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IA MIDPOINT ASSESSMENT RECOMMENDATIONS:
Project 2.b.iii ED Care Triage for At-Risk Patients

IA Recommendation #1
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.

ACTIONS TO ADDRESS PATIENT EDUCATION RECOMMENDATION
ACP is developing a multi-faceted educational and marketing campaign to deliver targeted messages to our patients, including those with an avoidable ED visit, non-users (those who haven't seen a Primary Care Provider in more than 12 months), and the general population. Recognizing that our ultimate goal is to prevent the ED visit in the first place, ACP is approaching this larger challenge from a number of perspectives. Our core message is to shift patient preference to primary care rather than the emergency room.

Collaboration with Partner Hospitals
In the four hospitals in ACP's ED Triage project – Jamaica Hospital, Flushing Hospital, Forest Hills Hospital, and Lenox Hill Hospital – educational materials tailored to patients who have been admitted to the ED with a non-urgent condition are currently provided upon discharge.

Provider Engagement
ACP's outreach to PCPs includes support in educating patients, particularly non-users and those with chronic illnesses.

- **Physician Patient Encounter**
  With a focus on follow-up visits for patients with chronic illness, ACP is supporting Physicians with patient information on illness self-management and awareness of symptoms that should prompt a call to the doctor, require a visit to an urgent care center, or necessitate emergency room intervention. Teach Back and Ask Me 3 intervention tools will be introduced to ensure patient understanding of information conveyed during the visit.

- **Health Education Information and Materials**
  Health education materials focused on illness self-management will be embedded in the EHRs to facilitate availability for patients across the network. Chronic disease-specific educational materials will describe the benefits of disease self-management, including signs and symptoms indicating when it is appropriate to seek various levels of care (e.g., guidance on how asthmatics can manage their illness and how to identify a true emergency). Educational materials also will be provided at community events (e.g., PTA meetings) and at health fairs. ACP plans to conduct three "Health Weeks" in the Summer, in partnership with local businesses such as fitness centers, health food stores, and medical practices.

- **Community Health Worker Intervention**
  ACP Community Health Workers (CHWs) have reached out (telephonically and in-person) to ~14,000 individuals identified as non-users by our partner MCOs. Ongoing outreach includes education around Medicaid benefit coverage and contact information to make an appointment with the assigned PCP. This effort has yielded new interventions based on a Plan Do Study Act model. Additional interventions will be attempted to focus more on attracting patients to care.

  ACP also conducted outreach to ~500 patients who had recently been hospitalized to link them to their Primary Care Provider for a follow up appointment.

Patient Engagement: Reinforcing the Relationship to the Primary Care Provider
Understanding that keeping patients healthy and engaged with their PCP is the best way to reduce avoidable ED visits, ACP is developing an educational initiative to encourage non-users to visit their PCP for a wellness visit. We believe the absence of a PCP relationship indicates that non-users may perceive the ED as a primary source of care, and a lack of preventive care indicates they may be at greater risk of allowing their health to deteriorate.

Chronic Disease Self-Management Support
The Stanford Model for Diabetes and Chronic illness supports direct intervention with patients by providers. Stanford Model programs provide patients with deeper health literacy around self-management, communicating with providers, and requesting assistance for chronic conditions.

Collaboration with Community Based Organizations
ACP will continue to host health literacy events in the community to educate patients about access services, including the role of the PCP, urgent care, and the emergency room, as well as social determinants. Instructions will be provided for patients to identify their assigned provider. All education will be provided in appropriate literacy and language levels. As part of the MAX series, ACP is forming relationships with CBOs in the next 60 days (DY3Q1).

Nutritional Workshops
To promote healthy eating and lifestyle modification, ACP CHWs are discussing the importance of regular wellness visits, nutrition and exercise at events such as DASH nutrition plan workshops in ACP hotspots. ACP has selected DASH as its preferred nutritional plan as it addresses a range of chronic illnesses (e.g., diabetes, hypertension, obesity), is simple to follow, and is easily adapted for ethnic cuisines. Cooking demonstrations and seminars are supported by multilingual videos, a blog, educational materials, and a website.

Public Service Announcements
ACP is in the process of creating PSAs for distribution through digital media and, potentially, television, in targeted areas. PSAs will highlight benefits of the ED vs. the PCP. ACP also is collaborating with the other PPSs operating in the Bronx (Bronx Lebanon, One City Health, Bronx Partners for Healthy Communities) on a shared strategy and message platform in the City's "sickest" borough.

TIMELINE FOR ACTIONS

Please refer to ‘ACP PPS MPA Action Plan Template Recommendation 1’ MS Excel document.

HOW ACP WILL TRACK PROGRESS IN EXECUTING THE ACTIONS

- ACP will be able to track educational materials printed out from EMRs, to ensure that educational materials are being given to appropriate patients.
- CHWs will track the number of calls made, patient encounters made, and will follow-up to track whether appointments were attended.
- Referrals to CBOs, as well as CBO engagement with patients will be tracked by respective parties and exchanged on a regular basis. ACP will work towards digital integration with partner CBOs.

HOW THESE ACTIONS REFLECT ACP’S OVERALL STRATEGY FOR MEETING ITS DSRIP GOALS

The proposed actions are directly tied to ACP’s DSRIP Project 2.b.iii, ED Care Triage for At-Risk Patients, goals and are rooted in our Cultural Competency/Health Literacy initiatives. Our strategy also is consistent with our unique role and remit as DSRIP’s only physician-led PPS.

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IA Recommendation #2

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.

ACTIONS TO ADDRESS SCHEDULING RECOMMENDATION

APPOINTMENT SCHEDULING PILOT

ACP is working diligently to technically integrate hospital partners with our diverse network of independent neighborhood physicians. Recognizing that ~80% of ACP's PCPs are connected either to the MDLand or eClinicalWorks (eCW) EHRs, we are focusing our efforts on developing functionality in these environments.

ACP is exploring the integration of eCW and MDLand EHRs into a single, online platform that would allow scheduling of patient appointments, either by ACP workers and/or by select hospital staff (patient navigators). To this end, ACP is launching a pilot involving an eCW online application – Healow – to create real-time, 24-hour direct scheduling access with PCPs that are on the eCW platform. ACP network PCPs will designate time slots to make available on Healow. When an authorized person books an appointment on the portal, PCPs will receive a direct booking in their EHR and/or an appointment alert.

Participation in this pilot will be based on several criteria, including the number and frequency of the PCP's patients with potentially preventable ED admissions. ACP will educate the providers on the purpose and function of the Healow application, and will gather time slots that providers will make available specifically for post-ED follow-up visits. Key to the pilot's success is that providers understand the purpose of the scheduling portal and fully collaborate in providing access for ED follow-up patients.

If the pilot is successful, ACP expects to expand the pilot to all ECW providers, with the potential to expand to all ACP PCPs.

In parallel, ACP is working closely with its hospital partners to facilitate access. For example, ACP has provided Jamaica Hospital with ACP PCP demographic and contact information, as well as walk-in times for providers, when available, for upload into the hospital's EPIC system. Allowing patient navigators to easily access this information will aid in appointment scheduling. ACP is continuously updating this database.

Lastly, ACP is in the process of signing a 1:1 information exchange agreement with Jamaica, which will allow Jamaica to send ACP notifications when ACP patients are discharged from the ED with a potentially preventable visit. ACP CHWs will then follow-up with patients to provide education, support in scheduling and completing a follow-up appointment.

TIMELINE FOR ACTIONS

Exploring integration eCW and MDLand EHRs into single, online platform (DY3Q1)
Determine cohort of practices for Healow pilot (DY3Q1)
Educate/Prepare Practices for Healow Pilot (DY3Q1)
Healow Pilot (DY3Q1)
Assess Healow Pilot Feedback (DY3Q2)
Assess Viability of Healow Rollout to EClinicalWorks Practices (DY3Q2)
Assess Viability of Healow Rollout to MDLand Practices (DY3Q2)
Jamaica Hospital 1:1 Information Exchange (DY3Q2)

TRACKING METHODOLOGY

eCW, and the scheduling solution application, Healow, are able to track user behavior in the system. Therefore, ACP will be able to track and analyze patient and provider use throughout the implementation process.

Selection of the Healow pilot practices will depend on practice size (to attain critical mass for the pilot), provider engagement level and will require providers to be on the eCW platform. ACP's Provider Engagement team will propose the pilot to our target providers, and select providers willing to actively participate in the pilot, make scheduling slots available for open access scheduling, and provide feedback to ACP on ways to improve the tool and process. The Provider Engagement team will track providers contacted, those interested but not selected for the pilot, and those included in the pilot.

Use of Healow will be tracked in the Healow system, and analytics will be regularly available to ACP to gauge provider and patient engagement throughout the trial. After the initial trial period is over, we will survey the providers on ease of use, and patient feedback. Ideally, all eligible practices will have Healow capabilities, but only the pilot providers will have Healow revealed to users. Therefore, should the pilot be successful, ACP can focus on educating providers, without significant additional integration work. As more providers use eCW, they will be introduced to Healow in a similar manner.

ACP has already had initial conversations with MDLand, and believe integration is feasible. Rough specifications have been outlined, and need to be completed. Prior to contract signing, ACP will survey providers using MDLand to ensure adequate buy-in of the tool - this engagement and the feedback will be tracked by ACP.

ACP is currently determining how the patient population for a 1:1 information exchange with Jamaica is to be defined. Once defined, ACP can begin to receive Clinical Notifications from the hospital.

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IA MIDPOINT ASSESSMENT RECOMMENDATIONS: 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.

ACP ACTION PLAN

The ACP network is comprised of independent, autonomous community-based health care providers, physicians, community-based organizations, and hospital partners. Most partners have well established businesses with demonstrated financial stability. Many providers also are members of one of ACP's founding IPAs, which provide a range of support services and resources.

It is important to note that the majority of ACP's participating physicians operate as independent businesses; no member of the ACP network has a contractual obligation to share financial data with ACP. A significant motivation for providers to participate in DSRIP through the ACP network is to maintain independence while gaining access to resources, expertise, and funds necessary to transform their practices and thrive in a value-based payment environment.

Through PCMH certification, care coordination, patient engagement and a host of other initiatives, ACP is helping these independent practices build efficient and sustainable businesses.

SURVEY INSTRUMENT

Per DSRIP, ACP requires network members to report on their financial stability. ACP has developed two surveys tools, tailored for independent physicians and for hospital partners and community-based organizations, to assess financial stability and offer follow-up with limited intervention.

Per the IA's recommendation, ACP reviewed and revised its surveys for 2017 to be clearer and to avoid false positives. The survey for physicians now uses four DSRIP financial sustainability criteria (e.g., days cash on hand, operating margin); a practice answering yes to one of these criteria will be contacted by an ACP representative for a more detailed discussion and, if appropriate, review of financial documentation ("hard data"). If a practice answers no to all four criteria, no further action is required.

ACP intends to conduct its annual survey in March, to meet our first-quarter goal. Based on the response rate and feedback, ACP will continue to adjust and fine-tune the survey tool.

EDUCATION
ACP's financial stability strategy is to inform, educate, and refer resources to physicians and providers to take constructive action to drive improvements in their business.

ACP is coordinating and collaborating with the physicians' respective IPAs and ACOs, which provide established and credible communications channels as well as a shared mission to support member practices. Encouraging and facilitating PCMH certification, assisting with complete and correct coding for full reimbursement, and rewarding patient engagement are examples of how we collaborate to help practices succeed.

ACP intends to introduce, in partnership with IPAs and ACOs, two new resources to help providers understand their practices' financial operations and resources available to them:

- Small Business Administration provides general financial education and resources through its local offices.

- Optimus IT Solutions provides technology solutions with added value of applicability such as digital medical bill coding and submission for Medicare VB payments through their IPAs to improve their revenue.

The strategy is to educate ACP's physician partners by leveraging resources afforded by the physicians' IPAs, encourage access to SBA local offices that provide financial educational assistance, and provide efficient technology solutions.

TIMELINE

- Revise survey instrument (DY2Q4)
- Distribute 2017 surveys by the end of ACP's fiscal-year (DY2Q4)
- Survey deadline three weeks after distribution (DY3Q1)
- Three (weekly) follow up reminders to complete surveys (DY3Q1)
- ACP Finance team performs analytics and reports survey results two weeks after deadline. (DY3Q1)
- ACP Finance and/or Physician Engagement representatives contact potential at-risk partners for additional information. (DY3Q1)
- ACP Finance and/or Physician Engagement representative arranges meeting with at-risk partners to review financial data, present analysis of financial matrix indicators, and provide list of available resources. (DY3Q1)
- Determine which providers are potentially at risk and designate a Finance and/or Physician Engagement representative as primary liaison for each at-risk partner. (DY3Q2)
- Refer at-risk providers to SBA local offices contact persons to seek help. (DY3Q2)
- Make arrangements and appointments with providers' IPA office to obtain advisory services; financial education and medical services bill coding. (DY3Q2)
- Refer to Optimus IT solutions for technology-related solutions. (DY3Q2)
- Track progress of at-risk partners (ongoing)
- Distribute mid-year survey to at-risk partners to track status against baseline measures. (DY3Q3)

TRACKING PROGRESS

ACP's Finance and Provider Engagement departments will be responsible for implementing the survey and identifying partners that are financially at risk. Once identified, a Finance department representative will be assigned to track and monitor that practice, along with a Physician Engagement team member. A mid-year survey will be implemented for these practices to determine status.

HOW THESE ACTIONS REFLECT PPS OVERALL STRATEGY

These actions are consistent with Financial Sustainability: Milestone #2:

Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.

IA MIDPOINT ASSESSMENT RECOMMENDATION #4: PARTNER ENGAGEMENT
PAOP Modification:

The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Use Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement.

The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP.

I. ACP ACTION PLAN: PARTNER ENGAGEMENT

Below is a detailed report for engaging partners based on Speed and Scale commitments across all projects, with specific focus on Primary Care, Mental Health and Substance Use providers as well as Community Based Organizations.

1. Primary Care

Project 2.a.iii. Health Home at Risk
ACP has engaged 592 of the 902 Primary Care Physicians (PCPs) who must be engaged by DY3Q2. The Physician Engagement team will work in collaboration with the Project Managers and Community Health Workers (CHWs) to engage 310 new PCPs over this six-month period.

Plan
ACP developed a protocol to identify patients at-risk of progressing to health home eligibility while emulating health home at the primary care office for these patients. In addition, ACP has worked with eClinicalWorks and MDLand EHRs to share information between PCPs and the PPS to coordinate care. After successfully passing its security workbooks, ACP has downloaded its first files of claims and encounter data. ACP is developing reports to identify diagnosis codes submitted for ACP attributed patients and is attempting to develop reports to screen for patients who might be appropriate for referral to Health Homes or the Health Home at Risk project. These reports will be developed by June 30, 2017.

Project 2.b.iv. Transition of Care
ACP has engaged 592 of the 902 PCPs who must be engaged by DY3Q2. The Physician Engagement team will work in collaboration with the Project Managers and Community Health Workers (CHWs) to engage 310 new PCPs over the next six months.

Plan
ACP has reinvigorated its relationship with a strong home visiting medical practice that will expand services within the Transitional Care Project. ACP is creating reports from newly

received SDOH data to identify patients with multiple re-admissions or potentially preventable conditions for proactive outreach.

See below regarding expansion of care management support for patients with behavioral health or substance use issues.

ACP has hired an executive to oversee this project who has held positions of responsibility with an HIV SNP and has considerable experience with transitional care and coordination with health homes.

Project 3.a.i. Integration of Behavioral Health & Substance Abuse in Primary Care
ACP has engaged 592 of the 902 PCPs who must be engaged by DY3Q2. The Physician Engagement team will work in collaboration with the Project Managers and Community Health Workers (CHWs) to engage 310 new PCPs in the six months.

Plan
ACP is working closely with NYC DOHMH, Dr. Kerner of PCG and NYS OMH to enhance its program to coordinate primary care with MH and SA Services. There are four main initiatives currently underway to improve physician engagement.

a. NYC DOHMH ThriveNYC program is working closely with ACP to embed mental health clinicians from the MH "Corps" program within 40 ACP Primary Care Practices. This will effectively co-locate MH and PC within the community based practice setting. Clinicians will be placed with the practices in September 30, 2017.
b. NYC DOHMH CPIC Program and Dr. Belkin are working closely with ACP on an innovative program, based on a California model, to have ACP CHWs assess two neighborhoods to identify roles within the community that could serve as peer supports for Behavioral Health. We are discussing how to integrate CPIC and MH Corp models. Assessment of CPIC program will be completed by June 30, 2017.
c. Working with VNSNY to develop a potential model for BH Case Management that would screen for Health Home. Also working with Armes Acres to explore a similar model for SA Case management. Evaluation of Pilot Protocol will be completed by May 31, 2017.
d. Research Study: ACP has successfully qualified to have one of its PCPs participate in a survey by Dr. Chung (Montefiore) to explore barriers to effectively integrating primary care and behavioral health. The study is underway and will last approximately one year.

Each of these four strategies align with the primary care plan by developing systems to promote the integration of BH or SA with Primary Care. These strategies create practical methods for achieving the goals in the plan.

These strategies are aimed at increasing physician engagement from the current 46% (MH) to achieve the full target by September 30, 2017.

Project 3.b.i. Cardiovascular Disease
ACP has successfully engaged its providers and exceeded the target for this project. Specifically, ACP has engaged 592 providers, which is more than the target of 549 PCPs who must be engaged by DY3Q2. The Physician Engagement team will continue working with engaged providers to ensure continuity and provide feedback on how to improve performance and quality

Project 3.c.i. Diabetes
ACP has successfully engaged its providers and exceeded the target for this project. Specifically, ACP has engaged 592 providers, which is more than the target of 549 PCPs who must be engaged by DY3Q2. The Physician Engagement team will continue working with engaged providers to ensure continuity and provide feedback on how to improve performance and quality.

Project 3.d.iii. Asthma
ACP has engaged 592 of the 902 PCPs who must be engaged by DY3Q2. The Physician Engagement team will work in collaboration with the Project Managers and Community Health Workers (CHWs) to engage 310 new PCPs in the six months.

Plan:
ACP has partnered with the Queens Asthma Coalition to assist with thought leadership around ways to improve physician engagement for this project. The Asthma Coalition has provided insight into various forms of Asthma Action Plans, indicating that ACP may not be counting all appropriate instances of engagement. ACP, with the support and guidance of the Coalition, is reviewing its Asthma Protocol and will conduct a small pilot to identify the various forms of Actions Plans that exist in physicians' EHRs.

2. Community Based Organizations (CBOs)

ACP undertook a significant initiative to review the CBOs in its network and the services they would provide to attributed patients. ACP created a profile form to log the type of services provided by each CBO, created a CBO Directory, and identified gaps in the CBO network. As a result, ACP has targeted an additional 15 CBOs to recruit into the network.

ACP, through Care Management and CHWs, will continue to link provider offices with CBOs to offer important services to patients. ACP has 9 CBOs in the network and is working to add another 15-20 CBOs before Open Enrollment closes on March 31.

II FUNDS FLOW

The funds flow strategy has been to distribute payments to ACP network providers based on implementation as well as engagement and reporting in DSRIP Year 0 and Year 1. We will distribute funds based on performance from DSRIP Year 2 through DSRIP Year 5. The funds flow budgeted percentage to below categories was as follow:

Practitioner - Primary Care	22%
Practitioner – Non-Primary Care	5%
Hospital	13.68%
Clinic	1.6%
Case Management	0.1%
Mental Health	2%
Community Based Organization	1.36%
Nursing Home	1.08%
Pharmacy	0.2%
Hospice	0.23%
All Others	1.43%

This funds flow was designed for our network partners to implement and participate in ACP's10 projects. It helps the ACP network partners build their infrastructure and improve the technology necessary to meet the performance metrics through DY5.

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Implementation Plan

Mid Point Assessment Recommendation #1: 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.		
ACP PPS Defined Milestones/Tasks		***Target Completion Date***
1. Develop a patient engagement and education plan on proper use of ED and alternative sites of care.		
Community Health Worker interventions (non-users)		3/31/2017
Stanford Model programs (Diabetes self-management)		6/30/2017
DASH Nutritional campaign (ongoing)		3/31/2017
Community health literacy events (ongoing)		9/30/2017
Get Focused	*PS 152 (Manhattan) “Pop Up Shop” (Exercise Event)*	3/31/2017
Get Focused	*PS 189 (Manhattan) Compass Program “Book Fair” (Exercise Event)*	3/31/2017
ACP Health Education Workshops	*PS 189 PTA (Manhattan) “ACP Introductory Workshop”*	3/31/2017
ACP Health Education Workshops	*PS 132 PTA (Manhattan) “Pre-Diabetes Prevention Talk”*	3/31/2017
ACP Health Education Workshops	*PS 189 PTA (Manhattan) “Pre-Diabetes Prevention Talk”*	3/31/2017
ACP Health Education Workshops	*PS 189 PTA (Manhattan) “Discussion About Heart Disease & High Blood Pressure”*	3/31/2017
Health Fairs & Expos	*American Diabetes Association Expo*	3/31/2017
Health Fairs & Expos	*Hostos Community College Wellness Festival*	3/31/2017
Health Fairs & Expos	*Our Lady Queen of Martys Church Health Fair*	3/31/2017
Chronic disease-specific educational materials		9/30/2017
Marketing Campaign launch		9/30/2017
Health Week events		9/30/2017
Bronx PPS Collaboration		9/30/2017

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Implementation Plan

Mid-Point Assessment Recommendation #4: The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement. The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP. The PPS must also submit a detailed report on how the PPS will ensure successful project implementation efforts with special focus on projects identified by the IA as being at risk. These reports will be reviewed and approved by the IA with feedback from the PAOP prior to April 1, 2017.			
ACP PPS Defined Milestones/Tasks			*Target Completion Date*
1. Develop a detailed plan for engaging partners across all projects.			
2.a.iii Health Home at Risk			Sep-17
	Primary Care Providers		
		66% partners	Mar-17
		34% partners	Sep-17
	Non-Primary Care		Sep-17
	Clinics		Sep-17
	Mental Health		
		46% partners	Mar-17
		54% partners	Sep-17
	Substance Abuse		
		24% partners	Mar-17
		76% partners	Sep-17
	Health Homes		Sep-17
	Community Based Organizations		
		67% partners	Mar-17
		33% partners	Sep-17
	Pharmacies		Sep-17
2.b.iii ED Triage			Mar-17
	Hospitals		Mar-17
2.b.iv Transition of Care			Sep-17
	Primary Care Providers		

	66% partners	Mar-17
	34% partners	Sep-17
	Non-Primary Care	Sep-17
	Hospitals	Mar-17
	Community Based Organizations	
	67% partners	Mar-17
	33% partners	Sep-17
3.a.i Integration of Behaviroral Health & Substance Abuse in Primary Care		Sep-17
	Primary Care Providers	
	66% partners	Mar-17
	34% partners	Sep-17
	Clinics	Sep-17
	Mental Health	
	46% partners	Mar-17
	54% partners	Sep-17
	Substance Abuse	
	24% partners	Mar-17
	76% partners	Sep-17
	Community Based Organizations	
	67% partners	Mar-17
	33% partners	Sep-17
3.b.i Cardiovascular Disease		Sep-17
	Primary Care Providers	Mar-17
	Non-Primary Care	Sep-17
	Clinics	Sep-17
	Mental Health	
	46% partners	Mar-17
	54% partners	Sep-17
	Substance Abuse	
	24% partners	Mar-17
	76% partners	Sep-17
	Health Homes	Sep-17
	Community Based Organizations	
	67% partners	Mar-17

	33% partners	Sep-17
	Pharmacies	Sep-17
3.c.i Diabetes		Sep-17
	Primary Care Provider	Mar-17
	Non-Primary Care	Sep-17
	Clinic	Sep-17
	Mental Health	
	46% partners	Mar-17
	54% partners	Sep-17
	Substance Abuse	
	24% partners	Mar-17
	76% partners	Sep-17
	Health Homes	Sep-17
	Community Based Organizations	
	67% partners	Mar-17
	33% partners	Sep-17
	Pharmacies	Sep-17
3.d.iii Asthma		Sep-17
	Primary Care Providers	
	66% partners	Mar-17
	34% partners	Sep-17
	Non-Primary Care	Sep-17
	Clinics	Sep-17
	Mental Health	
	46% partners	Mar-17
	54% partners	Sep-17
	Health Home	Sep-17
	Community Based Organizations	
	67% partners	Mar-17
	33% partners	Sep-17

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Partner Engagement

Advocate Community Providers, PPS		Partner Engagement									
Partner Category		*2.a.i. Integrated Delivery Systems*	*2.a.iii. Health Home at Risk*	*2.b.iii. ED Triage*	*2.b.iv. Transition of Care*	*3.a.i. Integration of Behavioral Health & Substance Abuse in Primary Care*	*3.b.i. Cardiovascular Disease*	*3.c.i. Diabetes*	*3.d.iii. Asthma*	*4.b.i. Tobacco Cessation**	*4.b.ii. Chronic Disease Prevention**
Practitioner - Primary Care		-	902	-	902	902	549	549	902	-	-
Practitioner - Non-Primary Care		-	1,428	-	1,428	1,428	1,428	1,428	1,428	-	-
Hospital - Inpatient/ED		-	-	3	13	-	-	-	-	-	-
Hospital - Ambulatory		-	-	-	-	-	-	-	-	-	-
Clinic		-	43	-	-	43	43	43	43	-	-
Mental Health		-	130	-	-	130	130	130	-	-	-
Substance Abuse		-	34	-	-	34	34	34	-	-	-
Case Management		-	-	-	-	-	-	-	-	-	-
Health Home		-	9	-	-	-	9	9	9	-	-
Community Based Organization (Tier 1)		-	15	-	15	15	15	15	15	-	-
Nursing Home		-	-	-	-	-	-	-	-	-	-
Pharmacy		-	6	-	-	-	6	6	-	-	-
Hospice		-	-	-	-	-	-	-	-	-	-
Home Care		-	-	-	-	-	-	-	-	-	-

**No provider speed and scale commitment for domain 4 projects on DSRIP Implementation Plan.*

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Funds Flow

		Funds Flow (all funds)			
Partner Category		***Funds Flow through DY2, Q3***	***Projected Funds Flow through DY2***	***% of Earned Dollars Planned for Distribution DY3****	***% of Earned Dollars Planned for Distribution DY4 - DY5****
Practitioner - Primary Care		$ 5,969,672	$ 11,602,778	22.00%	22.00%
Practitioner - Non-Primary Care		$ 745,177	$ 1,324,735	5.00%	5.00%
Hospital - Inpatient/ED***		***	***	***	***
Hospital - Ambulatory***		***	***	***	***
Clinic		$ 492,509	$ 492,509	1.60%	1.60%
Mental Health		$ 418,644	$ 433,153	2.00%	2.00%
Substance Abuse		$ -	$ -	0.00%	0.00%
Case Management		$ -	$ -	0.10%	0.10%
Health Home		$ -	$ -	0.00%	0.00%
Community Based Organization (Tier 1)		$ 314,176	$ 669,182	1.36%	1.36%
Nursing Home		$ 183,074	$ 226,110	1.08%	1.08%
Pharmacy		$ 7,176	$ 7,176	0.20%	0.20%
Hospice		$ 11,952	$ 11,952	0.23%	0.23%
Home Care		$ -	$ -	0.00%	0.00%
PMO		$ 18,004,200	$ 26,005,600	30.00%	30.00%
Hospital		$ 4,268,757	$ 7,568,021	13.68%**	13.68%**
All Other		$ 294,951	$ 356,411	1.43%	1.43%
Total		$ 30,710,289	$ 48,697,627		

**Planned distribution is based on DSRIP PPS Organizational Application Submitted to NYS DOH in 2014*

***Hospitals and other safety net providers – based on achievement of performance metrics related to overall DSRIP and project goals*

****Information under 'Hospital' category (row 23)*