Mount Sinai PPS

Mid Point Assessment
Action Plan

March 10, 2017

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

Mid-Point Assessment Recommendation:
Recommendation #1: Develop strategy to increase engagement of Primary Care Providers.

PPS Action Plan Narrative:
Please refer to the file entitled "MountSinaiPPS_R3_Corrective Action" which includes the Mount Sinai PPS' response to the above listed recommendation.

Implementation Plan:

Implementation Date:

Mid-Point Assessment Action Plan Due Date:

Non-Compliance with Mid-Point Assessment Action Plans:

Attachments:

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

Mid-Point Assessment Recommendation:

Recommendation #2: The IA recommends that the PPS develop a detailed action plan with specific dates and deliverables for the various Primary Care Plan strategies.

PPS Action Plan Narrative:

Since the submission of the Primary Care Plan, the Mount Sinai PPS (MSPPS) has made significant progress towards several of the strategies outlined in the Primary Care Plan. Specifically, MSPPS recently launched the eConsult initiative to two pilot partners, Internal Medicine Associates (IMA), the largest Medicaid practice at the Mount Sinai Health System, and Community Healthcare Network (CHN), a Federally Qualified Health Center. The eConsult initiative enables primary care physicians to communicate with specialists for advice regarding patients' conditions through secure messaging. Furthermore, this initiative will provide primary care providers greater access to specialists' expertise, supporting them in providing more comprehensive care, as well as increased access to specialty care for patients. Mount Sinai IMA has begun using the service for both diabetes and general endocrinology. CHN is in the beginning stages of the launch, with the most recent meeting occurring on March 2, 2017. Next steps for this initiative include rollout to additional PPS partners and training for incorporation into site's workflows. The eConsult program was put in place to address the population targeted by DSRIP Projects 3.b.i and 3.c.i which focus on chronic diseases such as diabetes and cardiovascular disease; in addition, this program supports several EPP measures that the PPS has prioritized, including diabetes monitoring for people with diabetes and schizophrenia, comprehensive diabetes care, and comprehensive diabetes screening.

Additionally, MSPPS will be launching a Community Paramedicine initiative on March 13th. The MSPPS Community Paramedicine pilot program seeks to reduce unnecessary emergency room visits and readmissions, by allowing for urgent assessments in the field by paramedics including coordination of care with emergency and primary care physicians via telemedicine. Community Paramedicine increases access to care through real-time consultation with patients' primary care provider, where an appropriate course of action can be determined. Thus far, four PPS partners have begun onboarding: the Institute for Family Health, a Federally Qualified Health Center, Visiting Nurse Service of New York, a not-for-profit home- and community-based healthcare organization in the United States, and Mount Sinai Heart and Behavioral Health practices. Furthermore, several introductory calls have been held with other PPS partners. This program aims to support the NYS Department of Health's DSRIP goal of reducing avoidable hospital use by 25% over 5 years.

Implementation Plan:

Action Plan attached.

Implementation Date:

Mid-Point Assessment Action Plan Due Date:

Non-Compliance with Mid-Point Assessment Action Plans:

Attachments:

1) *Mid-Point Assessment Action Plan Template*
    a. *MPA Implementation Plan Template*

Mid-Point Assessment Recommendation #2: The IA recommends that the PPS develop a detailed action plan with specific dates and deliverables for the various Primary Care Plan strategies.

PPS Defined Milestones/Tasks	*Target Completion Date*
1. Launch of eConsult at Mount Sinai Internal Medicine Associates	**3/31/2017**
Train providers on new feature and incorporation into workflow	2/28/2017
2. Launch of eConsult at Community Healthcare Network	**9/30/2017**
Planning meeting to occur	3/2/2017
Identify providers for Epic Care Link Access	3/31/2017
Grant Access to Provider	4/30/2017
Train providers on new feature and incorporation into workflow	7/31/2017
3. Launch of Community Paramedicine at Mount Sinai Heart	**4/1/2017**
Hold meetings to assess partner interest	1/4/2017
Socialization of Community Paramedicine Service	4/1/2017 (and ongoing)
Track progress of adoption	4/1/2017 (and ongoing)
4. Launch of Community Paramedicine at Institute for Family Health	**5/1/2017**
Hold meetings to assess partner interest	1/31/2017
Socialization of Community Paramedicine Service	5/1/2017 (and ongoing)
Track progress of adoption	5/1/2017 (and ongoing)
5. Launch of Community Paramedicine at Visiting Nurse Service of New York	**6/1/2017**
Hold meetings to assess partner interest	1/31/2017
Socialization of Community Paramedicine Service	6/1/2017 (and ongoing)
Track progress of adoption	6/1/2017 (and ongoing)
5. Launch of Community Paramedicine at Mount Sinai Behavioral Health	**7/1/2017**
Hold meetings to assess partner interest	2/1/2017
Planning meeting to occur	3/8/2017
Set up process and prepare providers (registration, user testing)	3/31/2017
Socialization of Community Paramedicine Service	7/1/2017 (and ongoing)

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

Mid-Point Assessment Recommendation:

Recommendation #3: 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 as to ensure success in DSRIP.

PPS Action Plan Narrative:

The MSPPS has developed and implemented a clinical care model that addresses the gaps in care targeting our patients with mental health disorders, diabetes, hypertension, smoking habits, while focusing on preventive access and screening and management of depression and substance abuse disorders. Our PPS implementation refined approach to engage partners of all provider types and implement clinical change across the network through a "Track" based strategy. Track one will launch in mid-March bringing together the acute care facilities, FQHCs, and clinics in the PPS to drive clinical improvement to drive clinical pathways targeting our selected priority measures below.

- *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication*
- *Diabetes Monitoring for People with Diabetes and Schizophrenia*
- *Controlling High Blood Pressure*
- *% Smokers discussed cessation meds*
- *% Smokers discussed cessation strategies*
- *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ± (M) (H) (CIN)*
- *Comprehensive Diabetes Screening – all three tests (HbA1c, dilated eye exam, and medical attention for nephropathy) (M) (H) (CIN)*

Track two will launch in April and will continue to engage primary care providers, substance use disorder providers, behavioral health practices, health homes and care management agencies, and community based organizations through concerted efforts to impact metrics that address access, screening, and management as per the below.

- *Adult Access to Preventive or Ambulatory Care - 20 to 44 years*
- *Adult Access to Preventive or Ambulatory Care - 45 to 64 years*
- *Adult Access to Preventive or Ambulatory Care - 65 and older**
- *Screening for Clinical Depression and Follow-Up Plan (M) (H) (CIN)*
- *Antidepressant Medication Management – Effective acute Phase Treatment (M) (H)*
- *Antidepressant Medication Management – Effective continuation Phase treatment (M) (H)*

- *Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days) (M) (H)*
- *Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days) (M) (H)*
- *Percentage of adults who receive a Breast cancer screening based on the most recent guidelines - Aged 50- 75 years (not a DOH reported metric but quality metric for most plans) (M) (CIN)*
- *Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50- 75 years (M) (CIN)*
- *Flu Shots for Adults Ages 18 – 64*
  Newly diagnosed HIV case rate per 100,000

Track three primary focus is to improve relationships between hospitals and community providers. This implementation strategy will focus on avoidable utilization through initiatives that addresses barriers to care coordination and care transition between acute care providers and community based providers throughout our PPS network. One of the foundations to our care management strategy is to screen all patients for social determinants of health, identify patients in need of care coordination services, refer for community based services and enroll eligible patients into the Health Home program. Critical components of our care management strategy are to maintain patient engagement with primary care and specialty care providers and establish and maintain care team connectivity that includes care managers, to further the goals of DSRIP of improving clinical outcomes and patient experience while reducing avoidable utilization for our targeted population with behavioral health disorders, substance abuse disorders, diabetes, and cardiovascular disease.

Implementation Plan:

Action Plan attached.

Implementation Date:

Mid-Point Assessment Action Plan Due Date:

Non-Compliance with Mid-Point Assessment Action Plans:

Attachments:

1) *Mid-Point Assessment Action Plan Template*
    a. *MPA Implementation Plan Template*
    b. *Partner Engagement*
    c. *Funds Flow*

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 #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.

PPS Defined Milestones/Tasks	*Target Completion Date*
1. Launch Track One	**6/30/2017**
Identify providers to engage in implementation activities	4/1/2017
Assess providers capacity and resource needs to engage in implementation activities	4/15/2017
Define PPS centralized resources and support	4/30/2017
Deploy PPS centralized resources and support	5/30/2017
Establish quality improvement and monitoring plan	6/30/2017
2. Launch Track Two	**7/1/2017**
Identify providers to engage in implementation activities	5/1/2017
Assess providers capacity and resource needs to engage in implementation activities	6/1/2017
Define PPS centralized resources and support	7/1/2017
Deploy PPS centralized resources and support	7/30/2017
Establish quality improvement and monitoring plan	8/30/2017
3. Launch Track Three	**8/1/2017**
Identify providers to engage in implementation activities	6/1/2017
Assess providers capacity and resource needs to engage in implementation activities	7/1/2017
Define PPS centralized resources and support	8/1/2017
Deploy PPS centralized resources and support	8/30/2017
Establish quality improvement and monitoring plan	9/30/2017
Establish process/workflow/policy&procedure to identify and enroll patients in inpatient/ER settings	6/30/2017 (and ongoing)
Establish process/workflow/policy&procedure to identify and enroll patients in outpatient settings	9/30/2017 (and ongoing)

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

		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		$ 1,869,967.26	$ 1,869,967.26	8.9%	8.9%
Practitioner - Non-Primary Care		$ 2,010,333.61	$ 2,010,333.61	9.6%	9.6%
Hospital - Inpatient/ED		$ 1,040,237.36	$ 1,040,237.36	5.0%	5.0%
Hospital - Ambulatory		$ 1,040,237.36	$ 1,040,237.36	5.0%	5.0%
Clinic		$ 2,180,010.18	$ 2,180,010.18	10.4%	10.4%
Mental Health		$ 1,966,422.25	$ 1,966,422.25	9.4%	9.4%
Substance Abuse		$ 1,342,249.06	$ 1,342,249.06	6.4%	6.4%
Case Management		$ 1,699,966.30	$ 1,699,966.30	8.1%	8.1%
Health Home		$ 917,108.40	$ 917,108.40	4.4%	4.4%
Community Based Organization (Tier 1)		$ 118,728.57	$ 118,728.57	0.6%	0.6%
Nursing Home		$ 1,037,407.35	$ 1,037,407.35	4.9%	4.9%
Pharmacy		$ 1,325,288.77	$ 1,325,288.77	6.3%	6.3%
Hospice		$ 83,069.13	$ 83,069.13	0.4%	0.4%
Home Care		$ 280,628.54	$ 280,628.54	1.3%	1.3%
Other (Community Based Organization, Not Tier 1)		$ 1,637,223.86	$ 1,637,223.86	7.8%	7.8%
Other (All Other)		$ 2,442,829.32	$ 2,442,829.32	11.6%	11.6%
Total*		$ 20,991,707.31	$ 20,991,707.31	100.0%	100.0%

* Note: this figure does not include funds flowed to partners who are no longer contracted partner organizations with MSPPS. An additional $73,766.99 was flowed to these 12 organizations.

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*	*2.b.iv*	*2.b.viii*	*2.c.i*	*3.a.i*	*3.a.iii*	*3.b.i*	*3.c.i*	*4.b.ii*	*4.c.ii*
Practitioner - Primary Care		37	20	9	16	25	12	13	17	13	12
Practitioner - Non-Primary Care		61	40	21	31	34	15	25	29	23	19
Hospital - Inpatient/ED		4	4	2	2	1	2	2	2	2	2
Hospital - Ambulatory		4	4	2	2	1	2	2	2	2	2
Clinic		61	31	14	25	43	23	18	24	16	18
Mental Health		75	35	12	28	53	32	18	23	19	18
Substance Abuse		47	17	8	18	35	24	6	7	9	12
Case Management		59	40	23	35	28	27	23	28	26	17
Health Home		5	4	1	5	2	1	2	2	2	2
Community Based Organization (Tier 1)		9	4	1	3	1	1	3	3	2	0
Nursing Home		44	40	14	11	2	3	18	21	8	3
Pharmacy		13	6	5	6	6	9	6	9	4	4
Hospice		14	13	5	9	1	3	7	10	2	3
Home Care		24	19	18	11	2	5	11	13	7	2
Other (Community Based Organization, Not Tier 1)		62	35	18	27	36	27	18	22	19	14
Other (All Other)		129	80	40	43	50	31	37	44	34	20