Mid-Point Assessment Recommendation:

Mid-Point Assessment Recommendation #1: The IA recommends the PPS create a plan to develop incentives to providers in order to engage them in this project [*2.a.iii*] and encourage them to hire CHWs. The Action Plan should outline specific steps to engage key PCP and Mental Health partners.

PPS Action Plan Narrative:

Bronx Health Access PPS has been developing our approach to Health Home at Risk Project (Project 2.a.iii, HH@R) since funding was received in late 2015. In early 2016, Project Co-lead Dr. David Ferris initiated discussions with Dr. Susan Kangovi of the Penn Center for Community Health Workers. The Penn Center is known for the development and spread of IMPaCT, an evidence-based CHW model for care.

Dr. Kangovi was invited to conduct Grand Rounds at BLHC to increase understanding among providers about the role of impact of community health workers. She also delivered a special Q&A with BHA partners on care coordination and shares lessons learned over her years of experience. Core tenets of the IMPaCT model include:

- *Ensuring CHWs are well trained and supervised;*
- *The approach is patient-centered not disease-centered,*
- *CHWs are integrated into health care systems*

Based on this model, the HH@R team had already set in motion some changes to improve outcomes and partner engagement. After receiving the IA recommendation, the HH@R project leadership continued to examine the scope of the project more closely. Below is a description of some of the issues uncovered and proposed solutions.

Issue: Identification of eligible patients

An on-going challenge for the HH@R project in DY2 was the identification of eligible patients. Early partners in this project found that when they were completing the eligibility screening, patients were discovered to have more than one chronic illness, thus being ineligible for enrollment into HH@R.

Solution: Embed care coordinators within a Behavioral Health or primary care practice

While many patients access primary care services when they are ill, providers are also aware of patients that may not be seriously ill but are on the trajectory for developing another chronic illness. HH@R project team experimented with connected CMAs directly with providers and within an ED setting. The team found that care coordinators, who were connected directly with a provider, experienced improved enrollment of new patients, improved communication and coordination with PCPs, and expressed more satisfaction from both parties. The practices were also able to conduct “bottom-up” referrals, identifying potential eligible patients seen in the office that day and conducting a warm handoff to care coordination or introducing care coordination services to the patient in advance.

Moving forward, all new care coordinators for the HH@R project will work as an embedded team member within a BH or primary care setting. Some partners already have BH or PCP

practices and will be encouraged to continue working closely with their existing network. The HH@R Operations Team will facilitate new linkages as needed.

Issue: Hiring of new CHWs

The Bronx is the least healthy county of all of NYS. Given the demographics and health disparities in this community, there were challenges in locating and enrolling patients that are Health Home at Risk. In 2016, HH@R began with 6 partners and 2 withdrew from the project as they were not able to sustain staff that were dedicated to HH@R. They cited the high risk pool in their community for this barrier. Based on these experiences, the HH@R project team saw a need to approach the project differently and to move away from the expectation that organizations hire CHW staff focused on HH@R.

Solution: Expand HH@R partners from 4 to 7 Case Management Agencies (CMAs) under the "hybrid" model

Bronx Lebanon Hospital Center, the largest attributed partner in the Bronx Health Access PPs, is also the lead agency for Bronx Health Home. As the designated Health Home, BLHC oversees a network of Case Management Agencies (CMAs) that deliver care coordination services for eligible patients. As partner CMAs provide services, they may also encounter patients that are not Health Home-eligible and have to refer them instead to other resources. These patients are eligible for HH@R. This presented an opportunity to align with existing Health Home partners and thus the team developed a "hybrid model." Under the "hybrid model," CMAs that contract with HH@R can carry a caseload of Health Home patients in addition to a small caseload of HH@R patients.

To date, 5 new partners have expressed interest in moving forward with a "hybrid model" contract as they agree with the premise of the HH@R project that early intervention can result in stabilization and reduction in health risk and avoidable service utilization. The newly-interested partners will be vetted by the HH@R administrative team to identify the best matches for the project. The project seeks to expand to a total of 7 partners by June 2017.

Issue: Support needed to spread best practices, provide QI support, and ensure partner agencies fully understand the scope and goals of HH@R

Based on experiences with early partners in the HH@R project, it appeared that the partner agencies had different strengths in engaging and assessing patients. Some partners were more advanced in their structure for supervision and training of care coordinators. In addition, there was continued confusion about program eligibility.

Solution: Hire a dedicated HH@R Operations Team (Project Manager and Program Associate);

As of September 2016, BHA has hired a Project Manager for HH@R, Nicole Bernier, LMSW, who will be the point-person for all project partners. Nicole will take the lead in on-boarding patients, identifying problem areas and spreading best practices for HH@R across partners. BHA has also hired Zenovia Melendez, Project Associate for HH@R, who will support partner agencies by confirming eligibility of referred patients and ensuring proper documentation of services.

Solution: Enhance Training and Support provided to CMAs;

In late 2016, all Bronx Health Home CMAs were required to participate in a 4-day training to build the capacity of Care Coordinators to build relationships with medical provider, to engage with clients, and assess and develop client-centered care plans. All HH@R project care coordinators participated in this training. In addition, HH@R project delivered a ½ day face-to-face training in January 2017 focused on HH@R. The training was done in coordination with the Bronx Health Home Director, Megan Fogarty, to ensure alignment with key strategies. Topics covered include:

- Health Homes and HH@R overview
- Goals and expectations of Care Coordinators
- HH@R Eligibility criteria
- Social Determinants of Health
- Meeting clinical quality goals
- Documentation

Solution: Develop and distribute HH@R Operations Manual to outline program scope, goals, eligibility criteria, and documentation requirements

An Operations Manual is currently in development for distribution to all HH@R partners. The manual is being developed with input from current partners and will include all the information shared in the January training, in addition materials to support quality improvement strategies.

Mid-Point Assessment Recommendation:

Recommendation #2*:* 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.

Recommendation #3: 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.

PPS Action Plan Narrative:

Fund Distribution to Partners: In response to the Independent Assessors recommendation to "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…." and "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)…," it's important to first understand the PPS' partner distribution and engagement methodologies. Each partner distribution methodology has a unique purpose and approach. The partner distribution methodologies can be grouped into the following buckets:

- Project Implementation distributions
- Centralized allocations
- Performance distributions
- To-be-created CBO Grant Opportunities
- Stakeholder Engagement

The following narrative will dive into each of these methodologies and discuss plans to adjust the PPS strategy to date.

Project Implementation distributions
Addressing recommendation #2 and #3 (funds flow, project implementation, and partner engagement)

Description*:* Project Implementation distributions stem from the PPS' need to implement the 10 DSRIP projects. Each of the PPS DSRIP *Domain 2,3,4* project workgroups, comprised of all organization types including FQHC's, IPA's, CBO's, Hospitals, clinics, etc., determine the projects budget and implementation plan. All organizations participating in the project are eligible to request start-up funds for hiring new staff, procuring new equipment, implementing workflows, etc. Once the project workgroup finalized and approves the budget, the PPS Finance and

Steering committees approve the budgets, by project, for implementation. These funds are reported as project implementation and not as partner distributions in MAPP.

These project implementation distributions are seen as necessary expenses to meet the DSRIP performance measures and Actively Engaged patient Achievement values. The PPS acknowledged early on that the larger the Project Implementation budget, the lower the performance distributions (colloquially called, "Funds Flow") will be in the early years. The Finance and Steering committee placed caps on the amount of implementation funding a project workgroup could request as the PPS's goal was to make performance payments early on in the project. This is covered in detail later in the narrative.

Reception and Next steps: The Project Implementation distributions were largely well received by project workgroups and will continue throughout the DSRIP program. These PPS expenses have helped jumpstart organizations hiring and purchasing of vital equipment necessary to improve DSRIP performance measures. The PPS will continue to make the project workgroups responsible for the project budgets, which includes prioritizing which project workgroups members receive which funding. This transparent process is seen as a major strength of the PPS and has allowed each of the project workgroup to engage the necessary partners to meet the Achievement Values (reporting and performing).

Although the PPS believes this process is equitable, this process is not without its shortcoming. A major shortcoming of this process is evident by the variances between the approved/authorized dollars vs. the incurred/paid dollars. In some projects, organizations have only invoiced the PPS for 10% of the total authorized amount. There are a few factors that cause this variance stemming from the PPS' reimbursement policy: The PPS will only reimburse expenses an organization has incurred, not budgeted. Since hiring staff and purchasing equipment takes time, there will always be a gap between budget approval and incurring expenses. Additionally, there will always be a lag between receiving the invoice and processing payment. Although the PPS expects these variances to decrease in later years, the PPS will implement a procedure to identify these variances early by reporting out monthly allowing for quick triaging. This plan is discussed in the Milestone section.

Milestones and Conclusion:
The below milestones outline the PPS' plan to address the narrative outlined above:

Mid-Point Assessment Recommendation #2:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Create process to identify budget variances (approved vs incurred), which will allow for early identification of projects/organizations facing difficulty spending project implementation dollars	9/30/2017
Task 1: Create an extract by project on budget variances between approved budget vs. incurred by PPS	3/30/2017
Task 2: Establish thresholds for escalation and frequency	3/30/2017
Task 3: Communicate with project workgroups of the new process.	8/30/2017
Task 4: Steering Committee approves process	9/30/2017

The above milestones and strategy should address the shortcoming of the Project Implementation distributions. Through early identification of variances between budget vs. actual expenses, the PPS will be able to work with organizations or projects flagged in this

report. The PPS may assist in identifying possible resources, assist in the procurement process, or help organizations in other ways as needed to help organizations/projects spend the already approved dollars quickly and effectively. Aiding organizations to fully ramp up implementation efforts is vital for the PPS' success in meeting the DSRIP goals, particularly quality outcomes.

Centralized Allocations:
Addressing recommendation #3 (funds flow, project implementation, and partner engagement)

Description: The Centralized allocations are expenses such as Information Technology investment, Workforce development /training, and Patient Centered Medical Home (PCMH), which benefit partners both directly through contracts and indirectly through shared benefits. These payments are seen as a centralized expense of the PMO, though each uniquely benefits partners. The following section explores each category:

Workforce Development and Training:

A central underpinning of DSRIP is to train and redeploy staff through the PPS. With this in mind, the workforce committee performed surveys and received project specific requests on training gaps throughout the community. Training requests can come from any committee or group within the PPS. With this information, the workforce committee created trainings for PPS members. The majority of training are open to everyone, though some trainings have prerequisite certifications or job positions (e.x. to enroll in nurse training, you must be an RN). In many scenarios, the workforce committee will contract with Subject Matter Expert organizations throughout the community to perform the trainings. These organizations include CBO organizations. The PPS plans to spend over $12 Million on workforce activities alone across all provider types. The workforce funding has become a significant tool to keep key partners engaged. For a complete look into the process and workforce plan, please see the following document. This document includes a detailed plan for engaging partners and a detailed timeline for meaningful engagement:

BHA Workforce Training Strategy.pdf

Patient Centered Medical Home (PCMH):

A core principle of DSRIP is primary care enhancement, which in some cases, involves workflow redesign. Additionally, the PPS has several project level milestones involving PCMH certification of its members. For these reasons, after a full RFP, the PPS selected an experience vendor to onboard organizations to NCQA PCMH and workflow redesign. These services **typically cost ~ $18,000 per site**, however since the PPS procured these services in bulk, the PPS secured a price of **$12,000 per site**. The PPS paid for this

service in its entirety for all Primary Care Provider groups in the PPS. The members who complete this certification will receive enhanced Medicaid rates including an additional:

- $8.00 PMPM for managed Medicaid
- $25.25 on Primary Care fee for service
- $29.00 on Professional service

The PPS has allocated **over $1 Million** for this initiative in the early years of DSRIP.

Information Technology Investment:

Much of the success of DSRIP involves robust sharing of data between partners and population health analytics. With this in mind, the PPS is funding large development efforts at the RHIO including population health dashboards, DSRIP specific HEDIS scores, social determinate date, trending of patient data, etc. Additionally, the PPS solutioned a tool labeled the ,"PPS Care Coordination Clearinghouse", which only PPS members will receive for free. This Information technology development and procurement will cost the PPS ~$1.3M annually or $6.5M over 5 years. All PPS member receive the benefits of this interoperability and reporting, which is necessary to improve clinical outcomes. The information technology investment crosses all provider types from hospitals to substance abuse providers to CBO's.

Reception and Conclusion: The Centralized PPS allocations outlined above have been very well received PPS wide. The PPS has examined these allocations and does not have a plan to change the strategy in the future. These centralized allocations have helped and will continue to help the PPS achieve the milestones and metrics, as well as DSRIP performance measures by keeping partners engaged. Although organizations may not receive a direct payout, the organizations and patients throughout the PPS will benefit from these expenditures.

Performance distributions
Addressing recommendation #2 and #3 ((funds flow and partner engagement)

Description: Similar to other PPS', the Bronx Health Access PPS has developed a Performance Distribution funds flow methodology to reward participation and performance PPS wide. In an effort to be as transparent as possible, the PPS went through an extensive process to develop the funds flow methodology. From August 2015 to December 2015, the PPS engaged Consulting firm to aid in the algorithm's development. The PPS provided some baseline considerations for the funds flow development:

- PPS Valuation is based on Speed and Scale, so the performance payments should mirror this methodology
- Distribution methodology must be flexible as the PPS shifts from reporting to performance
- The PPS should reward active project participants
- Although the projects are the revenue generation arm of the PPS, we must keep in mind there are centralized expenses such as Workforce, IT, and PMO which must be funded
- Each project will have unique needs to be successful in meeting the Milestones and Metrics as well as the clinical performance measures (e.x. HEDIS)

As the consultants developed the model, they worked through engaging Project workgroups, Key Stakeholders, Committees, etc. for input. IT was determined that a series of inputs called factors would be necessary to fairly allocate funds to partners. The PPS and project workgroups refined the key "Factors" between January 2016 to April 2016. The factors considered the following:

- Distribution Factor: Types of Providers/organizations offered varying importance to each project
  - Organization type, provider type, service type were all considered
- Contribution Factor: Weighing organizations was necessary
  - Attribution, participation in projects, NPI/MMIS, employee size
- Performance factor:
  - Milestones and Metrics, Actively Engaged, Good citizenship, and performance (quality of care)

After the project workgroups drafted these factors, each project workgroup reviewed a tool with project specific inputs for final sign-off. This tool generated actual amounts partners could receive if they performed at 100%. This occurred between April 2016 to June 2016. Once the project workgroups finalized their project-specific inputs, the Finance and Steering committee reviewed and approved key inputs and distribution (June and July 2016). After the approval of the board, the PPS trained providers on funds flow by recording Webinars on Funds Flow, holding in person sessions, and holding open Q and A sessions on Funds Flow throughout August 2016. After September 1st, the PPS calculated the final funds flow amounts and disbursed the first of many partner distributions. Since the mid-point assessment, the PPS has made an additional performance payout to partners. The first payout, in September 2016 was based on a $3,000,000 allocation while the second payout was in January 2017 based on a $6,000,000 allocation.

Reception and Next steps: As outlined in the Project Implementation distributions section, the PPS acknowledged that funding the Implementation of projects will decrease the funding available for performance distribution. This was a well thought out strategy, so the PPS anticipated the first performance distribution would be a modest amount ($3,000,000). This distribution occurred when the IA made their mid-point assessment. Since the assessment, the PPS has made an allocation twice the size of the first allocation, or $6,000,000.

As the PPS made these disbursements, the PPS held public webinars, calls, townhalls, and in person meetings. During these interactions, the PPS was able to identify the shortcomings of the Funds Flow. Below are some of the key highlights from these interactions:

- Organizations with many NPI/MMIS received higher payouts compared to organizations without NPI's. Since the PPS has a few organizations with many NPI's, the distribution proportionately benefited these organizations.
- Organizations expected a higher payouts
- Performance is currently measured as reporting, not quality improvement

The PPS has begun to work with the Steering Committee to evaluate other disbursement methodologies for the Performance distributions. The list of suggestions the PPS is looking into is outlined below:

- PPS can remove the "Provider type" and create alternative buckets such as a Primary care bucket, Specialty/Hospital bucket, and CBO bucket
- Use Attribution as an organizational "weight". Note: The PPS has already evaluated this method and found the distributions are very top heavy
- The PPS can change all performance measures. For example, PCP based organizations could provide year over year HEDIS results for select measures. Organizations with improvements will receive funding. Alternatively, the PPS could use the organizational specific HUBs in salient for the results.
- Remove performance distributions entirely and:
  - Create an RFP based compensation model for all organizations
  - Allow project workgroups to spend all performance dollars as implementation
- Remove Implementation Funds to allow for larger performance distributions
- Fund only certain provider types (i.e. PCP, Clinic), while removing funding for others (Non-PCP, Behavioral Health)

The options listed above are suggestions the PPS has received. The PPS is creating models to evaluate the best steps moving forward as well as looking to other PPS' funds flow methodologies.

Milestones and Conclusion:
The below milestones outline the PPS' plan to address the narrative outlined above:

Mid-Point Assessment Recommendation #2:	
PPS Defined Milestones/Tasks	***Target Completion Date***
2. Increase Performance Distribution to partners in the immediate term	
Task 1: Determine distribution amounts for partners	12/1/2016
Task 2: Propose and approve $6,000,000 distribution at Finance and Steering	1/1/2017
Task 3: Release Funds Flow announcement to project workgroups and committees	1/3/2017
Task 4: Deadline for partners to submit information for Funds Flow	1/30/2017
Task 5: Process payments to partners	2/1/2017
3. Evaluate Funds Flow to determine if a adjustments in methodology are warranted	
Task 1: Solicit suggestions at the Steering Committee for Funds Flow adjustments	1/15/2017
Task 2: Meet with key stakeholders to discuss funds flow adjustments	2/30/2017
Task 3: Draft potential adjustments in models	4/30/2017
Task 4: Review adjustments with key stakeholders to determine if changing Funds Flow should be pursued	6/30/2017

The PPS will model the alternative funds flow methods to determine if an adjustment should be made. The PPS will pursue any models resulting in a more equitable distribution of funds to partners improving the care throughout the PPS. The adjusted model must reward high quality care, which will improve the PPS quality scores throughout the region.

Notwithstanding the potential adjustments to the funds flow methodologies, the PPS results to date are outlined in the corresponding midpoint assessment documentation and snapshot below:

		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		$ 21,042	$ 107,360	1.0%	0.9%
Practitioner - Non-Primary Care		$ 64,157	$ 170,683	1.7%	1.5%
Hospital - Inpatient/ED		$ 78,608	$ 235,824	2.3%	2.1%
Hospital - Ambulatory		$ -	$ -	0.0%	0.0%
Clinic		$ 1,937,174	$ 5,883,105	57.4%	51.3%
Mental Health		$ -	$ -	0.0%	0.0%
Substance Abuse		$ 45,158	$ 98,298	1.0%	0.9%
Case Management		$ 212,828	$ 574,655	5.6%	5.0%
Health Home		$ 32,152	$ 93,293	0.9%	0.8%
Community Based Organization (Tier 1)		$ 95,036	$ 300,410	2.9%	2.6%
Nursing Home		$ -	$ -	0.0%	0.0%
Pharmacy		$ 13,489	$ 29,233	0.3%	0.3%
Hospice		$ -	$ -	0.0%	0.0%
LTC		$ 13,489	$ 64,073	0.6%	0.6%
Home Health		$ 26,998	$ 26,998	0.3%	0.2%
PMO		$ 6,293,070	$ 6,990,878	8.3%	9.8%
Total		$ 8,833,200	$ 14,574,810		

Note: Bronx Health Access PPS reserves the right, per the Special Terms and Conditions, to modify the amount and timing of its funds flow to partners as business conditions require. This Funds Flow schedule, and any reference to it, if any, in the accompanying narrative, reflects the PPS's expected strategy for distributing DSRIP funds to all network partners and should not be viewed nor interpreted as a commitment, either explicitly or implicitly, to distribute these funds with regard to the amount, timing or partner type.

A notable observation is certain provider types are funded significantly less that others provider types. The rational for this is the PPS flows dollars to organizations rather than to the providers employed at that organization. For example, the "Clinic" line above totaling nearly $5.9 Million is going to clinics that employ:

- 259 Primary Care Providers (~70% of the 2.a.i goal of 388 PCPs)
- 765 Non-Primary Care Providers (includes OB/GYN) (over 80% of the 2.a.i goal of 951 Non-PCPs)
- 141 Mental Health Providers
- 623 All Other providers

With this consideration in mind, the PPS has actually flowed performance payments to the following providers across projects:

- Primary Care Providers: 319
- Non-Primary Care Providers: 869
- Hospitals: 1
- Clinics: 28
- Mental Health Providers: 155
- Substance Abuse Providers: 35
- Case Management Providers: 9
- Health Homes: 2

- Community Based Organizations: 8
- Nursing Home Providers: 3
- Hospice: 3
- Pharmacies: 3
- All Other Providers 745

The above performance payments cross broad provider types and represent a large majority of the required provider engagement numbers outlined in the DSRIP application.

CBO Grant Opportunities

Addressing recommendation #2 and #3 (funds flow, project implementation, and partner engagement)

Description: In addition to the distributions outlined above, the PPS is in the midst of creating a new competitive grant opportunity for community-based organizations (CBO) who are members of BHA and which provide supportive services to underserved patients receiving primary care services in the central and south Bronx. This grant program is targeted to Tier 1 CBOs, although Tier 2 CBOs can participate for their non-reimbursable portion of the services they provide. We anticipate awarding $75,000 each to about 12 CBOs.

The New York State Department of Health defines Tier 1 CBOs as agencies not eligible to receive Medicaid funding for the social and supportive services they provide to their clients. CBOs will be expected to provide services to patients receiving primary care services from BHA primary care provider groups and improve individual health outcomes. The applications must outline the following:

- How does the project improve the health, bend the utilization for the patient population, and improve lives attributed to Primary Care Providers within the PPS
- How will the project measure the effectiveness of their project within a Value Based Payment framework

All awards will be required to track patients who they serve over time. The PPS will continually monitor the quality scores of members enrolled in these programs. At the end of the grant funding, the PPS looks forward to continue funding the projects/CBOs who have improved the quality of care the greatest relative to cost.

Reception and Next steps: Since the Mid-Point assessment, the PMO has communicated this proposal to Finance and Steering. Both committees have approved the concept; however the PPS must put together a full proposal to Steering for final approval. The committees realize the value of CBOs and view this as a great opportunity to measure CBO effectiveness for the long term. This enhanced engagement of CBOs at this critical juncture is essential for the PPS' success.

Milestones and Conclusion:
The below milestones outline the PPS' plan to address the narrative outlined above:

Mid-Point Assessment Recommendation #2:	
PPS Defined Milestones/Tasks	*Target Completion Date*
4. Create CBO Grant Opportunities Fund	
Task 1: Create framework for CBO Grant Opportunity	2/1/2017
Task 2: Present framework to Finance and Steering to receive initial approval	2/15/2017
Task 3: Draft Request for Proposal	3/15/2017
Task 4: Receive final approval for CBO RFP	5/30/2017
Task 5: Solicit responses for CBO RFP	8/30/2017
Task 6: Rank CBO responses and select winners	9/30/2017

The PPS strongly believes that pairing the CBOs with PCP-based organizations will improve the quality of care throughout the PPS. This RFP will allow the PCP groups to pilot these activities throughout the region, thereby improving the PPS quality scores and health outcomes in the Bronx. The PPS will be able to monitor the success of these pilots, which will allow for further funding opportunities post-grant.

Stakeholder Engagement
Addressing recommendation #3 (project implementation, and partner engagement)

Description: From the start of DSRIP, the PPS has organized and funded a stakeholder engagement workgroup designed to actively engage providers and other various community partners. The workgroup is responsible for all communication to the PPS partners, via various communications platforms. The workgroup is also responsible for providing support to the PMO and various projects with their deliverables and metrics. The goals of the workgroup is to engage and grow all stakeholders in the process of DSRIP and their role in the PPS, to educate all stakeholders on the benefits of DSRIP and the goals of the PPS. Outreach/Communication initiatives include, but are not limited to the following:

- Adding providers to PPS network based on needs (project specific and provider specific)
- PCMH Roll Out
- Bronx RHIO adoption
- Patient Engagement Communications (e.g. Opt Out Letter)
- Assist in the creation of the integrated delivery system
- DSRIP 101 Presentations
- Project Onboarding
- Webinars
- BHA Newsletter, Website and Outreach Materials
- Managing community events (e.g. Health fairs, Town Hall Meetings)

Although much of the Stakeholder Engagement plan and scope have been highlighted in the quarterly submissions, the workgroup has created a concept of domain Champions, each representing various types of partners within the Bronx Health Access PPS, and serve as experts in their respective fields. The Champion types are separated into two classifications: Professional and Clinical.

The Professional Champions fall into the following buckets:

- Substance Abuse /Behavioral Health

- Skilled Nursing Homes
- Housing
- Community Based Organizations (CBO)

The Clinical Champions fall into the following buckets:

- Primary Care (Hospital)
- Primary Care (Community)
- Pharmacy (Community)
- Pharmacy (Hospital)

The purpose of the Champions within the Stakeholder Engagement Workgroup is to obtain feedback on how these various partner types would best be engaged in participation with Bronx Health Access PPS. Below is a list of various engagement activities that will be completed based on the Champion feedback:

- Surveys (which will serve as a two-way communication for providing feedback)
- Panels (i.e. CBO Panel, Pharmacy Panel)
- In-person Meetings (i.e. Stakeholder Engagement Workgroup Meetings)
- Focus Groups
- Events
- Town Halls (On-going Event)
- Trainings

These various engagement activities are tracked and kept in a database for reporting and evaluation purposes. Engagement activities are monitored for efficacy and/or improvement.

Reception and Conclusion: The Stakeholder engagement workgroup has allowed the PPS to engage various provider types, obtaining valuable insight into the needs to PPS members. At this point, the PPS does not plan on changing the strategy going forward as the PPS' approach has been very valuable. The boots on the ground have helped the PPS engage all provider types, transitioning interested partners into project workgroups in turn, aiding the PPS to meet the Achievement Values.

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:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1.Expand partner network	**6/1/2017**
Expand HH@R partners from 4 to 7 Case Management Agencies (CMAs) under the "hybrid" model	6/1/2017
Embed all care coordinators within a primary care practice	6/1/2017
2. Improve Supervision and Training for HH@R care coordinators	**4/1/2017**
Hire a dedicated HH@R Operations Team (Project Manager and Program Associate)	9/1/2016
Enhance Training and Support provided to Care Coordinators	1/1/2017
Develop and distribute HH@R Operations Manual to outline HH@R goals, Eligibility criteria, and	4/1/2017
Mid-Point Assessment Recommendation #2 and #3:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Create process to identify budget variances (approved vs incurred), which will allow for early identification of projects/organizations facing difficulty spending project implementation dollars	**9/30/2017**
Task 1: Create an extract by project on budget variances between approved budget vs. incurred by PPS	3/30/2017
Task 2: Establish thresholds for escalation and frequency	3/30/2017
Task 3: Communicate with project workgroups of the new process.	8/30/2017
Task 4: Steering Committee approves process	9/30/2017
2. Increase Performance Distribution to partners in the immediate term	**2/1/2017**
Task 1: Determine distribution amounts for partners	12/1/2016
Task 2: Propose and approve $6,000,000 distribution at Finance and Steering	1/1/2017
Task 3: Release Funds Flow announcement to project workgroups and committees	1/3/2017
Task 4: Deadline for partners to submit information for Funds Flow	1/30/2017
Task 5: Process payments to partners	2/1/2017
3. Evaluate Funds Flow to determine if a adjustments in methodology are warranted	**6/30/2017**
Task 1: Solicit suggestions at the Steering Committee for Funds Flow adjustments	1/15/2017
Task 2: Meet with key stakeholders to discuss funds flow adjustments	2/30/2017
Task 3: Draft potential adjustments in models	4/30/2017
Task 4: Review adjustments with key stakeholders to determine if changing Funds Flow should be pursued	6/30/2017

4. Create CBO Grant Opportunities Fund	**9/30/2017**
Task 1: Create framework for CBO Grant Opportunity	2/1/2017
Task 2: Present framework to Finance and Steering to receive initial approval	2/15/2017
Task 3: Draft Request for Proposal	3/15/2017
Task 4: Receive final approval for CBO RFP	5/30/2017
Task 5: Solicit responses for CBO RFP	8/30/2017
Task 6: Rank CBO responses and select winners	9/30/2017

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

		Partner Engagement									
Partner Category		2.a.i									
PCPs		488	281	250	292	259	321	235	292	311	257
NonPCPs		1335	807	701	851	765	799	697	750	765	778
HospitalProviders		11	1	1	1	1	1	1	1	1	1
Hospital - Ambulatory		1	1	1	1	1	1	1	1	1	1
ClinicalProviders		58	21	17	22	23	25	16	17	19	21
MentalHealthProviders		321	147	117	161	144	142	115	127	145	140
SubstanceAbuseProviders		62	12	11	33	32	12	10	10	11	14
CaseManagementProviders		21	4	1	6	3	4	2	4	5	6
Health Home		2	2	1	2	1	1	1	1	1	1
Community Based Organization (Tier 1)		16	4		6	2	2	1		2	2
NursingHomeProviders		23	1	1	1	1	1	1	1	1	1
PharmacyProviders		28	2	1	2	1	1	1	1	1	1
HospiceProviders		7	1	0	2	0	0	1	2	0	0
Home Care		14	2	0	3	0	2	2	2	0	0
AllOtherProviders		1173	647	573	692	640	715	559	640	661	618

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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		$ 21,042	$ 107,360	1.0%	0.9%
Practitioner - Non-Primary Care		$ 64,157	$ 170,683	1.7%	1.5%
Hospital - Inpatient/ED		$ 78,608	$ 235,824	2.3%	2.1%
Hospital - Ambulatory		$ -	$ -	0.0%	0.0%
Clinic		$ 1,937,174	$ 5,883,105	57.4%	51.3%
Mental Health		$ -	$ -	0.0%	0.0%
Substance Abuse		$ 45,158	$ 98,298	1.0%	0.9%
Case Management		$ 212,828	$ 574,655	5.6%	5.0%
Health Home		$ 32,152	$ 93,293	0.9%	0.8%
Community Based Organization (Tier 1)		$ 95,036	$ 300,410	2.9%	2.6%
Nursing Home		$ -	$ -	0.0%	0.0%
Pharmacy		$ 13,489	$ 29,233	0.3%	0.3%
Hospice		$ -	$ -	0.0%	0.0%
LTC		$ 13,489	$ 64,073	0.6%	0.6%
Home Health		$ 26,998	$ 26,998	0.3%	0.2%
PMO		$ 6,293,070	$ 6,990,878	8.3%	9.8%
Total		$ 8,833,200	$ 14,574,810		

Note: Bronx Health Access PPS reserves the right, per the Special Terms and Conditions, to modify the amount and timing of its funds flow to partners as business conditions require. This Funds Flow schedule, and any reference to it, if any, in the accompanying narrative, reflects the PPS's expected strategy for distributing DSRIP funds to all network partners and should not be viewed nor interpreted as a commitment, either explicitly or implicitly, to distribute these funds with regard to the amount, timing or partner type.