NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Mount Sinai PPS

Appendix PPS Narratives

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

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Mount Sinai PPS, LLC

Highlights and successes of the efforts:

I. **GOVERNANCE COMMITTEE:**

Accomplishments:

The Mount Sinai PPS (MSPPS) is pleased to report the various accomplishments and successes of our robust governance model. Effective as of DY2 Q1, the MSPPS will have completed 8 out of 9 Governance Milestones. In doing so, it is our belief that we have created and maintained a transparent model build on open two-way communication. This sentiment regarding our high level of transparency has been echoed on numerous occasions from our partners and various stakeholders of the PPS. The Mount Sinai PPS prides itself on transparence in governance and is committed to this approach over the next 4 years. The sections below outline the details of our successful model.

- The MSPPS has established all governance structures for organizational and clinical committees including: Leadership (Board of Managers) Clinical Quality Committee, Workforce, Finance, IT, Compliance, Care Coordination Cross Functional Workgroup, Stakeholder Engagement, and Bed Compliment Workgroup. In doing so we have taken an inclusive approach ensuring that each committee is led by a dyad consisting of 1 co-chair from Mount Sinai, and 1 co-chair from a partnering organization. This has allowed us to maintain a well-informed, well-rounded perspective of the needs and interests of our partners, resulting in a successfully balanced and impartial governance model. As stated in the completion of Governance milestone #1; all committees have approved charters and co-chairs in place and the PPS has been legally established as an LLC with an approved leadership committee (serving as the "DSRIP Board of Managers"). The PPS has ensured structure and transparency across all committees including the Leadership Committee by way of regularly scheduled committee meetings, minutes which reflect discussion, and posting of committee materials, (as appropriate) to the MSPPS website to allow committee members the opportunity to review materials for any meeting at which they were not present.

- Similarly at the project level, all committees have been formed using a cross-section of the PPS partnership as members and a co-lead model that reflects both Mount Sinai and partner organization leadership. In order to maintain alignment across projects and DSRIP initiatives, all Clinical leadership reports into the PPS executive body, which provides guidance and oversight to clinical decisions. (Please refer to clinical section of midpoint assessment).

- The MSPPS has established a project management office (PMO) to facilitate the work of the aforementioned committees and project workgroups. The PMO has established a working

relationship with the Management Services Organization (MSO) in order to obtain infrastructure support for central project needs where necessary. (Example: resources for the development of a Call Center)

- The Governance Committee has established regular methods of communication and progress monitoring at all levels of the PPS. This includes but is not limited to: the Quarterly Reporting and Monitoring Tool used to monitor all reporting metrics and frequencies of all PPS committees, structured report-outs for the Board provided no less than quarterly, and a regular process for vetting forthcoming resolutions and decisions via the DSRIP Management Team (DMT).

- In response to the PPS' needs (and in response to Gov. M5) the Stakeholder Engagement Committee has formally convened via an approved charter, to further the inclusion of all stakeholders of the PPS. The committee established an agreed-upon set of definitions and common terminology to ensure that its members are working from the same platform of understanding - particularly as it relates to Community Based Organizations. In completing the Stakeholder Engagement plan, the group established a framework upon which to evaluate the level of interest and influence that a stakeholder possesses, as well as strategies on how to further engage critical stakeholders of the PPS. An example includes the recent development of the "Community Ambassador Program" and Consumer Advisory Board. (The Ambassador program will be further discussed in sections below.)

- The Workforce Committee was appointed as the developer of the Communications and Engagement Plan. As such, the workforce committee has created a detailed plan which defines the communications goals and strategies including what information should be communicated to which stakeholders of the PPS, through which medium, and at what frequency.

Innovations

Through our work to date, the MSPPS has remained highly transparent with partners and has maintained a very inclusive and custom approach when working with stakeholders in the following manner:

- **Community Ambassador Program**: The primary goal of the Ambassador program is to raise awareness and provide education on DSRIP to our partners. Secondly, the program aims to eventually facilitate community initiatives by way of empowering informed, engaged, community leaders. The key expectations of the lead Ambassadors are as follows:

  (1) Become a subject matter expert in DSRIP; increase engagement with other Stakeholders at a local level.
  (2) Solicit input from communities within the PPS.
  (3) Establish feedback loops to the Stakeholder Engagement committee and ultimately the PPS.

In order to ensure engagement is geographically diverse across the PPS, localized stakeholder engagement initiatives will take place by borough as the program develops. The Lead Ambassadors will help initiate these efforts by working with a co-ambassador. Future activities may include: localized "tours" or open houses of our partners across different geographies. This is one example of a way for our Stakeholders to understand one another's services and develop referral opportunities that can help the

consumers/patients served. All such efforts will be shared monthly with the Stakeholder Committee who will provide additional guidance. This program is supported by the Stakeholder Engagement Committee and Stakeholder Engagement manager.

- **Inclusion of FBO's:** the PPS has already established various relationships with faith-based organizations who are represented at the Stakeholder Engagement Committee and whose leadership is building relationships with our stakeholder and network teams. The PPS also presented DSRIP "101-level" education at some of the FBO networking events and will continue doing so on an as needed basis.

- **Provider Relations Concierge Approach:** because the MSPPS understands deeply the level of resources a partner organization needs to participate in DSRIP, our Provider Relation's team has taken a "concierge approach" to working with our network. By assigning each and every one of our 150+ contracted partners a provider representative from the PMO; we have established a more intimate level of contact. This has allowed for educational opportunities, Q&A, and a more personal DSRIP experience for our partners. For the PPS, this has afforded our team the opportunity to better understand the needs of partners and what they may be able to offer the network and contribute to clinical projects. It is through these relationships that our Provider Relations and Stakeholder Engagement teams have identified new partners for projects, new partners to fill gaps in the network and identified partners with potential to contribute to our speed and scale numbers.

- **PPS Events for Stakeholders:** In December of 2015, the PPS hosted the first Stakeholder Engagement Event. The purpose of this event was to provide a meet and greet session for partners during the earlier stages of DSRIP and to elicit feedback from partners on their experience with DSRIP. Attendees were set up in focus groups with discussions facilitated by key PPS partners. Through structured conversations among small groups, the PPS received valuable feedback on areas such as our communications approach. Specifically, partners expressed the need for more education on the funds flow process and wanted better guidance on how to prepare their organization for DSRIP from operational and financial perspectives. They also wanted more opportunities to network with other partners and identify ways to integrate services with one another. The PPS has since been able to use this feedback to drive communications and stakeholder engagement strategies. Since hosting the event, the PPS has held a contracting webinar series to inform partners on the funds flow process. The PPS has also established a partner relations and stakeholder engagement team to engage with partners and provide on-site support for DSRIP. MSPPS hopes to host similar events moving forward to help inform strategies that will improve PPS and partner relationships.

Plans for Future

As the MSPPS looks ahead to the end of DY2, and subsequent years in DSRIP we have identified the following areas of focus within the purview of governance:

- **Deepen CBO integration:** The MSPPS intends to deepen its existing relationship with CBO's, specifically those organizations who provide essential yet non-billable services to patients. The PPS has laid the groundwork in this area by including CBO's in our process mapping and workflow design sessions. The outputs of this analysis will help the PPS identify the types of patient needs our CBO's can fill. Additionally, the PPS has begun to identify CBO partners with a readiness to participate in

pilot projects. These projects will be designed as a "proof of concept" aimed at demonstrating objectively how such interventions can improve patient outcomes and DSRIP metrics. While the exact parameters of pilot participation are still under design, it will more than likely include some level of administrative and financial support for each pilot project. The anticipated outcome of the pilots is to help shape vendor contract arrangements.

- **Network Analysis and Refinement:** in order to create a robust and high-performing network, the PPS intends to assess its partners fairly and objectively using known industry standards. In addition to reviewing partner performance data at a future stage, the PPS is developing "score cards" for each provider type. These score cards developed in conjunction with subject matter experts from our partnership will assess partners via self-report across a range of business, efficiency, patient perspective, and quality measures. The completion of this exercise will give the PPS a deeper look into the strength of the network, as well as areas to target for improvement.

- **Continuous Engagement of PPS Stakeholder Engagement:** the PPS believes that its greatest resource is its partner network. As such, we will continue to engage partners at various levels. To further our efforts described above, we hope to embark on "road shows" to continually visit and engage with our partners. We hope to mobilize our Lead Ambassadors to discuss DSRIP and the future of integrated health care in our communities. Lastly, we hope to engage with state and local agencies to better understand the landscape of the communities which we serve.

I. FINANCE COMMITTEE:
(Budget, Funds Flow, Financial Sustainability)

Accomplishments:

Over the course of the past two years, Mount Sinai has been an early leader in structuring governance, management and stakeholder engagement for the finance workstream. Since mid-2014, the Mount Sinai finance committee has been deeply engaged with PPS stakeholders, encompassing a broad range of provider types and geographies. The committee has been instrumental in a number of critical activities over the past two years:

- Development of Initial Funds Flow and Allocation model for 2014 Implementation plan submission to DOH. The committee actively discussed and worked through the initial set of allocations that balanced the infrastructure needs of the PPS, expected roles of partners and financial mechanisms that would be necessary to ensure performance.

- Development of initial budget for DSRIP award to compare total potential vs. reliable (projected) dollars to be received based on likely performance. Given DSRIP awards are not a guarantee, the PPS felt it was appropriate to define a set of assumptions to inform early on, what might be the projected performance across metrics and subsequent drawdown against the award. This model later informed the adoption of a detailed Achievement Value (AV) model, similar to that produced by GNYHA to inform PPS strategy and budgeting.

- Development and dissemination of a preliminary partner financial sustainability survey (late 2014/early 2015). First of its kind at the time, to best of our knowledge, a comprehensive assessment of quantitative financial indicators and request for audited financials to gauge

financial state of PPS partners. Process and data was used to inform DY1 financial sustainability test; which was built with finance committee input and validation.

- Development and dissemination of 2015 (DY1) Partner Financial Sustainability survey to assess partner financial health and current managed care participation using a standard tool, assessing for eight quantitative financial indicators over 2 fiscal years and qualitative metrics. The survey will be used to monitor the impact of DSRIP on partners on a go forward basis, comparing historical baseline to ongoing performance to identify and potentially remediate partners potentially adversely impacted by DSRIP and transition to VBP models.

- Development of subsequent financial sustainability strategy and plan, charging the finance committee for ongoing monitoring of partner financial performance and risk. The strategy was adopted by the PPS Board of Managers in early 2016 (DY1). The strategy passively and pro-actively monitors for financial health, and as appropriate allows the Finance leadership to engage with clinical leadership and other PPSs to review potentially at-risk partners and potential impact on DSRIP performance.

- Development of DY1, DY2 and DY2-5 financial budget, five-year cash flow forecast to plan for PPS financial needs. These tools are particularly critical given the significant planned expenditures and uncertain and changing cash flow depending on funds source (e.g. CRFP, EPP, EIP). The financial models are tied to individual award buckets to allow for the prioritization of funding of mission critical services and activities as funds become available.

- Partner DY1 baseline contracting assessment was completed in October 2015 (DY1) to collect critical, comprehensive baseline information from partners for the following domains: administrative leadership, provider sites by provider type, project participation, NPIs and MMIS identifiers for attribution, basic provider data regarding services and capabilities to inform project roles and participation.

- NPI and attribution analysis was developed and maintained by the finance leadership to best interpret state data from attribution files in order to consolidate NPIs by contracting parent entity to associate PPS lives per partner. A methodology was devised to de-duplicate and maintain data as state source documents continued to evolve, ultimately leading to non-duplicated attribution files and most recently, provider interaction files that allowed for more accurate assessment of partner impact and association with PPS lives.

- Development of partner contracting model and dissemination of performance-based contracts and payments to all PPS partners. The PPS has adopted and completed one full round of contracts and partner payments for DY 1, and is actively developing contracts for DY2 Q1-2. An updated model for DY2 Q3-4 will further performance-based payments to align with PPS metrics across projects cumulatively and partner's impacts on outcomes, incentivizing direct performance to PPS clinical outcomes and process metrics. Safety net and non-safety net (CBO) partners received contracts and payments in DY1. The finance committee has also set aside funds for direct (centralized) contracts for CBOs as vendors for centralized and/or regional services for the PPS.

Innovations

- Partner survey to inform broad representation in committee: Based on early partner surveys in 2014 to gauge interest and capacity for PPS governance participation, the finance committee was able to identify and engage participation from all DOH-defined provider types from all of the geographic areas covered by the PPS, ensuring reasonable representation of the PPS and broad perspectives to inform strategic decisions and planning. The survey tool took into consideration partner ranked choices for governance committees, provider type and participation in other committees to ensure a diverse and even distribution of governance across the PPS.

- Financial Health Assessment: Utilizing the DOH PPS lead financial stability test as a reference document, the finance committee sought input from its members with relation to industry tools regarding key financial metrics and qualitative issues that would be pertinent to understanding partner performance. Through a series of working sessions, the committee developed a tool that was broad enough to be effective for all provider types, but not too detailed to preclude meaningful completion of the tool. Having reviewed other survey tools from other PPSs when available, we feel the final tool and proposed process is one of the more comprehensive currently utilized within the State.

- Contracting model: Leveraging a similar model utilized by an upstate PPS, the Mount Sinai PPS built on this framework to fit the current state of the PPS by including a clinical tiering component that enable clinical leadership to assign a value to partners based on project participation, potential impact on performance and planning. This tiering process addressed the perceived gap that the model relied to heavily on attribution alone. As the PPS approaches the next round of contracting, this tiering process as further evolved to include a more discrete set of criteria to better clarify partner tiers based on roles and potential value. The model itself balances attribution with project participation to define a partner share of funds, assigning a finite dollar amount per contractual metric. These metrics are developed by the respective committee and project leadership, intended to drive performance around critical PPS activities that will in turn support overall PPS performance and subsequent drawdown of funds.

- AV model: Recognizing the need to prioritize limited partnership bandwidth, PPS resources and funds, the PPS developed an AV model that helps associate award dollars by associated performance metrics and milestones, so that PPS leadership has a deep understanding and ability to strategically focus on AVs that will have the greatest change for success. This model further informs annual and overall DSRIP budget planning based on incremental learning and adjustments to performance assumptions that may increase/decrease projected reliable dollars for the PPS.

Plans for future:

Looking ahead, the finance committee has two primary areas of focus to close out DY2 and ensure readiness for DY3 and longer-term VBP strategies with MCOs and partners.

- Value-based Payment (VBP) strategy and baseline assessment (Implementation plan milestone):
    a. VBP strategy and principles: Working with the Board of Managers and population health

leadership of Mount Sinai Health System, the finance committee will define an overarching VBP strategy in line with the State's VBP roadmap, which will highlight our basic objectives, principles and summary of key considerations, risks and requirements for partners to advance from current state to future state business strategies.

b. VBP baseline assessment: Through the financial sustainability survey, baseline data was also captured with relation to managed care penetration for all lines of business. The survey sought to understand services and revenue under some form of capitation, as outlined by DOH's VBP roadmap criteria (levels), for each partner, asking for detail from the top three health plans by line of business to understand current VBP arrangements. The analysis will be complete in late summer and shared with the Board of Managers. This analysis will be instrumental in gauging partner's familiarity with VBP to date and what level of change will be required for this transformation, as well as who early adopters/champions may be.
c. Financial model and pro-forma (exact guidelines TBD per implementation plan): Pending further guidance from DOH, the PPS has begun to discuss the components necessary to model current revenue for the PPS and how the transition to VBP over the next three years will impact overall revenue, provider types, long-term sustainability of centralized services and what contracting/ financial alignment models may be necessary to cover required services and infrastructure post-DSRIP.

d. Partner VBP education: Based on the strategy defined by the PPS and vision outlined by DOH in the roadmap, the finance committee will begin to develop and disseminate educational material to PPS partners beginning in late summer/early Fall to share the overall Mount Sinai PPS strategy, but to also bring the broader group of partners up to speed on the trajectory for transformation that will impact their businesses moving forward.

e. MCO discussions: As part of the VBP strategy development and EIP/EPP work with MCOs, the PPS will begin tactical discussions with MCOs regarding potential contract models, delegation of services and coordination of data sharing and analytics.

f. Potential risk-models, financial alignment strategies and CBO contracts: The PPS leadership recognizes that not all partners are equally capable, culturally ready and willing to engage in VBP strategies, in addition to the fact that certain business models and services may not lend themselves to this form of reimbursement. With that in mind, the PPS is prepared for an incremental approach to VBP transformation, moving those most ready and willing into these arrangements first, while others, such as CBOs, may remain in largely FFS type contracts or sub-contracts with providers who are at risk for certain services. However, all services will begin or increase ties to performance standards, quality, patient experience and cost management. This end goal will be supported by ongoing partner learning, network refinement and development of contractual standards and performance expectations, which will continue to drive higher performance across the PPS as financial incentives align with desired process and outcome metrics of the PPS.

- Financial Sustainability: As defined in the PPS financial sustainability plan, finance co-leads will

continue to review baseline assessment data for the lowest scoring partners and conduct further screening and discussions to further qualify potential risks. The upcoming round of partner contracts will include language requiring partners provide ongoing and pro-active updates in between annual surveys should any material changes arise that may impact partner performance.

II. WORKFORCE COMMITTEE
(including: Cultural Competency and health literacy)

Accomplishments:

The Mount Sinai PPS (MSPPS) Workforce Committee was formed to develop and facilitate the submission of the original 2014 DSRIP application. It has since evolved to serve as subject matter expert and governance rubric for Workforce Development and related issues. The Workforce Committee has been instrumental in identifying challenges and potential solutions to address the network's transition to a value-based world including: (1) shifts in reimbursement structure, (2) the longitudinal evolution of related work tasks, the distillation of requisite skills, related training elements and delivery paradigms to support the creation of an Integrated Delivery System. To meet these challenges the Workforce Committee is committed to collaborations between diverse partners, labor, management, and alliances between external resources such as regional educational institutions and other PPSs. Major successes and innovations are included below.

1. Successfully recruited approximately 60 members of MSPPS centralized staff, including members of the Project Management Office, IT team, and Workforce Development team.

2. Developed a cooperative Workforce Committee representative of PPS partner types, subject matter experts, and labor representatives.

3. Negotiated Strategic Workforce Vendor contract with the 1199 Training and Employment Funds (Board of Managers approval October 2015). Built and sustained a supportive working relationship with the 1199 Training and Employment funds.

4. Conducted a current state assessment and benefits and compensation analysis with the assistance of the Center for Health Workforce Studies (DY1Q4).

5. Completed target state and gap analysis with Workforce Committee sign-off in DY2Q1.

6. Completed a Workforce Communication and Change Management Strategy in line with Governance Milestone #8, which outlines the key stakeholders, topics, and methodologies of communicating about workforce issues.

7. Met and exceeded PPS spending commitment for Workforce development in DY1.

8. CC/HL: Conducted survey on Cultural Competency/Health Literacy topics. Survey was completed with a 94% response rate. The results were reported at the Board of Managers and Town Hall

Meetings on May 26th, 2016.

9. CC/HL: Created a robust Cultural Competency/Health Literacy strategy after consideration of CC/HL survey and CNA.

10. CC/HL: Presented that strategy at GNYHA Workforce Workgroup as best practice and to develop collaborative relationships with other PPSs in the region.

Innovations

1. Developed a strategic framework for understanding how Value Based Payments and other related business changes are translated into workforce requirements. This framework takes into account changes in work tasks, clinical requirements, and financial sustainability considerations and informs a discussion of workforce support. The MSPPS will continue to refine this framework as more information becomes available.

2. MSPPS is in the process of creating a training strategy that includes a rigorous training process (steps included below). In this way, the process facilitates driving clinical value, and is specifically designed to spend money on training only when it drives value and not simply as a mechanism of spending down the workforce spend requirement.
    a. Determine Training Needs
    b. Research Training Options (may include a Request for Proposal process)
    c. Determine Best Option with input from clinical project team requestor
    d. Develop Training (either directly or through contract relationships with 1199 Training and Employment Funds in their role as primary administrator of training)
    e. Communicate with Partners
    f. Launch Training
    g. Report on Learning/Follow-up

3. Through the completion of the current state assessment, target state and gap analysis, MSPPS discovered that the MSPPS workforce includes over 100,000 members across diverse titles. This discovery redirected planning efforts away from strategizing about recruitment, to refocusing on training and raising the skill level and competency of the incumbent and future workforce. MSPPS believes that it is in this way that we can build a competent and sustainable workforce that meets the needs of the future Integrated Delivery System.

Plans for future

MSPPS Workforce Development is in the process of completing the following:

1. Training Strategy (to be completed DY2Q2) that takes into account clinical and workforce development needs, timelines and cost efficiency measures.

2. The establishment of a Training Steering Committee. This steering committee will look across clinical projects and IT developments to identify critical trainings and ensure that training efforts are aligned with IDS development value.

3. MSPPS is tentatively scheduled to go live with our Learning Management System ('PEAK' – Portal for Education and the Advancement of Knowledge) for partner use in DY2Q3. PEAK is currently used by Mount Sinai Health System, and when expanded, will facilitate centralized training registration and NYS DOH reporting.

4. Workforce Transition Roadmap (to be completed DY2Q2) that articulates how the Training Strategy and other efforts fit into a strategic workforce development timeline and framework.

5. Expand collaboration with regional educational institutions and PPS' to prepare for the future workforce needed in population health

---

-

III. AUDIT AND COMPLIANCE COMMITTEE

Accomplishments:

The Mount Sinai PPS has developed and implemented a robust Compliance Program. Effective as of DY1 the MSPPS has completed Milestone #3 and finalized a compliance plan that is consistent with New York State Social Services Law 363-d (SSL 363-d) and Title 18 of the New York Codes Rules and Regulations, Part 521 (18 NYCRR 521). Some of the significant accomplishment in Compliance as of DY 2 are the designation of a compliance officer, creation of an Audit & Compliance Oversight Committee, implementing a Code of Conduct and compliance policies, conducting training and education, creating an audit work plan, creation of cash disbursements and receipts policies and the establishment of a Hotline number to report fraud, waste and abuse. The sections below will provide a detail outline of the components that will contribute to a successful Compliance Program.

- Development of Corporate Compliance Program: The Committee was instrumental in the development of the MSPPS Compliance Policies and Code of Conduct, which were adopted by the MSPPS Board of Managers in 2015. Efforts to implement the Corporate Compliance Program include the establishment of an independent 24/7 confidential hotline and investigation number for MSPPS. The hotline has been marketed at PPS-wide events and posters have been distributed to partners to advertise the hotline to their employees and patients. Additional efforts include: monthly monitoring of the OIG, OMIG and GSA/SAM excluded provider list for the participating partners; implementation and distribution of a data security and confidentiality plan; and filing of the annual Audit and Compliance Program Certification with New York State OMIG for the MSPPS.

- Implementation of Cash Disbursements and Cash Receipts Controls: The Committee oversaw the development and distribution of an annual compliance risk assessment survey to existing and new partners of the MSPPS. In addition to questions assessing compliance protocols in place at the partner organizations, the survey also collected confirmation regarding the New York State Social Services Law Section 363-d and 18NYCRR Part 521 Certification and the Federal Deficit Reduction Act of 2205 Certification. Proof of these certifications is being collected on an annual basis. Based on the results of the survey, the MSPPS has begun implementing auditing of funds disbursement to the partners.
    a. Performed audit of funds to MSPPS partners based on risk assessment survey.
    b. Developed a cash disbursement policy for the MSPPS with specific procedures and

authorizations required for all cash disbursements from PPS funds.

c. Developed a voucher package, checklist, and protocol for distributing funds from the MSPPS.
d. Developed partner's CEO attestation to accompany each DSRIP disbursement to MSPPS partners.
e. Developed a policy and protocol on processing cash receipts from the NYS Department of Health to the MSPPS.

- **Compliance Training, Education and Outreach**
  a. Developed, distributed, and obtained confirmation regarding the implementation of annual Compliance Training & Education for all participating partners. Training and Education information is also available on the MSPPS website.
  b. Performed annual Compliance Training & Education for key Committees
  c. Developed an audit and compliance webpage on the MSPPS website which provides, among other information, the confidential DSRIP Hotline number, Audit and Compliance staff contact information to report fraud, waste and abuse and seek assistance, as well as compliance education and training materials.
  d. Created and distributed MSPPS Hotline posters to MSPPS partners to inform patients, employees, contractors to report fraud, waste and abuse in the DSRIP program.
  e. Attended town hall meetings and provided compliance updates and guidance to MSPPS partners.

Innovations:

- Developed a Fraud Awareness Training and Education program that focuses on fraud, major thefts, cyber security, bribery and other serious wrongdoing. Will provide Fraud Awareness Education to the MSPPS partners at the next town hall meeting and other venue.

Plans for the future:

- Continued to provide Fraud Awareness Training and Education to the MSPPS partners.
- On-going quarterly MSPPS Audit & Compliance Committee meetings.
- On-going monitoring of the confidential hotline number for MSPPS.
- On-going monthly monitoring of the OIG, OMIG and GSA/SAM excluded provider list for the participating partners.
- On-going annual Compliance Training & Education for key Committees.
- File annually the Audit and Compliance Program Certification with New York State Office of Medicaid Inspector General for the MSPPS.
- On-going monitoring of the data security and confidentiality plan.
- Continually updating and monitoring the MSPPS audit work plan.
- On-going audit of cash disbursement to MSPPS partners.

- On-going audit of cash receipts received from the NYSDOH to the MSPPS.
- Annually obtain confirmation from the MSPPS partners have filed the New York State Social Services Law Section 363-d and 18NYCRR Part 521 Certification and the Federal
- Deficit Reduction Act of 2205 Certification.
- On-going quarterly review of the Corporate Compliance Plan Policies and Code of Conduct for any necessary updates.
- On-going updates to the MSPPS audit and compliance webpage.
- Annually distribute an annual compliance risk assessment survey to existing and new partners of the MSPPS

IV. IT COMMITTEE

Accomplishments:

The Mount Sinai PPS IT Committee has provided an update of our accomplishments to date in our planning and implementation efforts to help the PPS network achieve DSRIP goals. The Committee has been working diligently and openly with various other committees and stakeholders to understand technology needs for the PPS network. We have also collaborated with our partners in the network via assessments, town halls, and webinars to better understand their capabilities and needs. Lastly, effective DY2 Q1, we will have completed IT Milestone #5 but submitting the last of the security workbooks. As such, we are very excited to share these accomplishments as detailed below.

1. **Health Information Exchange**
    a. MSPPS has engaged Healthix for HIE services
    b. MSPPS has developed a preliminary list of preferred data elements that partners are being requested to share for performance management and measurement
    c. In collaboration with Healthix, MSPPS has established a timeline to ensure partners are able to share data through the RHIO in a phased approach
    d. The MSPPS HIE team has developed various strategies that were reviewed and discussed with DOH (James Kirkwood) and the RHIOs. As a result, we have selected the strategy to leverage Healthix as the primary HIE, rather than the Howling Wolf strategy.

2. **Data Warehouse and Analytics**
    a. MSPPS has established a PPS data warehouse
    b. MSPPS has begun developing a performance management portal that will track performance of outcome measures. Thirteen performance measures are currently being tracked using this portal with data that is currently available to the MSPPS.
    c. MSPPS has started initial efforts to connect the internal MSPPS HIE to the data warehouse, through which the PPS will receive data from the RHIOs

3. **Command Center**
    a. The DSRIP Command Center, which is currently operating as a call center to support partners and patients, is live, with basic IT help desk functionalities, such as call tracking, call routing, reports and dashboards

4. **Community Gateway**
    a. Community Gateway, MSPPS's web-based partner portal to serve as a one-stop shop to access all the PPSs centralized IT solutions is now live with six pilot partners. The portal currently allows partners to view organizational profile information.

5. **Security**
    a. Created and submitted the full set of SSP workbooks to the State, which satisfies the requirement under IT milestone 5
    b. The PPS has established a secure workstation that complies with the State's security requirements which is used to ingest PHI data being shared by the state

6. **Infrastructure**
    a. Architecture of DSRIP environment has been finalized and is currently under development to support all centralized IT solutions

7. **Reporting**
    a. Established a process and mechanism to acquire and analyze actively engaged data centrally from engaged partners
    b. Successfully met actively engaged reporting goals every quarter for the past two years

8. **CRM**
    a. The CRM component of Salesforce is live with these functionalities: Contract Management, Survey Management, Project Management, Project Tracking, and partner database
    b. All PPS surveys are being deployed directly out of salesforce for seamless alignment with partner database in order to build a robust partner profile

9. **Partner IT Assessment**
    a. A preliminary IT assessment was completed. The objective of the assessment was to establish a baseline understanding of each partner's IT maturity. To that end, it covered a wide variety of topics, ranging from provider type, connectivity to HIE/RHIOs, use of EHRs, to patient-centered medical home certification level.
    b. A series of analyses has been done based on the assessment results to start formulating strategies surrounding design and implementation of centralized IT solutions

10. **TOM Sessions**
    a. MSPPS participated in TOM Sessions in 2015 with the State and other PPSs, lending its subject matter expertise in defining the IT target operating model for projects 2.a.i and 3.a.i

11. **Development of IT Team**
    a. Several analysts have been engaged to interface with business owners to carry out a variety of business requirement gathering and analyses
    b. Several PMs have been engaged to manage the clinical projects and centralized services
    c. A development team has been established with various technical analysts to build and

implement centralized IT solutions

12. Requirement Gathering and Analyses

a. For each clinical project, an IT representative has participated in the future-state process mapping session and subsequent workgroup meetings to start gathering business requirements
b. A preliminary IT analysis has been done for each clinical project that outlines IT understanding of project objectives and IT touch points in future-state process maps
c. A team of IT representatives has participated in all care coordination cross-functional workgroup to gather requirements for care management system and conduct gap analysis

---

V. PERFORMANCE REPORTING

Accomplishments:

- The Performance Reporting (PR) area has several noted accomplishments through the first half of DSRIP Demonstration Year 2. These accomplishments start with establishing a multidisciplinary workgroup reflecting a cross section of PPS interests. The workgroup meets weekly to strategically plan and discuss issues related to speed and scale reporting. The PR area has also begun regularly reporting monthly performance measure results from MAPP to clinical leadership groups. This is done in order to drive strategy and select priorities for various clinical interventions. The PR area has also collaborated with IT resources in order to develop reporting dashboards to provide program leadership with information for decision making. Examples include: using Salesforce for summarizing information about the PPS partner network, organizing quarterly reporting milestones and tasks, geomapping partner locations around New York City to understand service areas, and defining needs by understanding demographic characteristics of attribution. Finally the PR area has defined partner and project specific contract metrics that reflect interim steps thus helping the PPS achieve its collective performance measure targets. For example, the PPS has established a contract metric for partners to develop communication protocols between different provider types in order to achieve better patient outcomes in care transitions for project 2.b.iv.

Innovations

- By combining data from our Salesforce application with MAPP performance data provided by DOH, the PPS has been able to “hot spot” poor performing areas for select performance measures. The combining of data sources is preferred to the capabilities of MAPP alone because it allows the PPS to understand the network partners and services within particular high need areas. This data can help to drive the nature of the clinical interventions and define the priority of the interventions in certain partner organizations. For example; by hot spotting areas with high rates of avoidable hospital readmission, the PPS can target partners within these areas that could benefit from a defined intervention aimed at reducing readmits and use rapid cycle improvement techniques to pilot test an intervention. The PPS has also outlined plans for a Community Gateway portal for partners that will be used for securely sharing information and

communication with a large number of partner organizations in an efficient and standard way.

Plans for future

- The PPS is well positioned to accomplish future milestones by using data to prioritize both clinical areas and key partners for piloting rapid cycle improvement projects. The short term goals for the PPS are to outline a training program and then execute a strategy for implementing specific clinical interventions to innovate delivery in select partner organizations. In addition to developing a training program, the PR area will define critical performance metrics that will be shared with partners via the Community Gateway portal for monitoring and comparing performance where applicable while continuing to establish and monitor contract metrics for evaluating partner performance in transforming delivery to a high need population.

VI. POPULATION HEALTH

Accomplishments:

Although no committee exists for the Population Health work plan, the PPS has accomplished the initial step related to establishing the PMO to support and report progress on the development of clinical programming, network provider and patient engagement, financial and risk management, and IT infrastructure to support an Integrated Delivery System. Additionally, the PPS has established a Bed Complement and Utilization Workgroup that consists of partners/stakeholders who are impacted by bed reduction.

Innovations

Although no committee exists for Population Health, the PPS PMO has been engaged with Mount Sinai's Population Health team to better understand the existing tools, considerations, knowledge base, and strategies to assist the PPS with developing the integrated delivery system. Initial meetings have been held to educate the Mount Sinai Population Health team in understanding DSRIP requirements and the PPS network of providers, and initial areas of overlap included in the Clinical Integrations work plan milestone requirement related to the Clinical Integration Needs Assessment deliverable. This deliverable and its content was reviewed in conjunction with the Mount Sinai Population Health team in hopes of assisting both entities in obtaining an optimal and use end work product.

Furthermore, as described above in the Performance Reporting section, the PPS PMO has developed hot-spotting maps to determine the zip codes or collections of zip codes with the most opportunity for improvement related to DSRIP performance measures. Data from MAPP has been transposed into Tableau software to visually depict the NYC regions that require resources. The development and utilization of these maps assists with meeting project requirements and steps.

Plans for future

Upcoming plans to achieve DY2 milestones include periodic meetings with the Mount Sinai Population

Health team to ensure on-going alignment and seek any guidance on developing the hot spotting maps to drive clinical strategies and decision making. Geographic areas will be developed to inform hub development as well through the remainder of DY2.

VII. PRACTITIONER ENGAGEMENT

Accomplishments:

The Stakeholder Engagement cross functional workgroup has identified practitioners as a key stakeholder. The model identified to engage providers is the NCQA Patient-Centered Medical Home model, which is related to provider types, PCPs and Clinics. A PPS PCMH profile was completed to depict the DSRIP requirements for PCMH, the alignment of PCMH with DSRIP projects and performance measures, and the profile overview of PCMH maturity in the PPS. A PCMH cross-functional workgroup has met to review this information.

Innovations

The PPS has a large n-count of PCPs (1,751), and a large commitment of 1,381 PCPs expected to meet 2014 PCMH Level 3 recognition. The PCMH cross-functional workgroup has already identified existing challenges that practitioners may encounter with PCMH transformation, related to NCQA timelines and required technical assistance support. A large majority of the PCP n-count is not PCMH certified; as a result, the PPS PMO has researched and analyzed EHR Incentive Payment Program data to assess the Meaningful Use status of a PCP. This allows the PPS to better understand the EHR capability (or existence of one) for PCPs with PCMH certification and provide a higher readiness level rating.

Plans for future

The PCMH cross functional workgroup will continue to meet on a periodic basis to assist in meeting Practitioner Engagement work plan requirements, such as assessing partner challenges in engaging practitioners for PCMH transformation, developing communication strategies for practitioners and identifying early adopters within the provider network.

VIII. CLINICAL INTEGRATION

Accomplishments

- Milestone 1 of the Clinical Integration work plan pertaining to the development of Clinical Integration Needs Assessment (CINA) to distribute to all PPS partners has made significant progress, albeit its due date is scheduled for December 31, 2016. The CINA is a thorough questionnaire that requests clinical program-related questions related to partners' existing referral networks, care coordination capabilities, disease programs, care protocols, and quality programs. The CINA

questionnaire will be paired with another internal initiative, Clinical Value Scorecard, which asks questions specific to each provider type related to their business model, accreditation and designations, patient perspective, efficiency measures, and quality programs.

- Challenges that were foreseen included ensuring that appropriate content and questions were reflected to ensure the partner responses provide the PPS PMO with adequate and useful data. This challenge was mitigated by vetting content and questions through co-leads of the two clinical committees of the PPS.

Innovations

Although no committee specifically exists for the Clinical Integration work plan, the PPS is taking extraordinary steps in ensuring that outputs of the CINA and Clinical Value scorecard initiatives are examined by multiple stakeholders, including the Mount Sinai Population Health team, PPS clinical committees, PMO leadership and subject matter experts across our partnership. The degree of stakeholder review layers and input has been substantial.

Plans for future

The MSPPS plans to bring the CINA to completion by end of 2016 in order to begin making meaningful use of the data and obtaining a complete picture of the partner network. Additionally, by pairing the results of this assessment with the Clinical Value Assessment, and the previously collected IT assessments on partner IT connectivity and maturity, the PPS will develop a well-rounded picture of partner's ability to integrate. This information will inform strategies to operationalize clinical work flows among partners in distinct geographic regions, or hubs, by identifying opportunities for integration or existing integration.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Mount Sinai PPS, LLC

Project: 2.a.i

Challenges the PPS has encountered in project implementation:
Through July 2016, project 2ai has faced challenges with respect to requirements and steps of specific milestones. In regard to milestone 3, the PPS has developed a highly-functioning Care Coordination cross-functional workgroup, comprised of partners, health home leads, and care management agencies. A key objective of the group is to determine a care management solution for all partners in order to meet DSRIP and internal requirements. However, two challenges face the PPS- potential selection of a care management platform and creation of the universal care plan. The PPS is undergoing a selection process in which two care management platforms are being evaluated for standardized assessment of and goal-setting for medical, behavioral, public health and community support needs. In regard to milestone 11, the PPS has faced initial challenges with development of a Consumer Advisory Council. Planning discussions with a newly-formed Steering Committee and project 2ai workgroup led to improved progress as to the structure of the Council; however, there have been challenges with regard to forming concrete goals and objectives for the Council in addition to finding ways to represent consumer interests across the large geographic footprint of the PPS. In regard to milestone 7, the PPS has experienced barriers with obtaining data to assist with an assessment stage of PCMH transformation. Although the PPS has been able to access NCQA data sources for PCMH recognition status, access to other key data like Meaningful Use from vendors with proprietary and exclusive access has been a challenge.
Efforts to mitigate challenges identified above:
Care plans vary across partners and there is no “one size fits all” care plan. To ensure appropriate input is provided, conversations with GNYHA have brought together partners across multiple PPS’s, which have proved beneficial. The decision to develop a Consumer Advisory Council was met with much agreement, as it perceived by the Steering Committee and project 2ai workgroup that a new Patient Advisory Board was as a redundant layer due to the existing Patient Advisory Boards in place within PPS partners. The PPS is analyzing related project requirements and inventorying initiatives at existing partner Patient Advisory Boards to develop key objectives, focus groups, and topics that are relevant to systems-level discussion. These system-level discussions of the Council are necessary, and in contrast to the site/facility-level discussions that existing partner Patient Advisory Boards focus upon.

The PPS has accessed CMS and DOH resources, such as the EHR Incentive Program, to locate the Meaningful Use data related to the network's PCP NPIs. This alternative has given the PPS very valuable data that can assist with better understanding the PCMH readiness levels of each PCP and eligible practice site.

Implementation approaches that the PPS considers a best practice:

Community engagement was initially perceived as a risk in the project plan creation; however, project 2ai has made significant progress on Milestone 11 between May and July 2016. A Steering Committee, specifically designed and comprised of workgroup partner members in Cultural Competency & Health Literacy, Stakeholder Engagement, Project 4bii, and Project 2ai, has agreed upon the structural components of the Council, such as Council size, membership term, scope, and governance. The Council has also secured 12 nominations representing PPS patients and non-patients (providers, patient interest groups, MCOs). The Steering Committee has been an effective implementation driver and has effectively engaged partners.

Also, there has been strong participation from project workgroup members, consisting of senior leadership at the PPS' partner organizations across all provider types, city agencies, and MCOs. The workgroup has met on a monthly basis, and members are assigned to subworkgroups dedicated to overarching project deliverables. This method has created strong expertise and leadership in each deliverable area (e.g. PCMH, VBP, RHIO Connectivity) that informs and educates all workgroup members.

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

A key component of the success for project 2ai and the creation of the integrated delivery system is the engagement of MCOs. Currently, two MCOs represent and attend monthly project workgroup meetings, and a third MCO is being contacted for participation. These MCOs will represent the top-3 largest MCOs for the PPS. The MCOs currently participating in the workgroup discussions have been engaged, providing unique perspectives to other partner members and an opportunity for data sharing and collaboration.

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

Project 2ai has aligned and partnered closely with the PMO Data Management Team for in-depth analyses of the PPS attributed population. Performance measure data from MAPP, specifically claims-based measure data, has been re-purposed into an analytics tool to assist with creation of hot-spotting strategies. These strategies will inform which disease populations have the highest opportunities for improvement, and specifically, into which geographic regions specific clinical strategies should be prioritized and implemented.

Also, the impact of the DSRIP opt-out process is still under review as to the impact to the PPS attribution. The PPS assumes that members who opt-out will taper as the communications timeline proceeds.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Mount Sinai PPS, LLC

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:
As the MSPPS builds on successful and innovative programs to support patients in care transitions and the out-of-hospital setting, the project has encountered barriers to implementation for elements of care transitions to reduce 30-day readmission for chronic health conditions project. While viewing these challenges as opportunities for progress, it is helpful to place them into categories based on the fundamentals of each obstacle. It is important to note that this is an informal categorization to better understand and address these opportunities; therefore, many of them have varying degrees of relationship with more than one barrier category. The barrier categories are: Cultural, Financial, Education, Legal, Internal and interdisciplinary coordination, Technology, External and regional collaboration, and Other. Culture Cultural barriers describe some of the challenges associated with integrating new processes and protocols with existing workforce and processes. Working toward Milestone 4, "Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services," provided examples of some of these cultural challenges. In an effort to address this milestone, the group is working towards a process of enrolling all eligible patients into Health Homes or re-connecting them with assigned Health Homes prior to discharge from the hospital setting. After overcoming the barrier of identifying eligible patients in a timely manner, the time required for Health Home consent and enrollment in the hospital setting may have a negative impact on existing staff roles and responsibilities. This hurdle has been approached multi-fold, including pursuing some level of financial support for extra staffing, as well as parsing out the process to look at implementing only some elements, such as completing the consenting process and allowing a follow-up to be made when the work load has decreased, or by another person. There is also an effort to educate all levels of the hospital organization and workforce to understand Health Home, DSRIP, and PPS, and understand how they are beneficial to patients and communities. The academic hospital setting has been identified as having a valuable infrastructure for educating the clinical workforce by leveraging the weekly Grand Rounds and educational sessions that are required across all departments and service lines. Hospital administration is being engaged by utilizing existing hospital relationships among PPS and project leadership and joining meetings or focus groups already in place at the institutions. The discharge paperwork enhancement efforts as part of Milestone 1, "Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency," were carried out by the workgroup by first establishing a list of desired

improvements from the community stakeholder perspective. This list was then prioritized to 13 recommendations and brought to individuals or groups at the hospitals that are working towards similar goals. Among the challenges encountered was hesitation to make enhancements that implied a change, or additional responsibility, to physician or clinical workflow. The 2biv project leadership is currently meeting on a regular basis with the hospitals to assist with their efforts and illustrate how the out-of-hospital stakeholder perspective is beneficial to patient care transitions.

Finance

The 2biv group led discussions on how to enroll patients into, and connect them with, Health Homes prior to discharge from the ED and in-patient setting. It was acknowledged that multiple Health Homes may need to operate within one hospital location due to the volume of eligible patients and the labor- and technology-intensive requirements for identification, engagement, and enrollment. The Health Home partners participating in the 2ci, community navigation project had not been regular participants in the care transitions workgroups; therefore, joint 2ci and 2biv workgroup meetings were convened to illustrate their potential in the hospital setting and work through possible processes. Discussion included the possible financing for any increased staffing for partners, especially if those partners are not currently operating in the hospitals and shared risk. The two project workgroups continue working together and reviewing the possibility of utilizing hospital personnel to conduct Health Home enrollment processes within the hospital and then hand off the patient to an external Health Home partner.

Education

Challenges discovered relating to education varied depending on the purpose of the training and the characteristics of the provider type. For example, the hospital partners' need to educate and train a large scale workforce has necessitated exploration of an efficient modality for training, such as online learning systems and Continuing Medical Education lecture series that are already in place. For the smaller partner types as well as for smaller scale innovation projects, the group is exploring in-person group training sessions lead by experts from the respective innovation. Another solution the group is pursuing to mitigate some educational challenges is learning where partner and hospital personnel may possess certain skills, trainings or certifications that could be augmented to incorporate into care transitions innovations.

External and Regional Collaboration

This category is further broken down into challenges of care transitions collaborations with non-hospital partners, other Performing Provider Systems, EMS, municipal and outside organizations.

Most care transition innovations rely heavily on the hospital partners. As patients proceed through the care continuum from a hospital into the community, the non-hospital partners have an increasing role. One challenge has been elucidating the exact role of a non-hospital partner in the future implementation of new care transitions initiatives. This has challenges across the other barrier categories and the steps to mitigate this have included encouraging all partner types to participate in workgroup meetings, as well as inviting PPS partners that have only been active in other DSRIP projects and domains. This has brought important, new perspectives and experience to workgroup planning discussions.

With multiple PPSs in the same catchment area, there is ongoing recognition of the need to communicate and collaborate with other PPSs. This communication has included ad hoc meetings and direct

communication as well as a series of more formal meetings organized by third parties such as the Greater New York Hospital Association. The sharing of information and strategy with other PPSs is ongoing and will provide coordination in the effort to mitigate the challenge of caring for patients that may receive care from multiple PPSs.

The group has acknowledged the need to involve Emergency Medical Service agencies in the ongoing work of project 2biv. All categories of EMS agencies (municipal, volunteer, commercial, hospital) occupy the care transitions spectrum immediately prior to, and post-hospitalization as well as provide a direct pathway to the emergency room through 9-1-1 protocols. Furthermore, this pathway to the emergency room has the potential to indiscriminately cross pollinate visits across multiple PPSs. The complex challenge of the role of EMS in care transitions is being addressed through 2biv participation in 2bviii workgroups, Rapid Response Team subgroups, and Community Paramedicine.

The 2biv workgroup has recognized the important effect MCOs may have on any care transitions innovations to reduce all ED visits and hospitalizations as well as specifically to milestone 2, “Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.” Any care transitions initiatives put into place might be negatively impacted by internal MCO care transitions protocols that might send a patient to the ED. The workgroup recognizes the overlap with project 2ai goals and that all PPSs have the need engage the MCOs, so ongoing efforts to mitigate this challenge include a combined approach working together with the 2ai project to engage MCOs.

Internal Coordination

Some organizations contain several care transitions innovations with similar goals yet remain unknown even within the same organization. There is an ongoing effort to locate and describe these care transitions projects, and highlight similar goals and alignment with the PPS, as well as investigate how they could be a part of the PPS efforts. For example, a service line within a hospital might be implementing an initiative to reduce hospital readmission within their own unit and with minimal, if any, coordination with other departments or organizations. This challenge is being addressed by utilizing existing relationships to elucidate care transitions initiatives, and sending representatives to join their meetings and learn where there are areas of overlap with PPS goals, milestones and deliverables.

Other

The 2biv and 2bviii project partners frequently bring care transition innovation proposals to the PPS. The volume of proposal requests, in addition to the challenges of assessing a new model of care delivery, necessitated the creation of an objective vetting process. Part of the challenge is that care transition innovations, by definition, incorporate varying degrees of existing health care delivery elements, such as IT, workforce, home care, etc. The care transitions workgroup established, and is implementing, a process by which a partner submits a written proposal with a completed IT questionnaire, followed by a presentation to the Physician Champions for both 2biv and 2bviii. Due to the overlapping nature of these projects in the care continuum, this is a combined effort by both projects. The Champions have a 5 question scoring system using a Likert scale for each question. After independent scoring and comments are competed, the two scores are combined and any proposal meeting a threshold score out of a total of 50 points is then elevated to PPS committees and IT leadership for review and approval. Regardless of outcome, all proposals receive

constructive feedback from the PPS.

Information Technology

This section delineates the IT challenges from the perspective of the 2biv project workgroup. Due to the fundamental, integrated characteristic of IT in today's care transitions systems the group is confronted with an ongoing challenge of understanding what might be possible from an IT perspective while discussing innovative clinical care transitions processes. The group recognized early in the process that to overcome this challenge, there would have to be frequent and open communication channels between the PPS IT team and the project workgroup early in the process. The workgroup approached this challenge by inviting an IT representative to all levels of project discussion and enabling regular opportunities for IT to speak to partners at the beginning of each workgroup meeting. As IT develops solutions for the PPS, it has been valuable to provide them with the perspectives of community-based partners and stakeholders.

While elements of Milestone 1, "M1: Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency," and Milestone 2, "Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed," have revealed challenges in other barrier categories, there are also IT barriers. The 2biv workgroup recognized the difficulty of identifying the appropriate patients and engaging them on a large scale before they leave the hospital or ED. A successful approach has been used on a smaller scale, the Post-Acute Care Team (PACT), for highest risk patients; however, as the project scales up to a higher volume of patients with variable risk, the team is searching for the most efficient and effective criteria and method to identify a patient as early in the care transition process as possible. Complexities include EHR system interoperability and efficiently identifying patients on the morning census across all hospitals and service lines. While the IT specialists work on the technical aspects, the project group continues to work with IT to investigate necessary criteria and workflows for implementation in the hospital.

Data for baseline assessment of ED and hospital usage and readmission has been a challenge for 2biv. In order to understand the effectiveness of care transition innovations, the workgroup investigated how to establish a baseline of ED visits and hospital readmissions across the system in as close to real-time as possible. The group recognized that the delay in receiving the data makes it more difficult assess and improve the innovations within a short timeline. The group is working on multiple ways to overcome this barrier, including investigating what data is available and can be shared by partners with the PPS by as well as asking partners to report on the frequency they send patients to the ED or hospital and details of events. To the surprise of the workgroup, many partners do not currently track information on when the call 9-1-1 and the details surrounding the event. The workgroup is working with partners to investigate how they might begin collecting and reporting this information.

Efforts to mitigate challenges identified above:

As the MSPPS builds on successful and innovative programs to support patients in care transitions and the out-of-hospital setting, the project has encountered barriers to implementation for elements of care transitions to reduce 30-day readmission for chronic health conditions project. While viewing these challenges as opportunities for progress, it is helpful to place them into categories based on the fundamentals of each obstacle. It is important to note that this is an informal categorization to better understand and address these opportunities; therefore, many of them have varying degrees of relationship with more than one barrier category. The barrier categories are: Cultural, Financial, Education, Legal, Internal and interdisciplinary coordination, Technology, External and regional collaboration, and Other.

Culture

Cultural barriers describe some of the challenges associated with integrating new processes and protocols with existing workforce and processes. Working toward Milestone 4, "Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services," provided examples of some of these cultural challenges. In an effort to address this milestone, the group is working towards a process of enrolling all eligible patients into Health Homes or re-connecting them with assigned Health Homes prior to discharge from the hospital setting. After overcoming the barrier of identifying eligible patients in a timely manner, the time required for Health Home consent and enrollment in the hospital setting may have a negative impact on existing staff roles and responsibilities. This hurdle has been approached multi-fold, including pursuing some level of financial support for extra staffing, as well as parsing out the process to look at implementing only some elements, such as completing the consenting process and allowing a follow-up to be made when the work load has decreased, or by another person. There is also an effort to educate all levels of the hospital organization and workforce to understand Health Home, DSRIP, and PPS, and understand how they are beneficial to patients and communities. The academic hospital setting has been identified as having a valuable infrastructure for educating the clinical workforce by leveraging the weekly Grand Rounds and educational sessions that are required across all departments and service lines. Hospital administration is being engaged by utilizing existing hospital relationships among PPS and project leadership and joining meetings or focus groups already in place at the institutions.

The discharge paperwork enhancement efforts as part of Milestone 1, "Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency," were carried out by the workgroup by first establishing a list of desired improvements from the community stakeholder perspective. This list was then prioritized to 13 recommendations and brought to individuals or groups at the hospitals that are working towards similar goals. Among the challenges encountered was hesitation to make enhancements that implied a change, or additional responsibility, to physician or clinical workflow. The 2biv project leadership is currently meeting on a regular basis with the hospitals to assist with their efforts and illustrate how the out-of-hospital stakeholder perspective is beneficial to patient care transitions.

Finance

The 2biv group led discussions on how to enroll patients into, and connect them with, Health Homes prior to discharge from the ED and in-patient setting. It was acknowledged that multiple Health Homes may need to operate within one hospital location due to the volume of eligible patients and the labor- and technology-intensive requirements for identification, engagement, and enrollment. The Health Home partners participating in the 2ci, community navigation project had not been regular participants in the care

transitions workgroups; therefore, joint 2ci and 2biv workgroup meetings were convened to illustrate their potential in the hospital setting and work through possible processes. Discussion included the possible financing for any increased staffing for partners, especially if those partners are not currently operating in the hospitals and shared risk. The two project workgroups continue working together and reviewing the possibility of utilizing hospital personnel to conduct Health Home enrollment processes within the hospital and then hand off the patient to an external Health Home partner.

Education

Challenges discovered relating to education varied depending on the purpose of the training and the characteristics of the provider type. For example, the hospital partners' need to educate and train a large scale workforce has necessitated exploration of an efficient modality for training, such as online learning systems and Continuing Medical Education lecture series that are already in place. For the smaller partner types as well as for smaller scale innovation projects, the group is exploring in-person group training sessions lead by experts from the respective innovation. Another solution the group is pursuing to mitigate some educational challenges is learning where partner and hospital personnel may possess certain skills, trainings or certifications that could be augmented to incorporate into care transitions innovations.

External and Regional Collaboration

This category is further broken down into challenges of care transitions collaborations with non-hospital partners, other Performing Provider Systems, EMS, municipal and outside organizations.

Most care transition innovations rely heavily on the hospital partners. As patients proceed through the care continuum from a hospital into the community, the non-hospital partners have an increasing role. One challenge has been elucidating the exact role of a non-hospital partner in the future implementation of new care transitions initiatives. This has challenges across the other barrier categories and the steps to mitigate this have included encouraging all partner types to participate in workgroup meetings, as well as inviting PPS partners that have only been active in other DSRIP projects and domains. This has brought important, new perspectives and experience to workgroup planning discussions.

With multiple PPSs in the same catchment area, there is ongoing recognition of the need to communicate and collaborate with other PPSs. This communication has included ad hoc meetings and direct communication as well as a series of more formal meetings organized by third parties such as the Greater New York Hospital Association. The sharing of information and strategy with other PPSs is ongoing and will provide coordination in the effort to mitigate the challenge of caring for patients that may receive care from multiple PPSs.

The group has acknowledged the need to involve Emergency Medical Service agencies in the ongoing work of project 2biv. All categories of EMS agencies (municipal, volunteer, commercial, hospital) occupy the care transitions spectrum immediately prior to, and post-hospitalization as well as provide a direct pathway to the emergency room through 9-1-1 protocols. Furthermore, this pathway to the emergency room has the potential to indiscriminately cross pollinate visits across multiple PPSs. The complex challenge of the role of EMS in care transitions is being addressed through 2biv participation in 2bviii workgroups, Rapid Response Team subgroups, and Community Paramedicine.

The 2biv workgroup has recognized the important effect MCOs may have on any care transitions innovations to reduce all ED visits and hospitalizations as well as specifically to milestone 2, "Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed." Any care transitions initiatives put into place might be negatively impacted by internal MCO care transitions protocols that might send a patient to the ED. The workgroup recognizes the overlap with project 2ai goals and that all PPSs have the need engage the MCOs, so ongoing efforts to mitigate this challenge include a combined approach working together with the 2ai project to engage MCOs.

Internal Coordination

Some organizations contain several care transitions innovations with similar goals yet remain unknown even within the same organization. There is an ongoing effort to locate and describe these care transitions projects, and highlight similar goals and alignment with the PPS, as well as investigate how they could be a part of the PPS efforts. For example, a service line within a hospital might be implementing an initiative to reduce hospital readmission within their own unit and with minimal, if any, coordination with other departments or organizations. This challenge is being addressed by utilizing existing relationships to elucidate care transitions initiatives, and sending representatives to join their meetings and learn where there are areas of overlap with PPS goals, milestones and deliverables.

Other

The 2biv and 2bviii project partners frequently bring care transition innovation proposals to the PPS. The volume of proposal requests, in addition to the challenges of assessing a new model of care delivery, necessitated the creation of an objective vetting process. Part of the challenge is that care transition innovations, by definition, incorporate varying degrees of existing health care delivery elements, such as IT, workforce, home care, etc. The care transitions workgroup established, and is implementing, a process by which a partner submits a written proposal with a completed IT questionnaire, followed by a presentation to the Physician Champions for both 2biv and 2bviii. Due to the overlapping nature of these projects in the care continuum, this is a combined effort by both projects. The Champions have a 5 question scoring system using a Likert scale for each question. After independent scoring and comments are competed, the two scores are combined and any proposal meeting a threshold score out of a total of 50 points is then elevated to PPS committees and IT leadership for review and approval. Regardless of outcome, all proposals receive constructive feedback from the PPS.

Information Technology

This section delineates the IT challenges from the perspective of the 2biv project workgroup. Due to the fundamental, integrated characteristic of IT in today's care transitions systems the group is confronted with an ongoing challenge of understanding what might be possible from an IT perspective while discussing innovative clinical care transitions processes. The group recognized early in the process that to overcome this challenge, there would have to be frequent and open communication channels between the PPS IT team and the project workgroup early in the process. The workgroup approached this challenge by inviting an IT representative to all levels of project discussion and enabling regular opportunities for IT to speak to partners at the beginning of each workgroup meeting. As IT develops solutions for the PPS, it has been valuable to provide them with the perspectives of community-based partners and stakeholders.

While elements of Milestone 1, "M1: Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency," and Milestone 2, "Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed," have revealed challenges in other barrier categories, there are also IT barriers. The 2biv workgroup recognized the difficulty of identifying the appropriate patients and engaging them on a large scale before they leave the hospital or ED. A successful approach has been used on a smaller scale, the Post-Acute Care Team (PACT), for highest risk patients; however, as the project scales up to a higher volume of patients with variable risk, the team is searching for the most efficient and effective criteria and method to identify a patient as early in the care transition process as possible. Complexities include EHR system interoperability and efficiently identifying patients on the morning census across all hospitals and service lines. While the IT specialists work on the technical aspects, the project group continues to work with IT to investigate necessary criteria and workflows for implementation in the hospital.

Data for baseline assessment of ED and hospital usage and readmission has been a challenge for 2biv. In order to understand the effectiveness of care transition innovations, the workgroup investigated how to establish a baseline of ED visits and hospital readmissions across the system in as close to real-time as possible. The group recognized that the delay in receiving the data makes it more difficult assess and improve the innovations within a short timeline. The group is working on multiple ways to overcome this barrier, including investigating what data is available and can be shared by partners with the PPS by as well as asking partners to report on the frequency they send patients to the ED or hospital and details of events. To the surprise of the workgroup, many partners do not currently track information on when the call 9-1-1 and the details surrounding the event. The workgroup is working with partners to investigate how they might begin collecting and reporting this information.

Implementation approaches that the PPS considers a best practice:

The 2biv workgroup has established that in order to meet the large needs of care coordination for high-risk Medicaid patients, leveraging the hospitalization period for a patient as an opportunity for identification, engagement, and enrolment in Health Homes. The patient is more likely while in the hospital to be: In a moment of willingness to make personal lifestyle improvements; Accessible in a physical location; Accessible to be engaged in person. Bringing Health Homes into project 2biv discussions and meetings has been valuable. Among others, best practices have been established by several MSHS initiatives including the Post-Acute Care Team (PACT), Mount Sinai Visiting Doctors, and Mobile Acute Care Team. The PACT program is a labor-intensive initiative and would be available only for the highest risk (approximately 25% of Actively Engaged) hospitalized patients to receive regular, active care transition services for 30 days or longer. The lower risk patients would be referred to the Health Homes for care transition services.

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

Creation of a pediatric sub-group, integrating experts from various areas of pediatric care and care transitions to assist in addressing the needs of the pediatric population (reported to be 20% of PPS actively engaged) and the associated DSRIP process measures relating to pediatrics. This has included efforts to collaborate with the NYC Department of Education and explore collaboration with the East Harlem Asthma Center for Excellence.

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

Performance measure data from MAPP, specifically claims-based measure data, has been re-purposed into an analytics tool to assist with creation of hot-spotting strategies. These strategies will inform which populations have the highest opportunities for improvement, and specifically, as the project focuses on populations served by PPS hospitals, it highlights which programs and strategies should be prioritized and implemented based on a need for transitional care services. It emphasizes which areas served by the hospital could benefit most from services like health homes based on the level of readmissions by geographical area.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Mount Sinai PPS, LLC

Project: 2.b.viii

Challenges the PPS has encountered in project implementation:
As the MSPPS builds on current innovative programs to support patients in the out-of-hospital setting, the project team has encountered barriers to implementation for some elements of hospital-home care collaboration solutions. There have been similar technological challenges encountered with Milestone 9, "Utilize telehealth/telemedicine to enhance hospital-home care collaborations", Milestone 10, "Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services," and Milestone 12, "Use EHRs and other technical platforms to track all patients engaged in the project." One of these challenges is that there are many different electronic medical record systems already in use by different partners across the PPS. Furthermore, many partners participate in multiple PPSs, each with their own approach to electronic systems in use. The technical aspects of this challenge are being assessed by the PPS IT department and the 2bviii workgroup is assisting them when necessary to provide their stakeholder perspective. RHIO and HIE incorporation into the project 2bviii is also being looked at as an option to mitigate this challenge.
Efforts to mitigate challenges identified above:
Focus has been on developing protocols for communication between hospital and community providers, with an emphasis on trying to initiate notification protocols. Also working with Emergency Department leadership to encourage notification of PCP when possible. Transition toward Mount Sinai system-wide EMR should help with tracking of patients in our hospitals, as well as encouragement that community providers communicate to hospitals when one of their patients are being sent to the hospital should help in tracking those patients through Mount Sinai facilities. In addition, development of the HIE, in combination with the electronic PPS-wide care platform being developed for the Mount Sinai PPS, would allow for more open communication of patient data and would be more effective in tracking patients.
Implementation approaches that the PPS considers a best practice:

NEW YORK STATE | Department of Health

In order to address needs or certain project requirements, we have developed a pilot proposal rating system. If there is a partner or vendor that has an idea that can assist us in addressing a specific project need or provide a specific patient or data service, they may provide a written proposal and an IT assessment, and request to present it to our appointed project Physician Champions. During the presentation, vendors and partners provide a thorough presentation of the need they plan to address, and how, with thorough vetting from the Physician Champions. The Champions then score all aspects of the proposal to determine whether it is to go up the PPS's organizational structure for further review and approval.

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

Created a system in which we have worked with some of the main home care partners in our project to establish part-time RN Champions from partner's nursing staff. The RN Champion's job is to coordinate with the 2bviii leadership to implement and disseminate the 2bviii goals and activities within the organizations. This will include working toward implementation of a Rapid Response Team, integration of advance directives in routine care, and continued analysis of potentially avoidable ER visits and hospitalizations. The RN Champion will work closely with the MD champion to address these challenges and do the on-the-ground work necessary to move the 2bviii project forward within your organization.

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

Performance measure data from MAPP, specifically claims-based measure data, has been re-purposed into an analytics tool to assist with creation of hot-spotting strategies. These strategies will inform which populations have the highest opportunities for improvement, and it highlights which populations are at highest risk for readmission, and could benefit most from the presence of tools like a rapid response team. It emphasizes which populations might be at highest risk for readmission, and whether adequate home care services are available to these patients.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Mount Sinai PPS, LLC

Project: 2.c.i

Challenges the PPS has encountered in project implementation:

Information Technology

For the community navigation project to be fully implemented as the team envisioned, the services and patient engagement provided by the community navigators will have to be tracked via an **IT platform.** This platform must include Health Home service and eligibility information as well as non-Health Home community navigation services. For fully integrated PPS-wide community navigation through the Health Home and otherwise, a care plan should be accessible to members of a care team. Additionally, the care team members should be able to view the full care team, as well as progress notes related to ongoing care coordination work. This IT platform should also have available/sharable clinical information, appointment information, and RHIO connectivity.

Without such a platform, the time spent tracking and manually navigating the system will take away from patient care. Current operations across multiple HIT platforms would require the development of several secure file transfers to seamlessly exchange this information.

As of the end of June 2016 (DY2, Q1), this community based navigation project has not been able to leverage sufficient IT infrastructure. Meeting this challenge will be highly dependent on the robustness of the infrastructure made available (i.e. access to HH eligibility and assignment information, receipt of admission alerts, secure messaging among providers, integrated care planning, web-based resource tools and tracking). The impacted areas of the project include but are not limited to: efficiency and effectiveness of care coordination and allocation of resources, reduction of duplicated community navigation services, and increased Health Home conversion and HARP/HCBS assessment and connection to care.

Workforce

Another challenge relates to **workforce staffing, training, and supervision.** Given the current structure of Health Homes and the large volume of assignments, many CMAs have a diminished capacity to take on new patient assignments. This will be a challenge to both actively engaged (speed and scale ramp up) and providing quality care (effects performance/outcome measures for domain 2 projects). It is challenging for CMAs to front-load staff resources due to the current Health Home reimbursement structure. It takes time to train new staff and for the new staff members to achieve a full caseload. CMAs are therefore not able to cover the cost of the ramp up period for more than one new staff member at a time. This makes a large scale referral workflow for community navigation challenging, as volume is a concern. Additionally, not all PPS partners who provide community navigation are Health Home care management agencies. These organizations have no opportunity for reimbursement, and it is therefore very challenging to hire staff who are dedicated to this work.

Appropriate supervision is also necessary for accountable community-based patient care. In order to meet the project requirements and produce positive outcomes for performance and quality in the latter years, it is essential that appropriate clinical supervision is in place. Building a workforce of non- licensed staff working with some of the highest risk patients warrants a strategy around supervisory infrastructure to limit associated risks. With a project that spans multiple boroughs, lead Health Homes, and CMAs, standardizing this structure will be especially challenging.

Efforts to mitigate challenges identified above:

Mitigation of main challenge (IT): The use of the MAPP portal for Health Home-related services will provide some of the tracking, eligibility, and care team information mentioned in the challenges section above. As future phases of MAPP roll out, it will be essential that all providers assisting with this project are familiar and well-versed in the processes. We will partner with the State to provide trainings and will develop training materials for all staff that is standardized for tracking and sharing within the system. We will also explore other web-based systems that may assist other aspects of the work, especially interoperability with various EMRs, integrated care plans, HIEs, RHIOs, and scheduling systems. Leveraging existing HIT interface structures could allow the consumption and sharing of information in the interim.

This project works closely with the care coordination cross functional workgroup to build upon synergies of other work streams via committees like the IT committee and project workgroups such as 2biv, the care transitions project. This project also has representation on the DSRIP Call Center Steering Committee, the Clinical Quality Committee, and the Clinical Executive team to continue making connections and leveraging existing solutions/overlapping goals. Additionally, this project has given ongoing input into the creation of the Community Gateway, to ensure that all PPS partners have access to HH information, a community resource guide, and the HIE.

We have a dedicated IT lead and analyst to help gather business requirements for deliverables such as the web-based community resource guide (Milestone 2).

Mitigation of Workforce challenge: The financial and workforce investment in this project will be clearly defined. Our path to achieving more clarity involves close collaboration with the financial and workforce development entities to understand any potential burdens that fall outside of the scope of our expectations and strategize avenues for successfully managing those burdens. The services available through this project will allow for current Health Home staff to be more efficient and effective in their work. It will also assist with more successful outreach to patients who are especially difficult to find and engage. The project will increase Health Home enrollment by capturing patients when in an acute setting or while accessing services in the community. Additionally, the providers involved will be staged so that an evaluation can be completed after the first two quarters to determine needs and assess capacity.

Through this project, part of the staff will include licensed clinical SWs and RNs to provide support in a standardized manner to the community navigation staff. The hub of resources will also be helpful for real-time consultations. Additionally, trainings will be available as part of this project for ongoing education on specific diagnoses, care team collaboration and communication, patient behaviors, and interviewing/counseling techniques. These resources will be linked to PPS quality oversight of the project.

Additionally, the lead Health Homes and the Coalition of NY State Health Homes will assist in providing standards of care for Health Home services to align various lead Health Home policies and procedures. A PPS-wide protocol for Health Home referral is in development, and will assist CMAs in determining capacity once in place.

This project works closely with the care coordination cross functional workgroup to build upon synergies of other work streams such as the Workforce Committee.

Implementation approaches that the PPS considers a best practice:

1) **Best Practice is to Leverage Existing Resources** (ie. departments (social work), programs, resources initiatives already in place and building upon and enhancing the current Health Home structure.
2) **Best Practice is to participate in non-PPS initiatives** that have common objectives and goals to create synergies among the participants (Greater New York Hospital Association, East Harlem Community Health Committee, Inc)
3) **Best Practice is to conduct a strengths, weakness, opportunities, threat (SWOT) analysis** to augment enrollment in the Health Homes within the PPS, prioritizing HARP eligible clients.
4) **Best Practice is to pilot test** through the co-location of community-based navigators.
5) **Best Practice is to align** with potentially overlapping DSRIP workstreams and or projects (care coordination, stakeholder engagement, clinical executive, command center)
6) **Best Practice is to collaborate** with other PPSs' (Bronx Health Access PPS)

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

In addition to what is already being reported in quarterly reports either for Implementation Project Plan (IPP) reporting or overlapping Equity Infrastructure Program (EIP) Reporting, it is the PPS's intent utilize the growing PPS wide data analytical tools, resources and the actual results to increase efforts to engage the community based organizations and their respective communities.

Because there is a lot of overlap with other projects and work streams, leveraging the work outside of this workgroup will be beneficial in focusing on outcomes and quality (end of DY2/ Q2). The workgroup intends to use data on attributed patients to risk stratify and target those who are in the greatest need for community navigation services.

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

NEW YORK STATE | Department of Health

The initiation of enrollment into the Health Homes Serving Children on December 1, 2016 will be a population assisted through this project. Additionally, through the collaboration with 2biv, there is a larger focus on capturing patients who are in need of community navigation services while they are in an acute setting.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Mount Sinai PPS, LLC

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

There have been numerous challenges to the implementation of project 3ai – in terms of planning, requirements of PPS partners, and implementation of integrated care in partner sites.

Planning and Engagement Challenges

Project 3ai has approximately 30 partner sites represented on the project Workgroup, and many more planning to implement the project. Engaging partners in project development and execution is difficult, not only due to scheduling, but also because partners are at varying stages and steps in the process of implementing integrated care. It is also challenging to keep all of the partners (both workgroup and non-workgroup members) up to date on the project contract requirements.

Project Requirement Challenges

There are many regulatory issues around 3ai that are essential for both the PPS and partners to understand. For example, Federal Confidentiality Regulations for alcohol and substance use providers prohibit sharing of patient data from the partner to the Mount Sinai PPS. It is essential the PPS communicates this information to partners. In addition, there are project requirements that need to be informed by evidence and practice, such as the Warm Handoff, and project workgroups must define these requirements clearly for the project and all partners in a way that is scalable and fits into provider workflows. Finally, it is necessary to be extremely clear with partners about the parameters of meeting project requirements such as Actively Engaged identification and reporting.

Implementation Challenges

In addition to meeting project requirements, there are other partner level barriers to implementing integrated care, for example: finding space for additional staff as space in NYC clinics is limited and expensive; staffing upfront costs can also be cost-prohibitive and there is a small pool of trained and qualified staff to fill integrated care positions (social work, psychiatrists). These costs can be especially hard to front for smaller organizations. Coordinating and funding training for staff (both existing and new) is also challenging in executing integrated care models. In addition to site level issues, there are PPS and partner level challenges in understanding the new processes for Licensure / Billing / Waivers, communicating these processes to partners, and difficulties for partners in operationalizing at the sites. Finally, developing Clinical Protocols that are high level enough to be scalable but can be adopted and customized at a site level is ongoing difficulty for 3ai workgroup members.

Efforts to mitigate challenges identified above:

In order to address Planning and Engagement challenges, workgroup leaders have made on-going efforts to engage partner providers, via surveys, emails, phone calls, open access for questions/ concerns, in-person and conference call meetings. We have also come to a (as much as possible) mutually agreeable time for meetings and partners may vary their representation as needed. We have also attempted to take advantage of partners being at different steps in the integration process, by having partners share best practices and workflows with each other, by inviting staff to observe at site visits, and by setting common goals. We have also tried to be straightforward with our introduction of contracting metrics to partners, as metrics are developed based on workgroup deliverables, we have been upfront about metrics while in development, and provided group and 1:1 guidance on completing project metrics.

In order to address Project Requirement Challenges, we have communicated state guidance and asked SUD partners to only report aggregate data and have created an alternative reporting mechanism. In order to address the warm handoff requirement, as a workgroup we have defined the "ideal" warm handoff and are working to develop risk stratification for clinical guidance, and we have consulted with subject matter experts for guidance in this area. Finally, we have reviewed all actively engaged reporting requirements with workgroup partners, we have reviewed and confirmed definitions at meetings, and have offered IT and PMO reporting team support and assistance to partners.

In order to address Implementation Challenges at the site level, partners have been creative with their use of current and shared space. Similarly, partners have been creative in staffing their integrated care models by using current staff and finding funds and / or grants for new hires. Partners have also attempted to mitigate start-up costs by capitalizing on outside grants. We have attempted to communicate to partners about existing 3ai webinars, online resources, and collaborative learning opportunities among partners.
To clarify Licensure / Billing / Waivers issues, we have been in ongoing discussions with PCG, KPMG and NYS, and created a Summary Document for partners to illustrate which waivers or licensures they should apply for. Finally, to develop appropriate Clinical Protocols, we have initiated sub-workgroups (Screening Tools, Warm Handoffs, Medication Management, Pediatrics), and accessed expertise and resources outside the workgroup (Physician experts in SU/MH, Northwell Health SBIRT presentation).

Implementation approaches that the PPS considers a best practice:

Approaches the 3ai Workgroup has taken to project implementation:
Connectivity and Alignment with Overall MSPPS Structure, Content, and Process: The MSPPS identified a Behavioral Health Director – who also serves as a 3ai co-lead and clinical champion. Having someone in this role increases project connectivity to the PPS overall for clinical and administrative matters. We have also instituted standardized communications with partners (surveys, PPS website) and ad hoc communications when new information is released. Also, a regular schedule of meetings with in-person/telephonic/virtual options helps to connect partners to the project and PPS.
Building a Team at All Levels: Inclusivity and Building Consensus: The 3ai Leadership Team (3 co-leads: 2 from Mount Sinai and one partner, plus the Project Manager) hold weekly conference call meetings — building the Leadership Team while working on execution of the project. In order to meet project protocol requirements, we have created content sub-workgroups consisting of partner members and other content experts working together to build workflows and develop guidelines. We have also regularly had partners present the roll-out of integrated programs at their sites, discussing challenges and strategies for overcoming barriers. This has built a strong workgroup that is learning together and from each other.
Standardization with built in flexibility: In order to keep our established protocols at a high level and standardized across PPS sites, we participated as a workgroup representing all partner types, in Process

Mapping sessions to document workflow and provider responsibilities. We also focused early on in choosing Best Practice Guidelines/Protocols that partners were already using in successful integrated sites. We are working to finalize our PPS-wide tool kit to provide the tools to achieve standardization.

Problem solving mode throughout to maintain momentum: The 3ai Leadership Team is constantly reviewing the overall Structure and Work Process. In order to move the project objectives forward we have pursued all avenues to find answers (PCG, IA, NYC collaborative, GNYHA) and have communicated to the full workgroup even (and especially) when we do not know the answer. In addition, the Project Manager has worked with a group of 3ai project managers representing other PPSs to share ideas and reinforce understanding of the project guidelines.

Thinking beyond Project Management and DSRIP - Build Integrated Care into Clinical and Business Operations to increase Sustainability: We also are attempting to focus on operationalizing the build of a clinical program just as much as managing a project. This includes focus on non-clinical aspects of running a program—such as Legal, Compliance, Finance, and General Administrative issues. We regularly review and discuss the "Future State" beyond the quarter or the DSRIP year.

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

We are in the process of taking all of the evidence based materials we have reviewed and creating a 3ai Best Practices Implementation toolkit. We presented an initial draft of Integrated Care protocols to present to Clinical Quality Committee for review and approval. The manual will then be made available for piloting and continuous quality improvement to workgroup members and after to the greater PPS partnership for project implementation. As we finalize our protocols we will look to incorporate interventions to impact the Performance Measures.

We have also created a 3ai Waivers sub-workgroup to identify possible waivers for submission. The PPS has a waivers submission process created by the Compliance group and we have disseminated materials to workgroup members to identify needed waivers to streamline IDN implementation.

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

Our PPS has more partners who have identified interest in implementing Model 1 than Models 2 and 3. We had originally anticipated more even interest among models.

The most significant barrier to implementing Model 3 is the inability to bill for Depression Care Manager services, though we did have two out of four partners sites accepted into the OMH Collaborative Care Program. Expansion of this program would be helpful to our partners in terms of training and service support. Next steps include; working with Model 2 BH sites to identify specific barriers and solutions to implementing collaborative care; identifying additional PPS partners not currently participating in 3ai for implementation.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Mount Sinai PPS, LLC

Project: 3.a.iii

Challenges the PPS has encountered in project implementation:
There have been many challenges to implementing project 3aiii, in terms of creating a scalable intervention, working the intervention into current workflows, documentation and reporting, and integrating project goals into the overall Integrated Delivery Network. **Standardization Challenges** It has been difficult to standardize and scale the intervention and documentation of self-management goals across multiple providers – instituting new requirements can create duplication of work in sites already documenting medication related self-management goals. It is also challenging to create a high-level clinical protocol that will work across different provider settings with varying levels of supportive services and different staff types implementing the projects (clinicians and therapists versus care managers, etc.). Different provider types also use different platforms and standardized documentation methods. Clinical providers use EMRs and treatment plans versus Health Homes care coordinators who use Care Coordination platforms and care plans to document goals for patients. **Actively Engaged Challenges** In order to ensure compliance with actively engaged definitions and eligibility, the documentation requested from partners, especially those with less sophisticated EMR systems, has been onerous and labor intensive. Also, focusing on high Actively Engaged targets has made it difficult to allocate resources towards clinical program and protocol development. Finally, it was an additional challenge to have the actively engaged definition changed in DY1Q2 once we had already started building a protocol around wellness self-management and we lost progress in having to work with the NYSDOH and re-focus our efforts. **Integration of 3aiii** Collaboration is necessary between MSPPS workgroups with similar goals: care coordination workgroups developing standardized care plans with self-management goals and other clinical projects with self-management goals (3bi). It is challenging to balance the needs of the specific project work stream with the need to collaborate on a single product that can meet the needs of all projects and partners. We are also working on Care4Today, a mobile application build that is both patient and provider facing. For this to be successful it is essential to focus on interoperability with multiple platforms (EMRs, Care Coordination Platform, RHIOs, MSPPS Partner Portal) in order to create as seamless as possible workflow for partners. The Care4Today platform also needs to be integrated bi-directionally into MSPPS IT solutions; patients and clients need to be verified and / or registered via PPS patient data to decrease data entry and confirm data is connected with the correct patient or client. These considerations (along with a multitude of security requirements) need to be addressed to complete the launch of Care4Today across partner sites.

Efforts to mitigate challenges identified above:

In order to standardize and streamline the process of documenting self-management goals, we are identifying and capitalizing upon activities partners are conducting in their current workflows. We have developed criteria to participate in reporting actively engaged patient data. We are simultaneously working with partners on building a clinical program focused on development of PPS-wide best practices protocols including incorporation of evidence based assessments and treatment interventions; such as motivational interviewing and wellness-self management, and working with the patient in an on-going basis to assess goals and progress and create behavior change, while supporting clinicians in their work. We have also hired a Clinical Lead to develop protocols and trainings, assist with implementation and technical assistance, and lead a continuous quality improvement and evaluation processes. While this will be an on-going challenge, we have created sub-workgroups to provide input into the creation of a clinical protocol – we will be incorporating best practices and feedback from different provider types and settings. The protocol will need to offer an array of potential levels of intervention while safeguarding validity of the intervention.
We are also working to incorporate interventions to impact Performance Measures into our project protocols.

To minimize the burden of reporting on partners we will be working with compliance and reporting groups to request that partners maintain auditable data at their sites but only supply the PPS reporting team with minimum reporting requirements (CIN, name, date of service). We will need to create an attestation that partners have policies and procedures in place to ensure the integrity of their data. Compliance and legal representatives will need to review and approve this process before it can be used in quarterly reporting of actively engaged. We are also working to engage additional high volume partners beyond the workgroup to participate in project 3aiii and submit actively engaged data.

Integrating 3aiii activities into the IDN will be an on-going challenge. Meetings have commenced with representation from the care coordination cross functional workgroup leadership and IT representatives, and leadership from Project 3bi. Care4Today IT specialists have been in on-going meetings with MSPPS IT staff to address integration and security issues. Solutions are still a moving target and will not be operationalized in the near term.

Implementation approaches that the PPS considers a best practice:

Approaches the 3aiii Workgroup has taken to project implementation:
Connectivity and Alignment with Overall MSPPS Structure, Content, and Process: The MSPPS identified a MSPPS Behavioral Health Director – who has been serving as a connection to the overall MSPPS. Having someone in this role who is involved with 3aiii implementation increases project connectivity to the PPS overall for clinical and administrative matters. We have also instituted standardized communications with partners (surveys, PPS website) and ad hoc communications when new information is released. Also, a regular schedule of meetings with in-person/telephonic/virtual options helps connect partners to the project and PPS.
Building a Team at All Levels: Inclusivity and Building Consensus: The 3aiiii Leadership Team (1 Mount Sinai co-lead, 1 partner co-lead, the BH Director, the 3aiii Clinical Lead, and the Project Manager) hold weekly conference call meetings – building the Leadership Team while working on execution.
Content Sub-Workgroup: Partner members and other content experts (hospital and community providers, academic researchers, evaluation experts, Care4Today, and IT) are working together to build intervention

workflows/guidelines both for Care4Today and for partners that may not choose to use the Care4Today application.

Standardization with built in flexibility: In order to keep our established protocols at a high level and standardized across PPS sites, we participated as a workgroup representing all partner types, in Process Mapping sessions to document workflow and provider responsibilities. We are working to finalize our project wide Best Practices Manual to provide the tools to achieve standardization.

Early focus on choosing Best Practice Guidelines/Protocols: Project co-leads created a Treatment Adherence Template – developed using Wellness Self-Management and SAMHSA Illness and Recovery Modules, as well as Stages of Change theory. The template was shared with partners as a way to engage patients and collaboratively document and review self-management goals. This shared template can provide a framework for standardization, however, many partners already had in use robust self-management goals systems. As we continue to build the protocols we will focus on standardizing how patients are engaged and counseled as well as the interventions implemented to help patients meet their identified goals.

Problem solving mode throughout to maintain momentum: The 3aiii Leadership Team is constantly reviewing the overall guidelines and implementation process. In order to move the project objectives forward we have pursued all avenues to find answers (PCG, IA, Refuah PPS collaboration, etc.) and have communicated to the full workgroup even (and especially) when we do not know the answer. As mentioned earlier, we collaborated early on with our PPS's Performance Facilitator to achieve changes to Actively Engaged requirements.

Thinking beyond Project Management and DSRIP – Build Adherence Management into Clinical and Business Operations to increase Sustainability: We are focusing on operationalizing the build of a clinical program by integrating interventions into the current workflows and training existing staff in project implementation. We are also working to make the Care4Today mobile app a specialized tool for BH population health that will be used by providers and patients after DSRIP ends.

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

Since the original application for the 3aiii project, Care4Today has begun the development a new platform that will be utilized as one of the tools to help engage patients in self-management goals. The platform will aim to improve patient engagement and treatment adherence. Patients will self-report adherence to medications, appointments, and self-management goals (exercise, nutrition, smoking cessation, reducing drug and alcohol abuse). Providers will have visibility to patient reported metrics via a Provider dashboard. The end goal of the platform is to: 1) remotely engage the patient in their goals and 2) support patient care via a dashboard connection between the patient and the provider.

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

NEW YORK STATE | Department of Health

Many Health Home Care Management Agencies have expressed interest in participating in 3aiii due to their expertise in providing adherence support to the highest risk patients and clients.

We have also expanded to Opioid Replacement Therapy partners sites because of the high rate of MH and SUD, as well as physical health co-morbidities in this population.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Mount Sinai PPS, LLC

Project: 3.b.i

Challenges the PPS has encountered in project implementation:

NYS Smoker's Quitline referral process:

3bi project partners must facilitate referrals to NYS Smoker's Quitline. Although the NYS Smoker's Quitline offers three different referral processes (fax, secure online referral, and Opt-to-Quit), most 3bi partners were only aware of the fax option. Additionally, many partners encountered challenges using the fax option. Limited awareness of the three referral options was symptomatic of larger confusion amongst providers and patients about resources available through the Quitline.

Blood pressure without an advanced appointment or co-payment:

3bi partners must provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment. 3bi participants indicated this would be challenging as none of the sites are currently offering this service and/or feel they have the ability to provide the service. Key challenges to achieving the successful implementation of this service are ensuring proper measurement and designating qualified medical personnel to administer the blood pressure checks.

Self-management goal:

3bi project partners must document patient driven self-management goals in the medical record and review these goals with patients at each visit. 3bi partners identified this as a challenge because there is no standardized way to collect and record the self-management goals. Many partners indicated that self-management goals are regularly discussed at their sites, but are not documented in the EMR in a structured field—they are documented as free text. Consequently, data retrieval is complex and difficult. Additionally, educational materials are not easily accessible and/or available with the appropriate health literacy and cultural competence levels.

Access to durable medical equipment:

3bi identified access to necessary durable medical equipment for specific patient populations (e.g. blood pressure cuffs for patients with hypertension, scales for patients with heart failure) as a challenge. National Heart Failure Professional Society guidelines recommend that patients weigh themselves daily to monitor their fluid status and need for diuretics at home to prevent hospital admissions for decompensated heart failure. Many patients, however, do not have access to and/or cannot afford scales.

Best practices for aspirin prophylaxis:

3bi encountered challenges synthesizing guidelines and recommendations to identify best practices for Aspirin prophylaxis based on risk profile.

Lipid Management:
3bi encountered challenges synthesizing guidelines and recommendations to identify best practices for blood lipid management and recommendation for Statin Therapy for ASCVD Prevention and Management.

Efforts to mitigate challenges identified above:

Mitigation of NYS Smoker's Quitline referral challenge mitigation:
To increase awareness about referral options to the NYS Smoker's Quitline 3bi identified a contact (Patricia Bax) at the NYS Smokers Quitline. Ms. Bax was asked to present to the project co-leads and workgroup members on the different referral methods. During this presentation Ms. Bax explained each referral process in detail. 3bi was excited to learn about the additional referral options. As a follow up to this presentation the workgroup requested additional information on how other clinical sites have successfully operationalized the referrals. Ms. Bax connected the PMO with contacts at NYU and Stony Brook who are successfully doing EMR-based referrals to the Quitline. The NYU and Stony Brook contacts presented to the co-leads and workgroup members on successes and challenges. As a result of these presentations, and follow up materials distributed to the workgroup, many partners have expressed a strong desire to upgrade their referral processes. Ms. Bax offered to directly support partners interested in switching their referral process. 3bi also participated in the quarterly NYS Smoker's Quitline conference call and shared materials from this call with the workgroup. Finally, the co-leads and workgroup have been working to incorporate information about the NYS Smoker's Quitline into self-management goal educational printouts in an effort to increase exposure and awareness.

Blood pressure without an advanced appointment or co-payment challenge mitigation:
To support the successful implementation of this service the workgroup researched evidence-based strategies and practices. They used this information to create a protocol that stratifies patients based on their blood pressure level. The protocol also details the type of staff members that can support this service. Finally, the workgroup developed workflows to help appropriately triage patients.

Self-management goal challenge mitigation:
To address challenges administering and recording self-management goals, the co-leads and workgroup created a standardized form adapted from the Million Hearts Campaign. The workgroup also created educational resources for patients to accompany the form. All materials were presented at the Cultural Competency and Health Literacy Workgroup. Feedback from the Cultural Competency and Health Literacy Workgroup was incorporated into the final documents. The PMO is also working closely with IT to develop a process to document the goals in a care coordination platform, which partners will have access to. There is also an ongoing collaboration with IT to integrate these resources into patient visits at different partner sites.

Access to durable medical equipment challenge mitigation:

3bi identified necessary durable medical equipment for specific patient populations. This included blood pressure cuffs for patients with hypertension and scales for patients with heart failure.

Aspirin prophylaxis challenge mitigation:

The co-leads and workgroup developed a protocol for Aspirin prophylaxis using the latest guidelines from the American Heart Association and American College of Cardiologists. We will include this protocol in training for primary care providers and will work with IT to develop reminders for providers in the EMR.

Lipid management challenge mitigation:

The co-leads and workgroup developed a protocol and workflow for blood lipid management. They also developed recommendations for Statin Therapy for Aetherosclerotic CVD Prevention and Management using the latest guidelines from the American College of Cardiologists. We will include this protocol in training for primary care providers and will work with IT to develop reminders for providers in the EMR.

Implementation approaches that the PPS considers a best practice:

1) **Best practice is to collaborate with similar projects**. 3bi is working closely with 3ci to implement their projects. This collaboration includes weekly calls with 3bi and 3ci co-leads and a monthly in-person meeting with 3bi and 3ci workgroup members. Best practices, materials, meeting notes and project information are readily accessible to workgroup members from both projects.
2) **Best practice is to use evidence-based, latest, comprehensive, and easy to follow protocol and guidelines** with regard to cardiovascular disease prevention and management.
3) **Best practice is to develop educational materials**, which include, but are not limited to, the self-assessment goal sheets that are evidenced-based and culturally appropriate for the proper health literacy level, accessible in-print and EMR.

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

Project 3bi has been collaborating and aligning with the Workforce Committee to identify training opportunities and alignment between projects. In particular, the group is working to develop online trainings and create opportunities for Continuing Medical Education (CME) credits.

NEW YORK STATE | Department of Health

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
At this time there are no changes to the populations proposed to be served through the 3bi project.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Mount Sinai PPS, LLC

Project: 3.c.i

Challenges the PPS has encountered in project implementation:

Training:

Developing and implementing successful provider trainings was identified as a challenge. Different EMR systems across partners, varying internal organization structures, limited access to training resources, and varying workflows are key considerations/challenges being addressed as trainings are developed. Additionally, 3ci is determining the availability of staff to participate in trainings, whether the trainings should be in-person and/or online, and the appropriate content density and level.

Eye exam:

Protocols for the proper documentation, interpretation, and implementation of eye exams were identified as a challenge. Key challenges to administering eye exams include identification of patients not being tested annually and follow-up protocols; access to special equipment needed to perform proper assessments; and a standardized form for documentation across all specialties. One of the challenges was the referral. Information did not always come back to the referring party.

Nephropathy:

Access to guidelines for nephropathy screening and treatment was identified as a challenge. Key concerns are identifying individuals with diabetes or at risk for diabetes with early manifestations of kidney disease.

Integrating community-based services & partners:

3ci recognizing the value and importance of collaborating with community-based services and partners. In particular, the ability to make adequate referrals to community partners who can help achieve positive outcomes. However, this work requires a high level of integration that has been challenging.

Efforts to mitigate challenges identified above:

Training challenge mitigation:

Training using a slide deck and modules will be given in person and will also be made available online via Mount Sinai's online learning portal. Approval for Continuing Medical Education (CME) credit will be

submitted in August. Training content will be divided into sections and main take-home points will be emphasized and reinforced via proper post-training evaluation. The training content, modules, and performance is developed together with training and workforce experts from 1199 Training and Employment Fund (TEF) experts. The training will emphasize collaboration between partners with various capabilities to find common grounds and ensure all partners are working toward a common goal. Finally, the training will include a "training the trainer" approach.

Eye exam challenge mitigation:

To address challenges related to eye exams 3ci developed a standard form that can be incorporated into the HIE for use by all partners for the reporting on eye exams. This will allow for continuous collaboration between optometrists, ophthalmologists, physicians, and other clinicians. It will also help to close the loop on the referral process; ensuring physicians receive updates after a referral. Additionally, it ensures testing is accessible, tech-appropriate, and that results are understood and documented appropriately. Remote interpretation of results and reports will be available. Lastly, the PMO is in the process of developing a repository to enable patient identification and monitoring.

Nephropathy challenge mitigation:

3ci developed and presented a protocol for nephropathy screening and treatment. The project also met with medical personnel and management from the Institution of Family Health to learn about and develop a patient registry to identify those who need screening. This process for developing a registry was then disseminated to all 3ci partners.

Integrating community-based services & partners challenge mitigation:

3ci is working with a variety of community-based partners, such as City Health Works (a non-profit organization specializing in using community health workers for disease management and care coordination for high risk patients) to address integration challenges and establish best practices. 3ci is also working with other community based organizations in the project to better understand their services and how they can see their role in this project. 3ci participates in the Care Coordination Cross Functional Workgroup which spans a variety of partners and is focused on care coordination and relationships between partners (charter quote). Additionally, Care Coordination Cross Functional Workgroup is developing a resource guide with detailed information on community based organizations and services.

Implementation approaches that the PPS considers a best practice:

1) **A best practice is to collaborate with similar projects**. 3ci is working closely with 3bi to implement their projects. This collaboration includes weekly calls with 3bi and 3ci co-leads and a monthly in-person meeting with 3bi and 3ci workgroup members. Best practices, materials, meeting notes and project information are readily accessible to workgroup members from both projects.
2) **A best practice for eye exams** is to develop a clear and simple referral process, patient identification process, guidelines, a standard form and documentation in EMR, remote interpretation; and use of a retinal camera in the clinic.
3) **A best practice for nephropathy assessment and treatment** is to prompt an ongoing alert for patients who do not meet guidelines for best practices. Additionally, navigators and certified diabetes educators are used to ensure measures are appropriately collected and monitored.
4) **A best practice for educational content** is to use evidenced-based and culturally appropriate materials that are accessible in-print and through the EMR.

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

- Project groups collectively agreed there is a need for a disease management care plan. An existing template was available through Mount Sinai's EPIC Healthy Planet. 3ci worked to streamline the disease assessment document and align it with project goals. 3ci also edited language to a more appropriate clinical level. Edits were presented to the Care Coordination Cross Functional workgroup for final review and approval

- IT is working to determine different EMR capabilities and have information available through HIE.

- 3ci is collaborating with 1199 TEF and the workforce committee to develop and implement trainings.

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

At this time there are no changes to the populations proposed to be served through the 3bi project.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Mount Sinai PPS, LLC

Project: 4.b.ii

Challenges the PPS has encountered in project implementation:
Project 4bii workgroup has encountered various challenges to a speedy implementation. Among these challenges are the various issues at the partner's organizational level. For some organizations, these difficulties begin with IT. It is often difficult to obtain accurate, timely and usable data or to retrieve reports back from specialists. Many await the development of the PPS IT infrastructure (Healthix) in order to have more meaningful information. Other site specific challenges include that the groups are very diverse and each site, even within the same organization, may be at a different level of maturity. Other areas of difficult for project implementation include each organization's need for more staffing to complete new workflows or increased workforce training. Implementing new workflows for the project and developing scripts is time consuming and often difficult. The workgroup has also had a harder time engaging partners from organizations that do not provide direct patient care, such as community based organizations. Other challenges for successful implementation are more systemic. These include not fully understanding who our population is, finding these patientsand engaging them in their care. The 4bii project at Mount Sinai chose to focus on the following chronic disease screenings: breast, cervical and colorectal cancers, as well as chlamydia and Hepatitis C. These were chosen based on the indicators present in the Community Needs Assessment. However, it has been difficult to establish what the baseline is for the partners within the project. Additionally, it has been a challenge to understand the barriers to access care from a patient perspective. Providers in the workgroup have also expressed that it seems there may be duplication of work, with patients seeing multiple providers and all sites are working towards the same goal but without proper communication tools in place.
Efforts to mitigate challenges identified above:
In order to mitigate some of the challenges, the workgroup has maintained forward momentum by adapting workarounds. For IT challenges, such as data retrieval, DSRIP IT representatives join workgroup calls and meetings in order to provide some guidance on how best to obtain reports or how workgroup members can ask for support from their organizations IT group. These representatives are involved with many IT projects that will simplify the work being done in DSRIP and they provide updates as needed to ensure partners are aware of the projects' estimated completion dates (i.e. Healthix, Partner Portal). For staffing issues, the group has discussed using current staff to the top of their license and how to do this. We have also developed workflows in line with what partners are already doing, with only slight changes, so as not to overburden staff with too many changes at once. Sites are responsible for educating members on how to best adapt

by what is best for that site. In these workflows, there has been a focus to include the follow-up on results from referrals or outside organizations. This will also help our partners begin to form the habit of better communication. The workgroup has also tried to engage our non-clinical partners by selecting groups to present their work at workgroup meetings and discuss the key role they can play in the educational piece of chronic disease preventive screenings.

In terms of understanding our patient population, there is alignment with the Stakeholder Engagement Group and Project 2ai in the development of a Consumer Advisory Council. This council will establish patient focus groups in order to establish what patients perceive as their barriers to accessing care. Because the group does not have a baseline population to start with, the group has begun looking at the number of eligible patients and number screened for each disease type for one specific payer. This will allow each organization to see how they are performing individually, as well as compared to others in the network. Together, the group will discuss best practices and how to best outreach to patients using these screening percentages as a proxy for the population as a whole. Our community based organizations can get involved here by helping to identify additional patients that are due for screenings.

Implementation approaches that the PPS considers a best practice:

The implementation approach for serving the PPS patient population includes the recommendations of the US Preventive Services Task Force. The workgroup uses those protocol recommendations from the task force as best practice for chronic disease screening. Additionally, the workgroup considers a focus on payer missing services list as a best practice for identifying those patients who have not been screened for the specific diseases focused on for Project 4bii. At an organizational level, individual clinic EMRs can generate missing services lists internally to identify current patients due for screenings.

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

The workgroup is implementing a beta test of pay-for-performance data using the Healthfirst member missing services list. In select clinics, these reports will be used with the goal of improving outreach through refined workflow processes for cancers, chlamydia and Hepatitis C screening. The ultimate goal is to roll-out these best practices to all partners in the workgroup, serving the rest of the Medicaid population in our PPS network.

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

Cancers were found to be the second leading cause of death in all counties and the number one cause of premature death before age 75. The PPS chose to focus on breast, cervical and colorectal cancer based on the indication that screening is proven to be beneficial in reducing cancer-related deaths. The PPS area also has high rate of Hepatitis C infection. The workgroup chose to focus not only on screening of this disease, but also the management once a patient tests positive. New York City was also shown to have more cases of chlamydia than New York State, thus, was included in the project.


NEW
YORK
STATE
Department
of Health

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Mount Sinai PPS, LLC

Project: 4.c.ii

Challenges the PPS has encountered in project implementation:

Several challenges have created barriers to focusing and directing the work of the 4cii project work group. For many projects in Domains 2 and 3 DSRIP's defined performance metrics and actively engaged patient definitions and targets could be taken as marching orders from the very beginning. For project 4cii the direction was not as clear. As a domain 4 project we had no actively engaged definition or target to rally around. And the performance metrics for domain 4 tend toward high-level population-health, such as "Number of people who died before age 65" or "Rate of preventable hospitalizations for Hispanics age 18 or older." And is it not clearly defined how these metrics will be evaluated with respect to the 4cii workgroup. Even some more specifically articulated goals, such as increasing the percentage of HIV infected persons with a known diagnosis who are in care from 63% to 72%, and increasing the percentage of HIV infected persons who are virally suppressed to 45%, are already close to being achieved or are already achieved in the New York City region.

On the one hand, we are not hemmed in by specific performance measures – we have the freedom to shape the 4cii project work the way we'd like. But on the other hand we have had to explore for ourselves where we think we should have an impact.

A natural place to start was the population that DSRIP wants us to serve, the "attributed lives" in our PPS that could be targeted for 4cii interventions. How many of the PPS's attributed Medicaid members are HIV positive or are at risk? Where do they live? If they are in primary care, who are their primary care providers? These questions raised another challenge in that data on the attributed lives of the PPS was slow to arrive, and when it did arrive, tight data security measures made access very difficult. Claims data, while accessible via the Salient Interactive Miner tool (SIM), have suffered from a significant lag time and require a fair amount of technical expertise to extract from SIM.

Despite the challenges of the performance measures and lacking a clear picture of our attributed lives, we knew that we could look to our own partner organizations in the 4cii workgroup for ways to put "boots on the ground" and start working. One of the greatest strengths of our 4cii project is the partners involved. Our organizations have been working together for a long time to serve the HIV/AIDs community. They are experienced, savvy and productive, and some of us have known each other through this work for several years.

It has been our position from the start that the work and planning would not be hospital-driven or dictated

by the biggest partner in the room. Rather, this would be a truly collaborative effort, and the strength of the 4cii work group has made this possible. We have been pleased to have strong input from our partner organizations. However, this in itself can be a challenge. Gaining consensus among many partners to structure new interventions is an invigorating and robust effort; all of our partners are well versed in HIV care and have a wealth of experience to drive our work. Determining best practices is difficult as all are productive and depending on the goal one intervention may be more effective than another but such an evaluation is time consuming.

Finally, when we began to look at ways we can collaborate to share some of the effective work our organizations are doing, we encountered another challenge that pre-dates DSRIP: data sharing. Data points are still being developed and varied data collection systems continue to require interface solutions that are currently not in place. Visibility into lab results, hospital utilization, the outcomes of referrals, and other data can be very difficult when multiple providers are involved. The infrastructure for sharing data across providers is essential to collaborative care but takes time and resources to build. Mount Sinai PPS is investing in data sharing capability, but in the short term, it remains a challenge.

Efforts to mitigate challenges identified above:

To address the challenge of focus and measurement, in DY1, the 4cii work group tasked a smaller sub-group with coming up with some of our own metrics that we thought would serve the work. The group brought back the following five recommendations, which were discussed and adopted.

1. Engaged in Care as measured by number of people who had two visits for primary care for HIV related care with at least one visit during each half of the past year.
2. Viral Load Monitoring as measured by the number of people who had two viral load tests performed with at least one test during each half of the past year.
3. Viral Load Suppression as measured by the number of people whose most recent viral load result was below 200 copies.
4. Syphilis Screening as measured by the number of people living with HIV/AIDS, ages 19 years and older.
5. Syphilis screening is performed annually, done once in each calendar year.

While these five measures helped to mitigate the challenge of focus and measurement, this formation of a sub-group is an example of another mitigation tool. We have found the formation of a sub-committee, or even tasking two individuals from the group with providing recommendations on a topic, to be an effective way of coping with the challenge of arriving at consensus.

We currently have a sub-committee working on a proposed structure for a viral load suppression intervention. Looking forward, our partners have agreed to participate in sub-committee work along subject matter lines defined by the DSRIP HIV Coalition (topics such as PrEP implementation, peer-based interventions, data utilization, and other subjects). Our 4cii co-leads are represented on the HIV Coalition and one co-lead is the co-chair. These subcommittees should help move the work in specific areas forward while also providing focus and direction.

We found another means of providing direction by turning our attention to the activities identified in the Equity Infrastructure Program (EIP). The EIP's interest in developing a PPS-wide Cascade of Care dovetails nicely with the measurements that had been defined by our sub-group as discussed above. We have begun

work on “Cascades.”

Additionally, the EIP called our attention to HIV testing in the community and increasing the amount of testing being done. (More on the EIP related work below in the “Additional Details” section.)

As to mitigating our lack of visibility into the attributed lives of the PPS, the workgroup realizes that our partner organizations serve populations of individuals who may or may not be attributed to Mount Sinai. The services and programs we provide will not be limited to attributed members only, so we are proceeding to try to understand the HIV/AIDs population of people who walk through our doors and how we can have the greatest impact on their health and well-being, regardless of attribution. To that end we have begun talking with the New York City DOHMH about how to leverage meaningful data from their resources. And while we wait for the Mount Sinai PPS IT initiatives and the HIE connections to begin to pay dividends, we are working with the existing knowledge base of our participating 4cii members.

Implementation approaches that the PPS considers a best practice:

As stated above, one of the greatest strengths of our 4cii work group is the partners who are involved. We believe that one best practice is to leverage the expertise of these partners who are already engaged and successful in particular areas of HIV/AIDS work. In DY1, we created an inventory all of our partners’ HIV/AIDS service programs that could have a direct impact upon DSRIP goals. From this inventory of 28 programs we looked to identify those that could be considered “best practices” and present potential training opportunities for other programs to implement with limited investment.

Two specific areas where partner experience is providing models for the group are the use of peers and viral load suppression interventions.

Collaboration with other PPSs is another approach that we consider a best practice. The formation of the DSRIP HIV Coalition has already helped us structure our work through the formation of sub-committees and the insight of the convener, the NYC DOHMH, into efforts of other PPSs as well as efforts beyond DSRIP, is very valuable. We look forward to learning more from this collaboration in the near future and to benefiting from the expertise and advocacy of Amida Care who is involved with the coalition.

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

One focus of the group’s current work, mentioned above but not specifically detailed in the PPS Quarterly reports is the creation of a viral load suppression intervention that incorporates comprehensive care management and incentive payments to patients. This program is intended to build upon the work that Housing Works and the NYC DOHMH did with their “Undetectables” program. In fact the NYC DOHMH recently selected organizations to receive grants to implement “Undetectables.” We are looking at ways to create a similar but distinct intervention by taking the fundamentals of the program and adapting it to our PPS 4cii partners.

Two additional implementation efforts are related to the Equity Infrastructure Program (EIP). One EIP task is to develop a PPS-wide Cascade of Care. This ties-in with other viral load suppression work such as the “Undetectables” program and is consistent with measurements discussed above that our group considered important. We have collected data from partners on their “Cascades” and are now analyzing what is needed

to consolidate that data in a meaningful way.

The EIP also called our attention to HIV testing in the community. We have begun collecting information from our partners who already have regulatory permission to do this testing via CLIA waivers. We will next identify partners who do not yet have permission or capability to test and help them overcome any barriers.

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

No changes noted to the population proposed to be served by the project.