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DSRIP Independent Assessor

Mid-Point Assessment Report

OneCity Health PPS

Appendix PPS Narratives

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

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DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: New York City Health and Hospitals Corporation

Highlights and successes of the efforts:

OneCity Health PPS has a number of highlights and successes to recap for all organizational efforts:

Governance

OneCity Health's governance structure is designed to maximize consumer engagement, ensure transparency and accountability, set PPS priorities and direction, and discern potential risks both locally and across the system network. A Nominations Committee reviewed applications and conducted initial interviews and recommended membership for the Executive, Care Models, Stakeholders and Patient Engagement, Business Operations and IT, and Hub Steering Committees. Meeting frequency varies between the committees based on the level of feedback/input sought and the number of recommendations/approvals required toward milestone and task progress outlined in the State Implementation Plan.

To ensure focused attention on workforce as the DSRIP program is implemented, OneCity Health established the Workforce Committee, a subcommittee of the Stakeholder and Patient Engagement Committee whose membership is comprised primarily of labor partner representatives. The Workforce Committee is responsible for recommending protocols and processes related to monitoring workforce transformation efforts.

The Central Services Organization (CSO) held a half-day retreat on July 28th which brought together over 65 members from all levels of the PPS' formal governance structure. The objectives of the retreat were to provide an opportunity for members to strengthen network relationships within the PPS and understand how the individual and collective roles of committee members contribute to the attainment of building an integrated delivery system.

OneCity Health recognizes and aims to be respectful of the day-to-day obligations that committee members have to their own organizations. Accordingly, OneCity Health assigns dedicated support staff to each committee who manages logistics and prepares materials for distribution in advance of meetings.
OneCity Health shares 10 projects with the Maimonides PPS, nine with the St. Barnabas Hospital PPS, and seven with the Bronx-Lebanon PPS. Similar project selection allows for resource sharing and collaborative project planning and implementation, and familiarity with activities and governance processes among partners in multiple PPSs.

As an illustration of resource sharing and collaboration, OneCity Health formed a consortium with several other PPSs that together enlisted an expert vendor, BDO, to develop the PPS' workforce training and development strategy, streamline data collection across overlapping partners and reduce cost through a city-wide approach on to deriving a current state of the workforce.

Development and negotiation of the base agreement among partners were completed with the execution of the Master Services Agreement (MSA), which establishes general roles and responsibilities of partners, outlines a general framework for distributing DSRIP payments, provides basic legal terms for governing relationships among different parties, and outlines the governance process. A draft of the MSA was issued to all partners in April of 2015 and webinars were held to encourage review of and comments to the document. Over 150 comments were received – all comments were addressed, with many of the suggested changes incorporated. The MSA was approved by the OneCity Health Executive Committee in June of 2015 and remains the source document for OneCity Health partner contracting.

Workforce

Given the size and complexity of the PPS network and the quickly evolving healthcare landscape in New York City, high levels of coordination and alignment with other PPSs were required with respect to thoroughly understanding and standardizing roles, responsibilities, hiring and training of the workforce. As described above in the "Governance" section, OneCity Health spearheaded a consortium of four PPSs to procure a single consultant for completion of the baseline analysis design and execution. This approach greatly reduced the number of disparate reporting processes and decreased the burden on organizations who may have been involved in multiple PPSs.

NYC Health + Hospitals, the PPS's fiduciary and largest partner, continues multi-year access improvement efforts through building and redesign efforts aimed at expanding operational capacity, recognizing that primary care access is critical to transformation. OneCity Health also engages community providers through a range of supports including Patient-Centered Medical Home (PCMH) assessments and technical assistance in an effort to identify systems needed to make investments in and build infrastructure for improved primary care access.

Contracting with community based organizations to provide outreach and effective linkages is key to improving access. Consequently, training high functioning care management staff (e.g., care coordinators and care navigators) to provide culturally competent services continues to be a high priority for the PPS. 1199SEIU Training and Employment Funds (TEF) has partnered with OneCity Health in an advisory capacity to provide expertise on workforce development, including assistance with identifying evidence-based training resources for care management staff. TEF will leverage its resources and experience in working with other PPSs to align OneCity Health workforce efforts with statewide efforts.

Cultural Competency and Health Literacy (CCHL)

With input and recommendation from the Stakeholder and Patient Engagement Committee and approval from the Executive Committee, OneCity Health finalized the PPS CCHL strategy and developed a training strategy focused on addressing drivers of health disparities in a citywide service area characterized by a high degree of cultural, ethnic, and language diversity. The strategy was developed in accordance with committee guiding principles and extends the existing expertise and framework developed by NYC Health + Hospitals. Importantly, modification, enrichment, and expansion of the strategy by community partners, Consumer Advisory Workgroups, and other stakeholders were incorporated.

Within the PPS' service area, resource allocation and training strategy were guided by using the Community Needs Assessment to identify priority neighborhoods that experience disproportionate amounts of health disparities and "hot spot" zip codes where these populations reside and work. OneCity Health will partner

with TEF to assist with the identification of community based organizations that understand local needs and can develop/deploy evidence-based CCHL training efforts across the PPS workforce. Additionally, OneCity Health formalized collaboration with Bronx Partners for Healthy Communities (BPHC) PPS to jointly develop CCHL interventions and training offerings in overlapping PPS priority neighborhoods, framed by the Health Home At-Risk (2.a.iii) and Integration of Primary Care and Behavioral Health (3.a.i) projects. The PPS also plans to bolster CCHL efforts by procuring a vendor to conduct CCHL organizational assessments with a representative sample of partners and assess gaps and set baselines for benchmarks and improvement.

Effectively incorporating training into on-the-ground deployment of care models across a broad network of diverse partners and patients will continue to be a challenge. To mitigate this risk, OneCity Health recently released a Learning Management System (LMS) Support and Development RFP to centrally track CCHL and other training for clinical and non-clinical partners. The LMS will integrate with PeopleSoft, the web-based training platform used by the PPS' largest partner, NYC Health + Hospitals, to conveniently cater to a broad range of DSRIP-related training and education needs including clinical guidelines and processes, operational workflows, PPS standards, data collection and monitoring, etc. OneCity Health will leverage TEF's experience in intervention design to define training/retraining needs, select appropriate patient self-management tools and define evaluation methods for workers and for patient/consumer health improvement.

IT Systems & Processes

OneCity Health has developed a plan to educate and engage partners and achieve health information technology goals as detailed in the State Implementation Plan. As an example, the PPS is working to assess current IT capabilities throughout the PPS to best cater support to partners pursuing an Electronic Health Record transition and/or connection to a Qualified Entity (QE). In partnership with Digital Edge, OneCity Health conducted on-site assessments across the PPS to gauge the adoption and use of IT systems, processes, and functionality. In addition, a baseline assessment is being conducted with eligible PCMH sites to evaluate readiness, including IT utilization, towards achieving PCMH Level 3 certification.

To facilitate communication between providers, OneCity Health is using messaging through GSI, a centralized care coordination platform to facilitate communication between providers. OneCity Health is also working to create a unified QE consent to enable clinical data sharing across the PPS. The absence of consent across PPSs represents a continuing risk and has limited OneCity Health's ability to develop coordination strategies for shared partners with other PPSs, particularly with those in different QEs. Certain tasks within IT-related milestones are on hold until further New York State Department of Health (DOH) guidance is developed regarding consent across PPSs with shared partners.

Financial Sustainability

OneCity Health administered a ten-question financial health assessment that was approved by the Business Operations and IT Committee in January of 2016. Assessment results showed no financially fragile partners. A Financial Health Assessment Guiding Principles and Strategy document was subsequently developed.

In Demonstration Year 1, OneCity Health successfully earned 100% of eligible payments for completion of organizational milestones tied to achievement values. Beginning in Demonstration Year 2, the PPS prioritized the development of a comprehensive funds flow methodology needed to execute contracts in the initial phase of project implementation. To inform the development of a funds flow model, OneCity Health released a Master Partner Data Survey to gauge partner interest in project participation; 182

partners completed the survey, providing key information about their organizations. Funds were distributed to partners who completed the Master Partner Data Survey in recognition of the level of effort, coordination and reporting burden required to provide the PPS with up to date and accurate information.

The foundational principles of the funds flow framework were aligned with other models that have been successfully implemented at other PPSs around the state, but was adjusted based the PPS' commitment to uninsured and underinsured patients. The model incentivizes partners to meet strategic goals of the PPS by aligning specific metrics and targets to DSRIP requirements.

The initial funds flow model was approved in June for contracting by the Executive Committee with the recommendation of the Business Operations and IT Committee. A Comprehensive Schedule B was developed with inputs from the funds flow model and the Master Partner Data Survey. OneCity Health held and recorded a series of webinars to engage and educate partners on details of the Comprehensive Schedule B and began its distribution in early July. To date, 128 Comprehensive Schedule B contracts have been signed by partners.

OneCity Health will leverage expert consultation and lessons learned from current partner engagement to evolve its funds flow model to support project implementation in an outcomes-based environment as the PPS transitions away from process measures. Given both the extensiveness and variability in contracting knowledge and experience with managed care organizations in the PPS network, the PPS will require additional time beyond DY2 Q2 to engage partners in developing a detailed baseline assessment of revenue linked to value-based payment (milestone 4).

Performance Reporting

OneCity Health is enhancing its abilities to effectively manage performance within the network through the development of performance reporting structures and population health management tools.

A performance management framework was communicated to the PPS network in early July to review project implementation following the release of the Comprehensive Schedule B. Beginning in DY2 Q2, partners will be able to utilize a web-based partner portal to track submission of contract deliverables and monitor performance. A support desk structure was created recently in part to facilitate technical assistance around performance reporting. Additionally, a reporting manual was published to provide details on reporting requirements, such as file formatting and submission frequency. As the nature of contracting continues to evolve (see "Financial Stability"), OneCity Health is committed to a robust communications process with partners to mitigate risks associated with changes in approaches and standards needed to ensure DSRIP performance and the delivery of high-quality, patient-centered care.

Partners providing care coordination services are provided regular training on using GSI, the PPS care management platform, including basic functionality, interpreting reports, and using collected data to improve clinical outcomes for patients.

The PPS is actively building a data warehouse that will contain datasets from project, provider, partner, member, and claims information. Having multiple types of data housed within one warehouse will allow OneCity Health to conduct improved data analyses, enhance risk stratification models and inform the development of a super-utilizer strategy.

Practitioner Engagement

As documented in the practitioner training/education plan, OneCity Health utilizes a variety of approaches (e.g., Hub-based governance structure, in-person meetings, webinars, newsletters, and the OneCity Health website) to engage a diverse group of providers and partners.

As described in the "Cultural Competency and Health Literacy" section, the PPS is engaged in procuring a Learning Management Software (LMS) to build a platform that can provide practitioner training and education on care management, specific projects, and other general subject matters (e.g., DSRIP overview, quality improvement, data management). Although the LMS will not necessarily reduce the time burden associated with training modules, it was created in part to be responsive to busy schedules of the PPS healthcare workforce.

Both the practitioner communication and engagement strategy and training/education plans were recommended unanimously by the Stakeholder and Patient Engagement Committee. Additional details are found in the documentation submitted to support completion of DY2 Q2 Practitioner Engagement milestones.

Population Health Management

Efforts to gain a thorough understanding of partners in Demonstration Year 1 included the implementation of a Partner Readiness Assessment Tool (PRAT) used to rapidly gain basic network information and its various population health-related assets. In Demonstration Year 2, OneCity Health employed several other strategies to supplement partner data gathered in the PRAT. As detailed in other sections of this narrative (Financial Stability and IT Systems and Processes) a Master Partner Data Survey, onsite PPS-wide IT assessments, and PCMH readiness assessments were employed to strengthen data sharing and reporting capacity among network partners. Included in baseline assessment activities, PCMH vendors will identify and assist partners that need Electronic Health Records (EHRs) and/or connection to the Qualified Entities/ Statewide Health Information Network for New York (SHIN-NY).

As noted in the "Performance Reporting" section above, the PPS is investing in a data warehouse and business intelligence tools. Rather than solely relying on the QEs/SHIN-NY as a central strategy for Health Information Exchange (HIE), the data warehouse will enable greater control of analyses used to support population health management. As an example, while the DSRIP dashboards and Salient Interactive Miner (SIM) provide robust tools to analyze claims data, GSI's data feed into the data warehouse can provide additional information regarding OneCity Health's large uninsured and underinsured patient populations.

Clinical Integration

OneCity Health conducted the Clinical Integration Needs Assessment across the network via multiple methodologies as detailed in the narrative submitted for the completion of milestone 1.

OneCity Health's phased approach to clinical integration is reflected in its contracting activities. By intentionally emphasizing Domain 1 process measures in early years and shifting to outcome measure reporting in subsequent contracting years, the PPS is able to engage all partners, taking into account differing levels of partner readiness with respect to access, linkage, information technology, integrated care, care management and population health, and performance management.

Performance metrics were identified in the Clinical Integration Needs Assessment that reflects success across partner interfaces, including Domain 2 and Domain 3 metrics and measures within OneCity Health's Executive Performance Dashboard.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: New York City Health and Hospitals Corporation

Project: 2.a.iii

Challenges the PPS has encountered in project implementation:

Challenges that OneCity Health has encountered in implementing the Health Home At-Risk project include:

(1) Current fragmentation of care management offerings across the OneCity Health partner network: programs have different and often overlapping target populations, program structures, staffing models, and services, which can result in confusion for patients and either gaps in or duplication of services.

(2) Care management staff recruiting and training: particularly for nursing, but across many professional/worker types, building and training a pipeline of workers that meet a diversity of patient background and intensity of need is a challenge.

(3) Identification of and outreach to patients with one chronic condition who are at risk of worsening health, the target population specified by the Department of Health: based on the PPS's experience with Medicaid Health Homes and NYC Health + Hospital's (H+H) experience with its Medicare Shared Savings Program activities, the PPS anticipates that some members of the attributed population will be difficult to locate and may also be challenging to engage.

Efforts to mitigate challenges identified above:

(1) To mitigate the risks related to fragmented care management programs, the PPS is implementing an integrated care management strategy which will engage representatives from the OneCity Health network, including H+H, primary care sites, Health Homes, and managed care organizations (MCOs). The goal will be to identify scope and scale of services to be streamlined and built within each setting according to patient need (including community), and to have a single source of standard policies, procedures, care pathways and clinical protocols related to care transitions, referral management, team-based care, and data sharing and reporting.

(2) To mitigate the risk associated with recruiting and training sufficient care management staff, OneCity Health is working with partners, educators, and agencies to identify a pipeline of care management staff. OneCity Health also has contracted with organizations with expertise in workforce training (1199SEIU Training and Employment Funds, SUNY Downstate Medical Center, and others) to ensure that care management staff are adequately trained.

(3) OneCity Health will leverage the wealth of localized, on-the-ground expertise represented by the diverse group of community-based partners within the OneCity Health PPS to locate hard to reach, high-risk patients. Community based organizations (CBOs) may be best positioned to locate and reach out to some populations given their knowledge and experience. OneCity Health has created a care management screening tool to assist CBOs in identifying and referring patients in need of Health Home At-Risk services.

Implementation approaches that the PPS considers a best practice:

Active engagement and collaboration with Health Home lead partners and other PPSs in New York City that participate in Health Home At-Risk has helped inform implementation strategies for this project. OneCity Health also encouraged and assisted primary care sites in creating strong partnerships with a specific Health Home lead agency and/or one of the lead's subcontracted care management agencies. Health Home best practices indicate that strong working relationships between primary care sites and organizations that they often refer to, and warm handoffs, lead to higher referral and conversion rates. Primary care sites are also encouraged to designate a care management liaison to help facilitate a strong working relationship with a Health Home and increase provider participation.

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

OneCity Health continuously collaborates and engages with the four lead Health Homes within the network to support collaboration and consensus on project design and implementation. OneCity Health distributed a Schedule B for Health Home At-Risk to contract with these four lead Health Homes in July.

OneCity Health is working closely with the lead Health Homes to ensure alignment with other DSRIP initiatives where applicable, such as Care Transitions and Project 11.

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

The population originally proposed to be served by this project remains unchanged.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: New York City Health and Hospitals Corporation

Project: 2.b.iii

Challenges the PPS has encountered in project implementation:
Challenges faced in the ED Care Triage project include: (1) Limited primary care access and capacity, which can make it difficult for Emergency Department (ED) staff to obtain appointments within short time frames (2) Challenges in the ED setting in identifying, obtaining appointments with, and exchanging information with a large number of community-based primary care providers with whom IT interoperability is usually lacking (3) Heterogeneity of patients presenting in the ED, with the need to meet multiple types of patient needs within this setting. For example, ED staff must determine which patients indeed require primary care follow-up appointments and at what time interval, to ensure that appropriate care is provided to all patients without creating unnecessary follow-up visits in a setting of limited capacity. At the same time, for many ED patients, such as those who are homeless or have severe substance use disorders, primary care follow-up is unlikely to be adhered to without significant care management resources to support the patient
Efforts to mitigate challenges identified above

As with all clinical projects, OneCity Health has developed a phased approach to implementing project 2.b.iii so that frontline teams can effectively manage the improvement effort. Phase 1 focuses on primary care linkage; Phase 2 focuses on linkage to existing care management resources; and Phase 3 focuses on hiring ED transitions management staff for patients with complex needs. The phasing of this project allows the ED to focus on challenges of primary care linkage first, while ensuring that needs of more complex patients who require care management services will be addressed in Phases 2 and 3. Implementation will also be informed by lessons learned from the Center for Medicare & Medicaid Innovation (CMMI) ED Care Management project.

Specific efforts to mitigate the three challenges list above include:

(1) Participating EDs have mapped their current primary care linkage workflows using a framework of five standard process elements, and created plans to address gaps in the baseline workflow. The five standard process elements are identifying the correct continuity provider; determining the appropriate time interval for an appointment; communicating this to the scheduler; scheduling and documenting the appointment; and communicating the appointment and key clinical information to the patient. EDs applied this workflow to patients with primary care relationships within the same health care facility, with primary care relationships with an outside provider, or without any current primary care provider. This structured mapping and gap analysis supports EDs in creating rational processes to provide appointments with the correct provider at the needed time interval. This approach supports efficient use of limited primary care capacity and is hoped to improve no-show rates for ED follow-up appointments that are currently reported by facilities as 30-70%. In addition, EDs have worked with the primary care services within their facilities to find methods of scheduling patients that work from both operational perspectives. Finally, NYC Health + Hospitals is rolling out new contact center operational structures that facilitate scheduling of primary care appointments across all facilities in a borough. In the longer term, increased primary care capacity and access is a key need of the integrated delivery system.

(2) OneCity Health's efforts to engage community providers within the PPS are an important step in improving the interface between EDs and community providers. OneCity Health has also had preliminary discussions with Advocate and other PPSs about improving communication between OneCity Health ED and hospital facilities and community providers in other PPSs. Through the Capital Restructuring Financing Program (CRFP) award, the NYC Health + Hospitals contact center will be strengthened to support scheduling for the PPS.

(3) The structure of this project, which includes focuses on primary care linkage, linkage to care management resources such as Health Home, and dedicated ED transitions staffing, allows EDs to implement improved post-discharge planning for different levels of need within its patient population. Patients who require primary care follow-up will have strengthened linkage through this project, while a medically and/or socially complex patient will have increased care management and transitions support.

Implementation approaches that the PPS considers a best practice:

Biweekly meetings and calls with stakeholders in each ED implementing Phase One has enabled collaboration, troubleshooting, problem solving, and the sharing of best practices among the cohort. Workgroups that included ED staff, care management staff, and community-based partners informed the implementation design for Phases 2 and 3.

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

Because the Emergency Department-based intervention must be tailored to each patient's need and risk profile, OneCity Health is developing targeted efforts to address the needs of specific high-need populations, such as the homeless, substance abusers, and psychiatric patients. An advisory workgroup on the transitional needs of psychiatric patients informed implementation planning for patients discharged from psychiatric EDs or Comprehensive Psychiatric Emergency Programs (CPEPs).

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

The original population proposed to be served by this project remains unchanged.

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DSRIP Mid-Point Assessment - Project Narratives

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Section for every project the PPS is implementing

PPS Name: New York City Health and Hospitals Corporation

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:

Challenges to implementing this project included:

(1) Recruitment and hiring of staff for Transition Management teams to provide 30 days of supportive community-based care. This project requires hiring of new staffing in a market in which recruitment is competitive, especially for nursing staff.
(2) Integration of Transition Management teams into hospital environments in which clinical teams have not historically had a consistent focus on identification of patients' care management needs.
(3) Coordination of this project with other care management programs that may address some or all of a patient's transition needs and/or provider longer-term care management services. Other care management programs include those run by managed care organizations, Health Homes, primary care services, or other hospital-based services.

Efforts to mitigate challenges identified above:

(1) To mitigate the challenge of staff recruitment, OneCity Health engaged NYC Health + Hospitals Division of Home and Health Care to provide Transition Management services, and is currently discussing contracting for Transition Management services with five additional partner organizations. OneCity Health has supported partners' hiring practices by creating toolkits that include the roles and responsibilities of each member of the Transition Management team.

(2) OneCity Health has worked intensively with hospitals to prepare for, integrate, and provide feedback on transition management services. In order to facilitate integration of the Transition Management team into the hospital, OneCity Health worked with hospital leadership and clinical champions to form regularly meeting workgroups. These workgroups were formed prior to the incorporation of the Transition Management teams in order to design hospital specific workflows. OneCity Health created a Care Transitions project implementation toolkit for the hospital partner (which is distinct from the separate toolkit that supports the partners providing transition management services). In the toolkit for hospitals, the hospital partner is guided through topics that include forming a workgroup on transition management, designing local roll-out strategy across hospital units, designing and implementing staff education on transition management, and integrating case reviews and patient referrals into existing clinical workflows.

(3) The implementation toolkit for the Transition Management teams includes identification of and collaboration with patients' existing care management resources as part of core patient care workflows. To support the Transition Management teams in this work, the hospital's care transitions workgroup is charged with identifying and engaging existing hospital-based care management services, to facilitate the creation of joint processes that avoid redundancy and support appropriate collaboration in patients' care management.

Implementation approaches that the PPS considers a best practice:

OneCity Health has identified and employed several best practices intended to advance and support high quality project implementation.

In terms of implementation design,

- To ensure that all partners provide same, intended services for our patient at high risk of inpatient readmission, OneCity Health has defined a standardized team structure including at least one clinically licensed professional (a registered nurse (RN) or a social worker) and a non-clinical worker. The non-clinical worker is responsible for greeting patients, engaging them in Care Transition project, assisting the clinically licensed professional in gathering information needed for patient assessment, working with clinical team members to assist with the implementation of the discharge plan, and reporting barriers to effective service utilization.

- At least one member of the Transition Management team attends multidisciplinary rounds on the hospital unit. During multidisciplinary rounds, care teams within a given unit discuss new patients, provide updates on existing patients, and develop a plan for each patient. This has proven to be the most effective venue for Transition Management teams to receive referrals and provide updates on cases being followed in the community.

- To ensure timely engagement and communication between professionals, one best practice (adopted from prior experience of Health Homes) is to require care plan updates at least once per week. Care plans are documented in GSI web-based care management software and are required at a minimum to address the following six domains:
    a) Medication reconciliation
    b) Caregiver stress
    c) Self-education
    d) Post discharge follow-up appointment
    e) Social support services
    f) Diagnosis

For engagement and education of clinical leadership and frontline teams, onsite support from the OneCity Health project lead, coupled with biweekly meetings or calls with key leadership and clinical champions from each of the currently implementing hospitals has proven valuable. These meetings enable collaboration, troubleshooting, problem solving, and the sharing of experiences and best practices.

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

OneCity Health initiated meetings with five PPSs within the New York City service area to discuss implementation of the care transitions project and to learn from each other's best practices. Initial meetings have focused on target population, referral criteria, screening tools, and team composition. Topics for subsequent meetings may include notifications regarding shared patients (patients who receive services in primary care practices or hospitals in multiple PPSs, particularly those may have a Transition Manager in one PPS and may have an admission or ED visit in another).

OneCity Health recognizes that, as the care transitions program evolves, workflows and team structures will evolve and grow richer to meet the needs of different types of patients. To date, OneCity Health has focused on how team structures and workflows will differ to serve patients in psychiatric inpatient units as compared to medical/surgical units. OneCity Health convened an advisory workgroup to discuss how to engage and meet the needs of patients discharged from psychiatric inpatient services. As part of this conversation, planning discussions are underway to address how to sustain communication with homeless patients. This advisory workgroup, together with early experience with a Transition Management team in a psychiatric inpatient setting, allows us to develop focused efforts in order to address the needs of hard-to-reach populations who may require additional outreach and support.

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

The population originally proposed to be served by this project remains unchanged.

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PPS Name: New York City Health and Hospitals Corporation

Project: 2.d.i

Challenges the PPS has encountered in project implementation:

The PPS has encountered several challenges in implementing this project:

(1) Conducting outreach to and identifying the uninsured population, including the undocumented and those without formal connection to the healthcare system

(2) Overcoming cultural barriers for new immigrants, especially those with limited English language proficiency

(3) Devising and implementing a mechanism to track and document connections that are made to insurance and primary care among all partner types

Efforts to mitigate challenges identified above:

(1) To mitigate the challenges of engaging the uninsured and sometimes undocumented populations, OneCity Health has partnered with organizations that have culturally-responsive approaches and engaged trusted community leaders to identify, outreach and reconnect hard to-reach populations. OneCity Health also coordinated with community based organizations (CBOs) that have existing relationships to the community and outreach expertise.

(2) To mitigate the challenge of overcoming cultural barriers, OneCity Health has partnered with CBOs that have established relationships within these communities, and OneCity Health is further developing direct relationships with these populations through Community Advisory Workgroups and leveraging the Community Advisory Boards of New York City Health + Hospitals. The use of community health workers and peer educators will further support outreach and engagement efforts.

(3) To mitigate the challenge of tracking connections that are made to insurance and primary care, all partners are using the information that is logged into the Flourish data system and creating temporary spreadsheets to document connections. The PPS is exploring other low-cost tracking mechanisms for all partner types.

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Implementation approaches that the PPS considers a best practice:
One implementation approach that the PPS considers to be a best practice is the use of workgroups that consist of various partner types (including CBOs) to develop effective outreach strategies and create greater integration between social service providers and healthcare providers.
Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
There are no additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
The population originally proposed to be served by this project remains unchanged.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: New York City Health and Hospitals Corporation

Project: 3.a.i

Challenges the PPS has encountered in project implementation:
Challenges that OneCity Health has encountered in implementing the integration of primary care and behavioral health project include: (1) Limited staffing to support project implementation, due to multiple factors, all of which may contribute to higher costs to the PPS's safety net institutions: • Staffing shortages within both the behavioral health and primary care networks • Difficulty recruiting in setting of regional shortage (2) Capital resources to which OneCity Health's partners have access, which are necessary to implement capital projects and expand or reconfigure physical infrastructure, are strained or unavailable; and the capital projects may not be complete in time to impact materially DSRIP outcome measures due to the DSRIP program's aggressive timeline (3) Variation in co-location-like models deployed across partner organizations, presenting difficulty in integrating these interventions with existing operational practices (4) Program fragmentation and silos between mental health and substance abuse services • It is a challenge to seamlessly integrate this project's aims with ongoing efforts to prepare for HARP implementation across a number of OneCity Health partners' sites, representing significant patient volume • Integrating both substance abuse and mental health services with primary care requires significant changes in how behavioral health services are managed and overseen at an organizational and State level
Efforts to mitigate challenges identified above:

(1) To address limited resources for qualified staffing for this project, OneCity Health will consult and otherwise support its various partners on optimal integration practices, and will encourage staffing optimization, cross-training among practice teams, expanding practice hours of operation, and coordinating capacity across the PPS while considering the impact to patient access. Through intervention design and clinical guidelines, OneCity Health will also work to ensure the appropriate use of staffing resources: psychiatrists should treat the most serious behavioral health disorders, and PCPs with psychiatric consultation should treat stable patients as needed. In upcoming months, with consultants' support, OneCity Health plans to define sustainable business models for co-location

(2) For physical infrastructure constraints, PPS partners who have been awarded Capital Restructuring Financing Project (CRFP) capital funding will support planned space conversions for facilities participating in this project, as specified in the particular partners' CRFP awards

(3) To mitigate variations in co-location care model design, OneCity Health is working with practices to redesign current offerings within the framework of a standardized model with well-defined requirements and common definitions of integration and co-location. Though the PPS is standardizing the elements of the model, because of likely persistent staffing shortages, the model must accommodate a wide variety of staffing configurations in order to be feasible and sustainable. To determine existing availability of integrated care, OneCity Health asked community primary care partners to complete a survey detailing their current integrated care capabilities or offerings and is in a procurement process for a consultant vendor to guide ten community- and hospital-based sites through co-location efforts as model practices that may be replicable and scalable across the network. To further support integration, OneCity Health seeks to expand its current employed base of peer counselors who may be embedded in the community or practice settings

(4) To mitigate the risks associated with integration of this initiative with ongoing efforts to prepare for HARP implementation, OneCity Health has convened weekly planning sessions and has selected joint pilot sites from its largest partner, NYC Health + Hospitals, over the last several months such that transformation efforts are maximally aligned and frontline teams have a clear, singular roadmap for integration efforts

Implementation approaches that the PPS considers a best practice:

There are several approaches to each of the three models that may be considered best practice:

- To address those regulatory and billing concerns that act as barriers to implementation, OneCity Health is connecting practice sites with subject matter experts
- To address cultural barriers that may prevent primary care practices from managing the care of an expanded range of mental health conditions, OneCity Health has identified trainings intended for primary care based teams, particularly physicians, to improve competencies
- To encourage cross-partner learning and inform intervention design, OneCity Health will develop standards based on lessons learned from NYC Health + Hospitals' Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) implementation as well as a few model integration practices as exemplars

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
OneCity Health will use data collection and analysis strategies learned from NYC Health + Hospitals' three years of IMPACT implementation to accelerate performance measurement and improvement across the OneCity Health PPS network.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
The population originally proposed to be served by this project remains unchanged.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: New York City Health and Hospitals Corporation

Project: 3.d.ii

Challenges the PPS has encountered in project implementation:

Addressable challenges that the PPS has encountered in implementing the asthma home-based self management project include:

1) Community health worker (CHW) staffing capacity – current shortage of CHWs trained to provide in-home assessments according to current demand
2) Asthma educator staffing capacity – organizational resourcing to assign staffing appropriately within the pediatric primary care setting
3) Information technology (IT) interoperability – buildout of a new IT platform (GSI care management platform) to share patient information responsibly between/among community and practice settings

The PPS faces one likely unaddressable challenge: because updated guidance from New York State Department of Health (DOH) requires completion of an in-person home assessment in order to consider an attributed patient engaged, OneCity Health will be unlikely to achieve initial patient engagement ("speed and scale") estimates or commitments during the course of the DSRIP program. It is expected based on prior programs that 20-30% of patients offered CHW services will accept these services and allow a home visit. However, the PPS and its Executive Committee view the achievement of outcomes improvements via adherence to clinical best practices and the implementation of new relationships between community and in-clinic care teams to be of greater importance.

Efforts to mitigate challenges identified above:

To mitigate the addressable challenges identified above:

- In order to increase the number of available CHWs who can provide needed services in the community, OneCity Health is in process of contracting with partnered community-based organizations to provide these services. Twenty-seven partner organizations expressed interest in providing CHWs for this project, and initial contracting will be with a subset of these. OneCity Health has identified and communicated to partners acceptable trainings for CHW staff. OneCity Health is also working alongside the 1199SEIU Training & Employment Funds (TEF) and others in order to build a robust pipeline of workers who are well-trained and appropriate for this role; working with TEF will help ensure such training is consistent with State guidelines and workflows
- In order to increase the number of asthma educators to work within the clinic setting, experts within OneCity Health are collaborating with the NYS Asthma Regional Coalitions in the Bronx and Brooklyn

to provide asthma educator certification training to nurses and other professionals qualified to deliver patient education. From March through June 2016, there were 54 trainees enrolled
- The PPS developed a web-based patient registry and care coordination platform (through the GSI care management IT platform) to track interventions delivered to each asthma patient. GSI allows for multi-directional communication between clinical staff, CHWs, and home remediation care team members

As for the challenge that is likely unaddressable, OneCity Health has sent an appeal letter to the New York State Department of Health regarding the change in patient engagement definition.

Implementation approaches that the PPS considers a best practice:

OneCity Health has used the following best practices in implementing the asthma project:

To design the interventions such that they are actionable and reflect the input of experts and frontline teams:
- Given the PPS's size and the breadth of partner types involved, Project 3.d.ii is designed and tailored to each care setting and divided into specific phases
- OneCity Health established its Clinical Leadership Team and Community Health Worker Advisory Group to provide subject matter expertise
- To clearly identify the current state of staffing and other resources, operational workflows, and clinical practices, the PPS developed, distributed, and analyzed a readiness survey sent to its multitude of partners. The survey provides a baseline understanding of each respondent's current approach to asthma care management and helps inform what intensity of implementation effort that partner's site requires to meet Project 3.d.ii's goals

To support implementation and engage the teams that will carry out the work:
- For this project, the OneCity Health team developed implementation toolkits – one for clinicians and one for community health workers – with input from community and clinical experts. These toolkits outline the purpose and requirements of each project phase, including guidance on collaboration between clinical and non-clinical providers (e.g., community-based organizations)
- To engage frontline teams and clinical leadership within a site, OneCity Health uses a combination of on-site meetings, webinars, and other supports to encourage local ownership and improvement

For additional collaboration and learning of best practices:
- OneCity Health has had several discussions with the Community Care of Brooklyn (Maimonides) PPS to share plans and collaborate on best practice development for Project 3.d.ii, including discussions on sharing GSI software design in order to support this project

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

There are no additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports.

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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:
The population originally proposed to be served by this project remains unchanged.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: New York City Health and Hospitals Corporation

Project: 3.g.i

Challenges the PPS has encountered in project implementation:
Challenges OneCity Health has encountered in implementing the palliative care integration project stem primarily from the difficulty of integrating new workflows and skill-sets into demanding and complex primary care practices. Specifically, these challenges include the implementation of new workflows within a complex clinical environment; reserving enough time during a provider visit to have a meaningful conversation about advance planning or goals of care; shortage of staffing resources such as social workers to support advance directives and goals-of-care conversations and to address the needs of patients with advanced illness; difficulty finding time for palliative care skills training of staff and providers; the need for advanced cultural competency skills to navigate palliative care conversations with diverse patient populations; efficiently identifying the target population for management of advanced illness; and the need to establish new referral patterns and relationships. These challenges are made more acute by the many different projects that primary care partners are asked to incorporate as a result of DSRIP and other drivers of primary care transformation. Limited capacity of outpatient specialty palliative care services is also anticipated to be an obstacle to this project's implementation, as increased referrals are likely to be generated as a result of this project.
Efforts to mitigate challenges identified above:
Project implementation has been phased as three separate interventions, to be introduced into the primary care environment over time. This allows the primary care sites to pace their work over time for this complex project. Implementation thus far has focused on Intervention 1: Simple Advance Planning (Health Care Proxy). Primary care practices took a team approach for providing patients with structured counseling about health care proxies and an opportunity to complete a health care proxy form. To mitigate challenges with Intervention 1: Simple Advance Planning (Health Care Proxy), the PPS provided standardized training and materials to both providers and other members of the primary care team. The PPS also hosted five train-the-trainer sessions for practices to support their staff with appropriate training for structured counseling around health care proxies. Limitations in visit time were addressed by maximizing pre-visit time in the waiting rooms for patient education through flyers, posters and informational tables staffed by primary care team members or volunteers. Based on partner experience to date, a document was created that summarizes best practices and sample workflows for this intervention.

The PPS has actively engaged with clinicians and staff from primary care practices and specialty palliative care to plan implementation of Intervention 2: Symptom Management and Intervention 3: Advanced Illness Management. For implementation of these interventions, the PPS has identified solutions for anticipated challenges that were raised by partners, subject experts, and project workgroups. To address limited time for extended primary care visits, the PPS will work with primary care practices to explore billing and reimbursement options and the possibility of using physician extenders to support patients' palliative care needs. To improve limited social work staffing, the PPS will work with its partner network to support primary care team staffing to fill resource gaps, in concert with larger initiatives to develop Patient-Centered Medical Homes and care management infrastructure. Training methods will to the extent possible leverage existing training venues or staff meetings, and are being designed with input from primary care team members to use training time more effectively. Cultural competency needs will be addressed as part of PPS-wide cultural competency training. The PPS will work with primary care practices on approaches to identify patients with advanced illness, focusing on approaches that align with local practice workflows and patient populations. Existing palliative care and hospice resources will be leveraged to build new referral patterns and relationships.

Limited referral resources for specialty palliative care services will be mitigated by drawing on the PPS partner network's existing resources and identifying areas where capacity building is needed.

Implementation approaches that the PPS considers a best practice:

For implementation of Intervention 1: Simple Advance Planning (Health Care Proxy), identified best practices include interdisciplinary collaboration within the primary care team and incorporating structured counseling around the health care proxy into standard work for each adult primary care visit. Additionally, training primary care team members to have a conversation with patients about a health care proxy and their goals, values and preferences was a critical component of the implementation.

For implementation planning of Intervention 2: Symptom Management and Intervention 3: Advanced Illness Management, the PPS will create parameters for program implementation but allow some design flexibility at the site level. The PPS will identify locally developed solutions, communicate them to other partners, and leverage expertise of workgroups and of individual partners to create and improve project design. The PPS will draw on its partner network to identify feasible solutions for increasing access to specialty palliative care (outpatient and home-based).

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

As the phased roll-out of the project continues, the PPS hopes to align implementation with other primary care transformation and care management efforts. The PPS plans to engage with partners in the network to provide training and share resources to enrich primary care practices in their care for patients with serious illness, including strengthening ties between primary care and specialist palliative care/hospice providers.

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

The population originally proposed to be served by this project remains unchanged.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: New York City Health and Hospitals Corporation

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:
There have been several challenges encountered in project implementation. (1) Attempting to coordinate a city-wide project involving four PPSs, as fidelity to a model of care is more challenging when implementing across multiple PPSs (2) The need to engage large, external stakeholders such as the Department of Education (DOE), Office of School Health (OSH), and New York City Department of Health and Mental Hygiene (DOHMH) around implementation, with the related challenge that none of the PPSs had any experience as a PPS working with the public school system in New York City (3) The need to engage individual schools and staff
Efforts to mitigate challenges identified above:
(1) The PPSs adopted an approach that ensures fidelity to the model by forming a joint charter to implement one model for the project in all PPSs. Jewish Board of Family and Children Services (JBFCS) was chosen to lead project management efforts to ensure fidelity to a uniform model, and for their deep experience in working with schools. (2) We have successfully engaged DOE and OSH on project implementation through a Steering Committee, along with JBFCS and the four PPSs. (3) OSH has hired a part-time coordinator to support project implementation. OSH has expressed concern that schools and staff will be less engaged without support around students who are having difficulty accessing care in the community, and the PPSs are focusing efforts on meeting the needs of schools to access care by developing and coordinating child intake services modeled on the Urgent Evaluation Service at Maimonides Medical Center.
Implementation approaches that the PPS considers a best practice:

The PPSs formed a joint workgroup involving the four PPSs in order to develop a consensus-driven model and project concept document. Subject matter experts from each PPS were involved in creating the model and project concept document. This workgroup has also been important as a strategy of engagement within each PPS, and workgroup members from each PPS will play a role in local project implementation. Another important best practice has been engaging senior leadership from multiple stakeholders, including DOE, OSH, and DOHMH, to help shape the project from a high level. Finally, engaging JBFCS, who is partnering with the New York Academy of Medicine (NYAM) on project implementation, provides the PPSs with partners who have extensive experience with project implementation in schools.

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

The Mental Health and Substance Abuse (MHSA) schools-based project is being proposed in the context of other efforts to strengthen MHSA activities in schools, including THRIVE NYC, as well as two city initiatives to address community/renewal schools and high suspension schools. DOE, OSH, and DOHMH have worked with the PPSs to coordinate these efforts, so that we are able to strategically engage schools that are not implementing other city projects concurrently, with the goal of not overwhelming or confusing schools if they were to attempt to implement different, new programs at the same time.

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

One change to the population we are proposing to serve came from recognition from DOE and OSH that there are significant needs for providing MHSA-strengthening activities to elementary schools, rather than just middle and high schools. JBFCS will plan to pilot the schools-based project in elementary schools after implementation in 100 middle and high schools in NYC.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: New York City Health and Hospitals Corporation

Project: 4.c.ii

Challenges the PPS has encountered in project implementation:

Challenges encountered in project implementation thus far have been:

(1) Establishing bylaws and a Memorandum of Agreement (MOA) for the HIV Coalition:
OneCity Health, along with six other PPSs, have worked to establish a DSRIP HIV Coalition, as convened and managed by the New York City Department of Health and Mental Hygiene (DOHMH). Achieving consensus in the development of detailed Coalition bylaws and a MOA among the various PPSs involved and the DOHMH has been time-intensive. Over the last 12 months, the Coalition worked to develop the two documents, and as a part of that work, built a common understanding for a committee structure for sharing ideas and resources. They have aligned common projects, data definitions, and retrievable data across participating PPSs.

(2) Implementation Planning:
Significant challenges include identifying optimal ways to learn about and include the work of other PPSs, involving key HIV stakeholders who are not formally part of the HIV Coalition, and integrating the work of other OneCity Health projects. Planning requires a detailed understanding of current HIV practices and resources available in various care and support settings across the city, which itself involves multiple conversations with partners within and across PPSs to coordinate adequately with key stakeholders, and ensure that the 4.c.ii HIV Project efforts are designed and implemented in a logical and sustainable manner.

Efforts to mitigate challenges identified above:

In order to ensure that the 4.c.ii project is implemented with interventions that address identified resource gaps to PPS patients, OneCity Health has divided project implementation into several interventions. For the remainder of Demonstration Year 2, while actively participating in the Coalition, OneCity Health will focus on implementing screening and referral to pre-exposure prophylaxis (PrEP) services, expansion of screening and linkage to care services, and identification and training of peers. OneCity Health plans to launch the screening and referral to PrEP services intervention with its primary care partners in late summer 2016.

To address the HIV Coalition challenges mentioned above:

(1) There has been ongoing discussion within the Coalition on how to structure coalition work to advance internal consensus and to define DOHMH's role. The Coalition has identified the various PPSs' shared concerns about the language used to describe the Coalition and DOHMH's role. Each PPS has been given an opportunity to comment on and suggest revisions to the bylaws and MOA.

The Coalition co-chairs have reflected the PPSs feedback to DOHMH and a final version of the MOA is being drafted. Additionally, there have been ongoing discussions on how to include key outside, HIV-related parties and a process moving forward to include emerging parties in the population-wide efforts of the Coalition. For example, discussions took place after the PPSs meeting with NYS about defining the role of PPSs that did not select 4.c.ii. Specifically, questions around if those PPSs should work with the Coalition and if so, how they should work within the Coalition were discussed. Additionally, the Coalition discussed how to include smaller organizations (such as community based organizations) in its activities and agreed to invite them as participants of individual PPSs.

(2) Five content-specific committees have been established at the Coalition level to begin to address implementation of targeted interventions at the cross-PPS level.

(3) Individual PPSs have been participating in End the Epidemic Campaign meetings to shape its blueprint implementation and inform conversations around common data definitions and sources of data.

To address the implementation planning challenges mentioned above:

(1) OneCity Health is developing care model and implementation toolkits that will guide 4.c.ii implementation. These documents are being designed with and reviewed by key stakeholders who have diverse community and clinical expertise.

(2) OneCity Health is planning on developing three PPS-based advisory workgroups to provide additional guidance in the design and implementation of its HIV project interventions, including in particular PrEP availability, HIV screening, and linkage to care and peers.

Implementation approaches that the PPS considers a best practice:

HIV Coalition:

(1) Establishing an agenda process for the Coalition's meetings.

(2) Establishing Coalition Co-Chairs as representatives at public forums and as a liaison to public and private healthcare coalitions.

(3) Creating opportunities to share best practices between partner organizations from different PPSs, by facilitating presentations from representatives of other PPS's initiatives at NYC Health + Hospitals HIV Medical Director meetings.

Implementation Planning:

(1) Aligning with ongoing citywide, statewide and national initiatives (e.g., End the Epidemic, National AIDS Strategy)

(2) Focusing on addressing gaps in services for HIV patients by strengthening the interconnectivity between HIV clinical providers and community based organizations, and seeking input from key community stakeholders.

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

OneCity Health is building on the strength and knowledge of our partners to design targeted interventions around screening and referring to PrEP services, screening and linkage to HIV medical care, and peer support services. Interventions will have discrete phases to create a structured, phased implementation plan.

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

The population originally proposed to be served by this project remains unchanged.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: New York City Health and Hospitals Corporation

Project: 2.a.i

Challenges the PPS has encountered in project implementation:

Challenges to implementing this project included:

(1) Engagement of governance and inter-organizational implementing partner organizations who may not or may informally have had a history of working together; committee members understanding their roles and responsibilities within a newly-formed Performing Provider System (PPS) governance structure
(2) The scale and scope of PPS partner support required to meet the number of integrated delivery system (IDS) requirements including 2014 Level 3 Patient-Centered Medical Home (PCMH) recognition, Meaningful Use, and connectivity to a Qualified Entity (QE)
(3) Incorporating culturally competent and health literate training into on-the-ground deployment of care models across a broad network of diverse partners and patients
(4) Thorough understanding and standardization of roles, responsibilities, hiring and training of the workforce within a complex network and rapidly evolving healthcare landscape
(5) Identifying partners, processes, workflows and infrastructure to support an integrated care management/care coordination network
(6) Preparing partners to assume fiscal and operational risk given the current fee-for-service funding structures

Please note that other challenges and efforts to mitigate those challenges are more specifically described in individual project and organizational section narratives.

Efforts to mitigate challenges identified above:

(1) To mitigate the challenges associated with forming new partner networks, OneCity Health has aimed to operate with transparency and inclusiveness. The PPS has actively engaged community based organizations (CBOs) and other partners in joining the PPS and its governance committees. Hub-based Project Advisory Committees (PACs) were constituted to obtain localized feedback on implementation efforts from partners in the four New York City boroughs served by the PPS. Each governance committee developed guiding principles that reflect the importance of organizing around the needs of patients, families, and communities served by the PPS. OneCity Health management periodically updates the governance committee charters and reviews roles and/or responsibilities with committee members. The OneCity Health governance committees include participation from a variety of partner types who meet frequently to review and approve strategies, care models, assessments, and funds flow methodologies.

On July 28 2016, OneCity Health held a half-day retreat attended by over 65 governance committee members. Agenda items included updates on accomplishments, challenges and opportunities to date, discussion of the alignment across committees, as well as how partners should work together to create an integrated delivery system (IDS) that can comprehensively address the physical, behavioral and social and family support needs of patients in the PPS. This event also provided an opportunity for governance committee members to network with each other, while learning how they can serve effectively in their various governance roles.

OneCity Health further engages partners in the work of the PPS through facilitation of their participation in topic-specific workgroups (to inform planning and implementation), input into the development of materials (including project-specific implementation toolkits), on-the-ground support for education and project implementation (over 200 onsite visits conducted to partners), and education and updates through newsletters and webinars. Additionally, OneCity Health has spearheaded implementation meetings where partners involved in project implementation can share experiences including challenges and best practices, and receive updates from the PPS.

In keeping with our aim to be responsive to feedback from CBO partners, OneCity Health has planned four additional partner engagement opportunities via Requests for Applications (RFAs) to procure expertise within the year for:

- community engagement/focus group facilitation
- cultural competence training (curricula development and implementation)
- cultural competence and health literacy initiatives (intervention design/implementation)
- patient/client/consumer outreach and education

These efforts increase opportunities for CBOs to provide subject matter and content expertise for planning and implementation of key PPS activities. Additionally, to increase opportunities for engagement with labor partners, OneCity Health constituted a workforce committee.

(2) OneCity Health has made significant investments to mitigate challenges associated with meeting IDS requirements.

Expanding access to high-quality primary care requires a commitment to meeting National Committee on Quality Assurance (NCQA) 2014 Level 3 Patient-Centered Medical Home (PCMH) standards by Demonstration Year 3. OneCity Health has engaged three PCMH experts to conduct site level readiness assessment and provide technical assistance to over 45 primary care partners with over 90 sites, to achieve NCQA 2014 Level 3 PCMH accreditation. Site level readiness assessments commenced in July 2016 and to date, over 25 readiness assessments have been completed. Initial results indicate that 5 partners and 20 sites have already achieved NCQA 2014 Level 3 PCMH accreditation. Technical assistance to remaining partners and sites is expected to begin in September 2016.

OneCity Health has engaged a vendor to conduct onsite assessments to determine the technical capacity of partners to electronically share clinical data and connect to a Qualified Entity (QE). To date, over 100 in-person information technology (IT) assessments have been conducted. With the DSRIP-related capital grant awarded to the fiduciary and largest partner, New York City Health +

Hospitals, OneCity Health expects to provide further population health management and IT support to PPS partners in the near future.

Lastly, OneCity Health invested in a care management platform (GSI) to ensure documented coordination between various care management and care coordination teams. The GSI care management platform is currently in use by approximately 850 professionals across Health Home and other implementing partners for the Care Transitions and the Asthma Home-Based Self-Management projects. OneCity Health continues to work with the GSI vendor to further develop the platform and provide training to support ongoing project implementation.

(3) To mitigate challenges incorporating culturally competent and health literate (CCHL) care models across a broad and diverse partner and consumer network, OneCity Health designed and implemented a strategy to promote health equity through training/education of partners and education of consumers. This strategy was informed by results from the community needs assessment (identifying patient/geographic disparities) and a review of community-developed patient education and self-management materials and interventions. The approved strategy was reviewed and recommended by the Stakeholder and Patient Engagement Committee, whose membership includes representatives of CBOs. Specifics around the training and implementation strategy are further documented in the CCHL organizational narrative.

OneCity Health engaged a consultant to perform organizational assessments (including 30 focus groups) of cultural competence across 75 priority partner sites. These activities are intended to provide an important baseline from which to monitor and refine the training approach. Lastly, as mentioned in (1) above, OneCity Health has developed and is planning release a slate of RFAs for CBO expertise in conducting focus groups and delivering community-based interventions/trainings.

(4) To mitigate the challenge of understanding and standardizing worker roles, responsibilities, hiring, and training of the workforce across the network, OneCity Health completed a comprehensive strategy to engage and train the PPS workforce. This strategy was informed by the completed assessments of the PPS' current workforce (current state) and future workforce (target state) needs. Results were used to complete the required workforce analyses as detailed in the Workforce DY2 Q1 quarterly report narratives. Additionally, OneCity Health engaged the 1199SEIU Training and Employment Funds (TEF) to support strategy development and provide workforce advisory services. TEF is working with other PPSs on these efforts and is well positioned to provide a comprehensive statewide perspective on workforce issues.

OneCity Health identified training needs within the PPS by professional/worker type using both a top-down and bottoms-up approach to ensure broad applicability. To date, partners have participated in over 1,000 trainings on project- specific care models and interventions, and the care management platform. OneCity Health has identified and will accelerate several high-impact trainings (including motivational interviewing, community health worker, and care management) in the upcoming year.

(5) To date, OneCity Health has assessed the PPS care management/care coordination capacity through deployment of several assessments (partner readiness, IT, workforce and master partner data), engagement with Health Home and other partners, and deployment of a centralized care

management platform. Assessments provided information about partners' construct(s) (Health Home, PCMH or other) of care management/care coordination services offered, current or planned care management platform, workforce that provides care management/care coordination services, and trainings offered. OneCity Health has identified several areas of support that it will provide to strengthen our care management/care coordination network of partners:

- standardization of roles and responsibilities
- access to GSI care management platform or data sharing specifications to allow for interoperability or data extraction from partner systems for upload to GSI
- care management/care coordination training
- linkage of partners interested in providing care management/care coordination services to Health Home partners
- technical assessment for NCQA 2014 Level 3 PCMH accreditation, which includes standards for care coordination.

(6) To mitigate risks associated with preparing partners to assume fiscal and operational risk, OneCity Health has designed a phased approach to funds flow that gradually incentivizes partners towards achieving sustainable fiscal, clinical and operational transformation and outcomes. In November 2015, OneCity Health issued Master Services Agreements (MSAs) that established *general* roles and responsibilities for partners and OneCity Health, and in July 2016, Schedules B, which defined *specific* roles, responsibilities and performance metrics for partners, OneCity Health and NYC Health + Hospitals. Feedback from governance committees and other partners informed the development of the performance metrics outlined in Schedule B. Comprehensive Schedules B were issued to 182 partners for eight clinical projects and a distinct Schedules B for each of the remaining projects to allow partners to earn funds for Demonstration Years 1 and 2 project implementation efforts. The current contracting approach is similar to that of the PPS with NYS DOH, in that it allows partners to earn funds for performance on reporting and patient engagement. OneCity Health's support for project implementation includes an array of tools, training resources and technical support options including a support desk and web-based partner portal. Additionally, OneCity Health developed and released a reporting manual on August 1, 2016. Partner reporting requirements for DY2 will provide critical information to assist the PPS in learning more about its partners, how patients flow between partners and how the PPS will function as a coordinated network rather than a configuration of independent organizations.

OneCity Health is developing a contracting approach for Demonstration Years 3-5 with a focus on Value-Based Payment (VBP) readiness, required investments to build an IDS, and payment for outcomes rather than process or cost. As care management models can vary in structure and require adaption to local consumer and organizational factors, OneCity Health will continue to pursue better understanding of underlying cost structures. The PPS will convene regular meetings and collaborate closely with managed care plans including Healthfirst and MetroPlus to discuss need for alignment on incentives in order to sustain DSRIP efforts and achievements beyond the demonstration period. To address the needs of the uninsured sustainably, OneCity Health will need to work with partners and the NYS DOH to identify and advocate for further funding and/or payment reform related to serving this population.

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Implementation approaches that the PPS considers a best practice:

Outreach and communications strategy
Due to the high number of partners within the PPS, it is imperative that OneCity Health develops a multifaceted partner outreach and communications strategy to engage stakeholders in the ongoing work of building an IDS. OneCity Health uses a variety of messaging mediums to provide updates to frontline staff and other interested parties including: webinars, newsletters, website updates, membership on governance committees, participation in project and/or topic-specific workgroups, involvement in the development of project toolkits and workflows, and local borough-based in-person meetings. Most recently, a support desk was launched to systematically allow PPS staff to document and monitor receipt and follow-up on partner inquiries.

Phased Implementation Approach
OneCity Health has project implementation approach involves phases of implementation that are rolled out over time. Phasing allows partners/sites to work through complexities of planning and implementation of transformation and patient engagement activities according to a set timeline, and creates additional opportunities for buy-in from front-line staff as well as iteration and course correction.

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

Non-Medicaid-billing CBOs are vital contributors to OneCity Health's goal of becoming a truly IDS. A key feature of an IDS is that it is positioned to address social determinants of health including patients' education, economic stability, social and community context, neighborhood and environment, and healthcare needs. Though CBOs may not directly be involved in meeting all DSRIP requirements (e.g., patient engagement speed and scale targets), their contributions are recognized and represented in the Comprehensive Schedule B metrics associated with participation in 2.a.i (IDS).

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

The population originally proposed to be served by this project remains unchanged.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: New York City Health and Hospitals Corporation

Project: 3.b.i

Challenges the PPS has encountered in project implementation:

Challenges that OneCity Health has encountered in implementing the cardiovascular project include:

(1) At present, detailed understanding of the existing cardiovascular health improvement efforts is limited for the PPS's non-hospital, community based primary care network. This presents a challenge to design interventions that can be integrated seamlessly into approximately 40 practices' standard work.

(2) Because this project requires achievements of a large number of milestones encompassing multiple separate conditions, including improving hypertension management, aspirin use, cholesterol management, and tobacco cessation, designing the project in a way that can be easily communicated to and managed by primary care practices is a challenge.

Efforts to mitigate challenges identified above:

(1) To gain more knowledge about existing initiatives throughout the PPS network, OneCity Health developed a "Cardiovascular Baseline Survey" to assess the current state of each primary care practice within the network. During the pilot phase of the project, primary care sites from the PPS's largest partner, NYC Health + Hospitals (H+H), completed the survey and pilot implementation efforts were coordinated with H+H's Office of Population Health via biweekly meetings focused on hypertension improvement and tobacco cessation. In efforts to scale up, all additional OneCity Health primary care partners who will participate in this project will complete and submit a cardiovascular baseline survey by September 2016. This survey supplements more basic partner data obtained from the PPS's Partner Readiness Assessment Tool (PRAT) which was completed in May 2015.

(2) To effectively meet the multifaceted requirements of this project, OneCity Health has developed a phased approach to implementation of the cardiovascular project, based on factors including the timing of State milestones. Phase 1 focuses on implementing guidelines for management of hypertension, measuring and recording blood pressure, and incorporating self-management of cardiovascular conditions. Phase 2 focuses on generating a registry of hypertensive patients, establishing support for home blood pressure monitoring, and standardizing screening and counseling for tobacco smoking. OneCity Health is implementing key components of Phases 1 and 2

at H+H and working to scale the project further with additional partners. This allows primary care sites to work through the many milestones of this complex project over time. Key documents, such as the project's care model and implementation toolkit, were developed to provide partner guidelines for this phased approach.

Implementation approaches that the PPS considers a best practice:

PPS best practices include:

(1) Sharing of best practices with other PPSs participating in this project throughout the State, through monthly calls on the 3.b.i project.
(2) Engagement of partner sites to understand existing related quality improvement initatives, and workflows. PPS-wide project planning provides a central framework for accomplishing the project's goals and objectives, as evidenced in the care model and implementation toolkit; and allows for some local variability in implementation at individual sites, based on local baseline activities and organizational structure. This approach allows enhancements of cardiovascular health initiatives to build on existing work, rather than disrupting it.
(3) Leveraging of site-level expertise in the needs of partner organizations to meet cardiovascular population health goals. In surveying primary care sites about their existing activities and resources, the PPS included questions about specific components of this initiative, and also provided the opportunity for sites to report their own priorities for quality improvement. For example, including an open-ended question about cardiovascular management needs allowed several sites to emphasize their need for more culturally and linguistically competent patient education materials.

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

The Cardiovascular Project has been shaped by a Clinical Leadership Team and by the PPS's Care Models governance committee, as noted in Quarterly Reports. In addition, OneCity Health is currently identifying members for an ongoing cardiovascular workgroup to advise the PPS on key questions that will arise in the course of project implementation. This workgroup will allow integrated discussion between different primary care organizations and include members from different professional backgrounds to encompass community-based as well as clinical perspectives.

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

The original population proposed to be served by this project remains unchanged.