DSRIP Independent Assessor

Mid-Point Assessment Report

Nassau Queens PPS

Appendix PPS Narratives

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: Nassau Queens Performing Provider System, LLC

Highlights and successes of the efforts: Governance

Governance infrastructure. Nassau Queens PPS (NQP) has successfully implemented a delegated governance model with the creation of the Nassau Queens PPC, LLC. The NQP LLC membership is made up of three designated safety net hospital systems, Long Island Jewish Medical Center (LIJ), Nassau University Medical Center (NUMC/NuHealth) and Catholic Health Services of Long Island (CHS). As outlined in the Project Plan Application, these systems function as a "Hub" model with NUMC, a public hospital as the PPS lead. As delineated in the agreement among the Hubs, each Hub is responsible for the management of its facilities and participating partners, while collaboratively working with the NQP PMO. This governance structure has resulted in a strong working relationship among the Hubs and the PMO where information-sharing, best practices and reporting of DSRIP measures are communicated. The NQP PMO has provided administrative support to deliver DSRIP requirements. This entails managing the multiple work streams, workgroups and committees while capturing and consolidating process measures from each of the Hubs to report accordingly. Members from each of the Hubs have been represented in all of the various meetings and have had a high involvement in planning and implementing DSRIP process requirements across the NQP.

NQP's strategic direction and operations are more closely overseen by its Executive Committee and subcommittees which include Finance, Clinical Oversight and Quality, Information Technology, and Workforce. The Executive Committee is the LLC's Board of Managers. All committees meet monthly and have a bidirectional relationship with the Executive Committee.   This governance infrastructure relies heavily on the Project Advisory Committee (PAC) to provide input and guidance on NQP policies and to communicate in a bidirectional manner the current needs of the community. The Compliance Officer reports to the Executive Committee and is actively overseeing the implementation of the Compliance Plan. The Compliance Officer has reviewed all contracts and business associate agreements that have been executed by NQP.

The participants of each committee have considerable administrative, clinical, and community service expertise and make important contributions in the development of NQP, project implementation, and achievement of DSRIP goals. The Project Management Office is led by an Executive Director who reports to the Executive Committee. Each Hub has an operational leader who works collaboratively with the Executive Director and the PMO. The PMO and Hubs have administrative staff. All these individuals work as one team diligently and collaboratively in creating the integrated delivery system, implementing the 11 Projects and achieving DSRIP goals. The PMO is responsible for the organizational infrastructure and interfacing with the NYS DOH and the Independent Assessor. The Hubs are responsible for interfacing with patients, the community, providers in their respective service areas and for value-based payment contracting. There is dual responsibility in several areas such as technology, performance reporting, compliance, and quality. The Executive Director, PMO, and Hubs have implemented a positive culture with an effective implementation
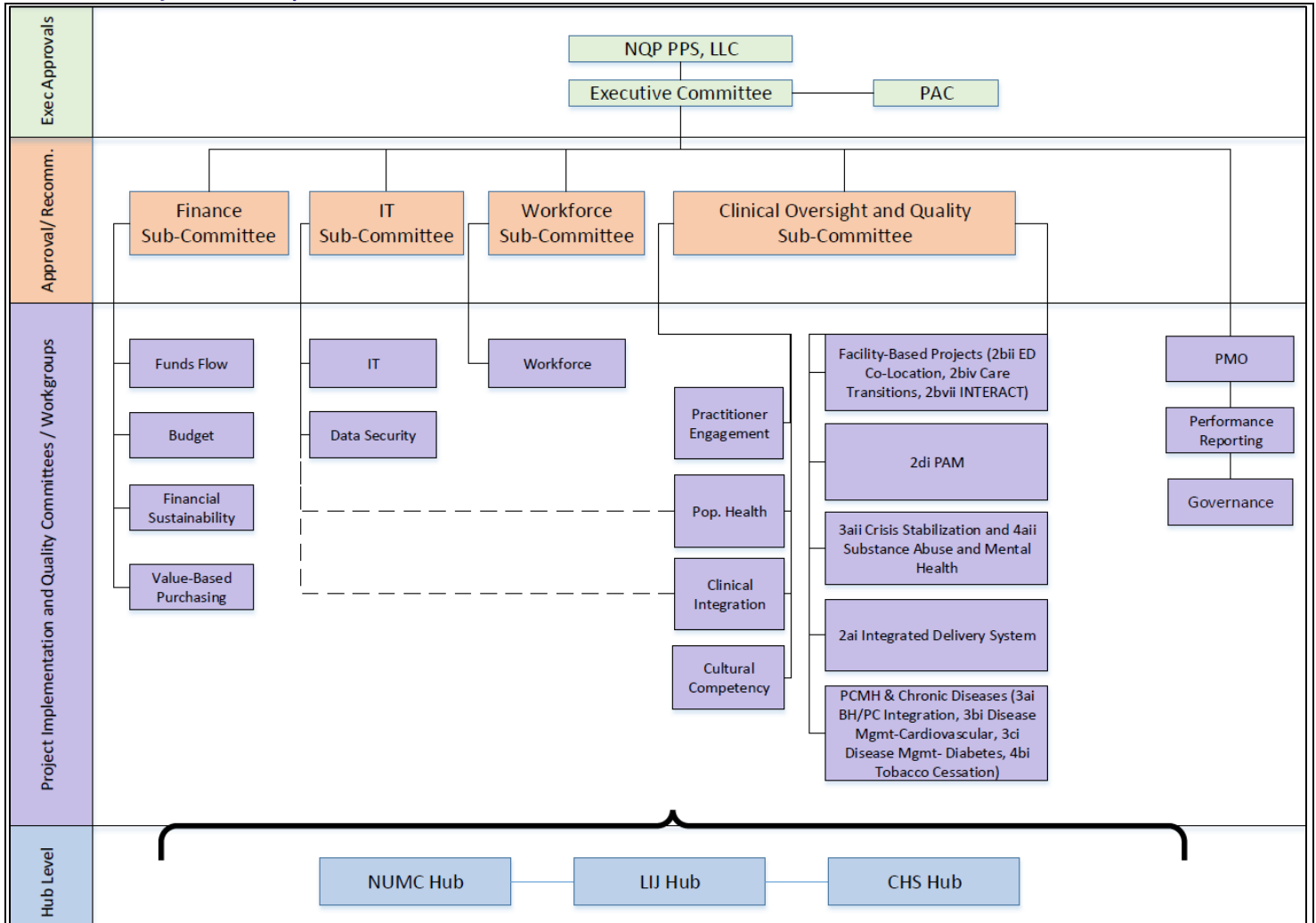
process which is responsive to the needs of the Executive Committee, Hubs, DOH and other stakeholders. This positive environment with a can-do attitude has made it possible for competing entities to come together and collaboratively work in the development of the IDS.

Diverse composition of committee members and work groups. The committees and work groups are composed of individuals representing relevant groups whose input and guidance are needed for the development and implementation of the integrated health delivery network. Representative groups include consumers, community based organizations, labor, skilled nursing facilities, FQHCs, primary care and specialty physicians, practitioners, health homes, hospitals, public agencies, public safety, food banks, health advocacy and coalitions among others. These diverse groups have enhanced the ideation for project development and implementation as each brings a unique experience from within the health delivery system. For example, at a recent CBO meeting all attendees learned about three national and local CBO partnerships with medical providers that are effective in transitions of care. Attendees also learned about the Healthy Home Pilot program sponsored by the Community Development Corporation of Long Island. The Healthy Home program is proving that by supporting individuals to age in place through home improvements and other supports, health outcomes are improved and health care costs are reduced.

The DSRIP vision. The members of NQP's governance committees and staff are invested in the vision of DSRIP. Currently all efforts are tied back to the long-term goal of developing an integrated delivery system where 25% reduction of avoidable hospital admissions and avoidable ED visits are achieved. In addition, engagement of partners to this vision is demonstrated in efforts invested in contracting to meet the State's goal of having 80-90% of Medicaid managed care payments in the form of a value based payments.

Successful structure to implement the vision. To ensure implementation of each milestone and task of the Project Plan, workgroups were formed and charters were developed to drive project requirements. Each work group is responsible for certain sections of the Project Plan and in turn each work group reports monthly up to its subcommittees for input, decision making and/or approvals of recommended policies, protocols, best practices, contracts and other recommendations. Subcommittees will evaluate the progress and recommendations of the Work Groups and recommend for approval to the Executive Committee. A visual of the implementation structure is shown below.

The chart shows an organizational structure with the following levels (left labels, read top to bottom):

Exec Approvals:
- NQP PPS, LLC
- Executive Committee — PAC

Approval/ Recomm.:
- Finance Sub-Committee
- IT Sub-Committee
- Workforce Sub-Committee
- Clinical Oversight and Quality Sub-Committee

Project Implementation and Quality Committees / Workgroups:
- Funds Flow
- Budget
- Financial Sustainability
- Value-Based Purchasing
- IT
- Data Security
- Workforce
- Practitioner Engagement
- Pop. Health
- Clinical Integration
- Cultural Competency
- Facility-Based Projects (2bii ED Co-Location, 2biv Care Transitions, 2bvii INTERACT)
- 2di PAM
- 3aii Crisis Stabilization and 4aii Substance Abuse and Mental Health
- 2ai Integrated Delivery System
- PCMH & Chronic Diseases (3ai BH/PC Integration, 3bi Disease Mgmt-Cardiovascular, 3ci Disease Mgmt- Diabetes, 4bi Tobacco Cessation)
- PMO
- Performance Reporting
- Governance

Hub Level:
- NUMC Hub — LIJ Hub — CHS Hub

Significant policies and reports approved by the Executive Committee to implement the vision. The governance and implementation structure have proven successful as they are allowing the governance members to effectively execute their oversight and guidance responsibilities. Following are examples of important policies and reports that the Executive Committee has reviewed and approved according to its delegated model.

- **Governance**:
    - Charters to formally establish the Executive Committee, Subcommittees, and Work Groups including reporting structures.
        - Clinical governance structure including clinical quality committees for each project.
    - Reporting and monitoring process with 11 key reports identified for monitoring operations.
    - Feedback from PAC meetings to inform current and future decision-making.
    - PAOP presentations preparation and feedback.
    - NQP PPS Milestone and Tasks Stop-Light Progress Tracker to monitor if milestones and tasks are on target.
- **Finance**:
    - Potential earnings matrix to understand the DSRIP earnings model and prioritize focus areas.
    - Budget and funds flow model, which designates funds for administrative functions, project startup,

reserves, and incentive funds for providers.
- Capital Applications to the Capital Restructuring Financing Program submitted on behalf of providers.
- Analysis of Financial Impact of Projects on Providers that informed financial stability planning and funds flow planning.
- Financial Stability Plan, Distressed Provider Plan, and review of providers on watch list.
- VBP-QIP process for a partner entity at financial risk.
- Establishment of Value Based Payment Workgroup (VBP) and policies that included
  - Assessment of providers' knowledge of VBP concepts
  - VBP educational campaign developed to train providers
  - Strategy to enter into discussions with MCOs about shared savings and other VBP options.
  - Baseline assessment of current contracted provider managed care payments under VBP options
- Compliance Plan consistent with NY State Social Services Law 363-d.
- Engagement with MCOs and respective contracts for the Equity Infrastructure Program (EIP) and Equity Performance Program (EPP).
- Annual budget.
- Projected DSRIP earnings vs. actual and corroborated by the DOH score card results.
- Monthly financial statements and cash flow reports.
- Distribution of Funds report.

- **Information Technology:**
  - Assessment to document the current IT state of each Hub, and for the PPS overall. The assessment focused on key functional requirements including care management software; registry functionality; RHIO connectivity through Healthix; interoperability; and data sharing capabilities. The assessment included the current state of providers' use of Electronic Health Records capabilities and PCMH readiness.
  - Target Operating Model (TOM) learning process to help NQP identify detailed business and system requirements needed to comply with DSRIP through the use of case studies within the context of project 2.a.i. The results of the TOM will help NQP develop a roadmap for achieving clinical data sharing and interoperable systems across the PPS.
  - RFP seeking proposals from vendors to provide integrated software platform that includes: data warehouse-HIE, analytic reports and dashboards, risk stratification, care management, and patient engagement. This platform is planned to be used in tandem with services offered by Healthix to enable analytics and interventions on the patient population with the goal of improving health status, achieving measurement goals, and creating the integrated health network.
  - Collaboration with Healthix to connect network providers to the RHIO. As the Hubs are contracting with providers, they are encouraging and facilitating data sharing with Healthix to increase the quantity of data and build value for participating providers and patients.
  - Data security plan through NUMC's completion of the 18 System Security Plan Workbooks. This plan allows NUMC to securely and safely evaluate claims and clinical data. The workbooks include: Access Control, Awareness and Training, Audit and Accountability, Security Assessment and Authorization, Configuration Management, Contingency Planning, Identity and Authentication, Incident Response, Maintenance, Incident Response, Maintenance, Media Protection, Physical and Environmental Protection, Planning, Program Management, Risk Assessment, System and Services Acquisition, System and Communication Protection, System and Information Integrity.
- **Workforce:**

- Workforce current state assessment which included a survey of network providers.
- Compensation and benefit analysis completed by BDO.
- Contract with BDO for the development of workforce future state roadmap.
- 1199 Training and Education Fund Contract for training purposes.
- Workforce spend tracking quarterly report to monitor spending vs. commitments.

- **Cultural Competency and Health Literacy**:
  - Cultural Competency and Health Literacy Strategic Plan directed at four targeted groups: clinical providers, non-clinical staff, community, and executive leadership/administration.
  - Cultural Competency and Health Literacy Training Strategy
    - Executive Committee was also trained on cultural competency and health literacy
  - RFP seeking vendors to provide training through interactive online-v learning platform to be used with the four targeted groups.

- **Practitioner Engagement**:
  - Monthly updates from Hubs on provider network development and contracting, onboarding and education of providers.

- **Population Health Management**:
  - Population Health Management Roadmap to support the transition to an integrated network where providers can view and share information. The Roadmap focuses on IT infrastructure, attainment of PCMH recognition, and high risk populations.

- **Performance Reporting**:
  - Performance Reporting and Improvement Plan which describes the approach to performance reporting, measurement, analysis, improvement, communication, and training that is used by NQP and its partners to meet the requirements of the DSRIP program. The Plan establishes guidelines for performance improvement and the use of Rapid Cycle Evaluation (RCE) methodology to improve outcomes and metrics.
  - Test dashboards for sharing with providers. The dashboards provide performance information at a provider level on Domain 2 and 3 metrics such as access to care and other HEDIS metrics. Goals of dashboards are 1) to share provider level performance information 2) identify top and bottom performers and best practices and 3) input into strategy development ad performance improvement efforts. The reports will inform future decisions on any action with regard to removing lower performing providers.
  - Status of metrics vs. baselines and goals.

- **Clinical Integration and Projects**:
  - Protocols associated with each project including Transitional Care Model, Care Transition Intervention, Transition of Care in Long Term Care associated with INTERACT, Patient Activation Measure, Million Hearts Campaign, ADA National Standards of Medical Care for Diabetes, SBIRT and PHQ-2/PHQ-9, 5 A's Tobacco Cessation, AHQR Health Literacy Universal Precautions Toolkit, AskMe3 Teach Back Method.
  - Best practice: core curriculum guidelines for care coordination worker training
  - Community Engagement Communication and Training Plan which outlines the methods and frequency by which community engagement takes place for CBOs, public agencies, individuals and the public at large.
  - Authority for Hubs to enter into contracts with CBOs for the purpose of patient engagement associated with Project 2.d.i.
  - Patient engagement speed and scale monthly report.
  - Primary Care Plan.

Transparency and Inclusion.   NQP shares its information with stakeholders openly through the NQP website http://www.nq-pps.org/.   NQP relies heavily on PAC members for guidance and exchange of critical information that informs governance and the projects. A favorite form of communication is round table discussions where community representatives address the PAC membership. For example, the 6/15/16 PAC meeting included these topics in a roundtable discussion: ED Diversion, Discharge Planning, and CBO Involvement Opportunities. The 3/15/16 PAC meeting included a panel discussion with skilled nursing facilities that are partnering with NQP to discuss their successes and challenges in using the INTERACT program.

DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Nassau Queens Performing Provider System, LLC

Highlights and successes of the efforts: FINANCIAL SUSTAINABILITY

The NQP Finance Sub-Committee has implemented important processes to ensure the financial soundness of the organization. These processes include the Network Financial Stability Plan, the Distressed Provider Plan, and the NQP Funds Flow Distribution Plan. The Network Financial Stability Plan and the Distressed Provider Plan describe how NQP monitors partners' performance in particular those that are financially fragile. The Funds Flow Plan defines how funds will be distributed to providers. These initiatives are described below.

The Network Financial Stability Plan which includes the Distressed Provider Plan was approved in DY1 Q4. The purpose of these plans is to establish an orderly process through which NQP can evaluate the financial viability of its most critical partners that are necessary to provide services for the Medicaid beneficiaries attributed to NQP. There are specific provisions to evaluate the financially distressed partners more closely and more frequently. Financially stressed providers are placed on a "Watch List" for closer monitoring. The frequency of review will be increased on a case by case basis as the Finance Sub-Committee deems appropriate for each specific case.

The Finance Sub-Committee is the executive leadership group that monitors the results of the assessments and the implementation of the Financial Stability Plan and Distressed Provider Plans.

The financial assessment of pertinent partners is conducted annually in order to determine whether any providers should be placed on a "Watch List" for further monitoring and compliance with an agreed-upon financial improvement plan.

For its first assessment, the Finance Sub-Committee conducted its evaluation of hospitals, based on NQP's Project Impact analysis that showed that hospitals are the entities most likely to experience a negative financial impact due to the implementation of the 11 DSRIP projects. NQP also evaluated FQHCs, given their high volume of Medicaid patients and their key role in DSRIP implementation. The financial assessment of other provider types is being evaluated as the Hubs on-board contracted providers.

During DY1 Q4, NQP applied its financial assessment model to the six hospitals in the network using the last two years of available financial information. This process identified one hospital, St. John's Episcopal Health Services (SJEH), for placement on the Watch List. This hospital was selected as it did not pass three out of the six financial ratios following the NQP criteria for the Watch List. The remaining five hospitals passed. CHS has made the review of the financial performance of St. John's Episcopal Hospital an integral part of its DSRIP relationship with SJEH as a participating partner in the CHS Hub. CHS reviews monthly financial statements with SJEH, and has weekly meetings with senior management at St. John's to discuss DSRIP and other DOH initiatives.

Funds Flow: In DY1 Q3 – Q4, NQP refined the budget and funds flow submitted with the DSRIP application. The Finance Committee refined the Five Year Funds Flow and Budget with three goals in mind:

1. Obtain a better understanding of operational budgets and reserves required at the PMO and Hub levels for the effective operation of the PPS.
2. Understand and better estimate the size of incentive pools by provider types by projects so that effective incentives could be offered to network providers.
3. Develop a revised budget given the improved understanding of original estimates.

The Funds Flow have resulted in the distribution of funds to the Hubs which in turn are distributing incentive funds to their respective contracted providers.

The NQP Executive Committee reviewed and approved the model on 12/22/15. Further refinements will be made as the DSRIP Program evolves. The refined budget and funds flow tables are presented below.

Budget

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	$ 70,830,459	$ 75,481,990	$ 122,063,851	$ 108,087,074	$ 70,830,459	$ 447,293,833
Cost of Project Implementation & Administration	$ 27,864,137	$ 29,694,012	$ 48,018,944	$ 42,520,591	$ 27,864,137	$ 175,961,820
Implementation	$ 12,128,276	$ 12,924,756	$ 20,900,953	$ 18,507,714	$ 12,128,276	$ 76,589,976
Administration (PMO & Hub)	$ 15,735,860	$ 16,769,255	$ 27,117,991	$ 24,012,877	$ 15,735,860	$ 99,371,844
Revenue Loss	$ 9,168,177	$ 9,770,263	$ 15,799,742	$ 13,990,611	$ 9,168,177	$ 57,896,970
Internal PPS Provider Bonus Payments	$ 24,816,702	$ 26,446,448	$ 42,767,225	$ 37,870,214	$ 24,816,702	$ 156,717,290
Cost of non-covered services	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -
Total Expenditures	$ 61,849,015	$ 65,910,723	$ 106,585,910	$ 94,381,417	$ 61,849,015	$ 390,576,079
Undistributed Revenue (Reserves)	$ 8,981,444	$ 9,571,268	$ 15,477,941	$ 13,705,657	$ 8,981,444	$ 56,717,754

Funds Flow

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	$ 70,830,459	$ 75,481,990	$ 122,063,851	$ 108,087,074	$ 70,830,459	$ 447,293,833
Practitioner – Primary Care Provider (PCP)	$ 14,721,635	$ 15,688,424	$ 25,370,151	$ 22,465,172	$ 14,721,635	$ 92,967,016
Practitioner – Non-Primary Care Provider (PCP)	$ 2,221,083	$ 2,366,944	$ 3,827,646	$ 3,389,366	$ 2,221,083	$ 14,026,121
Hospital	$ 15,382,738	$ 16,392,943	$ 26,509,446	$ 23,474,013	$ 15,382,738	$ 97,141,877
Clinic	$ 6,616,865	$ 7,051,403	$ 11,403,004	$ 10,097,316	$ 6,616,865	$ 41,785,452
Case Management / Health Home	$ 738,766	$ 787,282	$ 1,273,134	$ 1,127,355	$ 738,766	$ 4,665,304
Mental Health	$ 5,270,462	$ 5,616,580	$ 9,082,715	$ 8,042,710	$ 5,270,462	$ 33,282,930
Substance Abuse	$ 1,037,017	$ 1,106,120	$ 1,787,117	$ 1,582,486	$ 1,037,017	$ 6,548,758
Nursing Home	$ 5,183,469	$ 5,523,874	$ 8,932,798	$ 7,909,958	$ 5,183,469	$ 32,733,568
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -
Hospice	$ -	$ -	$ -	$ -	$ -	$ -
Community Based Organizations	$ 6,872,253	$ 7,323,563	$ 11,843,121	$ 10,487,038	$ 6,872,253	$ 43,398,229
All Other	$ 153,417	$ 163,492	$ 264,386	$ 234,113	$ 153,417	$ 968,824
PPS PMO	$ 3,651,310	$ 3,891,097	$ 6,292,392	$ 5,571,889	$ 3,651,310	$ 23,057,998
Total Funds Distributed	$ 69,059,697	$ 73,594,939	$ 119,012,256	$ 105,384,896	$ 69,059,697	$ 390,576,076
Undistributed Revenue (Reserves)	$ 8,981,445	$ 9,571,268	$ 15,477,942	$ 13,705,658	$ 8,981,445	$ 56,717,757

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PPS Name: Nassau Queens Performing Provider System, LLC

Highlights and successes of the efforts: CULTURAL COMPETENCY AND HEALTH LITERACY

NQP is pleased with the progress that is being made in implementing its cultural competency and health literacy framework throughout the PPS network. These efforts will reduce health disparities and will improve access to high-quality health care. Important milestones and tasks have been completed as shown below.

Diverse Representation on CCHL Workgroup: NQP's Cultural Competency & Health Literacy (CCHL) Workgroup is comprised of a diverse group of stakeholders and community-based organizations from Eastern Queens and Nassau. Workgroup members are representative of the diverse population in which the NQP serves. It includes representatives from the Korean Community Services of Metropolitan New York, the Roosevelt Community Revitalization Group, Planned Parenthood, the Hispanic Federation, LGBT Network, Make the Road NY, 1199, Cornell Cooperative Extension, Literacy Nassau, EAC Network, Sustainable LI, and NQP's PMO and Hubs. This group meets regularly to discuss milestones, provide guidance/oversight and evaluation for implementing culturally competent DSRIP projects.

Cultural Competency & Health Literacy Strategy: NQP's comprehensive strategy provides a framework for addressing and enhancing cultural competence and health literacy. This plan's framework includes: (1) cultural competence, which is the ability to provide an expanded cross-cultural approach to care of individuals with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, communication and linguistic needs; and, (2) health literacy, which happens when patients, or anyone on the receiving end of health communication, and providers, anyone on the giving end of health communication, truly understand one another. The goal of the plan is to reduce health disparities through enhancing cultural competency and health literacy efforts across the NQP communities served and partners. The strategy was informed by NQP's CCHL Survey, Community Forums and Hot-Spot analysis, as well as the input of the CCHL workgroup members.

Survey: The workgroup created and distributed a survey to providers and community-based organizations to inventory CCHL training and activities in the PPS. The survey was used to determine gaps, and to identify best practices to incorporate into NQP's CCHL Strategy. The survey was used to identify training needs and channels for CCHL providers, CBO and community member education. It was identified in the survey that there is a group of NQP partners that will need access to CCHL training outside of hub portals as well as a need for interactive web-based training to reach all PPS providers and partners. Areas of basic elements of CCHL training deficits were also identified. These needs were incorporated into a CCHL vendor training RFP that was distributed in DY2Q2 requesting a proposal for web-based v-learning CCHL training.

Community Forums: Community forums were also used to examine priority group's gaps in care and barriers to access. Community forums were held in DY1 Q3 at partners' offices in Jackson Heights, Rockaway Beach, Far Rockaway, and Jamaica. The community forums provided an opportunity to educate

the community about the aims of DSRIP and solicit feedback on the following questions. Here are some examples of the questions we asked the community.

- *What are the language problems you have when you try to use health services?*
- *Where do you go to learn about services?*
- *When you go to the doctor, are the instructions in English/Spanish?*
- *When you go to the doctor or pharmacy, do you understand the information given?*
- *What would be helpful to you to stay healthy and not go to the hospital?*
- *What methods of communication are easiest to provide information to the community?*

A forum was also help with CBOs discussing the following questions:

- *When it comes to Cultural Competency and Health Literacy, what are some of the barriers that your clients have talked with you about?*
- *Community members had 3 central question themes around their healthcare: What is it I need to do? What is this medication or procedure doing for me? How do I take it?*
- *Question 3: What is the best way to communicate with the population we are looking to target? For example, social media, emails, or text.*
- *Question 4: Is there anyone who works with a transient population that is not tethered to a traditional address? Does anyone use smartphones for texting or notifications?*
- *Question 5: What services or resources from a Cultural Competency/Health Literacy standpoint would make is easier for people to access healthcare? We spoke about the trust issue, but is there anything else that would make is easier to get the word out?*

The information solicited from both the community and CBOs' forums provided valuable information in which the NQP is using for the CCHL strategy.

CBO Summit: In DY1Q4, NQP, in collaboration with the Long Island Public Health Improvement Project (LIPHIP), Long Island Health Collaborative and the Suffolk Care Collaborative, conducted a series of community-based organization summits to assess the health and social service needs of Long Island residents. In total, 119 CBOs participated in the facilitated discussions. A qualitative data analysis of responses of CBOs who serve Nassau County residents, related to the NYSDOH Prevention Agenda Focus Areas, identified chronic disease prevention and management and mental health as the top 2 priorities. A healthy and safe environment was identified as the third-highest priority.

Health disparities, related to abuse, transportation, housing, finances and safety, were identified for the senior population, minorities, incarcerated individuals, transgender and other vulnerable groups. The top 3 barriers to health care included access, financial constraints, and insurance barriers. Access barriers included lack of support regarding patient navigation, patient advocates, establishing trust and respect with the community, community awareness of available services, coordination of existing medical, behavioral and social services, and inadequate public transportation or access to private transportation. Identified educational barriers were related to patient engagement (decision making, healthy lifestyles, patient activation measures, empowerment, and self-management skills), health system navigation, and health literacy (cultural competency, language, and effective communication).

CBO Engagement: As a result of the CBO summit, many of the CBOs expressed a desire to attend future events that facilitate networking among CBOs and providers. The LIPHIP, NQP and SCC are planning a networking event for the CBOs and care managers in the Fall of 2016 to address the CBO Summit needs and to improve population health activities. In addition, NQP has conducted outreach to CBOs to begin

formal engagement agreements to support the projects and workstreams, such as ethnic social service and mental health organizations (Korean Community Services, Chinese Planning Council, Hispanic Counseling Center), food access organizations (GOD's Love We Deliver, LI Cares, LI Harvest), mental health organizations (Central Nassau Guidance, NAMI) and others (YMCA, Family and Children's Association).

Hot-Spot Analysis: A CCHL sub-committee was formed and tasked to execute a hot-spotting analysis based on insurance, healthcare utilization, and disease prevalence. Data captured were the number of Medicaid beneficiaries, inpatient admissions, emergency department visits and other demographic information for the census tracts within the NQP. The methodology was chosen in order to identify areas in which, a targeted intervention could have the greatest impact on the health of the population. The workgroup met several times to review different methods and data sources. The analysis, shown below, identified 17 hot spot communities in NQP. This information was then shared with NQP project staff and partners to help identify communities that would benefit from targeted PPS resources. For example, the 2di vendor RFP included hotspots as target areas for PAM surveying and CCHL community education workshops were also included in the RFP as a deliverable for the vendors in addition to the PAM surveys and coaching.
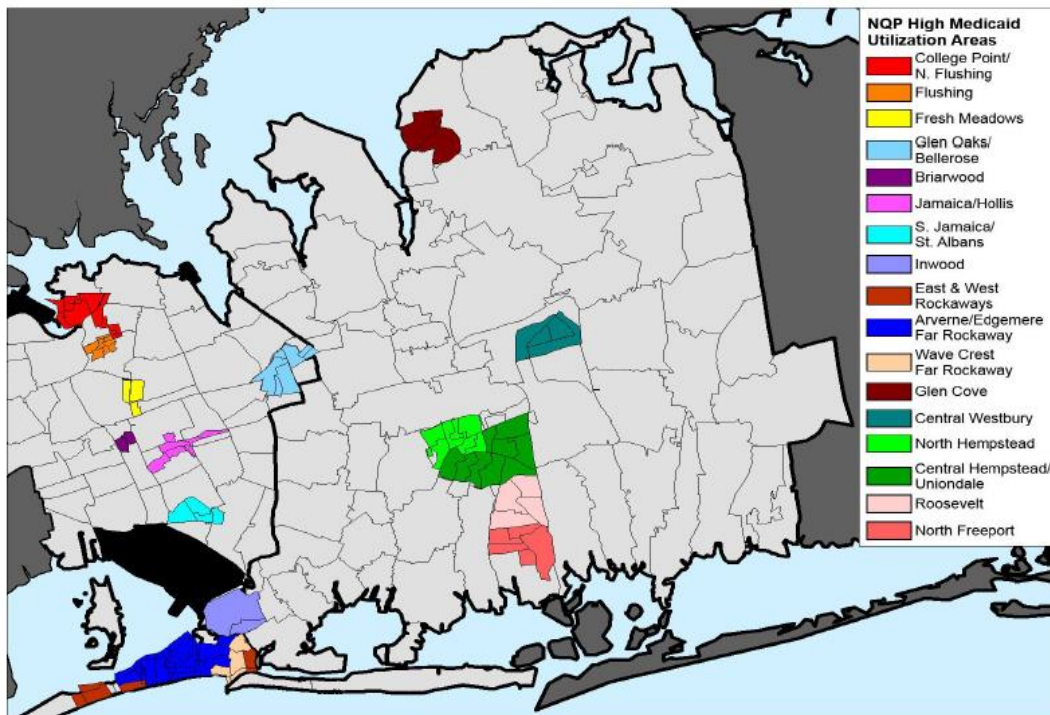
Training Strategy (approved by the Board of Managers on 6/23/16). The NQP CCHL Training Strategy outlines plans to train clinical and non-clinical partners on topics listed below. The Training Strategy is aligned with the NQP CCHL Strategic Plan. The Training Strategy addresses the following themes.

- The impact of social and cultural factors on health beliefs and behaviors
- The link between culture, language and patient safety outcomes, quality of care and health disparities
- The importance of empowering patients to become active partners in their healthcare
- The importance of unconscious bias in patient and family-centered care
- The tools and skills needed to manage these factors appropriately, including interpretation services, Ask Me3, iSpeak Cards, and health literacy patient education materials
- The importance of capturing accurate Race, Ethnicity, and Language Data

RFP for Training Vendor (issued on 6/20/16). The RFP seeks vendors that can assist NQP provide training through an interactive online v-learning platform. The curriculum would center on the themes identified in the Training Strategy as listed above. In addition, vendors are being requested to address training themes related to other training required by NQP's 11 projects.

CCHL Training Strategy & Roll-Out: The CCHL Workgroup and Leadership devoted significant time and effort to a CCHL Training Strategy that describes agreed-upon expectations for (1) on-boarding and annual CCHL education; (2) patient engagement and educational resources; (3) use of the teach-back method. The Training Strategy is tailored for NQP's three primary audiences: Clinical Providers, Non-Clinical Staff, and Executive Leadership/Administration. The strategy is available on NQP's website: http://www.nq-pps.org/application/files/2114/5710/1528/Cultural_Competency_and_Health_Literacy_Strategic_Plan.pdf The training strategy was used to develop the CCHL trainings described below.

CCHL Trainings

-CCHL Training Module: The CCHL Workgroup and Leadership developed a CCHL training module for clinical and non-clinical partners. In DY1 Q4, the CCHL trained the NQP Project and Hub leadership via webex, and the Project Advisory Committee in-person. The training is available on NQP's website: http://www.nq-pps.org/application/files/7814/5995/1758/NQP_CCHL_Training_WebEx__3_8_2106.pdf. In the on-boarding process, Hubs direct providers to view the training and sign an attestation. A Train-the-Trainer version was held for community-based organizations in DY2 Q1.

-CCHL Training & V-Learning Platform: NQP posted an RFP in DY2 Q1 for vendors to provide an interactive, online platform to support virtual learning (v-learning). This platform will help NQP reach more partners and track the number of people who attended the training. The vendor will also provide trainings on the core CCHL topics, including (a) the impact of social and cultural factors on health beliefs and behaviors; (b) the link between culture, language and patient safety outcomes, quality of care and health disparities; (c) the importance of empowering patients to be more of an active partner in their healthcare; and (d) the importance of unconscious bias in patient and family-centered care. Currently NQP is vetting out potential vendors for selection.

- Health Literacy and Cultural Competency Training. The CCHL workgroup began its CCHL trainings for the NQP network in DY1Q4.

- A live webinar was held on March 8, 2016 for Project and Work stream leadership, and was posted on the NQP website for all partners to view.
- The same presentation was given at the NQP DY1Q4 PAC Meeting on March 15, 2016, which is attended by a diverse group of NQP partners, including physicians, hospital staff, post-acute partners and CBOs.
- As each Hub meets with providers for the on-boarding process, it directs providers to view the training.
- A CBO CCHL Train-the-Trainer Community Training was also held on June 8, 2016 from 9am-12pm. The CBOs that attended the training were the vendors contracted for the 2di project (Planned Parenthood of Nassau County and EAC) and the community outreach worker from St. John's Episcopal Hospital and the NuHealth Family health centers. The CBOs and outreach workers will be training other

organizational staff and providing workshops to community members.
- Each NQP hub partner continues to offer in-person and web-based CCHL training to staff.

DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Nassau Queens Performing Provider System, LLC

Highlights and successes of the efforts: IT SYSTEMS AND PROCESSES

Current State Assessment of Current IT State for Each Hub and PPS Overall (approved by Board of Managers on 3/39/16). NQP completed an assessment focused on key functional requirements including care management software; registry functionality; RHIO connectivity through Healthix; interoperability; and data sharing capabilities. The assessment included the current state of providers' use of Electronic Health Records capabilities and PCMH readiness.

Provider Integration: NQP conducted a current state assessment focused on key functional requirements including care management software; registry functionality; RHIO connectivity through Healthix; interoperability; and data sharing capabilities. The assessment included the current state of providers' use of Electronic Health Records capabilities and PCMH readiness.

RHIO Collaboration: NQP is collaborating with Healthix to connect network providers to the RHIO. During the on-boarding process with PCPs and SNFs, each Hub is promoting and facilitating data sharing with Healthix. For example, LIJ currently has 15 Primary Care Physicians that are in the Healthix engagement process and NQP anticipates these providers will be connected by September/October. NUMC and CHS are following the same process to connect their network providers to the RHIO. The goal of the Healthix collaboration is to increase the quantity of data and build value for participating providers and patients. In addition, through participating in the TOM, NQP identified the need for a multidisciplinary workgroup to define, design, and manage clinical notifications between network providers and facilities. NQP will include Healthix in this workgroup and partner with them to send notifications and to provide secure messaging services. NQP anticipates sharing requirements with Healthix and collaborating on best strategies to address the data sharing needs.

Target Operating Model (TOM). NQP participated in IT TOM in DY2 Q1. All Hubs (Nassau University Medical Center, LIJ and Catholic Health Services) participated in the learning process to help NQP identify detailed business and system requirements needed to comply with DSRIP's Project 2.a.i. Across the given case studies, four main systems appeared as the core components needed to support an IDS: RHIO, Data and Analytics, Care Management and Patient Portal. The outcome of TOM included two reports – the Business Requirements Definition (BRD) report and the System Requirements Specifications (SRS) report – and five key decisions made by the NQP Hub Leads:

1. <u>ED Admission Alerts</u>: NQP agreed that ED admissions should automatically trigger alerts to patients' PCPs and Hub Care Managers. NQP will determine the alert rules based on a multidisciplinary workgroup.

2. <u>QE / RHIO Capabilities</u>: NQP agreed that clinical event notifications sent to a patient's attributed PCP and Hub Care Managers should include information about how to access the patient's updated

medical history in their Hub's EHR system. Specific instructions will be determined by a multidisciplinary workgroup.

3. Assigning PCPs: NQP agreed that if the patient does not have a PCP, it is the responsibility of their attributed Hub Care Management to assist them in identifying a PCP.

4. Cross-Hub Care Management: NQP agreed that two actions will be taken when patients see a provider who is not attributed to their Hub:

   a. The provider will provide care for that patient; and

   b. Having been notified via clinical event notification, the attributed Hub Care Managers will reach out to the patient to perform follow-up care management activities

5. Automated TOM Process Paths: NQP agreed that, when there are alternatives paths for sharing patient information based on Hub partner's IT maturity/interoperability/automation capabilities, the Target Operating Models will reflect the most automated and efficient process path vs. manual process paths. It was agreed that the IT TOM BRD and SRS reports will highlight areas where NQP Hubs will need to decide how they want to perform more manual process for Hub partners that cannot share discrete patient information, e.g. partners that do not have existing or the same EHR systems as the PCP and Hub Care Management, and/or connectivity/ability to share discrete information with the RHIO.

In addition, there are pending decisions for the Hub Leads to continue to discuss. These key decisions are listed in the table below. The TOM reports and remaining decisions will help NQP develop a roadmap for achieving clinical data sharing and interoperable systems across the PPS.

Remaining decisions on Process from TOM			
• Patient Portal • Patient Consent • Referral Process • Assigning PCPs • Appointment Tracking	• Patient Alerts • Prescription Adherence • Central Call Center Operations • Cross-Hub Care Management • ED Admission Alerts	• Emergency Services Capabilities • QE/RHIO Capabilities • Role of EDW • Hub Level Attribution • Providing RHIO with Hub-Level Attribution	• Alternative Process Paths • Automated TOM Process Paths • Hub Data & Analytics • VBP Contracting • VBP Financial Analytics

Sharing Care Plans through RHIO. LIJ and other members of NQP have participated in a multi-PPS workgroup facilitated by GNYHA. The goal of this workgroup is to design and implement a shared care plan through the RHIO. LIJ and Healthix are members of the initial pilot, and will incorporate NQP use-cases in the design. The results of this work will be directly applicable to the Cross-Hub Care Management model being used by NQP.

RFP for Integrated Software Platform. NQP issued an RFP seeking proposals from vendors to provide integrated software platform that have the following functionality: data warehouse-HIE, analytic reports and dashboards, risk stratification, care management, and patient engagement. This platform will be used in tandem with services offered by Healthix to enable analytics and interventions on the patient population

with the goal of improving health status, achieving measurement goals, and creating an integrated health network. The RFP responses were due 7/22/2016 and the committee will is scheduled to select a vendor shortly.

Data security plan / System Security Plan Workbooks. NUMC has submitted the System Security Plan (SSP) Workbooks to securely and safely receive, evaluate and protect claims and clinical data. LIJ and Catholic Health Services are in the process of completing their SSP Workbooks so that they can directly receive their respective claims and clinical data. Important decisions have been made by the PMO and its Hubs for data sharing. Each hub will host DOH data after the post opt-out process is completed. Each Hub will manage the secure infrastructure needed to share data with their associated partners

Tobacco Cessation. NQP is participating in two important Tobacco Cessation IT initiatives with the state. First, NQP is involved with workgroups designing 5As implementation in Allscripts and ECW, and will utilize these designs with network providers using those EHRs. Second, NQP is facilitating the design of an automated referral to the NYS Quitline through RHIO. This process would allow a physician to send demographic and referral information from their EHR through Healthix directly to the Quitline.

DSRIP Mid-Point Assessment - Organizational Narratives
PPS must submit a narrative highlighting
the overall organizational efforts to date.

PPS Name: Nassau Queens Performing Provider System, LLC

Highlights and successes of the efforts: PERFORMANCE REPORTING

NQP has a great Performance Reporting Workgroup composed of representatives from the three Hubs. This workgroup leverages their respective health systems' analytical structures to complement the analytical work that is being accomplished at the NQP PMO. This Work Group has identified why NQP has not met several of its patient engagement estimated goals and has provided extensive support for remediation. The Work Group is also focused on understanding the metric baselines and identifying strategies to achieve DOH measurement goals.

NQP and its Work Groups and Hubs are cognizant that the majority of funds to be earned by this PPS are associated with metrics. Therefore, there is great emphasis in the discovery and meaningful action to improve metric performance.

Performance Analysis for Project Workgroups: The Hub Leads have collaborated on performance analysis for project workgroups using data provided in MAPP and, more recently, Salient Interactive Miner (SIM). The workgroups have strategically leveraged these platforms and familiarized themselves in order to pull the data needed to report on the status of the PPS. In addition, the Hub Performance Reporting leads have worked collaboratively to improve their understanding of the available data and verify their analyses among each other. The workgroup has also executed a drill down of specific metrics to identify top and bottom performers to help in creating their short and long term strategies for improvement. Here is an example of some of the documents created by the workgroup to track the NQP metrics.

Domain 3: Behavioral Health
NQP Quality Metrics - Performance Reporting Workgroup

Prepared: 5/9/2016
Data covering: MY1 (July 2014 – June 2015)

Chronic Disease and Behavioral Health

Metrics Covered:

Measures	MY1 Numerator	MY1 Denominator	Performance at end of MY1	Comparison to Baseline or MY1 Annual Target	Performance Goal	Target for MY2	# of people needed to meet MY2 Target*	P4P Year	P4R ($)	P4P ($)
CVD Monitoring (CVD and Schizophrenia)	58	96	60.42%	Worse than baseline (70%)	92.23%	63.60%	3	DY 2	$381,425	$4,445,702
Diabetes Monitoring (DM & Schizophrenia)	444	681	65.20%	On track	89.80%	67.66%	17	DY 2	$381,425	$4,445,702
Diabetes Screening (Antipsychotic Medication)	1,853	2,525	73.39%	Below annual target (74.54%)	88.99%	74.95%	39	DY 2	$381,425	$4,445,702

Measure	Total PCPs	% no MC Assigned PCP	% with 80% MC Pop	% Providers with < 10	Comments	MC Plan and Health Home Analysis
Antidepressant Medication Mgmt (Acute)	814	29.8% (774)	55.0% (448)	97.7% (795)	• There are 4 providers of which an improvement from their current performance level to the performance goal (increasing their numerators by between 3 to 10) would ensure NQP meets its target.	Poor performing health plans include (members not in compliance): FidelisCare (193) HealthFirst (169) United Healthcare (164) 2,402 (92%) members not enrolled in Health Home Health Home (members not in compliance) - Hudson River HH (37) - North Shore (27) - Queens Coord (10)

MC Assigned PCP	HUB	Num	Denom	Measure Result
DELMONT JACQUELINE	CHS	27	62	44%
ADDES RICHARD DR.	NUMC	6	21	29%
HAWTHORNE HORACE DR.	NUMC	8	18	44%
MEDINA JUAN	CHS	3	15	20%

Short-term:
- Identify top PCPs with large attributed populations and help them to develop chase list for patients prescribed anti-depressants
- Follow up calls are carried out to ensure patients have filled the prescription and can have any questions answered
    - Identify who can do the follow up calls (ie. Social workers service corps, PA/MA, who is allowed to call about medications?)
    - What linkages can be made if patients have adherence barriers? Ie. Health Home, Care Management, CBOs

Other strategies:
- Ensure antidepressant medication management is understood by Health Home care teams (add to the Health Home cheat sheet)

Dashboard Prototypes to Share Meaningful Data with Providers. The Performance Reporting Work Group is currently developing dashboards to provide performance information at a provider level on Domain 2 and 3 metrics such as access to care and other HEDIS metrics. Goals of dashboards are 1) to share provider level performance information 2) identify top and bottom performers and best practices and 3) input into strategy development and performance improvement efforts. Examples of the test dashboards are shown below. Once the prototypes become "provider-ready" and completed, reports will be shared with providers according to pre-set distribution schedules.

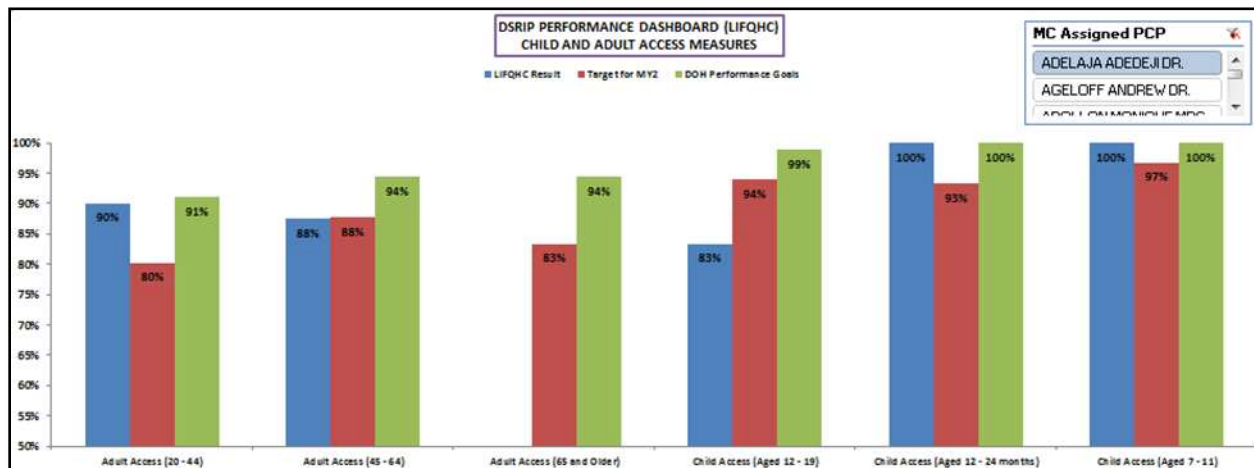**Figure 1: LIFQHC Dashboard: Child and Adult Access Measures**

Figure 2: Provider-Level Dashboard Example

DECADE EMMANUEL	Numerator	Denominator	Measure Result for MY1	Baseline for MY0	Performance Goals
Adult Access (20 - 44)	239	289	83%	81.63874225	91.0846954
Adult Access (45 - 64)	181	205	88%	88.37255684	94.3516309
Adult Access (65 and Older)	22	29	76%	82.68700308	94.4444444
Antidepressant Medication Mgmt (Acute)	4	8	50%	49.14204004	60
Antidepressant Medication Mgmt (Continuation)	3	8	38%	35.41468065	43.4782609
Antipsychotic Medication Adherence	8	11	73%	71.25171939	76.4705882
Child Access (Aged 12 - 19)	46	54	85%	92.92240979	98.8338093
Child Access (Aged 12 - 24 months)	9	9	100%	93.64452702	100
Child Access (Aged 25 months - 6)	12	17	71%	92.46552162	98.4210526
Child Access (Aged 7 - 11)	17	22	77%	96.19549312	100
Child ADHD Medication FollowUp (Initiation)	1	1	100%	54.41640379	72.2689076
Diabetes Monitoring (DM & Schizophrenia)	2	3	67%	58.28877005	89.7959184

Key stakeholders and hub leads have reacted positively to these dashboards as it gives them a snapshot of the current performance of the PPS.

Test dashboards for sharing with providers. The Performance Reporting Work Group is currently developing test dashboards to provide performance information at a provider level on Domain 2 and 3 metrics such as access to care and other HEDIS metrics. Goals of dashboards are: 1) to share provider level performance information; 2) identify top and bottom performers and best practices; and 3) input into strategy development ad performance improvement efforts. Examples of the test dashboards are shown below. Once the prototypes become "provider-ready" and completed, reports will be shared with providers according to pre-set distribution schedules.

Collaboration on PPS Activities: The Performance Measurement group meets biweekly, but the Hub Performance Reporting leads communicate much more frequently (often many times each week) to discuss reporting strategies. The collaboration has supported coordination on several PPS-level activities, such as the annual medical chart review and a contract to obtain CG CAHPS for the uninsured. Two Hubs are also in the process of data sharing and analyses in order to identify patients that receive care across hubs which could help improve Actively Engaged numbers for project 2.b.ii going forward.

Rapid Cycle Evaluation and Continuous Quality Improvement Plans. Rapid Cycle Evaluation (RCE) is used widely across the Hubs in an attempt to quickly assess the effectiveness of projects and initiatives being undertaken and to promote the continuous improvement. The Hubs plan to leverage existing methodologies in their DSRIP performance reporting activities. When Hubs receive baseline or performance data, it is expected that they will review the data, identify areas for improvement and develop performance improvement plans. The Hubs report experience using RCE methodologies, including Fast-Track Decision

Making (FTD), Plan Do Study Act (PDSA), Six Sigma, and Lean.

NQP is dedicated to achieving system-wide excellence by improving existing processes. As outlined in its Performance Reporting and Improvement Plan, NQP has developed an action planning process designed to identify and remedy instances where practice and provider performance is putting the PPS's overall performance at risk. Over the past months, the Hubs have been working to identify key performance indicators used for the action planning process.

For example, one of NQP's Hubs identified 4 metrics on which it will collect clinical data from its partners for the purposes of its action planning process. Templates have been developed to provide detailed information to the partners about the data being collected and the collection process. Once this data is being collected quarterly, the Hub plans to use this data to identify performance improvement opportunities. Identified partners that are required to undergo an action planning process will be supported through rapid cycle evaluation whereby a performance improvement methodology will be selected depending on the type of project, the resources available and the time lines.

Management of Lower Performing Providers. As described in NQP's Project Plan Application, this PPS intends to implement its policy to improve the performance of lower performance providers or remove them from the network if there is no effort and no improvement of results. The first step in compliance with this NQP policy is the assessment of its performance by providers to determine baselines, goals, and needed guidance for providers. Currently, NQP is in its initial stages of analysis as described previously. NQP's analytical work will be conducted addressing its highest and lowest performers in mind. NQP will make every effort to bring lower performing providers to higher levels. However, non-performing providers will be specifically engaged for process improvement and sanctions in place if no improvement is observed.

Training Program. The Performance Reporting Workgroup will develop a training program to educate providers on the performance reporting requirements and processes. The goal of the training program is for all providers to understand that DSRIP is a performance-based program and each of the Domain 2 and 3 projects has associated quality measures that providers are expected to reach. As part of the training program, this Performance Reporting & Improvement plan will be reviewed with all providers to educate them about the types of measures, the reporting schedule, and the tools for performance improvement.

PPS Name: Nassau Queens Performing Provider System, LLC

Highlights and successes of the efforts: WORKFORCE

Workforce Training & Retraining:
In its application, NQP estimated that less than 1% of NQP's workforce would be re-deployed and 30% of NQP's workforce would be retrained. In addition, NQP estimated that 2,000 new staff would be hired. Consistent with these estimates, the Workforce focus is on training and re-training programs.

To support training, NQP is in the process of contracting with 1199TEF to provide:
1) Curriculum development for training and retraining.
2) Training and retraining directly or through approved sub-contractors.
3) Other services within Contractor's experience and expertise.

The PPS is currently in the process of negotiating a contract with 1199TEF as the certified workforce vendor for the PPS. Once the contract is signed, each Hub will identify the training topics for 1199TEF and the number and type of staff to be trained through 1199TEF or its sub-contractors, or using the Hubs training infrastructure. NQP has compiled a preliminary inventory of training needs that will guide the Hubs' selection. These trainings will be used to ensure that all members of the NQP workforce are adequately prepared for the transformation DSRIP aims to achieve.

Workforce Milestones: NQP's Workforce workgroup has completed key milestones, including:
- Current State Assessment, approved DY1 Q4. NQP's Hubs and providers submitted responses to survey questions and information on their current state workforce. The information was used to establish the baseline assessment. The assessment studied workforce demographics, labor representation, job classifications, workforce challenges, bench strengths, separation trends, and recruitment and retention programs. The assessment concluded that partners in the NQP PPS have robust programs to build bench strength and recruit new hires into current vacancies. Additionally, as seen across New York State, partners have challenges recruiting clinical positions, especially RNs and behavioral health providers. As the PPS completes the additional workforce milestones, including the gap analysis and transition roadmap, the workforce workgroup will collaborate with network partners to determine the needs of the workforce for recruitment, redeployment, and retraining and key areas the PPS can provide assistance in.

- Compensation and Benefit Assessment, approved DY2 Q1. NQP engaged BDO Consulting, LLC to assist with the collection and analysis of workforce compensation data on NQP's current and future workforce. Hubs submitted compensation and benefits data collected, which BDO synthesized in accordance with the USDOJ Antitrust Safety Zone Exchanges of Price and Cost Information among Providers.

The compensation and benefits assessment included the development and distribution of a Current State Workforce survey to collect workforce data pertaining to its network. A total of 71 surveys were submitted by NQP Participants. As a result of collecting the surveys, NQP was able to analyze and report on the DOH job titles covering the following facilities types:

- Article 28 Diagnostic & Treatment Centers (FQHC)Home Care Agency
- Home Care Agency / Hospice
- Hospital Article 28 Outpatient Clinics
- Inpatient (Hospital/ED/ Inpatient Services Article 31 & Article 32)
- Non-licensed CBO
- Nursing Home/SNF
- Other
- Outpatient Behavioral Health (Article 31 & Article 32)
- Private Provider Practice

This compensation and benefits report was prepared in accordance with the USDOJ Antitrust Safety Zone Exchanges of Price and Cost Information among Providers.

In addition to assessing the compensation and benefits of NQP's current workforce, NQP, through its engagement with BDO, benchmarked the new roles or "emerging" job titles as a result of DSRIP. The workforce data presented in this report will be utilized by the PPS for future workforce planning, and as a baseline against which future workforce impacts can be measured. As NQP implements and further develops the DSRIP projects, additional new roles may be identified.

- Emerging Titles Analysis, in progress. BDO helped NQP benchmark the new roles or "emerging" job titles as a result of DSRIP. The workforce data presented in this report will be utilized by the PPS for future workforce planning, and as a baseline against which future workforce impacts can be measured.

Preliminary Inventory of Training Needs. The PPS has completed a preliminary inventory of training needs based on the work streams and projects that the PPS is completing. These trainings will be used to create the PPS training plan for the workforce and plan for future needs to ensure that all members of the workforce are adequately prepared for the paradigm shift DSRIP aims to achieve.

Project / Workstream	Milestone Name	Metric/Task/Deliverables	DSRIP Due Date
Clinical Integration	2. Develop a Clinical Integration Strategy	5. Training for all provider types will be developed and executed. Training will cover new work flows, new tools, and the underlying concepts of care coordination.	DY2Q2
Cultural Competency	2. Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	1. Identify patient-facing staff and CBO staff who would benefit from training on cultural competency and health literacy issues.	DY1Q3

Cultural Competency	2. Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	6. Evaluate training sessions regarding specific engagement strategies and patient engagement approaches.	DY2Q2
Financial Sustainability	4. Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	7. Conduct Stakeholder Engagement with PPS Providers - Survey providers regarding the value of educational efforts, their knowledge of VBP post-training and needs for additional training.	DY1Q4
Governance Workgroup	9. Inclusion of CBO	3. Engage CBOs to participate in projects for community education such as 2ai, 2bii, 2.d.i, and 3bi leveraging those that engage with patients in identified hot spots and/or have expertise in culturally and linguistically appropriate care	DY2Q1
IT	2. Develop an IT Change Management Strategy	6. The IT Committee will develop an IT specific education and training plan. This training plan will be integrated with NQP's overall training strategy.	DY2Q2
IT	4. Develop a specific plan for engaging attributed members in Qualifying Entities	6. Create a training plan for Community Health Worker (CHW) and hire.	DY2Q2
Performance Reporting	2. Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting	2. Identify PPS training capabilities and network training needs.	DY1Q3
Performance Reporting	1. Establish reporting structure for PPS-wide performance reporting and communication	11. Conduct training throughout network for reporters.	DY2Q2
Performance Reporting	2. Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting	1. Identify practices regarding billing and documentation that require training in order to ensure accurate and comparable submission of data to perform DSRIP measurement requirements.	DY2Q1

Performance Reporting	2. Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting	3. Develop a training strategy for performance measurement activities that includes organizations and individuals across the network, focused on clinical quality and performance reporting.	DY2Q3
Performance Reporting	2. Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting	4. Develop a provider training workforce based on needs and training strategy identified above.	DY2Q3
Practitioner Engagement	2. Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda	4. Schedule and execute training for all DSRIP projects.	DY2Q1
Practitioner Engagement	2. Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda	6. Determine content for onboarding, semi annual, and annual refresher training	DY2Q1
Project 2.a.i	11. Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally-competent community-based organizations, as appropriate.	4. Develop a workforce and training plan to train/retrain/redeploy community health workers, peers, care managers and other PPS staff in outreach and navigation. The training program will include modules on cultural competency and behavioral health to help PPS achieve high levels of patient engagement in all communities.	DY2Q3
Project 2.b.ii	2. Ensure that new participating PCPs will meet NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. At start up, the participating PCPs must have open access scheduling extended hours, and have EHR capability that is interoperable with theED.	4. Support implementation and provide technical assistance and training as needed to each co-located primary care practice on meeting the NCQA requirements.	DY3Q4

Project 2.b.vii	3. Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	5. Develop training strategy that will be reflected in the INTERACT training procurement (see below) across the PPS in collaboration with SNFs and champions.	DY1Q4
Project 2.b.vii	4. Educate all staff on care pathways and INTERACT principles.	2. Identify all staff that require training.	DY1Q4
Project 2.b.vii	7. Educate patient and family/caretakers, to facilitate participation in planning of care.	2. Identify existing education programs for patients, families and caregivers within NQP with regards to care for the elderly and disabled, including advance care planning and in alignment with INTERACT principles.	DY2Q1
Project 2.b.vii	1. Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	7. Conduct trainings based on agreed upon infrastructure and the results of the INTERACT selected trainers. Trainer will be responsible for (a) teaching on-site staff trainers; ensuring each SNF has identified a facility champion and (c) coordination of INTERACT Version 4.0 tools implementation across SNFs. Tools must include care paths and advance care planning tool.	DY2Q2
Project 2.b.vii	5. Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	6. Specific training of ACP tools addressed in curriculum design.	DY2Q2
Project 2.d.i	13. Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.	2. Coordinate PAM training sessions with Insignia Health for community navigators and other personnel, with participation from PAM training team (described in Milestone 2).	DY1Q3
Project 2.d.i	2. Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.	1. Identify individuals for the PPS-wide training team, including people familiar with patient engagement and activation.	DY1Q3

Project 2.d.i	2. Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.	2. Coordinate PAM® training session with Insignia Health for individuals identified in step 1.	DY1Q3
Project 2.d.i	5. Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	2. Develop a curriculum on patient activation techniques for providers.	DY2Q1
Project 2.d.i	11. Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	11. Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	DY3Q4
Project 2.d.i	14. Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	2. Provide training for community navigators using curriculum in Step 1. Offer additional trainings as needed.	DY3Q4
Project 3.b.i	10. Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	4. Coordinate periodic training at the hub level around patient identification and hypertension visit scheduling.	DY3Q4
Project 4.a.iii	2. In collaboration with Health Homes and CBOs, develop, implement and manage "Collaborative Care" in primary care teams including all relevant team members.	7. Conduct collaborative training for PCPs, MCOs, and Health Homes with shared patients.	DY2Q4
Project 4.a.iii	3. Develop strategies to deliver culturally and linguistically appropriate behavioral health services in collaboration with community-based organizations through staff training, based on patient needs as defined by patients and families.	6. Develop and produce PPS-wide culturally and linguistically appropriate health education materials on mental, emotional and behavioral health promotion for use across health systems in	DY2Q4

		appropriate languages based on cultural and linguistic needs. Distribute materials across NQP..	
Project 4.a.iii	3. Develop strategies to deliver culturally and linguistically appropriate behavioral health services in collaboration with community-based organizations through staff training, based on patient needs as defined by patients and families.	7. Engage the PPS-wide Cultural Competency and Health Literacy committee and the PPS-wide CBO workgroup for feedback on proposed Collaborative Care models and MEB partnerships as well as input on MEB training at the PPS level.	DY3Q4

Workforce Spend – Area of Risk: The NQP welcomes the opportunity to discuss further regarding this area of risk with the DSRIP Independent Assessor and the Department of Health, and looks forward to receiving further information and guidance as discussions continue between various PPSs, the Associations and the Department of Health. In the meantime, alternative plans to address this DSRIP element are being developed by NQP.

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Nassau Queens Performing Provider System, LLC

Project: 2.a.i

Challenges the PPS has encountered in project implementation:

Physician Engagement:

— <u>Non-Safety Net PCPs:</u> Only 1 in 5 attributed lives is currently assigned to a Safety Net Primary Care Provider in NQP. Because non-safety net providers are only eligible to receive a limited proportion of DSRIP payments due to the 5% rule, NQP has had challenges engaging all attested providers in the Integrated Delivery System. Hubs have learned that many providers may have more than 200 Medicaid patients, but this accounts for less than 35% of their panel, or was not fully reflected in the PPS attribution. Additionally, there are inaccuracies in the designations for some providers.

— <u>Medicaid Member Attribution:</u> The member count is based on the DOH Medicaid attribution for that provider in NQP. This data have been found to be outdated and/or incomplete relative to current Medicaid panels and is consistently protested by the providers. Since payments to PCPs are tied, at least in part, to a Per Member Per Month (PMPM) model, it is a challenge for the PPS to provide accurate data without consistent attribution numbers.

— <u>PCMH Certification:</u> The NQP finds the requirement that all primary care practices achieve NCQA 2014 PCMH Level 3 recognition very challenging. This is a time-intensive process for participating practices. It has also been a challenge to identify the required expertise needed to support practices because of the high demand for PCMH-Certified Content Expert (CCE) services.

IT Challenges:

— <u>Practice Fusion EHR:</u> Several safety net PCPs in NQP currently use the Practice Fusion EHR. It is excessively expensive for a RHIO to connect to this EHR, meaning these PCPs would not be able to connect to a RHIO, which is a project requirement. Lack of RHIO connectivity will also impact clinical data interoperability and cross-Hub care management.

— <u>EHR Modifications:</u> Implementing a new EHR or modifying an existing EHR to meet DSRIP requirements is time-consuming, expensive, and challenging for many providers. Additionally, some EHR vendors are more responsive than others. Several safety net PCPs in NQP currently use the Practice Fusion EHR, which has historically been very difficult to work with to implement EHR modifications.

— <u>Information Sharing:</u> The Hub structure requires Hubs to agree on a shared approach to business requirements and IT system specification design. While providers are assigned to only one Hub, patients will interact with multiple Hubs.

Patient Engagement:

— <u>Health Home Referrals:</u> It is challenging for PPS providers to know if a patient is enrolled in a Health Home or on a Health Home's potential patient list. Because there are multiple Health Homes within NQP, the ability to make a referral in a timely manner without increased transparency about Health Home attribution is a barrier to effective integration.

Efforts to mitigate challenges identified above:

Physician Engagement:

— NQP supports the New York State (NYS) Department of Health's (DOH) request for a policy exception to the current definition that would allow additional criterion applicable only to Managed Care plan-assigned PCPs for DSRIP purposes.

— Each hub is implementing its own PCMH recognition strategy for primary care physicians. Each Hub is engaging the help of outside vendors who have expertise in primary care transformation and will help practices achieve NCQA PCMH recognition.

IT Challenges:

— NQP is taking every opportunity to make the Department of Health aware of the challenges that Practice Fusion poses statewide; more than 2,000 primary care practices currently use Practice Fusion. If the Department of Health is unable to assist, with regard to a solution with Practice Fusion, then the Hubs are prepared to work with the practices to transition to a different EHR.

— NQP completed the IT TOM Workshop Series for Project 2.a.i., which defines Business Requirements and System Requirements. Details can be seen in the final IT TOM report. NQP has issued an RFP for a PPS-level Enterprise Data Warehouse solution, which would aggregate and share data across Hubs to support standards of care.   The RFP results will be evaluated by the end of August.

— NQP is developing an internal tool to stratify assigned beneficiaries across Hubs, which will be implemented into IT solutions such that each Hub is aware of who is responsible for a particular beneficiary at a given time.

Patient Engagement:

— NQP is interested in working with DOH or other PPSs to create a 1-800-NYS-HOME number that would provide 24/7 information about an individual's health home enrollment status to a healthcare professional in the Emergency Department or health care setting.

Hub Model:

— Hub workgroups are implementing their respective contracting strategies, targeting prioritized providers, and meeting regularly to ensure efforts are not being duplicated in contracting. Hubs maintain and share lists of contracted providers. In addition, the Performance Reporting Workgroup is analyzing the performance of desired practices before there is any managed care contracting.

Implementation approaches that the PPS considers a best practice:

Best practices are highlighted within the Project and other Organizational quarterly reports.

<table>
<tr><td>**Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:**</td></tr>
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An integrated, collaborative and accountable service delivery structure jointly created and supported by the Catholic Health System of Long Island (CHSLI), Long Island Jewish Medical Center (LIJ), and Nassau University Medical Center (NUMC) would have been unimaginable two years ago. However, since these "competitive collaborators" came together in October 2014 to conduct a Community Health Needs Assessment, there has been meaningful commitment from the leadership to transform the current system and to improve the health of the attributed population.

NQP's progress toward including all NQP partners in the IDS, ensuring that all safety-net providers are sharing information among clinical partners, and achieving 2014 Level 3 PCMH primary care certification is largely the result of the organization, strategy, and activities of the separate health systems (Hubs). Each Hub has assumed responsibility for a subset of NQP's provider network. Individually, these Hubs have successfully advanced key components of this project; however, the greater success is in the on-going collaboration and agreement on strategies for clinical integration, financial incentives, and performance measurement. These elements are the foundation for a long-term population health strategy for the region.

Several examples of coordination that extend beyond the Quarterly Report include:
- NQP Implementation Plan & Quarterly Reports: In July 2015, representatives from each Hub jointly wrote the Implementation Plan – writing, discussing, and finalizing each Task for every milestone as a group. With each Quarterly Report, the Hub Project Leads have prepared responses to the tasks and discussed any changes to the language or deadline. The Hub Leads read, review and signed-off on all narratives submitted with the Quarterly Report for all organizational work streams and projects.

- NQP Orientation: In May 2016, CHS, LIJ and NUMC all hired Hub-specific project managers. The Hubs organized a joint two-day orientation to welcome the new staff members. The orientation included pre-reading, introduction to Performance Logic, DSRIP, and presentations from each Hub.

- NQP PMO Hiring Process: Each Hub sent representatives to participate in the on-site interviews with Director-level candidates and the representatives agreed on the final candidates, including the Medical Director (started July 5), Director of Project Operation (started July 11), and the Workforce Director (started July 18). These new hires will be imperative to collaboration with the Hubs to operationalize an integrated delivery system.

NQP has also continually engaged CBOs in the project implementation activity. Examples of CBO engagement from DY1 – DY2 Q1 include:

- DY1 Q1: NQP held its Inaugural Integrated Delivery System (IDS) meeting on April 24, 2015 with representatives from Beacon Health Partners, Pederson-Krag, South Shore Association for Independent Living, Health & Welfare Council of Long Island, Nassau County Department of Health & Human Services, among others.
- DY 1 Q1: NQP held a CBO Engagement Meeting on June 9, 2015 to ask community-based service

providers to help guide meaningfully engagement with community-based organizations. The conversation focused on strategies for how best to outreach and partner with community-based organizations in the projects.

- DY1 Q3: In November 2015, NQP issued an RFP to community-based organizations to participate in Project 2.d.i. 14 CBOs responded with proposals. Each Hub selected a CBO with which to partner for project implementation.

- DY1 Q4: In January 2016, NQP Hub Leads met with five Hispanic-based organizations – the Hispanic Brotherhood of Rockville Centre, the Long Beach Latino Civic Association, the Hispanic Counseling Center, Circulo de la Hispanidad, and the Hempstead Hispanic Civic Association. These community-based service providers described their services and abilities to partner with the NQP hubs/health systems to connect people with timely care and improve population health. The meeting was a productive forum and a model for collaboration.

- DY 2 Q1: In June 2016, NQP invited CBOs to present at its PAC meeting, with a focus on organizations that create directories of social services, such as GNYHA's HITE and the United Way's 211.org.

Development of the Integrated Delivery System (IDS). NQP is pleased to report that it has met all the required milestones and tasks due by DY2 Q1; each helping to build the Integrated Delivery System for the benefit of its attributed Medicaid population and non-Medicaid populations.

As stated in NQP's Governance Section, NQP is focused on the development of the IDS. The implementation of all tasks is getting NQP closer to the IDS vision. NQP has either completed, or is in the process of implementing, the critical components of the IDS as follows:

- An effective and accountable governance and project implementation structure.

- PCMH-centric network that is identifying high risk populations for pertinent clinically-integrated interventions.

- The integration of primary care and mental health is being enhanced so that the previous patterns of fragmentation in care are eliminated.

- Engaging the disaffected population through its 2.d.i patient engagement efforts is in process achieving outreach and patient education.

- A comprehensive Cultural Competency and Health Literacy Plan is being implemented throughout the provider network.

- The development of a clinically-integrated network through NQP's contracting efforts and promoting pertinent and timely exchange of information through Healthix and other RHIOs is in process.

- The development of a comprehensive network of providers who will be addressing the social determinants through the inclusion and engagement of community-based organizations, public agencies, and public safety.

- The development of budgets and funds flow model to incentivize providers' for evidence-based outcomes.

- Promoting integration and health status improvement through the implementation of NQP's

Population Health Management and Clinical Integration Plans.

- The effective communication among all NQP providers through the implementation of its Community Engagement and Communication Plan.

- Care Coordination and care transitions initiatives are being implemented to reduce preventable hospital use. Collaboration with Health Homes and leveraging their care management systems is taking place.

- Robust workforce strategy for retraining staff on population health management initiatives are being developed and implemented.

- A structure for the timely and actionable rapid cycle analytics is being implemented.

- Through its Hubs, NQP is engaging with MCO's to explore and discuss VBP contracts to ensure the long-term sustainability of safety net providers.

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 to population

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

PPS Name: Nassau Queens Performing Provider System, LLC

Project: 2.b.ii

Challenges the PPS has encountered in project implementation:

Site Engagement (including workflow)**:**
— Workflow Development: NQP has faced challenges in standardizing workflow processes for a warm hand-off of patients from the ED to Primary Care that is co-located in the facility. Integrating IT tools for communication and data sharing between the two has been difficult.
— Varied Triage Processes: Sites have different interpretations of what services must be provided in the Emergency Department to patients who present with non-emergent conditions before they are triaged and directed to the co-located Primary Care Practice, in compliance with EMTALA. The challenge has been to develop workflows to support upfront triage so that patients with non-emergent conditions are quickly screened and redirected to the appropriate level of care without duplication of services or additional wait times.
— Appointment Workflows: Current process of connecting patients, who currently do not have an identified PCP at the time of ED presentation, to a PCP has been challenging and requires dedicated staff to contact the managed care organization, as well as the PCP practice, for a warm hand-off of the patient. At least one Hub is facing challenges identifying staff to support the high volume of primary care follow-up appointments within the timeframe listed in the discharge instructions and/or within 30 days of the ED visit (to meet the definition of "actively-engaged patient"); supporting this workflow requires additional staff resources.
— Resistance to Extended Hours: At least one Hub is facing difficulties with physician willingness and capability to expand the number of hours during which care is offered.

IT Challenges:
— Real-time notifications: There are no real-time notifications in existing RHIOs, MCOs, or other systems, to PCPs or to Health Homes when a patient visits the Emergency Department.

Patient Engagement:
— Health Home Referrals: It is challenging for Emergency Department providers to know if a patient is enrolled in a Health Home or on a Health Home outreach list. Because there are multiple Health Homes within NQP, the ability to make a referral in a timely manner without increased transparency about Health Home attribution is a barrier to effective integration.
— Cultural Competency & Health Literacy: Cultural competency and health literacy play a significant role in ED utilization. Providing appropriate education and ensuring the presence of bilingual staff and involvement of community-based organizations will be critical.

Financial Challenges:

— <u>Significant capital costs:</u> The capital costs of this project are significant. Several hospitals submitted capital grants to support the costs of a new co-located primary care practice in the ED. Before the capital awards were announced, sites were reluctant to move forward with plans when the funding was uncertain. Once the awards were announced in March, the sites that received funding began to move forward very quickly, while the sites that did not receive grants re-assessed their plans.
— <u>Aligned Incentives:</u> Reworking workflows and aligning Emergency Department physician incentives with the overall outcomes of the program, while ensuring compliance with EMTLA regulations for eligible patients, is an obstacle for NQP.

Efforts to mitigate challenges identified above:

Site Engagement:
— Care Coordination workgroups, with appropriate stakeholders, have been formed to examine care management protocols for medical screening exams and EMTALA standards. In addition, many sites have prioritized culturally-competent signage and education, so that patients with non-emergency conditions seek care at the primary care practice *first,* rather than registering in the Emergency Department and requiring triage and redirection.
— Hubs have Executive support in promoting and advocating for more appointment availability for ED patients in the collocated primary care offices, and for piloting new technologies to support online appointment scheduling.
— In place of the unit secretary, CHS/SJEH has temporarily worked this function into the patient access team supervisor role; however, volume is steadily growing and this solution is not sustainable over time.

IT Challenges:
— NQP continues to introduce Healthix to its partners to facilitate RHIO connectivity and will design a centralized clinical event notification model using a multi-disciplinary workgroup.
— CHS/SJEH will be contracting with Athena for EMR implementation in the PCMH/collocated primary care offices.

Patient Engagement:
— NQP and its Health Home partners are raising awareness of the challenge through membership organizations like GNYHA and in forums with Department of Health representatives to encourage a centralized solution (state or city-wide). NQP will continue to meet with the Health Homes to identify improvements to the referral process and create effective linkages.
— In addition to providing appropriate signage and education in its facilities, NQP is engaging community-based organizations for assistance with educational and support efforts to address CCHL of patients and staff.

Financial Challenges:
— CHS did not receive capital funding for this project. In an effort to move forward with the original proposal of building a primary care facility on the grounds of Mercy Medical Center, applications for grant funding are underway. Other options within Mercy Medical Center are being explored.

Implementation approaches that the PPS considers a best practice:

Prominent Location for Co-Located Practice:

— NUMC opened a primary care practice on the first floor of its hospital and the same floor as the Emergency Department. The primary care practice is adjacent to the entrance from the visitor's parking lot, which means it is highly visible to all hospital visitors and easily accessible from the Emergency Department.

— CHS's participating hospital, SJEH has recruited several Primary Care Physicians across three local PCMH facilities to implement open access scheduling of the co-located patient in the SJEH emergency room. Follow-up appointments are scheduled within 1-2 days of the patient's discharge. Marketing and Recruitment are on-going.

Patient- Centered Approach: The project workgroup has used a patient-centered approach to designing new workflows; the focus is a set of workflows in which patients with non-emergent conditions are evaluated and treated quickly. The team will monitor the implementation to assess patient experience and on-going ED utilization.

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

— **Urgent Care Partnerships:** Both LIJ and CHS have partnerships with Urgent Care centers in the community. These partnerships are part of the Hub strategies for creating alternatives to the emergency department and are being advertised in the community.

— **FQHC Partnerships:** NUMC has a collaborative agreement with the LIFQHCs it co-operates across Nassau County. This partnership will be utilized to ensure alternative care to the Emergency Department within the community. Its continued growth will be of great value to the NuHealth System.

— **Active ED Participation:** Emergency Medicine Physicians from all Hubs have been regular attendees at the project workgroup meetings; this project workgroup has more consistent representation from Emergency Medicine than any of the other project committees. The Emergency Department leadership has displayed great enthusiasm for this project and a strong readiness to redesign workflows,

— **Synergies with other NQP projects:** Many Medicaid patients who use the Emergency Department have behavioral health conditions. The implementation of this project is complemented by the implementation of Project 3.a.ii - Behavioral health community crisis stabilization services, which includes open access crisis services in the community and partnerships with community-based organizations to educate patients about alternatives to the emergency department.

— **Progress on Project Implementation and consistency with Project Plan**: NQP's implementation of this project is directionally consistent with the intent and commitment made in the Project Plan Application and NQP is pleased to report that all tasks have been completed through DY2Q1, in a comprehensive and timely manner.

NQP will continue its work towards improving access to primary care services at facilities co-located with Emergency Departments and is in process of identifying all appropriate locations and needs for

implementation. NQP will continue to support all facilities participating in this effort, including transformation to NCQA 2014 Level 3 PCMH status for all practices, use of open access scheduling, and adoption of protocols that ensure compliance with appropriate standards.

NQP is on target for completing the remaining tasks and milestones to successfully implement this project to meet the goal of increasing access to primary care and directing patients with non-emergent needs to the appropriate care, as evidenced above by NUMC's completion of a co-located facility and CHS's enhancements to an existing facility. NQP also has initiatives in place to overcome the risks that have been identified for this project.

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

There have been no changes to populations that were proposed through the project.

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

PPS Name: Nassau Queens Performing Provider System, LLC

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:

Site Engagement (including workflow)

— Transitional Care Manager Visitation Policies: Project 2.b.iv requires the "PPS to have a program in place to allow case managers to visit patients in the hospital and provide care transition services and advisement." Each Hub has its own transitional care managers who have access to their Hub's hospitals. Although this is the case, most Hubs have policies that restrict the ability of these transitional care managers to visit a patient in another Hub's hospital. The hospitals are geographically close to one another, enabling patients to seek care from multiple health systems. With this requirement, each of the hospitals in NQP will need to work to change or amend their hospital policies.

— Early Notification of Discharges: Early notification of planned discharges may be a challenge for some Hubs or their partners. These notifications currently only happen sporadically, and are not yet provided in real time by the MCOs or the RHIOs.

— High-Risk Patient Identification: The identification of high-risk patients based on social determinants is a challenge. Few EHRs capture the social determinants of healthcare in discrete fields that can be used to generate reports. NQP hospitals are in different stages of implementing risk stratification tools.

IT Challenges

— Community-based Organizations (CBO) EHR: Many CBOs have limited IT capability and are not connected to the RHIO, making patient tracking difficult. The lack of interoperability makes it difficult to share patient information in a timely and secure fashion.

Patient Engagement

— Health Home Eligibility: NQP has met with its largest Health Home partners, which all identified effective linkage between Health Home-eligible patients and services as a challenge. The difficulty is that a case manager in the Emergency Department or Inpatient Unit cannot easily determine if the patient is on a Health Home's outreach list or has been enrolled by a Health Home. If the case manager had access to this information (for both outreach and enrollment status), it would improve the number of linkage attempts and the success of those attempts.

— Resistance to Scheduling Appointments Pre-Discharge**:** Patients and staff are resistant to scheduling appointments prior to discharge (patients prefer to wait until they are home and clerical staff members are very busy).

Efforts to mitigate challenges identified above:

Site Engagement
— NQP has recognized that the Transitional Care Manager Visitation policy will be a challenge and has encouraged each Hub to prioritize this task.
— Potential strategies for early notification of discharge are discussed in the project workgroup meetings and each Hub understands the expectations and needs.
  o LIJ and its affiliates are in discussions with a vendor, 1Unit, to implement standardized discharge rounds that would include early notification of planned discharge.
  o CHS is rolling out a Care Management Organization embedding Transitions of Care (TOC) components of DSRIP by providing a 'High-Touch,' hands-on care coordination model within each facility. This model will be immediately initiated upon admission of an identified, high risk TOC patient. Within the model, an early discharge notification process will be developed.
— In the project workgroup, Project Leads share their experiences with different risk stratification tools. There is agreement that social determinants should be included, and Hubs are working to incorporate these factors into discrete fields that can be reportable.

IT Challenges
— A strategy for CBO engagement and participation will be established based on findings from the Care Coordination Initiative. We anticipate the development of incentives to be aligned once CBO engagement and contracting is finalized.
— Many of the IT interoperability issues will be mitigated once Healthix is more intimately involved in the IT TOM process and creates a standardized structure for connecting attested community-based providers and organizations to the RHIO.

Patient Engagement
— NQP and its Health Home partners are raising awareness of the challenge through membership organizations like GNYHA and in forums with Department of Health representatives to encourage a centralized solution (state- or city-wide). NQP will continue to meet with the Health Homes to identify improvements to the referral process and create effective linkages.
— Hubs are piloting different approaches to scheduling appointments prior to discharge and considering additional staffing as well as technology solutions to support appointment scheduling

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Implementation approaches that the PPS considers a best practice:

Seven Essential Intervention Categories: NQP included the National Transitions of Care Coalition's (NTOCC) 'Care Transition Bundle' (which includes Seven Essential Intervention Categories) its implementation plan (e.g. Medications Management and the safe use of medications by patients and their families and based on patients' plans of care).

Vendor support - CHS is contracting with xG Health Solutions, Inc. who is implementing a 'best-in-class' care management organization that is inspired by Geisinger, but is relevant to both CHS Nassau & Suffolk County PPSs. The CMO design will be based on available data for populations served to create the most effective model, focus on the best interest of the patient, and emphasize key P4P and P4R measures that drive success in value-based care.

Use of Social Determinants and Medical Factors: The use of social determinants in the identification of high risk patients is essential for successful readmission reduction. Other evidence-based scores (e.g. LACE) that

do not include these factors are less predictive, especially in the Medicaid population. NUMC's Transitions of Care model is based on care managers assisting high risk/chronically ill patients throughout the healthcare spectrum. The model is predicated on emphasizing care coordination in the ambulatory, as well as inpatient, settings and ensures that patients are strategically followed and flowed into the community through community-based organizations.

Community Needs Assessment: Hubs are leveraging the NQP Community Needs Assessment and hot-spotting data to prioritize care management deployment within the geographical area(s) of safety net hospital(s).

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

Collaboration across a range of Stakeholders: Project implementation includes a diverse group of stakeholders that represent the entire continuum of care, including primary care, emergency medicine, acute care (nursing, hospitalists, and case management), ambulatory care management, pharmacy, information services, home care, nursing education, community-based providers, Health Homes, and post-acute facilities. In some cases, this is the first time these departments have come to the table to work together.

Shared Learning and aligned processes: Two of the three NQP Hubs are participating in both NQP and SCC, which has contributed to similar implementation plans in the two PPSs and, ultimately, may lead to regional standardization in transition of care protocols.

Population Health Tools: The implementation plan is being supplemented to reflect the investments in infrastructure and personnel at each Hub to develop the population health analytics to identify the factors that increase a person's risk for readmission and to make this information accessible to inpatient staff.

Progress on Project Implementation and consistency with Project Plan: NQP's implementation of this project is directionally consistent with the intent and commitment made in the Project Plan Application and NQP is pleased to report that all tasks have been completed through DY2Q1, in a comprehensive and timely manner.

NQP continues to collaborate with its providers and community partners to develop discharge processes and workflows to ensure that directions are understood and implemented by the patients, particularly those at high risk of readmission (e.g. those with cardiac, renal, diabetes, respiratory and/or behavioral health disorders) and their caregivers, directions are properly documented by and for caregivers, and the proper support is in place, including from the community.

NQP is on target for completing the remaining tasks and milestones to successfully implement this project to meet the goal of reducing avoidable readmissions. NQP also has initiatives in place to overcome the risks that have been identified for this project.

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

The project is designed to serve the Medicaid and Managed Medicaid beneficiaries, but the redesigned hospital workflows, risk stratification tools, and new transition of care protocols will extend to all populations.

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

PPS Name: Nassau Queens Performing Provider System, LLC

Project: 2.b.vii

Challenges the PPS has encountered in project implementation:

Site Engagement:
— Clinical Staffing: Among the 60+ SNFs that are participating in Project 2.b.vii with NQP, the clinical practices and skills are not consistent. At sites with limited medical coverage, when staff members are trained to identify acute changes in condition early, the only recourse may be to transfer the patient to the Emergency Department for evaluation. This transfer may occur without a structured warm hand-off process in place and repeatedly for the same conditions.
— Low Medicaid attribution: Several SNFs that signed attestations with NQP have very few Medicaid lives attributed to NQP. The majority of their Medicaid lives have been attributed to other PPSs (e.g. NYP-Queens, SCC).
— Tracking Tools: The INTERACT Hospital Rate Tracking Tool can be challenging and time-consuming for facilities to complete on a monthly basis.

IT Challenges:
— EHR capabilities: Among the 60+ SNFs, sites are in very different phases of EHR implementation. This creates challenges for communication with other providers, INTERACT documentation and reporting. In addition, the cost of EHR implementation, upgrade, and maintenance (in terms of both capital cost and staff time) may be prohibitive for SNFs.
— RHIO awareness: Few sites are knowledgeable about or connected to a RHIO.

Patient / Caregiver Engagement:
— Patient and Caregivers Misconceptions: Patients and their caregivers/families request transfer to an Emergency Department despite SNF's abilities to provide clinical care on-site. Many patients and their families believe that the standard of care is of higher quality at the hospital and do not recognize the risks involved in the transfer. Additionally, discussions with patients, families, and caregivers regarding advanced directives can be sensitive and face resistance.

Efforts to mitigate challenges identified above:

Site Engagement:

— NQP is committed to working with each SNF to meet the performance and quality goals outlined in the INTERACT program through regular monitoring and evaluation; this includes consistent use of the INTERACT tools and achieving a reduction in the hospital transfer rate. Each Hub designed a Funds Flow model that incentivizes sites to have adequate clinical coverage to manage acute changes in condition on-site. Hubs have also contracted/are considering contracting with vendors to provide full project implementation support, INTERACT training, and readmission consulting/stratification services for each of the assigned DSRIP SNFs.

— For sites with few Medicaid lives overall, the potential incentive payments are smaller; however, Hubs can find other ways to partner with these facilities. For example, at least 2 of the 3 Hubs are participating in CMS's Bundled Payments for Care Improvement demonstration, and can use the shared savings to support quality improvement. The Performance Reporting workgroup has provided guidance to the Hubs to ensure patients are only reported once in the Patient Engagement counts, for sites that may have lives attributed to multiple PPSs.

— Hubs are offering INTERACT training that is specific to each SNF's needs and is inclusive of all the INTERACT 4.0 tools/toolkits. This training will include the use of the Hospital Rate Tracking Tool. A Facility Champion at each site will be INTERACT Certified and will continue to integrate the curriculum.

— NQP and its Hubs are assessing workforce needs of the SNFs to better support the SNFs in workforce transformation efforts in order to better manage the conditions of their patients.

IT Challenges:

— NQP is working with SNFs to evaluate and understand their capabilities and will offer support to close gaps in capabilities, implement EMRs, and connect to the RHIO.

Patient Engagement:

— SNFs are developing programs to educate patients and their families about the clinical services that can be provided on-site and are publicizing their quality ratings with their patients. Hubs have discussed creating materials for patients and families to describe the participation in quality improvement activities and the advantages of avoiding hospital transfer.

Implementation approaches that the PPS considers a best practice:

Hub Accountability for Implementation: Each Hub in NQP has responsibility for the INTERACT implementation at approximately 20 sites. This division of responsibility allows for effective oversight and monitoring. Implementation of INTERACT 4.0 tools and continuous monitoring of care quality will help reduce avoidable hospitalization.

Encourage RHIO Connectivity: NQP emphasizes RHIO connectivity during meetings with each SNF, since this connectivity could improve care transitions. Many SNF administrators are not familiar with RHIOs; Hubs will provide education and training opportunities. For example, LIJ is coordinating two webinars with Healthix for SNF leadership.

Support Care Management Processes: NQP will support creation and adoption of processes to facilitate successful care management, such as warm hand-offs and collaborative discharge planning between caregivers.

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

Telehealth: Several SNFs have pursued telehealth to increase their clinical coverage. The project workgroup has also discussed telehealth as a potential strategy to reduce transfers. For example, LIJ submitted a CRFP proposal for a telehealth program for several SNFs; while this project was not selected for funding, LIJ is pursuing alternate funding sources.

Sigmacare EHR: NQP has benefited in its implementation due to the popularity of the Sigmacare EHR, which plans to roll-out an INTERACT module and which is easy to connect to a RHIO.

NY-RAH: At least one facility within the PPS has been participating in the NY-RAH project phase I. More facilities are looking to participate in phase II to help reduce avoidable ED readmissions.

Progress on Project Implementation and consistency with Project Plan: NQP's implementation of this project is directionally consistent with the intent and commitment made in the Project Plan Application and NQP is pleased to report that all tasks have been completed through DY2Q1, in a comprehensive and timely manner.

NQP will continue to complete agreements with each of the SNFs in its network and successfully implement the INTERACT program at each facility, as well as the necessary supporting activities that are described above, such as development of educational programs for families and caregivers, coaching programs, and data sharing and clinical monitoring processes.

NQP is on target for completing the remaining tasks and milestones to successfully implement this project to ensure stabilization of patients and avoiding transfer to an acute care facility. NQP also has initiatives in place to overcome the risks that have been identified for this project.

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

There have been no changes to populations that were proposed through the project.

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

PPS Name: Nassau Queens Performing Provider System, LLC

Project: 2.d.i

Challenges the PPS has encountered in project implementation:

Insignia/Flourish Challenges:

— Survey Language: The survey is currently available on paper in approximately 40 languages, but not all 40 languages are available in Flourish and the only alternative option to note a participant's language preference is within the "Notes" option under the Coaching for Activation tab, which is not reportable. The library of languages was requested by all PPS's since October 2015, but only shared via Dropbox by Insignia in May 2016. Some of the surveys were not provided in the proper format, requiring additional work to be formatted into the appropriate survey presentation to collect participant response.

— Participant Unique Identifier: Insignia Health has prescribed a unique identifier to be used for each participant who does not have Medicaid. The unique identifier is comprised of a participant's date of birth, letters of their first and last name and portion of their zip code. The unique identifier section of the system is manually entered in a free form text box that does not have any quality assurance formatting measures to prevent incorrect formats. While it is impossible to guard against user error, the lack of formatting restrictions increases the likelihood that user-generated mistakes will not be identified and duplicate accounts may be created.

— Participant Insurance: Navigating uninsured participants to insurance programs is a primary goal of this project. The option of entering insurance information was requested of Insignia Health on or before October 2015 and a drop down option has been provided by request only as of May 2016. As a result of the delay, any insurance navigation completed prior to this date will need to be manually updated to Flourish, as patients are re-surveyed or coached, in order to capture and provide accurate reporting on insurance status.

— Flourish Coaching Guidance with No Tracking and Reporting: Currently, Insignia Health provides tracking and reporting for survey responses and basic participant demographics. Insignia Health does not provide any tracking or reporting options for health and navigational coaching activity within Flourish. When discussed, Insignia Health recommends that each PPS either create or purchase an additional database to address gaps in Flourish. The need for two databases creates a level of redundant processing, manual or electronic reconciliation and increased costs that are time intensive and inefficient.

— Managing Participant Survey and Health Coach Activity Needs: The Flourish platform currently does not provide a mechanism for managing system activity reminders, i.e follow up survey prompt by date; insurance activation follow up calls, or inter-coach communication to document in progress activity. These activities must be tracked through a separate mechanism outside Flourish for each health coach.

— Consent Documentation: Health systems include patient demographic and insurance information as PHI and PII and collect consent for PAM® participation. Insignia Health does not consider the information

collected as PHI and does not have a mechanism for uploading or recording any acknowledgment of consent forms in Flourish.

— <u>Business Associate and Master Service Agreements:</u> Insignia Health has Master Service and Business Associate Agreements in place with NQP, but is hesitant to establish a BAA with an individual hub. When this action was recommended by Hub legal departments, in order to pursue a CBO partnership and ensure protection of participant information, Insignia's reticence caused delays in the ability to move the project forward through survey activity or entering of data into the Flourish system. Language in the BAA is being revised to address this issue.

— <u>Inability to recognize duplicates in Flourish:</u> Since coaches can only access and input survey information for their specific hub, there is no mechanism for searching for prior PAM® surveys that may exists across other Hubs.

Challenges related to the survey process and data collection:

— <u>Surveying in the Emergency Department:</u> Several sites attempted to survey patients in the Emergency Department, but the survey response rates in the ED were much lower than in ambulatory practices and/or community-based settings.

— <u>Lists of LU/NU Members:</u> It has been time-consuming to collect lists of Low-Utilizing and Non-Utilizing Medicaid beneficiaries from each MCO. While MCOs have NU reports, they do not typically report LU members.

— <u>Re-Survey Process:</u> NQP has begun the re-survey process, and has encountered difficulties reaching patients to complete the re-survey.

— <u>Assigned PCP:</u> Many MCO members do not have an assigned PCP, which has increased the difficulty of connecting patients to a PCP.

Efforts to mitigate challenges identified above:

Activities to mitigate concerns related to Insignia/Flourish:

— NQP has re-formatted translated surveys as needed so that they can be properly administered and scored.

— NQP encourages staff to enter data carefully and check to ensure the patient identifier is entered correctly.

— NQP utilizes different dialects for surveys to better fit our patient population and ensure surveys can be properly administered and scored.

— NQP is in the process of finalizing a contract with CipherHealth, which can provide a platform to document coaching and navigation activities and has functionality to prompt health coaches.

Activities to mitigate concerns related to the survey process and data collection:

— Several sites are prioritizing the survey activity in ambulatory practices and at community events, rather than continuing to survey in the Emergency Department.

— SJEH has assigned a designated staff member and workflow process within the Fast-Track area of SJEH to capture uninsured patients via the registration process and survey within the dept. Data entry of the survey is carried out by the outreach team who will transition the patient by connecting them to insurance and/or CFA.

— In DY1, NQP only included uninsured individuals in the patient engagement reports. The Hubs continue to work with MCOs to obtain lists of LU and NU Medicaid beneficiaries. It has been easier to obtain NU lists than LU lists.

— The CHS PMO generates a weekly report which is manually audited for duplicates. While this solution is feasible now due to the low survey volumes during first phases of implementation, it is not feasible as a long term solution.

Implementation approaches that the PPS considers a best practice:

— **Coaching for Activation**: Hubs are working to incorporate the Coaching for Activation portion of the 2d.i project into their Care Coordination efforts. A more conclusive way to approach the Coaching for Activation efforts will be determined following the 2-day Insignia training session on August 18th and 19th.

— **Financial Unit Survey Administration:** Hubs have experienced success with integrating survey administration into the workflow of their financial units:
  o LIJ and its affiliates are leveraging their Financial Assistance Unit to administer the PAM® survey. The FAU primarily works with uninsured individuals and the staff has had an easy time incorporating the survey into its workflow. In fact, several staff members have indicated that administering the PAM® survey has been a positive addition to interactions with clients.
  o CHS will also begin leveraging in its Patient Financial Service resources by incorporating the PAM survey into the self-pay admission workflow. Additionally, CHS has collaborated with the MCO partners within SJEH to incorporate the PAM survey into the application process and transitioning the survey over to the outreach team for CFA once connected to insurance/primary care. NUMC is implementing the PAM efforts at its hospital site and at its affiliated FQHC.

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

— **Collaboration across Hubs:** NQP's 2.d.i Project Workgroup is one of the most active and engaged project workgroups. Together, the group has drafted an RFP, developed a common scoring rubric, reviewed and commented on 14 RFPs, repeatedly provided feedback to InsigniaHealth, evaluated CipherHealth's PAM® tools and technologies, and functioned as a productive learning collaborative. There is meaningful dialogue and communication occurring among all 3 Hubs and with community-based organizations.

— **Collaboration across PPSs:** Project management staff and Hub project leads communicate with other PPSs to discuss strategies to increase survey completion, to improve the efficiency of the Flourish platform, and to enhance the coaching and navigation program.

— **Progress on Project Implementation**: NQP is pleased to report that all tasks associated with 2.d.i Milestones have been completed timely through DY2Q1 and that implementation is directionally consistent with the intent and commitments made in the Project Plan Application. NQP is on target for completing the remaining tasks and milestones and has initiatives in place to overcome the risks that NQP has identified for this project.

Most importantly as NQP works with the uninsured and LU/NU populations, it will ensure that affected individuals are positively impacted by NQP's DSRIP projects and are learning about and have access to needed and financially-accessible primary care and preventive services. While it is still too early to

quantitatively evaluate results, NQP can directionally see a direct correlation between the tasks that NQP is implementing in 2.d.i and the improvement of this targeted populations' health status with the eventual reduction of preventable hospital use.

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

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— **Primarily Uninsured:** A significant change is that the identified population being served is primarily the uninsured and has not included the Low-Utilizing and Non-Utilizing members because the lists have not been provided by all the MCOs.   Our Hubs are currently engaging with the MCOs and will re-emphasize the need for this information.

— **Prenatal Care:** SJEH has begun preliminary discussions on targeting the Prenatal Care Assistance Program, both upon entry into the program and in preparation of their 6 week post-partum transition for self-wellness, as well as a caregiver to their child. The strategy includes creating algorithms for pregnancy wellness, post-partum/nursing wellness, and well-baby care plans.

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

PPS Name: Nassau Queens Performing Provider System, LLC

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

Physician Engagement:
— Resistance to Integrated Care: Some primary care physicians are resistant to screen for and treat behavioral health conditions. Most Primary Care Physicians do not have adequate time to manage issues that are not pertinent or brought up by the patient. They are also concerned that they may not have appropriate resources to support behavioral health needs identified by these screens. This is an example of treatment being provided in a silo and an opportunity for education.
— Excludes Ob-Gyn: The patient engagement definition is limited to patients who are screened at their primary care physicians' office. For example, women who are screened at their Ob-Gyn's office cannot be included in these counts. This appears to be inconsistent with the general treatment of Ob-Gyn providers as coming within the definition of Primary Care.

Access to Care:
— Stigma towards BH: Stigma about accepting treatment for behavioral health conditions is prevalent, especially in Asian communities. NQP includes a large Korean community in Eastern Queens. This community has been very vocal about the role stigma plays in preventing people from accessing available services.
Access to Care: Federal health authorities have designated about 4,000 areas in the U.S. as having a shortage of mental health professionals (i.e. areas with more than 30,000 people per psychiatrist). According to the American Medical Association, the total number of physicians in the U.S. increased by 45% from 1995 to 2013, while the number of adult and child psychiatrists rose by only 12%. During that span, the U.S. population increased by about 37% and millions more Americans became eligible for mental health coverage under the Affordable Care Act.

There is also a shortage of psychiatrists who serve the Medicaid population, particularly bilingual providers. A study by JAMA showed that 55% of psychiatrists accept patients covered by Medicare versus 86% of other providers.

Financial Challenges:
— Reimbursement challenges: Because of the size of its network (more than 1,200 PCPs), NQP believes that telehealth models will be important to ensure behavioral health services are available during all practice hours to all PCMH practices. However, providers cannot be reimbursed for ambulatory telehealth visits in non-rural areas.
— Billing and operational issues: Scheduling primary care and psychiatry visits on the same day is preferred by patients, but is not permitted by most payers.

Workforce Needs:
— Model 2: One Hub is investigating the enhancement of fulltime PCP availability in BH services to ensure that appropriate skill set is available.
— Behavioral Health Care Managers: Qualified behavioral health care managers are in high demand to meet the project requirements. The Behavioral Health care manager functions as a core member of a Collaborative Care team and is responsible for coordinating and supporting mental health care within the clinic and for coordinating referrals to services outside the clinic. This requires that care managers have the appropriate training and clinical licensure or certifications (e.g. Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Social Worker).

NQP expects that new hires will include recent graduates who will require more extensive orientation and on-the-job training and mentoring.

Efforts to mitigate challenges identified above:

Physician Engagement:
— NQP has identified several PCPs who are champions of Integrated Care. NQP and its Hubs are asking these providers to share their positive experiences with their colleagues and other physicians in the Network to help overcome resistance and improve actively engaged counts.

Access to Care
— NQP is working with its health system partners to increase access to psychiatrists for people with Medicaid and the uninsured. LIJ is exploring tele-health options to help increase access.
— NQP is engaging its network of providers and community-based organizations to promote awareness and understanding of mental health illness, including the Korean Community Services of Metropolitan New York to support culturally sensitive communication about mental health and the availability of mental health services for the Korean community in Eastern Queens.

Financial Challenges:
— NQP and its hubs are advocating for Medicaid reimbursement for tele-health services. LIJ recently submitted comments to the Department of Health in response to its proposed draft on Title 18 NYCRR: 505.38 Tele-health Services.
— DSRIP project implementation funds are supporting the co-location of behavioral health providers in primary care practices and temporarily providing relief from the need to bill for services.

Workforce Challenges:
— Queens-based practices applied for the Mental Health Services Corps program, and at least one NQP practice was selected to host a Corps-funded Behavioral Health Care Manager in 2016-17.
— NQP's network includes mental health providers and community-based organizations that can support on-going mentorship and training.

Implementation approaches that the PPS considers a best practice:

Telehealth: NQP is actively pursuing telehealth technology to support Collaborative Care and enable the virtual co-location of mental health specialists and primary care providers. Because of the size of its network (more than 1,200 PCPs), NQP believes telehealth models will be important to ensure behavioral health

services are available during all practice hours to all PCMH practices. Telehealth collaborative care involves an off-site team of behavioral health providers who are at a centralized location and who use telephones, videoconferencing, and EHRs to collaborate with primary care physicians and patients in their practice. The Department of Veterans Affairs (VA) has piloted and adopted models of Collaborative Care using telehealth technology and off-site staff with positive findings. Several providers in Texas also incorporated telehealth Collaborative Care in its DSRIP programs.

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

Progress on Project Implementation and consistency with Project Plan: NQP's implementation of this project is directionally consistent with the intent and commitment made in the Project Plan Application and NQP is pleased to report that all tasks have been completed through DY2Q1, in a comprehensive and timely manner.

NQP is working closely with its partners and is on target for completing the remaining tasks and milestones to successfully integrate behavioral health specialists into primary care clinics using the Collaborative Care model and supporting the PCMH model, to integrate primary care services into established behavioral health sites such as clinics and Crisis Centers, and to incorporate behavioral health specialists into primary care coordination teams. NQP continues to develop workflows and identify evidence-based guidelines to support these activities and has initiatives in place to overcome the risks that have been identified for this project.

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

None

PPS Name: Nassau Queens Performing Provider System, LLC

Project: 3.a.ii

Challenges the PPS has encountered in project implementation:

Provider / CBO / Public Agency Engagement:
— Many crisis services are provided by city and county agencies, and community-based organizations, which are not attributed to any of NQP's Hubs. This created challenges for proceeding with implementation and funding.
— Several programs operated by community providers have lost or are at risk for losing grant funding for crisis programs. This is an issue as we seek to determine which community providers we can engage to meet the project requirements.

Patient Engagement:
— There are numerous excellent crisis programs in Queens and Nassau, but many people in crisis turn to the Emergency Department because they are not aware of alternatives.
— The response time for mobile crisis teams can vary. The lack of uniformity can discourage individuals, caregivers, and/or residences from using these services.

IT Challenges:
— There are limitations on access to behavioral health medical records utilizing RHIO connectivity due to privacy limitations and patient consent processes.

Workforce Challenges:
— Crisis programs have reduced staffing on nights and weekends; these periods can have high demand for crisis services. Patients in crisis entering an ED on evenings or weekends are often admitted to inpatient psychiatric units, in the absence of alternatives.
— There is a greater need for qualified counselors to serve the current population needs.

Efforts to mitigate challenges identified above:

Provider / CBO / Public Agency Engagement:
— NQP's project workgroup has included stakeholders from Nassau County, New York City's OMH office, community-based organizations and representatives from the three Hubs. These workgroup meetings are the first time many of these individuals have come together, and the conversations have generated better awareness of existing programs and progress toward integration.
— NQP managed this project at the PPS-level in DY1; however, going forward, each Hub has selected project elements for which it will take responsibility. Hubs are responsible for working with city and community agencies and community-based organizations to meet the project requirements.
— NQP has received proposals from community-based providers to support programs whose grants have expired or about to expire. The Hubs are working with these providers to try to ensure continuity for the programs that are aligned with the DSRIP objectives and deliverables.

Patient Engagement:
— Nassau County has increased the number of mobile crisis teams, which has reduced the response time.
— In Queens, Transitional Services Inc. (TSI) plans to create a mobile response team to respond to the Creedmoor residences.
— Within the CHS hub, there is planning underway to develop 2 additional mobile crisis teams in areas of high need including the Far Rockaway and Southern Nassau County.
— Hotline services to be developed through a provider in the area of Far Rockaway in Queens County to offer additional services to handle this high need population
— The NUMC hub is also working with the DSS to address the needs of homeless population in crisis and to set up medical shelters.

IT Challenges:
— PPS hubs are actively working to connect to the RHIO and on obtaining consent to share patient information between various crisis stabilization service providers.

Workforce Challenges:
— NQP is focused on increasing capacity for crisis programs on weekdays and evenings, including walk-in appointments and respite care, to reduce weekend and night Emergency Department visits.
— The PPS and hub leads are reviewing CBOs and other stakeholders in the community that could contract to help provide more crisis interventions solutions including soup kitchens, homeless shelters, respite housing etc.

Implementation approaches that the PPS considers a best practice:

— **Collaboration across PPSs:** NQP participates in the 3.a.ii project calls convened by Robin Kerner (PCG Consultant), which includes multiple PPSs that have selected this project. Sharing lessons learned and strategies with other PPS is very beneficial for project implementation.

— **Tele-psychiatry**: Tele-psychiatry as a modality which will expand the capability of existing providers to offer services to individuals who are mobility limited or have social service issues that prevent them from coming into an office for face to face services.

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

— **Collaboration:** This project has brought together many stakeholders who have historically operated in silos. It is difficult in the quarterly report to highlight the value that monthly meetings have had in strengthening relationships, introducing clinicians, and bridging long-standing divides that have contributed to delays in care and fragmentation.

— **Increasing progress:** Many of the projects now garnering momentum have been discussed for a long time and can be supported due to the DSRIP funding to cover project implementation and hospital revenue loss. While initial progress has been slow, the teams (at the Hub-level and PPS-level) have gained the traction and support to start new programs in the remainder of DY2.

— **Progress on Project Implementation and consistency with Project Plan**: NQP's implementation of this project is directionally consistent with the intent and commitment made in the Project Plan Application and NQP is pleased to report that all tasks have been completed through DY2Q1, in a comprehensive and timely manner.

NQP is working closely with partners in the network and community to augment services related to this project, including the addition of new services and increasing the days and hours during which these services are available, such as for specialty psychiatric, mobile crisis, central triage, and observation unit services. NQP is on target to complete the remaining tasks and milestones to successfully implement the project to ensure individuals are aware of and directed to the appropriate services and the appropriate follow-up processes and support network is in place. NQP has initiatives in place to overcome the risks that have been identified for this project.

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

DSRIP Mid-Point Assessment - **Project Narratives**

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

PPS Name: Nassau Queens Performing Provider System, LLC

Project: 3.b.i

Challenges the PPS has encountered in project implementation:

Physician Engagement (including training and workflow)

— Blood Pressure Documentation: Some practices in the NQP readily satisfy Project Requirement 8 ("Provide opportunities for follow-up blood pressure checks without a copayment"), however, NQP has found that it is not possible for other practices to capture this service into their medical records without generating a bill.

— Scheduling System: Project 3.b.i requires (in Project Requirement 10 and Project Requirement 15) the implementation of an automated scheduling system. This will be particularly challenging for small, community-based primary care practices.

— Resistance to PCMH / Participation: The project requires NQP to engage 80% of the primary care providers within the network in this project, which is a challenge because NQP's network includes more than 1,200 PCPs. Moreover, less than 30% of NQP's PCPs are identified as safety-net providers (under the current definition). As a result, the NQP will need to incentivize, so all providers to participate, but anticipates limitations of that incentive, due to the 95%/5% funding guidelines.

PCPs have the ability to opt-out of the DSRIP program or projects individually. A handful of providers have expressed that the PCMH requirement is the reason they are not interested in participating.

— Self-Management Goals: The requirement to document self-management goals at every appropriate visit is a considerable challenge. Setting self-management goals is a time-consuming activity, and may occur only at an annual visit rather than every visit. While the requirement has been changed to every *relevant* visit, this has been difficult to translate and standardize into the automated reports.

IT Challenges:

— Practice Fusion EHR: Several safety net PCPs in NQP currently use the Practice Fusion EHR. It is prohibitively expensive for a RHIO to connect to this EHR, meaning these practices will not be able to connect to a RHIO, which is a project requirement. Lack of RHIO connectivity will also impact clinical data interoperability and cross-Hub care management.

— Extensive EHR Modifications: Project 3.b.i requires providers to "use the EHR to prompt providers to complete the 5A's of tobacco control." EHR modifications are time-consuming, expensive, and challenging for many providers. Some EHR vendors are also more responsive than others. Several safety net PCPs in NQP currently use the Practice Fusion EHR, which has historically been very difficult to work

with to implement EHR modifications.

— Documentation of Self-Management Goals in the EHR: When DSRIP began, none of NQP's Hubs had a way to document or report self-management goals in the EHR.

Efforts to mitigate challenges identified above:

Physician Engagement:
— NQP is sharing the strategies that have worked for practices so that others can successfully adopt the protocols and meet requirements related to documentation, scheduling, PCMH participation, and self-management goals. Providers have been very willing to share their experiences with their colleagues in the Project Workgroup.

— The Funds Flow model was designed by each Hub to incentivize providers, especially Safety Net PCPs, to apply for PCMH recognition. Each Hub is working to engage all PCPs in the process and is providing transformation support; however, NQP understands that some practices are not interested.

IT Challenges:
— NQP is taking every opportunity to make the Department of Health aware of the challenges that Practice Fusion poses statewide; more than 2,000 primary care practices currently use Practice Fusion. If the Department of Health is unable to assist in the development of a solution with Practice Fusion, then the Hubs are prepared to work with the practices to transition to a different EHR.

— Hub leads are working with network partners to identify EHR modifications to meet the project requirements. LIJ is also working with a state workgroup to collaboratively design evidence-based 5As enhancements to eClinicalWorks and Allscripts EHRs.

— Each Hub has built fields in their EHR so that self-management goals can be documented and are reportable. The EHR design incorporated the best practices on setting self-management goals to encourage the patient and physician to consider specific steps to reach the goal.

Implementation approaches that the PPS considers a best practice:

— **Harmonize PCP Project Participation:** NQP created a cross-walk of the 3.b.i and 3.c.i Project Requirements and the PCMH standards to streamline implementation. Sites that are applying for PCMH transformation have weekly or biweekly meetings to discuss their progress. As a result of the crosswalk, these meetings also include and address the Project 3.b.i requirements.

— **Disease Education Partnerships:** NQP offers the Chronic Disease Self-Management Program (also known as the 'Stanford Model') in partnership with community-based organizations, including the YMCA, to provide people with the skills needed to improve their health. Holding classes at community centers, rather than healthcare facilities, has boosted program enrollment. NQP has 4 CDSMP Master Trainers and offers the program in both English and Spanish.

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

Tobacco Cessation. NQP is participating in two important Tobacco Cessation IT initiatives with the state. First, NQP is involved with workgroups designing 5As implementation in Allscripts and ECW, and will utilize these designs with network providers using those EHRs. Second, NQP is facilitating the design of an automated referral to the NYS Quitline through the RHIO. This process would allow a physician to send demographic and referral information from their EHR through Healthix directly to the Quitline.

Progress on Project Implementation and consistency with Project Plan: NQP's implementation of this project is directionally consistent with the intent and commitment made in the Project Plan Application and NQP is pleased to report that all tasks have been completed through DY2Q1, in a comprehensive and timely manner.

NQP is working closely with its partners and is on target for completing the remaining tasks and milestones to understand current provider processes, aggregate best practices and evidence-based guidelines (e.g. Stanford Model for Chronic Disease) to identify high risk patients, and ensure the adoption of these within care management teams to improve management of cardiovascular disease in adults. NQP has initiatives in place to overcome the risks that have been identified for this project.

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

— No change

![New York State Department of Health logo]

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

PPS Name: Nassau Queens Performing Provider System, LLC

Project: 3.c.i

Challenges the PPS has encountered in project implementation:

Physician Engagement:
— Resistance to PCMH/Participation: The project requires NQP to engage 80% of the primary care physicians in the network in this project, which creates a challenge because NQP's network includes more than 1,200 PCPs. Moreover, less than 30% of NQP's PCPs are safety-net providers (under the current definition), so incentivizing all providers to participate is currently limited by the 95%/5% funding guidelines. A handful of providers have expressed that the PCMH requirement is the reason they are not interested in participating.

IT Challenges:
— Practice Fusion EHR: Several safety net Primary Care practices in NQP currently use the Practice Fusion EHR. It is prohibitively expensive for a RHIO to connect to this EHR, which means that these practices would not be able to connect to a RHIO, which is a project requirement. Lack of RHIO connectivity will also impact clinical data interoperability and cross-Hub care management.
— RHIO Reconciliation Challenges: Ensuring the RHIO is able to pull the relevant medical metrics from the EMR will require "language reconciliation" to ensure we are accurately tracking hemoglobin A1C tests.

VBP / MCO Engagement:
— Lack of MCO Involvement: There has not been a significant amount of input from the MCOs on their care coordination efforts despite NQP's efforts to engage with these organizations.

Efforts to mitigate challenges identified above:

Physician Engagement:
— The Funds Flow model was designed by each Hub to incentivize providers, especially Safety Net PCPs, to apply for PCMH recognition. Each Hub is working to engage all PCPs in the process and is providing transformation support.

IT (EHR / RHIO):
— NQP is taking every opportunity to make the Department of Health aware of the challenges that Practice Fusion poses statewide; more than 2,000 primary care practices currently use Practice Fusion. If the Department of Health is unable to assist in development of a solution with Practice Fusion, then the Hubs are prepared to work with the practices to transition to a different EHR.
— The Hub leads are working with Healthix to ensure language reconciliation is comprehensive and explored with all downstream providers.

MCO Engagement:

— The Value Based Payment workgroup has identified MCO engagement opportunities and has begun to reach out to the top payers to outline opportunities for engagement.

Implementation approaches that the PPS considers a best practice:

— **Harmonize PCP Project Participation:** NQP created a cross-walk of the 3.b.i and 3.c.i Project Requirements and the PCMH standards to streamline implementation. Sites that are applying for PCMH transformation have weekly or biweekly meetings to discuss their progress. As a result of the crosswalk, these meetings also include and address the Project 3.b.i requirements.

— **Disease Education Partnerships:** NQP offers the Chronic Disease Self-Management Program (also known as the 'Stanford Model') in partnership with community-based organizations, including the YMCA, to provide people with the skills needed to improve their health. Holding classes at community centers, rather than healthcare facilities, has boosted program enrollment. NQP has 4 CDSMP Master Trainers and offers the program in both English and Spanish.

— **Telehealth Monitoring:** The management of diabetes can be rather complex, but with the help of telehealth technology, this condition may be better handled by patients. At least two Hubs have programs in place that use telehealth technology to help newly diagnosed or complex diabetics. The services provide monitoring of vital signs and potentially blood sugar levels between visits.

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

Progress on Project Implementation and consistency with Project Plan: NQP's implementation of this project is directionally consistent with the intent and commitment made in the Project Plan Application and NQP is pleased to report that all tasks have been completed through DY2Q1, in a comprehensive and timely manner.

NQP is working closely with its partners and is on target for completing the remaining tasks and milestones to understand current provider processes, aggregate best practices and evidence-based guidelines (e.g. Stanford Model for Chronic Disease) to identify high-risk patients, and ensure the adoption of these within care management teams to improve management of diabetes in adults. NQP has initiatives in place to overcome the risks that have been identified for this project.

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 to population

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

PPS Name: Nassau Queens Performing Provider System, LLC

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:

MEB Subject:
— Mental, Emotional and Behavioral (MEB) health promotion is both an important and wide-ranging topic; in the absence of Domain 1 milestones, it has been challenging to identify a particular focus.
— Mental, Emotional and Behavioral (MEB) health promotion is a relatively new field; 'MEB' is not a well-known or well-understood term by the patient or provider communities.
— Data on the prevalence and incidence of MEB disorders (especially among children and adolescents) has limitations, and is dependent on local population surveys.
— Cultural and social stigmas are associated with MEB disorders.

— **IT Challenges:** RHIO connectivity, specifically focused to behavioral health medical records, is limited due to a lack of provider integration into the health information exchange, and limitations due to patient consent and privacy issues.

Efforts to mitigate challenges identified above:

MEB Subject:
— NQP has a group of engaged behavioral health stakeholders, including hospital providers and community-based organizations, who are participating in the 3.a.i and 3.a.ii workgroups, and helped identify gaps in substance abuse and MEB that would be a good fit for NQP in order to focus the clinical integration of the 4.a.iii project.
— NQP has begun education of stakeholders about MEB health promotion activities through project workgroups and committee meetings. This education will be expanded in the Workforce Training Strategy and will include engagements with CBO's to maximize provider and patient education.
— NQP's community health needs assessment was an initial step, and included quantitative data and survey responses. NQP will continue to use data to assess prevalence of MEB disorders in the population and work with community partners to improve data collection.
— Community outreach forums will continue to address cultural or social stigmas. The Cultural Competency & Health Literacy committee will manage the forums to ensure alignment with need and strategy.

IT Challenges:
— Review of the MEB efforts in the community will identify the CBOs and other stakeholders who play a meaningful role in promoting MEB prevention. NQP will prioritize these partners for RHIO connectivity.

Implementation approaches that the PPS considers a best practice:
— **SBIRT Screening:** Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Several NQP Hospitals have integrated the SBIRT screening in its Emergency Department and Article 28 sites. This is a best practice that can be scaled.   — **Educational Materials for Varied Audiences:** Educational material should be developed for providers, schools and other community-based organizations on the benefits of early screening and detection of BH diagnoses. The materials should be developed for audiences of all ages and in multiple languages.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
Project ECHO: Several members from LIJ affiliates attended Project ECHO training at the University of New Mexico. The ECHO model supports primary care providers develop the skills needed to treat a particular condition; LIJ plans to use this learning model to improve the treatment of pain management by primary care physicians by linking them to pain management experts. This is consistent with the goals and requirements of Project 4.a.iii.   **Progress on Project Implementation and consistency with Project Plan**: NQP's implementation of this project is directionally consistent with the intent and commitment made in the Project Plan Application and NQP is pleased to report that all tasks have been completed through DY2Q1, in a comprehensive and timely manner.   NQP is working with its partners to discuss and prioritize needs, identify evidence-based protocols, and discuss strategies to develop, implement, measure, and improve MEB services and infrastructure in the community. NQP is on target for completing the remaining tasks and milestones and has initiatives in place to overcome the risks that have been identified for this project.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
None

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Nassau Queens Performing Provider System, LLCNassau Queens Performing Provider System, LLC

Project: 4.b.i4.b.i

Challenges the PPS has encountered in project implementation:

Challenges to project implementation have been minimal as there is strong support for tobacco use cessation prevention within each Hub partner network. NQP has experienced partners who are leading the project, including LIJ's affiliated Center for Tobacco Control.

IT Challenges:
— There are multiple EHRs used by NQP's provider network, none of which include the utilization of the best practice / project requirement of the 5A's. The complexity of multiple EMR's within multiple organization workflows will create an implementation challenge.

— Currently, referrals to the NYS Smokers' Quitline are not captured or tracked by providers manually or within an EMR system.

Patient Engagement:
— The diverse population of NQP requires culturally competent health literacy educational materials that are specific to the clinical need, and that drive behavior changes.

MCO Engagement:
— There is a lack of MCO engagement in tobacco cessation prevention within NQP's planning processes for care management models. A more active collaboration is desired with MCOs, in order to leverage their smoking cessation benefit designs and to coordinate with NQP's care management initiatives.

Efforts to mitigate challenges identified above:

IT Challenges:
NQP is participating in two important Tobacco Cessation IT initiatives with the state. First, NQP is involved with workgroups designing 5As implementation in Allscripts and eClinical Works, and will utilize these designs with network providers using those EHRs. Second, NQP is facilitating the design of an automated referral to the NYS Quitline through RHIO. This process would allow a physician to send demographic and referral information from their EHR through Healthix directly to the Quitline.

Patient Engagement:

— Training programs will be constructed focused to tools and best practices (such as 5 A's and the NYS Smokers' Quitline).

— NQP's Cultural Competency & Health Literacy Workgroup will partner with hubs to create or revise existing health literacy patient brochures translated into the appropriate languages. Community-Based Organizations will provide additional resources for patient engagement and education.

MCO Engagement:
— The Value-Based Payment committee, which manages all coordinated efforts with MCOs, will work with MCO designated leaders to identify potential opportunities for operational and care management programmatic updates.

Implementation approaches that the PPS considers a best practice:

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

Tobacco Cessation Training Program: LIJ's affiliated Center for Tobacco Cessation has a training program designed for mental health providers; the Center has previously trained staff at Zucker Hillside Hospital. Through project implementation, the Center has been introduced to community-based mental health providers and organizations and successfully provided additional trainings.

Progress on Project Implementation and consistency with Project Plan: NQP's implementation of this project is directionally consistent with the intent and commitment made in the Project Plan Application and NQP is pleased to report that all tasks have been completed through DY2Q1, in a comprehensive and timely manner.

NQP is working with its partners to assess the current state of tobacco cessation efforts and strategies to promote adoption of tobacco use cessation best practices. NQP is on target for completing the remaining tasks and milestones and has initiatives in place to overcome the risks that have been identified for this project.

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

None