Workforce Strategy

Key Steps and Measurable Milestones

Domain 1 Process Measures - this section is linked to a specific achievement value in the implementation plan & quarterly report process

i. Workforce Strategy Budget Updates

[Note: You do not need to provide revised workforce budget numbers for the April 1 submission. A revised, finalized budget will be required (in the format set out below) before the end of DY 1. A detailed timeline of when this will be required will be published shortly. Once you have provided these revised workforce budget numbers, the quarterly reporting process will require you to provide updates on your actual spend compared to this budget.]

Funding Type	DY1 Spend	DY2 Spend	DY3 Spend	DY4 Spend	DY5 Spend	Total Spend
Retraining						
Redeployment						
New Hires						
Other						

ii. Workforce Impact Analysis and Updates

[Note: You do not need to provide revised workforce impact numbers for the April 1 submission. A revised, finalized set of workforce impact numbers (in the format set out below) will be required before the end of DY 1. A detailed timeline of when this will be required will be published shortly. Once you have provided these revised workforce impact numbers, the quarterly reporting process will require you to provide updates on (and evidence of) your redeployment, retraining and new hires compared to these forecasts.]

Workforce Implication	Percent of Employees Impacted (%)	Number of Employees Impacted
Redeploy		
Retrain		
New Hire		

Placement Impact	Percent of Retrained Employees Impacted (%)	Number of Retrained Employees Impacted
Full Placement		
Partial Placement		
No Placement		

iii. New Hire Employment Analysis and Updates

[Note: You do not need to provide revised new hire employment analysis numbers for the April 1 submission. A revised, finalized set of numbers will be required before the end of DY 1. A detailed timeline of when this information will be required will be published shortly. Once you have provided these revised New Hire numbers, the quarterly reporting process will require you to provide updates on (and evidence of) your new hires compared to these forecasts.]

Staff Type	New Hires Net Change
[staff type 1]	
[staff type 2]	

[staff type 3]	
[staff type 4]	
[…]	
[…]	

Key Issues - this section is not linked to the specific workforce achievement value

Workforce Impact Analysis	*Target Completion Date*	*Supporting Documentation*
Milestone: ***Define target workforce state (in line with DSRIP program's goals)***	DY1, Q4	Finalized PPS target workforce state, signed off by PPS workforce governance body. Subsequent quarterly reports will require an update on the implementation of your workforce transition roadmap, including any change to your target state.
Establish Workforce Sub-committee of the Executive Committee (including PPS Lead HR reps, selected PPS HR leaders, project leads, union representation, and other appropriate subject matter experts and key stakeholders) tasked with implementing and executing workforce related activities	DY1, Q2	
Workforce Sub-committee to review and confirm the previously developed workforce requirements (roles, FTE counts, organizational affiliation, salary and benefit assumptions, etc.) and the new services required for each DSRIP project and consolidated for the PPS	DY1, Q2	
Workforce Sub-committee with PMO support to perform a workforce impact assessment to determine the project-by-project impact on the PPS workforce (degree and magnitude of impacts by role/provider organization, key roles and responsibility changes, skills/competency changes, impact to staffing patterns, impact to caseloads, etc.)	DY1, Q3	
Workforce Sub-committee with PMO support to consolidate the project-by-project analysis in a comprehensive view of the areas within the PPS that will need more, less, or different resources to support the DSRIP projects	DY1, Q3	
Workforce Sub-committee (in collaboration with other PPSs if possible and possibly with PPS Executive Committee participation) and with 1199TEF support to estimate how NYP PPS workforce requirements may be either enabled or hindered by the workforce requirements of PPS in the same geography	DY1, Q3	
Workforce Sub-committee to define the future state workforce that is required for DSRIP projects to succeed	DY1, Q4	
Workforce Sub-committee to present future state workforce to PPS Executive Committee for discussion and ratification	DY1, Q4	
PPS Executive Committee ratifies future state workforce plan	DY1, Q4	

Milestone: ***Create a workforce transition roadmap for achieving your defined target workforce state.***	DY2, Q1	Completed workforce transition roadmap, signed off by PPS workforce governance body. Subsequent quarterly reports will require an update on the implementation of your workforce transition roadmap.
Workforce Sub-committee to develop governance/decision-making model that defines how and by whom any decisions around resource availability, allocation, training, redeployment and hiring will be made and signed off for review and ratification by PPS Executive Committee	DY1, Q3	
Workforce Sub-committee to develop consolidated transition roadmap map of all specific workforce changes required to the workforce; define timeline of when these changes will need to take place and what the dependencies are (for all training, redeployment and hiring in line with project timeline and needs)	DY1, Q4	
Workforce Sub-committee to present the workforce transition roadmap to PPS Executive Committee for discussion and ratification	DY2, Q1	
PPS Executive Committee ratifies the workforce transition roadmap	DY2, Q1	
Milestone: ***Perform detailed gap analysis between current state assessment of workforce and projected future state***	DY2, Q1	Current state assessment report & gap analysis, signed off by PPS workforce governance body. Subsequent quarterly reports will require an update on the implementation of your workforce transition roadmap.
Workforce Sub-committee to perform current state assessment of staff availability and capabilities across the PPS using techniques and processes previously used by NYP to minimize workforce impacts of delivery system change. Output includes identifying: *- Current roles who could fill future state roles through up-skilling and training;* *- Current roles who could potentially be redeployed directly into future state roles*	DY1, Q3	
Workforce Sub-committee to map current state analysis against future state workforce to identify new hire needs	DY1, Q3	
Workforce Sub-committee to refine budgetary implications of workforce change analysis and identify gaps to current DSRIP operating budget	DY1, Q3	
Workforce Sub-committee to update future state roadmap based on gap analysis (who, how many, when the transition of the workforce from the current state to the future state will occur)	DY1, Q4	
Workforce Sub-committee to finalize gap analysis	DY2, Q1	
Workforce Sub-committee to present gap analysis to PPS Executive Committee for discussion and ratification	DY2, Q1	

PPS Executive Committee ratifies gap analysis	DY2, Q1	
Milestone: ***Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.***	DY2, Q1	Compensation and benefit analysis report, signed off by PPS workforce governance body. Subsequent quarterly reports will require an update on the implementation of your workforce transition roadmap, including updates on compensation and benefits.
Workforce Sub-committee to identify the origin and destination of staff that are being redeployed to understand changes to impact jobs and Network Members	DY1, Q3	
Workforce Sub-committee to gather compensation and benefits information for existing roles that will potentially be redeployed and assess changes	DY1, Q3	
Workforce Sub-committee to estimate numbers of fully v. partially placed staff by role	DY1, Q4	
As appropriate, Workforce Sub-committee to develop and incorporate policies for impacted staff who face partial placement, as well as those staff who refuse retraining or redeployment, working with relevant stakeholders and with 1199TEF to understand statewide leading practice	DY1, Q4	
Workforce Sub-committee to finalize compensation and benefit analysis	DY2, Q1	
Workforce Sub-committee to present compensation and benefit analysis to PPS Executive Committee for discussion and ratification	DY2, Q1	
PPS Executive Committee ratifies compensation and benefit analysis	DY2, Q1	
Milestone: ***Develop training strategy***	DY2, Q1	Finalized training strategy, signed off by PPS workforce governance body. Quarterly reports will require evidence of up-take of training programs, including both individual training and training for new, multi-disciplinary teams. PPSs will need to provide: a description of training programs delivered and participant-level data, including training outcomes.
Workforce Sub-committee, in collaboration with 1199TEF and ASCNYC (likely future provider of "Peer Training Institute" in collaboration with NYP) to assess current state training needs, including the specific skills and certifications that staff will require	DY1, Q3	
Workforce Sub-committee to design training strategy, including goals, objectives and guiding principles for the detailed training plan; confirm process and approach to training (e.g. voluntary vs. mandatory etc.).	DY1, Q3	
Workforce Sub-committee to present training strategy to PPS Executive Committee for discussion and ratification	DY1, Q4	

PPS Executive Committee to ratify training strategy	DY1, Q4	
Workforce Sub-committee, in collaboration with ASCNYC and with input from 1199TEF, to develop mechanism to measure training effectiveness in relation to established goals once strategy and plan are implemented	DY2, Q1	
Workforce Sub-committee, in collaboration with ASCNYC and with input from 1199TEF, to develop detailed training plan (based on training strategy), including, methods, channels and key messages required for training based on project needs. This includes consideration of geography, language, level of education, training tools, and methods of delivery	DY2, Q1	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges and risks that you foresee in achieving the milestones set out above, including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

The NYP PPS has a strong track record of collaborating with key stakeholders in both adapting the workforce to meet emerging care delivery needs and using non-traditional healthcare workers (e.g., CHWs) from the community to improve outcomes, cultural competency and health literacy. The NYP PPS will build on that experience to optimize the workforce opportunities and demands of DSRIP.

Major risks to implementation of the Workforce Strategy and associated mitigation strategies include:
Competition for Human Resources. The risk of workforce shortages in the healthcare market is real. The national primary care physician shortage is projected to reach 12,500 to 31,100, according to a new study by the Association of American Medical Colleges and IHS. This scarcity is but one that exists in New York's marketplace, and these shortages will be exacerbated by demand for services brought about by the new DSRIP projects, especially given the number of PPSs in the Greater New York City region. One role in particular that will be in high demand is that of the culturally competent peer providers, i.e., Community Health Workers (CHWs) and Patient Navigators (PNs). These resources are critical to the success of each of the NYP PPS DSRIP projects. To mitigate our risk in this area, the NYP PPS will build on its solid relationships with such CHW organizations as Dominican Women's Development Center and Northern Manhattan Improvement Corporation, with whom we have been contracting for these kinds of positions for many years. We will also expand the number of organizations we source to a total of between three and six CBOs—adding CBOs such as Community League of the Heights, AIDS Service Center NYC (ASCNYC) and Northern Manhattan Perinatal Partnership—to hire the more than 35 peer providers needed. In addition, NYP and ASCNYC have applied for CRFP funding to develop a new Community Health Worker Training Center in Upper Manhattan. We expect that the rigorous training and placement afforded by this Training Center will be a draw to potential candidates in a crowded market.

Recruiting Specialized Workforce. Above and beyond general shortages in the healthcare market, a few of the NYP PPS projects require a very specialized workforce, which may be even more difficult to find immediately. For example, we will be looking for pediatric psychiatric NPs (Project 2.b.i) and palliative care specialists (Project 3.g.i). We will mitigate this risk by applying a search-firm approach to source and recruit top talent. This approach entails dedicated staff that will rigorously identify qualified candidates through networking, research and constant pursuit of a pipeline matching the position specifications. One example of NYP's innovative sourcing strategy leverages its electronic candidate relationship management (eCRM) tool in which email messages are sent directly to potential prospects with information on the Hospital, department and open position. NYP will also host career events, such as professional conferences and interview days, dedicated to the type of human capital needed. We understand, however, that delays in hiring specialized providers may have an impact on the speed of implementation for certain projects, and we have taken that into consideration in our project-specific implementation plans.

Finalization of DSRIP awards. *Until DSRIP awards--include scoring, attribution for valuation and PMPM--are finalized, it is difficult to anticipate the threat to the Workforce workstream. We expect our workforce strategy to have a higher proportion of new hires than redeployed / retrained workers which we cannot move forward aggressively on without a full understanding of funding levels. As such, variations in DSRIP revenues present a significant risk. Mitigation strategies currently include conservative planning and expectation-setting across the PPS. Should lower-than-expected awards be granted to the NYP PPS, we will return to core analyses to determine the best and more cost-effective contingency strategies that still allow major DSRIP goals to be achieved with the available workforce.*

Technical Training. *Most DSRIP projects depend on the successful implementation of new software systems, including EHRs, the care coordination platform Allscripts Care Director (ACD) and access to the Healthix RHIO. New and existing workers at all levels will need technical training and engagement support to ensure that impacted staff are ready, willing and able to succeed with the new system. To address this challenge, the NYP PPS will retain the 1199SEIU League Training and Employment Funds (TEF) as the lead workforce development provider. Using TEF's expertise in this area, the PPS will provide training to incumbent workers who need additional skills to do existing jobs and develop training for new staff. TEF will screen and contract with the most suitable educational vendors to deliver high-quality training conducted by expert clinical staff, experienced educators in adult learning theory and organizational development experts. TEF uses the City University of New York wherever possible to deliver training programs that offer college credit or where high-quality workforce and certificate programs meet industry needs. Training will also be delivered by external resources from the community or by the NYP internal training department (Talent Development). For some projects, we plan to engage with the NYC Department of Mental Health and Hygiene to assist in technical training (see Project 4.b.i). Software vendors such as Allscripts and Healthix will also conduct their own user training.*

Workforce Buy-In. *Change is difficult. The NYP PPS may have difficulty obtaining buy-in and support from frontline workers and key stakeholders given changes in roles and responsibilities, which in turn could impact DSRIP project success. To mitigate this risk, the PPS will continue to engage both senior and middle management and, where applicable, union representation (SEIU 1199, NYSNA) to gain worker support at all levels. DSRIP goals and impacts have been shared with NYP and Member senior and middle management and communication will continue. In addition, both 1199 SEIU and NYSNA, which have broad representation across the PPS, have had representation on the PPS Provider Advisory Committee (PAC) since its inception. A comprehensive change management strategy will also support this effort.*

Major Dependencies on Other Workstreams

Please describe the major interdependencies between your workforce transformation plans and other workstreams (e.g. cultural competency, clinical integration, financial sustainability, etc.)

Workforce strategy and management touches, and is touched by, all aspects of a delivery system reform program like DSRIP. As such, workforce success will depend on a variety of other DSRIP workstreams, including:

Governance. The PPS Committees will likely each have to address workforce impacts and make decisions regarding strategy, financing and priorities. Having effective, trusted, appropriately confidential and "big picture" representation will be central to executing the workforce strategy successfully.

Financing Training and Development. Workforce management and (re)training across the PPS will require a material investment. Therefore, the connection between our PPS workforce transformation team and the NYP PPS Finance Committee is crucial. To that end, the Finance Committee will have a member of the Workforce Sub-committee embedded within it.

Cultural Competency and Health Literacy Training. Interdependence also exists between workforce training and our cultural competency strategy. The NYP PPS has adopted a patient-centered approach to cultural competency, aligned with the National Quality Forum's (NQF) framework, which we will expand to our Network Members. In addition to role-specific training, the NYP PPS will train frontline staff and physicians involved in DSRIP projects to provide care that respects patients' "Culture of One." This approach treats patients as individuals whose culture is unique and a result of multiple social, cultural and environmental factors and avoids racial or ethnic stereotyping. The methodology stems from seminal research published by NYP's VP for Community Health, Dr. Emilio Carrillo, in 1999 and is used internationally as the basis for cultural competency training. Finally, providers (including Community Health Workers) and staff in certain projects will receive supplemental training on sensitivities related to specific target populations. For example, those involved in Project 3.g.i (Integration of Palliative Care into PCMHs) will receiving training on how to deal sensitively with patients facing advanced illnesses and their families. Those involved in Projects 3.e.i and 4.c.i (HIV/AIDS) will receive training that will include education on HIV as a disease, gender identity, substance abuse issues and disability issues.

IT Implementation & Technical Training. Most DSRIP projects depend on the successful implementation of new software systems, including EHRs, the care coordination platform Allscripts Care Director (ACD) and access to the Healthix RHIO. IT is only a tool; without appropriate technical training across the PPS, the tools will be ineffective in moving the DSRIP vision forward. As described above, the PPS has engaged TEF and others to assist with this training.

Clinical Integration. Workforce is closely tied to clinical integration, as much of the retraining of the workforce will focus on creating more integrated multi-disciplinary teams that cross organizational boundaries. Redeployment will also be critical in ensuring that the right staff are placed in the right location to support better clinical integration and the success of projects such as 3.a.i and 2.a.i.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
Workforce Sub-committee - PPS Lead	***Eric Carr***	***NYP HR executive on point for design and execution of all workforce-related activities***
Workforce Sub-committee	***Various NYP and Network Members***	***Provides overall direction, guidance and decisions related to the workforce transformation agenda***

Workforce Training Vendor	***1199 SEIU League Training and Employment Funds (TEF)***	***Lead workforce development provider who recommend (re)training for new and emerging positions, provide training to incumbent workers who need additional skills to do existing jobs and develop training for new occupations.***
Community Health Department	***Emilio Carrillo, MD, VP Community Health, NYP***	***Responsible for developing and executing cultural competency and health literacy training.***

Key Stakeholders

Please identify the key stakeholders involved in your workforce transformation plans, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		
Ron Phillips	***Chief Human Resources Officer, NYP***	***Support data collection of compensation and benefit information; current state workforce information and potential hiring needs.***
Andrea Procaccino	***Chief Learning Officer (Head of Training and Development), NYP***	***Provide oversight and input to development of training needs assessment, and subsequent training strategy and plan.***
Eliana Leve, LCSW, MA, CASAC	***Deputy Executive Director for Programs, AIDS Service Center NYC***	***Development of Community Health Worker Peer Training Institute in Upper Manhattan.***
Gil Kuperman, MD, PhD	***Director, Interoperability Informatics, NYP***	***Coordination of IT technical training.***

All PPS Network Members	***HR Contacts***	***Provide data and information for current state assessment and future state workforce needs (quarterly electronic surveys).***
External stakeholders		
1199 SEIU; NYSNA	***Labor/Union Representation***	***Expertise and input around job impacts resulting from DSRIP projects***
NYC DOHMH, Software Vendors	***Training Vendors***	***IT Technical Training***

IT Expectations

Please describe how the development of shared IT infrastructure across the PPS will support your plans for workforce transformation.

Shared IT infrastructure will support the workforce transformation. First, once our training strategy and plans are implemented, we will use IT to track training progress (e.g., who has been trained, the subject matter of the training, when the training took place, certification levels, etc.). Second, as the NYP PPS begins to execute the workforce transition roadmap, we will rely on IT capabilities to track staff movement and changes across the PPS (e.g., redeployed staff, net new hires, etc.). The NYP PPS will need support from IT to collect and report on changes to the PPS workforce to enable reporting on workforce process measures in quarterly progress reports. Finally, we will need IT support to track open positions and staffing needs across the PPS, essentially creating a job board, so that impacted workers (or those whose current jobs are at risk of elimination) have the ability to see job availability across the member organizations.

Technology is ever more critical to support the changing needs of the workforce. For example, the PPS IT infrastructure will enable retrained, redeployed and new hire staff to work efficiently and effectively in a variety of non-traditional settings through the development of tablet technologies that can be used in the field to support community-based staff. Such technologies will assist community-based workers in increasing health literacy, enable workers to share critical observations about risks which may have social and clinical implications, and allow for more hands-on, real-time connection with patients and caregivers. Developing and deploying such technology is a key component of the NYP CRFP IT Infrastructure application.

Progress Reporting

Please describe how you will measure the success of this organizational workstream and report on progress against your targets.

There are several measures of the success of the Workforce workstream. One is how the NYP PPS delivers against the current targets of redeployed, retrained and hired staff. Second is how financially sustainable the workforce transformation is based on performance against budget. Finally, we will assess worker satisfaction by measuring employee turnover. The Workforce Sub-committee will present this data to the Clinical/Operations Committee so there is an up-to-date understanding of how the recruitment, redeployment and retraining efforts are affecting the individual projects. In this way, the PPS will be able to react to and manage potential issues before they negatively impact the projects in a significant way.

The PMO will be a key partner to the Workforce Sub-committee in measuring, monitoring and reporting quarterly progress and developing and monitoring other leading indicators of workforce performance. Similarly, we will look to the 1199TEF for leading practices across the State regarding all aspects of workforce progress reporting, including methods, frequency, proxies, data definitions, etc.

Governance

Key Steps and Measurable Milestones

Domain 1 Process Measures

i. Governance structure updates	*Target Completion Date*	*Supporting Documentation*
Milestone: ***Finalize governance structure and sub-committee structure***	DY1, Q1	Governance and committee structure, signed off by PPS Board. Subsequent quarterly reports will require updates on committee structure and memberships (if relevant).
PMO identifies the size and number of standing committees (Executive, Finance, IT/Data Governance, Clinical Operations, Audit/Corporate Compliance)	DY1, Q1	
PMO to communicate to PPS Lead and Network Members to confirm composition and membership of standing committees	DY1, Q1	
PPS Governance Committees to install members of standing committees	DY1, Q1	
PMO develops regular meeting schedule for standing committees	DY1, Q1	
PPS Executive Committee reviews and ratifies final structure for standing committees: 4 PPS Committees and own PPS Executive Committee	DY1, Q1	
Ratified structure communicated to Project Advisory Committee (PAC)	DY1, Q1	
Milestone: ***Establish a clinical governance structure, including clinical quality committees for each DSRIP project***	DY1, Q3	Clinical Quality Committee charter and committee structure chart Subsequent quarterly reports will require minutes of clinical quality committee meetings to be submitted.

PMO facilitates Project Leads in development of Cross-Project quality governance guidelines (vision, approach, stakeholders, key Network Members selection process, scope of authority, etc.) for integrating quality programs across 10 Projects	DY1, Q2	
Convene PPS Clinical Operations Committee to review draft Cross-Project quality governance guidelines and recommend revisions as appropriate	DY1, Q2	
PPS Clinical Operations Committee ratifies final Cross-Project quality governance guidelines and recommends to Executive Committee for ratification	DY1, Q3	
PPS Executive Committee reviews and ratifies final Cross-Project quality governance guidelines	DY1, Q3	
Cross-Project quality governance guidelines communicated to Project Advisory Committee (PAC)	DY1, Q3	
PPS Clinical Operations Committee designates Project-level quality leads (representing both PPS Lead and Network Members) responsible for implementing the guidelines and recommends schedule for ad-hoc attendance and reporting	DY1, Q3	
Project-level quality leads, in collaboration with Project Leads and Project teams, recommend initial quality "leading indicators" for reporting to Clinical Operations Committee	DY1, Q3	
Milestone: ***Finalize bylaws and policies or Committee Guidelines where applicable***	DY1, Q2	Upload of bylaws and policies document or committee guidelines. Subsequent quarterly reports will require PPSs to articulate any
PMO drafts charter and guidelines (member responsibilities, term of service, voting rules, dispute resolution, policies for under-performing providers) for 4 standing PPS Committees (Finance, IT/Data, Clinical Operations, Audit/Corporate Compliance) and Executive Committee	DY1, Q1	
PPS Committees review and provide feedback re: draft charters and guidelines	DY1, Q1	
PPS Committees' comments incorporated by PMO	DY1, Q1	
PPS Committees ratify final charters and guidelines and recommend to Executive Committee for ratification	DY1, Q2	
PPS Executive Committee reviews and ratifies final charters and guidelines for 4 PPS Committees and Executive Committee	DY1, Q2	

Structures and charters communicated to Project Advisory Committee (PAC)	DY1, Q2	
ii. Governance process updates	***Target Completion Date***	***Supporting Documentation***
Milestone: ***Establish governance structure reporting and monitoring processes***	DY1, Q3	Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes Subsequent quarterly reports will require minutes of committee meetings, including evidence of two-way reporting between committees.
Executive Committee develops guiding principles for reporting and monitoring, including what information is shared with whom and when	DY1, Q2	
PMO to draft key Program-level process milestones and metrics relevant to 4 Committees' purviews and identify schedule of information availability	DY1, Q2	
PMO to synthesize milestones and metrics into draft Dashboards for reporting to 4 PPS Committees consistent with Committee purview	DY1, Q2	
4 PPS Committees review and provide feedback re: draft Dashboards and adequacy of information availability	DY1, Q2	
4 PPS Committees' comments incorporated by PMO	DY1, Q2	
4 PPS Committees ratify final Dashboards	DY1, Q3	
PMO selects key indicators from Dashboards for inclusion in Executive Committee Dashboard	DY1, Q3	
Executive Committee reviews and ratifies final Dashboard	DY1, Q3	

Key Issues

iii. Community engagement	*Target Completion Date*	*Supporting Documentation*
Milestone: ***Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)***	DY1, Q4	Community engagement plan, including plans for two-way communication with stakeholders. Subsequent quarterly reports will require evidence of implementation of community engagement plan, including evidence of community engagement events.
NYP Community Affairs to engage PAC subset (to include Network Members and non-members representing Community Boards, local religious leaders, community physicians and non-physician providers, NYC DOHMH, etc.) to collaboratively develop community engagement strategy and draft plan, including target audiences, content categories, communication vehicles and events	DY1, Q2	
Community engagement plan presented to PAC for review	DY1, Q3	
PAC confirms PAC subset as ongoing Community Engagement Subcommittee, charged with implementing plan; identifies any gaps in participation	DY1, Q3	
PPS Executive Committee reviews and ratifies final community engagement plan	DY1, Q3	
PMO publishes plan consistent with Subcommittee and PPS Executive Committee guidance	DY1, Q4	
Community Engagement Subcommittee commences monitoring of performance against plan	DY1, Q4	
PPS Executive Committee commences monitoring adherence to plan	DY1, Q4	

Milestone: ***Finalize partnership agreements or contracts with CBOs***	DY1, Q4	Signed CBO partnership agreements or contracts. Subsequent quarterly reports to require minutes of meetings with CBOs.
PMO recommends an inventory of relationships that require contracts (e.g., service contracts, quality agreements, IT relationships, network participation minimum requirements, etc.) and categorizes Network Members by contract type ("Agreement")	DY1, Q2	
PPS Finance Committee reviews Agreement inventory and categorization and provides feedback	DY1, Q2	
PMO, with assistance of PPS Lead resources (legal, quality, finance) drafts Agreement templates	DY1, Q2	
PPS Finance Committee reviews Agreement templates and provides feedback	DY1, Q3	
PPS Finance Committee comments incorporated by PMO	DY1, Q3	
PPS Finance Committees approves revised templates and recommends to Executive Committee for ratification	DY1, Q3	
Agreement templates ratified by Executive Committee	DY1, Q3	
Project Leads and PMO jointly draft project-specific Agreement schedules for Network Members consistent with PPS role	DY1, Q4	
Project Leads and PMO facilitate Agreement discussion w/Network Members	DY1, Q4	
Partnership agreements executed with Network Members, including CBOs	DY1, Q4	
Milestone: ***Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)***	DY1, Q4	Agency Coordination Plan. Subsequent quarterly reports to require updates on implementation of Agency Coordination Plan, including evidence of interaction with local agencies.
Project Leads to identify and define role of agencies to involve at State/Local level (e.g., NYC DOHMH, End of AIDS Taskforce, NYS Quitline, others TBD)	DY1, Q2	

PMO to integrate recommendations into agency coordination roadmap and present to PPS Clinical Operations Committee for review and feedback	DY1, Q2	
PPS Clinical Operations Committee comments incorporated by PMO	DY1, Q2	
Agency Coordination Plan ratified by Executive Committee, which will monitor adherence to Plan	DY1, Q3	
Agency delegates recruited	DY1, Q4	
Milestone: ***Finalize workforce communication & engagement plan***	DY1, Q3	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee). Subsequent quarterly reports to require updates on implementation of workforce communication & engagement plan.
PMO HR Lead to meet with 1199TEF to discuss workforce engagement and communication strategy and best practices (including objectives, principles, target audiences, channels, barriers and risks, milestones and measuring effectiveness)	DY1, Q2	
PMO HR Lead to engage Workforce Sub-committee in discussion of Network's workforce communication and engagement needs and to develop plan outline	DY1, Q2	
Workforce Sub-committee to integrate Network plan outline with PPS Lead communication and engagement needs	DY1, Q2	
Workforce Sub-committee to draft workforce engagement and communication plan and present to Executive Committee	DY1, Q3	
Executive Committee reviews and ratifies workforce engagement and communication plan	DY1, Q3	

iv. Inclusion of CBOs

Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network

Network members, including CBOs, are critical collaborators in the NYP PPS. The NYP PPS does not make a significant distinction between non-provider CBOs and CBOs; both are essential to the successful delivery of DSRIP projects. The NYP PPS expects the role of the CBOs to grow over time as more activity moves to the community setting and a greater opportunity exists for meaningful interventions by trained lay people in the home and/or community setting.

The PPS is contracting with between three and six CBOs—such as Community League of the Heights, ASCNYC, and Northern Manhattan Improvement Corporation —to hire more than 35 Community Health Workers (CHWs), health educators and interpreters. CHWs - the largest of this workforce at nearly 30 staff - are trained local community members who provide diagnosis-specific education in a linguistically and culturally appropriate manner to patients and families. They can also assess non-medical causes of hospital utilization, such as lack of transportation or food insecurity. Where necessary, trained interpreters will be hired to avoid the pitfall of "false fluency" and the limitations of using family interpreters or bilingual providers as ad hoc interpreters. We expect to enter into contracts for CHWs and related staff during DY1. Contracted CBOs for CHWs and related staff will be included in project delivery plans from inception. Involvement will include role definition, training requirements, standards of practice and quality expectations. These CBOs will help anchor our PPS Network in the communities we serve.

The PPS may contract with other CBOs for non-CHW and related staff services. Contracts under consideration include God's Love We Deliver, an organization that can provide medically-appropriate meals for beneficiaries impacted by 2.b.i and 2.b.iv; Meals on Wheels which provides screening and referral program for tobacco-using homebound recipients of their services and can impact 4.b.i; Washington Heights CORNER Project which, through outreach and needle exchange programs, can reach PLWA and others at risk for HIV/HCV/STIs who we seek to engage through 3.e.i and 4.c.i; and Charles B. Wang Community Health Center which may establish a tobacco cessation clinic to promote cessation for the Chinatown population under 4.b.i. We would expect these contracts to be in place by Q1DY2.

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in implementing your governance structure and processes and achieving the milestones described above, as well as potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

The NYP PPS has a proven track record of effectively leading collaborative teams of NYP, community providers and CBOs in the design and development of innovative care models. The Regional Health Collaborative is one example of a recent success story. The NYP PPS will build on that experience to optimize the governance of the NYP PPS and inform the management of governance risk.

Major risks to implementation of the Governance Structure and Processes, and associated mitigation strategies include:
Competition for community provider and CBO time : The NYP PPS geography has several different PPS and many community providers and CBOs are members of multiple PPS. As such, demands on these providers and CBO' time are high. We will mitigate this risk by: 1) rotational membership of 10-month Committee terms which decreases the length of service burden; 2) charging Committee members with representation for all like provider and CBO types which will ensure each segment's interests are always represented; and 3) building a broad membership for our Committees, which will allow others to carry more weight when some need to step away.

Sustaining community provider and CBO engagement over DSRIP term : Both competing demands for time within and across PPSs, and the need for community providers and CBOs to maintain their non-DSRIP businesses over the term of DSRIP will be risks. If not mitigated, these risks could result in a lack of engagement across the PPS, which could jeopardize the connectivity and inter-dependence required to produce the broad utilization changes to which DSRIP aspires. The primary mitigation strategy is to ensure that Committees produce meaningful work and engage community providers and CBOs in substantive decision-making at the Committee level. Similarly, engaging in fair and transparent funds flow will be important to securing community provider and CBO loyalty to and engagement with the PPS over time.

Major Dependencies on Other Workstreams

Please describe the key interdependencies between this and other workstreams (e.g. IT Systems and Processes, Practitioner Engagement, Financial Sustainability etc.)

Good governance is at the heart of a successful PPS. Therefore, interdependence with other workstreams is high. Good PPS governance will require several critical factors to be successful:
Strong IT systems and processes : IT systems and processes capable of collecting and analyzing key performance metrics are essential to support credible and accurate decision-making.

Effective communication among participating community providers and CBO : Active and open decision-making with strong participation from PPS members will support the engagement of community providers, CBOs, and the community at large.

Effective workforce management across the PPS : Training, education and funding must be designed to effectively support the changes needed across the delivery system.

Transparent and credible funds flow management : The effective commitment of DSRIP funds is required to stimulate participation and reward collaboration while buffering the negative impacts of DSRIP program progress on some provider organizations.

Engagement of practitioners across the continuum : Practitioner engagement is critical to achieving the levels of coordination and collaboration required to deliver the right services to the right patients at the right time and at the right locations.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
PPS Lead and Fiduciary	***NewYork-Presbyterian (David Alge, VP Integrated Delivery System Strategy, DSRIP Executive)***	***Policies and procedures; PMO leadership and resourcing; IT infrastructure leadership and resourcing; budgeting and funds flow; PPS legal, regulatory and compliance support; PPS Committee co-Leadership, Project Leadership; quality leadership and assurance***
Major FQHC Collaborators	***Charles B. Wang Community Health Center (Betty Cheng), Community Healthcare Network (Ken Meyers), Harlem United/Upper AIDS Ministry (Jacqui Kilmer), St. Mary's Center, Inc.***	***Committee membership; Protocol design for care transitions, ED triage and primary/behavioral integration, palliative care***
Major Post-Acute Collaborators	***MJHS (Jay Gormley), ArchCare (Eva Eng), Hebrew Home (David Pomeranz), VNSNY (Angela Martin)***	***Committee membership; Protocol design for care transitions, Ambulatory ICU***

Major Children's Healthcare Providers	***Leaders from Blythedale Children's Hospital, St. Mary's Hospital for Children, Northside Center for Child Development and others***	***Committee membership; Protocol design for care transitions, Ambulatory ICU***
Major Behavioral Health and Substance Abuse Providers	***Leaders from Argus Community (Daniel Lowy), The Bridge, ASCNYC (Sharen Duke), St. Christopher's Inn, and others***	***Committee membership; Protocol design for primary/behavioral integration, crisis stabilization, HIV COE***
Community Health Worker CBOs	***ASCNYC (Sharen Duke), Community League of the Heights, Northern Manhattan Improvement Corp (Mario Drummonds), DWDC and others***	***Committee membership; CHW workforce development; support for CHW technology design***
Community Organizations	***Various Community Boards and others***	***PAC membership; community feedback***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS with regard to your governance structure and processes.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		
All PPS Members	***Committee members***	***Representing other like organizations on Committees; providing input and feedback on policies, protocols, performance management, IT strategies and tactics, quality programs; Holding other members accountable***
PAC (internal)	***PAC membership***	***Represent PPS members interests and understand community needs***
1199 TEF	***Workforce expertise***	***Workforce (re)training, (re)deployment, reduction and hiring best practices and associated resources***
External stakeholders		
PAC (external)	***PAC membership***	***Represent community interests and understand PPS members' needs***

Workforce Collaborators (1199, NYSNA)	***Workforce advocacy***	***Support and advise re: workforce engagement plan, training plans, recruitment, workforce feedback***
NYC DOHMH	***Committee member***	***Provide integration with other PPS and input on governmental resources and priorities***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream and your ability to achieve the milestones described above.

A robust IT infrastructure is essential for the various governance committees to support effective and efficient decision-making and DSRIP goal achievement for the NYP PPS. The collection and analysis of data from participating community providers and CBOs will form the basis for an evidence-based process for evaluating effectiveness of PPS interventions across the ten projects as well as the contribution of the various community providers and CBOs in achieving DSRIP goals. Good data and information produced by this IT infrastructure will help build and maintain credibility within the PPS, with the PAC and with the broader community. The IT infrastructure will work collaboratively with the PPS PMO to create effective channels to share information on progress toward milestones, utilization and quality outcomes, and opportunities for community engagement through private and public information-sharing tools.

Key to the NYP PPS IT shared infrastructure will be:
1) successfully building on the current work deploying Allscripts Care Director (ACD) to selected community providers and CBOs involved in the existing NYP Health Home (e.g., ASCNYC). NYP has both an implementation blueprint and a recent and rich understanding of critical success factors and barriers to timely deployment which will heavily inform our approach to deploying ACD more widely across the PPS, and
2) leveraging our leadership role in the RHIO, Healthix, to assure priorities, design considerations, SHIN-NY related decisions, etc. advance the interests of DSRIP and do so in a timely way consistent with the stated DSRIP objectives. NYP plays important leadership roles on various Healthix committees and the Healthix Board.

Progress Reporting

Please describe how you will measure the success of this workstream.

The NYP PPS has a high likelihood of success in governance due to two important factors. The first is the relatively small size of the PPS membership; our thoughtful and strategic selection of Network Members who together cover the full spectrum of clinical and social determinants of health needs allows us to govern efficiently and effectively. Second, our experience working with many of the Network Members on existing population initiatives allows us to build on trusted relationships (e.g., Charles B. Wang Community Health Center and NYP Lower Manhattan Hospital on serving the Chinese population; Weill Cornell Medical Center and Community Healthcare Network serving underserved populations in Western Queens; Columbia University Medical Center and the myriad CBOs, community providers and pharmacies like ASCNYC, Washington CORNER Project and AIDS Healthcare Foundation serving PLWA/HIV).

The success of NYP PPS governance will be measured by: 1) adherence to these timeline commitments; 2) the application of Committee policies to resolve issues and meet unanticipated challenges; 3) the development, negotiation and execution of agreements to formalize PPS contractual relationships; 4) robust attendance at the Standing Committees and the Executive Committee; and 5) the management of performance for the PPS as a whole and for individual community providers and CBOs within the PPS.

Financial Sustainability

Key Steps and Measurable Milestones

Domain 1 Process Measures

i. Financial Sustainability Strategy Updates

Financial Sustainability Strategy Updates	*Target Completion Date*	*Supporting Documentation*
Milestone: ***Finalize PPS finance structure, including reporting structure***	**DY1, Q3**	PPS finance structure chart / document, signed off by PPS Board. Subsequent quarterly reports will require PPSs to provide minutes of Finance Committee meetings.
Complete PPS Finance Committee structure (including reporting structure), charter and Committee Guidelines per Governance workplan	DY1, Q2	
Define roles and responsibilities of PPS lead and finance function	DY1, Q2	
Develop PPS org chart that depicts finance function with reporting structure to PPS Executive Committee, PPS Finance Committee and PPS Lead Applicant.	DY1, Q2	
Obtain approval of finance function reporting structure from PPS Executive Committee, PPS Finance Committee and PPS Lead Applicant.	DY1, Q3	

Milestone: ***Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.***	**DY1, Q4**	Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers; -- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers In subsequent quarterly reports (i.e. between the annual assessment) PPSs will be requires to provide an update on: --the financial status of those providers identified as financially fragile, including those that qualified as IAAF providers; and how their status impacts their ability to deliver services -- the identification of any additional financially fragile providers; and -- the efforts undertaken to improve the financial status of
PMO drafts Financial Sustainability standards/thresholds using NYS DOH guidance and monitoring framework for PPS Finance Committee review	DY1, Q3	
PPS Finance Committee reviews standards/thresholds and monitoring framework and provides feedback	DY1, Q3	
PMO drafts Financial Sustainability survey of operational and financial metrics aligned with standards/thresholds for review by PPS Finance Committee	DY1, Q3	
PPS Finance Committee reviews survey and provides feedback	DY1, Q3	
PPS Finance Committees' comments incorporated by PMO	DY1, Q3	
PPS Finance Committee approves final survey	DY1, Q3	
PMO releases survey to all PPS members on behalf of PPS Finance Committee	DY1, Q4	
PPS Finance Committee reviews survey results and identifies financially fragile organizations, develops draft interventions, and finalizes monitoring framework; Recommends interventions and framework to PPS Executive Committee	DY1, Q4	

PPS Executive Committee reviews recommendations and ratifieds, as appropriate	DY1, Q4	
PPS Finance Committee communicates standards/thresholds and framework to PPS Network Members and to PAC	DY1, Q4	
PMO facilitates information-gathering discussions with selected PPS regarding opportunities for shared financial sustainability strategies, resources and timelines	DY1, Q4	
PPS Finance Committee (or approved designee) provides general guidance on the development of a sustainability plan to financially fragile organizations	DY1, Q4	
PPS Finance Committee to initiate quarterly, semi-annual and annual financial sustainability reporting as required under DSRIP	DY1, Q4	
Milestone: *Finalize Compliance Plan consistent with New York State Social Services Law 363-d*	**DY1, Q3**	Finalized Compliance Plan (for PPS Lead). Subsequent quarterly reports will require an update on ongoing compliance with 363-d.
Complete review of NY Social Services Law 363-d, determine scope and requirements of compliance program and plan based upon the DSRIP related requirements that are within the scope of responsibilities of the PPS Lead.	DY1, Q2	
Develop Compliance Plan to include written policies and procedures that define and implement the code of conduct and other required elements of the PPS Lead compliance plan that are within the scope of responsibilities of the PPS Lead.	DY1, Q2	
PPS Audit/Compliance Committee to review and approve Compliance Plan developed by PPS Lead - Compliance and PMO; recommends to PPS Executive Committee for ratification	DY1, Q2	
PPS Executive Committee ratifies PPS Compliance Plan	DY1, Q3	
PPS Audit/Compliance Committee, with support of PMO, to obtain confirmation from PPS network providers that they have implemented a compliance plan consistent with the NY State Social Services Law 363-d.	DY1, Q3	

PMO and PPS Finance Committee ensure that compliance plan requirements are integrated into Agreement templates	DY1, Q3	

ii. Progress Reports on the PPS Effort to Transition to Value-Based Payment Systems

Progress reports on the PPS effort to transition to value-based payment systems	***Target Completion Date***	***Supporting Documentation***
Milestone: *Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.*	**DY1, Q4**	Value-based payment plan, signed off by PPS board; Subsequent quarterly reports will require updates on implementation of that plan.
Milestone: Establish Value Based Payment Work Group and Initiate Engagement	**DY1, Q2**	
Convene VBP Work Group ("VBPWG") representative of PPS system. Consider representation from PPS providers, PCMH, FQHCs and plans	DY1, Q2	
Develop VBPWG Charter and guidelines	DY1, Q2	
VBPWG to develop communication plan and materials for providers to facilitate understanding of value based payment (VBP) and NYS VBP roadmap including levels of VBP and risk sharing options	DY1, Q2	
Milestone: Conduct Stakeholder Engagement with PPS Providers	**DY1, Q3**	
VBPWG to roll out communication plan and materials for providers to facilitate understanding of value based payment (VBP), to include levels of VBP and risk sharing options	DY1, Q3	
VBPWG to develop a self-reported, stakeholder engagement survey to assess the PPS provider population and establish a baseline assessment of: degree of experience operating in VBP models and preferred compensation modalities; and, performance under any existing VBP arrangements currently in place	DY1, Q3	
VBPWG to release stakeholder engagement survey	DY1, Q3	

VBPWG to compile stakeholder engagement survey results and analyze findings.	DY1, Q3	
Milestone: Conduct stakeholder engagement with MCOs	**DY1, Q4**	
VBPWG to conduct stakeholder engagement sessions with MCOs to discuss potential contracting options and requirements (workforce, infrastructure, knowledge, legal support, etc.).	DY1, Q4	
Milestone: Finalize PPS VBP Baseline Assessment	**DY1, Q4**	
VBPWG to develop initial PPS VBP Baseline Assessment, based on discussions at provider and MCO stakeholder sessions and survey results	DY1, Q4	
VBPWG to present initial PPS VBP Baseline Assessment to PPS Finance and Executive Committees for feedback	DY1, Q4	
VBPWG to present initial PPS VBP Baseline Assessment to PPS membership and PAC	DY1, Q4	
Milestone: ***Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest***	**DY2, Q3**	Value-based payment plan, signed off by PPS board Subsequent quarterly reports will require updates on implementation of that plan.
Milestone: Prioritize potential opportunities and providers for VBP arrangements.	**DY2, Q2**	
VBPWG to analyze total cost of care data provided by NYS DOH and other governmental agencies to identify opportunities related to an upside-only shared savings model ("UOSSM")	DY2, Q1	
VBPWG to identify challenges related to the implementation of the UOSSM model	DY2, Q1	

VBPWG to prioritize providers based on assessment of who is best prepared to engage in UOSSM	DY2, Q2	
VBPWG to conduct sessions with best-prepared providers to discuss the process and requirements necessary for UOSSM	DY2, Q2	
Milestone: Develop VBP adoption plan.	**DY2, Q3**	
VBPWG to draft VBP Adoption Plan which will include analyzing provider and PPS performance, proposing methods of dispersing shared savings and building infrastructure required to support performance monitoring and reporting.	DY2, Q2	
VBPWG to recommend VBP Adoption Plan to PPS Finance Committee for comments and recommendation to PPS Executive Committee	DY2, Q2	
PPS Executive Committee to review and ratify VBP Adoption Plan	DY2, Q2	
VBPWG to develop a timeline for best prepared providers to adopt UOSSM	DY2, Q3	
VBPWG to continue discussions with other providers regarding adoption of UOSSM.	DY2, Q3	
VBPWG to present initial PPS VBP Adoption Plan to PPS membership and PAC.	DY2, Q3	
NOTE: PPSs will ultimately be required to set target dates for the following three milestones, as well as the milestones above. However, this will not be required until the VBP Roadmap is confirmed and all milestone targets are finalized. A detailed timeline setting out the due dates for all the elements of the implementation plan that are not required by April 1st will be published shortly.		
<u>Milestone:</u> *Put in place Level 1 VBP arrangement for PCMH/APC care and*		
Step 1…		
Step 2…		
<u>Milestone:</u> *Contract 50% of care-costs through Level 1 VBPs, and ≥ 30% of*		
Step 1…		
Step 2…		
<u>Milestone:</u> *≥90% of total MCO-PPS payments (in terms of total dollars)*		

Step 1…		
Step 2…		

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.

Major risks to implementation of the Financial Sustainability workstream and achievement of outcome measure targets, and associated mitigation strategies include:
DSRIP Funding: The NYP PPS DSRIP calculated its project budgets based on communications from the State regarding both the PMPM and the preliminary attribution for the NYP PPS. We conducted sensitivity analyses, including the effects of a lower PMPM, lower-than-expected Domain 1 achievement values and lower-than-expected Domain 2 and 3 quality and clinical outcomes measures. The actual reduction in funding of 21% due to the change in attribution methodology and, possibly, a change in PMPM has resulted in a budget contraction of a similar magnitude. At the same time, there has been no communication regarding relief from any DSRIP reporting or performance requirements. Given that the fixed costs of DSRIP management and technology infrastructure have not changed, we remain concerned about the negative impact on our ability to sustainably implement the ten projects chosen and developed by the PPS during the application phase and the impact lower funding could have on our community providers and CBOs. Mitigation strategies include encouraging the State to address reporting and performance requirements in light of this significant funding decrease and conservative planning and expectation-setting across the PPS.

Acceptance by Network Members of the Financial Sustainability Plan and compliance with PPS reporting Requirements : It is anticipated that some Network Members may be reluctant to share their financial challenges with other network members, including potential competitors in other lines of business. In addition, some Network Members may be overwhelmed by (or not have robust enough financial reporting to adhere to) reporting requirements which may add stress and workload in particular to organizations which are already financially stressed. Mitigation strategies currently include simplifying reporting requirements to the extent possible within the constraints of the DSRIP requirements, and collaborating with other PPSs to encourage the State to develop and maintain a shared warehouse of financial sustainability metrics for PPS network members from around the State and, in the absence of that, collaborate with local PPSs with shared network members to share financial sustainability information and mitigation approaches.

Resources to maintain the financial sustainability monitoring : There is a risk should the requirements for financial sustainability reporting become onerous and the metrics either too numerous or not well-defined. This is a risk for the Network Members (as discussed above) and for the PPS Finance Committee and PMO as reporting requirements taken in aggregate across DSRIP are prolific. Mitigation strategies include allowing Network Members to self-report and attest to meeting the requirements (in lieu of PPS Finance Committee/PMO collecting and analyzing). A second mitigation strategy could be the State, regional PPSs, or the NYP PPS developing an IT capability for automatic metric submission and attestation by the Network Members.

Acceptance of funds

Adherence by Network Members to compliance reporting : It is anticipated that Network Members will have compliance plans that may not be fully aligned with the DSRIP requirements. Modifying their compliance plans may be a difficult task which requires involvement of their Boards and these organizations may be reluctant to modify long-standing compliance programs. Mitigation strategy includes allowing Network Members to self-report and attest to meeting the requirements (in lieu of PPS Compliance/Audit Committee/PMO collecting and analyzing).

Building basic understanding of VBP across the PPS membership : It is anticipated that many Network Members lack the knowledge and experience of non-fee-for-service models of reimbursement which puts at risk even starting the conversation regarding VBP. The preferred mitigation strategy is the State providing broad-based education for providers, including increasing levels of sophistication (and possibly including some sort of testing or certification to demonstrate proficiency). A less desirable model relies on the PPS Finance Committee (or designee) providing this education.

Collecting, analyzing and interpreting population health data to inform VBP Adoption Plan in a cost-effective way : Little experience exists in VBP structures for such an integrated delivery system in NYS and this presents a significant risk as the commitments made to achieve the 80-90% goal are fundamentally transformative to funds flow and present a significant threat to participants. In addition, the risk exists that preparing for VBP may be cost-prohibitive vis. the consultants, IT infrastructure, data analysis and contracting expertise that may need to be purchased. Mitigation strategies include: collaborating with the State for shared resources, including scrubbed and searchable population data for Medicaid attributed beneficiaries, and collaborating with other PPS in discussions with MCOs to increase scalability of this requirement.

Major Dependencies on Other Workstreams

Please describe any interdependencies with other workstreams (IT Systems and Processes, Clinical Integration, etc.)

Interdependence of the Financial Sustainability Workstream with other workstreams is high, including:
Governance : Network Members must accept and trust the governance of the PPS Finance Committee, Compliance/Audit Committee, Executive Committee and VBPWG as these committees have the authority to require financial and compliance reporting; order involvement with financially fragile organizations as needed; and, develop and recommend the VBP Adoption Plan.

Strong IT systems and processes : IT systems and processes capable of collecting and analyzing key performance and financial metrics are essential to support credible and accurate decision-making, forecasting and reporting.

Transparent and credible funds flow management : The effective commitment of DSRIP funds is required to stimulate participation and reward collaboration while buffering the negative impacts of DSRIP program progress on some provider organizations. Funds flow must be sufficient to support the material investment in assessing and establishing VBP capabilities without compromising the Project funding which is needed to impact utilization during the DSRIP term.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

Role	Name of person / organization (if	Key deliverables / responsibilities

PPS PMO	***David Alge, VP Integrated Delivery System and Isaac Kastenbaum, DSRIP PMO Director***	***Responsible for development and management of the PMO Finance function, including functional roles (AR, AP, treasury, etc.), subject matter experts, financial analysts, reporting resources, consultants (as needed) and supporting IT. The PMO will provide guidance and oversight related to the Financial Stability Plan.***
PPS Finance Committee Co-Chairs	***Robert Guimento, NYP VP ACN; Brian Kurz, NYP ACN Finance; Network Member (Rotating)***	***Responsible for the leadership and management of the PPS Finance Committee in its role in overseeing PPS Network Member financial sustainability, including adoption of thresholds, standards and framework.***
PPS Lead - Compliance	***Debora Marsden, Compliance Officer***	***Will oversee the development and implementation of the compliance plan of the PPS Lead and related compliance requirements of the PPS as they are defined. Scope would include the PPS Lead compliance plan related to DSRIP. The PPS Lead - Compliance will advise the Executive Committee.***
PPS Lead - Audit	***Debora Marsden, Compliance Officer***	***Engages and oversees internal and/or external auditors reporting to the Compliance/Audit Committee who will perform the audit of the PPS related to DSRIP services according to the audit plan recommended by the PPS Compliance/Audit Committee and approved by the PPS Finance Committee and Committees***

NYP Budget	***Richard Einwechter, Accounting***	***Oversees NYP accounts payable, treasury/banking and general ledger functions which NYP will be providing to the PPS***
NYP Grants Accounting	***Sameh Elhadidi, Accounting***	***Responsible for the day-to-day operations of the DSRIP Accounts Payable function related to the DSRIP funds distribution***
Audit	***TBD***	***External auditors will perform the audit of the PPS Lead including those services, functions and funds flows related to DSRIP***
VBP Work group (VBPWG)	***TBD***	***Coordinate overall development of VBP baseline assessment and plan for achieving UOSSM or IPC payments; engages third parties as needed to complete***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		
David Alge, VP Integrated Delivery System	***DSRIP Executive Lead***	***Oversight of the DSRIP initiative for the PPS***
Isaac Kastenbaum, Director Strategy	***DSRIP PMO Director***	***Day-to-day operations of the PMO and the PPS infrastructure including Governance***

Debora Marsden, Compliance Officer	***PPS Lead - Compliance*** ***PPS Lead - Audit***	***Oversight of Compliance and Audit functions, staffing and deliverables***
Gil Kuperman, MD, PhD, Director Interoperability Informatics	***PPS IT Infrastructure Lead***	***Information Technology related requirements for the finance function; access to data for the finance function reporting requirements***
Various (rotating)	***PPS Executive Committee***	***Oversight of PPS Finance and Audit Committee recommendations; review of VBP Adoption Plan***
Various (rotating)	***PPS Finance Committee***	***Oversight of financial sustainability plan development, implementation and enforcement; review of VBP Adoption Plan***
Various (rotating)	***PPS Compliance/Audit Committee***	***Oversight of compliance plan development, implementation and enforcement***
External stakeholders		
Various (rotating)	***PAC***	***Communication of community needs and interests related to network financial sustainability and compliance***
MMCOs and other payers, including special needs plans	***VBPWG***	***Productive engagement with the PPS VBPWG***
NYS DOH	***Defines related DSRIP requirements***	***Timely, exhaustive requirements; robust support for fulfilling; and easy access to enabling data, technology and other tools***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

The development of shared IT infrastructure across the PPS will support the PPS Finance Committee and the PMO in the financial sustainability work by providing the Network Members with capability for sharing and submitting reports and data pertaining to organizational performance in a secure, manipulable and compliant manner.

Shared IT infrastructure and functionality is critical to supporting the work of the VBPWG, including the development of the VBP Baseline Assessment and the VBP Adoption Plan, including:
Population Health Analytic Infrastructure : Systems, data sets, tools and technology
Allscripts Care Director : care coordination software that supports management of patient populations across the Network Membership
RHIO/SHIN-NY : interoperability and connectivity needed to share information to optimize timely and effective management of patient care

Progress Reporting

Please describe how you will measure the success of this organizational workstream.

The performance of the NYP PPS with respect to Financial Sustainability will be measured by the PPS PMO, as established by the Executive Committee. Success will be measured by: 1) adherence to these timeline and milestone commitments; 2) the deployment of the Financial Sustainability Plan including a manageable and measurable set of financial and operational metrics for routine reporting; 3) the effectiveness in either supporting financially fragile organizations in their return to health OR transitioning responsibilities for patient care and other services to stronger organizations; 4) the adherence to compliance commitments at a comparable rate to other PPSs; and 5) robust attendance and participation by the VBPWG.

Cultural Competency and Health Literacy

Key Steps and Measurable Milestones

Domain 1 Process Measures

Progress Reports on the Implementation of the Cultural Competency/ Health Literacy Strategies	*Target Completion Date*	*Supporting Documentation*
Milestone: ***Finalize cultural competency / health literacy strategy.***	DY1, Q3	Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes. Subsequent quarterly reports will require updates on the implementation of your cultural competency / health literacy strategy.
VP, Community Health develops expanded cultural competency/health literacy strategy ("CCHL") based on the core NYP "Culture of One" framework. Inputs will include: meetings and discussions with key CBOs, Network Members and community stakeholders; and a review of the health disparities and community needs in each NYP PPS service area (Southwest Bronx, Upper Manhattan, Upper East Side, Harlem, Western Queens and Lower Manhattan) via the CNA.	DY1, Q2	

VP, Community Health leads a small PPS-wide Working Group (including representatives from the Workforce Sub-committee as appropriate) to define plans for two-way communication with the community, e.g., through the PAC; identify which tools currently being used will be best to assist patients with self-management in different service areas; and set up a training schedule for all providers involved in DSRIP projects.	DY1, Q2	
Working Group presents CCHL strategy to Clinical/Operations Committee for feedback, revising as appropriate for approval.	DY1, Q2	
Clinical/Operations Committee approves CCHL strategy.	DY1, Q3	
Working Group to present CCHL strategy to Executive Committee for ratification.	DY1, Q3	
PPS Executive Committee to ratify CCHL strategy	DY1, Q3	
Working group presents strategy to PAC	DY1, Q3	

Milestone: ***Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).***	DY2, Q1	Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches Subsequent quarterly reports will require evidence of training programs delivered. PPSs will need to provide: a description of training programs delivered and participant-level data, including training outcomes.
VP, Community Health adapts existing cultural competency training curricula for additional workforce roles and communities (e.g., Chinese American in Lower Manhattan) in concert with key community members, city agencies, workforce stakeholders and Workforce Sub-committee. One example: different sets of providers will require different training (physicians, staff, peer providers, etc.).	DY1, Q3	

VP, Community Health, convenes same Working Group to review curricula and to present training strategy to Clinical/Operations Committee for feedback, revising as appropriate for approval.	DY1, Q3	
Clinical/Operations Committee approves training strategy.	DY1, Q4	
Working Group to present training strategy to Executive Committee for ratification.	DY1, Q4	
PPS Executive Committee to ratify training strategy	DY2, Q1	
Working group presents training strategy to PAC	DY2, Q1	

Key Issues

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in implementing your cultural competency / health literacy strategy and addressing the specific health disparities you are targeting (based on your CNA), and achieving the milestones described above - including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Much the NYP PPS service area is comprised of linguistically isolated ethnic and racial minorities. In response, the NYP PPS has adopted a patient-centered approach to cultural competency, known as the "Culture of One," which is aligned with the National Quality Forum's (NQF) framework. As part of the Culture of One, the NYP PPS realizes that the burden of clear communication and understanding is placed on the provider, not the patient. We have identified several risks with our implementation of this framework across the PPS.

Cultural Competency and Health Literacy Training . We must ensure that all providers on a patient's care team—across the continuum of care—are consistently and effectively trained in cultural competency and health literacy. Otherwise, we risk the same fragmented care that DSRIP seeks to remedy. To mitigate this risk, the NYP PPS will train frontline staff and physicians involved in DSRIP projects to provide care that respects patients' "Culture of One." This approach treats patients as individuals whose culture is unique and a result of multiple social, cultural and environmental factors and avoids racial or ethnic stereotyping. The methodology stems from seminal research published by NYP's VP-Community Health, Dr. Emilio Carrillo, in 1999 and is used internationally as the basis for cultural competency training. Additionally, providers and staff in certain projects will receive supplemental training on sensitivities related to specific target populations. For example, those involved in Project 3.g.i (Integration of Palliative Care into PCMHs) will receiving training on how to deal sensitively with patients facing advanced illnesses and their families. Those involved in Projects 3.e.i and 4.c.i (HIV/AIDS) will receive training that will include education on HIV as a disease, gender identity, substance abuse issues and disability issues. We will also establish a Cultural Competency/Health Literacy expert panel to review the health literacy level of DSRIP project educational material across the PPS.

The NYP PPS also intends to co-invest with the State through the CRFP and with ASCNYC as the lead in a Peer Training Institute which will be a PPS center for CHW, Patient Navigator, Health Educator and Interpreter training serving all NYP PPS projects and Network Members. These "peer providers" are trained local community members who provide diagnosis-specific education in a linguistically and culturally appropriate manner to patients and families. At the Peer Training Institute, these providers will learn to avoid the pitfalls of "false fluency" and of using family interpreters or bilingual providers as ad hoc interpreters. They are critical to mitigating the barriers presented by the cultural diversity of our attributed beneficiaries.

New Patient Population . Though NYP has extensive experience with Upper Manhattan communities, it has less experience with the Asian population that lives in Lower Manhattan, home to its newest hospital, NYP/LM. This service area is 6% African American, 16% Hispanic and 25% Asian. The majority of Asian people are of Chinese origin (75% of the Asian population; 18% of the total service area). Almost a third of the population is foreign-born, 60% of which originate from Asian countries. Twenty percent of the population speaks an Asian language, of which 65% speak English less than "very well." To address the challenge of working with this new population, the NYP PPS will collaborate with long-standing, experienced leaders in the community such as Charles B. Wang Community Health Center as well as the NYC Department of Health and Mental Hygiene for training, translated materials and so on. Projects specifically impacted by this risk are those involved at NYP/LM—Project 2.b.iii (ED Care Triage) and Project 2.b.iv (Care Transitions for 30-Day Readmissions)—as well as the city-wide Domain 4 Projects (4.b.i – Tobacco Cessation and 4.c.i – Decrease HIV Morbidity). For Project 4.b.i (Tobacco Cessation), we intend to collaborate with NYU's New York City Treats Tobacco program to craft provider training and patient education materials to effectively engage this specific population.

Practitioner Engagement . Engaging practitioners in training opportunities will be key to success. Because the PPS is made up of multiple Network Members, the Clinical/Operations Committee (along with Workforce and IT/Data Governance) will need a tight roll-out schedule to ensure that all providers are appropriately trained. In addition, the NYP PPS will establish and provide guidance to existing and new cultural competency committees at several large Network Members to ensure that the roll-out of the Culture of One program is tailored to the needs of specific organizations.

Data Collection . In order to analyze data and measure progress/success, we must capture the appropriate patient-level data at each encounter. These include but are not limited to ethnicity, race and preferred language. To mitigate the risk of not having appropriate data to analyze, cultural competency and health literacy training for registrars and other front-desk staff will include education on how to ask these sensitive questions and how to code them appropriately.

Major Dependencies on Other Workstreams

Please describe any interdependencies between this and any other workstreams (IT Systems and Processes, Practitioner Engagement, Financial Sustainability, etc.)

As Cultural Competency and Health Literacy are integral to the roll-out of all DSRIP projects, several interdependencies are noted below.

Workforce Strategy. The overlap between these two workstreams is related to 1) hiring and 2) training. First, the PPS will hire close to 40 culturally competent peer providers (Community Health Workers and Patient Navigators). This group of new employees is an important link between beneficiaries and medical/social services. Second, cultural competency and health literacy training is a key aspect of the PPS's workforce development strategy. To ensure standardized training across all staff, the Community Health Department and Workforce Sub-committee will work together to design and implement a training schedule, to be approved by the Clinical/Operations Committee. In addition, NYP and ASCNYC are partnering to develop a Peer Training Institute which will be a PPS center for Community Health Worker, Patient Navigator, Health Educator and Interpreter training serving all NYP PPS projects and Network Members.

Financial Sustainability. Similar to the Workforce Strategy workstream, we must be able to finance cultural competency and health literacy training. To that end, the Finance Committee has embedded within it a member of the Workforce Sub-committee, who will be able to speak to cultural competency and health literacy training. The Finance Committee will also invite the Community Health department to report on this training.

Governance. The NYP PPS will rely on several key Network Members, such as Charles B. Wang Community Health Center, to assist in its cultural competency and health literacy training. To keep these Network Members engaged, we will make sure they are among the first to serve on the Executive Committee and Clinical/Operations Committee.

Practitioner Engagement. The practitioner communication and engagement plan will include information and training on cultural competency and health literacy. Physicians (including house staff) will need separate training from care team staff (RNs, etc.).

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
Community Health	***Emilio Carrillo, MD, VP Community Health, NYP***	***Developing and executing cultural competency and health literacy strategy and training***
CCHL Strategy Work Group	***Emilio Carrillo, MD, VP Community Health, NYP and Various Others (NYP and Network Members)***	***Develop CCHL Strategy***

Community Health	***Victor Carrillo, Community Health***	***Executing strategy globally***
Organization-Based Cultural Competency Committees	***Multiple PPS Network Members***	***Executing strategy locally***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	***Role in relation to this organizational workstream***	***Key deliverables / responsibilities***
Internal stakeholders		
Andrea Procaccino	***Chief Learning Officer***	***Consulting on workforce***
Eric Carr	***Workforce Sub-committee Lead***	***Work with Community Health on training roll-out***
Charles B. Wang Community Center	***Experienced PPS Network Member***	***Assistance with cultural competency and health literacy training for Lower Manhattan population***
1199 Training & Employment Funds (TEF)	***Workforce training***	***Training assistance for frontline workers***
Employees / Practitioners	***Providers***	***Engage in training***
All PPS Network Members	***IT Contacts***	***Liaison***
Eliana Leve, LCSW, MA, CASAC	***Deputy Executive Director for Programs, AIDS Service Center NYC***	***Development of Community Health Worker Peer Training Institute in Upper Manhattan.***
External stakeholders		
NYC DOHMH	***Training and technical assistance***	***Technical assistance for projects at the NYP/LM campus***

NYU NYC Treats Tobacco	***Training and technical assistance***	***Technical assistance for Project 4.b.i - Tobacco Cessation***
1199 SEIU; NYSNA	***Labor/Union Representation***	***Expertise and input re cultural competency training***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support the development and implementation of your cultural competency / health literacy strategy and the achievement of the milestones described above.

Shared IT infrastructure development will support the implementation of our cultural competency / health literacy strategy in three ways: 1) Workflow support for care coordinators via Allscripts Care Director; 2) Documentation support for Community Health Workers; and 3) Enhancements to the patient portal.

Workflow support for care coordinators . The PPS will extend Allscripts Care Director (ACD), an application that supports the work flows of care coordinators to multiple Network Members across the care continuum. The application enables care coordinators to care for registries of patients; manage tasks related to those patients; and document assessments, care plans, problems, goals, interventions and future tasks. In this way, care team members across the continuum can be made aware of patients' cultural preferences.

Documentation support for Community Health Workers (CHWs) . Culturally competent CHWs will serve as a link between patients and medical/social services. The CHWs will see patients in their homes and document their findings, e.g., psychosocial issues that may be hurdles to the delivery of optimal care and recommendations for referrals to community-based organizations. Because CHWs are mobile, the PPS will provide them with a wireless-enabled tablet-based application for documentation. The application will allow both free-text and structured documentation approaches. The PPS will leverage lessons learned as part of a NYS eHealth Collaborative Digital Health Accelerator project in which NYP piloted electronic documentation for CHWs.

Enhancements to the patient portal . The PPS will develop a patient portal for patients. We will create specialized, relevant, multi-lingual content to improve health literacy such as asthma-related materials for parents of asthmatic children and information about managing multiple chronic diseases for adults. The content will be clinically oriented but also provide information about Network Members and social services available.

Progress Reporting

Please describe how you will measure the success of your cultural competency / health literacy strategy, including reference to specific health disparities.

Because the cultural competency / health literacy strategy is at the core of every project, we will measure its success by analyzing: 1) existing disparity-sensitive clinical outcomes measures, as defined by the National Quality Forum (NQF); 2) Ambulatory Care Sensitive Conditions (PQIs and PDIs); 3) measures associated with cultural competency; and 4) utilization (i.e., emergency department visits, hospitalizations and 30-day readmissions) and patient satisfaction. We will also track the number of providers (staff, physicians and peer providers) trained as measure of our progress.

Disparity-Sensitive Clinical Outcomes . Each project has its own clinical outcomes measures of success. We will select existing measures that qualify as "disparity-sensitive" as defined by the NQF, i.e., "those that serve to detect… differences in quality among populations or social groupings (race/ethnicity, language, etc.)." These measures include care with a high degree of discretion, such as the decision to prescribe medication to control a patient's pain (e.g., Project 3.g.i); communication-sensitive services, such as smoking cessation counseling (e.g., Project 4.b.i); social determinant-dependent, or patient self-management, measures, such as medication adherence to diabetes or CHF management (e.g., Projects 2.b.i, 2.b.iv); and outcome and communication-sensitive process measures, such as the provision of certain vaccines, where some groups may have specific concerns about some interventions or medications over others (e.g., Project 2.b.i).(1)

Ambulatory Care Sensitive Conditions . PQIs measure potentially avoidable hospitalizations for ambulatory care sensitive conditions and reflect issues of access to high-quality ambulatory care, which may be the result of disparities in care. Examples are short-term complications from diabetes and uncontrolled diabetes admission rate, both of which will likely be tracked by Project 2.b.i.

Cultural Competency Measures . We will track some of the NQF-endorsed measures associated with culture, language and health literacy. For example, patient readmission measures are included in this bucket due to the importance of patient-provider communication in transitions of care (e.g., Project 2.b.iv). Other examples are adherence to chronic care medication (e.g., Projects 2.b.i, 3.e.i) and the conducting of a depression assessment (e.g., Projects 2.b.i, 3.a.i, 3.a.ii, 3.g.i and 3.e.i).

Utilization and Patient Satisfaction . We will measure changes in utilization (admissions, readmissions and ED visits) and patient satisfaction (via Press Ganey) in aggregate and by categories such as race, ethnicity and preferred language, much as we did with the NYP Regional Health Collaborative (RHC). In October 2010, NYP, in association with the Columbia University Medical Center, launched an integrated network of patient-centered medical homes that were linked to other providers and community-based resources and formed a "medical village" in Northern Manhattan. Three years later, a study of 5,852 patients who had some combination of diabetes, asthma and congestive heart failure (CHF) found that emergency department visits, hospitalizations and 30-day readmissions had been reduced by 29.7%, 28.5% and 36.7%, respectively, compared to the year before implementation of the network. Patient satisfaction scores improved across all measures.(2)

(1) Weissman, Carrillo et al, "Commissioned Paper: Healthcare Disparities Measurement," National Quality Forum, October 4, 2011.
(2) Carrillo et al, "The NYP Regional Health Collaborative," Health Affairs, 33, No. 11 (2014) 1985-1992.

IT Systems and Processes

Key Issues

Current state analysis	*Target Completion Date*	*Supporting Documentation*
Milestone: ***Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).***	DY1, Q4	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment. Subsequent quarterly reports will require updates on the key issues identified and plans for developing the PPS's IT infrastructure.
Director of Interoperability Informatics develops IT assessment in concert with Healthix (RHIO) and Network Member IT counterparts. Tools will include surveys, emails, interviews and meetings.	DY1, Q2	
PMO distributes IT assessment to Network Members for feedback.	DY1, Q2	
PMO incorporates feedback from Network Members.	DY1, Q2	
IT/Data Governance Committee reviews and summarizes network IT capabilities.	DY1, Q3	
IT/Data Governance Committee presents assessment to Exec Committee for ratification.	DY1, Q4	

IT Governance	*Target Completion Date*	*Supporting Documentation*

Milestone: ***Develop an IT Change Management Strategy***	DY2, Q2	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes Subsequent quarterly reports will require an update on the implementation of this IT change management strategy.
Director of Interoperability Informatics leads group including project leaders, Network Members, Workforce Sub-committee members and others to develop NYP PPS IT change management strategy in response to assessment and in conjunction with IT/Data Governance Committee.	DY1, Q4	
IT/Data Governance Committee presents strategy to PAC.	DY1, Q4	
IT/Data Governance Committee presents final IT Change Management Strategy to Executive Committee; PPS Executive Committee ratifies strategy	DY2, Q1	
IT/Data Governance Committee works with Workforce Sub-committee to develop communication and training strategy for IT Change Management process.	DY2, Q2	
IT/Data Governance Committee creates process for monitoring the ongoing progress and performance of the change management strategy, including reporting back to Executive Committee as appropriate. This step will include input and expertise from the Workforce Sub-committee as well.	DY2, Q2	

Data Sharing	*Target Completion Date*	*Supporting Documentation*
Milestone: ***Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network***	DY2, Q2	Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include: -- A governance framework with overarching rules of the road for interoperability and clinical data sharing; -- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a common clinical data set
Director of Interoperability Informatics leads small internal group (clinicians, end users) to develop NYP datasharing and interopability plan.	DY1, Q3	
Corporate Director, Director of Interoperability Informatics and IT/Data Governance Committee develop PPS Network datasharing and interopability system in conjunction with vendors and RHIO.	DY1, Q3	
IT/Data Governance Committee presents Datasharing and Interoperability plan to Executive Committee for ratification	DY1, Q4	
The plan is presented to the PAC and communicated to Network Members to ensure transparency.	DY2, Q1	
IT/Data Governance Committee creates process for monitoring partner compliance with connectivity and data-sharing requirments, including reporting back to Executive Committee as appropriate. This step will include input and expertise from the Clinical/Operations Committee as well.	DY2, Q2	

<u>Milestone:</u> ***Develop a specific plan for engaging attributed members in Qualifying Entities***	DY2, Q1	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities. Subsequent quarterly reports will require updates on your progress in implementing this plan.
IT/Data Governance Committee reviews current RHIO consent process, including pitfalls experienced by clinical and operational staff in the current model.	DY1, Q2	
Clinical/Operations and IT/Data Governance Committees work with Community Health department to ensure that cultural competency and health literacy priniciples are incorporated into the new RHIO consent process.	DY1, Q3	
Clinical/Operations and IT/Data Governance Committees develop staged plan for outreach to Network Members to communicate RHIO consent processes, assist with implementation (as needed) and tracking/reporting member engagement.	DY1, Q3	
Director of Interoperability Informatics engages Healthix (QE) to work with Network Members to finalize plan, including getting feedback from Network Members on operational feasibility and cultural appropriateness.	DY1, Q4	
Clinical/Operations and IT/Data Governance Committees present joint NYP PPS RHIO plan to Executive Committee for ratification.	DY2, Q1	

Milestone: ***Develop a data security and confidentiality plan.***	DY1, Q4	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network. Subsequent quarterly reports will require an update on progress on implementing this plan.
Director of Interoperability Informatics and NYP Chief Information Security Officer lead small internal IT group (legal, security/privacy officers) to develop NYP data security and confidentiality plan, including security testing recommendations.	DY1, Q2	
Corporate Director IT, Director of Interoperability Informatics and Chief Information Security Officer work with IT/Data Governance Committee to finalize PPS Network data security and confidentiality plan.	DY1, Q3	
IT/Data Governance Committee presents Datasharing and Interoperability plan to Executive Committee for ratification.	DY1, Q4	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in creating and implementing your IT governance structure, your plans for data sharing across your network, your approach to data security and confidentiality, and the achievement of the milestones described above, including the potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

General Implementation Risks . The biggest risk to implementing the IT governance structure and network-wide infrastructure is that funding from the CRFP is not approved. The NYP PPS IT infrastructure is a prerequisite to achieving the goals of DSRIP, including improving population health, reducing the cost of healthcare services, increasing access to high-quality primary and specialty care, reducing avoidable hospital use and ensuring a sustainable model that continues after the DSRIP period has ended. If we receive less funding than expected, we will likely fund development out of DSRIP operational proceeds on a reduced scale. This will slow down the IT roll-out and may also negatively impact project outcomes.

Another risk is the need to develop new inter-institutional workflows. These workflows—which include the handoff of key pieces of clinical information—will need to fit into the workflow with minimal disruption and with maximal support from information technology capabilities. These challenges will be mitigated through leadership commitment from NYP and the Network Members as well as dedicated project management resources.

Third, there is a need to develop robust governance processes. The DSRIP-related workflows will require consistent processes and procedures to be created across multiple organizations. Governance and decision-making structures will be required to these complex and, at times, contentious, decisions. The mitigation approach will be to use the IT/Data Governance Committee to make decisions as needed, with approval from the Executive Committee where warranted.

Finally, there is the risk that our assumptions, though conservative, have still underestimated the budget for key parts of the infrastructure, e.g., the amount of RHIO connectivity required or the staffing costs related to securing informed consent for providers. To mitigate this risk, we plan to use operational funds earmarked for projects if needed, though this may slow down project implementation.

Data-Sharing Risks . Data-sharing risks include: 1) RHIO capacity; 2) Consent; and 3) Interoperability.
One of the key data sharing-related risks is the capacity of the RHIO to connect new members. Healthix has to support about eight PPSs citywide, and the number of new interfaces they will need to create is estimated at over 1,000. They have given us a tentative timetable that it will take until the end of 2016 to connect all NYP PPS Members. We will mitigate this risk by (i) prioritizing the connections so that the partners that are most important to achieving our goals will be connected first; and (ii)

Members. We will mitigate this risk by (i) prioritizing the connections so that the partners that are most important to achieving our goals will be connected first, and (ii) having a multi-layered data exchange strategy that includes—beside the RHIO—key members using Allscripts Care Director, the use of direct messaging and the secure exchange of auxiliary files when necessary.

Another data sharing related challenge will be consent. Obtaining consent can be operationally difficult to implement, yet RHIO consent is a core measure of success for the PPS. Mitigation approaches include (i) leadership commitment from the partners to participate in HIE-related obligations; (ii) educating partner organizations about the processes necessary to obtain consent; (iii) examining the "community-wide" consent options; and (iv) staffing, in the form of a "Community-based organization integration manager," to help partners organizations work through consent-related challenges.

Third, there is the challenge of interoperability amongst various vendors and with different Network Members. To mitigate this risk, the PPS intends to assure that all relevant PPS partners are connect to Healthix so that the Network Members can access the basic, necessary data to care for patients. NYP currently connects to the State Health Information Network for New York (SHIN-NY) via Healthix. Currently, only a minority of NYP PPS Network Members are Healthix participants. Sixty-nine (69) Network Members will join Healthix and participate in SHIN-NY-based health information exchange activities. Thirty-four (34) of those organizations will contribute their full clinical data set to Healthix so that other Network Members can use those data. Twelve (12) organizations will contribute encounter data, so records of encounters can be tracked by the RHIO. The remaining 23 organizations will contribute patient lists to Healthix so they can view the data of other Healthix participants. Healthix's messaging capabilities will also be leveraged to actively notify care managers about key events such as ED visits and admissions to other facilities.

Another risk mitigation strategy to address interoperability and the ability to share data is the implementation across the PPS of Allscripts Care Director (ACD), a care coordination platform supported by NYP. PPS members will use ACD to document patient assessments and care plans and to see documents entered by others who are caring for the patient. ACD currently is being used by several CBOs as part of NYP's Medicaid Health Home program and will be extended under DSRIP. In addition, a discharge planning application in place at NYP, Allscripts Care Manager, will allow inpatient care managers to identify and communicate with follow-up providers to facilitate the continuum of care.

Data Security and Confidentiality Risks . The goals of the PPS will be achieved through the implementation of technology-enabled work flows that include increased access to the patient's data by members of the patient's care team. The increased access will be achieved through (i) the use of Allscripts Care Director by Network Members and (ii) the use of Healthix. The broader availability of data increases the risk of unauthorized access and unauthorized use of the data.

To mitigate ACD's risks, ACD's privacy and security framework includes Business Associates Agreements (BAA), which establish privacy obligations under HIPAA; formal processes for creation and termination of user accounts; training in privacy and security; and password management. Healthix members sign a Participant Agreement, which obligates them to adhere to Healthix's Privacy and Security Policies, one key aspect of which is the obligation to obtain the patient's written affirmative consent before it can view the patient's data in Healthix. Participants must adhere to Healthix's privacy compliance program, under which participants must assure consent forms are current and contain proper language; demonstrate adequate user training; create processes for creating user accounts and roles-based access privileges; adhere to technical standards, e.g., password length; and conduct periodic audits.

Major Dependencies on Other Workstreams

Please describe the main interdependencies with other organizational workstreams (e.g. Performance Reporting, Clinical Integration, Financial Sustainability, etc.)

The IT Systems and Processes workstream will depend on:

Cultural Competency . As RHIO consent is an important part of the success of DSRIP, cultural competency and health literacy will be essential to the success of this workstream. The PPS must ensure that consent is accessible to a diverse audience. As discussed in other parts of the implementation plan, we will ensure accessibility by providing cultural competence and health literacy training to all frontline staff and peer providers who will be working with our attributed population. In addition, we intend to redesign patient registration areas in NYP's clinics to include a small education cubicle for private conversations with patients regarding health-related issues and obtaining RHIO informed consent as well as a patient education cubicle or kiosk.

Practitioner Engagement . IT is but a tool; in order for the workstream to be successful, practitioners must be engaged in learning new software or using existing software in new ways, as the case may be. Most DSRIP projects depend on the successful implementation of new software systems, including EHRs, the care coordination platform Allscripts Care Director (ACD) and access to the Healthix RHIO. New and existing workers at all levels will need technical training and engagement support to ensure that impacted staff are ready, willing and able to succeed with the new system. To address this challenge, the NYP PPS will retain the 1199SEIU League Training and Employment Funds (TEF) as the lead workforce development provider. Using TEF's expertise in this area, the PPS will provide training to incumbent workers who need additional skills to do existing jobs and develop training for new staff. Training will also be delivered by external resources from the community or by the NYP internal training department (Talent Development). For some projects, we plan to engage with the NYC Department of Mental Health and Hygiene to assist in technical training (see Project 4.b.i). Software vendors such as Allscripts and Healthix will also conduct their own user training.

Governance . The size of the NYP PPS--though small relative to others in the Greater NYC area--makes staying on the same page with regard to IT decisions important. The goals of the PPS will have to dictate the final local decisions, but the Data/IT Governance Committee and Clinical/Operations Committee will both provide operational and clinical decision-making to guide the Network.

Clinical Integration . As strategies and workflows are developed for network integration, the supporting IT infrastructure will be developed simultaneously so that these two aspects fit together to form a coherent process. Workflows and information technology support will be developed simultaneously to support: 1) the identification of the patients that can benefit from involvement with Network Members; 2) the methods that are used to inform Network Members about the need for engagement with the patient; 3) the data that needs to be available to Network Members; 4) the protocols that will be used to care for the patient; and 5) the methods for data flows from Network Members to other clinicians. Education, training and other operational processes related to the information systems (e.g., authorization) will be taken into account as clinical integration processes are implemented.

Performance Reporting . Information systems will be involved as performance measurement specifications are developed. We expect that some specifications will be related to DSRIP project goals, per se; other specifications will be related to quality measures and yet others will be related to more general performance improvement goals. Information Services will be involved with the project teams as these specifications are developed.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	*Name of person /*	*Key deliverables /*
Corporate IT Director for Analytics, NYP	***Niloo Sobhani***	***Co-Chair of IT/Data Governance Committee***
PPS Network Member	***Rotating***	***Co-Chair of IT/Data Governance Committee***
Director of Interoperability Informatics, NYP	***Gil Kuperman, MD, PhD***	***Implementation of IT infrastructure components; coordination of training***
Chief Information Security Officer, NYP	***Jennings Aske***	***Implementation of data security plan***
ACN/Financial Operations	***Brian Kurz***	***Architect of clinical operations (registration) redesign to implement RHIO consent process***
Clinical Expertise	***TBD***	***Clinician(s) familiar with the PPS population who can provide guidance on implementation of the RHIO consent process and other changes***
PPS Network Member Expertise	***Network Members TBD***	***Operations counterparts at Network Member sites who can provide guidance on shaping the RHIO consent process and other changes***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		
Aurelia Boyer	***Chief Technology Officer, NYP***	***Overseeing all IT implementation***
Rob Guimento	***VP, NYP ACN***	***Overseeing changes to registration at ACN to implement RHIO consent process***
Cheryl Parham	***Lead Counsel, NYP***	***Ensuring that contracts for software across the PPS are legal***
PPS Network Members	*--*	***Good faith efforts to incorporate necessary IT and encourage practitioners to use it***
Clinical/Operations Committee	***Several***	***Guidance on clinical and operational aspects of IT implementation***
External stakeholders		
RHIOs (Healthix, BRIC)	***Infrastructure, Training***	***Delivery of on-time project; user training***
Medicaid beneficiaries	***Recipients***	***Providing RHIO consent***
Software Application Vendors (Allscripts, etc.)	***Infrastructure, Training***	***Delivery of on-time project; user training***
1199 SEIU Training & Employment Fund	***Training***	***Training of front-line workers in new systems and processes***

Progress Reporting

Please describe how you will measure the success of this organizational workstream.

We will measure the success of this organization workstream in several ways, including:

• Successful roll-out of all seven components of the IT infrastructure project:
(1) Development of an automated work flow platform to support care coordinators. Metrics will include installation of Allscripts Care Director in targeted sites and usage statistics.
(2) Enhancements to the electronic health records (EHR) applications. Metrics will include tracking changes necessary for becoming a Level 3 PCMH as well as project-specific needs.
(3) Procurement and implementation of an automated application for mobile Community Health Workers. Metrics will include usage and usability statistics based on conversations with CHWs.
(4) Development of health information exchange (Healthix RHIO) so that members of the care team can interact optimally. Metrics will include number of connections and pace of roll-out.
(5) Data interfacing capabilities to move data among applications. Metrics will include number and type of data interfaces as well as utilization statistics.
(6) Enhancements to the NYP patient portal. Metrics will include the selection of the final patient portal and how often it is used by PPS beneficiaries.
(7) Development of an analytics platform to support the PPS. Metrics will include number and quality of reports developed to oversee the performance of the PPS.

• RHIO consent attempts and the consents themselves.

• Patient safety improvements, including reduced patient safety errors and adverse drug events.

Performance Reporting

Key Issues

Reporting Structure	*Target Completion Date*	*Supporting Documentation*
Milestone: ***Establish reporting structure for PPS-wide performance reporting and communication***	DY1, Q4	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation Subsequent quarterly reports will require updates on your progress on implementing this strategy and evidence of the flow of performance reporting information (both reporting 'up' to the PPS Lead and 'down' to the providers throughout the network)
PMO and Project Leads to draft performance reporting and communications strategy including confirming that Project Leads will be responsible for clinical and financial outcomes of their projects.	DY1, Q2	
Project Leads share performance reporting and communications strategy with key Network Members for input and incorporate feedback	DY1, Q2	
PMO integrates project-level strategies into a unified DSRIP program performance reporting and communications strategy	DY1, Q3	
PMO presents performance reporting and communications strategy to Clinical/Operations Committee for feedback and revision.	DY1, Q3	

IT/Data Governance Committee-selected work group maps out approach to creation and use of clinical quality and performance dashboards using Amalga and other analytics software to align with defined performance reporting and communications strategy.	DY1, Q3	
Clinical/Operations and IT/Data Governance Committees finalize strategies and present to PPS Executive Committee for ratification. (Includes RCE approach, outlined below.)	DY1, Q4	

Performance Reporting Culture	***Target Completion Date***	***Supporting Documentation***
Milestone: *Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting*	DY1, Q4	Finalized performance reporting training program. Subsequent quarterly reports will need to demonstrate up-take of training. PPSs will need to provide: a description of training programs delivered and participant-level data, including training outcomes.
Workforce Sub-committee will develop strategy to integrate new reporting processes and clinical metric monitoring workflows into the frontline staff and physician training curriculum. The Workforce Sub-committee will likely consult on feasibility of strategy with IT team.	DY1, Q2	
Workforce Sub-committee will work with 1199 TEF (lead workforce training vendor) to develop schedule for incorporating this training into overall DSRIP training schedule.	DY1, Q3	
Workforce Sub-committee will present training strategy to IT/Data Governance and Clinical/Operations Committees for feedback and approval.	DY1, Q3	
Workforce Sub-committee advises PPS Executive Committee of final performance reporting training program.	DY1, Q4	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in implementing performance reporting structures and processes and effective performance management within your network, including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Resistance to Change . One risk is practitioners who are resistant to changing practice in response to performance reporting. To mitigate this challenge, the PPS PMO will design practitioner surveys and analyze responses to gauge levels of engagement or resistance. The PPS Clinical/Operations Committee will represent practitioner interests, solicit input through surveys and recommend practitioner group structure to PPS Executive Committee as well as monitor practitioner engagement plan. In addition, we will establish Practitioner Groups, whose leads will represent practitioners to the Clinical/Operations Committee as needed to advance the engagement agenda. Our hope is that if practitioners feel they have a voice in the process, they will be more responsive to performance reporting and management.

IT Systems . Because of the complexity of the DSRIP initiative, there is a risk that the IT capabilities will not be able to provide practitioners and managers with the data they need to make decisions. To mitigate this risk, IT personnel will be involved as performance measurement specifications are developed.

Time Lag in Capabilities . We recognize that we will need to monitor performance starting April 1, 2015; clearly our reports will not be deployed at that point, which is a risk to the performance management system and culture. To address this challenge, we will prioritize reporting needs and roll them out incrementally. In the interim, we will rely on the State's data via the MAPP portal (e.g., performance on the claims-based, non-Hospital CAHPS DSRIP metrics as well as the DSRIP population health metrics) to benchmark ourselves against other PPSs and compare Network Members' progress internally. In addition, we will identify other available performance measures which may serve as effective proxies and leading indicators for some of the more important metrics, until the official measure is available.

Major Dependencies on Other Workstreams

Please describe any interdependencies with other workstreams (e.g. IT Systems and Processes, Practitioner Engagement, Financial Sustainability, etc.)

IT Systems and Processes . Clearly, IT infrastructure forms the backbone of reporting capabilities. Though inputs to the reports will come from clinicians, Project Leads, key Network Members and other stakeholders, the analytic output is dependent on the PPS' IT function putting it all together in a useful manner.

Governance . Without effective leadership and a clearly defined organizational structure, with clear responsibilities and lines of accountability, our ability to create a common culture and to embed performance reporting structures and processes will be severely hampered. The NYP PPS Clinical/Operations Committee will be responsible for reporting on PPS performance, both at an individual project level and at a network level. This Committee will be led by one NYP representative and one community provider or CBO representative, with membership including representation from all Network Members. This group will report directly to the Executive Committee and receive analytical support from the IT/Data Governance Committee and the PMO. The Finance Committee will also monitor financial performance (revenue and expenses) of the PPS. Both committees will report on the "State of the PPS" at bi-monthly committee meetings and at Executive Committee meetings.

Workforce Strategy . The size of the NYP PPS—from Network Member, staff and provider perspectives—will pose the classic management challenge of integration, e.g., gaining buy-in to the established governance and performance management structure and processes. The Workforce Sub-committee will provide overall direction, guidance and decisions related to the workforce transformation agenda, including developing a change management strategy that addresses performance management. In addition, providers will need training on using performance reporting systems and/or understanding how to read and interpret reports.

Likewise, Practitioner Engagement and Clinical Integration will both be critical to creating a common performance culture throughout the PPS network, and to embedding the new performance reporting practices within existing clinical practice.

Roles and Responsibilities

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

Role	Name of person / organization (if	Key deliverables / responsibilities
PMO	***Isaac Kastenbaum, Director, DSRIP PMO***	***Initial performance reporting strategy***
Project Leads	***Elaine Fleck MD, Adriana Matiz MD, Peter Steel MD, Jordan Foster PD, Patricia Peretz, Peter Gordon MD, Sam Merrick MD, Veronica Lestelle, Craig Blinderman MD, Ronald Adelman MD, Barbara Linder, Dianna Dragatsi MD, David Albert DDS and Julie Mirkin RN***	***Initial performance reporting strategy; clinical and financial outcomes for projects***
Workforce Sub-committee	***Eric Carr, Lead***	***Strategy to include performance reporting training into DSRIP-wide training, as appropriate***

IT Lead	***Gil Kuperman, MD, PhD, Director, Interoperability Informatics***	***Lead for creation of analytic tools***
Network Members	***various (TBD)***	***Provide input and feedback into performance reporting and communications strategy***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	*Role in relation to this*	*Key deliverables / responsibilities*
Internal stakeholders		
1199 TEF	***Training Vendor***	***Assist with scheduling and rolling out training***
Clinical/Operations Committee	***PPS Committee***	***Oversee roll-out of performance reporting***
IT/Data Governance Committee	***PPS Committee***	***Oversee roll-out of analytic tools for performance reporting***
Employees/Practitioners	***Providers***	***Engage in training and required reporting***
PPS Network Members	***IT and HR Contacts***	***Liaison for performance reporting implementation and training***
External stakeholders		
1199/NYSNA	***Labor Unions***	***Advising on workforce issues related to training***
DOH	***DSRIP measurement partner and customer***	***Providing guidance, best practices and tools to enhance value of performance reporting***
Medicaid Patients/Representatives	***Healthcare customer***	***Input into performance monitoring and continuous performance improvement processes***
Non-PPS IPAs/Physicians	***Shared patients***	***Provide input and feedback into performance reporting as impacts the non-PPS network member***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support your approach to performance reporting.

The NYP PPS will use a variety of analytics tools (Microsoft Amalga, Tableau, SAS, etc.) to develop reports that monitor process and outcome measures with data from EHRs, Allscripts Care Director (care management platform), the Healthix RHIO and implementation reports. The analytics platform will provide population health management capabilities for the PPS. The platform will identify eligible patients, receive identifying information from NYS and combine it with NYP medical records and PPS-wide care coordination platform data. Analysts will create data marts that—with graphical front-end tools—will provide management reports, quality reports, reports for regulatory reporting purposes, lists of patients meeting specific criteria that need care coordination services and predictive models that identify likely high utilizers of care. The analytics platforms will leverage NYP's existing database hardware and analytics software, but additional application software, database servers and hard disk storage will be needed to support the PPS.

Analytics reports, including baseline, current and target performance metrics, will be available on the PPS's intranet website. Performance data will be reviewed at weekly PMO meetings and bimonthly Clinical/Operations Committees; to achieve necessary targets, each group will develop a plan-do-study-act (PDSA) cycle for metrics that are not achieving their goals. Any major tweaks to project activities will be reviewed by the Executive Committee and the NYS DOH, when appropriate. The IT/Data Governance Committee will be responsible for interfacing with the Project Leads as well as the Clinical/Operations Committee to ensure that dashboards, reports and metrics are accurate and user-friendly, i.e., easy to read/understand and helpful in making decisions.

Progress Reporting

Please describe how you will measure the success of this organizational workstream.

From NYP's population health experience, we understand that effective rapid-cycle evaluation (RCE) is critical to the success of the NYP PPS's DSRIP projects. Effective RCE requires: 1) clear definitions and benchmarks for performance measurements; 2) developing the appropriate data governance standards; 3) scheduling regular meetings to review performance data; and 4) focusing on both process and outcomes data. We will measure the success of this workstream by examining the usefulness of reports, both to the PPS Committees and to practitioners, i.e., how much they are used to make decisions for the next reporting period. We will also look at how well providers and Network Members understand their performance.

Practitioner Engagement

Key Issues

Practitioner engagement / involvement in the DSRIP program	*Target Completion Date*	*Supporting Documentation*
Milestone: Develop practitioner communication and engagement plan	DY1, Q4	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee Subsequent quarterly reports will require evidence of ongoing communication and engagement, in line with plan, evidence of active professional peer groups and performance reporting to these groups.
PPS Clinical Operations Committee to identify key practitioner groups with the potential to influence DSRIP Program success. Groups may include: Primary Care practitioners (already constituted), Health Home Care Managers, Community Healthcare Workers (CHWs), providers to the Chinese community	DY1, Q2	
PPS Clinical Operations Committee with support of PMO to solicit input through a survey sent to all PPS Network Members as to interest in participating in proposed practitioner groups	DY1, Q2	
Based on survey responses, PPS Clinical Operations Committee to recommend practitioner groups to PPS Executive Committee for approval	DY1, Q3	

PPS Clinical Operations Committee, with input from PPS Project Leads, to develop engagement and communication plan including frequency of contact/meeting, potential agendas including educational sessions, information sharing approach, etc.	DY1, Q4	
Milestone: 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	DY2, Q1	Practitioner training / education plan. Subsequent quarterly reports will require evidence of training. PPSs will need to provide: a description of training programs delivered and participant-level data, including training outcomes.
PPS Clinical Operations Committee with support of PMO to solicit input through a second survey sent to practitioner group members regarding topics of interest for future training/education	DY1, Q4	
PMO in collaboration with Project Leads and practitioner representatives from PPS Clinical Operations Committee to develop core training/education plan for practitioner groups focused on: *a. Core goals of DSRIP program* *b. NYP PPS projects - goals, metrics, timing and key success factors* *c. Integration with existing initiatives*	DY2, Q1	
Based on survey results, PMO in collaboration with Project Leads and practitioner representatives from PPS Clinical Operations Committee to develop practitioner training/education plan which may include the following potential topics: *a. Best operational practices under DSRIP* *b. Best financial practices under DSRIP* *c. PPS resources available to address social determinants of health* *d. Intro to population health management* *e. Role of Health Homes* *f. IT trends: HIE, RHIO, SHIN-NY, etc. and impact on practitioners* *g. Building cultural competency and health literacy among practitioners*	DY2, Q1	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the current level of engagement of your practitioner community in the DSRIP program and describe the key challenges or risks that you foresee in implementing your plans for practitioner engagement and achieving the milestones described above. Describe any potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Major risks to implementation of the Practitioner Engagement workstream, and associated mitigation strategies include:
Competition for practitioner time: The NYP PPS geography has several different PPSs and many practitioners are members of multiple PPSs. As such, demands on these providers are high. We will mitigate this risk by: 1) seeking input from practitioners as to topics of interest, methods of communication and availability, so the training/education plan is sensitive to their needs; 2) collaborating (where feasible and practical) with other PPSs in general training and education topics; and 3) offering virtual participation for most training/education events.

Sustaining practitioner engagement over DSRIP term : Competing demands for time within and across PPSs, and the need for practitioners to maintain their non-DSRIP businesses over the term of DSRIP will be a risk. If not mitigated, that risk could result in a lack of engagement across the PPS which could jeopardize the level of awareness, knowledge and expertise required to produce the broad system transformation DSRIP aspires to. The primary mitigation strategy is to ensure that the practitioners are engaged in meaningful, efficient and effective training and education that delivers value to the practitioner and not just the NYP PPS or the DSRIP Program more broadly.

High practitioner turnover undermines common knowledge foundation: New care delivery models and new roles require significant practitioner up-staffing which is expected to lead to intense competition for resources. While the mitigation strategy for the resource competition remains elusive as of now, the mitigation strategy for delivering practitioner training/education in a high turnover environment may benefit first and foremost from a commitment by the State (including DOH, OMH, OPWDD, etc.) to developing and delivering high-value cross-PPS training modules. That means the training/education burden at the PPS level is specific to PPS projects, strategies and populations. Then, the mitigation strategies become: 1) simple, direct, "turnkey" training, especially virtual training and training which can be delivered in a "train-the-trainer" mode; and 2) collaborating (where feasible and practical) with other PPSs in general training and education topics so practitioners have a choice of trainings available and the expense burden is shared.

Technology as a barrier to engagement, collaboration and understanding: Practitioners are both dependent on, and frequently isolated by, technology. That is, technologies that support workflow, decision-making and record-keeping are frequently different within and across practitioner types. That can negatively affect engagement, communication and transformation of clinical practice. To mitigate this risk, a multi-pronged approach must be taken. One is a concerted effort to raise the level of all primary care practitioners through the common requirements and language of PCMH and Meaningful Use. Another is to emphasize connection to the RHIO and SHIN-NY so that practitioners have a better connection to the overall care of the patient populations they serve. Finally, deploying a technology like Allscripts Care Director for care management similarly helps build connections between practitioners and institutions.

Managing resistance to change in clinical pathways and care models: Certain practitioner types, esp. community physicians, will likely be resistant to changing practice. To mitigate this, the PPS may seek to: 1) collaborate with other PPS to create a common language related to delivery system change strategies and tactics; 2) draw on case studies of applicable initiatives that show success which may be available through the MIX platform; 3) enlist change management techniques currently deployed by the PPS Lead's training and education department; and 4) develop evidence-based practices and case-studies to support rationale for change.

Major Dependencies on Other Workstreams

Please describe any interdependencies with other workstreams (e.g. Clinical Integration, Population Health Management, Financial Sustainability, etc.)

Interdependence of the Practitioner Engagement Workstream with other workstreams is high, including:
Financial Sustainability/Budget: This commitment to practitioner engagement requires significant investments on the part of the PPS in an environment where: 1) proceeds from the DSRIP waiver are still unknown, and 2) specific mandates for practitioner engagement were not provided at the time PPS application and budgets were developed. While engaging practitioners was always a PPS plan, practitioner engagement plans will now need to be sized consistent with Waiver proceeds.

Governance and Financial Sustainability: The PPS Clinical Operations Committee is an essential conduit for practitioner interests and will need to consider practitioner needs perhaps more broadly than its actual representation at any given time. Similarly, the PPS Finance Committee will need to consider practitioner incentives.

Workforce Strategy: Promoting practitioner engagement will need to be done hand-in-hand with developing the practitioner workforce. The Workforce Sub-committee can provide an important perspective regarding training and change management across and within practitioner groups.

Strong IT systems and processes: IT systems and processes capable of collecting and analyzing key performance and financial metrics are essential to delivering evidence-based models, case studies and performance reports needed to engage practitioners and transform care delivery.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
PPS PMO - Network Relations	***TBD***	***Facilitate the development and implementation of the practitioner engagement strategy including designing surveys and analyzing responses; collaborate with other PPS as appropriate and with the State to encourage state-wide approach to training and education***

PPS Clinical Operations Committee Co-Chairs	***J. Emilio Carrillo, MD, NYP VP Community Health and Rotating PPS Network Member***	***Represent practitioner interests, solicit input through surveys and recommend practitioner group structure to PPS Executive Committee; monitor practitioner engagement plan***
Practitioner Group Leads	***TBD***	***Represent practitioner groups to the Clinical Operations Committee as needed to advance the engagement agenda***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		
Practitioners in PPS	***Target of engagement activities***	***Participation and feedback***
Project Leads	***Advising PPS Clinical Operations Committee***	***Practitioner preparedness/gaps***
PPS IT/Data Governance Committee	***Provider of infrastructure and enabling technologies***	***Identify practitioner type-specific needs and engage at practitioner level in addition to DSRIP Project focus***
External stakeholders		

Other PPSs in geography	***Potential Collaborator***	***Identification and facilitation of cross-PPS collaboration and engagement opportunities***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

Shared IT infrastructure will be required to collect and synthesize the data necessary for performance reporting that demonstrates practitioner performance, project performance and supports case study development. While a "shared IT infrastructure" is not required for easy access to virtual training and content, good IT will enable it.

In addition, we will build on the success of our current Health Home effort which uses shared IT to engage practitioners across a wide spectrum of practice. For example, we have recent experience engaging behavioral health practitioners (NYS Psychiatric Institute, The Bridge), care managers/coordinators (ACMH, Argus), post-acute providers (Hebrew Home, Isabella) in the targeted, high-touch management of this patient population on a common platform of Allscripts Care Director. The RHIO will further enable these and other practitioners to engage and collaborate.

Progress Reporting

Please describe how you will measure the success of this organizational workstream.

The success of this workstream will be measured by practitioner performance in meeting goals of DSRIP projects. In addition, success may be measured through practitioner surveys/feedback on engagement plan alignment with surveyed needs.

The effectiveness of this Workstream may also be measured through the measurement of training effectiveness and the recruitment and retention of practitioners in the various groups.

Population Health Management

Key Issues

	Target Completion Date	*Supporting Documentation*
Milestone: ***Develop population health management roadmap***	DY2, Q2	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities. Subsequent quarterly reports will require an update on the implementation of this roadmap.
PPS PMO to establish PMO-PCMH Team	DY1, Q1	
PPS PMO to conduct inventory of current PPS population health data sets and tools and map to other available data sets including the MAPP tool	DY1, Q2	
PPS PMO to align available data sets and tools with project-level needs (e.g., registries) and identify gaps	DY1, Q3	
PCMH Team to develop roadmap for bringing relevant practices to Level 3 2014 standards	DY1, Q3	
PPS PMO, PCMH Team and Workforce Sub-committee to identify workforce development, training and education needs for population health	DY1, Q3	

Drawing on CNA and other analyses, PPS PMO and PPS IT to conduct risk stratification analysis in order to prioritize high risk populations for targeted intervention	DY1, Q4	
PPS PMO to integrate all findings and analyses for presentation to PPS IT/Data Governance and Clinical Operations Committees for feedback and ratification	DY1, Q4	
PPS IT/Data Governance and Clinical Committees to ratify population health roadmap	DY1, Q4	
PCMH Team to staff and launch implementation team (a similar team has been active at the PPS Lead for several years)	DY1, Q4	
Project Leads to review new care models, pathways, measurement and monitoring needs not previously identified in order to monitor progress in managing population health	DY2, Q1	
PPS PMO to integrate emerging project-level pop health data needs into roadmap	DY2, Q2	
PPS PMO, PCMH Team and Workforce Sub-committee to roll out training plan consistent with roadmap	DY2, Q2	

Bed Reduction Plan	***Target Completion Date***	***Supporting Documentation***
Milestone: ***Finalize PPS-wide bed reduction plan***	DY3, Q1	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings. Subsequent quarterly reports will require updates on bed reductions across the network and updates on the delivery of your bed reduction plan.
PPS Lead to engage staff under supervision of PMO to model the impact of all DSRIP projects on inpatient activity, using PMO and DOH reports on reductions in avoidable hospital use when available	DY2, Q2	

Based on modeling and in consultation with provider network, PPS Lead to establish high-level forecasts of the following which will be updated periodically: *a. Reduced avoidable hospital use over time* *b. Any changes in required inpatient capacity; and* *c. Resulting changes in required community / outpatient capacity*	DY2, Q3	
PPS Lead to develop and ratify inpatient capacity change plan as appropriate	DY2, Q4	
PPS community providers impacted by forecasted capacity change to be advised by PPS Lead of magnitude and to determine the need for their own capacity change plan if such change not already contemplated in collaborative implementation planning	DY3, Q1	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.

Major risks to implementation of the Population Health workstream, and associated mitigation strategies include:
Current Care Delivery and Reimbursement Models : There is a disconnect presently between population health management demands and the approach to care delivery at the practice/provider level. Care remains siloed with providers still rewarded largely on the basis of procedures or other discreet clinical interventions rather than the health of the populations they serve. To mitigate this risk, performance bonuses expected to be available as a result of the waiver may be used to create incentives for adherence to population health metrics and techniques. In addition, more locally, we will structurally drive a better population health orientation through the use of interdisciplinary teams with active participation of care managers.

Community Provider Engagement in PCMH certification : DSRIP requires network participants to achieve PCMH and MU standards. Such standards come at a cost to providers, both in terms of real financial cost and the distractions and productivity hits the PCMH process can cause to practices. Two key mitigation strategies will be used: 1) the NYP PPS will provide material support to community providers who are on the journey to PCMH and MU by participating in the financing of the effort; 2) the NYP PPS will leverage its extensive experience bringing community providers to PCMH and MU standards, including deploying best implementation, training and education, documentation and other practices which reduce the adverse business impact on the community practices.

Collecting, analyzing and interpreting population health data : The risk exists that preparing for true population health management may be cost-prohibitive vis. consultants, IT infrastructure and data/statistical capabilities required. Mitigation strategies include: collaborating with the State for shared resources, including scrubbed and searchable population data for Medicaid attributed beneficiaries, and collaborating with other PPS to increase scalability of this requirement.

Financial Sustainability : The financial sustainability of the transformation to population health management and any one of the related VBP models of reimbursement is, to date in NYS, unproven. The complete universe of risks are not yet understood and there is great diversity in the sophistication of providers statewide. Mitigation strategy includes a deliberate and thoughtful approach to population health management and VBP enabled by conservative investments in associated infrastructure.

Major Dependencies on Other Workstreams

Please describe any interdependencies with other workstreams (IT Systems and Processes, Clinical Integration, Financial Sustainability, etc.)

Interdependence of the Population Health Workstream with other workstreams is high. In fact, Population Health is inextricably linked to Practitioner Engagement, Clinical Integration, IDS, Performance Reporting, Cultural Competency, Workforce and IT.

Practitioner Engagement and Clinical Integration : The PPS needs a strong and well-executed practitioner engagement strategy. The practitioner engagement training & education described in the Practitioner Engagement section will include education regarding population health management so clinicians can begin to make the shift in approach and practice necessary for success under the DSRIP program. Similarly, effective population health management requires new models of clinical integration, especially integration with those providers and CBOs that impact the social determinants of health.

IT Systems and Processes and Performance Reporting : The foundation of effective population health management is IT. Without a robust population health IT capability, efforts will be short-lived and unmeasurable. Putting the resources in place to build this capability will be critical to Program Success. Similarly, building a capable performance reporting function which makes proper use of Rapid Cycle Evaluation will be important to the smart design and maintenance of population health efforts.

Workforce Transformation and Cultural Competenc y: Shifting to a population health sensibility requires both new kinds of workers as well as existing workers with new expertise and understanding. Teaming with the Workforce Sub-committee to ensure the programmatic needs of population health are married to the project-level needs of service delivery will be important. Integrating Cultural Competency into the hiring, training, staffing and workflow processes will be critical to making this redesigned workforce most effective.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	Name of person / organization (if known at	Key deliverables / responsibilities
PPS PMO-Population Health Team	Gil Kuperman, Niloo Sobhani and others	Design DSRIP population health IT approach and integrate it with existing population health IT efforts
PPS CNA Team	Emilio Carrillo, Victor Carrillo and others	Provide integration of CNA findings with population health approach
PPS PMO-PCMH Team	Victor Carrillo and others	Develop roadmap to achieving 2014 NCQA Level 3 standards and Meaningful Use across the PPS
PPS PMO	Isaac Kastenbaum	Provide integration across clinical, financial, IT and performance reporting functions and demands
PPS Network Members impacted by care model delivery changes	various	Support population health approach despite significant differences to current operations and strategies
PPS Network Members impacted by capacity changes	various	Forecast changes in capacity needs

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		
PPS Clinical Operations Committee	***Both adviser to and consumer of population health function***	***Self-educate on this new capability to provide effective leadership to PPS efforts***
PPS CBO Network Members	***Provider of enhanced roles under population health***	***Bring expertise related to social determinants of health to PPS in design of population health strategy***
External stakeholders		
NYS DOH	***Driver of population health approach for Medicaid population***	***Facilitate population health collaboration statewide***
Various City and State agencies	***Consumer of population health data***	***Provide population health expertise for different populations/diseases***
MCOs	***VBP stakeholder***	***Provide insight and expertise into population health management approaches that may be relevant to NYP PPS***
Other PPSs	***Beneficiaries of and contributors to pop health success***	***Collaborate to enable cross-PPS integration/visibility***

IT Expectations

Please describe the current Population Health Management IT capabilities in place throughout your PPS network and what your plans are at this stage for leveraging these capabilities and/or developing new IT infrastructure.

The PPS Lead, NYP, has emerging population health IT capabilities and has acquired and implemented population health software on a limited basis. At this point, we have not yet explored other population health IT capabilities outside of the Lead but will do so under the direction of the IT/Data Governance Committee.

The PPS IT function is developing detailed plans for the building population health IT adequate to serve the needs of the PPS. That effort will be funded by a combination of DSRIP Waiver proceeds (for which there is a detailed IT budget currently) and by the CRFP IT grant (pending approval) which will support the purchase of assets needed to build the necessary population health IT platform.

Finally, we will look to emerging strategies and technologies across NYS to identify best practices for population health IT in the context of the DSRIP program.

Please describe how you will measure the success of this organizational workstream.

The success of the Population Health Management workstream will be measured by the ability of the PPS to both track and manage individual PPS attributed beneficiaries across the PPS continuum while also assessing those beneficiaries against the outcomes and costs of the entire attributed beneficiary population. Specifically, we will use both DSRIP required outcome measures as well as our own specific population health metrics which will be recommended to the PPS IT/Data Governance Committee by the Project Leads in collaboration with the PPS Clinical Operations Committee.

Clinical Integration

Key Issues

Clinical Integration	*Target Completion Date*	*Supporting Documentation*
Milestone: Perform a clinical integration 'needs assessment'	DY2, Q2	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration
Based on experience to date implementing DSRIP Projects, the PMO, in consultation with Project Leads, to design a clinical integration needs assessment framework to use for each of the DSRIP projects. This framework will outline the people, process, technology and data components that are relevant for clinical integration as it pertains to each of the DSRIP project target populations (including the technical requirements for data sharing and interoperability)	DY1, Q4	
Based on experience to date implementing DSRIP Projects, the PMO, in consultation with Project Leads, to create a map of the providers to be involved in each DSRIP project, incorporating the community needs assessment and the current partner lists. This provider map will cover the entire continuum of the providers involved	DY2, Q1	
Based on experience to date implementing DSRIP Projects, the PMO, in consultation with the Project Leads and the CNA team, to perform a gap analysis of the provider network involved in that project, using the clinical integration needs assessment framework to determine which elements of clinical integration (people, process, technology and data components) are currently present and where they are completely or partially lacking.	DY2, Q2	
Project Leads to present clinical integration needs assessment to PPS Clinical Operations Committee for discussion and ratification	DY2, Q2	
PPS Clinical Operations Committee to ratify clinical integration needs assessment	DY2, Q2	

Milestone: Develop a Clinical Integration Strategy	DY3, Q1	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools Subsequent quarterly reports will require an update on the implementation of this strategy.
Using clinical integration needs assessment as foundation, Project Leads, in collaboration with key Network Members associated with each DSRIP project, define what the target clinical integrated state should look like from a people, process, technology and data perspective and identify the main functional barriers to achieving integration	DY2, Q2	
Project Leads, in collaboration with key Network Members associated with each DSRIP project, and using previous analyses, define and prioritize the steps required to close the gaps between current state and desired future state	DY2, Q2	
Care Transition Project Lead, in collaboration with their Network Members, to facilitate the identification of people, process, technology and data synergies required for integrated and seamless transitions from inpatient to the outpatient and/or home care settings.	DY2, Q2	
PMO to integrated findings and recommendations and, with IT, to facilitate the identification of people, process, technology and data commonalities/synergies required for clinical integration across projects.	DY2, Q3	
PMO, in collaboration with PPS Finance Committee, to develop incentives (financial, service, technology) to encourage clinical integration	DY2, Q3	
PMO facilitates aggregation of gap closure steps, clinically integrated care transitions approach, operational and IT synergies and incentives into clinical integration strategy	DY2, Q4	
Project Leads, with PMO support, to present clinical integration strategy to PPS Clinical Operations Committee for review and ratification	DY3, Q1	
PPS Clinical Operations Committee ratifies clinical integration strategy	DY3, Q1	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in improving the level of clinical integration throughout your network and achieving the milestones described above. Describe potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Major risks to implementation of the Clinical Integration Workstream, and associated mitigation strategies include:
Managing resistance to change in care delivery models: Certain providers will likely be resistant to changing practice in support of a more clinically integrated model. In addition, many providers who are critical links in the integration chain operate largely in silos from the other pieces of the delivery system. To mitigate this, the PPS may seek to: 1) invest in resources to support clinical integration (care and case managers, mid-level providers, data-sharing technologies) and decrease the burden on the provider; 2) draw on case studies of applicable initiatives that show success which may be available through the MIX platform; 3) enlist change management techniques currently deployed by the PPS Lead's training and education department.

High practitioner turnover may be a barrier to consistent, sustainable integration : New care delivery models and new roles require significant practitioner up-staffing which is expected to lead to intense competition for resources. The mitigation strategy for supporting consistent, sustainable integration in a high turnover environment may include simple, direct, "turnkey" training for new providers on clinical integration resources, processes, policies, protocols/pathways and dashboards; this may be developed by the PPS Lead's training and education departments in collaboration with Network Member training staff, or in collaboration with industry groups like GNYHA, HANYS, 1199TEF or other PPS.

Conflicting or overwhelming demands on providers participating in more than one PPS : Many providers--post acute, community physicians, CBOs and behavioral health providers--have obligations in more than one PPS. Clinical integration strategies may look different from PPS to PPS. Providers may be overwhelmed with slightly different or even conflicting approaches to clinical integration which will make their participation impractical. Mitigation strategies may include: 1) collaboration with other PPSs to standardize approaches, terminology, reporting requirements, etc. where possible by further developing plans to engage with them, especially those two PPSs with a heavy presence in Manhattan; and 2) a relentless commitment to basing these clinical integration strategies in simplicity and common sense, removing bureaucratic and administrative hurdles.

Strong clinical integration requires strong IT systems and processes locally and at the State/regional level, and is a significant investment for the PPS and for participating Network Members :
New IT and communications are needed to support data and information-sharing between providers, levels of care and with CBOs. Designing and building new tools for data sharing when a significant amount of the sharing infrastructure is the responsibility of the RHIO(s) and SHIN-NY is a complex challenge. To mitigate this risk, we will: 1) Continue to use our leadership position in the RHIO to push the RHIO and SHIN-NY to accelerated, high performance; and 2) integrate members of the PPS IT/Data Governance Committee into the team developing the clinical integration strategy.

Major Dependencies on Other Workstreams

Please describe any interdependencies with other workstreams (IT Systems and Processes, Practitioner Engagement, Financial Sustainability, etc.)

Interdependence of the Clinical Integration Workstream with other workstreams is high, including:
Practitioner Engagement : The PPS needs a strong and well-executed practitioner engagement strategy. The practitioner engagement training & education described in the Practitioner Engagement section will include education regarding clinical integration so clinicians can develop the skills and capabilities required to deliver integrated care across the continuum and with non-traditional partners in healthcare delivery.

Cultural Competency : Patients as well as practitioners will need to adapt to the new models of care, integration and population health. As such, we will incorporate Cultural Competency into the Clinical Integration approach.

IT Systems and Processes : Without a solid IT foundation to support data sharing and communication between and among providers and CBOs, clinical integration is manual and unsustainable. IT systems and processes will therefore need to be designed and built (a) with the goal of reducing administrative processes from their current levels and (b) with the input of clinical end users. Putting the resources in place to build this capability will be critical to Program Success.

Workforce Transformation : Shifting to a model of clinical integration requires both new kinds of workers as well as existing workers with new expertise and understanding. Teaming with the Workforce Sub-committee to ensure the skills and expertise required to work in an effective inter-disciplinary manner are developed will be important.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
PPS Clinical Operations Committee Co-Chair	***Emilio Carillo MD, NYP VP for Community Health***	***Provide overall community health and clinical integration expertise and leadership to the PPS Clinical Operations and Executive Committees for the development of the clinical integration strategy***
Project Leads and Key Network Members	***Elaine Fleck MD, Adriana Matiz MD, Peter Steel MD, Jordan Foster PD, Patricia Peretz, Peter Gordon MD, Sam Merrick MD, Veronica Lestelle, Craig Blinderman MD, Ronald Adelman MD, Barbara Linder, Dianna Dragatsi MD, David Albert DDS and Julie Mirkin RN plus key Network Members TBD***	***Provide expertise and leadership for the development of the clinical integration strategy, report on its progress to the PPS Clinical Operations Committee***
CNA Team	***Emilio Carillo MD and Victor Carillo***	***Support the identification of resource gaps in the community***
PMO	***Isaac Kastenbaum, DSRIP PMO Director***	***Provide project management coordination and facilitation so that strategy is consistent and efficient across projects***
IT	***Gil Kuperman MD, PhD, Director Interoperability Informatics***	***Provide IT expertise and facilitation to prioritize and streamline IT infrastructure needed for effective data sharing***
PPS Finance Committee	***Robert Guimento, Brian Kurz and others***	***Provide financial expertise and leadership to the PPS Clinical Operations and Executive Committees for the development of incentives to support clinical integration***
Workforce Sub-committee	***Eric Carr, VP HR and others TBD***	***Develop (re)training and recruitment appropriate to support clinical integration needs***
Practitioner Groups	***various***	***Provide feedback to Project Leads and to PPS Clinical Operations Committee regarding effectiveness of clinical integration strategy***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		
Practitioners	***Users of new roles, processes, technology and data***	***Provide feedback including recommendations for streamlining and sustainability***
Clinical Leadership at PPS Lead and Network Member organizations (post-acute, primary care, behavioral health, substance abuse, etc.)	***Champions for new roles, processes, technology and data***	***Participation in PPS Clinical Operations Committee, ad hoc work groups, the PAC and in other public forums to champion the change***
External stakeholders		
Groups that address the social determinants of health (e.g., DOHMH, End of the Epidemic Taskforce, NYS Quitline and others)	***Social determinants of health and clinical integration***	***Resources, expertise and perspective on statewide approaches to addressing social determinants of health***
Groups involved in care management/care coordination of populations (e.g., NY e-Health Collaborative)	***Care management/care coordination and clinical integration***	***Resources, expertise and perspective on statewide approaches to addressing care management/care coordination for Medicaid population***
Professional and Trade Groups (e.g., GNYHA, HANYS, PCDC and others)	***Industry approaches to clinical integration***	***Resources, expertise and perspective on statewide approaches to achieving clinical integration across regions and providers***
Civic/Community Advocacy Groups (e.g., Community Boards 12 and 1, United Way of NYC and others)	***Community needs and clinical integration***	***Resources, expertise and perspective on local and regional approaches to addressing community needs***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

Effective clinical integration will require relevant information to be readily accessible for all providers across the patient care spectrum. For some providers this will mean becoming PCMHs or enhancing their level of certification, for others it will mean joining the RHIO, for still others it will mean learning and utilizing Allscripts Care Director and tracking and monitoring registries of Medicaid beneficiaries participating in the PPS. The development of the clinical integration strategy and the development of the project plans will help determine which IT infrastructure elements are high priority. Elements will include:

- Architecture
- Data sharing and confidentiality protocols
- Platforms
- Approach to automated and manual processes
- Data reporting and performance monitoring
- Secure messaging and alerts
- Role of portals

The State will play a key role in supporting clinical integration from an IT standpoint. In particular, accelerating the SHIN-NY will be critical to bridging geographical regions. In addition, if the State can redesign the RHIO consent process to streamline the consent to the PPS level (versus the provider level), that would materially facilitate integration.

Progress Reporting

Please describe how you plan to measure the success of clinical integration in your PPS network over time.

Clinical integration done well has direct and measurable impact on the population served. The DSRIP Domain 1, 2 and 3 measures related to patient satisfaction, utilization and clinical process and outcome indicators will improve if clinically integrated care--people, process, technology, data sharing, etc.--is delivered. The strategy for measurement and monitoring is just now getting underway and will be an iterative process given its complexity and the inadequacy of many current systems and approaches in measuring clinical integration. Retention of providers in the Network will be one indicator of the success of the PPS in creating an administratively manageable and navigable strategy. Measurement of patient experience with respect to clinical integration will also become an indicator of success. That measurement approach, which may include patient surveys, has yet to be defined.

DSRIP Budget Table

In the table below, please detail your PPS's projected DSRIP budget allocation for the next five years.

NOTE:

- This table requires your budget forecast on an annual basis. The quarterly reports will require you to submit your actual spend against these budget categories on a quarterly basis.

- This table contains three budget categories. Please add rows to this table as necessary in order to add your own additional categories and sub-categories. The budget categories used in this table should reflect the budget categories you used in your application.

- In the 'Waiver Revenue' row, you should enter your expected waiver revenue, based on your project valuations

Waiver Revenue shown is the "maximum value" amount and the achievement of 100% of performance-based payments as was directed in the Application process. Changes to the NYP PPS application budget include the following:
1) "Administration and Overhead" budget increased from 10% to 15% due to a) better understanding of the significant reporting requirements that will be borne by the PMO, requiring an investment in those resources, and b) the shifting of some project-level IT expenses from "Project Implementation Costs" to the centralized IT function captured here.
2) "Project Implementation Costs" decreased from 65% to 60% due to the IT cost shift mentioned in Item 1 and to a conservative budget process during the application period which assumed lower application scores resulting in a lower total waiver revenue. Expenses remained the same but total Waiver Revenue has increased due to a stronger set of application scores resulting in a decline in the percentage of revenue those expenses represent.
3) "Increased Program Capacity" costs increased from 5% to 7% due to a more refined calculation of the costs associated with meeting the atttributed population's demand for primary and specialty referral access.
4) "Bonus Payments" combined with "Contingency" decreased from a combined 20% to 18% as Waiver Revenue reduction does not support same level of bonus payments given fixed costs. Un-spent contingency is assumed to partially fund bonus payments.

Budget Items	DY1	DY2	DY3	DY4	DY5	TOTAL
Waiver Revenue (using potential maximum value)	$ 17,115,920	$ 17,722,581	$ 23,789,194	$ 21,969,210	$ 17,115,920	$ 97,712,825
Administration and Overhead	$ 2,190,771	$ 2,905,267	$ 3,371,484	$ 3,322,408	$ 3,409,653	$ 15,199,583
Project Implementation Costs (NYP and Network Members)	$ 6,032,389	$ 13,613,375	$ 13,277,178	$ 12,728,437	$ 12,844,435	$ 58,495,814
Increased Program Capacity	$ 263,352	$ 567,495	$ 1,520,155	$ 1,888,905	$ 2,268,717	$ 6,508,624
Contingency Fund	$ 8,629,407	$ (3,556)	$ 20,377	$ 29,461	$ (11,030,980)	$ (2,355,291)
Bonus Payments (DSRIP milestone and hi performance achievement)	$ -	$ 640,000	$ 5,600,000	$ 4,000,000	$ 9,624,095	$ 19,864,095
Total Expenditures	$ 17,115,920	$ 17,722,581	$ 23,789,194	$ 21,969,210	$ 17,115,920	$ 97,712,825
Undistributed Revenue	$ -	$ -	$ -	$ -	$ -	$ -

DSRIP Flow of Funds

Designing your funds flow	*Target Completion Date*				*Supporting Documentation*
Milestone: ***Complete funds flow budget and distribution plan and communicate with network***					***Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology.*** ***Subsequent quarterly reports will require updates to the budget and funds flow tables contained in this template.***
1. Complete a preliminary PPS Level budget for Administration and Overhead, Project Implementation, Increased Program Capacity, Contingency and Bonus (includes performance achievement and revenue loss) categories	DY1, Q2				
2. Project Leads and PMO jointly draft project-specfic provider level budget.	DY1, Q3				
3. Develop a funds flow approach and distribution plan that integrates project-specfic provider level budgets and PPS level budget.	DY1, Q3				
4. Finance Committee reviews funds flow approach and distribution plan provding comment and input prior to ratification and recommendation to Executive Committee.	DY1, Q3				
5. Obtain approval from Executive Committee.	DY1, Q3				
6. Prepare PPS, Project and Provider level funds flow budgets for review and approval by Finance Committee.	DY1, Q3				
7. Incorporate agreed upon funds flow plan and requirements to receive funds into applicable PPS Participation Agreements.	DY1, Q4				
8. Communicate to PPS members the funds flow plan with a particular focus on how PPS level funds are achieved, the administrative requirements related to the plan, and reporting and distribution schedules.	DY1, Q4				

In the table below, please detail your PPS's projected flow of DSRIP funds for the next five years, splitting out the flow of funds by provider type. The provider types used here match the categories used for the Speed & Scale portion of your Project Plan Application.

NOTE:

- This table requires your funds flow projections on an annual basis. The quarterly reports will require you to submit your actual distribution of funds to these provider categories on a quarterly basis.

- These quarterly submissions of actual funds distribution will ultimately be required at the provider level (as opposed to the provider type level required here)

- In the 'Waiver Revenue' row, you should enter your expected waiver revenue, based on your project valuations

- Actual distribution of funds may vary from these forecasts over the course of the DSRIP program. PPSs will therefore be able to revise these forecasts through the quarterly reporting process.

If the forecast funds flow that you set out here deviates from the approach to the distribution of DSRIP funds that you articulated in your application you must explain this variance below.

The PPS and PPS Lead Administration costs from the Project Plan Application are shown in the "All Other" Item below.

Funds Flow Items	DY1	DY2	DY3	DY4	DY5	TOTAL
Waiver Revenue	$ 17,115,920	$ 17,722,581	$ 23,789,194	$ 21,969,210	$ 17,115,920	$ 97,712,825
Primary Care Physicians	$ 305,482	$ 903,587	$ 1,419,985	$ 1,285,490	$ 1,874,164	$ 5,788,707
Non-PCP Practitioners	$ 305,482	$ 935,587	$ 1,699,985	$ 1,485,490	$ 2,355,368	$ 6,781,912
Hospitals	$ 569,609	$ 1,821,516	$ 3,843,551	$ 3,251,108	$ 5,549,719	$ 15,035,503
Clinics	$ 589,534	$ 1,463,976	$ 2,438,417	$ 2,834,399	$ 3,242,255	$ 10,568,582
Health Home/Care Management	$ 1,042,215	$ 2,864,429	$ 2,934,022	$ 3,021,037	$ 3,110,643	$ 12,972,346

Behavioral Health	$ 624,055	$ 1,779,154	$ 2,316,825	$ 2,208,928	$ 2,824,991	$ 9,753,952
Substance Abuse	$ 208,018	$ 603,718	$ 865,608	$ 802,976	$ 1,102,065	$ 3,582,386
Skilled Nursing Facilities/Nursing Homes	$ -	$ 32,000	$ 280,000	$ 200,000	$ 481,205	$ 993,205
Pharmacies	$ -	$ 32,000	$ 280,000	$ 200,000	$ 481,205	$ 993,205
Hospice	$ -	$ 32,000	$ 280,000	$ 200,000	$ 481,205	$ 993,205
Community Based Organizations	$ 591,848	$ 1,578,262	$ 1,625,610	$ 1,674,378	$ 1,724,610	$ 7,194,708
All Other	$ 4,154,655	$ 5,336,742	$ 5,195,090	$ 4,257,591	$ 4,111,040	$ 23,055,116
Total Funds Distributed	$ 8,390,897	$ 17,382,970	$ 23,179,093	$ 21,421,397	$ 27,338,468	$ 97,712,825
Undistributed Revenue	$ 8,725,023	$ 9,064,634	$ 9,674,735	$ 10,222,548	$ -	$ 0

General Project implementation section

This General Project Implementation section will apply across all of your DSRIP projects. In this section you describe your PPS's overall approach to the implementation of your DSRIP projects, as well as some of the factors that will apply to all projects – such as your PPS's approach to prject performance monitoring. You will be required to provide an update on these headings in each quarterly report, although there will be no specific achievement value attached to these updates.

Overall approach to implementation

Please summarize your intended approach to the implementation of your chosen DSRIP projects, including considerations around how this approach will allow for the successful development of concurrently implementing DSRIP projects

The overall approach to implementation is based on the Collective Impact model of social innovation. As described by the Stanford Social Innovation Review, collective impact is "the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem…. Unlike most collaborations, collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants."

The centralized infrastructure is represented by the five-committee structure of the NYP PPS Collaborative Contracting Model of governance: Executive Committee, Finance, IT/Data Governance, Clinical/Operations and Audit/Corporate Compliance ("Governance Committees"). The Executive Committee is the entity from which all PPS functions receive their guidance and to which they ultimately report. The remaining four committees are responsible for executing the Executive Committee's vision and implementing and monitoring the projects.

The NYP PPS has established a Project Management Office (PMO) consisting of dedicated staff who will work across the PPS to provide the operational and project management aimed at ensuring all milestones and metrics are met as well as aligning the clinical and operational standards under which the entire PPS will operate. This staff will be led and managed by NYP's VP, Integrated Delivery System, who will also at as the PPS Executive Lead on the Executive Committee.

Work, however, will be done at the local level. Each of the 10 Project Leads (clinical, operational and administrative staff such as Service Line leaders and providers) will be supported by individual Project Managers sitting inside the PMO. This dyad will be responsible for designing the implementation plan in close collaboration with Network Members, executing day-to-day project operations and shepherding the projects through a structured process designed to ensure success of the program through a common agenda, shared measurement and mutually reinforcing activities among the Project Leads, Network Members and project teams. The PMO will continue regular meetings with all Project Leads to discuss ideas, issues and roadblocks as well as to ensure provider inclusion and commitment to the goals of the PPS.

The Project Managers and Project Leads will report regularly to the Governance Committee on implementation metrics (e.g., number of staff hired/trained, outreach efforts, encounters) and relevant quality and outcome metrics (e.g., HIV viral load suppression). All of the projects will be connected through the broader processes taking place across the PPS and monitored by the PPS Executive Committee. These broader processes include but are not limited to: IT infrastructure development; workforce training and management; and Medicaid MCO negotiations and contracting.

Major dependencies between work streams and coordination of projects

Please describe how your approach will handle interdependencies between complementary projects, as well as between projects and cross-cutting PPS initiatives - for example, an IT infrastructure upgrade, or the establishment of data sharing protocols.

The most significant interdependency among projects has to do with the IT infrastructure necessary to support the development of an integrated delivery system for the NYP PPS's atributed Medicaid population. Ensuring that patients receive optimal care will require providers across the PPS to have the most accurate information about the current state of the patient—including the patient's clinical and utilization data and the names of other providers and CBOs involved in the patient's care—so that the care provider can make appropriate care decisions and use available resources most effectively. The NYP PPS IT/Data Governance Committee, jointly led by NYP's Corporate Director of Analytics, Ambulatory Care Network Chief Medical Officer and a to-be-determined Network Member, will be responsible for overseeing the implementation of the IT Infrastructure and reporting progress regularly (at least bi-monthly) to the NYP PPS Executive Committee. Note: If we receive less funding than expected from the CRFP, we will likely fund development out of DSRIP operational proceeds on a reduced scale. This will slow down the IT roll-out and may also negatively impact project outcomes.

The PPS's Workforce Strategy will provide an opportunity for cross-project collaboration. Two examples are technical training and cross-project hiring. First, most DSRIP projects depend on the successful implementation of new software systems, including EHRs, the care coordination platform Allscripts Care Director (ACD) and access to the Healthix RHIO. New and existing workers at all levels will need technical training and engagement support to ensure that impacted staff are ready, willing and able to succeed with the new system. To address this challenge, the NYP PPS will retain the 1199SEIU League Training and Employment Funds (TEF) as the lead workforce development provider. Using TEF's expertise in this area, the PPS will provide training to incumbent workers who need additional skills to do existing jobs and develop training for new staff. Training will also be delivered by external resources from the community or by the NYP internal training department (Talent Development). For some projects, we plan to engage with the NYC Department of Mental Health and Hygiene to assist in technical training (see Project 4.b.i). Software vendors such as Allscripts

and Healthix will also conduct their own user training. Second, several projects are hiring individuals who will work across projects. Examples include the full-time Spanish/English interpreter to be shared by the two Behavioral Health projects (3.a.i and 3.a.ii) and the full-time Program Manager to be shared by the two HIV projects (3.e.i and 4.c.i). We have established a Workforce Committee which will provide overall direction, guidance and decisions related to the workforce transformation agenda.

Cultural Competency and Health Literacy training is a key to the success of all projects. The NYP PPS has adopted a patient-centered approach to cultural competency, aligned with the National Quality Forum's (NQF) framework, which we will expand to our Network Members. The NYP PPS will train frontline staff and physicians involved in DSRIP projects to provide care that respects patients' "Culture of One." This approach treats patients as individuals whose culture is unique and a result of multiple social, cultural and environmental factors and avoids racial or ethnic stereotyping. The methodology stems from seminal research published by Dr. Emilio Carrillo, VP, Community Health in 1999 and is used internationally as the basis for cultural competency training. Additionally, providers and staff in certain projects will receive supplemental training on sensitivities related to specific target populations. For example, those involved in Project 3.g.i (Integration of Palliative Care into PCMHs) will receiving training on how to deal sensitively with patients facing advanced illnesses and their families. Those involved in Projects 3.e.i and 4.c.i (HIV/AIDS) will receive training that will include education on HIV as a disease, gender identity, substance abuse issues and disability issues. To ensure standardized training across all staff, the Community Health and Human Resources functions at NYP will work together to design and implement a training schedule, to be approved by the Clinical/Operations Committee. In addition, NYP and ASCNYC are partnering to develop a Peer Training Institute which will be a PPS center for Community Health Worker, Patient Navigator, Health Educator and Interpreter training serving all NYP PPS projects and Network Members.

Overlapping goals and requirements of different projects could lead to duplicate efforts without strong, centralized planning and management. For example, managing transitions of care more effectively will be a central part of multiple projects, and without a proactive approach to our Care Transitions Strategy there is a risk that different protocols will be developed at different sites or in different projects. Many projects also share same or similar project requirements (e.g. 30-day Care Transitions and Ambulatory ICU). To address this issue, the Clinical/Operations committee has been charged with defining: standard care protocols for transitions of care; standards for information exchange across the PPS; communication plans to Network Members, community stakeholders and Medicaid beneficiaries; and standard performance measures and feedback mechanisms.

In addition, we will map out all of the project requirements affecting our committed providers and develop a "heat map" of the project requirements that show where they cross-cut and which providers will be involved in the most projects. For those project requirements that are most pervasive, we will set up specific teams tasked with driving consistent, coordinated implementation. For example, we know already that achieving PCMH 2014 Level 3 certification is a requirement for many projects. We will set up a dedicated PCMH Certification Team that will be responsible for all relevant providers meeting this project requirement according to the timetable set out in our project speed of implementation forecasts. This team will be led by NYP's VP for Community Health, Dr. Emilio Carillo, who has significant experience transforming the 13 NYP

speed of implementation forecasts. This team will be led by [illegible] for Community Health, Dr. Emilio Carrillo, who has significant experience transforming the 15 NYH Ambulatory Care Network clinics to NCQA PCMH designation as well as supporting numerous community providers in their PCMH journey. Dr. Carillo will work closely with the IT team, which will be rolling out the infrastructure to achieve these PCMH goals.

There are three primary PPSs that overlap with ours: Mount Sinai PPS, New York City's Health and Hospital Corporation's PPS ("One Health NYC") and Advocate Community Partners (ACP). During the Design Grant phase we met with both Mount Sinai and HHC about potential project overlap and collaborations. In both instances it was agreed that starting in DY1 we would meet to explore operational and infrastructure opportunities such as the development of common clinical protocols for those projects where we have overlap, shared training resources, a common approach to leveraging the RHIO and a general "best practices" sharing. In addition, we have met with Advocate Community Partners to understand their PPS and describe our projects/vision for the PPS, particularly with respect to the Lower Manhattan service area. We have also started conversations with the New York Hospital Queens Performing Provider System; NYHQ is a new member of the NewYork-Presbyterian Healthcare System and, given the close tie between the two PPS Lead institutions, we will work to develop common platforms and workflows. Finally, we plan to use the MRT Innovation eXchange (MIX) to collaborate with other PPSs and build solutions to the complex challenges we will face as we implement our DSRIP projects.

For Tobacco Cessation (Project 4.b.i), we have joined with the NYC Department of Health and Mental Hygiene, in the project coordination role, to implement media campaigns and technical training. The other PPSs in this collaboration include: Advocate Community Partners, Lutheran Hospital and North Shore Hospital System. Though no overlapping PPSs in the NYP PPS service area are undertaking Decrease HIV Morbidity (Project 4.c.i), a few in NYC are tackling Project 4.c.ii, "Increase early access to, and retention in, HIV care." We will work to coordinate efforts with existing and ongoing initiatives in our service area, including the NYSDOH AIDS Institute NYLinks project and the End of AIDS campaign.

Overview of key stakeholders and how influenced by your DSRIP projects

In the below table, please set out who the key stakeholders are that play a major role across multiple DSRIP projects. Please give an indication of the role they play and how they impact your approach to delivering your DSRIP projects.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals driving/managing the projects, whereas the 'Key Stakeholders' table is for the people/organizations with a stake in the projects, but who are not responsible for driving them.

Key stakeholders	*Role in relation to your DSRIP projects*	*Key deliverables / responsibilities*
David Alge, VP Integrated Delivery System	***DSRIP Executive Lead***	***Oversight of the DSRIP initiative for the PPS***

Debora Marsden, Compliance Officer	*PPS Lead - Compliance* *PPS Lead - Audit*	*Oversight of Compliance and Audit functions, staffing and deliverables*	
Clinical Leadership at PPS Lead and Network Member organizations (post-acute, primary care, behavioral health, substance abuse, etc.)	*Champions for new roles, processes, technology and data*	*Participation in PPS Clinical Operations Committee, ad hoc work groups, the PAC and in other public forums to champion the change*	Clinicians
Practitioners	*Users of new roles, processes, technology and data*	*Provide feedback including recommendations for streamlining and sustainability*	
1199 SEIU; NYSNA	*Labor Representation*	*Expertise and input around job impacts resulting from DSRIP projects*	Workforce Transformation
1199 SEIU Training & Employment Funds (TEF)	*Workforce Training - Lead Workforce Training Vendor*	*Technical training curriculum development; recruiting support*	
Eliana Leve, LCSW, MA, CASAC	*Deputy Executive Director for Programs, AIDS Service Center NYC*	*Development of Community Health Worker Peer Training Institute in Upper Manhattan.*	
Ron Phillips	*Chief Human Resources Officer, NYP*	*Support Workforce Strategy implementation in each project*	
Andrea Procaccino	*Chief Learning Officer (Head of Training and Development), NYP*	*Support Workforce Strategy, Cultural Competency adoption in each project*	
NYC DOHMH, Software Vendors	*Training Vendors*	*IT Technical Training*	

RHIOs (Healthix, BRIC)	*IT Infrastructure*	*PPS- and city-wide provider communication*	IT
Aurelia Boyer	*Chief Technology Officer, NYP*	*Overseeing all IT implementation*	
Various PPS Network Members (rotating)	*All PPS Standing Committees*	*Oversight of PPS Standing Committee Roles*	
PPS CBO Network Members	*Provider of enhanced roles under population health*	*Bring expertise related to social determinants of health to PPS in design of population health strategy*	Community Insight
PAC	*PAC membership*	*Represent PPS members interests and understand community needs*	
Groups that address the social determinants of health (e.g., DOHMH, End of the Epidemic Taskforce, NYS Quitline and others)	*Social determinants of health and clinical integration*	*Resources, expertise and perspective on statewide approaches to addressing social determinants of health*	
Groups involved in care management/care coordination of populations (e.g., NY e-Health Collaborative)	*Care management/care coordination and clinical integration*	*Resources, expertise and perspective on statewide approaches to addressing care management/care coordination for Medicaid population*	
Community Needs Assessment Team	*Emilio Carillo MD and Victor Carillo*	*Support the identification of resource gaps in the community*	
NYS DOH	*Driver of population health approach for Medicaid population*	*Facilitate population health collaboration statewide*	

MCOs	***VBP stakeholder***	***Provide insight and expertise into population health management approaches that may be relevant to NYP PPS***
Other PPSs	***Beneficiaries of and contributors to pop health success***	***Collaborate to enable cross-PPS integration/visibility***

Other Agencies and Organizations

Roles and responsibilities

Please outline the key people & organizations that play a role in the delivery of your PPS's DSRIP projects, as well as what their responsibilities are regarding governance, implementation, monitoring and reporting on your DSRIP projects.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals driving/managing the projects, whereas the 'Key Stakeholders' table is for the people/organizations with a stake in the projects, but who are not responsible for driving them.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
Project Leads and Key Network Members	***Elaine Fleck MD, Adriana Matiz MD, Peter Steel MD, Jordan Foster MD, Patricia Peretz, Peter Gordon MD, Sam Merrick MD, Veronica Lestelle, Craig Blinderman MD, Ronald Adelman MD, Barbara Linder, Dianna Dragatsi MD, David Albert DDS and Julie Mirkin RN plus key Network Members TBD***	***Provide expertise and leadership for development and implementation of projects***

PMO	***Isaac Kastenbaum, Director Strategy, NYP and Director of NYP PPS PMO***	***Provide project management coordination and facilitation so that strategy is consistent and efficient across projects***
IT	***Niloo Sobhani, Corporate Director IT, NYP and Gil Kuperman MD, PhD, Director Interoperability Informatics, NYP***	***Develop and implement IT infrastructure needed for success of projects***
PCMH Certification Team	***Emilio Carillo MD, VP Community Health, NYP***	***Drive the implementation of NCQA 2014 Level 3 PCMH certification across the PPS***
Community Health Department	***Emilio Carillo MD, VP Community Health, NYP and Victor Carrillo, Director Community Health, NYP***	***Design and implement cultural competency training across the PPS***
NYP ACN	***Rob Guimento, VP NYP ACN and Brian Kurz, NYP ACN Finance, NYP***	***Oversee the increase in capacity at ACN practices***
Workforce Sub-Committee	***Eric Carr, HR Director NYP and others TBD***	***Develop (re)training and recruitment; develop and implement change management strategy***
Legal	***Cheryl Parham, Lead Counsel, NYP***	***Pursue regulatory waivers and relief on behalf of projects; ensure contracts among Network Members and with vendors are sufficient***

Managed Care Office	***Dov Schwartzben, SVP Managed Care, NYP***	***Lead conversations and negotiations with MMCOs***

IT requirements

Information technology will play a crucial role in the development of an effective, integrated performing provider system. It is likely that most projects will require some level of supporting IT infrastructure. Please describe the key elements of IT infrastructure development that will play a role in multiple projects.

Over five years, the NYP PPS plans to invest $13.3 million of its DSRIP funds and $6.5 million in capital funding through the CRFP Grant and a 100% NYP match (pending approval) to develop connectivity across the PPS. (Note: If we receive less funding than expected from the CRFP, we will likely fund development out of DSRIP operational proceeds on a reduced scale. This will slow down the IT roll-out and may also negatively impact project outcomes.) The work has seven main components:

1. Work Flow Support for Care Coordinators . The PPS will extend the Allscripts Care Director (ACD) care coordination platform to multiple Network Members. The application enables care coordinators to care for registries of patients; manage tasks related to those patients; and document assessments, care plans, problems, goals, interventions and future tasks. The application includes embedded guidelines to ensure adherence to appropriate care.

2. EHR Enhancements . The inpatient and outpatient EHR at NYP, Allscripts Sunrise Clinical Manager (SCM), will be enhanced to support the work flows of physicians and nurses. Alerts and reminders will be created to notify these care providers about patients that are eligible for specialized services. For example, SCM will notify the physician and nurse when they are seeing a patient who is in the Ambulatory ICU program or who is eligible for ED triage services. The EHR also will be enhanced to enable specialized documentation templates so that quality data or other information relevant to the DSRIP program (e.g., tobacco cessation counseling, order sets for patient navigators) can be captured.

3. Support for Community Health Workers (CHWs) . Culturally competent CHWs will serve as a link between patients and medical/social services. The CHWs will see patients in their homes and document their findings, e.g., psychosocial issues that may be hurdles to the delivery of optimal care and recommendations for referrals to community-based organizations. Because CHWs are mobile, a wireless-enabled tablet-based application is necessary for documentation. After a requirements-gathering process, hardware and software will be selected, the application will be implemented and CHWs will be trained in the use of the hardware and application. The application will allow both free-text and structured documentation approaches. The PPS will leverage lessons learned as part of a NYS eHealth Collaborative Digital Health Accelerator project in which NYP piloted electronic documentation for CHWs.

4. Health Information Exchange . NYP currently connects to the State Health Information Network for New York (SHIN-NY) via its regional health information organization (RHIO), Healthix. Currently, only a minority of NYP PPS Collaborators are Healthix participants. Sixty-nine (69) Collaborators will join Healthix and participate in SHIN-NY-based health information exchange activities. Thirty-four (34) of those organizations will contribute their full clinical data set to Healthix so that other Collaborators can use those data. Twelve (12) organizations will contribute encounter data, so records of encounters can be tracked by the RHIO. The remaining 23 organizations will contribute patient lists to Healthix so they can view the data of other Healthix participants. The NYP PPS will also leverage direct exchange technologies to share patient information, when appropriate, across its network members.

5. Data Interfaces . We will create additional data interfaces—including inter-application interfaces—to increase data availability to members of the care team. Examples include the ability to: (1) upload files to the NYP Enterprise Master Patient Index so that attributed patients and patients enrolled in each of the DSRIP projects can be identified; (2) transmit specialized documentation data from the EHR to ACD to be shared appropriately with Collaborators across the continuum; and (3) transmit data in structured form from ACD and the EHR to the NYP analytics platforms so that management and quality reports can be created.

6. Enhancements to Patient Portal . MyNYP.org, NYP's PHR, will serve as the patient portal for patients enrolled in Ambulatory ICU programs. We will create specialized, relevant content to improve health literacy such as asthma-related materials for parents of asthmatic children and information about managing multiple chronic diseases for adults. The content will be clinically oriented but also provide information about Collaborators and social services available.

7. Analytics Platform . The analytics platform will provide population health management capabilities for the PPS. The platform will identify eligible patients, receive identifying information from NYS and combine it with NYP medical records and PPS-wide care coordination platform data (see #2). Analysts will create data marts that—with graphical front-end tools—will provide management reports, quality reports, reports for regulatory reporting purposes, lists of patients meeting specific criteria that need care coordination services and predictive models that identify likely high utilizers of care. This process will be highly coordinated with the State's MAPP tool and other analytic platforms.

Performance monitoring

Please explain how your DSRIP projects will fit into your development of a quality performance reporting system and culture.

From NYP's population health experience, we understand that effective rapid-cycle evaluation (RCE) is critical to the success of the NYP PPS's DSRIP projects. Effective RCE requires: (1) clear definitions and benchmarks for performance measurements; (2) developing the appropriate data governance standards; (3) scheduling regular meetings to review performance data; and (4) focusing on both process and outcomes data.

The NYP PPS Clinical/Operations Committee will be responsible for reporting on PPS performance, both at an individual project level and at a network level. This Committee will be led by one NYP representative and one community provider or CBO Collaborator, with membership including representation from all Collaborators. This group will report directly to the Executive Committee and receive analytical support from the IT/Data Governance Committee and the PMO. The Finance Committee will also monitor financial performance (revenue and expenses) of the PPS. Both committees will report on the "State of the PPS" at bi-monthly committee meetings and at Executive Committee meetings.

The NYP PPS will use a variety of analytics tools (Microsoft Amalga, Tableau, SAS, etc.) to develop reports that monitor process and outcome measures with data from the Hospital EHR, Allscripts Care Director (care management platform), the Healthix RHIO and implementation reports. These reports, including baseline, current and target performance metrics, will be available on the PPS's intranet website. Performance data will be reviewed at weekly PMO meetings and bimonthly Clinical/Operations Committees; to achieve necessary targets, each group will develop a plan-do-study-act (PDSA) cycle for metrics that are not achieving their goals. Any major tweaks to project activities will be reviewed by the Executive Committee and the NYS DOH, when appropriate. We recognize that we will need to monitor performance starting April 1, 2015; clearly our reports will not be deployed at that point. To address this challenge, we will prioritize reporting needs and roll them out incrementally, likely beginning toward the end of DY 1. In the interim, we will rely on the State's data via the MAPP portal to benchmark ourselves against other PPSs as well as compare Network Members' progress internally.

For those providers with limited EHR connectivity, the NYP PPS will provide material financial support to help them integrate technology into their workflows. The NYP PPS will leverage its extensive experience bringing community providers to PCMH and MU standards, including training and education. In the interim, the NYP PPS will devote resources to ensuring that performance reporting occurs in low-tech ways (paper, interviews, etc.) to ensure that performance management and reporting includes alll PPS members.

Community engagement

Please describe your PPS's planned approach for driving community involvement in the DSRIP projects, how you will contract with CBOs for these projects, how community engagement will contribute to the success of the projects, and any risks associated with this.

The NYP PPS will drive community involvement in the DSRIP projects through the Provider Advisory Committee, or PAC. The PAC consists of 57 members, 23 from the community (e.g., local government, senior centers and churches), 31 from PPS provider (e.g., primary care, behavioral health and long-term care providers) and three members from two labor unions. The PAC met monthly through the design/planning period; it will continue to meet quarterly through the five DSRIP years. The most recent agenda included such topics as a presentation on regional and PPS IT capabilities and plans, best practice experience in readmission reduction from a Network Member, key community workforce needs and capabilities, and a presentation from the NYC DOHMH Primary Care Information Program.

In addition, Medicaid beneficiaries will be able to provide feedback on PPS performance, including the addition/removal of Collaborators through two methods: (1) submitting feedback through a regularly scheduled PAC meeting directly or through a representative; or (2) submitting feedback through the NYP PPS public website. All comments will be reviewed by the PMO and presented to the Executive Committee every other month. Patient satisfaction scores measured by PressGaney will also be used to incorporate patient feedback.

Network members, including CBOs, are critical collaborators in the NYP PPS. The PPS is contracting with between three and six CBOs —such as Community League of the Heights, ASCNYC and Northern Manhattan Improvement Corporation—to hire more than 35 Community Health Workers (CHWs), health educators and interpreters. CHWs—the largest of this workforce at nearly 30 staff—are trained, local community members who provide diagnosis-specific education in a linguistically and culturally appropriate manner to patients and families. They can also assess non-medical causes of hospital utilization, such as lack of transportation or food insecurity. Where necessary, trained interpreters will be hired to avoid the pitfall of "false fluency" and the pitfalls and limitations of using family interpreters or bilingual providers as ad hoc interpreters. We expect to enter into contracts for CHW and related staff during DY1. Contracted CBOs for CHWs and related staff will be included in project delivery plans from inception. Involvement will include role definition, training requirements, standards of practice, compliance and quality expectations. These CBOs will help anchor our PPS network in the communities we serve.

The PPS may contract with other CBOs for non-CHW and related staff services. Contracts under consideration include God's Love We Deliver, an organization that can provide medically-appropriate meals for beneficiaries impacted by 2.b.i and 2.b.iv; Meals on Wheels which provides screening and referral program for tobacco-using homebound recipients of their services and can impact 4.b.i; Washington Heights CORNER Project which, through outreach and needle exchange programs, can reach

People Living with HIV/AIDS (PLWH) and others at risk for HIV/HCV/STIs who we seek to engage through 3.e.i and 4.c.i; and Charles B. Wang Community Health Center, which may establish a tobacco cessation clinic to promote cessation for the Chinatown population under 4.b.i. We would expect these contracts to be in place by Q1DY2. Contracted CBOs for non-CHW staff or services will be included in project delivery plans from inception. Involvement will include process flow, IT enablement, reporting needs, educational materials and other beneficiary collateral, compliance and quality expectations. These CBOs will help extend the reach of our PPS network in the communities we serve.

Community engagement will contribute to the success of the projects in two ways:
1. Members of the PAC are often closer to the ground than are the members of the NYP PPS Executive Committee or even the project leaders. This forum will be critical to hearing feedback—positive and negative—about which aspects of our projects are working and which are not. The PAC might also be a source of referrals for hard-to-recruit positions.
2. CHWs, contracted directly from CBOs, are a critical element of the NYP PPS DSRIP endeavor. Many of the gaps in access and navigation we identified in our Community Needs Assessment are not structural but the result of healthcare access barriers grounded in cultural and social determinants of health. These barriers—including language and literacy—affect patients' use of the system and ultimately their health outcomes. Culturally competent and well-trained CHWs are a big part of the answer to this issue. Without them, we cannot be successful.

There are three primary risks associated with our community strategy:
1. Member Engagement. If the PPS does not communicate its vision effectively with Network Members and the Community, we may lose the interest and dedication of the very individuals and organizations who will ensure the projects are a success. That is why we are committed to providing a regular forum (the PAC) for feedback as well as informal feedback channels through the relationships we have developed in the community. Over the last ten years, the NYP Community Health department has been active in developing PCMHs in the community, launching and refining its Patient Navigator and Community Health Worker programs (such as WIN for Asthma) and working with local government. Members of these organizations and constituencies can pick up the phone at any time to address concerns with NYP leadership in addition to formal feedback at the PAC.
2. CBO Sustainability. We recognize that some of the CBOs with whom we will contract are financially fragile. The NYP PPS Finance Committee will develop a monitoring process for those providers identified as potentially vulnerable (see Financial Sustainability workflow). The PPS budget and flow of funds plan provides the financial support necessary to support all providers as they work with the PPS on project-specific goals and deliverables. In those instances where the Executive and Finance Committees of the PPS think it an appropriate use of DSRIP funds, the PPS Finance Committee (or designee) will work with a provider facing financial instability to develop a sustainability plan.
3. Competition for Resources. We anticipate high demand for capable Community Health Workers. For CHWs, the PPS will apply a "search-firm-like" approach to source and

recruit top talent in collaboration with the host CBOs. This approach entails dedicated staff that will rigorously identify qualified candidates through networking, research and constant pursuit of a pipeline matching the position specifications. More importantly, we have been contracting with CBOs for these kinds of positions for years and have built solid relationships with such organizations as Dominican Women's Development Center and Northern Manhattan Improvement Corporation, which will aid us in our search.

4. New Population. NYP has limited experience with the Asian population that lives in Lower Manhattan, home to its newest hospital, NYP/LM. The service area is 25% Asian. The majority of Asian people are of Chinese origin (75% of the Asian population; 18% of the total service area). Almost a third of the population is foreign-born, 60% of which originate from Asian countries. Twenty percent of the population speaks an Asian language, of which 65% speak English less than "very well." To ensure success with the Asian and Asian-American population in Lower Manhattan, the PPS will work with Charles B. Wang Community Health Center to find and source appropriate CHWs and Patient Navigators (for the EDs).

2.a.i - Create an Integrated Delivery System focused on Evidence Based Medicine and Population Health Management

1. Measurable milestones and implementation risks

Sub-section 1. Major risks to implementation and mitigation strategies

Please describe what the major risks are for this project, as well as the actions that you plan to take to mitigate them.

DSRIP Funding : The NYP PPS DSRIP calculated its project budgets based on communications from the State regarding both the PMPM and the preliminary attribution for the NYP PPS. We conducted sensitivity analyses, including the effects of a lower PMPM, lower-than-expected Domain 1 achievement values and lower-than-expected Domain 2 and 3 quality and clinical outcomes measures. The actual reduction in funding of 21% due to the change in attribution methodology and, possibly, a change in PMPM has resulted in a budget contraction of a similar magnitude. At the same time, there has been no communication regarding relief from any DSRIP reporting or performance requirements. Given that the fixed costs of DSRIP management and technology infrastructure have not changed, we remain concerned about the negative impact on our ability to sustainably implement the ten projects chosen and developed by the PPS during the application phase and the impact lower funding could have on our community providers and CBOs. Mitigation strategies include encouraging the State to address reporting and performance requirements in light of this significant funding decrease and conservative planning and expectation-setting across the PPS.

IT Connectivity . A major implementation risk will be IT connectivity across the PPS Network Members, each with different software platforms or limited IT capabilities. To mitigate this risk, the NYP PPS plans to invest $13.3 million of its DSRIP funds and $6.5 million in capital funding through the CRFP Grant and a 100% NYP match (pending approval) to develop connectivity across the PPS. Plans include: a) extending NYP's care coordination application, Allscripts Care Director (ACD), to multiple Network Members; b) connecting nearly 70 Network Members to the local RHIO and SHIN-NY for tracking patients city-wide; and c) creating additional data interfaces between organizations that will increase data availability for members of the care team, e.g., the ability to transmit specialized documentation data from the EHR to ACD to share across the PPS. The PPS has developed a detailed timeline that includes a phased roll-out (e.g., largest and most integral Network Members will be first in line for ACD and Healthix connectivity) to ensure that the important work of DSRIP is still being done in the absence of a fully functioning system. IT funding will come from the first two DSRIP payments as well as NYP's own capital budget. If, however, we receive less funding than expected from the CRFP, we will likely fund the remainder out of DSRIP operational proceeds on a reduced scale. This will slow down the IT roll-out and may also negatively impact project outcomes.

Cultural Diversity . A risk to the success of the DSRIP program lies with the cultural diversity inherent in our PPS population. Much the NYP PPS service area is comprised of linguistically isolated ethnic and racial minorities. The gaps in access and navigation identified by the NYP PPS Community Needs Assessment are often the result of healthcare access barriers grounded in cultural and social determinants of health. These barriers affect patients' use of the system and ultimately their health outcomes. Dr. Emilio Carrillo, NYP's VP-Community Health, has done extensive research into these barriers, resulting in a comprehensive, evidence-based understanding of how they prevent access for minority and poor communities. The three types of barriers are reciprocally reinforcing and affect healthcare access individually or in concert. Each barrier is associated with low preventive screening, late presentation to care, lack of treatment and often improper utilization of healthcare services, which in turn result in poor health outcomes and health disparities.

To mitigate this risk, the NYP PPS has adopted a patient-centered approach to cultural competency, aligned with the National Quality Forum's (NQF) framework, which we will expand to our Network Members. The NYP PPS will train frontline staff and physicians involved in DSRIP projects to provide care that respects patients' "Culture of One." This approach treats patients as individuals whose culture is unique and a result of multiple social, cultural and environmental factors and avoids racial or ethnic stereotyping. The methodology stems from seminal research published by Dr. Carrillo in 1999 and is used internationally as the basis for cultural competency training. NYP/LM is a new partner in the NYP system with a predominantly Asian (25%, of which 75% are of Chinese origin) patient population. Collaboration with long-standing, experienced leaders in the community such as Charles B. Wang Community Health Center as well as the NYC Department of Health and Mental Hygiene will allow us to effectively engage this specific population. Finally, we intend to co-invest with the State through the CRFP and with ASCNYC as the lead in a Peer Training Institute which will be a PPS center for CHW, Patient Navigator, Health Educator and Interpreter training serving all NYP PPS projects and Network Members. These types of workers are critical to mitigating the barriers presented by the cultural diversity of our attributed beneficiaries.

Increased Demand . We anticipate the risk of an increase in demand for NYP's and our Network Members' services, both of which are already stressed in some service delivery areas. There are two strategies to mitigate this risk and meet excess demand. First, we intend to expand primary, behavioral care and selected specialty care capacity through increased staffing levels, expanded practice hours and/or physical capacity expansion at four major PPS centers for outpatient care: the NYP Ambulatory Care Network clinics (including school-based clinics), Harlem United/Upper AIDS Ministry, St. Mary's Center and Community Healthcare Network. Such investment will increase the numbers of providers, particularly mid-level providers and care managers; fund Health Educators and Community Health Workers who build cost-effective service capacity; create exam rooms to accommodate additional patient volume; create a swing space for care managers, palliative care specialists and Community Health Workers; redesign registration areas to increase privacy and confidentiality; and upgrade waiting areas to increase efficiency and patient education. And for those patients who need it, Isabella Geriatric Center has applied for funding to create a 16-bed hospice and residential unit in Upper Manhattan. The physical capacity expansion is dependent on funding applied for under the CRFP. If we receive less funding than expected from the CRFP, we will likely fund development out of DSRIP operational proceeds and organizations' capital budgets on a reduced scale. This will slow down the development of capacity and may also negatively impact project outcomes. (See below for a discussion of workforce shortages and our hiring strategy for getting these programs up and running.)

Second, we will build additional IT capacity and capability in our Network Members, allowing them to manage their volume more effectively, reduce duplication in services and care for patients in the non-acute setting. The hard asset investments are dependent on funding applied for under the CRFP and will enable NYP as PPS lead to deliver necessary infrastructure and support Network Members in their efforts.

Workforce Shortages . The risk of workforce shortages in the healthcare market is real. The national primary care physician shortage is projected to reach 12,500 to 31,100, according to a new study by the Association of American Medical Colleges and IHS. This scarcity is but one that exists in New York's marketplace, and these shortages will be exacerbated by demand for services brought about by the new DSRIP projects. In addition, a few of the NYP PPS projects require a very specialized workforce, which may be even more difficult to find immediately. For example, we will be looking for pediatric psychiatric NPs (Project 2.b.i) and palliative care specialists (Project 3.g.i). We will also be competing with other PPSs for Community Health Workers (CHWs), Patient Navigators (PNs) and other community-based talent. We will mitigate this risk in three ways. First, we have established a Workforce Sub-committee which will provide overall direction, guidance and decisions related to the workforce transformation agenda, including recruiting. Second, the PPS will apply a search-firm approach to source and recruit top talent. This approach entails dedicated staff that will rigorously identify qualified candidates through networking, research and constant pursuit of a pipeline matching the position specifications. One example of NYP's innovative sourcing strategy leverages its electronic candidate relationship management (eCRM) tool in which email messages are sent directly to potential prospects with information on the Hospital, department and open position. NYP will also host career events, such as professional conferences and interview days, dedicated to the type of human capital needed. Finally, NYP and AIDS Service Center have applied for funding to develop a new Community Health Worker Training Center in Upper Manhattan. We expect that the rigorous training and placement afforded by this Training Center will be a draw to potential candidates.

Meeting PCMH Standards . A requirement of this project is to ensure that appropriate providers meet NCQA 2014 Level 3 PCMH standards by the end of DY 3. This is a labor-intensive process. We will set up a dedicated PCMH Certification Team that will be responsible for all relevant providers meeting this project requirement according to the timetable set out in our project speed of implementation forecasts. This team will be led by NYP's VP for Community Health, Dr. Emilio Carillo, who has significant experience transforming the 13 NYP Ambulatory Care Network practices to NCQA PCMH designation as well as supporting numerous community providers in their PCMH journey. Dr. Carillo will work closely with the IT team, which will be rolling out the infrastructure to achieve these PCMH goals. For providers that have already met 2008 or 2011 Standards, the NYP PPS has a detailed roadmap in place regarding how to move providers to the next level, as NYP has a lot of experience transforming its own and community-based practices into NCQA 2011 Level 2 and 3 PCMHs. For providers who are at the beginning of the PCMH journey, the NYP Community Health department will work with them closely to develop an aggressive timeline and roll-out schedule to ensure that they are on target to meet or exceed the DY 3 requirement. One risk that is out of our hands is the amount of time the application will take to turn around once it is submitted. While we are hopeful that the State will fast-track these applications, we are counting the date of submission of the certification to NCQA as our commitment date, rather than the receipt of the certification.

PPS Integration . The size of the NYP PPS—from Network Member, staff and provider perspectives—will pose the classic management challenge of integration, e.g., gaining buy-in to the established governance structure and overcoming resistance to new tools. In addition, DSRIP will entail several cultural shifts in how providers deliver care, such as a shift from fee-for-service to value-based payments and a shift from unit-based, acute care to collaborating across a continuum of care with a focus on preventive care. The PPS may have difficulty obtaining support from frontline workers and key stakeholders, which in turn could impact DSRIP project success. To mitigate this risk, the NYP PPS has a developed a multi-faceted engagement approach to Network Member, staff and provider integration. Specifically, the PPS will:

1) Establish a Workforce Sub-committee, which will provide overall direction, guidance and decisions related to the workforce transformation agenda, including developing a change management strategy.

2) Develop cross-project functional groups (e.g., Finance, Workforce, PCMH Certification), project-specific groups (e.g., palliative clinical integration) and "stakeholder" groups (e.g., Primary Care Working Group, Community Health Worker Practitioner Group) to gain buy-in from Network Members and providers. These groups will be able to flag areas of resistance and refer them to PPS leadership if they cannot be resolved locally.

3) Engage union representation (1199 SEIU, NYSNA) to gain frontline and mid-level worker support. Both 1199 SEIU and NYSNA have had seats on the PPS Provider Advisory Committee (PAC) since its inception. We will also contract with 1199 SEIU Training and Employment Funds (TEF) to assist with change management at the frontline worker level.

4) Collaborate with external resources, such as other PPSs to create common language related to delivery system change strategies and tactics or case studies of successful initiatives, which may be available through the MIX platform.

2.b.i Ambulatory ICUs

1. Measurable milestones and implementation risks

Sub-section 1. Major risks to implementation and mitigation strategies

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

[Please enter response here]

Sub-section 2. Project Implementation Speed

*Please specify how many providers will have met **all** of the project requirements (as set out in the Project Plan Application) per quarter. PPSs will be required to provide a progress report on this in each quarterly report and submit evidence of their progress to the Independent Assessor. The PPS's performance against these targets will drive the 'Project Implementation Speed Achievement Value' for each payment period.*

Some project requirements are provider type-specific. A list of those project requirements that are provider type-specific will be published in due course.

Your count of providers meeting 100% of project requirements per quarter should be non-cumulative - i.e. each cell represents the number of providers meeting 100% of the project requirements in that quarter.

Project Implementation Speed table

	Total # providers committed (as per project plan application)	***No. of providers per category meeting 100% of project requirements per quarter***														
		DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Number of Ambulatory ICUs meeting all project requirements																

Sub-section 3. Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table

Expected # of actively engaged patients (total, as per project plan application)	*21170*														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	4,234	5,928	8,468	2,117	5,293	7,410	10,585	3,387	8,468	11,855	16,936	4,234	10,585	14,819	21,170

2.b.iii ED Care Triage for At-Risk Populations

1. Measurable milestones and implementation risks

Sub-section 1. Major risks to implementation and mitigation strategies

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

[Please enter response here]

Sub-section 2. Project Implementation Speed

*Please specify how many providers will have met **all** of the project requirements (as set out in the Project Plan Application) per quarter. PPSs will be required to provide a progress report on this in each quarterly report and submit evidence of their progress to the Independent Assessor. The PPS's performance against these targets will drive the 'Project Implementation Speed Achievement Value' for each payment period.*

Some project requirements are provider type-specific. A list of those project requirements that are provider type-specific will be published in due course.

Your count of providers meeting 100% of project requirements per quarter should be non-cumulative - i.e. each cell represents the number of providers meeting 100% of the project requirements in that quarter.

Project Implementation Speed table

	Total # providers committed (as per project plan application)	***No. of providers per category meeting 100% of project requirements per quarter***														
		DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Emergency Departments with Care Triage that meet all project requirements																

Sub-section 3. Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table

Expected # of actively engaged patients (total, as per project plan application)	*21497*															
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	5,375	6,450	10,750	4,000	8,000	12,000	16,000	5,374	10,748	16,122	21,497	5,374	10,748	16,122	21,497

2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

1. Measurable milestones and implementation risks

Sub-section 1. Major risks to implementation and mitigation strategies

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

[Please enter response here]

Sub-section 2. Project Implementation Speed

*Please specify how many providers will have met **all** of the project requirements (as set out in the Project Plan Application) per quarter. PPSs will be required to provide a progress report on this in each quarterly report and submit evidence of their progress to the Independent Assessor. The PPS's performance against these targets will drive the 'Project Implementation Speed Achievement Value' for each payment period.*

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Project Implementation Speed table

	Total # providers committed (as per project plan application)	***No. of providers per category meeting 100% of project requirements per quarter***														
		DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Primary Care Physicians																
Non-PCP Practitioners																
Hospitals																
Health Home / Care Management																
Community Based Organizations																
All Committed Providers																

Sub-section 3. Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table															
Expected # of actively engaged patients (total, as per project plan application)	***2538***														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	25	50	150	315	635	950	1,269	475	952	1,427	1,904	635	1,269	1,904	2,538

3.a.i Integration of Primary Care and Behavioral Health Services

IMPORTANT: Please select which model(s) you will pursue for this project by highlighting the cell(s) of the corresponding model(s) in YELLOW	Model 1 (PCMH)	**Model 2 (BH)**	Model 3 (IMPACT)

1. Measurable milestones and implementation risks

Sub-section 1. Major risks to implementation and mitigation strategies

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

[Please enter response here]

Sub-section 2. Project Implementation Speed

*Please specify how many providers will have met **all** of the project requirements (as set out in the Project Plan Application) per quarter. PPSs will be required to provide a progress report on this in each quarterly report and submit evidence of their progress to the Independent Assessor. The PPS's performance against these targets will drive the 'Project Implementation Speed Achievement Value' for each payment period.*

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Your count of providers meeting 100% of project requirements per quarter should be non-cumulative - i.e. each cell represents the number of providers meeting 100% of the project requirements in that quarter.

Project Implementation Speed table

	Total # providers committed (as per project plan application)	***No. of providers per category meeting 100% of project requirements per quarter***														
		DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Primary Care Physicians																
Non-PCP Practitioners																
Clinics																
Behavioral Health																
Substance Abuse																
Community Based Organizations																
All Other																
All Committed Providers																

Sub-section 3. Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table

Expected # of actively engaged patients (total, as per project plan application)	*2258*														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	0	0	113	0	452	700	1,355	300	847	1,100	1,693	600	1,129	1,600	2,258

3.a.ii Behavioral Health Community Crisis Stabilization Services

1. Measurable milestones and implementation risks

Sub-section 1. Major risks to implementation and mitigation strategies

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

[Please enter response here]

Sub-section 2. Project Implementation Speed

*Please specify how many providers will have met **all** of the project requirements (as set out in the Project Plan Application) per quarter. PPSs will be required to provide a progress report on this in each quarterly report and submit evidence of their progress to the Independent Assessor. The PPS's performance against these targets will drive the 'Project Implementation Speed Achievement Value' for each payment period.*

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Your count of providers meeting 100% of project requirements per quarter should be non-cumulative - i.e. each cell represents the number of providers meeting 100% of the project requirements in that quarter.

Project Implementation Speed table

	Total # providers committed (as per project plan application)	***No. of providers per category meeting 100% of project requirements per quarter***														
		DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Number of Crisis Intervention Programs meeting all project requirements																

Sub-section 3. Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table

Expected # of actively engaged patients (total, as per project plan application)	*1300*															
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	12	30	100	100	400	500	800	250	650	800	1,300	300	650	900	1,300

3.e.i Comprehensive Strategy to Decrease HIV/AIDS Transmission to Reduce Avoidable Hospitalizations—Development of Center of Excellence for Management of HIV/AIDS

1. Measurable milestones and implementation risks

Sub-section 1. Major risks to implementation and mitigation strategies

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

[Please enter response here]

Sub-section 2. Project Implementation Speed

*Please specify how many providers will have met **all** of the project requirements (as set out in the Project Plan Application) per quarter. PPSs will be required to provide a progress report on this in each quarterly report and submit evidence of their progress to the Independent Assessor. The PPS's performance against these targets will drive the 'Project Implementation Speed Achievement Value' for each payment period.*

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Project Implementation Speed table

	Total # providers committed (as per project plan application)	*No. of providers per category meeting 100% of project requirements per quarter*														
		DY1, Q2	DY1, Q3	DY1, Q4	DY2, Q1	DY2, Q2	DY2, Q3	DY2, Q4	DY3, Q1	DY3, Q2	DY3, Q3	DY3, Q4	DY4, Q1	DY4, Q2	DY4, Q3	DY4, Q4
Primary Care Physicians																
Non-PCP Practitioners																
Clinics																
Health Home / Care Management																
Behavioral Health																
Substance Abuse																
Pharmacy																
Community Based Organizations																
All Other																
All Committed Providers																

Sub-section 3. Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table

Expected # of actively engaged patients (total, as per project plan application)	*5040*															
	DY1, Q2	DY1, Q3	DY1, Q4	DY2, Q1	DY2, Q2	DY2, Q3	DY2, Q4	DY3, Q1	DY3, Q2	DY3, Q3	DY3, Q4	DY4, Q1	DY4, Q2	DY4, Q3	DY4, Q4	

Patients Engaged	1,723	2,336	3,445	867	1,941	2,600	3,882	1,083	2,165	3,248	4,330	1,260	2,520	3,780	5,040

3.g.i Integration of Palliative Care into the PCMH Model

1. Measurable milestones and implementation risks

Sub-section 1. Major risks to implementation and mitigation strategies

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

[Please enter response here]

Sub-section 2. Project Implementation Speed

*Please specify how many providers will have met **all** of the project requirements (as set out in the Project Plan Application) per quarter. PPSs will be required to provide a progress report on this in each quarterly report and submit evidence of their progress to the Independent Assessor. The PPS's performance against these targets will drive the 'Project Implementation Speed Achievement Value' for each payment period.*

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Project Implementation Speed table

	Total # providers committed (as per project plan application)	***No. of providers per category meeting 100% of project requirements per quarter***														
		DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Primary Care Physicians																
Non-PCP Practitioners																
Clinics																
Hospice																
Community Based Organizations																
All Other																
All Committed Providers																

Sub-section 3. Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table

Expected # of actively engaged patients (total, as per project plan application)	*2465*															
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	0	0	400	300	600	900	1,800	616	1,232	1,848	2,465	616	1,232	1,848	2,465