doing Outreach to community based organizations, schools, and other non-healthcare settings to make information more accessible to the community through public health campaigns.
9. Creating pathways for communication and sharing of patient information between different services partners to promote integrated and seamless delivery of care.
10. Training in structural competency for staff involved with patient care (Structural competency material can be found in the Resource Repository).

Programmatic outcomes and practice transformation initiatives will be assessed through use of the Plan, Do, Study, Act (PDSA) model of process improvement to test changes and assess their impact on patient engagement and outcomes. This model is also being used to aid in the development of health literate educational materials for patients and staff.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Montefiore Hudson Valley Collaborative

Project: 4bi Tobacco Cessation

Challenges the PPS has encountered in project implementation:

Challenges we have encountered and planned mitigation strategies related to implementation of the 4bi Tobacco Cessation Public Health Project fall into several categories as outlined below:

Evidence Based Guidelines

Implementing the 5A's (Ask, Advise, Access, Assist, Arrange) –Although this is a project requirement, consensus was not reached by the **Hudson Region DSRIP Public Health Council** (PHC) that the 5A's were the only or best approach to engaging patients around tobacco cessation. Motivational Interviewing is another evidence-based approach to working with patients toward Tobacco Cessation that identifies a person's readiness to change as the trigger for goal setting around a change plan. The spirit of Motivational Interviewing emphasizes the importance of accepting a patient where they are, which means respecting their autonomy if they are not ready or willing to quit smoking. This is counter to the 5A's strategy which emphasizes the need to "advise" every patient to quit regardless of readiness.

Mitigation: Partners and Community Stakeholders will conduct a review of literature and ensure consensus that more than one Evidence Based approach is acceptable

IT Challenges: Quit Line Referrals and Implementing the 5A's into EMR

Quitline Referrals: Interfaces with the NYS Quitline are not available for every practice: operational, technical and cost barriers exist.

Mitigation: Each participating practice to review best mode of connecting patients to resources, including NYS Quitline. Whenever possible, automated referral to NYS Quitline through EHR is preferred. We are working closely with the Quitline to share data that will help us capture the impact of our population health strategies

EMR Variation: Implementing the 5A's

The large variance in EMRs, clinical workflows, and reporting capabilities among partners has created challenges in implementing all the goals of the project. Identifying all partner sites and existing policies of those sites has also been a challenge

Mitigation: Partnership with Center of Excellence for Health Systems Improvement has allowed us to leverage the work they are doing on 5A's in EMRs. PDSA's targeting workflows among the Public Health Council members have helped align workflows and share best practices. A partner survey conducted by the Public Health Council has helped identify partner locations and existing campus policies.

Finance, Sustainability and Resource Challenges:

MCO Coverage and reimbursement for Smoking Cessation therapies: There are differences between MCO's in their coverage patterns for various tobacco cessation medications. This is confusing for providers and patients who often shift between MCOs for medical coverage.

Mitigation: Advocacy efforts focused on increasing cessation treatment coverage and reimbursement

OTC Prescriptions require Rx for MCOs to cover benefit: The MCO requirement that OTC nicotine replacement products require a prescription in order for patients to use this benefit is confusing for patients and doctors. Doctors who are not aware of this

requirement often feel uncomfortable writing Rx for OTC medications. This occasionally results in ping pong game where patient are send back and forth to their doctors to ask for the OTC prescription.

Mitigation: There is a need for physician education. We are working with our CBO and LGU partners and state resources including the Center of Excellence for Health Systems Improvement state contractors to identify best practices and resources to educate and engage physicians. The PPSs are also guiding partner PDSAs around this challenge to identify best practices for physician education and tracking.

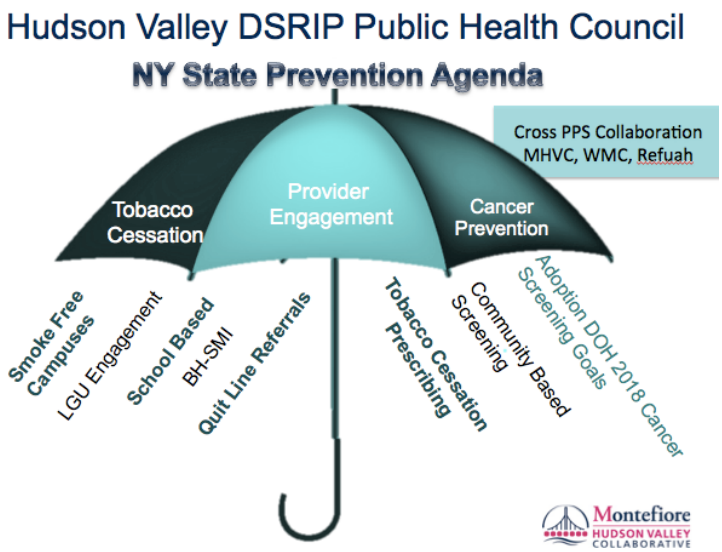
Efforts to mitigate challenges identified above:

Please see mitigation strategies as outlined above.

Implementation approaches that the PPS considers a best practice:

Cross PPS Collaboration, CBO and Provider Engagement:
Creation of the Public Health Council

The **Hudson Region DSRIP Public Health Council (HRD-PHC)** represents a collaborative effort between the three Hudson Valley PPSs (Montefiore Hudson Valley Collaborative, Westchester Medical Center PPS, and Refuah Community Health Collaborative) to develop an infrastructure to engage our partners around our Domain 4 Public Health initiatives.



The Goals of the HVD-PHC include:

- Decrease tobacco use in target populations of focus identified in our CNA (youth and people with SMI)
  - We know that 23% of smoking diagnoses are for members below the age of 30.
- Increase delivery of high quality cancer screening prevention and management services
- Create linkages to connect patients to community preventative resources throughout the Hudson Valley region.
- Share best practices, align on initiatives and identify gaps in patient and provider engagement.

HRD- PHC Membership includes representation from the 3PPSs and multiple stakeholder groups including:

- Behavioral and Mental health providers,
- Primary care providers, FQHCs,

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- LGUs and
- Other community agencies (*See document A,B, and C*)

Background

Despite huge improvements in smoking cessation state-wide in recent years, smoking continues to be a prevalent issue in the Hudson Valley with percentage rates of adults who smoke ranging from 9.7% in Rockland County up to 28.9% in Sullivan County. Rates have not declined among young adults, adults with low-socioeconomic status, adults with poor mental health, and adults with co-morbid behavioral health conditions: our core clients. By reason of these circumstances, the council has committed to addressing the many gaps that have led to these disparities.

Best Practices and Summary of Efforts-to-Date

In DSRIP year one, emphasis was on building the infrastructure of the council, fostering the spirit of collaboration among varying stakeholders across the Hudson Valley, and aligning on goals and efforts by sharing best practices and resources.

Quitline Engagement

Establishing a baseline for smoking rates and overall Quitline usage across the Hudson Valley.

- Regional analysis of data shared by New York State Smokers Quitline completed
- Results shared with PHC members and local government organizations at an August Hudson Valley Health Regional Officers Network (HVHRON) meeting. (*See document D*)
- Analysis identified that 28.53% of patients that contacted the Quitline were age 34 and younger.
    - The council recognized that an opportunity to target interventions towards the casual and young smokers. See below:

Targeted Ad Campaigns

An advertising campaign targeted to teens and their caregivers, to inform them of the harmful effects of the newly popular electronic smoking devices was launched.

- **Collaborative effort between the 3 PPSs** and **Student Assistant Services Corporation** (a community based organization focused on substance abuse prevention in schools and communities)
    - Campaign targeted
        - approximately 116,860 students attending 137 public high schools and middle schools in the eight county region and their parents
    - Ads were disseminated to different school districts across the Hudson Valley region. (*See document E*).
        - Local CBOs in each county were engaged by SAS to aid ad dissemination efforts
    - Ads can be downloaded freely for use in other regions and to support other initiatives in multiple formats from the HRD-PHC website.

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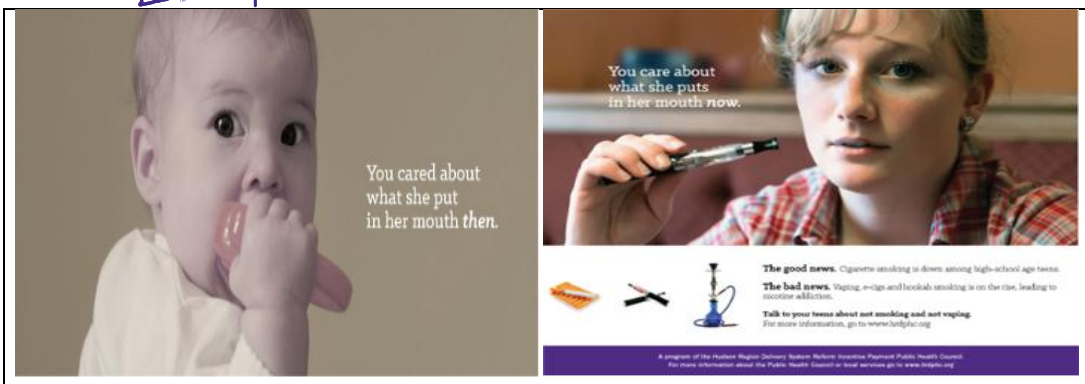

- The Council recognized that the social use of these smoking devices among teens is rising rapidly.
  - Teens are misinformed about the harmful effects these devices have in relation to combustible cigarettes.
  - Parents lack information about these devices including: their appearance, and the negative implications that they have on their children's health.

- **Phased Campaign Strategy:**
  - **Great American Smoke Out** -Fall 2015
  - **Kick Butts** -Spring 2016
  - **Great American Smoke Out** - Fall 2016

Provider Education

Background:
Salient data received in DY1, identified that while 77.9% of patients with a tobacco use diagnoses code have a primary care visit, only 22.5% of those patients receive cessation interventions.

> *Evidence supports that although behavioral health providers believe that helping patients stop smoking is part of the role of mental health professionals (90% of psychiatrists and psychiatric nurse practitioners) and 80% usually ask about smoking status, they are less likely to actually recommend nicotine replacement therapy (34%) and prescribe cessation medications to smokers (29%). In fact only 12% felt well prepared from prior education to treat tobacco.*

These findings represent a gap in care and an opportunity to increase the use of cessation counseling and treatment through provider education.

In addressing our milestone four commitment as it relates to developing a region-wide provider training, the council is working to develop a tobacco cessation intervention training plan, where we will be collaborating with community based organizations such as the Center for a Tobacco Free Hudson Valley to deploy the training.

With the intention of aligning our training strategy with findings from our Community Needs Assessment, we intend to target training resources to providers who care for patients from neighborhoods with higher than expected respiratory illness. To this end we are deploying a targeted partner survey in these zip codes to assess Quitline engagement, smoke free grounds policies, current tobacco cessation treatment methodologies to understand existing workflows and aptitude to ramp up cessation interventions, and training capacity. (*See document F*).

Rapid Cycle Improvement Interventions: PDSA Cycles of Change

The PDSA model will enhance partners' ability to track outcome measures which are the pathway to participation in value-based arrangements.

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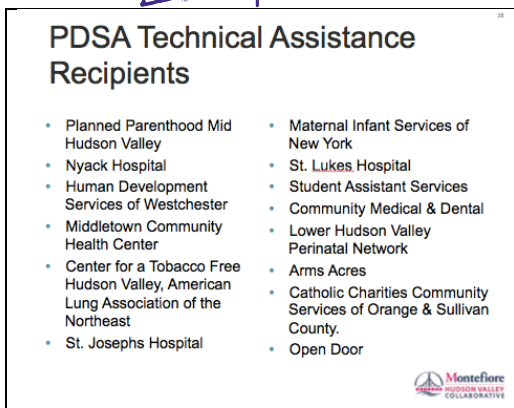

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

- PDSA work at Planned Parenthood around referrals to the Quitline
- Working with the NYS Quitline to obtain reports and referral data to share with partners.
- Created subgroups of the public health council to discuss specific populations such as behavioral health.
- Dr. Damara Gutnick, our MHVC medical director, was invited to sit on the Advisory Board of the Center of Excellence for Health Systems Improvement for a Tobacco Free NY (COE).
- Given the alignment between the COE's mission (See below) and DSRIP program goals, Dr. Gutnick's participation has facilitated programmatic collaboration between both organizations that will support economies of scale. For example:
    - Both organizations recognize the need PDSA skills development within organizations in order to facilitate integration of evidence based guidelines into practice.
        - The COE is therefore training their regional contractors to be PDSA facilitators.
        - As this is closely aligned with MHVC efforts we are sharing materials and coordinating our work to support our HVD PHC partners in their transformation.
    - Integration of the 5A's into EMRs
        - The COE has convened a series of workgroups with FQHC representation to help facilitate the integration of the 5A's into commonly used EMRs including eCW.

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

The introduction of e-cigarettes presented a new challenge, particularly for young people: The HRD PHC therefore collaboratively developed and disseminated a campaign around anti "vaping" targeting youth.

With Phase 2 contracting well underway and clinical projects kicking off, the full impact to populations is still being assessed. However, through collaborative efforts, a solid plan has been developed to address community needs, combat health disparities, and the gaps in service originally referenced in our application and project implementation plans.

MHVC project workgroups keep these issues at the forefront of their work to create and implement each project. Initial plans for this work began with the formal creation of the CCHL (Cultural Competency & Health Literacy) Strategy which was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Montefiore Medical Center

Project: 4.b.ii Cancer

Challenges the PPS has encountered in project implementation:
Challenges the Montefiore Hudson Valley Collaborative (MHVC) has encountered and planned mitigation strategies related to implementation of the 4.b.ii Cancer Prevention project fall into several categories as outlined below: **<u>Communications platform to connect partners from 3 PPSs</u>** Our implementation plan proposed using The MiX to facilitate collaboration in the region. Though we did make an effort to enroll participants on The MiX, it did not prove to add value; committee members preferred established modes of communication. **Mitigation:** Robust committee participation from all three PPS in the Hudson Valley and from county health departments, partner provider organizations and other stakeholders through a combination of email, face-to-face and web/phone meetings. **<u>Evidence Based Guidelines</u>** Provider participants voluntarily reported on cancer screening rates and best practices to the Public Health Council, and used different methods for tracking screening rates so it was difficult to compare results. **Mitigation:** Under the leadership and guidance of the 2PPS leads, the group agreed on USPSTF protocols for cancer screening, adopted the NYS 2018 Goals and will continue to discuss best practices for how to monitor screening rates.
Efforts to mitigate challenges identified above:
Please see mitigation strategies as outlined above.

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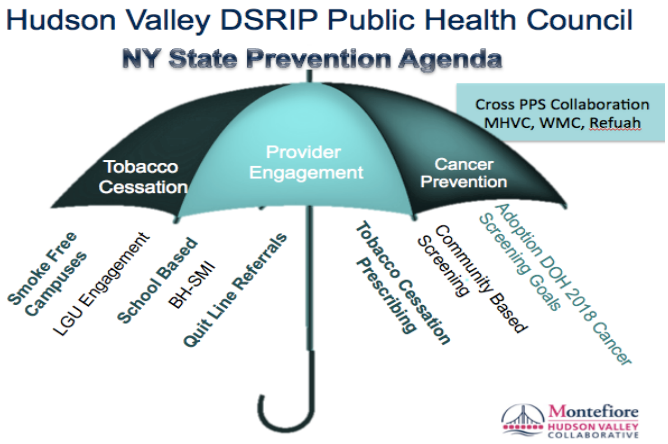
Implementation approaches that the PPS considers a best practice:

Cross PPS Collaboration, CBO and Provider Engagement:

The **Hudson Region DSRIP Public Health Council (HRD-PHC)** represents a collaborative effort between the three Hudson Valley Performing Provider Systems (PPS)-Montefiore Hudson Valley Collaborative, Westchester Medical Center PPS, and Refuah Community Health Collaborative- to develop an infrastructure to engage our partners around our Domain 4 Public Health initiatives.



The Goals of the HRD-PHC include:

- Increase delivery of high quality cancer screening prevention and management services
  - Specifically increase screening rates for cervical, breast, and colorectal cancers
    - Screening rates for these cancers are lower in the Hudson Valley than the State average
  - Enhance patient cancer screening education and empowerment
    - Twenty-five percent of members do not know where to go for cancer screening
  - Enhance provider screening protocols and adherence to timely follow-up of abnormal test results
  - Create linkages to connect patients to community preventative resources throughout the Hudson Valley region.
- Share best practices, align on initiatives and identify gaps in patient and provider engagement.
- Decrease tobacco use in target populations of focus identified in our CNA (youth and people with SMI)
  - We know that 23% of smoking diagnoses are for members below the age of 30.

HRD- PHC Membership includes representation from multiple stakeholder groups:

- Behavioral and Mental health providers
- Primary care providers, FQHCs
- LGUs, and
- Other community based organizations **Background**

Cancer is the number one cause of premature death, most notably among minority populations. Salient data revealed that the Montefiore Hudson Valley Collaborative Network has a higher rate of members with a cancer diagnosis (2.1%) than that of New York State as a whole (0.5%). Our findings conclude that it may be attributed to low screening rates and a necessity for patient and provider education. This highlights the need

to improve preventive cancer care intervention within the Hudson Valley.

Best Practices and Summary of Efforts-to-Date

In the first year of project implementation, the Cancer Prevention Workgroup focused their efforts on:

- Sharing current practices,
- Aligning on screening goals and guidelines,
    - Adoption of the NYS Prevention Agenda 2018 Goals for cervical, breast, and colorectal cancer screening.
- Launching PDSA workshops and structured PDSA coaching technical assistance.
- Building community partnerships to facilitate the adoption of available resources to help us reach the larger project goal of increasing access to high quality chronic disease prevention and management.

Low Cancer Screening Rates

With the current Hudson Valley baseline screening rates in mind, the Cancer Prevention Workgroup initiated project implementation by setting goals for the MHVC network, sharing best practices, and identifying areas for improvement:

- The Cancer Prevention Workgroup reviewed and adopted the NYS Prevention Agenda 2018 Goals for cervical, breast, and colorectal cancer screening

Cancer Type	Cervical	Breast	Colorectal
NYS Prevention Agenda 2018 Goals	88%	80.5%	80%

- Workgroup reviewed the United States Preventive Task Force (USPSTF), the American Cancer Society (ACS), and the American Congress of Obstetricians and Gynecologists' (ACOG) cancer screening guideline recommendations
- Workgroup members shared their current organizational screening guidelines and existing care models (included current workflows and follow up protocols)

Patient Education and Empowerment

The workgroup is focusing their efforts on patient education, empowerment, and advocacy through the use of community resources and care management services.

The workgroup recently invited two members from the Albert Einstein College of Medicine to present on their proven community based cancer screening initiatives. These hands-on approaches to patient education and empowerment will assist the workgroup in their future initiatives and education strategies. Presenters include:

- Bruce Rapkin, PhD Presentation: Queens Library Health Link Project – Community based approach to

improving cancer prevention and screening among underserved populations.
    - Tailored participatory programs
    - Culturally and linguistically competent patient education
    - Increased patient knowledge of the importance of early detection, awareness of free screenings, and increased the number of patients seeking cancer information
- Rosy Chhabra, PhD Presentation: Cervical Health in the Community (C.H.I.C) Project
    - Peer Driven Intervention focused on reaching and educating Latina women in the Bronx between the ages of 18-50 about HPV and the importance of cervical cancer prevention.
    - Trained participants to be peer health advocates for family and other women in their communities and social networks.

Provider Education

The Cancer Prevention Workgroup integrated targeted, dedicated cancer screening community based organizations into the Workgroup to have a continuous flow of best practice sharing and collaboration. The Cancer Prevention Workgroup also deployed a provider education workshop focused on using the Plan/Do/Study/Act (PDSA) model to increase cancer screening rates within their institutions.

- Cancer Services Program (CSP) - Shared information on Care Management Resources
- American Cancer Society (ACS) – Shared past and current initiatives, available resources, and extended invitations for future collaborations.
- PDSA Cancer Screening Workshop – Although participants differed in their current involvement with screening, (the populations they serve and opportunities for improvement) the PDSA model offers a common process that all organizations can use to introduce changes in practice and improve patient outcomes. The workshop focused on implementing the first stages of PDSA that would emphasize improving adherence to cancer screening.
    - PDSA Template used for workshop implementation – The Montefiore Hudson Valley Collaborative created a PDSA template that has been adopted and is being used to implement the council PDSA initiatives. The PDSA template has been shown across a number of forums and is also being disseminated throughout the Montefiore Hudson Valley Collaborative network.

Training on PDSA method for Quality Improvement

The PDSA model will enhance partners' ability to track outcome measures which are the pathway to participation in value-based arrangements.

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PDSA Technical Assistance Recipients

- Planned Parenthood Mid Hudson Valley
- Nyack Hospital
- Human Development Services of Westchester
- Middletown Community Health Center
- Center for a Tobacco Free Hudson Valley, American Lung Association of the Northeast
- St. Josephs Hospital
- Maternal Infant Services of New York
- St. Lukes Hospital
- Student Assistant Services
- Community Medical & Dental
- Lower Hudson Valley Perinatal Network
- Arms Acres
- Catholic Charities Community Services of Orange & Sullivan County.
- Open Door

Montefiore HUDSON VALLEY COLLABORATIVE

Practitioner and Patient Engagement:

At MHVC we strive to **engage our partners** in project implementation work **in a way that is meaningful, values and integrates their expertise and incorporates a patient-centered lens.** Below we outline several best practices that have helped us effectively engage our partners in project design and implementation and incorporating the patient voice into our work.

- **Workgroup "Rules of Engagement":** With the goal of establishing a non-competitive collaborative spirit that fosters a high degree of active participation within our project workgroups, MHVC facilitated the development of **"Rules of Engagement"** that defined the way workgroup members agreed to work together. (See Practitioner Engagement Plan Appendix).

- **Incorporating partner feedback into our work:** Because we value each partners voice related to program implementation, we routinely survey our partners after each workgroup meeting to ensure that members feel engaged. Feedback is reported back to our workgroups and Clinical Quality Subcommittee and incorporated into workgroup processes

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- I**nstilling the patient voice** into our project design using evidence based strategies including the "Esther Project" **has helped to convene and engage diverse stakeholder groups with a common goal of providing quality care** for their patients.

First implemented in Sweden, the "Esther Project" uses "patient personas" ("Esther's") for each project, co-created within our project workgroups, to challenge partners to consider the patient perspective during every aspect of project design. **By continually asking . . . *"What does Esther want?"* and *"How will this new process feel for Esther?"* diverse partner stakeholders are challenged to consider the patients perspective, needs and wants above their own organizational goals.**

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Project Design and MHVC's Contracting Model:

MHVC is utilizing a dynamic contracting strategy that is described in greater detail in other project narratives, to link funds flow to completion of process metrics ("Project Implementation Milestones" (PIMs) or contracting milestones). This innovative funds flow strategy will help move public health efforts for the Domain 4 projects forward. For example, for this contracting period (Phase 2), MHVC primary care providers, FQHCs and Specialists will be required to develop the infrastructure to report cancer screening rates.

We will continue to use this model, creating project milestones in six-month cycles, to ensure active feedback on project success.

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

- Dr. Damara Gutnick, our MHVC medical director was invited to sit on the Advisory Board of the Center of Excellence for Health Systems Improvement for a Tobacco Free NY (COE).
- Given the alignment between the COE's mission (See below) and DSRIP program goals, Dr. Gutnick's participation has facilitated programmatic collaboration between both organizations that will support economies of scale. For example:
    - Both organizations recognize the need PDSA skills development within organizations in order to facilitate integration of evidence based guidelines into practice.
        - The COE is therefore training their regional contractors to be PDSA facilitators.
        - As this is closely aligned with MHVC efforts we are sharing materials and coordinating our work to support our HVD PHC partners in their transformation.
    - Integration of the 5A's into EMRs
        - The COE has convened a series of workgroups with FQHC representation to help facilitate the integration of the 5A's into commonly used EMRs including eCW.

Center of Excellence for Health Systems Improvement for a Tobacco Free NY. (COE)

The Center promotes large-scale systems and policy changes to support the universal provision of evidence-based tobacco dependence treatment services.

- Supports 10 regional contractors throughout New York State in their work with health systems and organizations that serve those populations for which smoking prevalence rates have not decreased in recent years (adults with low income and poor mental health)
- Focus on providing capacity building assistance services around topics like:
  - How to engage and obtain buy-in from leadership to implement system-level changes that will result in the identification and intervention with every tobacco user who seeks care
  - Development of materials to support contractors in their regional work including training curriculum and patient education materials.
  - Aligning efforts to implement the 5 A's into EMRs
- Support statewide efforts to increase the percentage of healthcare provider organizations that have formally adapted and implemented systems and policies to assist smokers in quitting
- Promote a policy environment that is favorable to the universal provision of evidence-based tobacco cessation services in these settings, which will include federally qualified health centers and other safety net providers
- Convenes workgroups comprised of key membership from statewide entities and other stakeholder's organizations to inform their efforts.

Performance Monitoring and Sharing

In our DSRIP application, as it relates to performance monitoring and sharing we committed to using data for quality improvement efforts and feeding data back to providers, measuring disparities in outcomes for different cultural groups; monitor progress on reducing these disparities; and publish the results to encourage peer-pressure and best practice sharing. In order to do so, Montefiore Hudson Valley Collaborative has to establish and collect a number of baselines to understand the network's current practices and capabilities via:

- MHVC Network Assessment - One of the goals is to acquire information on current network performance monitoring and capacity to collect performance data.
- MHVC Phase 2 Cancer Screening Contracting Metrics – MHVC Network partners participating in this project will have to submit cancer rates or report project planning efforts to begin reporting rates by 3/31/2018.

Workforce Training Commitments

For more information, please review the Montefiore Hudson Valley Collaborative Workforce and Cultural Competency and Health Literacy training strategies for domain 4 projects.

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

With Phase 2 contracting well underway and clinical projects kicking off, the full impact to populations is still being assessed. However, through collaborative efforts, a solid plan has been developed to address community needs, combat health disparities, and the gaps in service originally referenced in our application and project implementation plans.

MHVC project workgroups keep these issues at the forefront of their work to create and implement each project. Initial plans for this work began with the formal creation of the CCHL (Cultural Competency & Health Literacy) Strategy which was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners.

Using the assessment and evaluative findings the MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners. In March, 2016, we modified our CCHL Strategy to include Key Factors to Improve Access to Quality Healthcare. Further, projects have begun to be actively implemented and rolled out to partners.

MHVC is responsible for implementing organization-wide and project specific activities to ensure cultural competency and health literacy remain priorities at each level of care delivery (e.g. from the partners to clerical staff). The following are current, on-going and/or planned activities that are key factors to improving access to quality healthcare and address social determinants of health.

Cross Cutting/MHVC Wide Initiatives to Improve Patient Access to Care

1. Engaging partners to work together by conducting individual site visits and regional meetings. The purpose of these meetings is to learn about available services, linkages between partners, and needs assessment. These meetings are opportunities to provide education and resources regarding best practices for improving access to care.
2. Inviting members of the CCHL workgroup (who are also members of clinical project workgroups) to attend and take part in ongoing project implementation planning as well as development of specific tasks (more details listed below).
3. Providing patients with additional means of transportation to ensure they can reach healthcare partners.
4. Opening additional primary and behavioral healthcare services in areas with gaps.
5. Using telemedicine to provide primary, preventive and behavioral healthcare services to areas with gaps.
6. Expanding hours of service and open access scheduling to make scheduling easier and more readily available.
7. Co-locating services to create “one-stop-shops” for patients to receive their behavioral and primary care needs (through the Integrated Primary and Behavioral Health (3.a.i.) and Medical Village (2.a.iv) projects).
8. Doing Outreach to community based organizations, schools, and other non-healthcare settings to make information more accessible to the community through public health campaigns.

9. Creating pathways for communication and sharing of patient information between different services partners to promote integrated and seamless delivery of care.
10. Training in structural competency for staff involved with patient care (Structural competency material can be found in the Resource Repository).

Programmatic outcomes and practice transformation initiatives will be assessed through use of the Plan, Do, Study, Act (PDSA) model of process improvement to test changes and assess their impact on patient engagement and outcomes. This model is also being used to aid in the development of health literate educational materials for patients and staff.

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

PPS Name: Montefiore Medical Center

Project: 2.a.i

Challenges the PPS has encountered in project implementation:

Today, the Montefiore Hudson Valley Collaborative (MHVC) is a partnership of more than 250 organizations representing a diverse group of stakeholders including hospitals, Federally Qualified Health Centers (FQHC) and Behavioral health organizations, to community-based organizations and public sector agencies that address the social determinants of health. Together, we are working to redesign the healthcare delivery system in the Hudson Valley, and collaboratively transform into an integrated system that seamlessly delivers the right care in the right place at the right time. Successful transformation is dependent upon strong relationships between diverse stakeholders, development of Information Technology (IT) systems that can talk to one another, and practitioners that are willing to use these shared systems to communicate, to listen and to learn from each other to collaboratively care for our Hudson Valley community.

Within this narrative, we have detailed some of the barriers and best practices we have encountered in the deployment of Project 2.a.i, the creation of an integrated delivery system (IDS).

Infrastructure Build

Challenge: Managing technology by provider type can add complexity to implementing a truly integrated IT model.
In collaboration with the MHVC IT Subcommittee a tiered assessment model has been developed to identify partner technology capabilities and identify gaps.

- A partner score is based on multiple domains to identify the appropriate level of project implementation support
- Partners are assigned to an incremental and tiered strategy based on level of IT adoption and IT readiness
- IT adoption expectations and tiered approach will vary by provider and stakeholder type

Below is a Sample Tiered Approach in Assessing Partners (Stakeholder Type: Hospitals, PCPs)

	Tier 1 High Technology	Tier 2 Moderate Technology	Tier 3 Low Technology
MU	MU Certified EHR in use, fully optimized to capture data	MU Certified EHR in use, not fully optimized to capture data	MU Certified EHR is not present or being implemented
PCMH	PCMH Level 3 certified	PCMH Level 3 accreditation underway	PCMH Level 3 accreditation cannot be achieved until EHR implemented
RHIO	Connected	Plan in place to connect within 6-9 months	Plan in place to connect within 12 months
IT Infrastructure	Strong IT infrastructure in place to support DSRIP reporting needs	Moderate IT Infrastructure in place to support DSRIP reporting needs	Poor IT Infrastructure in place to support DSRIP reporting needs
Potential Intervention and Support	Low Support to ensure success	Moderate support to ensure success	Heavy support to ensure success

MHVC will continue to work with our partners to assess current state activities, as well as identify gaps. As our clinical projects are launched, we will continue to build infrastructure to support an integrated delivery system. MHVC will also be focusing efforts to expand on our knowledge of key network CBO's IT capabilities.

Challenge: There are multiple PPS leads in the Hudson Valley and one QE, HealthlinkNY.

Mitigation Best Practice: MHVC has been working collaboratively with our QE, HealthlinkNY. The collective goal is to evaluate the current state of RHIO adoption in the Hudson Valley. There is also a strong focus on discussing the scope of services that the QE may provide to support MHVC deliverables, population health management and facilitating a plan to prioritize partner adoption as well as appropriately defining how each provider type should be connected. The existence of a sole QE also allows MHVC to focus on engagement and partner connectivity with that RHIO.

Challenge: There are a large number of partners utilizing paper-based records.

Mitigation Best Practice: MHVC is working with provider groups that have no EHR in place to promote EHR adoption through the use of a vetted solution currently in place for Montefiore's community physician groups that are members of the Montefiore ACO. That system is called Medgen. Medgen is a certified MU Stage 2 EHR. All quality and HCC prompts and data capture elements have been implemented. This solution is low cost and can be implemented in as little as two weeks of signing a contract.

Challenge: Data Security Measures may not be in place or the proposed requirements might be beyond the capabilities of the partner.

Mitigation:

- MHVC executed Business Associate Agreements with contracted partners as part of our Cooperating Provider Agreement which enable the exchange of PHI
- MHVC has created a secure infrastructure to receive PHI from our partners – Secure FTP
- MHVC has provided detail to its partners on core data elements needed and has only asked for required data for collection across projects and project specific fields for speed and scale reporting

At the same time, to support MHVC's clinical integration efforts, care transition projects and management of care plans; data will need to be securely exchanged between members' care providers. Since there are no national standards for the exchange of care management data, MHVC and its partners will define a MHVC Care Management Data Interface Specification that will be used to create and exchange files of data extracted from partner care management systems.

MHVC has worked with GNYHA to:

- Identify and recommend set of core care plan data elements
- Recommend nomenclature and structural conventions for care plan organization
- Develop guidelines for supplemental care plan data elements and applications

We plan to utilize QE functionality for Care Plan exchange. This can be achieved through direct messaging; QE secure messaging and care plan upload as a static document or structured data/CCDA to the QE.

Clinical Interoperability (EHRs):

Challenge: Currently many electronic health records do not have the capacity to track self-management goals, Asthma actions plans or Care Plans in the EHR since these activities are often added as free-text. Without this function, it is impossible to query the system to obtain a report and more vitally, it is hard for providers to see what goals patients committed to on previous appointments and follow-up on them. Additionally since there is no standardized template or format, many partners have varied interpretations on what core data elements should be included, and therefore the ability to share this data across systems is hindered.

Mitigation: Some MHVC partners have created functionality within their systems and we will leverage their experience to guide the development of practical IT solutions for partner organizations. To expedite the adoption of these standards into practice and

into EHRs MHVC has created contractual metrics in our Phase II contracts that tie dollars to partner's ability to track and report these metrics.

Population Health Management
Challenge: Receipt of timely claims data and impact of opt out

Mitigation strategies include: a) Encouraging DOH for expedient delivery of the data that includes cost data, as well as consider other potential data sources to use in lieu of claims data. b) Educating PPS partners about the opt-out process so that they will be able to help educate their patients about the benefits of data sharing.

Efforts to mitigate challenges identified above:

Please see above section.

Implementation approaches that the PPS considers a best practice:

Network Development & Contracting:

MHVC has been working to stand up a DSRIP network of partners, to meet DSRIP Deliverables and to build a sustainable future state. For our Phase I contracts, distributed in November 2015, MHVC utilized the only data that we had, NYS attribution data to prioritize partners participation in the PPS. The 50 targeted partner Organizations together represented more than 90% of our attributed lives. Once identified, MHVC engaged these partners in current state assessment activities to fulfill DSRIP organizational milestones, build critical network intelligence and to build upon the future state project maps of each project.

Both contracted and non-contracted partners collaborated to support project design activities within subcommittee and workgroup settings. These same partners, with the knowledge of both the organizational and project specific milestones and tasks that had been committed to by the PPS, provided critical input in the development of MHVC's Phase II contract metrics. The metrics will not only push MHVC's success in DSRIP milestones, but will be instrumental in impacting quality outcomes, by identifying opportunities to support partners with training and "ground level support" needed to transform these practices, ie; Tracking the adoption of the PHQ-9 depression screening as outlined in project 3a.i, but additionally asking partner's to track screening yield. Low screening yield will alert MHVC Clinical staff of opportunities to engage front line staff in Motivational Interviewing, Cultural Competency or similar training to move the needle.

Inclusion of clinical, operational and financial staff in the development of contract metrics will ensure that the work and investments made within DSRIP will lead to lasting, sustainable practice transformation far beyond this project.

Even with the success of our contracting method, we also understood the limitations of attribution as the source for building a comprehensive & sustainable network – particularly as it pertains to Community Based Organizations, many of which do not bill Medicaid. To support the build of a larger, non-traditional Network, MHVC leveraged the Community Health Needs Assessment CBO Workbook to identify, visit and engage 45 CBOs during DSRIP Year 1. In addition MHVC leveraged our Network Assessments of contracted partners to begin to frame a priority CBO list, by asking partners to identify their CBO relationships to inform our CBO strategy and future phases of contracting. Details regarding our CBO strategy are articulated later in this narrative and in the organizational narrative.

In July, MHVCs Phase II Contracts were delivered to 69 partner organizations.

Details on the maturing of MHVC's funds flow structure from pay for process to pay for performance, as aligned with NYS DSRIP funding are further articulated below.

Phase 1 Contracts -100% Pay for process

- 30% based on receipt of signed contract and pre-payment data request
- 35% based on timely & successful completion of process metrics

- 35% withhold for timely & successful completion of ALL Metrics (to prevent metric picking)

Phase II PP1 Contracts – 75% Pay for process/ 25% Pay for performance

- 10% based on receipt of signed contract
- 65% based on timely & successful completion of process metrics
- 25% based on performance of outcome metrics (partners must complete all process measures to be eligible for outcome dollars)

Practitioner Engagement – Best Practices:

We have found that the majority of our MHVC practitioners, regardless of stakeholder type, share a common goal with the MHVC team: we are all committed to improving quality care for our patients. Below we outline several unique strategies our MHVC team has incorporated to collaboratively engage practitioners in our work.

- **Culture of Transparency, Accountability, and Shared Decision Making:** At MHVC we are committed to ensuring our partners are kept aware of the challenges and opportunities that exist in developing and growing the MHVC network, and the level of administrative oversight required to ensure DSRIP deliverables are on track. Our partners have a unique "boots on the ground" perspective of implementation opportunities and needs as well as expertise in project and systems design and clinical guidelines. MHVC values this expertise and seeks to appropriately incorporate it into our project development and implementation planning.

- **"Patient Voice":** First launched in Sweden, the "Esther Project" uses a patient persona (Esther) to engage diverse stakeholder groups around systems redesign. Clinical/Quality workgroup members are encouraged to incorporate Esther's perspective into the redesign process by continually asking themselves . . . "What does Esther need?" and "what does Esther want?" Since many of our MHVC practitioners, regardless of stakeholder type, are deeply committed to their patients and to improving the quality of care they receive, we identified this unifying commitment to quality care as a strategic engagement opportunity. To this end, we collaboratively developed MHVC "Esther" personas for each DSRIP projects and challenge our partners to keep the patients voice and perspective in mind as we plan for systems and practice redesign that aims to improve patient flow, experience and quality.

- **Incorporating the Spirit of Motivational Interviewing (MI) into our engagement work:** Motivational Interviewing is an evidence-based skill set that partners can use to guide patients toward "change". "The spirit of MI" (Compassion, Acceptance, Partnership and Evocation) forms the foundation of MI and adherence to MI spirit is associated with movement toward change. In contrast, when people are told what to do, they are more likely to resist change. DSRIP initiatives are all about making major changes across systems, including roles and responsibilities, workflows, IT infrastructure, job descriptions, and care delivery system processes. These represent just some of the changes that practitioners will need to make as we transition to an integrated delivery system that serves as the foundation for our VBP future. Recognizing that any change is hard, our MHVC team is committed to modeling Motivational Interviewing with partners to collaboratively develop strategies to help move systems toward change. For example, aligned with the "Spirit of MI," our subcommittees and workgroups collaboratively developed "Rules of Engagement" that define standards of how our workgroup members will work together (see Appendix). These are reviewed at the start of each workgroup meeting with emphasis on the opportunity for modifications and additions to be made.

- **Sustainability Strategy:** MHVC is committed to the long term financial sustainability of the Hudson Valley network and community of care. A fundamental goal of MHVC's DSRIP work has been, and will continue to be, the drive towards a successful Value Based Payment (VBP) arrangement future for our partners. The clinical innovations our partners already practice, and those they have committed to making, will be the foundation of that sustainable future. Close collaboration with our network ensures that the resources that lead to quality care and that drive VBP payments will be in reach for partners throughout the Hudson Valley. MHVC, building off of Montefiore Health System's decades of VBP experience, is uniquely positioned to turn high quality care into value based reimbursement for our partners. To this end MHVC is a close partner in the creation and setup of the Hudson Valley IPA (HVIPA) which will be both the vehicle for the continuation of our DSRIP progress and the way in which our network will earn the value it creates over the life of the DSRIP program.

Community Based Organization (CBO) Engagement:

MHVC is putting building caring relationships first and foremost in our approach to developing a diverse, active, connected network of community based partners. We connected to CBOs by conducting one-to-one meetings, attending regional meetings and events, producing informational webinars, distributing a monthly newsletter, and inviting CBOs to participate in workgroups & subcommittees. Now that we see a high level of engagement by our CBO partners, we can focus on assisting them with needs they have related to managed care readiness. To that end, MHVC is partnering with New York Association of Psychiatric Rehabilitation Services (NYAPRS) to provide targeted technical assistance on topics ranging from VBP arrangements and sustainability to board relations and networking. NYAPRS is a statewide coalition with expertise in community based care and organizational structure with an emphasis on valuing difference and promoting cultural competence in all aspects of their work. The MHVC partnership with NYAPRS reflects our commitment to support CBO partners to develop the practices, knowledge and skills needed to thrive in a managed care environment.

Through DY2 Q1 MHVC has reached out to engage our community based partners through in-person visits to obtain their input including: needs, linkages, concerns, capacities, and feedback on our communication/engagement efforts. Our listening tour included: 3 regional meetings throughout the Hudson Valley in June 2015 with nearly 500 participants, coalition meetings in 3 counties, meetings with county government officials and partners in 7 counties, and one-on-one meetings with executive leaderships of over 35 individual organizations. We also worked closely with CBOs to ensure they understand the timing, scope, resource and training needs of our MHVC projects as they related to their work.

Below is a summary of the stakeholder involvement to date:

- **Introductory Meetings---** Face-to-face site visits introduced MHVC to community based partners, thanking them for their participation, learning about their capacities and concerns, and providing an update on MHVC development.
- **Workgroup & Subcommittee Engagement---**Based on MHVC engagement work, the MHVC has recruited representatives from our CBO partners to provide valuable expertise and perspective to MHVC's subcommittees and workgroups.
- **"3rd Friday Webinars"--** The MHVC listening tour identified CBOs who offer a wealth of knowledge, innovative practices and expertise, which MHVC has been featuring in the "3rd Friday" webinar series – a standing monthly webinar attended by hundreds of partners and members of the community . CBOs have created content and led some of these webinars.
- **Establishing a Presence in the MHVC Region—**MHVC is maintaining a presence at regional provider and coalition meetings, conferences and events as well as setting up regional offices to ensure close contact with the region.
- **CBO Technical Assistance Program with NYAPRS---** MHVC will launch our first round of technical assistance for CBO's with a group of 30 organizations that are reflective of our 7 county geography. The scope of training will include technical assistance, VBP training, board relations and networking guidance and will follow the existing relationships (links) between hospital and primary care partners and CBOs.

Next Phase of CBO engagement will include but is not limited to:

- MHVC will revisit governance structure to ensure appropriate network representation, including CBOs, and inclusive of organization requests to join
- Map CBO relationships to MHVC contracted organizations in order to understand existing local practice patterns and key CBO roles
- Network resource directory
- RHIO connectivity assessment and technical assistance

  Funds flow model with our contracted entities to value work of CBOs in support of the Integrated Delivery System...

Approach to Population Health Management:

During DSRIP year 1, in consultation with Montefiore CMO, MHVC stood up the Population Health Workgroup. This multi-disciplinary team comprised of partner organizations and Montefiore CMO subject matter experts is charged with identifying target populations and the interventions that should be delivered to improve care. The workgroup is co-facilitated by Montefiore

CMO and MHVC and was built to provide a transparent, collaborative process to define what services are standardized, centralized and/or delegated for the MHVC network.

Partner perspective on the needs of the MHVC community of care combined with MHVC's knowledge of existing programs and services that can be leveraged and/or expanded upon, was instrumental in building our population health strategy.

Our Population Health Workgroup was established with the following guiding principles:

- Develop Network of the **right** partners with the **right** roles and geographic coverage that allows for key providers and CBOs to be identified for contracting through DSRIP and the future state IPA
- Support standardized **care coordination and referral** processes across continuum
- Ability to collect, analyze and report on clinical, quality and process **data** across the continuum
- **Coordinate DSRIP payments** with other payments to properly incentivize sustainable care delivery structure, processes and outcomes
- Establish the value proposition for MHVC and IPA to providers and payers
- Develop Intentionally "packaged" **MSO services** to define percent of premium cost and delegation opportunities through IPA
- Build a robust **DSRIP team** to drive and mange State requirements
- Coordinate unified **partner relations** with one consistent **"value story"** tailored to various types of providers and CBOs regarding value proposition of IPA, ACO, PPS
- Develop defined options for partners to subcontract with other partners and take risk for lives attributed to the subcontracted entity, including **IPA to IPA contracts**

Below are the goals of the Population Health Workgroup:

- Ensure the network developed by MHVC achieves DSRIP goals including the transition to value based payment (VBP)
    - Exploration of centralized services
    - Identification of additional services that are impactful in achievement of metrics and transition to VBP
    - Ensure alignment of MHVC and Hudson Valley IPA services
- Review the Population Health Management framework for MHVC Integrated Delivery System (IDS) including Network Refinement and Centralized Services to:
        - Ensure availability of the right care and the right place at the right time
        - Ensure care and wellness services measurably improve quality outcomes and member experience, as well as global cost.

In consultation with our partners MHVC is well suited to deploy a sustainable population health management strategy that leverages the sophistication and innovation of Montefiore Health System, and the best practices in place within the Hudson Valley.

IT Systems and Processes:

MHVC's is working to create an information technology architecture which helps transform health care delivery from a process which generates data, to a process which utilizes information to achieve improved clinical performance outcomes and reduced cost.

This will be achieved through individuals, partners, and other organizations providing patient-centered care to the Medicaid members served by the DSRIP Program. To achieve these goals, MHVC is developing processes to:

- Ensure timely, easy, and secure access to appropriate and accurate information in the pursuit of their patient care activities
- Provide information that enables outcomes improvement
- Increase collaboration and information sharing among care providers to enhance patient care

MHVC's IT infrastructure and strategy is interconnected with all other organizational workstreams, and serves as the foundation of a clinically integrated healthcare delivery system. With our partners at differing levels of IT capabilities and using differing platforms, we will pursue a realistic approach to achieving an integrated delivery system by focusing efforts on:

- Leveraging existing infrastructure (i.e. Use of People, Process, Technology)
- Adopting an incremental approach to developing the technology landscape
- Educate/Inform/Engage – ensure participation is understood and embraced
- Developing technology solutions that are flexible and sustainable enough to support other strategic initiatives with similar requirements
- Use a requirements driven approach – let priorities drive focus

Over the past several months MHVC has accomplished the following:

- MHVC has completed the IT Current State Assessment, identifying both capabilities and gaps across our network, including readiness for data sharing and the implementation of interoperable IT platform(s). The results of the assessment have given MHVC critical knowledge of the network and clear next steps for IT integration. These elements will be key to MHVC's ability to properly rollout a Population Health Roadmap and a Clinical Integration Strategy in the coming months.

- MHVC has partnered with the Primary Care Development Corporation (PCDC) to implement our PCMH strategy. They are in the field assessing practices readiness for transformation and bucketing practices according to their readiness level so that we can provide targeted technical assistance support for EHR, RHIO PCMH transformation and project alignment activities. Our PCDC scope of work offers different types of support, from telephonic assistance to onsite intense coordination for practices that need it. Offering different levels of support will be essential in our work to transform small community based practices.

- MHVC is working collaboratively with our QE, HealthlinkNY. The collective goal is to evaluate the current state of RHIO adoption in the Hudson Valley. There is also a strong focus on discussing the scope of services that the QE may provide to support MHVC deliverables and facilitating a plan to prioritize partner RHIO adoption and appropriate types of connectivity. To help encourage organizations to start the connection process, MHVC has been promoting state funded programs such the Data Exchange Incentive Program, to help cover the costs of the initial process. The promotion of this information has been done via PPS webinars, monthly newsletters and one-on-one conversations

- MHVC has created a secure infrastructure to support the exchange of clinical data with its Partners. Data Exchange Application & Agreement (DEAA) is in place with contracted partners. All 18 System Security Plan (SSP) workbooks have been completed and submitted to the State, making MHVC one of the first networks able to pull down and utilize state claims data.

- To increase EHR adoption, MHVC is working with providers that reported having no EHR in place. MHVC is promoting EHR adoption through the use of a vetted solution currently in place for Montefiore's community physician groups that are members of the Montefiore ACO. Medgen is a certified MU Stage 2 EHR. All quality and HCC prompts and

data capture elements are integrated into this platform. This solution is low cost and can be implemented within as little as two weeks of contract signing.

In the coming months, MHVC along with the IT Subcommittee, will be developing and overseeing the implementation of the IT change management strategy, clinical data sharing and interoperable systems roadmap, engagement of attributed members in qualifying entities and the population health roadmap. The network has made great progress on IT integration and will continue that work in the quarters to come.

Preparation for VBP:

MHVC, working with its extensive and innovative network, is well positioned to continue to move towards Value Based Payment (VBP) arrangements. The Montefiore Health System has been on the forefront of VBP arrangements for more than two decades and has become a national leader in the drive for value over volume. MHVC has leveraged the extensive knowledge base of our Care Management Organization (CMO) and their strong MCO relationships to lay groundwork for a VBP future for Westchester and the Hudson Valley. MHVC has begun the work of transition to VBP for providers in the Hudson Valley. This includes, but is not limited to:

- Performing a financial health and sustainability current state assessment to understand and begin to address key sustainability issues. This will be followed by a VBP readiness assessment in DY2 Q2
- Working closely with MHVC Population Health Management workgroup to standardize centralized services and network refinement that will be impactful in achievement of quality metrics and transition to VBP through DSRIP and the HV IPA.
- Serving as an administrator for the VBP QIP program which allows MHVC to further strengthen MCO relationships on behalf of key members of the MHVC network and leverage those relationships and the learning from the program down to other network partners.
- Serving as a key player in the standing up of the Hudson Valley Integrated Provider Association (IPA) as a vehicle for VBP participation

Approach to Funds Flow:

Over the course of DY1, MHVC worked closely with partners (including the Finance and Sustainability Subcommittee and ad hoc partner workgroups) to develop a funds flow methodology that supports DSRIP success.

MHVC is committed to a funds flow model that is a careful steward of state and federal dollars and distributes funds in a thoughtful, fair, and equitable manner. At the same time this model recognizes critical MHVC partners and supports the development of an Integrated Delivery System infrastructure to ensure a financially stable future for MHVC partners in the Hudson Valley.

The funds flow process is highly iterative and will continue to be revised as DSRIP and the MHVC network matures. In late 2015, MHVC contracted with partners via a Phase 1 funds flow focused on network development. In Phase I of contracting, MHVC focused on the MHVC partners that represented more than 90% of our network attribution. This group of 50 partners was eligible to receive $5M in partner payments. In early July 2016, MHVC's Phase II contracts will be released with a focus on roles and responsibilities for program implementation and clinical outcomes. More detail on both phases can be found below. Phase II contracts will take MHVC's targeted partner list from 50 to 69 and will increase the allocated partner funding from $5 million in Phase I to $7.2 million in Phase II, Performance Period I. Further, the evolving structure of contracting will now have 75% of funds earned via successful completion of Project Milestones and 25% of funds earned via the MHVC's ability to successfully meet clinical outcomes set and measured by New York State. As of August 5th MHVC has flowed $154,425 to partners that have executed their Phase II contracts.

High-level allocation of funding

The MHVC budget and funds flow methodology aligns with definitions set forth in the MHVC Implementation Plan and are aligned with the budget projections reported in the December 2014 MHVC Lead Agency DSRIP application. Funds are allocated to the following budget categories:

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MHVC 5-Year Funds Flow Average by Bucket

Budget Category	%
Cost of Project Implementation	45%
- Administrative costs including network management, DSRIP program office administrative support for PPS operations, legal support, PPS compliance - Centralized services will support creating shared infrastructure of the PPS and will include costs of shared IT infrastructure (to support performance reporting and data sharing), care management functions, central training and workforce development. Costs of implementation will be higher in the initial years to reflect the financial needs to set up DSRIP infrastructure (mirroring process and reporting metrics)	
Revenue Loss	10%
- Some partners will experience revenue decline in Medicaid population, as well as in Medicare and commercial populations Designed with the aim to help providers overcome the initial period of set-up costs and lost revenues while focusing on the right metrics as they grow and transform their services - To qualify for revenue loss compensations, partners will need to meet both progress and performance benchmarks and demonstrate ability to shift to sustainable system	
Internal PPS Provider Bonus Payments	40%
- Support project implementation and continued care delivery transformation - Provide reimbursement for services not currently covered under existing FFS contracts - Reward partners for outperforming on target milestones - The gradual shift from process to outcome measures aims to mirror the DSRIP incentive structure - Building on existing ACO experience, distribution of funds will be based on attribution, case mix and partners' performance against project milestones & performance measures	
Other (Contingency and Innovation)	5%
- Funds dedicated for continuous innovation and piloting new clinical programs - Discretionary funding to account for unforeseen expenses or underperformance	
Total	100%

Considerations for funds flow to partners

We have designed the MHVC funds flow methodology to closely mirror the DOH methodology. Funding will be tied directly to stakeholders' role in projects and outcomes and will be distributed to partners by assessing the patient population impacted by the projects. As the needs of each partner may be slightly different, partners will have autonomy and will maintain control over individual budgets and implementation plans (in close collaboration with the MHVC office). We expect partners to provide regular status updates to ensure DOH milestones and requirements are met. Reflecting how MHVC will earn incentive payments from the DOH, partner funds will be increasingly tied to performance over the course of DSRIP.

MHVC's Phase I of funding (October – December 2015) was allocated to partners based on provider type, network development needs and member attribution. Phase II funding will cover the 18 month period July 2016 – December 2017 and is organized in three 6-month contract periods. Each contract period will reflect the most current data available from DOH related to member attribution and a partner's claims history as well as a partners role in Project Milestones, their use of shared services, and regional needs. Additionally funds flow will continue to adhere strictly to the "95/5" safety net rule that ensures that 95% of partner payments are distributed to safety net entities. MHVC will ensure that the roles of CBOs are valued in the funds flow methodology by recognizing their critical role in regional communities of care and a value based future.

MHVC Funds Flow Key Compliance Principles

- No payments will be made to partners before MHVC receives payment
- No payments will be made to partners without executed contracts
- Funds Flow methodologies are created through a collaborative process with the MHVC
- Finance and Sustainability Subcommittee and submitted to the MHVC Steering Committee for review and feedback

MHVC under Montefiore Health System's leadership sought out an independent Internal Audit conducted by KPMG. We had strengths identified in the following categories: partner contracting, partner disbursement, cash management, financial

management, budgeting, forecasting, expenditure authorization, and DSRIP program compliance. This was an opportunity to improve upon existing controls and KPMG assisted MHVC by providing several recommendations to improve business practices, processes, and internal controls to help mitigate operational risk. MHVC considers this a best practice.

Workforce:

MHVC, with the help of a strong workforce governing body, is actively working with project workgroups on a workforce transformation strategy and has successfully completed the five workforce milestones and one governance milestone defined by the state, including: target workforce state, transition roadmap, detailed gap analysis, compensation and benefits analysis, training strategy, and workforce communication and engagement strategy.

The workforce transformation team also worked closely with the cultural competency workstream on trainings and with the practitioner engagement and communications teams on general DSRIP education for practitioners, as well as overall workforce communications.

The workforce transformation team is working closely with the IT workstream and the performance reporting workstream on tools to track retrained, redeployed, and newly hired staff, as well as on jobs clearinghouse and possible eLearning functions.

We recognize the need to apply quality improvement tools and processes to our training and education efforts, as we do with our clinical and business practices. It is imperative that training is both effective and accessible across our network. It is also important that our training content areas target knowledge requirements for both clinical and administrative workers.

We identified focus areas for our Recruitment & Retention Strategy:

- Job Board / Clearing House
- Career Ladders/Succession Planning
- Workforce Diversity initiatives
- Recruitment and selection processes

MHVC and its network partners believe that employees displaced should be viewed as assets, not liabilities, and managed accordingly — otherwise valuable human capital will be lost which could otherwise be utilized to create value and offset future recruitment and training costs. Closing gaps through redeployment of displaced employees through retraining, internal recruitment and flexible working options is a sensitive and complex issue that requires careful management. Our approach is to play an active role, where possible and appropriate, in employee redeployment.
These are the focus areas for our Retraining & Redeployment Strategy:

- Structural Mapping
- Analysis & Review of Alternative Roles
- Forecasting & Phased Reductions
- Support Processes for Impacted Staff

Closing our workforce gaps is a collaborative initiative with our network partners and stakeholders. One of the key ways we plan to collaborate is by aligning our efforts to expand the knowledge and effectiveness of the workforce to promote a more successful transformation. Organizational change and development will be a challenge for all of our network partners; however, by working collaboratively, we can connect various types of providers, share techniques for redeploying and retaining workers, and identifying promising practices in a range of areas.

These are the focus areas for our Organizational Development Strategy:

- Organizational Culture Change
- Change Risk and Readiness
- Communication and Engagement
- Cultural Competency & Health Literacy

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

Training strategy to support IDS projects:

The Montefiore Hudson Valley Collaborative (MHVC) and its network partners are prepared to embark on a workforce training effort to support the Integrated Delivery System (IDS) projects through the development of the Workforce Training Strategy. The overarching goal of this strategy is to enhance and introduce learning concepts to its network partners on topics which include: population health, value-based healthcare, care management and cost-effective care coordination that meets or exceeds defined quality standards.

Under the leadership of the MHVC Workforce Transformation Subcommittee and input from MHVC network partners, the Workforce Training Strategy was created to address training needs for identified staff impacted by the IDS initiative. The Workforce Training Strategy includes: clinical staff training related to population and care management, non-clinical staff training required support skills needed to reinforce the new care model, and opportunities to leverage learning institutions /educational programs and existing partner learning practices to fulfill its overarching goal.

Engagement with Health Homes:

MHVC has included representation from regional Health Homes in our Steering Committee, subcommittees and project workgroups, to ensure that their perspective is included in the designed implementation of our projects. We have facilitated one-on-one meetings with the regional Health Homes to more broadly discuss more care management infrastructure, access to data and outreach efforts.

During DSRIP year 1 we learned that the Health Homes were seeking a new Care Management System. As indicated in our challenges and mitigations section MHVC had intended to leverage expansion of the Health Home system as part of our tiered approach to population health management. Additionally, also mentioned above, we did not receive claims data until June. To that end, during DSRIP Year 2, MHVC will continue to engage with our Health Homes partners to further define our work together. This includes discussions on how we can utilize analytics to empower them with data, identifying and spreading best practices in engaging patients, and increasing Health Home enrollment rates.

Within our interactions in the field we identified that many providers had gaps in knowledge as to what a Health Home was and how to refer patients for enrollment. We also identified that many partners were duplicating these efforts within their practice/facility without a viable funding stream. To support this, we are working with the Health Homes to develop additional educational materials and to co-create a PPS wide Health Home referral policy. During DY2Q1 our Health Home Partners jointly facilitated a webinar for our MHVC Network. The webinar provided an overview of the NYS Health Home program and was well received by partners. MHVC has committed to disseminating our PPS wide Health Home referral policy by 9/30/16. Because of the significance of ensuring linkages to these services are in place MHVC has included a metric in our Phase II contract, that ties dollars to our partners attested review and adoption of the MHVC Health Home referral policy.

Engagement with MCOs:

MHVC's initial engagement with MCOs has been focused on DSRIP Supplemental programs (EIP/EPP) and VBP QIP. MHVC has successfully executed EP contracts with MVP, Affinity and Fidelis and VBP QIP contracts with MVP and Fidelis (with new VBP QIP negotiations with Affinity and WellCare underway). Throughout DSRIP Year 2 MHVC intends to mature these relationships and continue regular meetings to strategize on the initiatives being deployed to our shared population.

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

With Phase 2 contracting well underway and clinical projects kicking off, the full impact to populations is still being assessed. However, through collaborative efforts, a solid plan has been developed to address community needs, combat health disparities, and the gaps in service originally referenced in our application and project implementation plans.

MHVC project workgroups keep these issues at the forefront of their work to create and implement each project. Initial plans for this work began with the formal creation of the CCHL (Cultural Competency & Health Literacy) Strategy which was developed on the precept of combating health disparities by addressing the social determinants of health in transforming care in the lower Hudson Valley. A community needs assessment was completed to capture broad concerns of communities served by MHVC network partners.

Using the assessment and evaluative findings the MHVC developed a CCHL strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within MHVC network partners. In March of 2016, we modified our CCHL Strategy to include Key Factors to Improve Access to Quality Healthcare. Further, projects have begun to be actively implemented and rolled out to partners.

MHVC is responsible for implementing organization-wide and project specific activities to ensure cultural competency and health literacy remain priorities at each level of care delivery (e.g. from the partners to clerical staff). The following are current, on-going and/or planned activities that are key factors to improving access to quality healthcare and address social determinants of health.

Cross Cutting/MHVC Wide Initiatives to Improve Patient Access to Care

1. Engaging partners to work together by conducting individual site visits and regional meetings. The purpose of these meetings is to learn about available services, linkages between partners, and needs assessment. These meetings are opportunities to provide education and resources regarding best practices for improving access to care.
2. Inviting members of the CCHL workgroup (who are also members of clinical project workgroups) to attend and take part in ongoing project implementation planning as well as development of specific tasks (more details listed below).
3. Providing patients with additional means of transportation to ensure they can reach healthcare partners.
4. Opening additional primary and behavioral healthcare services in areas with gaps.
5. Using telemedicine to provide primary, preventive and behavioral healthcare services to areas with gaps.
6. Expanding hours of service and open access scheduling to make scheduling easier and more readily available.
7. Co-locating services to create “one-stop-shops” for patients to receive their behavioral and primary care needs (through the Integrated Primary and Behavioral Health (3.a.i.) and Medical Village (2.a.iv) projects).
8. Doing Outreach to community based organizations, schools, and other non-healthcare settings to make information more accessible to the community through public health campaigns.
9. Creating pathways for communication and sharing of patient information between different services partners to promote integrated and seamless delivery of care.
10. Training in structural competency for staff involved with patient care (Structural competency material can be found in the Resource Repository).

Programmatic outcomes and practice transformation initiatives will be assessed through use of the Plan, Do, Study, Act (PDSA) model of process improvement to test changes and assess their impact on patient engagement and outcomes. This model is also being used to aid in the development of health literate educational materials for patients and staff.