CITYWIDE PROJECT ADVISORY COMMITTEE (PAC) MEETING

March 14, 2018

NYC HEALTH+ HOSPITALS | ONE CITY HEALTH

Today's Discussion

- Follow-up from December 6th PAC Meeting
- Update on the Independent Assessor (IA) Visit
- Brief Updates
  - Phase II Closeout and Phase III Contracting Update
  - Partner Payments
  - Update on PPS Performance and Outcome Measures
  - Upcoming Dates and Events
- Remarks from Israel Rocha, CEO, OneCity Health
- Updates on Ongoing OneCity Health Initiatives
  - Innovation Fund Update
  - Social Determinants: Updates and Upcoming Opportunities
  - OneCity Health Learning Management System (LMS) Update
  - Cultural Competency and Health Literacy Update
- Update on Hospital and Community Integration

Today's Discussion

- **Follow-up from December 6th PAC Meeting**

Thank You for your Feedback at the December 6th PAC Meeting

- At our December 6, 2017 Project Advisory Committee (PAC) meeting, we received a number of questions focused on social determinants of health, opportunities to work closely with hospitals, and other ongoing initiatives
- Today's presentation includes status updates on important items raised at our last PAC meeting including:
  - New York State (NYS) Department of Health (DOH) partner types informed Phase III contracting partner types
  - Types of issues that are raised by partners through the OneCity Health support desk and how these issues are being addressed
  - Addressing social determinants of health via OneCity Health innovation Fund
  - Leveraging NowPow to identify partners in the PPS, where they are located, and the types of programs and services they provide
  - Formalizing and strengthening the interfaces between community and hospital partners

Today's Discussion

- Follow-up from December 6th PAC Meeting
- **Update on the Independent Assessor (IA) Visit**

Update on the Visit from the Independent Assessor (IA)

- The DSRIP Independent Assessor (IA) conducted onsite audits of all 25 New York State Performing provider Systems (PPSs) over the course of the last few months to review progress of implementation of DSRIP projects and assess the PPSs' overall progress toward meeting DSRIP goals
- This audit encompassed DSRIP year two activities as well as follow-up on Mid-Point Assessment Action Plan efforts
- The audit focused on 1) workforce strategy 2) finances and funds flow 3) review of sample data providing evidence of partner agreements and patient engagement 4) clinical data sharing and interoperability and, 5) a detailed walkthrough of Project 2.b.iv – Care Transitions to Prevent 30-Day Readmissions
- As part of their assessment, the IA randomly selected PPS partners participating in the Care Transitions to Prevent 30-Day Readmissions project to demonstrate the patient journey through this intervention
- Formal findings from all site visits are scheduled to be released in April 2018 and will be available on the New York State Department of Health's (NYS DOH) website

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Development of Phase III CSB Partner Types

OneCity Health utilized the NYS DOH definitions to inform the development of the partner types that informed the OneCity Health Phase III Comprehensive Schedules B (CSB)

- Identified the types of service(s) PPS partners provide and assigned the partner to the associated partner type whose services are the partner's the top revenue drivers
- For example, if 90% of a partner's revenue is from Nursing home, 5% from primary care, and 5% from home care, OneCity Health assigned the partner to the Nursing Home category

NYS DOH Provider Type Classifications

Rate	Definitions
Clinic	Free standing diagnostic and treatment centers (including FQHCs); also OASAS and OMH clinics providing medical services; *Some hospitals may be included primarily due to hospital labs ordered by community practitioners
Behavioral Health	Inpatient and Outpatient Mental Health, Psychiatric, Residential Treatment services
Hospice	Free standing hospice providers
Case/Care Management – Health Homes	Case Management (Early Intervention, OMH, OASAS, HIV/AIDS), Health Home
Hospital/Freestanding Inpatient/Rehab	Inpatient and Outpatient Hospital; Mental Health and Substance Abuse free standing inpatient services; Rehab Hospitals
SNF-Nursing Home	Nursing Homes & Rehab
Substance Abuse	Inpatient and Outpatient Substance Abuse
Pharmacy	Pharmacies
PCP & Non-PCP (Practitioner)	Physicians, Physician Practices, Nurse Practitioners, Dentists, Non Institutional Long Term Care Providers, other professional services
All Other	Home Health, OPWDD Inpatient and Outpatient, Labs (Including practitioners on lab claims), other

Phase II Closeout and Performance

To assist partners in successfully closing out their Phase II CSB, OneCity Health provided a one-time opportunity for to complete outstanding remediation and submission of Phase II metrics by March 5, 2018

- These submissions are now being reviewed by OneCity Health

OneCity Health is also in the process of determining partner payment eligibility for Phase II Patient Engagement Metrics

- Partners who are eligible for these payments will be notified when invoices are available for submission in the OneCity Health Partner Portal

Rate	Definitions	Phase II CSB Metric Submission Performance as of 2/28/18
Submission Rate	% of **assigned** Phase II CSB process and patient engagement metrics that were submitted by the deadline	**66%**
Remediation Rate	% of **submitted** Phase II CSB process and patient engagement metrics that were remediated	**17%**
Resubmission Rate	% of **remediated** Phase II CSB process and patient engagement metrics that were resubmitted	**87%**
Approval Rate	% of **submitted** Phase II CSB metrics that were approved for payment	**96%**
Total Assigned Metrics	Total number of Phase II CSB process and patient engagement metrics that were assigned to Phase II CSB partners	**3,111**

Improving Partner Inquiry Resolutions

- At our last PAC meeting, partners inquired about how we are analyzing and responding to the issues that come to the OneCity Health support desk
- OneCity Health has identified the following four areas that account for the majority of tickets created by the Support Desk, and has worked to improve our resolution of these issues in the following ways:

Category	Relevant Improvements
Navigating the Partner Portal Includes inquiries relating to partners requesting assistance with submitting contract metrics and accessing information in the Portal	To support partner metric submissions, the support desk utilizes WebEx (webinar technology) to trouble-shoot technical issues and educate partners on OneCity Health Partner Portal navigation
Confirmation of metric submission and invoice status Includes inquiries relating to the status of metric and invoice submissions	To provide real-time confirmation of metric submissions and invoice status, the support desk now has "read-only" access to the OneCity Health Partner Portal which allows them to view a partner's view into the OneCity Health Partner Portal
Understanding reporting requirements Includes inquiries relating to partners seeking additional guidance on what is required for reporting on a metric	To reduce issue resolution time and ensure that partners receive reporting guidance in advance of reporting deadlines, OneCity Health streamlined the escalation process for these issues
Requests for Portal access Includes requests from partners for access to the Portal	▪ To support partners in the registration process, the OneCity Health Partner Portal registration guide, previously included in the OneCity Health Partner Reporting Manual, was also posted to the OneCity Health website ▪ To ensure partner access to Phase III metrics in the Portal, the support desk proactively contacted all primary Portal users to confirm all organizational Portal users

Summary of Phase III Contracting Effort

- Phase III Comprehensive Schedule B (CSB) contracts were distributed to **169 partners** starting in late December with a January 1, 2018 effective date.
- OneCity Health made, at minimum, three outreach attempts to remind partners who had not signed to do so before the February 15, 2018 deadline, in addition to a "final notice" letter mailed to all partners who had not signed by the first week of February 2018

Activity	Phase I	Phase II	Phase III
CSB Issued	184 Partners	203 Partners	169
CSB Signed	173 Partners (94.5%)	193 Partners (95.1%)	167 (98.8%)
Contract Duration	9 Months	9 Months	2 Years, 3 Months
Total Partner Share of Funds Approved (Inclusive of Distinct Schedules B)	$55M	$85M	$162M
Percent Process/Outcome metrics	100% Process	75% Process, 25% Outcome	<50% Process >50% Outcome
Funds Allocation Methodology	Driven by Project selection	Driven by Project selection & Partner type	Driven by Primary Partner Type

Phase III: Project Implementation Support

- As we did at the start of Phase II, OneCity Health will again be reaching out to all of our Phase III CSB partners to schedule one-on-one Implementation support meetings
- In addition to these meetings, OneCity Health provides a variety of additional implementation support resources to assist our partners' implementation efforts including:

Implementation Materials and Resources

- Project Implementation Summaries
- Project Implementation Toolkits
- Project Overviews (e.g., pre-recorded webinars)
- Calendars of key dates
- OneCity Health website
- OneCity Health Partner Portal

Technical Assistance (TA) and Support

- Onsite or remote and group or one-to-one technical assistance and support
- Training opportunities
- Performance monitoring and improvement
- OneCity Health Support Desk

Partner Payments: Progress Update

Type of Allocation	Total Phase I Allocation (July 5, 2016 – March 31, 2017)	Total Phase I Paid to Partners (as of March 9, 2018)	Total Phase II Allocation (April 1, 2017 – December 31, 2017)	Total Phase II Paid to Partners (as of March 9, 2018)
Comprehensive Schedule B (CSB) (excluding patient engagement)	$28.5M	$27.2M	$64.6M	$37.8M
Distinct Schedule B	$18.6M	$5.4M	$10M	$.2M
Patient Engagement	$8M	$5.7M	$10.4M	$0M
TOTAL	$55.1M	$38.3M	$85M	$38M

Overview of Outcomes Measurement

There are a total of 57 outcome measures tied to the DSRIP program:

- Outcome measures are distinct measures defined by the NYS DOH as requirements of the DSRIP program
- The PPS becomes eligible for DSRIP funds upon the successful achievement of these measures
- Outcome measures are our goals as an overall PPS, do not require reporting by individual partners, and performance id determined by NYS DOH analysis of Medicaid claims data

For the Phase III CSB, OneCity Health prioritized 25* outcome measures:

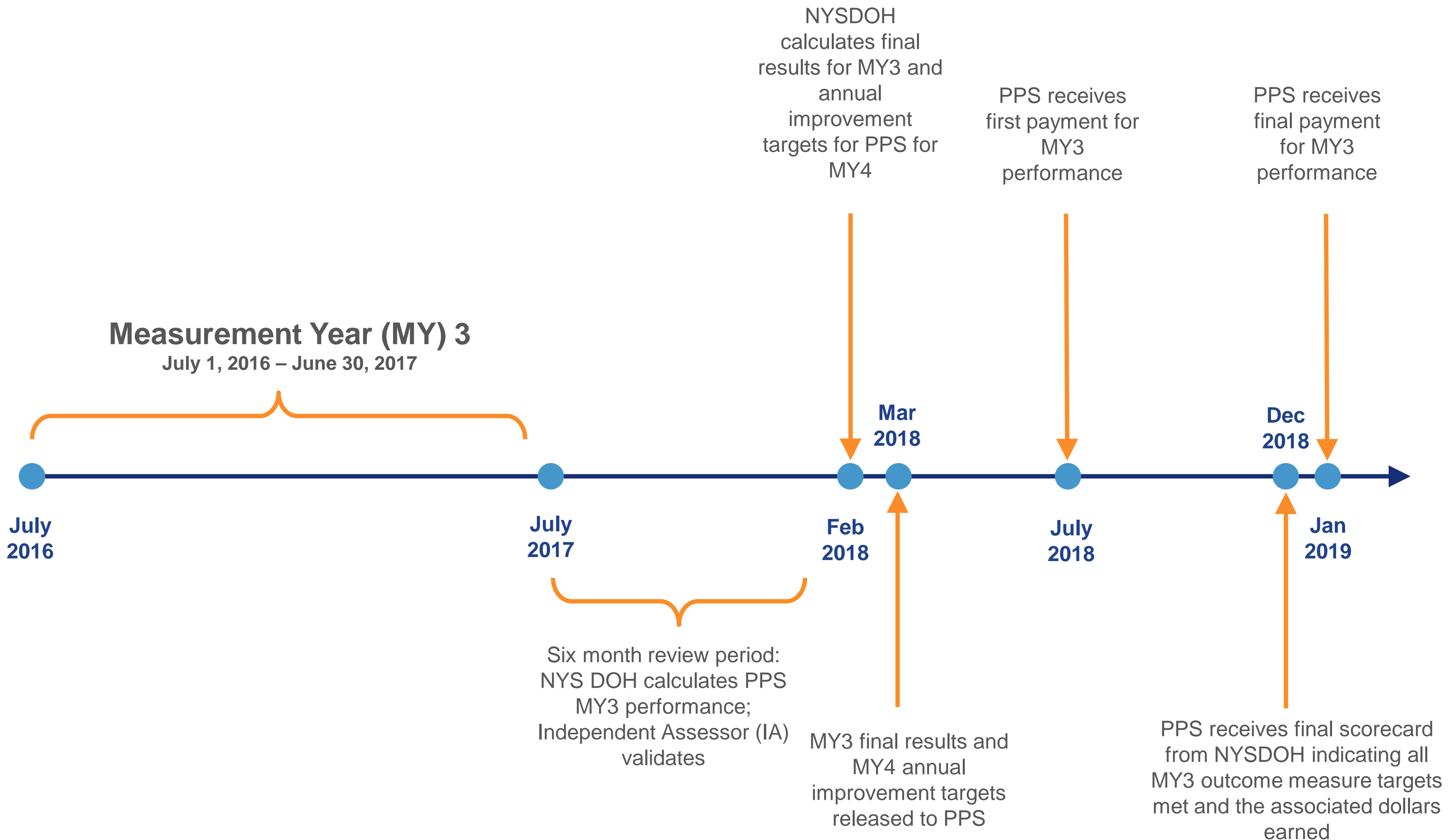
- All 14 outcome measures prioritized in the Phase II CSB were included in the Phase III CSB

OneCity Health will notify eligible partners of earned payments for Phase II CSB outcomes measures in the Spring of 2018

- A partner is only eligible to receive the Phase II CSB allocation for an outcome measure if they a) successfully complete at least 50% of their Phase II CSB process metrics, and b) the PPS meets the annual improvement target for that outcome measure

** As with process metrics, not all outcome measures apply to all partners.*

Determining Performance and Payment – Timeline



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Phase II & III CSB Outcome Measure Performance Summary

- Below is a high level summary of the OneCity Health PPS performance on outcome measures that were in the Phase II and III Comprehensive Schedule B
- Results for all Phase III CSB outcome measures can be found in the appendix; results for all 57 outcome measures can be found in the "PPS Performance and Outcome Measures: Additional Resources" handout

CSB Phase	Outcome Measure Performance Period	# of Outcome Measures included in CSB	# of Outcome Measures Met/On Track to Meet Annual Target	# of Outcome Measures Did not Meet/Not On Track to Meet Annual Target	# of Outcome Measures Missing Performance Results Determination
Phase II	MY2 (July 1, 2015 – June 30, 2016)	14	11	3	0*
Phase III	MY3 (July 1, 2016 – June 30, 2017)	25	8	16	1

* We have not received MY2 performance results data from NYS DOH for two Phase II CSB measures, Controlling high blood pressure and Prevention Quality Indicator # 8 (Heart Failure), but received confirmation from the NYS DOH that the PPS is eligible to receive payment for these two measures for the MY2 performance period

Data Source: New York State Department of Health

Upcoming Events: Details available on the OneCity Health Events Calendar

March 15: Collaborative Care webinar: PHQ-9 Screening for Depression

March 15: Webinar – Health Literacy: A Tool for Effective Communication and Engagement. Hosted by The University at Albany, State University of New York

March 15: NowPow training (webinar)

March 16: Care management training: Care Coordination Fundamentals and Chronic Diseases (in-person)

March 22: Collaborative Care webinar: Primary Care Psychopharmacology for Anxiety

March 26: Primary Care & Population Health Grand Rounds: The Role of Primary Care in Treating Substance Use (webinar)

March 26: Networking Event for NYC Adult BH HCBS Providers, Lead Health Homes, CMAs, and MCOs (hosted by The Coalition for Behavioral Health)

March 27: NowPow training (webinar)

March 27: Care management training: Care Plan Documentation (in-person)

March 28: OneCity Health VBP Webinar - Strategy and Information Management. Geared towards clinical partners, we are hosting this webinar in collaboration with the McSilver Institute

March 30: In-person training – Addressing the Housing Needs of Patients. Training to be held in Queens

April: Attend our LMS webinars – please keep an eye out for additional information

April 3: NowPow training (webinar)

April 3: Wellness Self-Management Plus (WSM+) Facilitator Training

April 10: Please join us for our next OneCity Health Partner Webinar

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OneCity Health Innovation Awards: Update and Next Steps

The deadline to submit an application was March 2, 2018. Thank you to everyone that submitted! Here is an update on next steps for applicants

- OneCity Health strongly supported collaboration amongst partners to address social determinants of health by encouraging joint applications among partner and non-partner organizations.
- We received a total of **41** confirmed applications for the Innovation Fund
  - **23** of these applications included at least one collaboration, for a total of over **55** organizations represented in a variety of configurations
  - **7** of the lead applicants are Tier 1 (non-Medicaid billing) Community Based Organizations (CBOs)
- **5** organizations will serve on the Innovation Award Selection Committee (OneCity Health, New York Immigration Coalition, Greater New York Hospital Association, United Hospital Fund, and Northern Manhattan Perinatal Partnership)
  - These organizations did NOT submit or collaborate on any applications
  - All applications will be reviewed by at least **2** committee members (a OneCity Health representative and an external committee member);
- Each application will be given a 1-100 score, based on the criteria in the application
- For applications that are selected for funding, we expect to notify the lead applicants by Spring. The lead applicant will receive an email from InnovationAward@onecityhealth.org
  - We will then begin the process of distributing to the lead applicant a distinct Schedule B
  - More details will be provided at that time
- We will also notify lead applicants from applications that are not selected to receive funding
- Please note, as of Monday, March 5, we have emailed a confirmation to all lead applicants that submitted an Innovation Award application confirming receipt of their submission
  - The email was sent by InnovationAward@onecityhealth.org
  - If you submitted an application and did **NOT** receive a confirmation, please reach out to the OneCity Health support desk at ochsupportdesk@nychhc.org or 646-694-7090 **by tomorrow, March 15, at noon**

Social Determinants: NowPow Electronic Directory and Referral Tool

As of March 5, 2018, 95 partners have been granted access to the NowPow product, NowRx

NowRx provides a comprehensive and searchable resource directory of New York City social service organizations and enables partners to recommend services to patients/clients via email, text, and/or print

Partners who would like to gain access to NowRx must complete the following steps:

1. Sign a NowPow Participation Agreement sent via Docusign
2. Designate staff person to attend a NowRx training (as listed on OneCity Health website)
3. Complete and send in the Onboarding Form to designate your organization's user

As a reminder, the Phase III Comprehensive Schedule B (CSB) includes process metric N_008, where partners must demonstrate use of the PPS' approved social services referral platform (i.e., NowPow) to generate and/or receive at least fifteen (15) social service referrals per quarter

Partners must report their performance on generating and/or receiving referrals on a quarterly basis via NowPow generated reports that are available for download directly through the software

The below activities are in the pipeline for OneCity Health's roll out of NowPow in 2018 and beyond:

- Apply a special designation to all PPS partners with an MSA so that a pink ribbon will appear by their organization name in the directory and they will appear at or near the top of all searches that relate to services they provide
- Granting additional NowRx licenses to organizations for high utilizing organizations
- Plan for and launch of another NowPow product—PowRx— which enables referrals directly to and messaging with CBOs
- Understand key trends in utilization and embedding of NowRx into existing workflows. Recommend best practices and software feature tweaks, as appropriate

Social Determinants: Prioritized Social Supports

Housing Support

- **Medical Respite**. Citywide planning process, involving City agencies and local health systems, to develop a framework for short-term residential care and support (i.e. medical respite) for homeless that are medically ready for hospital discharge but require medical and support services prior to transition to other housing. {OneCity Health is participating}
- **City Agency Collaborative of PPS'.** NYC DOHMH has been convening NYC PPS to collaboratively design intervention(s) that address concrete social needs among housing unstable New Yorkers in distinct neighborhoods with the ultimate goal of reducing preventable ED visits and inpatient admissions for ambulatory-sensitive conditions. {OneCity Health is participating}
- **Documenting Homelessness**. We are doing internal work to identify opportunities to more routinely and effectively document homelessness among NYC H+H patients in our electronic registration systems.

Legal Support

- In an effort to build the capacity of frontline staff to screen and refer for legal needs of clients / patients, we have been holding a series of attorney-facilitated trainings for partners. Topics have included:
  - Immigration
  - Palliative Care
  - Behavioral Health
  - Housing
- To date, **194** staff from partner organizations have been trained on how to screen and refer for legal needs of clients and patients
- For a list of upcoming legal support trainings please visit the OneCity Health website at onecityhealth.org

Social Determinants: Upcoming in 2018

Social Needs Screening.
Informed by current field testing at a few facilities, development of a "starter kit" for organizations / facilities interested in testing a social needs screening tool

Research & Evaluation.
Designing an evaluation study assessing the impact of meeting social needs on specific health outcome or indicator (e.g. HbA1C for diabetics)

OneCity Health Web Site Materials.
We are building out a section of the OneCity Health web site to hold materials and notices related to the Social Determinants work. *Stay tuned!*

Update on OneCity Health's Learning Management System (LMS)

The OneCity Health Learning Management System (LMS) is a free resource for all PPS partners and their employees

- Provides a "one-stop-shop" for OneCity Health's training-related information and activities
- Allows employees and partners to register for in-person and online training courses, take online training courses, view a training calendar, and much more

Beginning in February 2018, the LMS was made available to the 10 OneCity Health PPS CBO strategic advisors as a pilot. It will be launched PPS-wide starting in April 2018

Two LMS introductory webinars will be held in April to provide an overview of the platform

- The target audience for these webinars includes partner-appointed LMS administrators and executives
- Recorded versions of the webinar will be made available prior to the April launch

How will partners hear about next steps for the LMS, and how can they sign up?

- DSRIPSupport (DSRIPSupport@nychhc.org)
- OCHWorkforceTeam (ochworkforceteam@nychhc.org)

LMS Survey Results (December 2017)

<table>
<tr><th colspan="2">After the last PAC meeting, a survey was sent to all partners about the LMS</th></tr>
<tr><td>Purpose</td><td>To hear feedback from partners related to training needs, training content, and lessons learned from past experience. Partners were also asked to identify an LMS administrator at their organization to support implementation</td></tr>
<tr><td>Response</td><td>21 survey responses received</td></tr>
<tr><td>Key Findings</td><td>Top 3 categories most critical for employees to receive training:
1. Care Management
2. Primary Care and Chronic Disease Management
3. Healthcare Transformation
Specific subject areas for training:
▪ Chronic Disease (Screening, Assessing, Managing, Treatment)
▪ Comprehensive Interviewing Skills
▪ Evidence-based Leadership Training
▪ Evidence-Based Practices in Motivational Interviewing, Cognitive Behavior Therapy,
▪ Value Based Payment
▪ Social Determinants of Health
▪ Population Health</td></tr>
</table>

OneCity Health's Cultural Competence and Health Literacy Assessment

Where are we today?

- Organizational Assessments completed
- Focus Groups conducted
- Problem-Solving Solutions Workshops convened
- Organizational Action Plans submitted
- PPS-wide Action Plan and Training Plan being finalized

Specific training considerations identified for inclusion in the Action Plan and Training Plan:

- Certificate of Advanced Training in LGBTQ Healthcare
- Communicating Cross-Culturally
- Cultural Competence and Health Literacy
- Diversity & Inclusion
- Race & Ethnicity, LGBTQ, Age & Generations
- Effective Communication Strategies
- Language Access
- Unconscious Bias

The Training Plan is scheduled to be launched in April 2018

Overview of Assessment Results to Date

	Organizational Assessment	Focus Groups
Purpose	To provide OneCity Health and participating PPS partners an opportunity to identify disparities and gaps in service delivery, promote best clinical and administrative processes	To gather qualitative data through the perspectives of patient/clients experience in utilizing the services of PPS partner organizations
Response	▪ 22 PPS partners ▪ 52 sites (22 clinical, 30 non-clinical) ▪ 1,654 staff and 3,657 patient/client surveys collected	168 Participants (128 Women, 38 Men, 1 Gender Queer, 1 Transgender Woman)
Outcomes	**Key Priority Areas for Improvement:** ▪ Workforce Development and Training ▪ Individual Engagement ▪ Evaluating Performance ▪ Leadership Commitment ▪ Data Collection	**Key Findings – most discussed themes across all groups:** **Access to Services** ▪ Participants reported limited and delayed access, especially among the undocumented **Cultural Competence** ▪ Participants reported feeling a sense of bias towards non-English speakers, uninsured, undocumented, and individuals with substance abuse disorders ▪ Participants reported that health care and social service providers lack sensitivity, empathy and an understanding of cultural beliefs and practices of racial and ethnic groups **Patient/Client and Provider Communication and Engagement** ▪ Participants reported that providers are process focused, lack sincerity, respect, and dignity for the person being provided services ▪ Participants reported feeling rushed, and being provided unclear communication and directions

Overview of Assessment Results to Date - *continued*

	Problem Solving Solutions Workshops
Purpose	To utilize the organization self-assessment report to facilitate development of an action plan aimed at improving critical aspects of patient/client relations and processes that will result in increased satisfaction and improved outcomes
Response	▪ 8 Workshops conducted ▪ 15 PPS partner organizations represented ▪ 47 PPS partner representatives participated
Outcomes	Key Priority Categories for Action Plan Improvement Efforts: ▪ Cultural Competency Training ▪ Effective Communication Strategies ▪ Health Literacy ▪ Language Services

How will PPS partners hear about training opportunities?

DSRIPSupport E-Newsletters and E-mails
(DSRIPSupport@nychhc.org)

OCH Workforce Team E-mails
(ochworkforceteam@nychhc.org)

OneCity Health Learning Management System
(www.lms.onecityhealth.org)

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Update on Hospital and Community Integration

We Work In Service To You: How Are We Doing?

Please take a brief anonymous survey to help us better serve you

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APPENDIX

Phase III CSB Outcome Measure Performance

Measure ID	Measure Name	Description	MY1 Results Status*	MY2 Results Status	MY3M11 Results Status
Access to Primary Care					
OM_1	**Adult Access to Preventive or Ambulatory Care - 20 to 44 years**	Number of adults 20 to 44 years old who had an ambulatory or preventive care visit during the measurement year	☆	✗	▼ (red)
OM_2	**Adult Access to Preventive or Ambulatory Care - 45 to 64 years**	Number of adults 45 to 64 years old who had an ambulatory or preventive care visit during the measurement year	☆	✗	▼ (red)
OM_3	**Adult Access to Preventive or Ambulatory Care - 65 and older**	Number of adults 65 and older who had an ambulatory or preventive care visit during the measurement year	☆	☆	▼ (green)
OM_4	**Children's Access to Primary Care - 12 to 24 Months**	Number of children ages 12 to 24 months who had a visit with a primary care provider during the measurement year	☆	✗	▼ (green)
OM_5	**Children's Access to Primary Care - 12 to 19 years**	Number of children 12 to 19 years old who had a visit with a primary care provider during the measurement year	☆	✗	▼ (yellow)
OM_6	**Children's Access to Primary Care - 25 months to 6 years**	Number of children ages 25 months to 6 years old who had a visit with a primary care provider during the measurement year	☆	✗	▼ (red)
OM_7	**Children's Access to Primary Care - 7 to 11 years**	Number of children 12 to 19 years old who had a visit with a primary care provider during the measurement year	☆	✗	▼ (yellow)

KEY

☆	Measure year result met annual improvement target	▼ (green)	Monthly results is at or above monthly target
✗	Measure year result did not meet annual improvement target	▼ (yellow)	Monthly results is within one percentage point of target for a measure that is a percentage score, or within 5% of target for a non-percentage, total rate metric
		▼ (red)	Monthly results is not within one percentage point of target for a measure that is a percentage score, or within 5% of target for a non-percentage, total rate metric

Data Source:
New York State
Department of Health

* In MY1, all outcome measures were P4R, therefore the PPS automatically earned dollars for successfully submitting reports within the defined time frame.

Phase III CSB Outcome Measure Performance

Measure ID	Measure Name	Description	MY1 Results Status*	MY2 |Results Status	MY3M11 Results Status
Potentially Avoidable Utilization					
OM_15	PDI 90 – Composite of all measures	Overall composite per 100,000 population aged 6-17. Includes admissions for any of the following: asthma, diabetes with short term complications, gastroenteritis, or urinary tract infection	☆	☆	▼ (red)
OM_16	Potentially Preventable Emergency Room Visits	Preventable ER visits (as defined by CPT code) reported per 100 enrollees.	☆	☆	▼ (red)
OM_17	Potentially Preventable Readmissions	Number of readmission chains (at risk admission followed by one or more clinically related readmission within 30 days of discharge. Expressed per 100,000 enrollees.	☆	☆	▼ (yellow)
OM_18	Potentially Preventable Emergency Department Visits (for persons with BH diagnosis)	Number of preventable emergency room visits as defined by revenue and CPT codes	☆	☆	▼ (yellow)
OM_19	PQI 90 – Composite of all measures	Overall composite per 100,000 population aged 18 and older. Includes admissions for any of the following: diabetes w/ ST complications, diabetes w/ LT complications, uncontrolled diabetes w/out complications, diabetes with lower extremity amputation, COPD, asthma, hypertension, heart failure, angina without cardiac procedure, dehydration, bacterial pneumonia, or UTI	☆	☆	▼ (red)

KEY			
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Phase III CSB Outcome Measure Performance

Measure ID	Measure Name	Description	MY1 Results Status*	MY2 Results Status	MY3M11 Results Status
Potentially Avoidable Utilization					
OM_22	**Pediatric Quality Indicator # 14 Pediatric Asthma**	Number of admissions for primary asthma dx among pts 2-17. Expressed per 100,000 patients	☆	☆	▼ (red)
OM_23	**Prevention Quality Indicator # 15 Younger Adult Asthma**	Number of admissions for primary asthma dx among pts 18 -39. Expressed per 100,000 patients	☆	☆	▼ (green)
OM_24	**Prevention Quality Indicator # 7 (HTN)**	Number of admissions for primary hypertension dx among patients 18 and older. Expressed per 100,000 patients	☆	☆	▼ (green)
OM_25	**Prevention Quality Indicator # 8 (Heart Failure)**	Number of admissions for a primary diagnosis of heart failure among pts 18 and older. Expressed per 100,000 patients	**Data not available**	**Data not available**	▼ (red)

KEY			
☆	Measure year result met annual improvement target	▼ (green)	Monthly results is at or above monthly target
✘	Measure year result did not meet annual improvement target	▼ (yellow)	Monthly results is within one percentage point of target for a measure that is a percentage score, or within 5% of target for a non-percentage, total rate metric
		▼ (red)	Monthly results is not within one percentage point of target for a measure that is a percentage score, or within 5% of target for a non-percentage, total rate metric

Data Source:
New York State
Department of Health

* In MY1, all outcome measures were P4R, therefore the PPS automatically earned dollars for successfully submitting reports within the defined time frame.

Phase III CSB Outcome Measure Performance

Measure ID	Measure Name	Description	MY1 Results Status*	MY2 Results Status	MY3M11 Results Status
Chronic Disease Management					
OM_10	Controlling High Blood Pressure	Number of people whose blood pressure was adequately controlled as follows: • below 140/90 if ages 18-59; • below 140/90 for ages 60 to 85 with diabetes diagnosis; or • below 150/90 ages 60 to 85 without a diagnosis of diabetes	Data not available	Data not available	Data not available
OM_8	Asthma Medication Ratio (5 - 64 Years)	Number of people with a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	☆	☆	▼ (red)
OM_20	Statin Therapy for Patients with Cardiovascular Disease –Statin Adherence 80%	Number of people who achieved a proportion of days covered of 80% for the treatment period	Data not available	Data not available	▼ (red)
OM_21	Medication Management for People with Asthma (5 - 64 Years) - 75% of Treatment Days Covered	Number of people who filled prescriptions for asthma controller medications during at least 75% of their treatment period	☆	☆	▼ (green)

KEY

Symbol	Meaning	Symbol	Meaning
☆	Measure year result met annual improvement target	▼ (green)	Monthly results is at or above monthly target
✘	Measure year result did not meet annual improvement target	▼ (yellow)	Monthly results is within one percentage point of target for a measure that is a percentage score, or within 5% of target for a non-percentage, total rate metric
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Data Source:
New York State
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Phase III CSB Outcome Measure Performance

Measure ID	Measure Name	Description	MY1 Results Status*	MY2 Results Status	MY3M11 Results Status
Behavioral Health					
OM_9	**Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia**	Patients aged 18-64 with cardiovascular disease and schizophrenia must complete an LDL-C test in MY	☆	☆	▼ (yellow)
OM_13	**Follow-up after hospitalization for Mental Illness – within 30 days**	Reports the % of patients hospitalized for a MH condition who complete an outpatient follow-up appointment within 30 days of discharge	☆	✘	▼ (green)
OM_14	**Follow-up after hospitalization for Mental Illness – within 7 days**	Reports the % of patients hospitalized for a MH condition who complete an outpatient follow-up appointment within 7 days of discharge	☆	✘	▼ (green)
OM_11	**Diabetes Monitoring for People with Diabetes and Schizophrenia**	Number of people 18 to 64 years old with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year	☆	✘	▼ (green)
OM_12	**Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication**	Number of people 18 to 64 years old with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, and had a diabetes screening test during the measurement year	☆	☆	▼ (yellow)

KEY			
☆	Measure year result met annual improvement target	▼ (green)	Monthly results is at or above monthly target
✘	Measure year result did not meet annual improvement target	▼ (yellow)	Monthly results is within one percentage point of target for a measure that is a percentage score, or within 5% of target for a non-percentage, total rate metric
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Data Source:
New York State
Department of Health

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Progress Towards Achieving PCMH Recognition

- Within the PPS, there are **269** sites that are potentially eligible for Patient-Centered Medical Home (PCMH) / Advanced Primary Care Model (APC) certification
- These **269** sites are spread across **53** partners
- Of the **269** eligible sites located in the network, as of January 31, 2018:
  - **54%** have achieved PCMH 2014 Level 3 / APC Model certification
  - **23%** are in progress towards achieving PCMH 2014 Level 3 / APC Model certification
  - **23%** have decided not to pursue PCMH / APC Model certification by March 31, 2018 due to limited resources at their site or

Potential PCMH / APC-eligible Sites in PPS	Total Sites	Total Partners/Systems*
Total potential eligible sites	269	53

Progress Towards Achieving Advanced Models of Primary Care:	Total Sites	Total Partners/Systems*
Achieved	144	43
In Progress	63	16
Not Pursuing	62	12

*Numbers will not sum to this overall total because partners (systems) are represented more than once across categories

Progress Towards Achieving RHIO / Electronic Connectivity

- Regional Health Information Organization (RHIO) connectivity is a DSRIP requirement for all OneCity Health partners that either provide clinical services and/or have an Electronic Medical Record (EMR)
- The OneCity Health Implementation Team is in the process of reaching out to partners and coordinating the work of Digital Edge and NYC Health + Hospitals IT, which enables the connection to the RHIO
- Technical assistance provided by Digital Edge and NYC Health + Hospitals is for connection to the New York Care Information Gateway (NYCIG) RHIO
  - As of March 1, 2018, 53 partners have signed Participation Agreements to connect to the NYCIG RHIO. OneCity Health is in the process of connecting these partners to the RHIO
- OneCity Health is also in the process of procuring an EMR option to be provided free of charge to partners who do not have a Meaningful Use-certified EMR
  - Of the 53 partners / systems eligible for PCMH certification (see previous slide), OneCity Health has confirmed that 45 partners currently have a Meaningful Use-certified EMR in use
  - OneCity Health is in the process of confirming EMR capabilities of additional partners to support PPS reporting to the NYS Department of Health (NYS DOH)

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