OneCity Health
Partner Reporting Manual
Phase III

July 2019
This updated Phase III OneCity Health Partner Reporting Manual replaces the version released in March 2019, and reflects the following updates:

- **Section I: Metrics**
  
  - A Second Amendment has been issued to extend the following Phase III process metrics:
    - PS_001 (Care Transitions) page 27
    - PS_002 (Care Transitions) page 29
    - PS_003 (Asthma) page 31
    - PS_004 (Asthma) page 33
    - PS_006 (Health Home At-Risk) page 37
  
  - A Second Amendment has been issued to extend the following Phase III Distinct Schedule B’s:
    - DSB_IPM page 68
  
  - Guidance for reporting on the DSB_NYLAG metrics have been updated in the Reporting Manual page 69
# TABLE OF CONTENTS

Updates to the OneCity Health Partner Reporting Manual ................................................................. 1
Table of Contents ....................................................................................................................................... 2
About .......................................................................................................................................................... 4
Reporting Manual Key Terms ...................................................................................................................... 5
Reporting & Invoicing Workflow .................................................................................................................. 6
Section I: Metrics ........................................................................................................................................ 8
  Process Metrics ........................................................................................................................................ 9
    N_001 ......................................................................................................................................................... 12
    N_002 ......................................................................................................................................................... 13
    N_003 ......................................................................................................................................................... 14
    N_004 ......................................................................................................................................................... 15
    N_005 ......................................................................................................................................................... 17
    N_006 ......................................................................................................................................................... 18
    N_007 ......................................................................................................................................................... 20
    N_008 ......................................................................................................................................................... 21
    N_009 ......................................................................................................................................................... 24
    N_010 ......................................................................................................................................................... 25
    N_011 ......................................................................................................................................................... 26
    PS_001 ......................................................................................................................................................... 27
    PS_002 ......................................................................................................................................................... 29
    PS_003 ......................................................................................................................................................... 31
    PS_004 ......................................................................................................................................................... 33
    PS_005 ......................................................................................................................................................... 35
    PS_006 ......................................................................................................................................................... 37
    PS_007 ......................................................................................................................................................... 40
    PS_008 ......................................................................................................................................................... 43
    PS_009 ......................................................................................................................................................... 47
    PS_010 ......................................................................................................................................................... 50
    PS_011 ......................................................................................................................................................... 53
    PS_012 ......................................................................................................................................................... 54
    QI_001 ......................................................................................................................................................... 56
    QI_002 ......................................................................................................................................................... 59
ABOUT

This reporting manual is intended for OneCity Health Performing Provider System (PPS) partners. This document supplements any payment rules found in a partner’s individual Master Services Agreement (MSA) and corresponding Schedules B for Phase III of Delivery System Reform Incentive Payment (DSRIP) implementation, beginning January 1, 2018 through March 31, 2020. The Phase III Comprehensive Schedule B issued to partners is for calendar year 2018, which is the first budget period. In order to receive payment for a specific metric, all required information must be completed, and supporting details or documentation must be provided as requested.

Individual partners’ Schedules B include specific metrics based on information provided by the partner to OneCity Health; the metrics discussed in this manual may not be applicable to all partners. In addition, the information specified within this manual is subject to change based on revised New York State Department of Health (NYS DOH) guidelines, partner needs, and/or OneCity Health needs. Additional information on project and metric requirements can be found in the Phase III Comprehensive Schedule B Project Implementation Summaries and additional supporting materials available on the OneCity Health Partner Portal.

This document was prepared by OneCity Health Services staff to provide information about reporting on all Phase III Comprehensive Schedule B metrics and is organized into two sections:

- **Metrics**
  - Detailed reporting guidance on the metrics and measures included in partners' Schedules B

- **OneCity Health Partner Portal Overview**
  - Overview of how to use the OneCity Health Partner Portal to submit metric and invoice documentation

If you have any questions, please contact your respective Hub Liaison or the OneCity Health support desk:

- **Email**: ochsupportdesk@nychhc.org
- **Phone Number**: (646) 694-7090
- **Hours of Operation**: Monday- Friday, 9 a.m. to 5 p.m. EST
### REPORTING MANUAL KEY TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>OneCity Health</td>
<td>New York City's largest Performing Provider System (PPS) that consists of over 200 partners in four borough-based hubs; implements 11 interrelated projects across the PPS network to close critical gaps in the continuum of care</td>
</tr>
<tr>
<td>MSA</td>
<td>Master Services Agreement (MSA); establishes partnership between an organization and OneCity Health to conduct DSRIP work</td>
</tr>
<tr>
<td>Schedule B</td>
<td>Agreement that defines specific roles and responsibilities between OneCity Health Services and PPS partners related to specific projects, detailing flow of funds</td>
</tr>
<tr>
<td>Phase III</td>
<td>Contracting period from January 1, 2018 – March 31, 2020; the Phase III Comprehensive Schedule B was distributed via DocuSign to your organization’s primary signatory and covers Performance Period 1 of Phase III, from January 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Process Metric</td>
<td>Requirement developed by OneCity Health to measure project completion and flow funds to partners; to validate completion of metric, partners must submit reporting documentation and invoice documentation</td>
</tr>
<tr>
<td>Outcome Measure</td>
<td>Requirement developed by NYS DOH to measure DSRIP implementation to flow funds to PPS; achievement determined by NYS DOH after the end of contracting period (Dec. 31); partner payment dependent on overall PPS achievement of each outcome measure</td>
</tr>
<tr>
<td>OneCity Health Partner Portal</td>
<td>Online platform where partners can view, report on, and invoice for the metrics outlined in their Phase III Schedules B; will be referred to as “Portal” throughout this manual</td>
</tr>
</tbody>
</table>
REPORTING & INVOICING WORKFLOW

You will report on metrics by logging into the OneCity Health Partner Portal and entering required information or uploading documentation as specified for each metric. Specific instructions on how to report each metric are included in Section I of this manual.

Overview of Reporting & Invoicing through the OneCity Health Partner Portal

1. Partner logs into the Portal
2. Partner completes metric submission
3. Partner completes preliminary invoice submission

*OneCity Health validates submission as complete*

YES → Pending invoice is finalized

NO → Metric is returned to partner and preliminary invoice is automatically rejected. Partner has 14 days to resubmit metric

As described in Section II, when you submit a report through the Portal you will complete the corresponding invoice at the same time.

After your report and invoice are submitted, they will be reviewed for content and completeness by OneCity Health. If your report is approved, payment can be expected within 60 days* from when the pending invoice is finalized.

*For Outcome Measures and Patient Engagement reporting, payment will be made to partners after the PPS receives payment from the NYS DOH, and may exceed this 60 day timeframe.*
Section I: METRICS
SECTION I: METRICS

This section includes detailed information on what and how to report on metrics from the Phase III Comprehensive Schedule B, as well as any distinct Schedules B; however, the actual reporting templates, surveys, or other forms for submission will be available through the Portal as they are finalized by OneCity Health. All guidance included in this manual is subject to change. For the most up to date information on each metric, refer to the Portal.

The Phase III Comprehensive Schedule B includes two different types of reporting requirements: **Process Metrics** and **Outcome Measures**.

### PROCESS METRICS

- Some Phase III Process Metrics are similar to those from Phase II; others have evolved in Phase III to encourage and reward activities that more directly impact patient and clients
- Your Comprehensive Schedule B includes a specific list of Process Metrics assigned based on partner type
- Every metric has a specific metric ID and due date
- You must report through the Portal according to due dates specified in the contract and the reporting manual
- All submissions are reviewed by OneCity Health
- You must successfully achieve Process Metrics to receive payment
- Some partners will report on Patient Engagement Metrics (similar to Phase II), but these have been incorporated into Process Metrics for Phase III
- Reporting on these Patient Engagement metrics is the same as in Phase II; payment for these metrics is dependent on PPS achievement as a whole
- If you have these Patient Engagement Metrics in your Schedule B, you will be eligible to earn funds above your partner total eligible allocation based upon reported contribution to these metrics

### OUTCOME MEASURES

- Similar to the Outcome Measures included in partners’ Phase II contracts
- A subset of Outcome Measures were prioritized from a larger list of pay-for-performance DSRIP outcome measures defined by NYS DOH
- Outcome Measures are assigned to partners based on partner type
- Outcome Measures are our goals as an overall PPS and do NOT require reporting by partners
- You will receive payment for Outcome Measures in your Schedule B if:
  - The PPS successfully meets the NYS DOH target for each individual outcome measure **AND**
  - You successfully complete a minimum of 50 percent of the Process Metrics in your Comprehensive Schedule B (excluding certain metrics, as explained in your contract)
- Payments are made to eligible partners for Outcome Measures after the PPS receives payment from the NYS DOH

★NOTE: The metrics included in this section will NOT apply to all partners. You are responsible for reporting only on the metrics included in your organization’s specific Schedule B. Only those metrics will appear when you log on to the Partner Portal.
**PROCESS METRICS**

The chart below lists a summary of all the process metrics from the Comprehensive Schedule B. Metrics shaded in orange apply to all partners:

<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Metric Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>N_001</td>
<td>Sign Comprehensive Schedule B through DocuSign and return NYC Health + Hospitals Vendor Demographics Form to OneCity Health Services within forty-five (45) days of the effective date.</td>
</tr>
<tr>
<td>N_002</td>
<td>Complete the Financial Assessment survey as designed and administered by OneCity Health Services.</td>
</tr>
<tr>
<td>N_003</td>
<td>Complete the Compensation and Benefits survey as administered by the vendor.</td>
</tr>
<tr>
<td>N_004</td>
<td>Report the total number of staff hired, redeployed or retrained to complete DSRIP related activities in the Workforce Impact Survey as designed and administered by OneCity Health Services.</td>
</tr>
<tr>
<td>N_005</td>
<td>Demonstrate successful completion of Value Based Payment training as administered by OneCity Health Services.</td>
</tr>
<tr>
<td>N_007</td>
<td>Demonstrate that Electronic Health Record (EHR) meets connectivity to a Regional Health Information Organization (RHIO)/Health Information Exchange (HIE) and Statewide Health Information Network of New York (SHIN-NY) requirements.</td>
</tr>
<tr>
<td>N_008</td>
<td>Demonstrate use of an approved social services referral platform to generate and/or receive at least fifteen (15) social service referrals per quarter.</td>
</tr>
<tr>
<td>N_009</td>
<td>Report on the number of unique patients that received Meds to Beds services that include medication reconciliation and delivery of medication to an inpatient facility pre-discharge.</td>
</tr>
<tr>
<td>N_010</td>
<td>Report on the number of unique patients referred by a OneCity Health Transition Management Team that have received medication reconciliation and associated follow-up services.</td>
</tr>
<tr>
<td>N_011</td>
<td>Demonstrate high rating on the Centers for Medicare and Medicaid Services (CMS) Five-Star Quality Rating System Score for Nursing Homes.</td>
</tr>
<tr>
<td>PS_001</td>
<td>Identify and connect appropriate patients to the OneCity Health Care Transitions program.</td>
</tr>
<tr>
<td>PS_002</td>
<td>Demonstrate that a minimum of sixty (60%) percent of patients assigned in the OneCity Health Care Transitions program have at least one (1) care plan update completed for each week of enrollment.</td>
</tr>
<tr>
<td>PS_003</td>
<td>Identify and connect appropriate patients to the OneCity Health Asthma Community Health Worker (CHW) program.</td>
</tr>
<tr>
<td>PS_004</td>
<td>Demonstrate that a minimum of thirty (30%) percent of patients enrolled in the OneCity Health Asthma Community Health Worker (CHW) program have a completed home visit.</td>
</tr>
<tr>
<td>PS_005</td>
<td>Identify and connect appropriate patients to the OneCity Health Health Home At-Risk program.</td>
</tr>
<tr>
<td>PS_006</td>
<td>Demonstrate that care coordination activities have been completed for a minimum of sixty (60%) percent of patients assigned to the OneCity Health Health Home At-Risk program.</td>
</tr>
<tr>
<td>PS_007</td>
<td>Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria. (2.b.iii Emergency Department Triage for At-Risk Populations).</td>
</tr>
</tbody>
</table>
### Metric ID | Metric Summary
--- | ---
**PS_008** | Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria. (3.a.i Integration of Primary Care and Behavioral Health Services).
**PS_009** | Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria. (3.b.i Evidence-Based Strategies for Disease Management in High-Risk/Affected Populations, Adults Only).
**PS_010** | Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria. (3.g.i Integration of Palliative Care into the PCMH Model).
**PS_011** | Submit documentation of at least thirty (30) completed Integrated Palliative Care Outcome Scale (IPOS) assessments for eligible primary care patients as detailed by OneCity Health Services.
**PS_012** | Demonstrate that applicable uninsured patients were connected to primary care providers and/or insurance specialists.
**QI_001** | Demonstrate implementation of and report progress on a quality improvement (QI) activity to address one (1) of the eligible measures indicated by OneCity Health related to primary care and behavioral health integration.
**QI_002** | Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to address Human Immunodeficiency (HIV) screening and linkage to care.
**QI_003** | Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to address standardization of discharge planning for Congestive Heart Failure.
**QI_004** | Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to increase statin use amongst applicable patient population.
**QI_005** | Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to improve follow up after hospitalization for mental illness.

This Manual also includes reporting requirements for the following distinct Schedule B metrics:

### Metric ID | Metric Summary
--- | ---
**ADV_01** | Quarterly Payment for Strategic Advice for 1199SEIU Training and Employment Funds.
**INNOVATION_FUND** | Innovation Fund Awardees create a Project Plan, Update the Project Plan and submit a Progress Report.
**DSB_IPM** | Payment for Asthma Integrated Home Assessment and Remediation.
**DSB_NYLAG** | Upload the invoice and sign in sheet for all trainings, listing each training date and topic.
**DSB_PCMHFEE** | Sign Patient-Centered Medical Home (“PCMH”) Application and Survey Tool Fees – Schedule B, and submit payment receipt(s) for Interactive Survey System 2014 PCMH Survey Tool and/or Clinician Submission Fees (“Application Fees”).
**DSB_SAW** | A primary or alternate Workgroup Member must attend a minimum of 80% of all Strategic Advisory Workgroup meetings held during the term of the Schedule B.
**TRN_01** | 1199SEIU Training and Employment Funds Scheduled Partner Training.
There are some metrics that have multiple reporting periods. For each of these metrics, you will see discrete metrics in your Comprehensive Schedule B, corresponding to the different due dates.

For each of these metrics, the reporting instructions will include a table indicating the corresponding metric IDs, due dates, and time periods to report on for each metric. Below is an example of this:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_001.1</td>
<td>April 30, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>PS_001.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>PS_001.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>PS_001.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>
N_001

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>N_001 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Sign Comprehensive Schedule B through DocuSign and return NYC Health + Hospitals Vendor Demographics Form to OneCity Health Services within forty-five (45) days of the effective date.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>February 23, 2018</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Sign Comprehensive Schedule B utilizing DocuSign and return NYC Health + Hospitals Vendor Demographics Form to OneCity Health Services and attest to contract execution on the OneCity Health Partner Portal by the specified due date as outlined in this Comprehensive Schedule B.</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

The Comprehensive Schedule B was distributed to partners via DocuSign. Complete instructions for signing the Schedule B are available on the OneCity Health website here: http://www.onecityhealth.org/wp-content/uploads/17MISC0006-Instructions-for-Signing-OCH-Schedule-B.pdf

There are three steps to signing your Comprehensive Schedule B:

1) **Sign your contract via DocuSign:** The contract must be signed by February 15, 2018 in order to participate in Phase III contracting.

2) **Complete the NYC Health + Hospitals Vendor Demographics Form:** The Vendor Demographics Form is available on the OneCity Health website here and is newly required by NYC Health + Hospitals for all OneCity Health partners in 2018

3) **Submit the contract-signing attestation and completed Vendor Demographics Form through the Portal:** Log into the Portal to attest to signing the Phase III Comprehensive Schedule B and upload your completed form by February 23, 2018

Once your contract is fully executed and the attestation and Vendor Demographics Form are submitted, your organization will be eligible to receive its Phase III Participation Metric, worth ten percent of your organization’s total maximum valuation for Phase III.

**NOTE:** In order to complete this metric and receive the participation metric, you must sign the contract by February 15, 2018 and submit metric N_001 through the Portal by February 23, 2018.
N_002

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>N_002 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Complete the Financial Assessment survey as designed and administered by OneCity Health Services.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>September 15, 2018</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Complete the Financial Assessment survey and submit to OneCity Health Services by the specified due date as outlined in this Comprehensive Schedule B.</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

All PPSs bear responsibility for building and maintaining a network with adequate scope of services and geographic reach. To that end, OneCity Health will conduct initial and ongoing financial assessments to identify partners that may be at financial risk or considered financially fragile that could potentially jeopardize the PPS’s ability to meet the needs of our patients and the goals of DSRIP. Taking steps to assist partners as deemed appropriate by PPS Governance is an integral part of our development of a strong, integrated delivery system.


The 2017 assessment was conducted in September 2017 via the OneCity Health Partner Portal. The 2017 assessment questions are also available to view on the OneCity Health website for reference purposes.

The 2018 assessment will be available for completion in the Portal and a PDF of the survey will be made available on the OneCity Health website for reference purposes. Similarly to the previous assessments, the 2018 assessment questions will be the same for all partner types and will be collected at the system level.
N_003

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>N_003 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Complete the Compensation and Benefits survey as administered by the vendor.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>February 23, 2018</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Complete the Compensation and Benefits survey and submit to the designated vendor and demonstrate completion on the OneCity Health Partner Portal by the specified due date as outlined in this Comprehensive Schedule B.</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

The BDO Center for Healthcare Excellence and Innovation (BDO), in collaboration with NYC Health + Hospitals - OneCity Health, is documenting each partner’s staffing configuration and employee compensation and benefits to fulfill a DSRIP reporting requirement from the NYS DOH. NYS DOH requires that each PPS participate in surveying its partner organizations to establish an understanding of DSRIP’s effect on the compensation and benefits of providers in PPSs across New York State.

To complete the metric, partners must complete the fillable PDF survey sent via email from BDO’s “DSRIPSurvey” email account; the survey is not available for download in the Portal.

All recorded compensation and benefits data are confidential. Any compensation and benefits data reported publicly or to the PPS (by BDO) will be provided only in the aggregate and will not identify specific employees or organizations. Anti-trust provisions will be followed.

Submitting your Compensation and Benefits survey is a two-step process. Both steps are required.

**Step 1:** When your survey is completed, the saved form can either be emailed back to BDO via the ‘Submit by E-Mail’ button at the end of the survey or by emailing the survey directly to DSRIPsurvey@bdo.com. You must send it by February 23, 2018 to be paid for completing the metric. Submissions will not be considered valid after that time.

**Step 2:** By February 23, 2018, you must also attest to your submission of the survey to BDO on the OneCity Health Portal. If you do not complete the attestation in the Portal, you will not receive payment for completing this metric.
As DSRIP proceeds with implementation, OneCity Health’s partner network will likely experience workforce changes. Specifically, we expect that there will be a need to hire and train more clinical and non-clinical staff and retrain existing staff to meet workforce demands and address areas of greatest need.

In an effort to collect information about DSRIP-related workforce shifts, the NYS DOH requires that PPSs submit system-level data on the number of newly hired, redeployed, and retrained staff as a result of DSRIP. The data must be submitted in accordance with NYS DOH job titles and facility types.

The Workforce Impact Survey (Survey) is an essential step in determining DSRIP-related workforce shifts among partners. The Survey template is sent to partners as an Excel attachment via email from the OneCity Health “DSRIPSupport” email account and is made available to partners on the OneCity Health website as well. The Survey is not available for download in the Portal.

The Survey template must be completed at a system level, and as such should capture aggregate workforce shifts across sites within your system. To be considered complete, you must answer all applicable questions on Tab 2 after carefully reviewing the instructions on Tab 1. If you answer “Yes” to question 4 on Tab 2, you must complete question 4a and fill out Tabs 3 – 11 accordingly. For example, if you indicate that your System experienced workforce shifts in the inpatient facility type on question 4a, you must indicate the relevant shifts in newly hired, retrained, or redeployed staff in Tab 8, “Inpatient.”

**Submitting your final Workforce Impact Survey is a two-step process. Both steps are required.**

**Step 1:** When your form is completed, you must send your saved Excel Survey file to the OneCity Health support desk at ochsupportdesk@nychhc.org. You must send it between April 1
and April 15, 2018 to be paid for completing the metric. Submissions will not be considered valid before or after that time.**

**Step 2:** By April 15, 2018 you must also attest to your submission of the Survey on the OneCity Health Portal. If you do not complete both steps (survey submission and the attestation in the Portal), you will not receive payment for completing this metric.

**It is important to note that OneCity Health will review each Survey submitted to the support desk. You may hear from us after you have submitted your Survey to resolve any issues and help ensure your Survey is completed accurately. If this is the case, you will have the opportunity to resubmit your Survey before April 15th. If you do not resubmit, you will not be paid for the metric. You only need to attest one time in the Portal that you submitted your Survey.
N_005

Metric ID – Metric Type | N_005 – Process
---|---
Metric | Demonstrate successful completion of Value Based Payment training as administered by OneCity Health Services.
Due Date(s) | January 15, 2019
Participant Obligations | Provide documentation that demonstrates completion of the trainings as outlined in this Comprehensive Schedule B.

REPORTING INSTRUCTIONS

Attending Value-based payment (VBP) training is a PPS-wide metric that every partner (and the relevant staff within those partners) must meet. The NYS DOH requires that all PPS partners receive training about value-based payments in the context of DSRIP as well as integrated delivery systems. The evolving value-based payment system that health care will be operating within is focused on increasing value to patients, communities, payers and other stakeholders. Value-based payment will shift the way that health care services are paid for, from the current volume-based (fee-for-service) model, to paying for value. Value can be defined as high quality care delivered at a reasonable cost. This payment model shift is required to sustain health care service delivery reforms being implemented under DSRIP. There is no one model for payment reform that New York State has adopted and it is important for all of us to understand the potential options that may be available and how they apply to the work you are doing under DSRIP.

There are several VBP trainings currently available on the OneCity Health Learning Management System (LMS) [https://lms.onecityhealth.org/](https://lms.onecityhealth.org/).

To complete the requirements for this metric, partners may attend any relevant VBP training.

When reporting on this metric, partners will be required to upload to the OneCity Health Portal proof of training completion in 2018 for at least one employee. This proof may include:

- Any certificate of completion of a VBP training from the OneCity Health Learning Management System or any other external training
- A training sign-in sheet, along with an agenda and/or copy of training materials for any VBP training held at your organization
N_006

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>N_006 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due Date(s)</td>
<td>January 15, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>(1) Attest to completion of NCQA PCMH Level III, NCQA PCMH 2017, or NYS DOH APC recognition; (2) Include evidence of recognition for all eligible primary care practices; and (3) Report effective date(s) of recognition. See Section F2 of Phase III Comprehensive Schedule B for additional process metric details</td>
</tr>
</tbody>
</table>

**REPORTING INSTRUCTIONS**

You will earn a percentage of the eligible amount listed in your contract for this metric depending upon the date of recognition and reporting for all eligible primary care practices. As detailed in Section F2 of the Phase III Comprehensive Schedule B:

<table>
<thead>
<tr>
<th>Date of recognition and reporting</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of recognition and reporting for all eligible primary care practices by March 31, 2018</td>
<td>Partner receives <strong>100%</strong> of metric maximum valuation</td>
</tr>
<tr>
<td>Completion of recognition and reporting for all eligible primary care practices after March 31, 2018 but by December 31, 2018</td>
<td>Partner receives <strong>50%</strong> of metric maximum valuation</td>
</tr>
</tbody>
</table>

When reporting on this metric, you will be required to identify all eligible primary care practices.

**Eligible primary care practices** are defined as those that provide comprehensive primary care services. Comprehensive primary care is: 1) whole-person care; 2) where the personal clinician provides first contact, continuous, comprehensive care; 3) care is coordinated or integrated across the health care system; and 4) team-based care.

When reporting on this metric, you will be required to indicate the following *for each eligible primary care practice in your system*:

- Whether the practice has achieved National Committee on Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Level III 2014, NCQA PCMH 2017, or NYS DOH Advanced
Primary Care (APC) recognition. For each practice that has achieved recognition, provide the following:

- Effective date of recognition
- Upload evidence of recognition for each practice. Evidence of recognition must indicate effective date of recognition and may include: applicable Certificate of Recognition from NCQA or documentation from the NYS DOH demonstrating APC recognition

- If the practice has not achieved recognition, please provide a justification for why that site chose not to pursue NCQA PCMH or NYS DOH APC recognition

**For each practice that you indicate is not eligible**, please provide a justification for why the site is not an eligible primary care practice.

**You can only submit this metric once through the Portal** – do not complete your submission until you are ready to provide documentation for all eligible practices.
N_007

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>N_007 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Demonstrate that Electronic Health Record (EHR) meets connectivity to a Regional Health Information Organization (RHIO)/Health Information Exchange (HIE) and Statewide Health Information Network of New York (SHIN-NY) requirements.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>January 15, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Provide documentation that demonstrates EHR connectivity to a RHIO/HIE and active utilization of HL7 Automatic Data Transfer (ADT) message feeds. See Section F2 of Phase III Comprehensive Schedule B for additional process metric details</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

You will earn a percentage of the eligible amount for this metric listed in your contract depending upon the date of achieving EHR connectivity to a RHIO/HIE and active utilization of HL7 Automatic Data Transfer (ADT) message feeds. As detailed in Section F2 of the Phase III Comprehensive Schedule B:

<table>
<thead>
<tr>
<th>Date of achievement</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement of EHR connectivity to a RHIO/HIE and active utilization of HL7 ADT message feeds by June 30, 2018</td>
<td>Partner receives 100% of metric maximum valuation</td>
</tr>
<tr>
<td>Achievement of EHR connectivity to a RHIO/HIE and active utilization of HL7 ADT message feeds after March 31, 2018 but by December 31, 2018</td>
<td>Partner receives 50% of metric maximum valuation</td>
</tr>
</tbody>
</table>

When reporting on this metric, you will be required to identify the date of connectivity and upload supporting documentation that demonstrates that connectivity. Supporting documentation may include a screenshot, excerpt, or report that demonstrates RHIO connectivity and active utilization of HL7 ADT message feeds, and the date by which this connectivity was achieved. For CBO partners, use of a RHIO patient portal is considered connectivity; supporting documentation for this connectivity may include a screenshot that demonstrates use of the patient portal functionality.

**Note:** Use of GSI alone, as well as use of the NowPow social services referral platform, do not constitute connectivity to the RHIO.
**N_008**

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>N_008 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Demonstrate use of an approved social services referral platform to generate and/or receive at least fifteen (15) social service referrals per quarter.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>May 15, 2018; July 31, 2018; October 31, 2018; January 31, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Submit verification that demonstrates that social service referrals were generated or received for at least fifteen (15) patients/clients through the approved platform during the quarterly reporting window.</td>
</tr>
</tbody>
</table>

**REPORTING INSTRUCTIONS**

There are four due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>N_008.1</td>
<td>May 15, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>N_008.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>N_008.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>N_008.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

The OneCity Health PPS has made available to its partners a social services referral platform called NowPow (www.nowpow.com). Our shared goal with the rollout of this system is to promote the utilization of an efficient method of connecting individuals with unmet social needs to appropriate social services.

NowPow offers multiple software products with specific features. NowRx is a web-based software that includes 1) a comprehensive social service directory (inclusive of all OneCity Health PPS partners, along with thousands of other CBOs in New York City) and 2) the ability to send recommended organizations directly to patients via text, email and print. PowRx includes all the features of NowRx and a functionality for users to send referrals directly to community-based organizations.

We understand that some organizations may use other electronic systems to make social service referrals, such as other web-based platforms (e.g. Healthify), and that some multi-service organizations make social service referrals within their own organization through their own electronic system. If a given organization prefers to use a different web-based platform than NowPow or their existing electronic system, your organization is still able to attest to this metric. We have provided below alternate instructions on how to submit documentation attesting to meeting this metric for those organizations.
To demonstrate achievement of this metric, you must provide proof that your organization has generated and/or received at least 15 social service referrals through the system within the quarter of the reporting period (e.g. January 1 – March 31st, 2018 equals the period on which organizations should report by May 15, 2018).

**Below are key definitions relevant to this metric:**

**“Approved social service referral platform”:** A web-based social service directory and referral software that enables users to identify and send referrals for social services directly to patients / clients and/or to social service organizations. (E.g. NowPow, Healthify.) In some cases, an approved social service referral platform may be an organization’s own electronic system through which they make and document referrals to other units within their organization that provide social services.

**“Referral”:** The action of 1) sending a recommendation of a social service organization or site directly to a patient / client through an electronic or print transaction; and/or 2) sending a structured message to a community organization requesting a social service appointment for a patient / client through an electronic transaction.

**“Social Services”**: Services that address social needs and well-being which include but are not limited to: government benefits that provide income assistance and / or placement to meet basic needs such as food, housing, utilities, child care; emergency food (e.g. via a food pantry); legal services; capacity-building such as financial literacy, job training, or education classes.

**“Nudge”:** The action of sending a recommendation of an organization(s) found within the NowPow directory to a patient / client via text or email.

**For organizations using NowPow. Partners can access utilization reports through the Administrator Dashboard:**

- Each organization that has a NowRx user license has a designated “Administrator” (in most cases, the organization’s designated NowRx user is also the Administrator). If you are unaware of who that is, you can send an email to support@nowpow.com and inquire.
- Reports are available via the Administrator Dashboard on the 15th of the month following the last month of the designated quarter it is reporting on. E.g. April 15th for the quarter including January 1st – March 31st. They are automatically available through your Administrator Dashboard under the “Executive Summary” section.)
- The Administrator should log into NowPow via app.nowpow.com. At the top right, you will see a tab that says “Admin”. Click on that and you will enter the dashboard that includes your organization’s utilization reports.
- Please retrieve the following report:
  - Under the blue “Executive Summary” tab, retrieve the “User Activity - Summary” report, which capture a number of metrics on the user(s)’ utilization of the software during that given time period. Both an Excel and PDF version are available for download.
– they contain the exact same information.
  o To ensure you are accessing the cumulative report for the given quarter, ensure that on
    the left sidebar highlighted in blue under “2018 Reports”, that the last month of the
    quarter is highlighted {i.e. “March” for the January – March reporting period}.
  o The key metric which captures the number of referrals (or nudges) is “# of Total Shared
    Referrals,” which captures number of eRxs shared, services nudged and services printed.
  - For each quarterly reporting period, enter the sum of the applicable monthly numbers in the “# of Total Shared Referrals” metric.
  - Upload to the Portal the applicable report(s) for the quarter of your reporting period.
  - If you are having issues accessing your quarterly report and it is after the 15th of the following
    month, please contact NowPow’s Support Desk through the Support Portal on NowPow or by
    sending an email to support@nowpow.com.

Please note: if you receive your NowRx (or PowRx) license via another PPS that is not OneCity Health, you may still submit a report according to the above instructions to attest to completion of this metric.

For organizations using other web-based platforms or electronic systems.

  - For organizations using other web-based social service referral platforms, please obtain and
    upload a report that addresses the following key elements for each quarterly reporting period
    (or each month within each quarterly reporting period):
      o # of social service referrals sent by Type of social service (e.g. emergency food)
      o # of social service referrals received by your organization by Type of social service (e.g. emergency food)
  - For organizations using other electronic systems for referrals (e.g. an electronic medical record),
    please request from the system vendor (or put together if vendor is unable to) a quarterly or
    monthly report that demonstrates the number of social service referrals generated and/or
    received within the reporting time period. It should include some specific information on what
    types of social services were referred out, within or into the organization.
      o Elements to include in the report should be
        ▪ # of social service referrals sent by Type of social service e.g. emergency food
        ▪ # of social service referrals received by your organization by Type of social service (e.g. emergency food)
      o Please do not include patient-level details or any protected health information in these
        reports. Our main goal is to assess the activity of incoming or outbound social service
        referrals in aggregate.
**N_009**

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>N_009 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Report on the number of unique patients that received Meds to Beds services that include medication reconciliation and delivery of medication to an inpatient facility pre-discharge.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Provide documentation that demonstrates the number of unique patients that received Meds to Beds services. See Section F2 of Phase III Comprehensive Schedule B for additional process metric details</td>
</tr>
</tbody>
</table>

**REPORTING INSTRUCTIONS**

**There are four due dates for this metric:**

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>N_009.1</td>
<td>April 30, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>N_009.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>N_009.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>N_009.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

Download the Excel reporting template from the Portal. The template will provide instructions on how to report the information below.

After completing the template, upload the template to the Portal and enter the following information from the template directly into the Portal:

- The number of patients who had:
  - Medications delivered to an inpatient facility pre-discharge or within 48 hours post-discharge; AND
  - Pharmacist Medication Reconciliation completed within 48 hours post-discharge

When completing the template, please enter complete information for all unique patients that received Meds to Beds services for the quarter on which you are reporting. Only insured patients should be included in your reporting on this metric.
### N_010

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>N_010 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Report on the number of unique patients referred by a OneCity Health Transition Management Team that have received medication reconciliation and associated follow-up services.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>July 31, 2018; October 31, 2018; January 31, 2019; April 30, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Provide documentation that demonstrates the number of unique patients that were referred by a OneCity Health Transition Management Team and received medication reconciliation and associated follow-up services.</td>
</tr>
</tbody>
</table>

**See Section F2 of Phase III Comprehensive Schedule B for additional process metric details**

### REPORTING INSTRUCTIONS

There are four due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>N_010.1</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>N_010.2</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>N_010.3</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>N_010.4</td>
<td>April 30, 2019</td>
<td>January 1, 2019 – March 31, 2019</td>
</tr>
</tbody>
</table>

Download the Excel reporting template from the Portal. The template will provide instructions on how to report the information below.

After completing the template, upload the template to the Portal and enter the following information from the template directly into the Portal:

- The number of patients who received:
  - Medication reconciliation by the Pharmacist within 3 days of referral; AND
  - A 3-month assessment of medication adherence

When completing the template, please enter complete information for all unique patients that received medication reconciliation and associated follow-up services for the quarter on which you are reporting.
N_011

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>N_011 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Demonstrate high rating on the Centers for Medicare and Medicaid Services (CMS) Five-Star Quality Rating System Score for Nursing Homes.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>December 31, 2018</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Submit evidence of CMS Five-Star Quality Rating System Score for Nursing Homes for Participant’s nursing home facility(ies). See Section F2 of Phase III Comprehensive Schedule B for additional process metric details</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

You will earn a percentage of the eligible amount listed in your contract for this metric as detailed in Section F2 of the Phase III Comprehensive Schedule B. The percentage will be determined upon the average of the CMS Five Star Overall Rating Score reported for each nursing home reported.

<table>
<thead>
<tr>
<th>Average CMS Five-Star Quality Rating System Score across all facilities</th>
<th>Payment for this metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average of 5.00 Stars</td>
<td>Partner receives 100% of metric maximum valuation</td>
</tr>
<tr>
<td>Average of 4.00 – 4.99 Stars</td>
<td>Partner receives 75% of metric maximum valuation</td>
</tr>
<tr>
<td>Average of 3.00 – 3.99 Stars</td>
<td>Partner receives 50% of metric maximum valuation</td>
</tr>
<tr>
<td>Average of less than 3.00 Stars</td>
<td>Partner receives 0% of metric maximum valuation</td>
</tr>
</tbody>
</table>

When reporting on this metric, you will be required to identify all eligible nursing homes.

Eligible nursing homes are defined as “residential health care facilities that serve individuals who need 24-hour nursing care and supervision due to their clinical conditions, functional impairments and/or need for specialized services; and are licensed and regulated by the New York State Department of Health and federal Centers for Medicare and Medicaid Services (CMS).”

When reporting on this metric, you will be required to indicate the following for each eligible nursing home in your system:

- Whether the nursing home has achieved an October 2018 CMS Five Star Overall Rating Score
- Upload evidence of October 2018 CMS Five Star Overall Rating Score for each nursing home. Evidence may include: applicable CMS ‘Nursing home profile’ or other documentation from CMS
- For each nursing home that you indicate is not eligible, please provide a justification for why that nursing home is not eligible.

NOTE: You can only submit this metric once through the OneCity Health Partner Portal – do not complete your submission until you are ready to provide documentation for all eligible nursing homes.
PS_001

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>PS_001 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Identify and connect appropriate patients to the OneCity Health Care Transitions program.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019; April 30, 2019; July 31, 2019; October 31, 2019;</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Provide documentation that reports the total number of patients connected to the OneCity Health Care Transitions program and meet the quarterly target defined by OneCity Health. This reports the number of patients (per episode) that were enrolled by Transition Management Teams as a result of work with the hospital.</td>
</tr>
</tbody>
</table>

See Section F2 of Phase III Comprehensive Schedule B for additional process metric details

REPORTING INSTRUCTIONS

There are seven due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_001.1</td>
<td>April 30, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>PS_001.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>PS_001.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>PS_001.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extension Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_001.5</td>
<td>April 30, 2019</td>
<td>January 1, 2019 - March 31, 2019</td>
</tr>
<tr>
<td>PS_001.6</td>
<td>July 31, 2019</td>
<td>April 1, 2019 – June 30, 2019</td>
</tr>
<tr>
<td>PS_001.7</td>
<td>October 31, 2019</td>
<td>July 1, 2019 – September 30, 2019</td>
</tr>
</tbody>
</table>

In order to receive payment for this metric each quarter, a partner must meet the indicated threshold of a minimum of 150 referred patients for each Transition Management Team.

A patient referral is defined as a patient who meets the referral criteria established by each participating hospital inpatient medical and/or behavioral health unit(s).

A partner will be held to these targets for teams considered active for the complete three-month reporting period. In order to be considered “active,” a team must include at least one licensed healthcare professional and accept patient referrals from the clinical teams on a participating hospital’s inpatient medical and/or behavioral health unit(s).
As an example, the table below illustrates the minimum number of patients that must be enrolled in the Care Transitions program to meet the payment threshold, based on the number of active Transition Management Teams for the quarter:

<table>
<thead>
<tr>
<th>Total # of Transition Management Teams</th>
<th>Minimum # of enrolled patients/quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>150</td>
</tr>
<tr>
<td>2</td>
<td>300</td>
</tr>
<tr>
<td>3</td>
<td>450</td>
</tr>
<tr>
<td>4</td>
<td>600</td>
</tr>
</tbody>
</table>

When reporting on this metric, you will be required to enter the following information in the Portal:

- Number of active Transition Management Teams for the three-month reporting period
- Number of referred patients
- Upload required supporting documentation including:
  - Patient-level supporting documentation (e.g., patient tracker or electronic medical record report) that identifies the total number of patients referred to the OneCity Health Care Transitions program for the reporting period. The supporting documentation must include the following elements for each patient:
    - Last name
    - First name
    - Gender
    - Date of birth
    - Medicaid Client Identification Number (required where applicable)
    - Date of referral to the Care Transitions program
  - Narrative describing any changes in the number of “active” Transition Management Teams during the quarter you are reporting on

For all metrics with a quarterly performance target, your submission will be reviewed for completeness to determine if the information you reported matches your uploaded supporting documentation:

- If your submission is complete and meets the quarterly performance target, it will appear as “Completed” in the Portal, and an invoice for payment will be generated.
- If your submission is complete but does not meet the quarterly performance target, it will still appear as “Completed” in the Portal, but will not generate an invoice for payment.

**Note:** OneCity Health needs to report to the NYS DOH on patients engaged by partners for this project, so it is important to submit these metrics even if your submission does not meet the quarterly performance target.
**Metric ID – Metric Type**  
**PS_002 – Process**

**Metric**  
Demonstrate that a minimum of sixty (60%) percent of patients assigned in the OneCity Health Care Transitions program have at least one (1) care plan update completed for each week of enrollment.

**Due Date(s)**  
April 24, 2018; July 25, 2018; October 25, 2018; January 25, 2019*; April 24, 2019; July 24, 2019; October 24, 2019;

**Participant Obligations**  
Accurately document within GSI all patients that have been enrolled in the Care Transitions Program in the defined reporting period and each weekly update made to the care plan.

Provide patient level documentation that demonstrates at least sixty (60%) percent of assigned care transitions patients have at least one (1) care plan update completed for each week of enrollment.

*The due dates for this metric were changed from: April 30, 2018; July 31, 2018; October 31, 2018; and January 31, 2019*

### REPORTING INSTRUCTIONS

There are seven due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_002.1</td>
<td>April 24, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>PS_002.2</td>
<td>July 25, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>PS_002.3</td>
<td>October 25, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>PS_002.4</td>
<td>January 25, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Extension Metric:</td>
<td>Report due date:</td>
<td>Reporting time period:</td>
</tr>
<tr>
<td>PS_002.5</td>
<td>April 24, 2019</td>
<td>January 1, 2019 - March 31, 2019</td>
</tr>
<tr>
<td>PS_002.6</td>
<td>July 24, 2019</td>
<td>April 1, 2019 – June 30, 2019</td>
</tr>
<tr>
<td>PS_002.7</td>
<td>October 24, 2019</td>
<td>July 1, 2019 – September 30, 2019</td>
</tr>
</tbody>
</table>

In order to receive payment for this metric, partners must meet a threshold of a minimum of 60% of assigned patients have at least four care plan updates during the 30 day care transitions episode. Once this threshold is met, partners will be paid $150 per patient per care plan update, with a maximum of four updates per patient during each care transitions episode. See examples below:
Example scenarios:

<table>
<thead>
<tr>
<th>Example scenarios</th>
<th>Partner Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% - 59% of assigned patients have 4 care plan updates</td>
<td>Threshold is NOT met - Partner does not receive any payment for this metric</td>
</tr>
<tr>
<td>60% of assigned patients have 4 care plan updates</td>
<td>Threshold is met – Partner receives payment of $150 per care plan update ($)600 per assigned patient</td>
</tr>
<tr>
<td>&gt;60% of assigned patients have up to 4 care plan updates</td>
<td>Partner receives payment of $150 per care plan update (up to a maximum of $600 per assigned patient)</td>
</tr>
</tbody>
</table>

When reporting on this metric, you will be required to enter the following information in the Portal:

- Information to demonstrate that payment threshold was met:
  - Numerator: Number of graduated patients with 4 care plan updates
  - Denominator: Total number of graduated patients
- Total number of care plan updates (up to a maximum of 4 per patient)
- Upload required supporting documentation including:
  - Patient-level supporting documentation (e.g. GSI report) that includes all patients enrolled in or graduated from the OneCity Health Care Transitions program during the reporting period. The supporting documentation must include the following elements:
    - Last name
    - First name
    - Gender
    - Date of birth
    - Medicaid Client Identification Number (required where applicable)
    - Date of enrollment in the Care Transitions program
    - Date of assignment in the Care Transitions program
    - Date(s) of care plan update (up to a maximum of 4 per patient)

Provide supplemental documentation if applicable that captures additional engaged patients in this project for OneCity Health review.

Note: A care plan update must occur weekly (every 7 days); all four updates cannot occur during the last week of assigned status.

For all metrics with a threshold for performance, your submission will be reviewed for completeness to determine if the numerator and denominator you reported match your uploaded supporting documentation:

- If your submission is complete and meets the threshold for performance (60%), it will appear as “Completed” in the Portal, and an invoice for payment will be generated, based on the criteria detailed above.
- If your submission is complete but does not meet the threshold for performance (60%), it will still appear as “Completed” in the Portal, but will not generate an invoice for payment.

Note: OneCity Health needs to report to the NYS DOH on patients engaged by partners for this project, so it is important to submit these metrics even if your submission does not meet the quarterly performance threshold.
### PS_003

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>PS_003 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Identify and connect appropriate patients to the OneCity Health Asthma Community Health Worker (CHW) program.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019; April 30, 2019; July 31, 2019;</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Provide documentation that reports total number of patients connected to the OneCity Health Asthma CHW program and meet the quarterly target defined by OneCity Health. Connected is defined as a patient having been referred to the home visit program in GSI. A complete connection must include a completed asthma action plan in GSI.</td>
</tr>
<tr>
<td></td>
<td><em>See Section F2 of Phase III Comprehensive Schedule B for additional process metric details</em></td>
</tr>
</tbody>
</table>

#### REPORTING INSTRUCTIONS

There are six due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_003.1</td>
<td>April 30, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>PS_003.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>PS_003.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>PS_003.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extension Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_003.5</td>
<td>April 30, 2019</td>
<td>January 1, 2019 - March 31, 2019</td>
</tr>
<tr>
<td>PS_003.6</td>
<td>July 31, 2019</td>
<td>April 1, 2019 – June 30, 2019</td>
</tr>
</tbody>
</table>

When reporting on this metric, you will be required to enter the following information in the Portal:

- Total number of unique patients connected to the OneCity Health Asthma Community Health Worker (CHW) program during the reporting period
  - Connected is defined as a patient having been referred to the home visit program in GSI. A completed connection must include a completed asthma action plan in GSI
  - Note: every partner has a quarterly performance target defined in their Phase III Comprehensive Schedule B. In order to receive payment for this metric, the number of connections reported must meet the quarterly performance target
Upload patient-level supporting documentation that supports the total number of connections reported. This supporting documentation must include the following elements:
  - Last name
  - First name
  - Gender
  - Date of birth
  - Medicaid Client Identification Number (required where applicable)
  - Date completed asthma action plan uploaded in GSI

For all metrics with a quarterly performance target, your submission will be reviewed for completeness to determine if the information you reported matches your uploaded supporting documentation:
  - If your submission is complete and meets the quarterly performance target, it will appear as “Completed” in the Portal, and an invoice for payment will be generated.
  - If your submission is complete but does not meet the quarterly performance target, it will still appear as “Completed” in the Portal, but will not generate an invoice for payment.

**Note:** OneCity Health needs to report to the NYS DOH on patients engaged by partners for this project, so it is important to submit these metrics even if your submission does not meet the quarterly performance target.
**Metric ID – Metric Type** | **PS_004 – Process**
--- | ---
**Metric** | Demonstrate that a minimum of thirty (30%) percent of patients enrolled in the OneCity Health Asthma Community Health Worker (CHW) program have a completed home visit.
**Due Date(s)** | April 24, 2018; July 25, 2018; October 25, 2018; January 25, 2019*; April 24, 2019; July 24, 2019;
**Participant Obligations** | Accurately document within GSI all patients that have been enrolled in the Asthma CHW Program in the defined reporting period and the status of a completed home visit.
Provide documentation that demonstrates thirty (30%) percent of patients enrolled in the Asthma CHW Program have a completed home visit.
A completed home visit includes a completed home assessment and follow up care coordination services with the medical provider.

*See Section F2 of Phase III Comprehensive Schedule B for additional process metric details*

---

*The due dates for this metric were changed from: April 30, 2018; July 31, 2018; October 31, 2018; and January 31, 2019*

**REPORTING INSTRUCTIONS**

There are six due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_004.1</td>
<td>April 24, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>PS_004.2</td>
<td>July 25, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>PS_004.3</td>
<td>October 25, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>PS_004.4</td>
<td>January 25, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

**Extension Metric:**

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_004.5</td>
<td>April 24, 2019</td>
<td>January 1, 2019 - March 31, 2019</td>
</tr>
<tr>
<td>PS_004.6</td>
<td>July 24, 2019</td>
<td>April 1, 2019 – June 30, 2019</td>
</tr>
</tbody>
</table>

In order to receive payment for this metric, partners must meet a threshold of a minimum of 30% of patients enrolled in the OneCity Health Asthma Community Health Worker (CHW) program have a completed home visit. Once this threshold is met, partners will be paid $325 per home visit, with a maximum of three home visits per patient during 2018. See examples below:

<table>
<thead>
<tr>
<th>Example scenarios:</th>
<th>Partner Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% - 29% of enrolled patients have a completed home visit</td>
<td>Threshold is NOT met - Partner does not receive any payment for this metric</td>
</tr>
<tr>
<td>30% of enrolled patients have a completed home visit</td>
<td>Threshold is met – Partner receives payment of $325 per home visit</td>
</tr>
</tbody>
</table>
30% of enrolled patients have a completed home visit. Partner receives payment of $325 per home visit [up to a maximum of 3 home visits ($975 per patient) per year].

When reporting on this metric, you will be required to enter the following information in the Portal:

- Information to demonstrate that payment threshold was met:
  - Numerator: All patients with a status of ‘assigned’ or ‘enrolled’ in GSI who had a home visit completed
  - Denominator: All patients with a status of ‘assigned’ or ‘enrolled’ in GSI at any time within the reporting time period
- Total number of completed home visits for the reporting period
  - NOTE: maximum of 3 visits per patient per year
- Upload required supporting documentation including:
  - Patient-level supporting documentation that includes all patients enrolled in the OneCity Health Asthma Community Health Worker (CHW) program during the reporting period. The supporting documentation must include the following elements:
    - Last name
    - First name
    - Gender
    - Date of birth
    - Medicaid Client Identification Number (required where applicable)
    - Date(s) of home visits
    - Any other relevant information to support the numerator and denominator

Provide supplemental documentation if applicable that captures additional engaged patients in this project for OneCity Health review.

For all metrics with a threshold for performance, your submission will be reviewed for completeness to determine if the numerator and denominator you reported match your uploaded supporting documentation:

- If your submission is complete and meets the threshold for performance (30%), it will appear as “Completed” in the Portal, and an invoice for payment will be generated, based on the criteria detailed above.
- If your submission is complete but does not meet the threshold for performance (30%), it will still appear as “Completed” in the Portal, but will not generate an invoice for payment.

Note: OneCity Health needs to report to the NYS DOH on patients engaged by partners for this project, so it is important to submit these metrics even if your submission does not meet the quarterly performance threshold.
PS_005

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>PS_005 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Identify and connect appropriate patients to the OneCity Health Health Home At-Risk program.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019; April 30, 2019;</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Provide documentation that reports total number of patients (per episode) connected to the OneCity Health Health Home At-Risk program and meet the quarterly target defined by OneCity Health.</td>
</tr>
</tbody>
</table>

See Section F2 of Phase III Comprehensive Schedule B for additional process metric details

REPORTING INSTRUCTIONS

There are five due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_005.1</td>
<td>April 30, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>PS_005.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>PS_005.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>PS_005.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Extension Metric:</td>
<td>Report due date:</td>
<td>Reporting time period:</td>
</tr>
<tr>
<td>PS_005.5</td>
<td>April 30, 2019</td>
<td>January 1, 2019 - March 31, 2019</td>
</tr>
</tbody>
</table>

An “appropriate” patient referral is defined as a patient diagnosed with at least one (1) chronic health condition and is at risk of worsening health.

When reporting on this metric, you will be required to enter the following information in the Portal:

- Total number of patients connected (referred) to the OneCity Health Health Home At-Risk program during the reporting period
  - Note: every partner has a quarterly performance target defined in their Phase III Comprehensive Schedule B. In order to receive payment for this metric, the number of connections (referrals) reported must meet the quarterly performance target
- Upload patient-level supporting documentation that supports the total number of connections (referrals) reported. This supporting documentation must include the following elements for each patient:
  - Last name
  - First name
  - Gender
- Date of birth
- Medicaid Client Identification Number (required where applicable)
- Date of referral to the OneCity Health Health Home At-Risk program

For all metrics with a quarterly performance target, your submission will be reviewed for completeness to determine if the information you reported matches your uploaded supporting documentation:

- If your submission is complete and meets the quarterly performance target, it will appear as “Completed” in the Portal, and an invoice for payment will be generated.
- If your submission is complete but does not meet the quarterly performance target, it will still appear as “Completed” in the Portal, but will not generate an invoice for payment.

Note: OneCity Health needs to report to the NYS DOH on patients engaged by partners for this project, so it is important to submit these metrics even if your submission does not meet the quarterly performance target.
**PS_006**

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>Metric ID – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_006 – Process</td>
<td></td>
</tr>
</tbody>
</table>

**Metric**

Demonstrate that care coordination activities have been completed for a minimum of sixty (60%) percent of patients assigned to the OneCity Health Health Home At-Risk program.

**Due Date(s)**

April 24, 2018; July 25, 2018; October 25, 2018; January 25, 2019*, April 24, 2019; July 24, 2019; October 24, 2019;

**Participant Obligations**

Accurately document all patients that have been assigned in the Health Home At-Risk Program in the defined reporting period.

Provide documentation that demonstrates sixty (60%) percent of patients assigned to the Health Home at Risk Program have completed care coordination activities.

Care coordination activities include completed care plan and coordination with the medical provider.

*The due dates for this metric were changed from: April 30, 2018; July 31, 2018; October 31, 2018; and January 31, 2019

**REPORTING INSTRUCTIONS**

There are seven due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_006.1</td>
<td>April 24, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>PS_006.2</td>
<td>July 25, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>PS_006.3</td>
<td>October 25, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>PS_006.4</td>
<td>January 25, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extension Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_006.5</td>
<td>April 24, 2019</td>
<td>January 1, 2019 - March 31, 2019</td>
</tr>
<tr>
<td>PS_006.6</td>
<td>July 24, 2019</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>PS_006.7</td>
<td>October 24, 2019</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
</tbody>
</table>

In order to receive payment for this metric, a partner must meet a threshold of completed care coordination activities for a minimum of 60% of patients assigned to the OneCity Health Health Home At-Risk program. Once this threshold is met, a partner will be paid $225 per patient per month, up to a maximum of 6 months per patient per each Health Home At-Risk episode of enrollment. For example:
Example scenarios:

<table>
<thead>
<tr>
<th>Care Coordination Activities</th>
<th>Partner Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% - 59% of assigned patients completed care coordination activities</td>
<td>Threshold is NOT met - Partner does not receive any payment for this metric</td>
</tr>
<tr>
<td>60% of assigned patients have completed care coordination activities</td>
<td>Threshold is met – Partner receives payment of $225 per patient per month (up to a maximum of 6 months per patient per each episode of enrollment)</td>
</tr>
<tr>
<td>&gt;60% of assigned patients have completed care coordination activities</td>
<td>Partner receives payment of $225 per patient per month (up to a maximum of 6 months per patient per each episode of enrollment)</td>
</tr>
</tbody>
</table>

**Note:** *Care coordination activities* include development of an individualized care plan inclusive of goal(s) and intervention(s) and coordination with a patient’s (client’s) primary care provider.

**When reporting on this metric, you will be required to enter the following information in the Portal:**

- Number of assigned patients (clients) receiving completed care coordination activities:
  - For 3 months
  - For 2 months
  - For 1 month
- Information to demonstrate that the performance threshold was met:
  - Numerator: Total number of assigned patients with at least one completed care coordination activity [this value will auto-calculate in the Portal from the information entered above]
  - Denominator: Total number of patients assigned to the OneCity Health Health Home At-Risk program during the reporting period
- Upload required supporting documentation including:
  - Patient (client)-level supporting documentation that includes all patients (clients) assigned to the OneCity Health Health Home At-Risk program during the reporting period. The supporting documentation must include the following elements for each patient (client):
    - Last name
    - First name
    - Gender
    - Date of birth
    - Medicaid Client Identification Number (required where applicable)
    - Date of referral to the Health Home At-Risk program

Provide supplemental documentation if applicable that captures additional engaged patients in this project for OneCity Health review.
Note: If a patient (client) converts to the Health Home program during the reporting period, you cannot report such patient (client) for any of the subsequent remaining month(s) of the reporting period.

For all metrics with a threshold for performance, your submission will be reviewed for completeness to determine if the numerator and denominator you reported match your uploaded supporting documentation:

- If your submission is complete and meets the threshold for performance (60%), it will appear as “Completed” in the Portal, and an invoice for payment will be generated, based on the criteria detailed above.
- If your submission is complete but does not meet the threshold for performance (60%), it will still appear as “Completed” in the Portal, but will not generate an invoice for payment.

Note: OneCity Health needs to report to the NYS DOH on patients engaged by partners for this project, so it is important to submit these metrics even if your submission does not meet the quarterly performance threshold.
**PS_007**

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>PS_007 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria. (2.b.iii Emergency Department Triage for At-Risk Populations).</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 24, 2018; July 25, 2018; October 25, 2018; January 25, 2019*</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Submit timely and accurate reports based on the defined criteria outlined in this Comprehensive Schedule B, see Section F2.</td>
</tr>
</tbody>
</table>

*The due dates for this metric were changed from: April 30, 2018; July 31, 2018; October 31, 2018; and January 31, 2019

**REPORTING INSTRUCTIONS**

This metric involves reporting on Patient Engagement (similar to Phase II), but it has been incorporated into Process Metrics for Phase III. In addition to the metric-specific instructions below, please see the [Supplemental Information on Patient Engagement Reporting](#) included at the end of this section for your reference.

In the Portal, there are two different Excel reporting templates available for this metric, depending on which quarter you are reporting on.

- The templates will provide instructions on how to report on this project’s “actively engaged” patients.
- The NYS DOH’s definition and clarifying information of “actively engaged” patients for this metric are included below as well.

Please see the table below which identifies the reporting time period and other details for each metric:

<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Report due date</th>
<th>Reporting time period</th>
<th>Reporting template to use</th>
<th>Information to enter into Portal when reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_007.1</td>
<td>April 24, 2018</td>
<td>DSRIP Year 3, Quarter 4 (DY3 Q4): January 1, 2018 – March 31, 2018</td>
<td>Template 1_PS_007_DY3Q4</td>
<td>Upload the completed reporting template</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Report engaged patients for this quarter only</td>
<td></td>
<td>Enter the number of actively engaged patients for DY3Q4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reporting template to use:</td>
<td></td>
<td>Enter the cumulative number of actively engaged patients (<strong>For this quarter, this will be the same number as the one you just entered – the number engaged for DY3Q4</strong>)</td>
</tr>
<tr>
<td>PS_007.2</td>
<td>July 25, 2018</td>
<td>DSRIP Year 4, Quarter 1 (DY4 Q1): April 1, 2018 – June 30, 2018</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| PS_007.3 | October 25, 2018 | **Reporting time period:**  
- DSRIP Year 4, Quarters 1 - 2 (DY4Q1-2): April 1, 2018 – September 30, 2018:  
  - Include new patients engaged DY4Q2: July 1, 2018 – September 30, 2018  
  - Include previously reported patients engaged DY4Q1: April 1, 2018 – June 30, 2018  
**Reporting template to use:**  
- Template 2_PS_007_DY4Q1-3  
**Information to enter into Portal when reporting:**  
- Upload the completed reporting template  
- Enter the number of unique actively engaged patients for DY4Q2  
- Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above) (**For this quarter, this will be the same number as the one you just entered – the number actively engaged for DY4Q1**) |
| PS_007.4 | January 25, 2019 | **Reporting time period:**  
- DSRIP Year 4, Quarters 1 - 3 (DY4Q1-3): April 1, 2018 – December 31, 2018:  
  - Include new patients engaged DY4Q3: October 1, 2018 – December 31, 2018  
  - Include previously reported patients engaged DY4Q1-2: April 1, 2018 – September 30, 2018  
**Reporting template to use:**  
- Template 2_PS_007_DY4Q1-3  
**Information to enter into Portal when reporting:**  
- Upload the completed reporting template  
- Enter the number of unique actively engaged patients for DY4Q3  
- Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above) |
NYS Department of Health’s definition / clarifying information of “actively engaged” patients:

<table>
<thead>
<tr>
<th>Definition</th>
<th>The number of participating patients presenting to the ED, who after medical screening examination were successfully redirected to a PCP or Health Home care manager as demonstrated by a scheduled appointment, or successfully redirected to a PCP en route to ED.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarifying Information</td>
<td>The term “successfully redirected” means that the patient had or was made aware of an appointment with a PCP or Health Home care manager within 30 days after ED presentation and medical screening. Health Home care manager will only serve an option for those patients enrolled in a Health Home at time of presentation to the ED. A redirection could occur within or en route to the ED.</td>
</tr>
<tr>
<td>Counting Criteria</td>
<td>A count of patients who meet the criteria over a 1-year measurement period. <strong>Duplicate counts of patients are NOT allowed.</strong> The count is not additive across DSRIP years.</td>
</tr>
</tbody>
</table>

Source: [https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-10-28_actively_engaged_definitions.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-10-28_actively_engaged_definitions.pdf) (Note: The information above reflects updated guidance provided by the DOH on July 1, 2016.)
### PS_008

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>PS_008 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria. (3.a.i Integration of Primary Care and Behavioral Health Services).</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 24, 2018; July 25, 2018; October 25, 2018; January 25, 2019*</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Submit timely and accurate reports based on the defined criteria outlined in this Comprehensive Schedule B, see Section F2 below.</td>
</tr>
</tbody>
</table>

*The due dates for this metric were changed from: April 30, 2018; July 31, 2018; October 31, 2018; and January 31, 2019

**REPORTING INSTRUCTIONS**

This metric involves reporting on Patient Engagement (similar to Phase II), but it has been incorporated into Process Metrics for Phase III. In addition to the metric-specific instructions below, please see the Supplemental Information on Patient Engagement Reporting included at the end of this section for your reference.

In the Portal, there are two different Excel reporting templates available for this metric, depending on which quarter you are reporting on.

- The templates will provide instructions on how to report on this project’s “actively engaged” patients.
- The NYS DOH’s definition and clarifying information of “actively engaged” patients for this metric are included below as well.

Please see the table below which identifies the reporting time period and other details for each metric:

<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Report due date</th>
<th>Reporting details</th>
</tr>
</thead>
</table>
| PS_008.1  | April 24, 2018  | **Reporting time period:**
|           |                 | • DSRIP Year 3, Quarter 4 (DY3 Q4): January 1, 2018 – March 31, 2018
|           |                 | • Report engaged patients for this quarter only
|           |                 | **Reporting template to use:**
|           |                 | • Template 1_PS_008_DY3Q4
|           |                 | **Information to enter into Portal when reporting:**
|           |                 | • Upload the completed reporting template
|           |                 | • Enter the number of unique actively engaged patients for DY3Q4
|           |                 | • Enter the cumulative number of actively engaged patients (**For this quarter, this will be the same number as the one you just entered – the number engaged for DY3Q4**) |
| PS_008.2 | July 25, 2018 | **Reporting time period:**  
- DSRIP Year 4, Quarter 1 (DY4 Q1): April 1, 2018 – June 30, 2018  
- Report engaged patients for this quarter only  
**Reporting template to use:**  
- Template 2_PS_008_DY4Q1-3  
**Information to enter into Portal when reporting:**  
- Upload the completed reporting template  
- Enter the number of unique actively engaged patients for DY4Q1  
- Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above) (**For this quarter, this will be the same number as the one you just entered – the number actively engaged for DY4Q1**) |
| PS_008.3 | October 25, 2018 | **Reporting time period:**  
- DSRIP Year 4, Quarters 1 - 2 (DY4 Q1-2): April 1, 2018 – September 30, 2018:  
  - Include *new patients* engaged DY4Q2: July 1, 2018 – September 30, 2018  
  - Include *previously reported patients* engaged DY4Q1: April 1, 2018 – June 30, 2018  
**Reporting template to use:**  
- Template 2_PS_008_DY4Q1-3  
**Information to enter into Portal when reporting:**  
- Upload the completed reporting template  
- Enter the number of unique actively engaged patients for DY4Q2  
- Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above) |
| PS_008.4 | January 25, 2019 | **Reporting time period:**  
- DSRIP Year 4, Quarters 1 - 3 (DY4 Q1-3): April 1, 2018 – December 31, 2018:  
  - Include *new patients* engaged DY4Q3: October 1, 2018 – December 31, 2018  
  - Include *previously reported patients* engaged DY4Q1-2: April 1, 2018 – September 30, 2018  
**Reporting template to use:**  
- Template 2_PS_008_DY4Q1-3  
**Information to enter into Portal when reporting:**  
- Upload the completed reporting template  
- Enter the number of unique actively engaged patients for DY4Q3  
- Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above) |

**NOTE:** When completing the reporting template for this metric, you will be required to indicate which Model each listed patient was engaged within. Guidance on all three models is included below.
NYS Department of Health’s definition / clarifying information of “actively engaged” patients:

Model 1: Co-location of behavioral health into primary care setting

<table>
<thead>
<tr>
<th>Definition</th>
<th>The total number of patients receiving appropriate preventive care screenings that include mental health/substance abuse.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarifying Information</td>
<td>The PPS is expected to utilize the preventive care screening based on nationally-accepted best practices determined to be age-appropriate. Any staffer working at a PCMH/APCM Service Site who is qualified to perform a preventive care screening can do so. However, preventive care screenings conducted with a patient via telepsychiatry alone will not count within this active engagement definition. Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record. The expectation of a co-located primary care-behavioral health site is that there is a licensed behavioral health provider on site engaged in the practice.</td>
</tr>
<tr>
<td>Counting Criteria</td>
<td>A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are NOT allowed. The count is not additive across DSRIP years.</td>
</tr>
</tbody>
</table>


Model 2: Co-location of primary care into behavioral health setting

<table>
<thead>
<tr>
<th>Definition</th>
<th>The total number of patients receiving primary care services at a participating mental health or substance abuse site.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarifying Information</td>
<td>Primary care services are defined as preventive care screenings billed through Current Procedural Terminology (CPT) codes. The mental health and substance abuse sites have to be partners within the PPS in order to count. Any staffer working at a Behavioral Health Site who is qualified to perform a preventive care screening as required within the project can do so. Appropriate screenings would only count if the PCP or the clinical staff provided the results of the screen and they are incorporated into the medical record. The only types of “primary care providers” that may be utilized to provide primary care services within the BH site are participating PCPs, NPs, and physician assistants working closely with a PCP.</td>
</tr>
<tr>
<td>Counting Criteria</td>
<td>A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are NOT allowed. The count is not additive across DSRIP years.</td>
</tr>
</tbody>
</table>


Model 3: IMPACT model (Improving Mood – Promoting Access to Collaborative Treatment)

<table>
<thead>
<tr>
<th>Definition</th>
<th>The total number of patients screened using the PHQ-2 or 9 / SBIRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarifying Information</td>
<td>Patients in this model will only count as actively engaged if they receive either the PHQ-2, PHQ-9, or SBIRT screenings. All five principles of the IMPACT model</td>
</tr>
</tbody>
</table>
must be in place for a site to count. Any staffer working within the IMPACT model who is qualified to perform a preventive care screening as required within the project can do so. Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.

| Counting Criteria: | A count of patients who meet the criteria over a 1-year measurement period. **Duplicate counts of patients are NOT allowed.** The count is not additive across DSRIP years. |

**PS_009**

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>PS_009 - Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria. (3.b.i Evidence-Based Strategies for Disease Management in High-Risk/Affected Populations, Adults Only).</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 24, 2018; July 25, 2018; October 25, 2018; January 25, 2019*</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Submit timely and accurate reports based on the defined criteria outlined in this Comprehensive Schedule B, see Section F2 below.</td>
</tr>
</tbody>
</table>

*The due dates for this metric were changed from: April 30, 2018; July 31, 2018; October 31, 2018; and January 31, 2019*

**REPORTING INSTRUCTIONS**

This metric involves reporting on Patient Engagement (similar to Phase II), but it has been incorporated into Process Metrics for Phase III. In addition to the metric-specific instructions below, please see the [Supplemental Information on Patient Engagement Reporting](#) included at the end of this section for your reference.

In the Portal, there are two different Excel reporting templates available for this metric, depending on which quarter you are reporting on.

- The templates will provide instructions on how to report on this project’s “actively engaged” patients.
- The NYS DOH’s definition and clarifying information of “actively engaged” patients for this metric are included below as well.

Please see the table below which identifies the reporting time period and other details for each metric:

<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Report due date</th>
<th>Reporting details</th>
</tr>
</thead>
</table>
| PS_009.1  | April 24, 2018 | Reporting time period:  
  - DSRIP Year 3, Quarter 4 (DY3 Q4): January 1, 2018 – March 31, 2018  
  - Report engaged patients for this quarter only  
Reporting template to use:  
  - Template 1_PS_009_DY3Q4  
Information to enter into Portal when reporting:  
  - Upload the completed reporting template  
  - Enter the number of unique actively engaged patients for DY3Q4  
  - Enter the cumulative number of actively engaged patients (**For this quarter, this will be the same number as the one you just entered – the number engaged for DY3Q4***) |
| PS_009.2 | July 25, 2018 | Reporting time period:  
• DSRIP Year 4, Quarter 1 (DY4 Q1): April 1, 2018 – June 30, 2018  
• Report engaged patients for this quarter only  
Reporting template to use:  
• Template 2_PS_009_DY4Q1-3  
Information to enter into Portal when reporting:  
• Upload the completed reporting template  
• Enter the number of unique actively engaged patients for DY4Q1  
• Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above) (**For this quarter, this will be the same number as the one you just entered – the number actively engaged for DY4Q1**) |
| PS_009.3 | October 25, 2018 | Reporting time period:  
• DSRIP Year 4, Quarters 1 - 2 (DY4 Q1-2): April 1, 2018 – September 30, 2018:  
  o Include new patients engaged DY4Q2: July 1, 2018 – September 30, 2018  
  o Include previously reported patients engaged DY4Q1: April 1, 2018 – June 30, 2018  
Reporting template to use:  
• Template 2_PS_009_DY4Q1-3  
Information to enter into Portal when reporting:  
• Upload the completed reporting template  
• Enter the number of unique actively engaged patients for DY4Q2  
• Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above) |
| PS_009.4 | January 25, 2019 | Reporting time period:  
• DSRIP Year 4, Quarters 1 - 3 (DY4 Q1-3): April 1, 2018 – December 31, 2018:  
  o Include new patients engaged DY4Q3: October 1, 2018 – December 31, 2018  
  o Include previously reported patients engaged DY4Q1-2: April 1, 2018 – September 30, 2018  
Reporting template to use:  
• Template 2_PS_009_DY4Q1-3  
Information to enter into Portal when reporting:  
• Upload the completed reporting template  
• Enter the number of unique actively engaged patients for DY4Q3  
• Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above) |

**NOTE:** For the purposes of defining “High Risk/Affected Populations,” OneCity Health has elected to focus on adult patients with cardiovascular conditions. Actively engaged patients for this metric should only include adult patients who either are diagnosed with a cardiovascular disease or are at high-risk for developing a cardiovascular disease. This can include, but is not limited to, patients diagnosed with coronary artery disease or congenital heart disease or patients who have certain risk factors including hypertension, diabetes, or obesity.
NYS Department of Health’s definition / clarifying information of “actively engaged” patients:

<table>
<thead>
<tr>
<th>Definition</th>
<th>The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarifying Information</td>
<td>Core components require documentation of patient-driven, self-management goals in the medical record, which are reviewed at every appointment. Information must be updated in the medical record on an ongoing basis and goals should be reviewed at every appointment. Key patient information needs to be available through the HIE throughout the PPS. This is needed so that, for example, a cardiologist and PCP seeing the same patient can access the same information through the RHIO.</td>
</tr>
<tr>
<td>Counting Criteria</td>
<td>A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are NOT allowed. The count is not additive across DSRIP years.</td>
</tr>
</tbody>
</table>

**PS_010**

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>PS_010 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria. (3.g.i Integration of Palliative Care into the PCMH Model).</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 24, 2018; July 25, 2018; October 25, 2018; January 25, 2019*</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Submit timely and accurate reports based on the defined criteria outlined in this Comprehensive Schedule B, see Section F2 below.</td>
</tr>
</tbody>
</table>

*The due dates for this metric were changed from: April 30, 2018; July 31, 2018; October 31, 2018; and January 31, 2019

**REPORTING INSTRUCTIONS**

This metric involves reporting on Patient Engagement (similar to Phase II), but it has been incorporated into Process Metrics for Phase III. In addition to the metric-specific instructions below, please see the [Supplemental Information on Patient Engagement Reporting](#) included at the end of this section for your reference.

In the Portal, there are two different Excel reporting templates available for this metric, depending on which quarter you are reporting on.

- The templates will provide instructions on how to report on this project’s “actively engaged” patients.
- The NYS DOH’s definition and clarifying information of “actively engaged” patients for this metric are included below as well.

Please see the table below which identifies the reporting time period and other details for each metric:

<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Report due date</th>
<th>Reporting details</th>
</tr>
</thead>
</table>
| PS_010.1  | April 24, 2018  | **Reporting time period:**  
- DSRIP Year 3, Quarter 4 (DY3 Q4): January 1, 2018 – March 31, 2018  
- Report engaged patients for this quarter only  
**Reporting template to use:**  
- Template 1_PS_010_DY3Q4  
**Information to enter into Portal when reporting:**  
- Upload the completed reporting template  
- Enter the number of unique actively engaged patients for DY3Q4  
- Enter the cumulative number of actively engaged patients (**For this quarter, this will be the same number as the one you just entered – the number engaged for DY3Q4***) |
<table>
<thead>
<tr>
<th>PS_010.2</th>
<th>July 25, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reporting time period:</strong></td>
<td></td>
</tr>
<tr>
<td>• DSRIP Year 4, Quarter 1 (DY4 Q1): April 1, 2018 – June 30, 2018</td>
<td></td>
</tr>
<tr>
<td>• Report engaged patients for this quarter only</td>
<td></td>
</tr>
<tr>
<td><strong>Reporting template to use:</strong></td>
<td></td>
</tr>
<tr>
<td>• Template 2_PS_010_DY4Q1-3</td>
<td></td>
</tr>
<tr>
<td><strong>Information to enter into Portal when reporting:</strong></td>
<td></td>
</tr>
<tr>
<td>• Upload the completed reporting template</td>
<td></td>
</tr>
<tr>
<td>• Enter the number of unique actively engaged patients for DY4Q1</td>
<td></td>
</tr>
</tbody>
</table>
| • Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above) (**For this quarter, this will be the same number as the one you just entered – the number actively engaged for DY4Q1**)

<table>
<thead>
<tr>
<th>PS_010.3</th>
<th>October 25, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reporting time period:</strong></td>
<td></td>
</tr>
<tr>
<td>• DSRIP Year 4, Quarters 1 - 2 (DY4 Q1-2): April 1, 2018 – September 30, 2018:</td>
<td></td>
</tr>
<tr>
<td>o Include <em>new patients</em> engaged DY4Q2: July 1, 2018 – September 30, 2018</td>
<td></td>
</tr>
<tr>
<td>o Include <em>previously reported patients</em> engaged DY4Q1: April 1, 2018 – June 30, 2018</td>
<td></td>
</tr>
<tr>
<td><strong>Reporting template to use:</strong></td>
<td></td>
</tr>
<tr>
<td>• Template 2_PS_010_DY4Q1-3</td>
<td></td>
</tr>
<tr>
<td><strong>Information to enter into Portal when reporting:</strong></td>
<td></td>
</tr>
<tr>
<td>• Upload the completed reporting template</td>
<td></td>
</tr>
<tr>
<td>• Enter the number of unique actively engaged patients for DY4Q2</td>
<td></td>
</tr>
<tr>
<td>• Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PS_010.4</th>
<th>January 25, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reporting time period:</strong></td>
<td></td>
</tr>
<tr>
<td>• DSRIP Year 4, Quarters 1 - 3 (DY4 Q1-3): April 1, 2018 – December 31, 2018:</td>
<td></td>
</tr>
<tr>
<td>o Include <em>new patients</em> engaged DY4Q3: October 1, 2018 – December 31, 2018</td>
<td></td>
</tr>
<tr>
<td>o Include <em>previously reported patients</em> engaged DY4Q1-2: April 1, 2018 – September 30, 2018</td>
<td></td>
</tr>
<tr>
<td><strong>Reporting template to use:</strong></td>
<td></td>
</tr>
<tr>
<td>• Template 2_PS_010_DY4Q1-3</td>
<td></td>
</tr>
<tr>
<td><strong>Information to enter into Portal when reporting:</strong></td>
<td></td>
</tr>
<tr>
<td>• Upload the completed reporting template</td>
<td></td>
</tr>
<tr>
<td>• Enter the number of unique actively engaged patients for DY4Q3</td>
<td></td>
</tr>
<tr>
<td>• Enter the cumulative number of unique actively engaged patients for the DSRIP year to date (April 1, 2018 – end of reporting time period listed above)</td>
<td></td>
</tr>
</tbody>
</table>
NOTE: For the purposes of reporting on this metric, “palliative care services” delivered in the PCMH setting may include: Health Care Proxies; Do Not Resuscitate orders; Living Wills; Pain Screenings; Referral to Hospice; or Medical Orders for Life-Sustaining Treatment (MOLST).

NYS Department of Health’s definition / clarifying information of “actively engaged” patients:

<table>
<thead>
<tr>
<th>Definition</th>
<th>The number of participating patients receiving palliative care services at participating PCMH sites, in accordance with the adopted clinical guidelines.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarifying Information</td>
<td>To be considered receiving “palliative care services,” participating patients must be receiving palliative care from providers at the PCMH site that have appropriately integrated palliative care into practice models. Thus, the intent of this project is not to limit services to be provided only by palliative care specialists, but also to include members of the clinical team who have been trained to bring integrated palliative care into practice models. Palliative care services can include both services billed to Medicaid, as well as services not billable to Medicaid that are clearly documented in the patient’s medical record. Palliative care services provided through this project must meet the principles established by the Center to Advance Palliative Care, be consistent with the NQF’s A Crosswalk of National Quality Forum Preferred Practices (<a href="https://media.capc.org/filer_public/88/06/8806cedd-f78a-4d14-a90e-aca688147a18/nqfcrosswalk.pdf">https://media.capc.org/filer_public/88/06/8806cedd-f78a-4d14-a90e-aca688147a18/nqfcrosswalk.pdf</a>), or the most updated guidance.</td>
</tr>
<tr>
<td>Counting Criteria</td>
<td>A count of patients who meet the criteria over a 1-year measurement period. <strong>Duplicate counts of patients are NOT allowed.</strong> The count is not additive across DSRIP years.</td>
</tr>
</tbody>
</table>

**PS_011**

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>PS_011 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Submit documentation of at least thirty (30) completed Integrated Palliative Care Outcome Scale (IPOS) assessments for eligible primary care patients as detailed by OneCity Health Services.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Provide documentation that demonstrates completion of at least thirty (30) IPOS assessments for eligible primary care patients.</td>
</tr>
</tbody>
</table>

**REPORTING INSTRUCTIONS**

There are four due dates for this metric:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS_011.1</td>
<td>April 30, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>PS_011.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>PS_011.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>PS_011.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

Provide all required information demonstrating completion of the Integrated Palliative Care Outcome Scale (IPOS) assessment for eligible primary care patients. **In order to receive payment for this metric, you must submit documentation of at least 30 completed Integrated Palliative Care Outcome Scale assessments for the quarter you are reporting on.**

All information provided must be in the format prescribed by the NYS Department of Health in the IPOS Assessment Data File Format Template. Additional guidance will be made available.

To report on this metric, please upload to the Portal a single Excel file (e.g., .xls, .xlsx, .csv) that includes all information for all eligible patients. The attachment must include all information required by the NYS Department of Health.
**PS_012**

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>PS_012 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Demonstrate that applicable uninsured patients were connected to primary care providers and/or insurance specialists</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Provide documentation that reports total number of applicable uninsured patients connected to primary care providers and/or insurance specialists and meet the quarterly target defined by OneCity Health.</td>
</tr>
</tbody>
</table>

*See Section F2 of Phase III Comprehensive Schedule B for additional process metric details*

**REPORTING INSTRUCTIONS**

OneCity Health has provided an Excel template for tracking connections to insurance and primary care. You may use this template or any other documentation that identifies the following information:

- PAM® ID
- First name
- Last name
- Date of birth
- Address including zip code
- Phone number
- Date first PAM® completed
- PAM® score
- Date second PAM® completed
- PAM® score
- Survey language
- Primary care appointment information
  - Date primary care appointment scheduled
  - Name and address of primary care provider
  - Date of actual primary care appointment
- Insurance navigator appointment information
  - Date insurance navigator appointment scheduled
  - Name and address of insurance navigator
  - Outcome of insurance enrollment
  - Date of insurance enrollment
Please note: only report unique individuals; an individual should not be listed more than once on your template.

When reporting on this metric, you will be required to upload the template or other supporting documentation to the Portal and enter the following information:

- Of all individuals to whom you administered the PAM® survey, provide the number of uninsured individuals who were connected to primary care providers
  - Connection is defined as scheduling a primary care appointment
- Of all individuals to whom you administered the PAM® survey, provide the number of uninsured individuals who were connected to insurance specialists
  - Connection is defined as scheduling an insurance navigator appointment
- Of all individuals to whom you administered the PAM® survey, provide the number of unique individuals served either through connection to primary care and/or connection to insurance
  - Note: Every partner has a quarterly referral target defined in their Phase III Comprehensive Schedule B for total number of applicable uninsured individuals who must be connected to primary care providers and/or insurance specialists.
    In order to receive payment for this metric, the number of connections reported must meet the quarterly target
- Total number of individuals trained in administering the PAM® survey for the quarter on which you are reporting
  - Note: Individuals who administer the PAM® survey must have received PAM training.
  - If any trainings were conducted during the reporting quarter, you must upload the Excel training template and a PDF of the attendance training template that includes the signatures of the training attendees

For all metrics with a quarterly performance target, your submission will be reviewed for completeness to determine if the information you reported matches your uploaded supporting documentation:

- If your submission is complete and meets the quarterly performance target, it will appear as “Completed” in the Portal, and an invoice for payment will be generated.
- If your submission is complete but does not meet the quarterly performance target, it will still appear as “Completed” in the Portal, but will not generate an invoice for payment.

Note: OneCity Health needs to report to the NYS DOH on patients engaged by partners for this project, so it is important to submit these metrics even if your submission does not meet the quarterly performance target.
**QI_001**

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>QI_001 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Demonstrate implementation of and report progress on a quality improvement (QI) activity to address one (1) of the eligible measures indicated by OneCity Health related to primary care and behavioral health integration.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019</td>
</tr>
</tbody>
</table>

**Participant Obligations**

Identify one (1) QI activity and report the QI plan and baseline data for one (1) of the following indicators based on provider type:

For primary care providers:
- Antidepressant Medication Management; OR
- Screening for Clinical Depression and Follow-Up Plan; OR
- Initiation and/or Engagement of Alcohol and Other Drug Dependence Treatment.

For mental health providers:
- Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication; OR
- Diabetes Monitoring for People with Diabetes and Schizophrenia: OR
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia.

For substance abuse treatment providers:
- Preventive care screening for physical health conditions (e.g. diabetes, cardiovascular disease, etc.); OR
- Linkage to primary care services; OR
- Management of physical health conditions (e.g. diabetes, cardiovascular disease, etc.).

Report performance against the baseline data and provide a progress update for the selected indicator.

**REPORTING INSTRUCTIONS**

There are four due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI_001.1</td>
<td>April 30, 2018</td>
<td>Baseline Period</td>
</tr>
<tr>
<td>QI_001.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018 or Baseline Period (if baseline was not previously reported for QI_001.1)</td>
</tr>
<tr>
<td>QI_001.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>QI_001.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>
**Indicator descriptions:** Select one (1) of the following nine (9) indicators based on provider type to conduct related quality improvement activities during the reporting time periods of the metric:

**For primary care providers integrating behavioral health services:**

1. **Antidepressant Medication Management**: Patients 18 years of age and older who were treated with antidepressants, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 6 months. Two rates are used:
   - Effective Acute Phase Treatment: Patients who remained on antidepressant medication for at least 84 days (12 weeks)
   - Effective Continuation Phase Treatment: Patients who remained on antidepressant medication for at least 180 days (6 months); OR
2. **Screening for Clinical Depression and Follow-Up Plan**: Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen; OR
3. **Initiation and/or Engagement of Alcohol and Other Drug Dependence Treatment**: Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are used:
   - Percentage of patients who initiated treatment within 14 days of the diagnosis
   - Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

**For mental health providers integrating primary care services:**

4. **Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication**: Percentage of patients 18 to 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year; OR
5. **Diabetes Monitoring for People with Diabetes and Schizophrenia**: Percentage of patients 18 to 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year; OR
6. **Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia**: Percentage of members 18 to 64 years of age with schizophrenia and cardiovascular disease who had a low-density lipoprotein cholesterol (LDL-C) test during the measurement year.

**For substance abuse treatment providers and other behavioral health service providers (e.g. pediatric behavioral health providers) integrating primary care services:**

7. **Preventive care screening for physical health conditions (e.g. diabetes, cardiovascular disease, etc.):** Percentage of patients engaged in behavioral health treatment receiving age-appropriate and risk factor driven preventive care screenings; OR
8. **Linkage to primary care services**: Percentage of patients receiving behavioral health treatment connected to and/or engaged with primary care services; OR

9. **Management of physical health conditions (e.g. diabetes, cardiovascular disease, etc.):** Percentage of patients engaged in behavioral health treatment with chronic disease diagnoses and stabilized chronic health conditions (e.g. improvement in HbA1C levels, LDL-C levels, blood pressure, etc.)

**Quality improvement activity description**: The quality improvement activity should collect and analyze data from available data sources and test changes/interventions to achieve improvement goals related to the selected indicator as described.

**Instructions for reporting on this metric are included below. All information will be entered into the Portal. The submission should be completed at a system level.**

The first report submission should be for baseline performance on the selected indicator and include the following:

- **Aim**: Describe and/or upload the quantitative and/or qualitative goal(s) of your quality improvement activities and how the goal is anticipated to impact the selected indicator
- **Baseline Performance**: Describe and/or upload the baseline performance period and quantitative and/or qualitative measurement results related to the goal(s). The baseline performance period should include at a minimum a six month period after October 1, 2016. If baseline measurement results are not available, please describe the plan to establish a baseline measurement by the following reporting period.
- **Data Source**: Describe and/or upload the data source(s) that will be used to measure performance

*Please note that the baseline performance submission will only be accepted for QI_001.1 or QI_001.2, if baseline submission is missed for QI_001.1.*

Subsequent report submissions should be progress updates for performance against the baseline on the selected indicator and include the following:

- **Reporting Period Performance**: Describe and/or upload the quantitative and/or qualitative measurement results related to the goal(s) during the reporting time period
- **Action**: Describe and/or upload actions during the reporting time period taken to improve goal(s) described during the baseline performance period and the outcomes of these actions

*All partners may be subject to audit.*
QI_002

Metric ID – Metric Type
QI_002 – Process

Metric
Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to address Human Immunodeficiency Virus (HIV) screening and linkage to care.

Due Date(s)
April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019

Participant Obligations
Review HIV screening assessment report and establish a QI plan based upon assessment results.
Report on HIV screening and linkage performance following provided performance indicators.

REPORTING INSTRUCTIONS

There are four due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI_002.1</td>
<td>April 30, 2018</td>
<td>January 1, 2018 – March 31, 2018</td>
</tr>
<tr>
<td>QI_002.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>QI_002.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>QI_002.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

Each partner will be provided an individualized Agency Assessment Report based on information submitted to OneCity Health through the HIV Assessments of Program Interventions survey administered during Phase II. This report will identify suggested areas to focus on for your quality improvement plan.

There will be two Quality Improvement Plan Templates posted to the Portal (one for clinical and one for non-clinical providers) to support your planning and reporting around your quality improvement activities for this metric.

When reporting on this metric through the Portal, you will be required to provide the following information by completing and uploading the applicable template:

The first report submission should be your Quality Improvement Plan for 2018 and include the following:

- Selection of at least three (3) Improvement Areas based on Agency Assessment Report.
- Brief Project Narratives (200-500 words each) detailing the timeline for completing the three projects, project goals, and key measurement(s) per project (with a baseline value) and timeframe for project efforts.
• Data Summary Table with baseline data from 2017 and data for the first quarter on which you are reporting.

Subsequent report submissions should be status reports on quality improvement and include the following:

• Narrative on activities to date on the three Improvement Areas selected. Must include key measurement baseline value and value at time of reporting.
• Data Summary Table with baseline data, data reported in previous quarter(s), and data for the latest quarter on which you are reporting.

Please see the Quality Improvement Plan Template for additional details and specifications on what should be included in the narratives and data summaries referenced above.
QI_003

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>QI_003 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to address standardization of discharge planning for Congestive Heart Failure.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Identify one (1) QI activity and report the QI plan and baseline data for the intended cohort. Report performance against the baseline cohort data and provide a progress update.</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

There are four due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI_003.1</td>
<td>April 30, 2018</td>
<td>Baseline Period</td>
</tr>
<tr>
<td>QI_003.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018 or Baseline Period (if baseline was not previously reported for QI_003.1)</td>
</tr>
<tr>
<td>QI_003.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>QI_003.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

Measure description: Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to address standardization of discharge planning for Congestive Heart Failure (CHF). Using data on your current discharge workflow, select one of the following discharge processes for patients with CHF:

1. Oral medication regimen, stable for at least 24 hours
2. No intravenous vasodilator or inotropic agent for at least 24 hours
3. Near optimal/optimal volume status achieved
4. Near optimal/optimal pharmacologic therapy for Heart Failure
5. Need for medication adherence, daily weights and sodium restrictions understood by patient/family.
6. Ambulation before discharge to assess functional capacity
7. Careful observation before and after discharge for worsening, or development of, renal dysfunction, electrolyte abnormalities and symptomatic hypotension
8. Plans for more intensive post-discharge management (scale present in home, visiting nurse, or telephone follow-up no longer than 3 days after discharge) (When)
9. Follow-up clinic visit is scheduled within 7-days of hospital discharge is documented (Where/ When/with Whom)

10. Referral for formal heart failure disease management or outpatient

**Quality improvement activity description:** The quality improvement activity should collect and analyze data from available data sources and test changes/interventions to achieve improvement goals related to the measure as described.

**Instructions for reporting on this metric are included below. All information will be entered into the Portal. The submission should be completed at a system level.**

The first report submission should be for baseline performance on the QI activity to address standardization of the selected discharge process and include the following:

- **Aim:** Describe and/or upload the quantitative and/or qualitative goal(s) of your quality improvement activities and how the goal will impact standardization of the selected discharge process
- **Baseline Performance:** Describe and/or upload the baseline performance period and quantitative and/or qualitative measurement results related to the goal(s). The baseline performance period should include at a minimum a six month period after October 1, 2016. If baseline measurement results are not available, please describe the plan to establish a baseline measurement by the following reporting period.
- **Data Source:** Describe and/or upload the data source(s) that will be used to measure performance

*Please note that the baseline performance submission will only be accepted for QI_003.1 or QI_003.2, if baseline submission is missed for QI_003.1.*

Subsequent report submissions should be progress updates for performance against the baseline on follow-up activity to address standardization of the selected discharge process and include the following:

- **Reporting Period Performance:** Describe and/or upload the quantitative and/or qualitative measurement results related to the goal(s) during the reporting time period
- **Action:** Describe and/or upload actions during the reporting time period taken to improve selected goal(s) described during the baseline performance period and the outcomes of these actions

**All partners may be subject to audit.**
QI_004

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>QI_004 - Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to increase statin use amongst applicable patient population.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Identify one (1) QI activity and report the QI plan and baseline data for the intended cohort. Report performance against the baseline cohort data and provide a progress update.</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

There are four due dates for this metric:

<table>
<thead>
<tr>
<th>Metric: QI_004.1</th>
<th>Report due date: April 30, 2018</th>
<th>Reporting time period: Baseline Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI_004.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018 or Baseline Period (if baseline was not previously reported for QI_004.1)</td>
</tr>
<tr>
<td>QI_004.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>QI_004.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

Measure description: Patients 18 years of age and older with CVD risk prescribed Statin therapy to goals according to the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Disease (ASCVD) risk in Adults. Use data on current rates of Statin therapy for patients in one of the following high ASCVD risk groups:

1. Individuals with clinical ASCVD
2. Individuals with primary elevations of LDL-C ≥190 mg/dL
3. Individuals 40-75 years of age with diabetes, LDL-C 70-189 mg/dL
4. Individuals 40-75 years of age without clinical ASCVD or diabetes, LDL-C 70-189 mg/dL and >7.5% estimate 10-year ASCVD risk.

Quality improvement activity description: The quality improvement activity should collect and analyze data from available data sources and test changes/interventions to achieve improvement goals related to the indicator as described.

Instructions for reporting on this metric are included below. All information will be entered into the Portal. The submission should be completed at a system level.
The first report submission should be for baseline performance on the quality improvement (QI) activity to increase Statin use amongst the applicable population and include the following:

- **Aim:** Describe and/or upload the quantitative and/or qualitative goal(s) of your quality improvement activities and how the improvement intervention will increase Statin use.
- **Baseline Performance:** Describe and/or upload the baseline performance period and quantitative and/or qualitative measurement results related to the goal(s). The baseline performance period should include at least a six-month period after October 1, 2016. If baseline measurement results are not available, please describe the plan to establish a baseline measurement by the following reporting period.
- **Data Source:** Describe and/or upload the data source(s) that will be used to measure performance.

*Please note that the baseline performance submission will only be accepted for QI_004.1 or QI_004.2, if baseline submission is missed for QI_004.1.*

Subsequent report submissions should be progress updates for performance against the baseline on follow-up activity to increase Statin use amongst the applicable population and include the following:

- **Reporting Period Performance:** Describe and/or upload the quantitative and/or qualitative measurement results related to the goal(s) during the reporting time period.
- **Action:** Describe and/or upload actions during the reporting time period taken to improve selected goal(s) described during the baseline performance period and the outcomes of these actions.

*All partners may be subject to audit.*
**QI_005**

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>QI_005 – Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to improve follow up after hospitalization for mental illness.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018; July 31, 2018; October 31, 2018; January 31, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Identify one (1) QI activity and report the QI plan and baseline data for the intended cohort.</td>
</tr>
<tr>
<td></td>
<td>Report performance against the baseline cohort data and provide a progress update.</td>
</tr>
</tbody>
</table>

**REPORTING INSTRUCTIONS**

There are four due dates for this metric:

<table>
<thead>
<tr>
<th>Metric: QI_005.1</th>
<th>Report due date: April 30, 2018</th>
<th>Reporting time period: Baseline Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI_005.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018 or Baseline Period (if baseline was not previously reported for QI_005.1)</td>
</tr>
<tr>
<td>QI_005.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>QI_005.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

**Measure description**: Patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are used:

1. The percentage of patients who received follow-up within 30 days of discharge
2. The percentage of patients who received follow-up within 7 days of discharge

**Quality improvement activity description**: The quality improvement activity should collect and analyze data from available data sources and test changes/interventions to achieve improvement goals related to the measure as described.

**Instructions for reporting on this metric are included below. All information will be entered into the Portal. The submission should be completed at a system level.**

The first report submission should be for baseline performance on follow up after hospitalization for mental illness and include the following:

- **Aim**: Describe and/or upload the quantitative and/or qualitative goal(s) of your quality
improvement activities and how the goal is anticipated to impact follow up after hospitalization for mental illness

- **Baseline Performance:** Describe and/or upload the baseline performance period and quantitative and/or qualitative measurement results related to the goal(s). The baseline performance period should include at a minimum a six month period after October 1, 2016. If baseline measurement results are not available, please describe the plan to establish a baseline measurement by the following reporting period.

- **Data Source:** Describe and/or upload the data source(s) that will be used to measure performance

*Please note that the baseline performance submission will only be accepted for QI_005.1 or QI_005.2, if baseline submission is missed for QI_005.1.*

Subsequent report submissions should be progress updates for performance against the baseline on follow up after hospitalization for mental illness and include the following:

- **Reporting Period Performance:** Describe and/or upload the quantitative and/or qualitative measurement results related to the goal(s) during the reporting time period

- **Action:** Describe and/or upload actions during the reporting time period taken to improve goal(s) described during the baseline performance period and the outcomes of these actions

*All partners may be subject to audit.*
ADV_01 (TRAINING AND EMPLOYMENT FUNDS ADVISORY)

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>ADV_01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Quarterly payment for strategic advice for 1199SEIU Training and Employment Funds.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>July 1, 2018; October 1, 2018; January 1, 2019; April 1, 2019; July 1, 2019; October 1, 2019; January 1, 2020</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Provide supporting documentation to justify this quarterly strategic advice payment.</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

There are seven due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADV_01.1</td>
<td>July 1, 2018</td>
<td>April 1, 2018 – June 30, 2018</td>
</tr>
<tr>
<td>ADV_01.2</td>
<td>October 1, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>ADV_01.3</td>
<td>January 1, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>ADV_01.4</td>
<td>April 1, 2019</td>
<td>January 1, 2019 – March 31, 2019</td>
</tr>
<tr>
<td>ADV_01.5</td>
<td>July 1, 2019</td>
<td>April 1, 2019 – June 30, 2019</td>
</tr>
<tr>
<td>ADV_01.6</td>
<td>October 1, 2019</td>
<td>July 1, 2019 – September 30, 2019</td>
</tr>
<tr>
<td>ADV_01.7</td>
<td>January 1, 2020</td>
<td>October 1, 2019 – December 31, 2019</td>
</tr>
</tbody>
</table>

Partner must upload a work plan for the full quarterly reporting period, which includes all required information.

Partner must execute the developed work plan for the reporting period.

A minimum of one file must be uploaded to submit the metric.
### DSB_IPM (INTEGRATED PEST MANAGEMENT)

**Metric ID – Metric Type**
- DSB_IPM.1; DSB_IPM.2; DSB_IPM.3; DSB_IPM.4; DSB_IPM.5; DSB_IPM.6; DSB_IPM.7; DSB_IPM.8; DSB_IPM.9

**Metric**
Quarterly payment for Asthma Integrated Home Assessment and Remediation

**Due Date(s)**
- September 29, 2017; January 31, 2018; April 30, 2018; September 30, 2018; February 28, 2019; April 30, 2019; July 31, 2019; October 31, 2019; January 31, 2020;

**Participant Obligations**
Partner shall perform the services described in Schedule B (the “Services”), which will be subject to review with modifications made to align with any proposed changes to the work plan.

---

#### REPORTING INSTRUCTIONS

There are nine due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSB_IPM.1</td>
<td>September 29, 2017</td>
<td>July 1, 2017 to September 30, 2017</td>
</tr>
<tr>
<td>DSB_IPM.2</td>
<td>January 31, 2018</td>
<td>October 1, 2017 to December 31, 2017</td>
</tr>
<tr>
<td>DSB_IPM.3</td>
<td>April 30, 2018</td>
<td>January 1, 2018 to March 31, 2018</td>
</tr>
<tr>
<td>DSB_IPM.4</td>
<td>September 30, 2018</td>
<td>April 1, 2018 to August 31, 2018</td>
</tr>
</tbody>
</table>

**Extension Metric:**

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSB_IPM.5</td>
<td>February 28, 2019</td>
<td>September 1, 2018 to December 31, 2018</td>
</tr>
<tr>
<td>DSB_IPM.6</td>
<td>April 30, 2019</td>
<td>January 1, 2019 to March 31, 2019</td>
</tr>
<tr>
<td>DSB_IPM.7</td>
<td>July 31, 2019</td>
<td>April 1, 2019 to June 30, 2019</td>
</tr>
<tr>
<td>DSB_IPM.8</td>
<td>October 31, 2019</td>
<td>July 1, 2019 to September 30, 2019</td>
</tr>
<tr>
<td>DSB_IPM.9</td>
<td>January 31, 2020</td>
<td>October 1, 2019 to December 31, 2019</td>
</tr>
</tbody>
</table>

Please upload all supporting documentation to justify each integrated pest management (IPM) invoice payment submission, including invoices from the IPM vendors and Personnel Services.

A minimum of one file must be uploaded to submit the metric.

Each metric due will be inclusive of all services rendered based on dates of service under the Schedule B.
**DSB_NYLAG (NEW YORK LEGAL ASSISTANCE GROUP)**

Please note, all new DSB_NYLAG metrics are under Phase III in the Portal.

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>DSB_NYLAGTraining.1, DSB_NYLAGTraining.2, DSB_NYLAGTraining.3, DSB_NYLAGTraining.4, DSB_NYLAGTraining.5, DSB_NYLAGTraining.6, DSB_NYLAGTraining.7, DSB_NYLAGTraining.8, DSB_NYLAGELEARNING, DSB_NYLAGRESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Upload the invoice and sign in sheet for all trainings, listing each training date and topic.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>December 31, 2019; June 30, 2020</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Submit the invoice and sign in sheet for all trainings, listing each training date and topic.</td>
</tr>
</tbody>
</table>

**REPORTING INSTRUCTIONS**

There are three different types of metrics available for submission in the Portal:

**Training and Data Sharing (DSB_NYLAGTraining)**

Partner must upload invoice(s) and sign-in sheet(s) listing each training date and topic for trainings provided to OneCity Health partners (either individual or bundled in the invoice).

Timing of invoice upload is at the partner’s discretion. Under this contract, partner is not to exceed 16 trainings during the contract period. The Portal tracks the number of trainings submitted so far under this contract and will not allow the partner to invoice for more than 16 trainings.

If a submission is remediated, please submit the trainings under the same metric (e.g. if you submit 6 trainings under DSB_NYLAGTraining.1 and the metric approver remediates the metric, please do not resubmit the 6 trainings under DSB_NYLAGTraining.2. Instead you must resubmit for those trainings under DSB_NYLAGTraining.1.)
E-Learning (DSB_NYLAGELEARNING)

Partner must upload invoice(s) for the E-Learning Module(s) and Toolkit(s). This invoice should include an upload of the toolkit and screenshot of the e-learning modules developed for OneCity Health. This metric is due in the portal by December 31, 2019.

Research & Evaluation (DSB_NYLAGRESEARCH)

Partner must upload invoice(s) for Research and Evaluation. This invoice should include a research summary and description of data collection and sharing by NYLAG research support provided through the Distinct Schedule B funding.
**DSB_PCMHFee (Reimbursement of PCMH Application Related Fees)**

<table>
<thead>
<tr>
<th>Metric ID</th>
<th>DSB_PCMHFee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Sign Patient-Centered Medical Home (“PCMH”) Application and Survey Tool Fees – Schedule B, and submit payment receipt(s) for Interactive Survey System 2014 PCMH Survey Tool and/or Clinician Submission Fees (“Application Fees”)</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>April 30, 2018</td>
</tr>
</tbody>
</table>
| Participant Obligations | 1. Submit payment receipts for the Survey Tool License (the “Survey Tool”) and/or Clinician Submission Fees (“Application Fees”) to OneCity Health Services in the format and process prescribed by OneCity Health Services.  
2. Submit invoices to OneCity Health Services in prescribed format by the metric due date, which is 30 days after the contract period ends. Please see your Patient-Centered Medical Home (PCMH) Application and Survey Tool Fees – Schedule B for details. |

**REPORTING INSTRUCTIONS**

This metric only applies to partners who have executed their Patient-Centered Medical Home (PCMH) Application and Survey Tool Fees – Schedule B ("DSB_PCMHFee"). Please consult your Distinct Schedule B for details about the terms and conditions related to reimbursement. If you have 19 or fewer sites, you can only complete one submission. For this reason, please submit requests after all reimbursable costs have been incurred.

Below is a description of the information you will be requested to provide for this metric. The actual questions and supplemental documentation must be completed and uploaded directly through the Portal.

**PREPARATION:**

Before you complete your submission in the Portal, it will be helpful to gather the following documents and files:

- Your organization’s Distinct Schedule B – PCMH Application Fees, which includes the total not to exceed dollar amount, eligible sites, and payment criteria
- Copy of National Committee for Quality Assurance (NCQA) PCMH payment receipt(s) for all sites requesting reimbursement (e.g., survey tool(s), application/clinician submission fee(s))
- Calculations of requested reimbursements for 1) all survey tools and 2) all application fees. (This is only relevant if you are requesting reimbursement for more than one site).

**Reporting through the Portal:**

The following information should be reported at an organizational level on behalf of all primary care sites that you are requesting reimbursement for their PCMH 2014 recognition application fees.

1. **Have you signed the Patient-Centered Medical Home (“PCMH”) Application and Survey Tool Fees – Schedule B?**
   - The Distinct Schedule B was sent to the designated signatory of your organization. Only partners who have executed their Patient-Centered Medical Home (“PCMH”) Application and Survey Tool Fees – Schedule B are eligible for this metric.

2. **Attestation that your organization has not previously received reimbursement from another source (e.g. another PPS, organization or health plan) for the survey tool license and/or application fees associated with this invoice.**

3. **Are you requesting reimbursement for Payment for Interactive Survey System 2014 PCMH Survey Tool in this submission?**

   **If YES, please enter the following information:**
   - Requested Reimbursement Amount (“invoice amount”)
     - If you are requesting reimbursement for more than one site, enter total reimbursement amount for all survey tools in this submission
   - Date cost was incurred (“receipt date”)
     - If you are requesting reimbursement for more than one site, enter the earliest receipt date
   - Upload all related survey tool receipts. They should correspond to the sites you select at the bottom of your submission
     - The receipt should list the practice name and correspond to a site listed in your organization’s DSB_PCMHFee

4. **Are you requesting reimbursement for National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) application fees (“per-clinician submission fees”) in this submission?**
If YES, please enter the following information:

- Requested Reimbursement Amount ("invoice amount")
  - If you are requesting reimbursement for more than one site, enter total reimbursement amount for application fees
- Date cost was incurred ("receipt date")
  - If you are requesting reimbursement for more than one site, enter the earliest receipt date
- Upload all related application fee receipts. They should correspond to the sites you select at the bottom of your submission.
  - The receipt should list the practice name and correspond to a site listed in your organization’s DSB_PCMHFee

Total requested from questions 3 and 4:

- The total dollar amount requested will be auto-calculated based on inputs above

Total Not-To-Exceed amount from contract:

- The total Not-to-Exceed dollar amount will be auto-populated in the Portal based on your contract

5. Please select all sites that you are requesting reimbursement for in this submission:

- The sites listed are the sites listed in your Patient-Centered Medical Home (PCMH) Application and Survey Tool Fees – Schedule B. These sites are the sites OneCity Health had on file for you when this contract was generated.
- **Note:** If your system has 19 or fewer sites, you can only complete one submission in the Portal for reimbursement. For this reason, please only submit this request for reimbursement after all eligible costs have been incurred.
- **Note:** If your system has 20 or more sites, you can complete more than one submission in the Portal for reimbursement. However, you can only submit one request for any given site. For this reason, please include a site in a submission only after all eligible costs have been incurred for that particular site.
DSB_SAW (STRATEGIC ADVISORY WORKGROUP)

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>Strategic Advisory Workgroup.1, Strategic Advisory Workgroup.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>A primary or alternate Workgroup Member must attend a minimum of 80% of all Strategic Advisory Workgroup meetings held during the term of the Schedule B.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>March 15, 2019; March 15, 2020</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Submit report detailing which of the Strategic Advisory Workgroup meetings the primary or alternate attended.</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

A primary or alternate Workgroup Member must attend a minimum of 80% of all Strategic Advisory Workgroup meetings held during the term of the Schedule B. Submit a report detailing which of the Strategic Advisory Workgroup meetings the primary or alternate Workgroup Member attended.
INNOVATION_FUND (ONECITY HEALTH’S INNOVATION FUND)

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>InnovationFund.1, InnovationFund.2, InnovationFund.3, InnovationFund.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>Create a project plan.</td>
</tr>
<tr>
<td></td>
<td>Update the project plan and submit a progress report.</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>July 16, 2018; October 1, 2018; April 1, 2019; July 1, 2019</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Submit project plan outlining project implementation over the course of the contracting period, including milestones/benchmarks highlighted in innovation fund application proposal.</td>
</tr>
<tr>
<td></td>
<td>Submit updated project plan outlining project implementation since last submitted plan, including milestones/benchmarks highlighted in innovation fund application proposal. Submit progress report answering all four questions outlined below.</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

There are four due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>InnovationFund.1</td>
<td>July 16, 2018</td>
<td>Baseline Period</td>
</tr>
<tr>
<td>InnovationFund.2</td>
<td>October 1, 2018</td>
<td>July 15, 2018 - September 30, 2018</td>
</tr>
<tr>
<td>InnovationFund.3</td>
<td>April 1, 2019</td>
<td>October 1, 2018 - March 31, 2019</td>
</tr>
<tr>
<td>InnovationFund.4</td>
<td>July 1, 2019</td>
<td>April 1, 2019 - June 30, 2019</td>
</tr>
</tbody>
</table>

The first report submission:

Partners will produce a project plan in accordance with their Innovation Fund application proposal. The project plan will contain a schedule for the year July 1, 2018 – June 30, 2019. The project plan will include measurable achievements and key milestones/benchmarks tied to specific dates over the specified period.

When reporting on this metric, please upload your project plan that includes all of the specific elements outlined in your Distinct Schedule B. Participant shall submit further revised project plans as requested by OneCity Health.
Subsequent report submissions require the completion of the following two elements:

1) **Update project plan.** Participant shall submit revised project plans to OneCity Health providing an update on achievements and milestones.

2) **Submit progress report.** The progress report must contain the following components:
   1. Describe progress made to date (1-2 pages)
   2. List 3 - 5 accomplishments to date (i.e. did you: hire all staff, enroll xx number of patients/clients, develop work plans) based on your work plan. If there is any variance, please explain
   3. List challenges to date (i.e. unexpected staffing changes, enrollment difficulties, IT infrastructure issues). Is there anything that OneCity can do to help?
   4. Next steps – please describe next steps that will happen over the next 3-6 months
TRN_01 (TRAINING AND EMPLOYMENT FUNDS TRAINING)

<table>
<thead>
<tr>
<th>Metric ID – Metric Type</th>
<th>TRN_01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>1199SEIU Training and Employment Funds Scheduled Partner Training</td>
</tr>
<tr>
<td>Due Date(s)</td>
<td>Open for unlimited submissions</td>
</tr>
<tr>
<td>Participant Obligations</td>
<td>Provide supporting documentation, including training dates scheduled, to justify this partner training payment.</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

Provide supporting documentation, including training dates scheduled, to justify this partner training payment.

a. Deliver the Training Unit and/or the Training Engagement on the terms of the Scope of Work and any subsequent amendment(s) directly and/or via a subcontractor;

b. Provide an electronic copy of a written agreement with any subcontractor utilizing the process dictated to Participant by OneCity Health Services prior to delivery of the Training Unit or Training Engagement;

c. Execute all payment processes, inclusive of services provided directly and via subcontractors, utilizing the template and processes dictated by OneCity Health Services;

d. Invoices uploaded to the Portal must include the following information:
   - The date on the invoice is updated to show the actual date the invoice was submitted (not generated)
   - The “dates of service” are fully indicated by month, date(s) and year covered by the invoice deliverables
   - The description contains the accurate title of the deliverable (i.e. the training; training series; webinar; module etc.) in an itemized fashion, and includes a one to two sentence description of its purpose.

e. The following must be uploaded with the invoice:
   - The executed corresponding SOW
   - Any relevant documents for the specific invoice that clarify payment terms etc.

Invoicing

Partner may submit for any amount. The amount is not to exceed the maximum identified in the SOW.
**SUPPLEMENTAL INFORMATION ON PATIENT ENGAGEMENT REPORTING**

The information included in this section applies to the following Process Metrics:

<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Project</th>
<th>Metric Summary</th>
</tr>
</thead>
</table>
| PS_007    | ED Care Triage (2.b.iii)                     | Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria:  
The number of participating patients presenting to the ED, who after medical screening examination were successfully redirected to a PCP or Health Home care manager as demonstrated by a scheduled appointment, or successfully redirected to a PCP en route to ED. |
| PS_008    | Primary Care and Behavioral Health (3.a.i)   | Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria:  
Model 1: The total number of patients receiving appropriate preventive care screenings that include mental health/substance abuse  
Model 2: The total number of patients receiving primary care services at a participating mental health or substance abuse site  
Model 3: The total number of patients screened using the PHQ-2 or 9 / SBIRT. |
| PS_009    | Cardiovascular (3.b.i)                       | Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria:  
The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.). |
| PS_010    | Palliative Care (3.g.i)                      | Report the number of actively engaged patients based upon NYS DOH and PPS defined criteria:  
The number of participating patients receiving palliative care services at participating PCMH sites, in accordance with the adopted clinical guidelines.  
*Note: For the purposes of reporting on this metric, “palliative care services” delivered in the PCMH setting may include: Health Care Proxies; Do Not Resuscitate orders; Living Wills; Pain Screenings; Referral to Hospice; or Medical Orders for Life-Sustaining Treatment (MOLST).* |

These metrics involve reporting on Patient Engagement (similar to Phase II), but have been incorporated into Process Metrics for Phase III. In addition to the metric-specific instructions found earlier in this section, below is additional information on Patient Engagement reporting for your reference.
OVERVIEW OF PATIENT ENGAGEMENT REPORTING

Patient engagement reporting (also referred to as “Patient Speed and Scale”) is the process in which your organization submits a list of Medicaid patients who meet eligibility criteria for being “actively engaged” within a project for a particular reporting period. Patients who are dually eligible for Medicaid and Medicare may be included in this list.

WHAT DOES “ACTIVELY ENGAGED” MEAN?

As defined by the New York State Department of Health, ‘actively engaged’ means that the Medicaid patient population is engaged through project implementation. This reporting category is narrower than the overall DSRIP project scope of work. Actively engaged may also be referred to as “Patient Speed and Scale” and represents one measurement among many that informs the State on the effectiveness of DSRIP work. OneCity Health is assessed every quarter by the NYS Department of Health to determine whether PPS-wide actively engaged targets are reached for applicable projects. The State distributes payments to the PPS every six months if the set targets are met.

WHO COUNTS AS “ACTIVELY ENGAGED”?

It is important to note that actively engaged patients do NOT have to be patients that are attributed to the OneCity Health PPS. Any NYS Medicaid patient receiving the services specified in each project’s actively engaged definition meets the criteria and can be “counted” by OneCity Health toward its actively engaged patient target.

Please take all necessary steps to ensure that the rosters of actively engaged patients your organization submits to OneCity Health contain a unique list of patients that are not reported to any other PPS during DSRIP Year (DY4), April 1, 2018 – March 31, 2019. Please reference the diagrams below that illustrate this principle. Also, for each project, patients may not be duplicated within a DSRIP Year. This means that each actively engaged patient may only be reported once out of the four quarters, per project, even if they may have been engaged multiple times within DY4.
UNIQUE ROSTERS FOR ACTIVELY ENGAGED PATIENTS

A partner CAN report unique patients to separate PPSs.

A partner CAN report unique patients to one PPS.

A partner CANNOT attribute the same patients to several PPSs.

**NOTE:** Actively engaged patients may only be reported once out of the four quarters, per project, even if they may have been engaged multiple times within DY4.
D. REVIEW AND APPROVAL OF PATIENT ENGAGEMENT REPORTS

★NOTE: Payment for all metrics involving patient engagement depends on whether the whole OneCity Health PPS collectively meets its patient engagement targets. If OneCity Health is successful in achieving these targets, partners will be eligible to earn funds above their total partner eligible allocation based upon reported contribution to these metrics.

Partners will be placed in a tier, which will be determined based on the partner’s performance relative to their peers. Each tier will have an associated allocation, which will be split evenly among the partners within a tier. After the DSRIP Year ends, eligible partners will be able to submit invoices for all patient engagement metrics submitted.
OUTCOME MEASURES

Outcome Measures are distinct measures defined by NYS DOH as requirements of the DSRIP program. The PPS becomes eligible for DSRIP funds upon the successful achievement of these measures. The Outcome Measures in the Phase III Comprehensive Schedule B are a subset of the NYS DOH DSRIP Outcome Measures that the NYS DOH holds the OneCity Health PPS accountable for. Partners have been assigned Outcome Measures in their Comprehensive Schedule B based upon their organization’s Partner Type.

Since Outcome Measures are based on the PPS’s performance as a whole, there are NO individual partner reporting requirements for these measures. Performance and payment for these measures will be calculated by NYS DOH for the OneCity Health PPS as a whole; OneCity Health will then distribute payment to eligible partners.

Your organization becomes eligible to receive payment for its assigned Outcome Measures if:

- Your organization successfully completes at least 50% of its Process Metrics*; AND
- The PPS meets the NYS DOH target for the Outcome Measure

*For the purposes of calculating the 50% threshold, the following metrics (if they appear in your Phase III Comprehensive Schedule B) are excluded: N_007; PS_007; PS_008; PS_009; and PS_010.

At the end of the contractual period, partners who are eligible for payment will have an invoice that requires submission generated in the Portal.

The chart below lists a summary of all the outcome measures included in the Comprehensive Schedule B along with the NYS DOH’s description for each. These descriptions are provided as background information only – there are no reporting requirements for partners. As with process metrics, not all outcome measures apply to all partners.

<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Outcome Measure Name</th>
<th>Measure Description</th>
</tr>
</thead>
</table>
| OM_1      | Adult access to preventive care (age 20-44)               | Numerator: Number of adults who had an ambulatory or preventive care visit during the measurement year  
Denominator: Number of adults ages 20 to 44 as of June 30 of the measurement year |
| OM_2      | Adult access to preventive care (age 45-64)               | Numerator: Number of adults who had an ambulatory or preventive care visit during the measurement year  
Denominator: Number of adults ages 45 to 64 as of June 30 of the measurement year |
<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Outcome Measure Name</th>
<th>Measure Description</th>
</tr>
</thead>
</table>
| OM_3      | Adult access to preventive care (age 65+) | **Numerator:** Number of adults who had an ambulatory or preventive care visit during the measurement year  
**Denominator:** Number of adults ages 65 and older as of June 30 of the measurement year |
| OM_4      | Child access to preventive care (age 1-2) | **Numerator:** Number of children who had a visit with a primary care provider during the measurement year  
**Denominator:** Number of children ages 12 to 24 months as of June 30 of the measurement year |
| OM_5      | Child access to preventive care (age 12-19) | **Numerator:** Number of children who had a visit with a primary care provider during the measurement year or year prior  
**Denominator:** Number of children ages 12 to 19 years as of June 30 of the measurement year |
| OM_6      | Child access to preventive care (age 25M-6Y) | **Numerator:** Number of children who had a visit with a primary care provider during the measurement year  
**Denominator:** Number of children ages 25 months to 6 years as of June 30 of the measurement year |
| OM_7      | Child access to preventive care (age 7-11) | **Numerator:** Number of children who had a visit with a primary care provider during the measurement year or year prior  
**Denominator:** Number of children ages 7 to 11 years as of June 30 of the measurement year |
| OM_8      | Asthma Medication Ratio (5 – 64 Years) | **Numerator:** Number of people with a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year  
**Denominator:** Number of people, ages 5 to 64 years, who were identified as having persistent asthma |
| OM_9      | Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia | **Numerator:** Number of people who had an LDL-C test during the measurement year  
**Denominator:** Number of people, ages 18 to 64 years, with schizophrenia and cardiovascular disease |
| OM_10     | Controlling High Blood Pressure | **Numerator:** 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  
**Denominator:** Number of people, ages 18 to 85 years, who have hypertension |
<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Outcome Measure Name</th>
<th>Measure Description</th>
</tr>
</thead>
</table>
| OM_11     | Diabetes Monitoring for People with Diabetes and Schizophrenia                         | **Numerator:** Number of people who had both an LDL-C test and an HbA1c test during the measurement year  
**Denominator:** Number of people, ages 18 to 64 years, with schizophrenia and diabetes                                                                 |
| OM_12     | Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication | **Numerator:** Number of people who had a diabetes screening test during the measurement year  
**Denominator:** Number of people, ages 18 to 64 years, with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication |
| OM_13     | Follow-up after hospitalization for Mental Illness – within 30 days                   | **Numerator:** Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 30 days of discharge  
**Denominator:** Number of discharges between the start of the measurement year to 30 days before the end of the measurement year for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders |
| OM_14     | Follow-up after hospitalization for Mental Illness – within 7 days                    | **Numerator:** Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 7 days of discharge  
**Denominator:** Number of discharges between the start of the measurement year to 30 days before the end of the measurement year for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders |
| OM_15     | PDI 90 – Composite of all measures ±                                                 | **Numerator:** Number of admissions which were in the numerator of one of the pediatric prevention quality indicators  
**Denominator:** Number of people 6 to 17 years who were enrolled in Medicaid for at least one month as of June 30 of measurement year |
| OM_16     | Potentially Avoidable Emergency Room Visits ±                                         | **Numerator:** Number of preventable emergency visits as defined by revenue and CPT codes  
**Denominator:** Number of people (excludes those born during the measurement year) as of June 30 of measurement year |
<p>| OM_17     | Potentially Avoidable Readmissions ±                                                 | <strong>Numerator:</strong> Number of readmission chains (at risk admissions followed by one or more clinically related readmissions within 30 days of discharge) |</p>
<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Outcome Measure Name</th>
<th>Measure Description</th>
</tr>
</thead>
</table>
| OM_18     | Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) ± | **Numerator:** Number of preventable emergency room visits as defined by revenue and CPT codes  
**Denominator:** Number of people with a BH diagnosis (BH definition used in member attribution; excludes those born during the measurement year) as of June 30 of measurement year |
| OM_19     | PQI 90 – Composite of all measures ±         | **Numerator:** Number of admissions which were in the numerator of one of the adult prevention quality indicators  
**Denominator:** Number of people 18 years and older who were enrolled in Medicaid for at least one month as of June 30 of measurement year |
| OM_20     | Statin Medication Adherence                  | **Numerator:** Number of people who achieved a proportion of days covered of 80% for the treatment period  
**Denominator:** Number of males age 21 to 75 or females age 40 to 75 who have had an MI, CABG or PCI in the year prior or a diagnosis of ischemic vascular disease in both the measurement year and year prior AND who were dispensed at least one high or moderate-intensity statin medication. |
| OM_21     | Medication Management for people with Asthma (5-64 years) - 75% of treatment days covered | **Numerator:** Number of people who filled prescriptions for asthma controller medications during at least 75% of their treatment period  
**Denominator:** Number of people, ages 5 to 64 years, who were identified as having persistent asthma, and who received at least one controller medication |
| OM_22     | Pediatric Quality Indicator #14 - Pediatric Asthma | **Numerator:** Number of admissions with a principal diagnosis of asthma  
**Denominator:** Number of people ages 2 to 17 who were enrolled in Medicaid for at least one month as of June 30 of the measurement year |
| OM_23     | Pediatric Quality Indicator #15 - Younger Adult Asthma | **Numerator:** Number of admissions with a principal diagnosis of asthma  
**Denominator:** Number of people ages 18 to 39 who were enrolled in Medicaid for at least one month as of June 30 of the measurement year |
<p>| OM_24     | Prevention Quality Indicator #8 - Heart Failure | <strong>Numerator:</strong> Number of admissions with a principal diagnosis of heart failure |</p>
<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Outcome Measure Name</th>
<th>Measure Description</th>
</tr>
</thead>
</table>
| OM_25     | Prevention Quality Indicator #7 - Hypertension | **Numerator:** Number of admissions with a principal diagnosis of hypertension  
            |                                            | **Denominator:** Number of people 18 years and older who were enrolled in Medicaid for at least one month as of June 30 of measurement year |
Section II: PARTNER PORTAL OVERVIEW
SECTION II: ONECITY HEALTH PARTNER PORTAL OVERVIEW

This section provides an overview on navigating the OneCity Health Partner Portal, including:

- Overall Portal guidance and policies
- Registering for an account
- Logging in and viewing metrics
- Submitting and invoicing for metrics
- Resubmitting reports that have been returned to you for remediation

Access to the Portal is required for reporting and invoicing on all metrics.

What Can I Do on the Partner Portal?

✓ View all of your organization’s Schedule B metrics
✓ Download templates and other resources for reporting on metrics
✓ Submit metric reporting and invoicing materials to OneCity Health
✓ Update your organization’s contact information

If you have any questions, please contact the OneCity Health support desk:

- Email: ochsupportdesk@nychhc.org
- Phone Number: (646) 694-7090
- Hours of Operation: Monday- Friday, 9 a.m. to 5 p.m. EST
A. OVERALL PORTAL GUIDANCE AND POLICIES

GUIDANCE ON PORTAL USERS

Your organization should designate at least two Portal users. All Portal users have permission to access metrics, view payment/contract information, submit metrics, and invoice for payments.

- Due to the potentially sensitive nature of the materials available on the Portal, OneCity Health asks senior leadership for confirmation for primary portal users. These primary users have the added responsibility to approve any additional individuals to your account.
- When an additional individual needs access, he or she should register for the Portal and contact OneCity Health to request access. The primary user from your organization must also send an email to the OneCity Health support desk to confirm this additional access.
- **Deactivating accounts:** If a colleague who has Portal access leaves your organization, please contact the OneCity Health support desk so their access can be removed.

POLICY REGARDING TIMEFRAME FOR REQUESTING PORTAL ACCESS

After you register for the Portal and contact OneCity Health to request access, you will not be able to immediately submit reports because your access must be verified by OneCity Health.

⭐️ **NOTE:** You must register for the Portal at least seven business days in advance of a reporting deadline. No extensions on reporting deadlines will be granted because of Portal access if you did not register at least seven business days in advance.

POLICY REGARDING METRIC EXTENSION REQUESTS DUE TO TECHNICAL ISSUES

If you are experiencing any technical issues with reporting on a metric in the OneCity Health Partner Portal, you must report the technical issue to the OneCity Health support desk by 5 p.m. on the day of the reporting deadline in order to be considered for an extension of the metric due date.

Additionally, you must also email screenshots or a video recording of the issue to the support desk or contact the support desk to allow them to record the technical issue, via WebEx, in real time. OneCity Health will review your supporting evidence and determine whether or not it is a technical issue and therefore warrants an extension of the metric due date.

⭐️ **NOTE:** If you miss a metric deadline and cite a technical issue as the reason for doing so but did not follow the procedure above you will not be considered for an extension of the metric due date.
POLICY REGARDING TIMEFRAME FOR SUBMITTING REQUESTS FOR REPORTING GUIDANCE TO THE SUPPORT DESK

Please review metric reporting instructions prior to the submission deadline. While OneCity Health will attempt to address all questions about reporting instructions in advance of a reporting deadline, only questions submitted three business days in advance of a deadline are guaranteed a response before the submission deadline.

★NOTE: If you miss a metric deadline and cite lack of clarification about reporting instructions as the reason for doing so but did not follow the procedure above you will not be considered for an extension of the metric due date.

** All other extension requests will be reviewed by OneCity Health on a case-by-case basis and must be submitted to the OneCity Health support desk at least three business days in advance of the reporting deadline**

INTERNET BROWSER COMPATIBILITY

The OneCity Health Partner Portal is most compatible with Google Chrome as your web browser. To download and install Google Chrome visit:

https://www.google.com/chrome/browser/desktop/index.html
B. CREATING AN ACCOUNT IN THE PORTAL

Follow the steps below to register for the Portal:

2. Select “Sign Up” in the middle of the screen.

3. Once “Sign Up” is selected in the sub menu you will be brought to this screen:
4. Fill in your account information. Your email address will be your username. Under “Display Name,” enter your first and last name.

5. After completing all the required fields, click the “Register” button. After you submit your account information you will be brought back to the home screen.

6. To complete the registration process, you must contact the OneCity Health support desk to request Portal access:
   - Email: ochsupportdesk@nychhc.org
   - Phone: (646) 694-7090 (Monday through Friday, 9am – 5pm)

   Note: Your account will not be activated without contacting the support desk.

7. Your email address will then be verified by OneCity Health. Once verified, you will be granted access to the Portal and receive an email notifying you that your account has been activated.

8. After your account has been activated, the next time you log in, you will see information that is customized to your user profile.
C. LOGGING INTO AND NAVIGATING THE ONECITY HEALTH PARTNER PORTAL

Once you are registered and logged into the Portal, you will be able to view the specific metrics that appear in your organization’s Comprehensive Schedule B as well as metrics from any distinct Schedules B that your organization is responsible for reporting on.

For each metric, you will be able to access instructions, download relevant templates and implementation materials, enter required information, and upload documentation for reporting and invoicing for payment. The screenshots and directions below illustrate how to navigate the Portal.

Logging in to the Portal:

- Please enter your Portal username in the “Email” section
- Enter your password in the “Password” section
- Click “Log In”
After you log in, you will see your dashboard. The static navigation pane on the left side will help you maneuver through the Portal.

- Your name will show up at the top; please confirm it is accurate
- Your organization will be on the top left. If your name or your organization’s name is not accurate, please contact the support desk.

On the navigation panel on the left side, you can access your metrics from all three phases:
To see the metrics your organization is responsible for as part of your Phase III contracts, select “Metrics” under “Phase III”

You will now see a chronological list of the Phase III Process Metrics your organization is responsible for completing, organized in the following categories:

- **Requires Remediation**: Metrics that have been returned to you for resubmission
- **Incomplete**: Metrics with an upcoming due date
- **Pending**: Metrics that have been submitted to OneCity Health and are awaiting review or are in the process of being reviewed and approved
- **Complete**: Metrics that have been submitted and approved by OneCity Health
- **Past Due**: Metrics where the deadline has passed and you did not successfully submit a report to OneCity Health

Further details about the process for [resubmitting reports](#) are available at the end of this section.

Please note, the images below from the Portal are from the Phase II Portal. However, the look and flow of the Portal are exactly the same when accessing Phase III. The following guidance is meant to serve as general information on utilizing the Portal.
Click anywhere in the white box to select a specific metric.
D. REPORTING AND INVOICING THROUGH THE ONECITY HEALTH PARTNER PORTAL

After selecting a specific metric, you will be able to view a summary, your obligation, your eligible allocation for completing the metric (if applicable), as well as access any reporting templates or implementation materials.

- To view more specific instructions, click “Metric Reporting Instructions” on the top right.
- To begin the submission process, click “Submit Metric” on the top right.

How Should I Name Files?

When uploading files to the Portal as part of metric submissions, please include the following information in the file name with underscores in between:

1) Organization name; 2) Metric ID; 3) File description (e.g., template)

Example: OrganizationName_PE002_Template.xlsx
After you click “Submit Metric,” you will be brought to the next page. This page will be different for every metric, depending on what is required to complete the metric.

- For example, it may be a survey to complete or a document to download, complete and upload.
- The status bar at the top displays your progress with each metric, and the steps that are left to compete.
- Click “Next” to move through the submission process.

After submitting a report, you will be asked to confirm it with your name, email and user ID. Click “Next” again.
At the time of metric submission, you will also preview the preliminary invoice for each metric. This pending invoice submission is finalized at the time of metric approval.

- After confirming your report, the next step is to confirm the preliminary invoice.
- As in Phase II, you no longer have to wait to submit the invoice until after the metric is approved.

**NOTE:** If your organization would prefer to submit invoices separately from reporting, please contact the OneCity Health support desk so we can accommodate your needs.

When you confirm the preliminary invoice, you will see the invoice number, your address, and basic instructions at the top. Scroll down to complete the process.
To complete the invoice, enter your name and email, check the certification/acknowledgement box, and then click “Next.”

Finally, attest to the submission and click “Submit.”
• The Portal will ask you to reconfirm your submission; all submissions are final once you click “Yes, submit it”.

After you submit, you will be taken back to the submission page for that individual metric. On that page you can view the report to see a record of what you submitted:

• “View Report” will take you to full record of information submitted for the metric
• The “View Invoice” link will not be activated until your submission and invoice for that metric have been approved by OneCity Health
On the “View Report” page, you will be able to see a full record of information submitted for that metric. If you scroll to the bottom of the report screen, you will also be able to see a complete history of all actions related to that submission.

This “Report Actions History” will be updated with new activities as the submission moves through the review process. Below is an example of what this history looks like:

![Report Actions History Example](image1)

On the dashboard, submitted invoices are available to view – you can only view invoices here after they have been approved.

![Dashboard Screenshot](image2)
E. RESUBMITTING REPORTS

The process for resubmitting reports when a metric is not approved is the same in Phase III as it was in Phase II.

Below is general guidance on the remediation process, followed by step-by-step instructions for how to view metrics that require remediation and resubmit reports through the Portal.

OVERALL GUIDANCE ON REMEDIATION

After you submit a metric, you are responsible for checking the Portal to follow up on the status of your submission:

- If a submission is returned to you for remediation, it will immediately appear at the top of your metrics page as shown in the screenshot on the next page.
- From the time the metric is returned to you in the Portal, **you will have 14 calendar days to resubmit**. The new deadline for submission will be displayed in the Portal. **You must resubmit the metric by the new deadline.** If you miss this deadline, the metric will move to the “Past Due” section in the Portal and will no longer be available for submission.
- When resubmitting the metric, you will be able to view remediation details directly in the Portal. You will only need to resubmit the specific information that was incorrect or missing in your initial submission – you do not need to resubmit the entire metric.
- **You will only be given two chances to remediate an individual metric** (i.e., an initial submission plus two remediation attempts). If the required information is not provided after these two remediation opportunities, the metric will be closed for submission. If you have questions about what is needed for a remediation, please contact the OneCity Health support desk.
At the top of the main Metrics page, you will see any metrics requiring remediation, along with the new deadline for submission:

When you select a metric, you will be taken to the metric summary page. On the metric summary page you will see the new deadline for submission.

- Click “View Report” to see a record of the information submitted, remediation guidance, and an activity overview for the submission.
- Click “Resubmit Metric” when you are ready to resubmit.
When you go to resubmit the metric, you will see exactly which parts of the submission require remediation and which parts were approved. You will only need to resubmit the parts that require remediation.

- Portions of the metric that have been approved will appear in green, while those that require remediation will appear in red.
- All specific remediation guidance will appear in red text directly on the page.
- The process for completing the sections requiring remediation and resubmitting the metric are identical to the original submission.
- At the end of the resubmission, you will be required to confirm the report and preliminary invoice, as you did when you initially submitted.

Remember, you must resubmit by the deadline shown in the Portal, which will be 14 calendar days from when the metric is returned to you.

You will only need to resubmit the portions of the metric that require remediation. The status bar at the top tracks your progress through the submission, the same way it does for the initial submission:

After you resubmit, you can view the report and monitor the progress of the submission the same way you did for the initial submission.
General Reporting Guidance:

- Only include patient protected health information (PHI) when specifically requested and only include the minimum PHI required to fill in the template or complete the metric. The Portal is secure for handling necessary PHI submissions.

- The data provided to OneCity Health may be shared with the New York State Department of Health or OneCity Health partners. The extent to which data is shared is contingent on the specific metric, therefore the metric reporting instructions should be referenced for further details.

Need Help?

If you have any questions or trouble accessing the Portal, please contact the OneCity Health support desk:

- Email: ochsupportdesk@nychhc.org
- Phone Number: (646) 694-7090
- Hours of Operation: Monday- Friday, 9 a.m. to 5 p.m. EST