NEW YORK STATE | Department of Health

PPS Information Packet

Prepared for the Project Approval and Oversight Panel

Mid-Point Assessment Meetings

January 31, 2017 – February 3, 2017

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Contents

Adirondack Health Institute PPS

PPS Overview

Lead Organization	Adirondack Health Institute
PPS Service Area	Saratoga, Hamilton, Franklin, Clinton, St. Lawrence, Fulton, Essex, Warren, Washington
Attribution for Performance	81,090
Attribution for Performance (2.d.i.)	N/A
Attribution for Valuation	143,640
Total Award Dollars	$186,715,496
Core Team	1) Margaret Vosburgh – Chief Executive Officer 2) Bob Cawley – Chief Information Officer 3) Eric Burton – Chief Financial Officer 4) Kate Clark – Chief Administrative Officer

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.ii.	Increase certification of primary care practitioners with Patient centered medical homes certification and/or advanced primary care models
2.a.iv.	Created a medical village using existing hospital infrastructure
2.b.viii.	Hospital home-care collaboration solutions
2.d.i.	Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care.
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral health community crisis stabilization services
3.a.iv.	Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs.
3.g.i.	Integration of palliative care into the patient centered medical home model
4.a.iii.	Strengthen mental health and substance abuse infrastructure across systems
4.b.ii.	Increase access to high quality chronic disease preventative care and management in both clinical and community settings

Funds Flow by Partner Category

Total Funds Available (DY1)	**$28,195,877.01**	
Total Funds Earned (through DY1)	**$28,104,145.23 (99.67% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$12,501,682.22 (44.48% of Earned Funds)**	
Partner Type	**Funds Distributed**	**AHI (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$74,000.00	0.59%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$3,207,185.77	25.65%
Clinic	$1,014,793.88	8.12%
Case Management/Health Home	$442,859.92	3.54%
Mental Health	$770,704.35	6.16%
Substance Abuse	$527,265.54	4.22%
Nursing Home	$223,986.66	1.79%
Pharmacy	$0.00	0.00%
Hospice	$139,250.00	1.11%
Community Based Organizations[1]	$253,271.04	2.03%
All Other	$1,059,761.50	8.48%
Uncategorized	$54,150.00	0.43%
Non-PIT Partners	$243,050.00	1.94%
PMO	$ 4,491,403.56	35.93%
TOTAL	**$12,501,682.22**	**100%**

[1] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Adirondack Health Institute	Project	2.b.viii: Hospital-home care collaboration solutions	The IA recommends the PPS develop an education strategy to address the patient lack of knowledge regarding the role of various caregivers in this project and to more effectively engage patients regarding the benefits for their care
2	Adirondack Health Institute	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS develop a strategy to educate the CBOs about their role in DSRIP, the PPS and their role in this project for improved partner engagement in project implementation
3	Adirondack Health Institute	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS provide further orientation and develop education materials for partners that are hesitant to conduct PAM surveys
4	Adirondack Health Institute	Project	3.a.i: Integration of primary care and behavioral health services	The IA requires the PPS develop a comprehensive action plan to address the implementation of this project in consultation with the Project Advisory Committee (PAC) that must be reviewed and approved by the Board of Directors.
5	Adirondack Health Institute	Project	3.g.i (Integration of palliative care into the patient centered medical home model)	The IA recommends the PPS develop a training strategy to inform the targeted population of the role of palliative care services and the distinction between hospice care
6	Adirondack Health Institute	Project	3.g.i (Integration of palliative care into the patient centered medical home model)	The IA recommends the PPS develop a workforce strategy to increase the number of board certified palliative care professionals to assist with training PCPs or to consider other options such as telehealth for consultation.
7	Adirondack Health Institute	Project	Cultural Competency and Health Literacy	The IA recommends that the PPS develop a strategy to address how it will measure the

#	PPS	Section	Focus Area	IA Recommendation
				effectiveness of their CCHL outreach efforts across the PPS network
8	Adirondack Health Institute	Organizational	Cultural Competency and Health Literacy	The IA recommends that the PPS develop a strategy to better address the effectiveness of the CCHL Training of its partners
9	Adirondack Health Institute	Organizational	Cultural Competency and Health Literacy	The IA recommends that the PPS establish metrics that it will use to demonstrate the extent to which it is reaching and engaging Medical beneficiaries and the uninsured
10	Adirondack Health Institute	Organizational	Financial Sustainability and VBP	The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements
11	Adirondack Health Institute	Organizational	Governance	The IA recommends that the PPS develop and provide a strategy to increase oversight and accountability of the PHNs to ensure that projects are being implemented in a timely manner
12	Adirondack Health Institute	Organizational	Governance	The IA recommends that the PPS develop a plan to ensure that all partners engaged in project implementation efforts have an executed contract by the end of DY2, Q4 to ensure the PPS is able to successfully meet project milestones, Patient Engagement targets, and the performance goals of the DSRIP Program.

Advocate Community Providers, Inc.

PPS Overview

Lead Organization	Advocate Community Providers, LLC
PPS Service Area	Brooklyn, Queens, Manhattan
Attribution for Performance	644,916
Attribution for Performance (Project 2.d.i)	N/A
Attribution for Valuation	312,623
Total Award Dollars	$700,038,844
Core Team	1) Dr. Ramon Tallaj – Chairman of the Board 2) Mario Paredes – Chief Executive Officer 3) Mary Ellen Connington– Chief Operating Officer 4) Alexandro Damiron – Chief of Staff 5) Tom Hoering – VP, Legal Affairs 6) Tonguc Yaman – Chief Information Officer 7) Corey Maher – Chief Technology Officer 8) Lidia Virgil – VP, Healthcare Innovation 9) Tom Gimler – Compliance Officer 10) Dr. Diego Poneiman – Chief Medical Officer

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health Homes At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.b.iii.	ED Care Triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
3.a.i.	Integration of primary care and behavioral health services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular Health)
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (Diabetes)
3.d.iii.	Implementation of evidence-based medicine guidelines for asthma management
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health

Funds Flow by Partner Category

Total Funds Available (DY1)	**$88,781,903.36**	
Total Funds Earned (through DY1)	**$87,756,004.47 (98.84% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$23,799,011.61 (% of Earned Funds)**	
Partner Type	**Funds Distributed**	**ACP (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$7,673,869.10	32.24%
Practitioner - Non-Primary Care Physician (PCP)	$1,149,999.18	4.83%
Hospital	$3,431,579.00	14.42%
Clinic	$437,043.21	1.84%
Case Management/Health Home	$0.00	0.0%
Mental Health	$36,666.58	0.15%
Substance Abuse	$0.00	0.0%
Nursing Home	$0.00	0.0%
Pharmacy	$0.00	0.0%
Hospice	$0.00	0.0%
Community Based Organizations[2]	$0.00	0.0%
All Other	$1,106,253.09	4.65%
Uncategorized	$287,949.69	1.21%
Non-PIT Partners	$0.00	0.0%
PMO	$9,675,651.75	40.66%
Total	**$23,799,011.61**	**100.00%**

[2] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Advocate Community Providers	Project	2.b.iii.: ED care triage for at-risk populations	The IA recommends that the PPS create a plan to continue to educate patients regarding ED use and alternative sites of care in order to successfully continue to engage patients.
2	Advocate Community Providers	Project	2.b.iii.: ED care triage for at-risk populations	As the PPS acknowledges the technological difficulty it has incurred in connecting hospitals and PCPs to guarantee timely scheduling of PCP appointments by a patient navigator at the ED, the IA recommends the PPS address this through workflow agreed upon as part of partner agreements.
3	Advocate Community Providers	Organizational	Financial Sustainability and VBP	The IA recommends that the PPS tailor the Financial Sustainability survey of its partners. The survey should aim to gather hard data to assess the financial state of its partnering organizations in order to determine fragility. The IA further recommends that the PPS educate its partners on the role of the PPS in terms of assisting them financially.

Albany Medical Center Hospital PPS

PPS Overview

Lead Organization	Albany Medical Center Hospital
PPS Service Area	Albany, Columbia, Greene, Saratoga, Warren
Attribution for Performance	69,883
Attribution for Performance (Project 2.d.i)	69,697
Attribution for Valuation	107,781
Total Award Dollars	$141,430,548
Core Team	1) Dr. Louis Filhour: Chief Executive Officer 2) Dr. Kallanna Manjunath: Medical Director, Center for Health Systems Transformation, DSRIP 3) Lauren Ayers: Director of Financial Operations 4) Dr. Brendon Smith: Director of Clinical Integration 5) Christine McIntyre: Chief Operating Officer

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health home at-risk intervention program: proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.
2.a.v.	Create a medical village/alternative housing using existing nursing home infrastructure
2.b.iii.	ED care triage for at-risk populations
2.d.i.	Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care.
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral health community crisis stabilization services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.d.iii.	Implementation of evidence- based medicine guidelines for asthma management
4.b.i.	Promote tobacco use cessation, especially among low socioeconomic status populations and those with poor mental health
4.b.ii.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings

Funds Flow by Partner Category

Total Funds Available (DY1)	**$21,214,481.87**	
Total Funds Earned (through DY1)	**$20,891,180.33 (98.48% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$7,652,276.96 (36.63% of Earned Funds)**	
Partner Type	**Funds Distributed**	**Albany Medical Center (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$53,676.00	0.70%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$937,796.00	12.26%
Clinic	$64,927.00	0.85%
Case Management/Health Home	$45,081.00	0.59%
Mental Health	$80,944.00	1.06%
Substance Abuse	$19,979.00	0.26%
Nursing Home	$20,526.00	0.27%
Pharmacy	$0.00	0.00%
Hospice	$0.00	0.00%
Community Based Organizations[3]	$20,259.00	0.26%
All Other	$522,245.00	6.82%
Uncategorized	$33,335.00	0.44%
Non-PIT Partners	$36,948.00	0.48%
PMO	$5,816,560.96	76.01%
Total	**$7,652,276.96**	**100.00%**

[3] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Albany Medical Center	Project	2.a.i.: Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	The IA recommends that the PPS develop a corrective action plan to successfully complete the project requirements that the IA determined were not completed by the PPS Speed & Scale commitment date for this project. The PPS must provide a revised timeline for the completion of the six project requirements that were not completed by DY2, Q2 as part of this action plan.
2	Albany Medical Center	Project	2.b.iii.: ED care triage for at-risk populations	The IA recommends that the PPS develop a corrective action plan to successfully complete the project requirement that the IA determined was not completed by the PPS Speed & Scale commitment date for this project. The PPS must provide a revised timeline for the completion of the one project requirement that was not completed by DY2, Q2 as part of this action plan.
3	Albany Medical Center	Project	3.b.i.: Evidence-based strategies for disease management in high risk/affected population (adult only)	The IA recommends that the PPS develop a corrective action plan to successfully complete the project requirements that the IA determined were not completed by the PPS Speed & Scale commitment date for this project. The PPS must provide a revised timeline for the completion of the 13 project requirements that were not completed by DY2, Q2 as part of this action plan.
4	Albany Medical Center	Project	3.d.iii.: Implementation of evidence-based medicine guidelines for asthma management	The IA recommends that the PPS develop a corrective action plan to successfully complete the project requirements that the IA determined were not completed by the PPS Speed & Scale commitment date for this

#	PPS	Section	Focus Area	IA Recommendation
				project. The PPS must provide a revised timeline for the completion of the three project requirements that were not completed by DY2, Q2 as part of this action plan.
5	Albany Medical Center	Organizational	Community Based Organization Contracting	The IA recommends that the PPS develop a clear strategy of contracting with CBOs.
6	Albany Medical Center	Organizational	Community Based Organization Contracting	The IA recommends that the PPS finalize contracts with partnering CBOs.
7	Albany Medical Center	Organizational	Cultural Competency and Health Literacy	The IA recommends that the PPS develop an action plan to implement its CCHL trainings to partners.
8	Albany Medical Center	Organizational	Primary Care Plans	The IA recommends that the PPS develop a detailed action plan to articulate what parts of the current Primary Care Plan have been implemented. The IA also recommends that this plan defines the planning phase and implementation phase discretely.

Alliance for Better Health Care

PPS Overview

Lead Organization	Alliance for Better Health Care, LLC
PPS Service Area	Albany, Fulton, Montgomery, Rensselaer, Schenectady, Saratoga
Attribution for Performance	123, 484
Attribution for Performance (Project 2.d.i)	94,000
Attribution for Valuation	193,150
Total Award Dollars	$250,232,844
Core Team	1) Jacob Reider: Chief Executive Officer 2) Meg Wallingford: Senior Vice President for Transformation 3) Thomas McCarroll: Vice President, Performance Operations 4) John Collins: Chief Medical Officer 5) Melissa Russom: Director of Communications and Stakeholder Management

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.b.iii.	ED care triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30-day readmissions for chronic health conditions
2.b.viii.	Hospital-home care collaboration solutions
2.d.i.	Implementation of patient activation activities to engage, educate, and integrate the uninsured and low/non-utilizing Medicaid populations into community based care
3.a.i.	Integration of primary care and behavioral health services
3.a.iv.	Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
3.d.ii.	Expansion of asthma home-based self-management program
3.g.i.	Integration of palliative care into the Patient-centered medical home model
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.b.i.	Promote tobacco use cessation, especially among low socioeconomic status populations and those with poor mental health

Funds Flow by Partner Category

Total Funds Available (DY1)	**$37,537,450.21**	
Total Funds Earned (through DY1)	**$36,912,871.53 (98.34% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$22,592,249.40 (61.20% of Earned Funds)**	
Partner Type	**Funds Distributed**	**Alliance (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$2,100,000.00	9.30%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$6,000,000.00	26.56%
Clinic	$5,250,400.00	23.24%
Case Management/Health Home	$750,000.00	3.32%
Mental Health	$130,925.00	0.58%
Substance Abuse	$150,000.00	0.66%
Nursing Home	$0.00	0.00%
Pharmacy	$0.00	0.00%
Hospice	$100,000.00	0.44%
Community Based Organizations[4]	$206,750.00	0.92%
All Other	$4,359,823.00	19.30%
Uncategorized	$0.00	0.00%
Non-PIT Partners	$0.00	0.00%
PMO	$3,544,351.40	15.69%
TOTAL	**$22,592,249.40**	**100.00%**

[4] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Alliance for Better Health Care	Project	2.b.iii: ED care triage for at-risk populations	The IA recommends the PPS develop a training strategy to address the patient lack of knowledge regarding the shift to primary and preventive care away from the ED.
2	Alliance for Better Health Care	Project	2.b.iv: Care transitions intervention model to reduce 30-day readmissions for chronic health conditions	The IA recommends the PPS develop a strategy to centralize the approach it is taking across the network to address care transitions and include behavioral health and psychosocial issues.
3	Alliance for Better Health Care	Project	2.b.iv: Care transitions intervention model to reduce 30-day readmissions for chronic health conditions	The IA recommends the PPS educate their network partners about the available models of transitions of care.
4	Alliance for Better Health Care	Project	2.b.viii: Hospital-home care collaboration solutions	The IA recommends the PPS develop a strategy in conjunction with home health agencies to align the documentation in order to prevent miscommunication and missing information.
5	Alliance for Better Health Care	Project	2.b.viii: Hospital-home care collaboration solutions	The IA recommends that the PPS workforce committee develop a strategy to recruit home health aides.
6	Alliance for Better Health Care	Project	3.d.ii: Expansion of asthma home-based self-management program	The IA recommends the PPS workforce committee develop a strategy to recruit certified asthma educators.
7	Alliance for Better Health Care	Project	3.d.ii: Expansion of asthma home-based self-management program	The IA recommends the PPS develop a standard curriculum to train community health workers in asthma home-based self-management.
8	Alliance for Better Health Care	Project	3.d.ii: Expansion of asthma home-	The IA recommends the PPS develop a strategy to engage

#	PPS	Section	Focus Area	IA Recommendation
			based self-management program	their patient population in this project.
9	Alliance for Better Health Care	Organizational	Community Based Organization Contracting	The IA recommends that the PPS develop an action plan to address the contracting with CBOs.
10	Alliance for Better Health Care	Organizational	Cultural Competency and Health Literacy	The IA recommends that the PPS develop a strategy to address how it will measure the effectiveness of their CCHL outreach efforts across the PPS network.
11	Alliance for Better Health Care	Organizational	Cultural Competency and Health Literacy	The IA recommends that the PPS develop a strategy to better address the CCHL training needs of its partners.
12	Alliance for Better Health Care	Organizational	Cultural Competency and Health Literacy	The IA recommends the PPS develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured.
13	Alliance for Better Health Care	Organizational	Financial Sustainability and VBP	The IA requires the PPS to assess the status of its network partner's involvement in VBP.
14	Alliance for Better Health Care	Organizational	Financial Sustainability and VBP	The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements.
15	Alliance for Better Health Care	Organizational	Partner Engagement	The IA requires the PPS to develop an action plan to increase partner engagement, in particular for PCPs and Behavioral Health partners.

Bronx Health Access (Bronx-Lebanon)

PPS Overview

Lead Organization	Bronx Lebanon Hospital Center
PPS Service Area	Bronx
Attribution for Performance	142,054
Attribution for Performance (Project 2.d.i)	N/A
Attribution for Valuation	70,861
Total Award Dollars	$153,930,779
Core Team	1) Dennis Maquiling – Executive Director, Bronx Lebanon 2) Doris Saintil – Site Director 3) Steven Maggio – Senior Project Manager 4) Suneel Parikh – PPS Medical Director

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.b.i.	Ambulatory Intensive Care Units (ICUs)
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
3.a.i.	Integration of primary care and behavioral health services
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.d.ii.	Expansion of asthma home-based self-management program
3.f.i.	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.c.ii.	Increase early access to, and retention in, HIV care

Funds Flow by Partner Category

Total Funds Available (DY1)	**$19,438,405.61**	
Total Funds Earned (through DY1)	**$19,235,488.56 (98.96% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$3,944,925.75 (20.51% of Earned Funds)**	
Partner Type	**Funds Distributed**	**Bronx Health Access (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$21,042.15	0.53%
Practitioner - Non-Primary Care Physician (PCP)	$15,087.13	0.38%
Hospital	$0.00	0.00%
Clinic	$2,015,782.20	51.10%
Case Management/Health Home	$244,979.34	6.21%
Mental Health	$0.00	0.00%
Substance Abuse	$45,157.55	1.14%
Nursing Home	$0.00	0.00%
Pharmacy	$13,488.99	0.34%
Hospice	$0.00	0.00%
Community Based Organizations[5]	$13,488.99	0.34%
All Other	$130,636.43	3.31%
Uncategorized	$40,466.97	1.03%
Non-PIT Partners	$0.00	0.00%
PMO	$1,404,796.00	35.61%
TOTAL	**$3,944,925.75**	**100.00%**

[5] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Bronx Health Access (Bronx-Lebanon)	Project	2.a.iii: Health Home At-Risk Intervention Program	The IA recommends the PPS create a plan to develop incentives to providers in order to engage them in this project and encourage them to hire CHWs. The Action Plan should outline specific steps to engage key PCP and Mental Health partners.
2	Bronx Health Access (Bronx-Lebanon)	Organizational	Partner Engagement	The IA recommends that the PPS develop and implement a strategy for distributing funds to all partners to ensure continued engagement of those partners in supporting the PPS to be successful in reaching project milestones, performance metrics, and earning Achievement Values.

Bronx Partners for Health Communities (St. Barnabas)

PPS Overview

Lead Organization	St. Barnabas Hospital
PPS Service Area	Bronx
Attribution for Performance	356,863
Attribution for Performance (Project 2.d.i)	N/A
Attribution for Valuation	159,201
Total Award Dollars	$384,271,362
Core Team	1) Leonard Walsh – Chief Operations Officer 2) Irene Kaufmann – Executive Director, DSRIP 3) J. Robin Moon – Senior Director, DSRIP Care Delivery & Practice Innovations 4) Dr. Amanda Ascher – Medical Director

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.b.iii.	ED care triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30-day readmission for chronic health conditions
3.a.i.	Integration of primary care and behavioral health services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Cardiovascular Health)
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes)
3.d.ii.	Expansion of asthma home-based self-management program
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.c.ii.	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)

Funds Flow by Partner Category

Total Funds Available (DY1)	**$48,058,146.86**	
Total Funds Earned (through DY1)	**$48,000,126.41 (99.88% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$36,132,645.00 (75.28% of Earned Funds)**	
Partner Type	**Funds Distributed**	**BPHC (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$13,066,322.00	36.16%
Clinic	$2,197,246.00	6.08%
Case Management/Health Home	$0.00	0.00%
Mental Health	$384,536.00	1.06%
Substance Abuse	$0.00	0.00%
Nursing Home	$0.00	0.00%
Pharmacy	$0.00	0.00%
Hospice	$0.00	0.00%
Community Based Organizations[6]	$2,920,589.00	8.08%
All Other	$0.00	0.00%
Uncategorized	$318,932.00	0.88%
Non-PIT Partners	$37,500	0.10%
PMO	$17,207,520.00	47.62%
TOTAL	**$36,132,645.00**	**100.00%**

[6] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Bronx Partners for Health Communities (SBH)	Project	2.a.iii: Health Home At-Risk Intervention Program	The IA recommends that the PPS create a plan to address the shortage of qualified and trained staff to engage in this project, thus improving the availability of proper care management and creating a foundation for appropriate referrals.
2	Bronx Partners for Health Communities (SBH)	Project	2.a.iii: Health Home At-Risk Intervention Program	The IA recommends the PPS work with its partners in deciding on a vendor to provide IT solutions. The PPS will need to work with the vendor and network partners to address interoperability requirements that will enable the necessary data exchange for proper care management planning and documentation, as well as accurate patient engagement counts.
3	Bronx Partners for Health Communities (SBH)	Organizational	Partner Engagement	The IA recommends that the PPS develop a strategy to increase partner engagement across all project, with a specific focus on Mental Health patterns for Domain 3a projects.

Care Compass Network

PPS Overview

Lead Organization	Care Compass Network (a.k.a Southern Tier Rural Integrated Performing Provider System)
PPS Service Area	Broome, Chemung, Chenango, Cortland, Delaware, Schuyler, Steuben, Tioga, and Tompkins Counties
Attribution for Performance	102,386
Attribution for Performance (Project 2.d.i)	97,548
Attribution for Valuation	186,101
Total Award Dollars	$224,540,275
Core Team	1) Mark Ropiecki: DSRIP Executive Director 2) Robin Kinslow-Evans: Strategic Advisor 3) Robert Carangelo: Finance Officer

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.c.i.	Development of community-based health navigation services
2.d.i.	Implementation of Patient Activation activities to engage, educate, and integrate the uninsured and low/non-utilizing Medicaid populations into community based care
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral Health community crisis stabilization services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.g.i.	Integration of palliative care into the PCMH model
4.a.iii.	Strengthen Mental Health and Substance Abuse infrastructure across Systems
4.b.ii.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings

Funds Flow by Partner Category

Total Funds Available (DY1)	**$33,825,792.21**	
Total Funds Earned (through DY1)	**$33,258,037.14 (98.32% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$2,804,647.00 (8.43% of Earned Funds)**	
Partner Type	**Funds Distributed**	**Care Compass (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$10,830.00	0.39%
Clinic	$5,255.00	0.19%
Case Management/Health Home	$0.00	0.00%
Mental Health	$4,397.50	0.16%
Substance Abuse	$6,730.00	0.24%
Nursing Home	$17,265.00	0.62%
Pharmacy	$3,160.00	0.11%
Hospice	$0.00	0.00%
Community Based Organizations[7]	$21,257.50	0.76%
All Other	$9,345.00	0.33%
Uncategorized	$101,240.00	3.61%
Non-PIT Partners	$0.00	0.00%
PMO	$2,625,167.00	93.60%
TOTAL	**$2,804,647.00**	**100.00%**

[7] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Care Compass Network	Project	2.a.i: Create Integrated Delivery Systems	The IA recommends the PPS develop a strategy to increase partner engagement to support the successful implementation of this project and in meeting the PPS' DSRIP goals.
2	Care Compass Network	Project	2.b.iv: Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	The IA recommends the PPS develop a strategy to increase partner and community engagement.
3	Care Compass Network	Project	2.b.iv: Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	The IA recommends the PPS develop a plan to increase outreach and education materials to partners.
4	Care Compass Network	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS develop a strategy to assist partners in better identifying the targeted population for this project.
5	Care Compass Network	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS develop a plan to increase outreach and education materials to partners with respect to patient activation measures.
6	Care Compass Network	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS create a plan to address the shortage of primary care physicians engaged in this project in order to meet their project implementation speed commitments.
7	Care Compass Network	Project	3.a.i: Integration of primary care and behavioral health services	The IA recommends the PPS create a plan to address the shortage of primary care physicians engaged in this project in order to meet their

#	PPS	Section	Focus Area	IA Recommendation
				project implementation speed commitments.
8	Care Compass Network	Project	3.a.i: Integration of primary care and behavioral health services	The IA recommends the PPS develop a plan to address the workforce challenges with licensed behavioral health specialists and care coordinators.
9	Care Compass Network	Project	3.b.i: Evidence-based strategies for disease management in high risk/affected populations (adult only)	The IA requires the PPS develop a comprehensive action plan to address the implementation of this project in consultation with the Project Advisory Committee (PAC) that must be reviewed and approved by the Board of Directors. This Action Plan must detail how the PPS will monitor and intervene when project milestones, partner engagement, or patient engagement for this project fall behind schedule.
10	Care Compass Network	Project	3.b.i: Evidence-based strategies for disease management in high risk/affected populations (adult only)	The PPS should develop a strategy to educate their partners on the value of DSRIP in order to increase their engagement.
11	Care Compass Network	Project	3.b.i: Evidence-based strategies for disease management in high risk/affected populations (adult only)	To address the issue of partner reluctance to participate in this project due to perceived lack of reimbursement, the PPS should develop creative strategies, either in the form of services, consultation, or work with a vendor to assist the PPS in this outreach.
12	Care Compass Network	Project	3.b.i: Evidence-based strategies for disease management in high risk/affected populations (adult only)	In order to address the issue of identifying targeted panels of patients eligible to be included in this project, the IA recommends that the PPS convene a group of stakeholders to develop a

#	PPS	Section	Focus Area	IA Recommendation
				strategy to develop common solutions.
13	Care Compass Network	Project	3.g.i: Integration of palliative care into the PCMH Model	The IA requires the PPS develop a comprehensive action plan to address the implementation of this project in consultation with the Project Advisory Committee (PAC) that must be reviewed and approved by the Board of Directors. This Action Plan must detail how the PPS will monitor and intervene when project milestones, partner engagement, or patient engagement for this project fall behind schedule.
14	Care Compass Network	Project	3.g.i: Integration of palliative care into the PCMH Model	The IA recommends that the PPS finalize its contracting arrangements with their partners and begin flowing funds.
15	Care Compass Network	Project	3.g.i: Integration of palliative care into the PCMH Model	To address the issue of partner reluctance to participate in this project due to perceived lack of reimbursement, the PPS should develop creative strategies, either in the form of services, consultation, or work with a vendor to assist the PPS in outreach.
16	Care Compass Network	Organizational	Community Based Organization Contracting	The IA recommends that the PPS accelerate finalizing contracts with its partnering Community Based Organizations in order to fully implement projects.
17	Care Compass Network	Organizational	Cultural Competency and Health Literacy	The IA recommends that the PPS develop an action plan to roll out its trainings to its workforce and partners.
18	Care Compass Network	Organizational	Cultural Competency and Health Literacy	The IA recommends that the PPS develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured.

#	PPS	Section	Focus Area	IA Recommendation
19	Care Compass Network	Organizational	Financial Sustainability and VBP	The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements.
20	Care Compass Network	Organizational	Partner Engagement	The IA recommends that the PPS develop a strategy to increase partner engagement throughout the PPS, particularly with Primary Care Providers and Non-Primary Care Providers.
21	Care Compass Network	Organizational	Patient Engagement	The IA requires the PPS to develop a plan to increase patient engagement across all projects.
22	Care Compass Network	Organizational	Primary Care Plans	The IA recommends that the PPS develop an action plan to address the deficiencies identified in the Primary Care Plan, notably the lack of specificity on the primary care strategy of the PPS, the limited detail on progress towards implementation of the primary care strategies, and the role of the PPS in monitoring and overseeing the implementation of the primary care strategies.

Central New York Care Collaborative

PPS Overview

Lead Organization	Central New York Care Collaborative
PPS Service Area	Cayuga, Lewis, Madison, Oneida, Onondaga, Oswego
Attribution for Performance	186,744
Attribution for Performance (Project 2.d.i)	
Attribution for Valuation	262,144
Total Award Dollars	$323,029,955
Core Team	1) Virginia Opipare: Executive Director 2) Lauren Wetterhahn: Director of Program Operations and Strategy 3) Joe Reilly: Chief Information Officer

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.b.iii.	ED care triage for at-risk patients
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.d.i.	Implementation of Patient Activation activities to engage, educate, and integrate the uninsured and low/non-utilizing Medicaid populations into community based care
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral Health community crisis stabilization services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.g.i.	Integration of palliative care into the PCMH model
4.a.iii.	Strengthen Mental Health and Substance Abuse infrastructure across Systems
4.d.i.	Reduce premature births

Funds Flow by Partner Category

Total Funds Available (DY1)	**$42,464,808.32**	
Total Funds Earned (through DY1)	**$42,013,143.76 (98.94% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$10,008,030.79 (23.82% of Earned Funds)**	
Partner Type	**Funds Distributed**	**CNYCC (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$4,927,906.27	49.24%
Clinic	$1,160,921.82	11.60%
Case Management/Health Home	$97,003.25	0.97%
Mental Health	$215,758.44	2.16%
Substance Abuse	$45,343.55	0.45%
Nursing Home	$146,193.49	1.46%
Pharmacy	$4,164.35	0.04%
Hospice	$12,874.15	0.13%
Community Based Organizations[8]	$6,678.87	0.07%
All Other	$303,596.24	3.03%
Uncategorized	$19,914.05	0.20%
Non-PIT Partners	$71,318.31	0.71%
PMO	$2,996,358.00	29.94%
TOTAL	**$10,080,030.79**	**100.00%**

[8] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Central New York Care Collaborative	Project	2.a.iii: Health Home At-Risk Intervention Program	The IA recommends that the PPS develop a training plan to educate PCPs on the care coordination requirements for this project.
2	Central New York Care Collaborative	Project	2.a.iii: Health Home At-Risk Intervention Program	The IA recommends that the PPS develop a care coordination resource to support PCPs.
3	Central New York Care Collaborative	Project	2.a.iii: Health Home At-Risk Intervention Program	The IA recommends that the PPS establish a system for identifying the targeted patients to assist the PCPs for this project as part of overall PPS population health strategy in working with its network partners.
4	Central New York Care Collaborative	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends that the PPS finalize the contracts with partners participating in this project.
5	Central New York Care Collaborative	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends that the PPS increase the trainings available to assist partners in implementing this project.
6	Central New York Care Collaborative	Organizational	Community Based Organization Contracting	The IA recommends that the PPS develop a clear strategy of contracting with CBOs.
7	Central New York Care Collaborative	Organizational	Community Based Organization Contracting	The IA recommends that the PPS finalize contracts with partnering CBOs.
8	Central New York Care Collaborative	Organizational	Cultural Competency and Health Literacy	The IA recommends that the PPS develop an action plan to roll out its trainings to partners.
9	Central New York Care Collaborative	Organizational	Cultural Competency and Health Literacy	The IA recommends that the PPS develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured.

#	PPS	Section	Focus Area	IA Recommendation
10	Central New York Care Collaborative	Organizational	Financial Sustainability and VBP	The IA recommends that the PPS hire a Finance Director.
11	Central New York Care Collaborative	Organizational	Primary Care Plans	The IA recommends that the PPS develop an action plan to detail how the PPS will move its approach to primary care from the planning stages to implementation.

Community Care of Brooklyn (Maimonides)

PPS Overview

Lead Organization	Maimonides Medical Center
PPS Service Area	Brooklyn, Queens
Attribution for Performance	448,420
Attribution for Performance (Project 2.d.i)	N/A
Attribution for Valuation	212,586
Total Award Dollars	$489,039,450
Core Team	1) Dr. David Cohen – PPS Lead, CEO 2) Dr. Karen Nelson – Chief Medical Officer 3) Caroline Greene – Chief Administration and Financial Officer

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.b.iii.	ED care triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
3.a.i.	Integration of primary care and behavioral health services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular health)
3.d.ii.	Expansion of asthma home-based self-management program
3.g.i.	Integration of palliative care into the PCMH Model
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.c.ii.	Increase early access to, and retention in, HIV care

Funds Flow by Partner Category

Total Funds Available (DY1)	$61,274,725.54	
Total Funds Earned (through DY1)	$61,274,725.54 (100.00% of Available Funds)	
Total Funds Distributed (through DY2, Q2)	$26,519,732.46 (43.28% of Earned Funds)	
Partner Type	**Funds Distributed**	**CCB (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$662,856.31	2.50%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$9,184,905.11	34.63%
Clinic	$1,246,465.03	4.70%
Case Management/Health Home	$714,213.34	2.69%
Mental Health	$96,598.37	0.36%
Substance Abuse	$0.00	0.00%
Nursing Home	$0.00	0.00%
Pharmacy	$0.00	0.00%
Hospice	$0.00	0.00%
Community Based Organizations[9]	$2,182,835.86	8.23%
All Other	$734,656.46	2.77%
Uncategorized	$436,769.29	1.65%
Non-PIT Partners	$15,945.76	0.06%
PMO	$11,244,486.93	42.40%
TOTAL	**$26,519,732.46**	**100.00%**

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Maimonides	N/A	N/A	No recommendations have been made by the IA at the Mid-Point Assessment.

[9] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Community Partners of Western NY (Sisters of Charity Hospital)

PPS Overview

Lead Organization	Sisters of Charity Hospital
PPS Service Area	Chautauqua, Erie, Niagara
Attribution for Performance	85,278
Attribution for Performance (Project 2.d.i)	N/A
Attribution for Valuation	43,375
Total Award Dollars	$92,253,402
Core Team	1) Amy White-Storfer, Director 2) Carlos Santos, MD, Chief Medical Officer 3) Phyllis Gunning, Director of Clinical Programs

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.b.iii.	ED care triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.c.ii.	Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services
3.a.i.	Integration of primary care and behavioral health services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.f.i.	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)
3.g.i.	Integration of palliative care into the PCMH Model
4.a.i.	Promote mental, emotional and behavioral (MEB) well-being in communities
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health

Funds Flow by Partner Category

Total Funds Available (DY1)	**$11,642,656.72**	
Total Funds Earned (through DY1)	**$11,569,832.48 (99.37% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$7,911,089.65 (68.38% of Earned Funds)**	
Partner Type	**Funds Distributed**	**CPWNY (% of Funds distributed)**
Practitioner - Primary Care Physician (PCP)	$1,000,740.00	12.65%
Practitioner - Non-Primary Care Physician (PCP)	$77,093.00	0.97%
Hospital	$2,924,517.00	36.97%
Clinic	$0.00	0.00%
Case Management/Health Home	$13,009.00	0.16%
Mental Health	$0.00	0.00%
Substance Abuse	$0.00	0.00%
Nursing Home	$0.00	0.00%
Pharmacy	$0.00	0.00%
Hospice	$150,768.00	1.91%
Community Based Organizations[10]	$2,579,928.87	32.61%
All Other	$0.00	0.00%
Uncategorized	$62,162.00	0.79%
Non-PIT Partners	$0.00	0.00%
PMO	$1,102,871.78	13.94%
TOTAL	**$7,911,089.65**	**100.00%**

[10] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Community Partners of Western New York (CPWNY)	Project	2.b.iii.: ED care triage for at-risk populations	The IA recommends the PPS create a systematic process of triaging patients who are not linked to a Health Home, to a PCP in order to (1) Increase engagement of a broad patient population; (2) Meet patient engagement targets; and (3) Ensure access to services before getting linked to a Health Home.
2	Community Partners of Western New York (CPWNY)	Project	2.b.iii.: ED care triage for at-risk populations	The IA recommends the PPS create a plan to address the shortage of primary care physicians engaged in this project.
3	Community Partners of Western New York (CPWNY)	Project	2.c.ii.: Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services	The IA recommends the PPS develop an action plan to shorten the credentialing process of providers in order to improve the patient and partner engagement shortcomings.
4	Community Partners of Western New York (CPWNY)	Project	3.f.i.: Increase support programs for maternal & child health (including high risk pregnancies)	The IA recommends that the PPS explore opportunities to expand the services for this project into Erie County which is a part of the PPS service area and impacts a significant portion of the patient population.
5	Community Partners of Western New York (CPWNY)	Project	3.g.i: Integration of palliative care into the PCMH Model	The IA recommends that the PPS create an action plan to increase the presence of palliative team members in primary care practices in order to increase referrals, which will further improve patient engagement shortcomings.
6	Community Partners of Western New York (CPWNY)	Project	3.g.i: Integration of palliative care into the PCMH Model	The PPS should also create a plan to continue partner engagement beyond the original training.

#	PPS	Section	Focus Area	IA Recommendation
7	Community Partners of Western New York (CPWNY)	Organizational	Financial Sustainability and VBP	The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements.
8	Community Partners of Western New York (CPWNY)	Organizational	Partner Engagement	The IA recommends that the PPS develop a strategy to increase partner engagement throughout the PPS network. The limited partner engagement across multiple projects is a significant risk to the ability of the PPS to implement its DSRIP projects and meet the DSRIP goals.

Finger Lakes PPS

PPS Overview

Lead Organization	Finger Lakes PPS
PPS Service Area	Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates
Attribution for Performance	296,058
Attribution for Performance (Project 2.d.i)	
Attribution for Valuation	413,289
Total Award Dollars	$565,448,177
Core Team	1) Carol Tegas: Executive Director 2) Janet King: Director, Project Management Office 3) Jose Rosario: IT Director 4) Dr. Sahar Elezabi: Chief Medical Officer 5) Peter Bauman: Director of DSRIP Operations

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.b.iii.	ED care triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.vi.	Transitional supportive housing services
2.d.i.	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral health community crisis stabilization services
3.a.v.	Behavioral Interventions Paradigm (BIP) in Nursing Homes
3.f.i.	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.b.ii.	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer

Funds Flow by Partner Category

Total Funds Available (DY1)	$84,536,164.97	
Total Funds Earned (through DY1)	$84,536,164.97 (100% of Available Funds)	
Total Funds Distributed (through DY2, Q2)	$33,418,909.43 (39.53% of Earned Funds)	
Partner Type	**Funds Distributed**	**FLPPS (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$442,585.89	1.32%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$19,561,196.60	58.53%
Clinic	$2,886,257.64	8.64%
Case Management/Health Home	$117,499.64	0.35%
Mental Health	$251,142.05	0.75%
Substance Abuse	$238,022.84	0.71%
Nursing Home	$47,690.55	0.14%
Pharmacy	$6,000.00	0.02%
Hospice	$6,000.00	0.02%
Community Based Organizations[11]	$383,955.18	1.15%
All Other	$744,455.86	2.23%
Uncategorized	$226,386.18	0.68%
Non-PIT Partners	$139,205.00	0.42%
PMO	$8,368,512.00	25.04%
TOTAL	**$33,418,909.43**	**100.00%**

[11] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Finger Lakes PPS (FLPPS)	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS develop an action plan to increase CBO and other partner participation in this project.
2	Finger Lakes PPS (FLPPS)	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS develop an action plan to educate CBOs on their vital role in the DSRIP program.
3	Finger Lakes PPS (FLPPS)	Project	3.a.i: Integration of primary care and behavioral health services	The IA recommends that the PPS develop an action plan to identify and introduce opportunities for mental health professionals to partner with primary care providers, especially in more rural parts of their region. The data in this assessment indicates that FLPPS has only engaged five Mental Health and Primary Care Providers to date. The PPS' success in implementing this project will not only impact its ability to earn performance funding but also High Performance Funds.
4	Finger Lakes PPS (FLPPS)	Organizational	Cultural Competency and Health Literacy	The IA recommends that the PPS develop an action plan to roll out its trainings to workforce and partners with specific dates. FLPPS must also develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured and report out on these strategies to the IA.
5	Finger Lakes PPS (FLPPS)	Organizational	Financial Sustainability and VBP	The IA recommends that the PPS create an action plan to address the assessment of its network partners for VBP readiness, and establish a plan to further educate and support their partners' moves toward VBP arrangements.

#	PPS	Section	Focus Area	IA Recommendation
6	Finger Lakes PPS (FLPPS)	Organizational	Partner Engagement	The IA requires the PPS to develop an action plan to increase partner engagement. The plan needs to provide specific details by each project for partner engagement.

Leatherstocking Collaborative Health Partners (Bassett)

PPS Overview

Lead Organization	Bassett Medical Center
PPS Service Area	Delaware, Herkimer, Madison, Otsego, Schoharie
Attribution for Performance	41,716
Attribution for Performance (Project 2.d.i)	
Attribution for Valuation	62,043
Total Award Dollars	$71,839,378
Core Team	1) Sue van der Sommen: DSRIP Executive Director 2) Tom Manion: Director of Operations & Strategic Planning 3) Amy Van Kampen: Director of Performance Metrics 4) Dr. James Anderson: Medical Director, Behavioral Health and Integrated Services 5) Swathi Gurjala: DSRIP Program Manager 6) Wendy Kiuber: Network Operations Coordinator 7) Dr. Steven Heneghan: Chief Medical Officer 8) Mallory Mattson: Network Operations Manager 9) Kara Travis: Senior Director, Patient Services

Projects Selected

Project	Project Description
2.a.ii.	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.viii.	Hospital-Home Care Collaborative Solutions
2.c.i.	Development of community-based health navigation services
2.d.i	Implementation of Patient Activation activities to engage, educate, and integrate the uninsured and low/non-utilizing Medicaid populations into community based care
3.a.i.	Integration of primary care and behavioral health services
3.a.iv.	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
3.d.iii.	Implementation of evidence-based medicine guidelines for asthma management

3.g.i.	Integration of palliative care into the PCMH model
4.a.iii.	Strengthen Mental Health and Substance Abuse infrastructure across Systems
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health

Funds Flow by Partner Category

Total Funds Available (DY1)	**$10,670,793.28**	
Total Funds Earned (through DY1)	**$10,428,994.55 (97.73% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$8,985,993.64 (86.16% of Earned Funds)**	
Partner Type	**Funds Distributed**	**LCHP (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$4,797,087.56	53.38%
Clinic	$48,346.85	0.54%
Case Management/Health Home	$90,731.01	1.01%
Mental Health	$3,131,63	0.03%
Substance Abuse	$93,541.81	1.04%
Nursing Home	$703,306.71	7.83%
Pharmacy	$0.00	0.00%
Hospice	$55,303.03	0.62%
Community Based Organizations[12]	$50,034.28	0.56%
All Other	$356,578.37	3.97%
Uncategorized	$274,812.39	3.06%
Non-PIT Partners	$303.00	0.00%
PMO	$2,512,817.00	27.96%
TOTAL	**$8,985,993.64**	**100.00%**

[12] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

1	PPS	Section	Focus Area	IA Recommendation
1	Leatherstocking Collaborative Health Partners PPS (Bassett)	Project	2.c.i.: Development of community-based health navigation services	The IA recommends the PPS develop a training strategy to educate their partners and the targeted population about community based health navigation services.
2	Leatherstocking Collaborative Health Partners PPS (Bassett)	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS develop a strategy to assist partners in better identifying the targeted population for this project.
3	Leatherstocking Collaborative Health Partners PPS (Bassett)	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS develop plan to increase outreach and education materials to partners with respect to patient activation measures.
4	Leatherstocking Collaborative Health Partners PPS (Bassett)	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS create a plan to address the shortage of primary care physicians engaged in this project in order to meet their project implementation speed commitments.
5	Leatherstocking Collaborative Health Partners PPS (Bassett)	Project	3.g.i: Integration of palliative care into the PCMH Model	The IA recommends that the PPS create an action plan to increase collaboration between palliative care team members and primary care practices (either onsite or via telemedicine) in order to increase referrals, which will further improve patient engagement shortcomings.
6	Leatherstocking Collaborative Health Partners PPS (Bassett)	Organizational	Governance	The IA recommends the PPS hire a Compliance Officer who reports directly to the EGB.
7	Leatherstocking Collaborative Health Partners PPS (Bassett)	Organizational	Partner Engagement	The IA recommends LCHP strengthen their community and partner education and engagement, in particular with entities outside the lead entity, Bassett Healthcare.
8	Leatherstocking Collaborative Health	Organizational	Primary Care Plans	The IA recommends that the PPS develop an action plan to

1	PPS	Section	Focus Area	IA Recommendation
	Partners PPS (Bassett)			address the concerns raised in the Primary Care Plan, notably the lack of an overall approach or strategic plan for primary care and the limited detail on the scale of implementation efforts.
9	Leatherstocking Collaborative Health Partners PPS (Bassett)	Organizational	Primary Care Plans	The IA recommends that the PPS develop an action plan to document its approach to addressing the challenges identified for compensation models and incentives for providers that will impact the PPS' primary care strategy related to VBP.

Millennium Collaborative Care

PPS Overview

Lead Organization	Erie County Medical Center
PPS Service Area	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming
Attribution for Performance	252,737
Attribution for Performance (Project 2.d.i)	
Attribution for Valuation	309,457
Total Award Dollars	$243,019,729
Core Team	1) Al Hammonds, Executive Director 2) Anthony J. Billietier, MD, Chief Medical Officer 3) Michelle Mercer, RN, Chief Clinical Integration Officer 4) Jan Brown, Director of Human Resources 5) Juan Santiago, Administrative Director 6) Katherine Panzarella, Director of Finance 7) Christine Blidy, Chief Network Officer Tammy Fox, Director, Project Management Office

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.b.iii.	ED care triage for at-risk patients
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.viii.	Hospital-Home Care Collaborative Solutions
2.d.i.	Implementation of Patient Activation activities to engage, educate, and integrate the uninsured and low/non-utilizing Medicaid populations into community based care
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral Health community crisis stabilization services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.f.i.	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)
4.a.i.	Promote mental, emotional and behavioral (MEB) well-being in communities
4.d.i.	Reduce premature births

Funds Flow by Partner Category

Total Funds Available (DY1)	**$34,271,286.07**	
Total Funds Earned (through DY1)	**$33,704,481.48 (98.35% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$16,916,710.23 (50.19% of Earned Funds)**	
Partner Type	**Funds Distributed**	**Millennium (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$2,223,245.36	13.14%
Clinic	$1,339,456.00	7.92%
Case Management/Health Home	$81,364.88	0.48%
Mental Health	$1,580,343.00	9.34%
Substance Abuse	$343,246.00	2.03%
Nursing Home	$889,118.00	5.26%
Pharmacy	$0.00	0.00%
Hospice	$0.00	0.00%
Community Based Organizations[13]	$1,793,897.75	10.60%
All Other	$1,268,553.00	7.50%
Uncategorized	$62.50	0.00%
Non-PIT Partners	$1,010,395.23	5.97%
PMO	$6,387,028.51	37.76%
TOTAL	**$16,916,710.23**	**100.00%**

[13] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Millennium Collaborative Care	Organizational	Financial Sustainability and VBP	The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements.
2	Millennium Collaborative Care	Organizational	Partner Engagement	The PPS must develop a plan for more actively engaging its network partners across all projects to ensure the successful completion of project milestones and meeting all DSRIP performance goals.
3	Millennium Collaborative Care	Organizational	Primary Care Plans	The IA recommends that the PPS develop a plan to address the limited data presented in the Primary Care Plan for baseline capacity, HPSA, and workforce needs to better understand and address any potential challenges to the primary care plan efforts resulting from limited primary care capacity.

Montefiore Hudson Valley Collaborative

PPS Overview

Lead Organization	Montefiore Health System
PPS Service Area	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Attribution for Performance	229,654
Attribution for Valuation	105,752
Total Award Dollars	$249,071,149
Core Team	1) Allison McGuire: Hudson Valley Collaborative, DSRIP ED 2) Marlene Ripa: Hudson Valley Collaborative, DSRIP Coordinator 3) Dr. Damara Gutnick: Hudson Valley Collaborative, CMO 4) Bayard King: Hudson Valley Collaborative, CFO

Projects Selected

Project	Project Description
2.a.i.	Create integrated delivery systems that are focused on evidence-based medicine / population health management
2.a.iii.	Health home at-risk intervention program: proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.a.iv.	Created a medical village using existing hospital infrastructure
2.b.iii.	ED care triage for at-risk populations
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral health community crisis stabilization services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (cardiovascular health)
3.d.iii.	Implementation of evidence- based medicine guidelines for asthma management
4.b.i.	Promote tobacco use cessation, especially among low socioeconomic status populations and those with poor mental health
4.b.ii.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings

Funds Flow by Partner Category

Total Funds Available (DY1)	$31,677,077.80	
Total Funds Earned (through DY1)	$31,501,511.94 (99.45% of Available Funds)	
Total Funds Distributed (through DY2, Q2)	$19,313,051.01 (61.31% of Earned Funds)	
Partner Type	**Funds Distributed**	**Montefiore (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$1,292,307.85	6.69%
Practitioner - Non-Primary Care Physician (PCP)	$214,229.69	1.11%
Hospital	$1,859,935.29	9.63%
Clinic	$2,228,004.03	11.54%
Case Management/Health Home	$388,911.34	2.01%
Mental Health	$1,680,965.73	8.70%
Substance Abuse	$1,169,049.21	6.05%
Nursing Home	$43,372.76	0.22%
Pharmacy	$6,532.00	0.03%
Hospice	$272.69	0.00%
Community Based Organizations[14]	$8,650.25	0.04%
All Other	$482,554.17	2.50%
Uncategorized	$0.00	0.00%
Non-PIT Partners	$0.00	0.00%
PMO	$9,938,266.00	51.46%
TOTAL	**$19,020,426.43**	**100.00%**

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Montefiore Hudson Valley Collaborative	N/A	N/A	No recommendations have been made by the IA at the Mid-Point Assessment.

[14] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category

Mount Sinai PPS

PPS Overview

Lead Organization	Mount Sinai Health System
PPS Service Area	Brooklyn, Queens
Attribution for Performance	364,804
Attribution for Performance (Project 2.d.i)	
Attribution for Valuation	136,370
Total Award Dollars	$389,900,648
Core Team	1) Art Gianelli — President, MSPPS 2) Jill Huck – Executive Director of PMO, MSPPS 3) Dr. Edwidge Thomas — Medical Director, MSPPS 4) Patti Cuartas, — Senior Director of IT, MSPPS 5) Stefani Rodiguez — Associate Director of Projects, MSPPS 6) Dr. Brian Wong— Medical Director, Behavioral Health

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.viii.	Hospital-Home Care Collaboration Solutions
2.c.i.	Development of community-based health navigation services
3.a.i.	Integration of primary care and behavioral health services
3.a.iii.	Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only)
4.b.ii.	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer
4.c.ii.	Increase early access to, and retention in, HIV care

Funds Flow by Partner Category

Total Funds Available (DY1)	$47,377,903.32	
Total Funds Earned (through DY1)	$46,991,131.82 (99.18% of Available Funds)	
Total Funds Distributed (through DY2, Q2)	$30,823,046.78 (65.59% of Earned Funds)	
Partner Type	**Funds Distributed**	**Mount Sinai (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$58,740.80	0.19%
Practitioner - Non-Primary Care Physician (PCP)	$155.95	0.00%
Hospital	$1,039,526.62	3.37%
Clinic	$2,431,581.68	7.89%
Case Management/Health Home	$390,968.17	1.27%
Mental Health	$1,081,673.31	3.51%
Substance Abuse	$294,402.02	0.96%
Nursing Home	$43,016.34	0.14%
Pharmacy	$245,599.11	0.80%
Hospice	$247,117.93	0.80%
Community Based Organizations[15]	$245,576.68	0.80%
All Other	$2,740,595.24	8.89%
Uncategorized	$107,648.65	0.35%
Non-PIT Partners	$48,027.30	0.16%
PMO	$21,848,417.00	70.88%
TOTAL	**$30,784,865.26**	**100.00%**

[15] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Mount Sinai PPS	Project	3.a.iii: Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance	The IA recommends the PPS review its current plan for implementing this project and develop a plan to initiate efforts on all required project milestones.
2	Mount Sinai PPS	Organizational	Partner Engagement	The IA recommends that the PPS develop a strategy to increase partner engagement across all projects being implement and across all partner categories with a specific focus on increasing the engagement of Primary Care Practitioners.
3	Mount Sinai PPS	Organizational	Primary Care Plans	The IA recommends that the PPS develop a detailed action plan with specific dates and deliverables for the various Primary Care Plan strategies.

Nassau Queens PPS

PPS Overview

Lead Organization	Nassau University Medical Center
PPS Service Area	Nassau, Queens
Attribution for Performance	417,162
Attribution for Performance (Project 2.d.i)	281,301
Attribution for Valuation	1,030,400
Total Award Dollars	$535,396,603
Core Team	1) Robert Hettenbach, Executive Director 2) Gilberto Burgos, MD, Medical Director 3) Ha Nguyen, Director of Project Operations 4) Nancy Copperman, Cultural Competency and Health Literacy Director 5) Thomas Poccia, Finance Director 6) Karen Czizk, Workforce Director 7) Thomas Melilo, Communications Director Megan Ryan, Compliance Director

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.b.ii.	Development of co-located primary care services in the emergency department (ED)
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.d.i.	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral health community crisis stabilization services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular Health)
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes Care)
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

Funds Flow by Partner Category

Total Funds Available (DY1)	**$77,696,913.56**	
Total Funds Earned (through DY1)	**$76,188,200.78 (98.06% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$32,843,141.26 (43.11% of Earned Funds)**	
Partner Type	**Funds Distributed**	**Nassau Queens (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$26,641,000.00	81.12%
Clinic	$0.00	0.00%
Case Management/Health Home	$0.00	0.00%
Mental Health	$2,000,000.00	6.09%
Substance Abuse	$0.00	0.00%
Nursing Home	$0.00	0.00%
Pharmacy	$0.00	0.00%
Hospice	$0.00	0.00%
Community Based Organizations[16]	$0.00	0.00%
All Other	$0.00	0.00%
Uncategorized	$0.00	0.00%
Non-PIT Partners	$0.00	0.00%
PMO	$4,202,141.26	12.79%
TOTAL	**$32,843,141.26**	**100.00%**

[16] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Nassau Queens Performing Provider System	Project	2.a.i: Create Integrated Delivery Systems	The IA recommends the PPS develop a strategy to increase partner engagement to support the successful implementation of this projects and in meeting the PPS' DSRIP goals.
2	Nassau Queens Performing Provider System	Project	2.a.i: Create Integrated Delivery Systems	The IA recommends that the PPS provide a detailed plan for how each Hub will implement its own PCMH recognition strategy for primary care physicians.
3	Nassau Queens Performing Provider System	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends that the PPS detail how the new vendor IT platform will accelerate the low Partner and Patient Engagement for this project.
4	Nassau Queens Performing Provider System	Project	3.a.i: Integration of primary care and behavioral health services	The IA recommends that the PPS and its hubs detail a "train the trainer" plan between the providers with positive experiences with this project to other physicians in the Network.
5	Nassau Queens Performing Provider System	Project	3.a.ii: Behavioral health community crisis stabilization services	The IA recommends that the PPS outline the specifics related to how the hub model will produce better results for this project.
6	Nassau Queens Performing Provider System	Project	3.b.i: Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular Health)	The PPS narrative addressed challenges surrounding PCP engagement in this project and sought to mitigate this challenge by incentivizing providers to obtain PCMH certification. This is neither a requirement nor a barrier to implementing this project. As this project focuses on disease management for cardiovascular health the IA recommends that the PPS create a plan to engage the proper patient and partner types while focusing on the purpose of the project and the

#	PPS	Section	Focus Area	IA Recommendation
				successful implementation of the same.
7	Nassau Queens Performing Provider System	Project	3.c.i: Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes Care)	The PPS narrative addressed challenges surrounding PCP engagement in this project and sought to mitigate this challenge by incentivizing providers to obtain PCMH certification. This is neither a requirement nor a barrier to implementing this project. As this project focuses on disease management for diabetes, the IA recommends that the PPS create a plan to engage the proper patient and partner types while focusing on the purpose of the project and the successful implementation of the same.
8	Nassau Queens Performing Provider System	Organizational	Partner Engagement	The IA recommends that the PPS develop a strategy to increase partner engagement throughout its target area, with a specific emphasis on engaging Behavioral Health (Mental Health and Substance Abuse) and PCP partners. Behavioral health providers and integration with primary care are essential to realize the project goals of behavioral health integration and to be able to earn the high performance funds.
9	Nassau Queens Performing Provider System	Organizational	Patient Engagement	The IA recommends that the PPS develop a strategy to increase and consistently maintain patient engagement levels throughout its target area. This is another high risk area where the PPS has previously missed targets and associated DSRIP payments.

New York Presbyterian - Queens

PPS Overview

Lead Organization	New York Presbyterian/Queens
PPS Service Area	Queens
Attribution for Performance	29,627
Attribution for Performance (Project 2.d.i)	
Attribution for Valuation	12,962
Total Award Dollars	$31,776,993
Core Team	1) Maureen Buglino – Vice President for Community Medicine and Emergency Medicine 2) Maria D'Urso – Administrative Director, Community Medicine 3) Sadia Choudhury – Executive Director 4) Dr. Robert Crupi – Chief Medical Officer

Projects Selected

Project	Project Description
2.a.ii.	Increase certification of primary care practitioners with patient centered medical home (PCMH) certification and/or advanced primary care models (as developed under the NYS Health Innovation Plan (SHIP))
2.b.v.	Care transitions intervention for skilled nursing facility (SNF) residents
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.viii.	Hospital-home care collaboration solutions
3.a.i.	Integration of primary care and behavioral health services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (cardiovascular health)
3.d.ii.	Expansion of Asthma Home-Based Self-Management Program
3.g.ii.	Integration of palliative care into nursing homes
4.c.ii.	Increase early access to, and retention in, HIV care

Funds Flow by Partner Category

Total Funds Available (DY1)	$3,873,313.65	
Total Funds Earned (through DY1)	$3,873,313.65 (100.00% of Available Funds)	
Total Funds Distributed (through DY2, Q2)	$845,758.44 (21.84% of Earned Funds)	
Partner Type	**Funds Distributed**	**NYPQ (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$11,541.98	1.36%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$213,157.32	25.20%
Clinic	$72,087.55	8.52%
Case Management/Health Home	$0.00	0.00%
Mental Health	$29,791.48	3.52%
Substance Abuse	$0.00	0.00%
Nursing Home	$60,675.00	7.17%
Pharmacy	$0.00	0.00%
Hospice	$1,974.00	0.23%
Community Based Organizations[17]	$33,334.00	3.94%
All Other	$14,865.24	1.76%
Uncategorized	$22,459.00	2.66%
Non-PIT Partners	$0.00	0.00%
PMO	$385,872.87	45.62%
TOTAL	**$845,758.44**	**100.00%**

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	New York Presbyterian – Queens	N/A	N/A	No recommendations have been made by the IA at the Mid-Point Assessment.

[17] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

North Country Initiative (Samaritan)

PPS Overview

Lead Organization	North Country Initiative (Hospital - Samaritan Medical Center was original lead applicant)
PPS Service Area	Jefferson, Lewis, St. Lawrence Counties
Attribution for Performance	39,755
Attribution for Valuation	61,994
Total Award Dollars	$78,062,821
Core Team	1) Erika Flint: Executive Director, Fort Drum Regional Health Planning Organization 2) Brian Marcolini: Director, Fort Drum Regional Health Planning Organization 3) Thomas Carman: CEO, Samaritan Medical Center 4) Tracy Leonard: Deputy Director, Fort Drum Regional Health Planning Organization 5) Ian Gant: Population Health Program Manager, Fort Drum Regional Health Planning Organization 6) Corey Zeigler: CIO, Fort Drum Regional Health Planning Organization (Note: Corey is also the CIO Steering Committee Co-Chair) 7) Lindsay Knowlton: DSRIP Finance Director

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.ii.	Increase certification of primary care practitioners with patient centered medical home certification and/or advanced primary care models (as developed under the NYS Health Innovation Plan (SHIP))
2.a.iv.	Created a medical village using existing hospital infrastructure
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.d.i.	Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care.
3.a.i.	Integration of primary care and behavioral health services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (cardiovascular health)
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (diabetes care)

3.c.ii.	Implementation of evidence-based strategies for disease management in high risk/affected populations (adults only) (diabetes care)
4.a.iii.	Strengthen mental health and substance abuse infrastructure across systems
4.b.ii.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings

Funds Flow by Partner Category

Total Funds Available (DY1)	**$11,688,961.00**	
Total Funds Earned (through DY1)	**$11,688,961.00 (100.00% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$7,794,988.51 (66.69% of Earned Funds)**	
Partner Type	**Funds Distributed**	**NCI (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$276,501.21	3.55%
Practitioner - Non-Primary Care Physician (PCP)	$74,086.88	0.95%
Hospital	$911,871.81	11.70%
Clinic	$2,742,251.48	35.18%
Case Management/Health Home	$115,580.21	1.48%
Mental Health	$718,875.21	9.22%
Substance Abuse	$129,162.55	1.66%
Nursing Home	$76,763.86	0.98%
Pharmacy	$8,944.66	0.11%
Hospice	$10,899.35	0.14%
Community Based Organizations[18]	$108,374.20	1.39%
All Other	$108,121.09	1.39%
Uncategorized	$49,967.20	0.64%
Non-PIT Partners	$0.00	0.00%
PMO	$2,463,588.80	31.60%
TOTAL	**$7,794,988.51**	**100.00%**

[18] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	North Country Initiative (Samaritan)	Organizational	Financial Sustainability and VBP	The IA recommends the PPS develop a strategy to enhance partner engagement with MCOs to achieve VBP goals.

NYU Lutheran PPS

PPS Overview

Lead Organization	NYU Lutheran Medical Center
PPS Service Area	Brooklyn
Attribution for Performance	116,211
Attribution for Performance (Project 2.d.i)	
Attribution for Valuation	74,326
Total Award Dollars	$127,740,537
Core Team	1) Larry McReynolds – Executive Sponsor 2) Alessandra Taverna-Trani – Executive Director 3) Dr. Isaac Dapkins – Chief Medical Officer 4) Lisa Vancheri – Director, Long Range Financial Planning, NYU Langone

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.b.iii.	ED care triage for at-risk populations
2.b.ix.	Implementation of observational programs in hospitals
2.c.i.	Development of community-based health navigation services
3.a.i.	Integration of primary care and behavioral health services
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes Care)
3.d.ii.	Expansion of asthma home-based self-management program
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.
4.c.ii.	Increase early access to, and retention in, HIV care

Funds Flow by Partner Category

Total Funds Available (DY1)	**$16,492,433.47**	
Total Funds Earned (through DY1)	**$16,475,414.50 (99.90% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$7,598,768.27 (46.12% of Earned Funds)**	
Partner Type	**Funds Distributed**	**NYU Lutheran (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$663,702.00	8.73%
Clinic	$2,110,315.27	27.77%
Case Management/Health Home	$0.00	0.00%
Mental Health	$0.00	0.00%
Substance Abuse	$25,000.00	0.33%
Nursing Home	$0.00	0.00%
Pharmacy	$0.00	0.00%
Hospice	$0.00	0.00%
Community Based Organizations[19]	$125,115.00	1.65%
All Other	$123,678.00	1.63%
Uncategorized	$49,262.00	0.65%
Non-PIT Partners	$57,604.00	0.76%
PMO	$4,444,092.00	58.48%
TOTAL	**$7,598,768.27**	**100.00%**

[19] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	NYU Lutheran PPS	Project	3.d.ii.: Expansion of asthma home-based self-management program	The IA recommends the PPS develop an action plan to educate patients on the benefits of home-based asthma visits in order to engage patients in the project. The PPS must also create a plan to expedite the time needed to negotiate with vendors and integrate home visits into the infrastructure to engage partners in the project.
2	NYU Lutheran PPS	Organizational	Community Based Organization Contracting	The IA recommends the PPS create a plan and commit resources for the engagement of CBOs in all areas the PPS articulated in its Community Engagement Plan.
3	NYU Lutheran PPS	Organizational	Partner Engagement	The IA recommends that the PPS develop a strategy for ensuring partner engagement across all projects being implemented by the PPS.
4	NYU Lutheran PPS	Organizational	Primary Care Plans	The IA recommends the PPS develop an action plan to address the concerns related to sufficient primary care capacity in the Primary Care Plan.

OneCity Health (NYC HHC)

PPS Overview

Lead Organization	New York City Health + Hospitals
PPS Service Area	Brooklyn, Bronx, Manhattan, Queens
Attribution for Performance	657,070
Attribution for Performance (Project 2.d.i)	2,097,260
Attribution for Valuation	2,760,602
Total Award Dollars	$1,215,165,724
Core Team	1) Dr. Christina Jenkins – PPS Lead/ CEO 2) Inez Sieben - COO 3) Wilbur Yen – Chief of Staff 4) Dr. Anna Flattau — CMO 5) Nicole Jordan-Martin – Executive Manager

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.b.iii.	ED care triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.d.i.	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
3.a.i.	Integration of primary care and behavioral health services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.d.ii.	Expansion of asthma home-based self-management program
3.g.i.	Integration of palliative care into the PCMH Model
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.c.ii.	Increase early access to, and retention in, HIV care

Funds Flow by Partner Category

Total Funds Available (DY1)	**$185,217,395.43**	
Total Funds Earned (through DY1)	**$184,985,371.51 (99.87% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$16,817,150.41 (9.09% of Earned Funds)**	
Partner Type	**Funds Distributed**	**NYC HHC (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$6,238.55	0.04%
Practitioner - Non-Primary Care Physician (PCP)	$1,361.77	0.01%
Hospital	$114,909.68	0.68%
Clinic	$84,361.57	0.50%
Case Management/Health Home	$76,924.15	0.46%
Mental Health	$66,476.39	0.40%
Substance Abuse	$3,289.85	0.02%
Nursing Home	$9,534.74	0.06%
Pharmacy	$11,465.99	0.07%
Hospice	$2,175.89	0.01%
Community Based Organizations[20]	$159,402.52	0.95%
All Other	$224,646.59	1.34%
Uncategorized	$50,799.72	0.30%
Non-PIT Partners	$42,427.00	0.25%
PMO	$15,963,136.00	94.92%
TOTAL	**$16,817,150.41**	**100.00%**

[20] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	OneCity Health (HHC)	Project	2.a.i: Create Integrated Delivery Systems	The IA recommends that the PPS develop a plan to increase partner engagement to ensure the PPS I able to successfully meet project implementation milestones, performance metrics, and DSRIP goals.
2	OneCity Health (HHC)	Project	3.d.ii: Expansion of asthma home-based self-management program	The IA recommends the PPS continue to pursue workforce solutions through its identified workforce partners to foster workforce pipeline for necessary workers with appropriate skillsets.
3	OneCity Health (HHC)	Project	3.d.ii: Expansion of asthma home-based self-management program	The IA recommends the PPS continue to collaborate with the NYS Asthma Regional Coalitions to provide asthma education certification trainings.
4	OneCity Health (HHC)	Organizational	Funds Flow	The IA recommends that the PPS accelerate a contracting strategy to distribute funds to their partners to promote more engagement.
5	OneCity Health (HHC)	Organizational	Partner Engagement	The IA recommends that the PPS develop an action plan to increase partner engagement across all projects being implemented by the PPS.

Refuah Community Health Collaborative

PPS Overview

Lead Organization	Refuah Health Center (FQHC)
PPS Service Area	Orange and Rockland Counties
Attribution for Performance	42,153
Attribution for Valuation	26,804
Total Award Dollars	$45,634,589
Core Team	1) Chanie Sternberg: Refuah Health Center, President and CEO 2) Dr. Corinna Manini: Refuah Health Center, Medical Director 3) Rachel Merk: CTO, Refuah Health Center 4) Alexandra Khorover: Legal Council 5) Shaindy Landerer: Director of Finance

Projects Selected

Project	Project Description
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.ii	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))
2.c.i	Development of community-based health navigation services
3.a.i	Integration of primary care and behavioral health services
3.a.ii	Behavioral health community crisis stabilization services
3.a.iii	Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance
4.b.i	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

Funds Flow by Partner Category

Total Funds Available (DY1)	$5,760,035.23	
Total Funds Earned (through DY1)	$5,760,035.23 (100.00% of Available Funds)	
Total Funds Distributed (through DY2, Q2)	$2,362,160.44 (41.01% of Earned Funds)	
Partner Type	**Funds Distributed**	**Refuah (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$7,500.00	0.32%
Clinic	$659,172.00	27.91%
Case Management/Health Home	$19,500.00	0.83%
Mental Health	$28,000.00	1.19%
Substance Abuse	$21,000.00	0.89%
Nursing Home	$11,500.00	0.49%
Pharmacy	$1,500.00	0.06%
Hospice	$4,000.00	0.17%
Community Based Organizations[21]	$27,000.00	1.14%
All Other	$42,000.00	1.78%
Uncategorized	$14,000.00	0.59%
Non-PIT Partners	$0.00	0.00%
PMO	$1,526,988.44	64.64%
TOTAL	**$2,362,160.44**	**100.00%**

[21] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Refuah Community Health Collaborative	Organizational	Cultural Competency and Health Literacy	Although the PPS is utilizing a pre- and post-test to measure provider knowledge, it is not clear what measures the PPS is using to assess the effectiveness of the cultural and linguistic training when applied by partners in the network. The IA recommends that the PPS develop measures to assess the current cultural competency of the clinical providers within its network along with the impact any cultural competency training provided to the same providers to address the effectiveness of its CCHL trainings.

Staten Island PPS

PPS Overview

Lead Organization	Staten Island PPS
PPS Service Area	Staten Island
Attribution for Performance	76,295
Attribution for Performance (Project 2.d.i)	96,782
Attribution for Valuation	180,268
Total Award Dollars	$217,087,986
Core Team	1) Joe Conte – Executive Director, DSRIP 2) Dr. Salvatore Volpe – CMO, DSRIP 3) William Myhre – Sr. Director of Workforce, DSRIP 4) Anyi Chen – IT, DSRIP 5) Victoria Njoku-Anokam – Director of Behavioral Health 6) Jessica Steinhart – Director of Ambulatory Initiatives 7) Lashana Lewis – Finance Lead 8) Celina Ramsey – Dr. Health Literacy, Diversity and Outreach, DSRIP

Projects Selected

Project	Project Description
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.viii.	Hospital-home care collaboration solutions
2.d.i.	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
3.a.i.	Integration of primary care and behavioral health services
3.a.iv.	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs

3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes Care)
3.g.ii.	Integration of palliative care into nursing homes
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.b.ii.	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer

Funds Flow by Partner Category

Total Funds Available (DY1)	**$33,087,178.06**	
Total Funds Earned (through DY1)	**$33,021,929.35 (99.80% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$21,046,384.50 (63.73%% of Earned Funds)**	
Partner Type	**Funds Distributed**	**SIPPS (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$555,678.00	2.64%
Practitioner - Non-Primary Care Physician (PCP)	$365,969.00	1.74%
Hospital	$6,471,692.00	30.75%
Clinic	$514,547.00	2.44%
Case Management/Health Home	$1,372,556	6.52%
Mental Health	$234,288.00	1.11%
Substance Abuse	$890,816.50	4.23%
Nursing Home	$3,147,917.00	14.96%
Pharmacy	$0.00	0.00%
Hospice	$0.00	0.00%
Community Based Organizations[22]	$272,731	1.30%
All Other	$1,288,806.00	6.12%
Uncategorized	$107,500.00	0.51%
Non-PIT Partners	$337,821.00	1.61%
PMO	$5,486,063.00	26.07%
TOTAL	**$21,046,384.50**	**100.00%**

[22] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Staten Island PPS	N/A	N/A	No recommendations have been made by the IA at the Mid-Point Assessment.

Suffolk Care Collaborative

PPS Overview

Lead Organization	Stony Brook University Hospital
PPS Service Area	Suffolk
Attribution for Performance	212,287
Attribution for Performance (Project 2.d.i)	305,957
Attribution for Valuation	437,896
Total Award Dollars	$298,562,084
Core Team	1) Joe Lamantia, Chief of Operations for Population Health, Stony Brook Medicine 2) Dr. Linda Efferen, Medical Director 3) Alyssa Scully, Senior Director, Project Management Office 4) Kevin Bozza, Senior Director, Network Development & Performance Kelli Vasquez, Senior Director, Care Management & Care Coordination

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.ix.	Implementation of observational programs in hospitals
2.d.i.	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
3.a.i.	Integration of primary care and behavioral health services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular Health)
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes Care)
3.d.i.	Development of evidence-based medication adherence programs (MAP) in community settings– asthma medication
4.a.ii.	Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
4.b.ii.	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer

Funds Flow by Partner Category

Total Funds Available (DY1)	$40,473,338.27	
Total Funds Earned (through DY1)	$40,473,338.27 (100% of Available Funds)	
Total Funds Distributed (through DY2, Q2)	$15,469,854.13 (38.22% of Earned Funds)	
Partner Type	**Funds Distributed**	**SCC (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$339,800.00	2.20%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$5,771,052.61	37.31%
Clinic	$684,261.00	4.42%
Case Management/Health Home	$792,930.52	5.13%
Mental Health	$0.00	0.00%
Substance Abuse	$0.00	0.00%
Nursing Home	$8,000.00	0.05%
Pharmacy	$0.00	0.00%
Hospice	$0.00	0.00%
Community Based Organizations[23]	$500,317.00	3.23%
All Other	$3,438,135.00	22.22%
Uncategorized	$8,851.00	0.06%
Non-PIT Partners	$0.00	0.00%
PMO	$3,926,507.00	25.38%
TOTAL	**$15,469,854.13**	**100.00%**

[23] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Suffolk Care Collaborative (Stony Brook)	Organizational	Partner Engagement	The IA recommends that the PPS review its Partner Engagement reporting and develop a plan for engaging network partners across all projects to ensure the successful implementation of DSRIP projects.

The New York and Presbyterian Hospital

PPS Overview

Lead Organization	The New York and Presbyterian Hospital
PPS Service Area	Bronx, Manhattan
Attribution for Performance	88,886
Attribution for Performance (Project 2.d.i)	
Attribution for Valuation	47,293
Total Award Dollars	$97,712,825
Core Team	1) Dr. David Alge – PPS Lead, CEO 2) Isaac Kastenbaum – Executive Director 3) Phyllis Lantos – Chief Financial Officer Aurelia G. Boyer– Chief Information Officer

Projects Selected

Project	Project Description
2.a.i.	Create integrated delivery systems that are focused on evidence-based medicine / population health management
2.b.i.	Ambulatory intensive care units (ICUs)
2.b.iii.	ED care triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30-day readmissions for chronic health conditions
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral health community crisis stabilization services
3.e.i.	Comprehensive strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of excellence for management of HIV/AIDS
3.g.i.	Integration of palliative care into the patient centered medical home (PCMH) Model
4.b.i.	Promote tobacco use cessation, especially among low socioeconomic status (SES) populations and those with poor mental health
4.c.i.	Decrease HIV morbidity

Funds Flow by Partner Category

Total Funds Available (DY1)	**$12,446,255.69**	
Total Funds Earned (through DY1)	**$12,426,867.40 (99.84% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$8,280,909.68 (66.64% of Earned Funds)**	
Partner Type	**Funds Distributed**	**NY Presbyterian (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%
Hospital	$7,373,064.90	89.04%
Clinic	$146,030.00	1.76%
Case Management/Health Home	$0.00	0.00%
Mental Health	$0.00	0.00%
Substance Abuse	$0.00	0.00%
Nursing Home	$0.00	0.00%
Pharmacy	$0.00	0.00%
Hospice	$0.00	0.00%
Community Based Organizations[24]	$42,937.00	0.52%
All Other	$0.00	0.00%
Uncategorized	$77,127.00	0.93%
Non-PIT Partners	$0.00	0.00%
PMO	$641,750.78	7.75%
TOTAL	**$8,280,909.68**	**100.00%**

[24] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	The New York and Presbyterian Hospital	Project	3.e.i: Comprehensive strategy to decrease HIV/AIDS transmission	The IA recommends that the PPS obtain long-term space for the HIV Center of Excellence (CoE) that can accommodate growth of staff and patients attributed to the program.
2	The New York and Presbyterian Hospital	Project	3.e.i: Comprehensive strategy to decrease HIV/AIDS transmission	The PPS needs to demonstrate effective collaboration with CBOs and other resources to ensure appropriate access to substance abuse treatment.
3	The New York and Presbyterian Hospital	Project	3.g.i: Integration of palliative care into the patient centered medical home model	The IA recommends that the PPS create an action plan to increase the presence of palliative team members in primary care practices in order to increase referrals, which will further improve patient engagement.
4	The New York and Presbyterian Hospital	Project	3.g.i: Integration of palliative care into the patient centered medical home model	The IA recommends that the PPS develop a plan to increase outreach and education materials to partners with respect to end of life care. The plan should include ongoing support and resources with educational updates for partners and their staff.
5	The New York and Presbyterian Hospital	Organizational	Cultural Competency and Health Literacy	The IA recommends the PPS implement the strategies and execute the training on CCHL as articulated in its submitted plans. The execution of this strategy needs to articulate how the PPS will measure the effectiveness of its CC/HL outreach efforts to the target population.

Westchester Medical Center

PPS Overview

Lead Organization	Westchester Medical Center (Public Hospital)
PPS Service Area	Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester Counties
Attribution for Performance	144,456
Attribution for Performance (Project 2.d.i)	453,409
Attribution for Valuation	573,393
Total Award Dollars	$273,923,615
Core Team	1) June Keenan: PPS DSRIP lead; Senior VP, Delivery System Transformation Executive Director, Center for Regional Healthcare Innovation Westchester Medical Center (WMC) 2) Dr. Deborah Viola: ViP, Director, Health Services Research and Data Analytics, Center for Regional Healthcare Innovation WMC 3) Dr. Janet (Jessie) Sullivan: ViP, Medical Director, Center for Regional Healthcare Innovation, WMC 4) Peg Moran: VP, Operations, Center for Regional Healthcare Innovation, WMC 5) Maureen Doran: VP, Integrated Care Network, Center for Regional Healthcare Innovation, WMC

Projects Selected

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.a.iv.	Crate a medical village using existing hospital infrastructure
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.d.i.	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral health community crisis stabilization services
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only)

3.d.iii.	Implementation of evidence-based medicine guidelines for asthma management
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.
4.b.ii.	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)

Funds Flow by Partner Category

Total Funds Available (DY1)	**$41,832,853.56**	
Total Funds Earned (through DY1)	**$41,669,647.57 (99.61% of Available Funds)**	
Total Funds Distributed (through DY2, Q2)	**$37,884,118.76 (90.92% of Earned Funds)**	
Partner Type	**Funds Distributed**	**Westchester (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$90,356.77	0.24%
Practitioner - Non-Primary Care Physician (PCP)	$756,718.23	2.00%
Hospital	$435,984.35	1.15%
Clinic	$347,676.18	0.92%
Case Management/Health Home	$219,161.76	0.58%
Mental Health	$346,268.05	0.91%
Substance Abuse	$317,956.29	0.84%
Nursing Home	$27,989.75	0.07%
Pharmacy	$4,852.50	0.01%
Hospice	$9,023.75	0.02%
Community Based Organizations[25]	$37,070.00	0.10%
All Other	$4,238,603.24	11.19%
Uncategorized	$12,457.14	0.03%
Non-PIT Partners	$161,320.00	0.43%
PMO	$30,878,680.76	81.51%
TOTAL	**$37,884,118.76**	**100.00%**

[25] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Mid-Point Assessment Recommendations

#	PPS	Section	Focus Area	IA Recommendation
1	Westchester Medical Center	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS develop a strategy to assist partners in better identifying the targeted population for this project.
2	Westchester Medical Center	Project	2.d.i: Implementation of Patient Activation Activities	The IA recommends the PPS develop plan to increase outreach and education materials to partners with respect to patient activation measures.
3	Westchester Medical Center	Project	3.a.i: Integration of primary care and behavioral health services	The IA recommends that the PPS develop an action plan to identify and introduce opportunities for mental health professionals to partner with primary care providers. It will be important to increase the engagement of PCP and Mental Health partners in this project to ensure the project is implemented successfully and the PPS is positioned to meet the performance metrics for Domain 3a projects. The engagement of partners to successfully implement this project is further emphasized by the additional value associated with this project through the High Performance Fund, where six of the 10 eligible measures are tied to Domain 3a projects.
4	Westchester Medical Center	Organizational	Partner Engagement	The IA requires the PPS to develop an action plan to increase partner engagement. The plan needs to provide specific details by each project for partner engagement.