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Mid-Point Assessment Action Plan

Attached:

Mid-Point Assessment Corrective Action Plan Narrative

Mid-Point Assessment Action Plan Template

- Implementation Plan
- Partner Engagement Template
- Funds Flow Template

Mid-Point Assessment Recommendations:

#	PPS	Section	Focus Area	Final Recommendation	Page
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.	pp. 2-3
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.	pp.3-4
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.	pp.4-6
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.	pp.6-8
5	Westchester Medical Center	Organizational		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.	pp. 9-12

PPS Action Plan Narrative:

Introduction

The WMCHealth PPS (PPS) has developed a comprehensive strategy to address the five recommendations put forth by the Independent Assessor and the Project Advisory Oversight Panel. Two recommendations are organizational, including Partner Engagement and the PAOP "White Paper" recommendation. The three recommendations related to specific projects are addressed separately in the pages that follow and demonstrate the PPS's commitment towards remedying the noted deficiency.

In accordance with guidance from the Independent Assessor (IA) the PPS has created a series of new milestones and tasks within the Mid-Point Assessment Implementation Plan template to ensure all recommendations are adequately addressed. The segment of the Implementation Plan relevant to each recommendation is embedded in the corresponding narrative. Each narrative section details specific actions the PPS has taken or plans to take in addition to a timeline and associated methodology for tracking the successful execution of the strategy in order to meet DSRIP goals. This strategy ensures that partner engagement and funds flow processes are sufficient to provide the necessary foundation to support both network partners and the PPS achieve DSRIP goals and performance measures.

WMCHealth Approach to DSRIP: Building Sustainable Healthy Communities

WMCHealth PPS has conscientiously approached partner engagement, contracting and funds flow through the lens of creating a long-term infrastructure for sustainability that extends beyond the life of DSRIP to create integrated healthy communities.

The PPS is anchored by the WMCHealth Network (WMCHealth) which includes its flagship Westchester Medical Center. WMCHealth has recently acquired seven financially-challenged hospitals creating a newly-minted health network comprised of ten hospitals employing more than 12,000 individuals throughout eight counties in the Hudson Valley. Each of WMCHealth's facilities provides critical healthcare services regardless of an individual's insurance status.

In 2016, New York State Department of Labor named Westchester Medical Center as one of the top ten private-sector employers in the Hudson Valley region.[1] Recognizing the role each of these hospitals play in the economic vitality of the communities they serve, WMCHealth PPS has undergone significant steps to create and evaluate a replicable model for healthcare transformation and economic sustainability that ensures reliable access to high-quality healthcare services and a consistent workforce pipeline for community residents.

Through comprehensive community-level assessments, stakeholder interviews, and asset mapping of three priority cities: Poughkeepsie, Kingston, and Port Jervis, WMCHealth PPS has commenced the requisite research to evaluate the need and efficacy of deploying an "Anchor Model" strategy. This model builds upon the successes of each DSRIP project, capitalizes on local network relationships and empowers community organizations to think beyond healthcare to advance solutions that will enhance their communities. WMCHealth is equipping its hospitals and network partners with the technological, workforce, and training resources to facilitate community-specific, cross-sector collaboration that encourages each locality to leverage its existing assets, attract new resources, and define a cohesive strategy to improve their communities and the health of its residents.

Recommendations

Recommendation # 1: 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.

Specific action of the PPS to remedy the deficiency:

Mid Point Assessment Recommendation #1:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Recruit additional 2.d.i participating partner organizations as necessary to ensure that PAM © surveys are being collected in all high-priority zip codes for the target population.	***9/30/2017***
Geomap current participating PAM© partner organizations against WMCHealth PPS's 9 priority zip codes.	3/31/2017
Analyze results and identify potential new partners and/or new sites to help close gaps in coverage.	6/30/2017
Engage and train additional organizations and/or sites to better identify the targeted population for this project and conduct PAM ©surveys in identified high-priority zip codes.	9/30/2017

Prior to DSRIP Implementation, WMCHealth PPS (PPS) conducted an extensive regional assessment of community needs. Using rigorous analysis of geospatial data, extant health, socio-demographic, and environmental data, the PPS isolated "hot spots"—locations with statistically significant values depicting patterns of disease or higher-than average presence of known variables impacting population health measures. The result was the identification of nine, high-priority ZIP codes, illustrated in Figures 1 and 2, to target DSRIP project implementation efforts.

Recognizing that these priority ZIP codes were most likely to be home to the highest concentration of uninsured and non/low-utilizing Medicaid recipients, they became target locations to engage, educate, and integrate this population into community-based care in accordance with DSRIP requirements for Project 2.d.i. Partner organizations within priority zip codes were identified and engaged in Project 2.d.i to conduct Patient Activation Measures (PAM©) surveys. WMCHealth PPS collaborated with staff from each partner organization to review their intake process, patient population, organizational structure, and IT capabilities, in order to develop a workflow for collecting PAM© surveys and for coaching the uninsured and non/low-utilizing Medicaid beneficiaries on how to more effectively access health care services. Tailoring how and where the survey is conducted to the particular circumstances of each participating partner enable partners to reach and assist the target population. As of DY2Q3, twenty-two organizations in high-risk neighborhoods use the PAM © survey to assess the patient's/client's underlying knowledge, skills and confidence integral to managing one's own health and healthcare. A full list of partner organizations conducting surveys can be found in Figure 3 below.

[1] Source Division of Research & Statistics analysis of info USA ARC employer database and publicly available information. https://labor.ny.gov/stats/nys/Largest-private-sector-employers-NYS.shtm

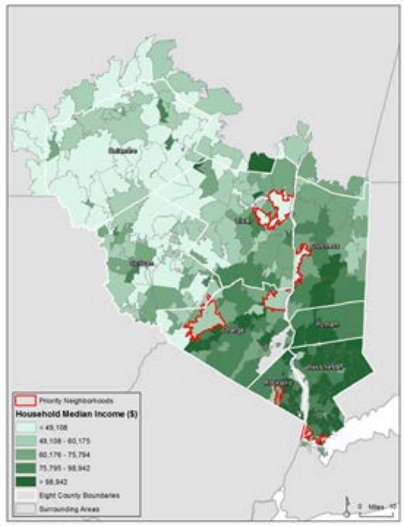

Figure 1.

Nine Hudson Valley Priority Zip Codes	
Dutchess County	Poughkeepsie (12601)
Orange County	Newburgh (12550), Middletown (10940)
Rockland County	Spring Valley (10977)
Ulster County	Kingston (12401)
Westchester County	Mt. Vernon (10550), Yonkers (10701 and 10705), New Rochelle (10801)

Figure 2.

Organizations Conducting PAM Surveys	
MHA Westchester	DOH Rockland
Department of Mental Health Rockland county	MISN
Health Alliance	Hope Community Services
Lexington Center for Recovery	Westchester Medical Center (Cederwood clinic)
Mental Health Association of Westchester	Guidance Center of Westchester Inc.
Crystal Run Healthcare LLP	Cornerstone Family Healthcare
Llobet Medical Group	Food Bank for Westchester
Hudson Valley Community Services Inc.	Family of Woodstock, Inc.
Open Door Family Medical Center Inc.	Planned Parenthood Hudson Peconic Inc.
Planned Parenthood Of Mid-Hudson Valley	Community Resource Center
Middletown Community Health Center Inc.	Fallsburg Pediatrics

Figure 3.

In order to track progress and validate that PPS efforts are assisting partners in better identifying the target population, WMCHealth PPS will Geomap all partners conducting the PAM© surveys in relation to PPS-identified priority zip codes. Based on outcomes of this analysis, as needed, the PPS will ask existing partner organizations to extend PAM© survey activity to additional sites and/or will approach new organizations to contract with the PPS to participate in Project 2.d.i. Geomapping participating partners will allow the PPS to ensure Project 2.d.i is adequately implemented in priority zip codes at locations where the targeted patient population is most likely to be found.

Recommendation #2: 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.

Specific action of the PPS to remedy the deficiency:

Mid Point Assessment Recommendation #2:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Launch Webinar Series to instruct partner organization staff on how to help low and non-utilizing Medicaid beneficiaries to identify their health coverage information and engage with primary care services.	***3/31/2017***
Contract with appropriate vendor to develop training materials and resources for use by partner organizations to help partners educate clients/patients on how to effectively connect with their MCO and/or PCP.	*2/14/2017*
Conduct webinar trainings for select partner organization staff.	*3/31/2017*
Place webinar training materials on PPS Learning Management System for ongoing partner access.	*3/31/2017*
2. Launch CG-CAHPS Improvement Collaborative	***9/30/2017***
Meet with pilot site FQHC and CG-CHAPS vendor to review terms of proposed contract.	*4/30/2017*
Begin sampling of uninsured patients for Measurement Year 3	*5/30/2017*
Identify other potential partners to participate in CG-CAHPS Improvement Collaborative.	*6/30/2017*
Convene CG-CAHPS Improvement Collaborative with FQHC participants	*9/30/2017*

The PPS conducted in-depth, partner-specific PAM© survey trainings for all partners contracted for Project 2.d.i. Trainings employed a "train-the-trainer" model which empowered the organizations to train additional staff without further PPS intervention. Additionally, ongoing and monthly support trainings, sponsored by the PPS, are offered three times a month through Insignia in an accessible online format.

Recognizing that one of the goals of Project 2.d.i is to increase appropriate utilization of primary care preventive services amongst low/non-utilizing Medicaid members, the PPS will increase outreach and education by launching a webinar training series for organizations conducting PAM© surveys that will enable partner staff to educate patients and clients on how to effectively use their health insurance benefits and connect with primary care services. The training will instruct partner organization staff to provide information to low/non-utilizing Medicaid beneficiaries on how to use their Medicaid ID cards; identify their health plan (MCO) and primary care provider (PCP); and connect with primary and preventative care services. The training will be launched in March, 2017.

This training along with other PAM© training materials will be available on the WMCHealth PPS online Learning Management System platform so that participating partners have ongoing access to trainings as needed for new staff.

WMCHealth PPS participates with the Greater New York Hospital Association (GNYHA) Statewide Project 2.d.i Work Group (the Work Group) to share ideas and best practices with other PPS's on how to encourage the low/non-utilizing Medicaid population segment to engage in primary care services. Low and non-utilizing Medicaid Beneficiaries are identified from claims data; only New York State (NYS) has the complete and current data set needed to simultaneously identify the PPS, the MCO and the assigned PCP of low/ non-utilizing Medicaid beneficiaries. Through the Work Group, the PPS will propose a collaborative NYS/PPS/MCO/PCP outreach campaign to encourage low/non-utilizing Medicaid beneficiaries to access preventive primary care services.

Another requirement of Project 2.d.i is use of the CG-CAHPS survey to assess uninsured patients regarding their level of satisfaction with clinical services received in an ambulatory setting. Federally Qualified Health Centers (FQHC) provide services to patients regardless of insurance status or ability to pay. To complete this requirement while remaining compliant with patient privacy regulations, the PPS contracted with an FQHC partner to conduct a CG-CAHPS survey of their uninsured patients. In turn, the FQHC contracted with an approved CG-CAHPS vendor to conduct surveys in both English and Spanish. For measurement year two, 266 de-identified survey responses were then shared with the PPS, which allowed the PPS to successfully exceed project requirements for Measurement Year 2 (MY2).

Detailed reports including aggregated data and national benchmarks produced by the CG-CAHPS vendor provided insightful and actionable data on patient experience for use by the FQHC. Based on the success and utility of this MY2 survey the FQHC approached the PPS about expanding the survey for subsequent years to include insured patients. Including insured patients is beyond the scope of requirements for Project 2.d.i but could potentially advance the goal of improving patient satisfaction scores for DSRIP Domain 2 performance measures.

WMCHealth PPS will propose to FQHCs and other large primary care partners, that the PPS establish a CG-CAHPS Improvement Collaborative (the Collaborative). Participating FQHC partners will conduct monthly CG-CAHPS surveys of a sample of uninsured patients as well as a sample of Medicaid patients. The responses of the uninsured patients will be de-identified and submitted to the PPS to meet the requirements for the annual 2.d.i.CG-CAHPS survey of the uninsured. Partnering providers who do not serve the uninsured will sample Medicaid beneficiaries. FQHC and other primary care partners will be invited to participate in the Collaborative with a goal of including partnering providers who together provide care to more than half of the WMCHealth PPS attributed patients. Monthly sampling using the CG-CAHPS survey from participants in the Collaborative will provide an opportunity for testing innovations to improve patient satisfaction scores.

As the PPS's focus shifts from implementation to performance, work of the CG-CAHPS Improvement Collaborative will align with DSRIP objectives by more broadly addressing and improving patient satisfaction measures required for Domain 2 performance. CG-CAHPS questions comprise 4 of the 16 performance measures applicable to Domain 2 projects and 7 of 9 metrics applicable to WMCHealth PPS Domain 3 projects. This aligns the work conducting outreach to the uninsured with the performance measures used to evaluate DSRIP overall.

Recommendation #3: 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.

Specific action of the PPS to remedy the deficiency:

Mid Point Assessment Recommendation #3:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Convene the Behavioral Health Project Advisory Quality Committee comprised of the Behavioral Health Primary Care (BH-PC) Integration Subcommittee and the BH Crisis Sub-Committee to review the progress on Projects 3.a.i and 3.a.i.i	***6/30/2017***
Review membership and participation in both the BH-PC Integration Subcommittee and the BH Crisis Subcommittee for inclusion of appropriate stakeholders.	*4/30/2017*
Recruit additional committee participants as needed.	*6/30/2017*

Convene the Behavioral Health Project Advisory Quality Committee comprised of the BH-PC Integration Subcommittee and the BH Crisis Subcommittee to review the progress on Projects 3.a.i and 3.a.i.i.	*6/30/2017*
2. Complete the MY3 Cross-PPS work through the Hudson Region DSRIP Clinical Council (HRDCC) to improve outcomes for actionable Behavioral Health performance measures.	***6/30/2017***
Report to the WMCHealth Quality Steering Committee the findings of the HRDCC Clinical Council advisory work group regarding clinical standards for management of patients on anti-psychotic medications.	*3/31/2017*
Reconvene Cross-PPS BH stakeholder group to review use to date of the PSYCKES database for identification of patients whose care is not compliant with performance measures and to address concerns identified by BH providers and other partners on efforts to date to address DSRIP BH performance measures. (HRDCC has previously hosted webinars for partners on the use of the PSYCKES data and made materials on use of PSYCKES available via learning platform.)	*5/30/2017*
Based on feedback, revise and redistribute educational materials describing how to use PSYCKES & other data sources to improve BH performance measures.	*6/30/2017*
3. Establish WMCHealth PPS Performance Measure Workgroups to address actionable Behavioral Health improvement performance measures.	***9/30/2017***
Identify existing primary care and behavioral health partners to participate as initial (pilot site) workgroup.	3/31/2017
Create initial strategic implementation and operational templates to evaluate site-specific workflow and projected strategy to improve high-performance measures at each pilot site(s).	4/30/2017
Review first round PDSA results from initial pilot site(s) and modify protocols as appropriate.	6/30/2017
Assess gaps in workgroup membership to ensure adequate representation from primary care, mental health, substance abuse disorder, and community based partners as needed for impact on the performance measures.	6/30/2017
Recruit additional workgroup participants as needed.	8/30/2017
Convene workgroup and create strategic implementation and operational templates to evaluate site-specific workflow and projected strategy to improve performance on measures in each participating organization.	9/30/2017

WMCHealth PPS recognizes the critical role of Project 3.a.i in achieving the broader DSRIP objective of sustaining integrated healthcare services. To that end, the PPS has significantly invested in infrastructure for the deployment of quality behavioral health services in community and primary care settings.

Oversight of Project 3.a.i. is provided by the Behavioral Health-Primary Care Integration Subcommittee of the Behavioral Health Project Advisory Quality Committee (BH-PAQC) which reports to the WMCHealth PPS Quality Committee. The PPS has chosen to implement "Model A" of Project 3a.i. Implementation of Behavioral Health Screening Tools and Protocols into Primary Care Settings. From the beginning of PPS implementation, behavioral health providers, including substance use disorder providers, have played an active role in committee activities. Some of the earliest work of the committee was to review screening tools for substance use and to include universal screening for substance use in the committee's recommended guidelines. The Behavioral Health-Primary Care Integration Subcommittee is derived and accountable to the larger BH-PAQC which includes additional community-based mental health and substance use disorder providers. Citing the recommendations of the Independent Assessor (IA), the PPS will convene the broader BH-PAQC to ensure inclusive stakeholder oversight of Project 3.a.i. A full list of BH-PAQC members will be made available upon request.

To support primary care organizations' understanding of Project 3.a.i requirements and to make the necessary structural changes to enact its protocols, WMCHealth PPS has contracted with Dr. Andrew P Levin, a board certified physician in Adult Psychiatry, with over 30 years of experience in clinical and forensic psychiatry. Dr. Levin, in tandem with the PPS Behavioral Health Integration team, has conducted comprehensive site visits to assess partner's progress towards closing gaps while identifying challenges in implementing requisite project milestones.

Site-specific analysis validated the necessity for developing evidence-based protocols for antidepressant management and care engagement processes in primary-care settings. Collaboration amongst members of the Behavioral Health Integration Subcommittee led to the creation of detailed standards of care for medication management, distilled from national models and guidelines.

The PPS has prioritized creating an actionable strategy to address the DSRIP Performance Measures pertaining to behavioral health. This work began last May with a Cross-PPS meeting of regional behavioral health stakeholders including representatives of FQHCs, Hospitals providing psychiatric services, Article 31 Behavioral Health Clinics, Health Homes, Medicaid Managed Care Organizations and all three PPSs in the Hudson Valley. The group discussed strategies for improving outcomes as measured by DSRIP performance measures and has continued to meet and to develop workflows and other collaborative approaches to closing identified gaps in care. An outcome of that collaboration was a webinar to help behavioral health partners effectively use the PSYCKES database to identify patients.

Due to timing of provider contracting and provider engagement reporting, WMCHealth PPS believes the Independent Assessor's early mid-point evaluation of Project 3.a.i's provider engagement which was completed at the end of DY2Q2 did not reflect the full breadth of involvement of behavioral health partners in the project as described above. At the time of the Mid-Point Assessment the PPS had attributed provider engagement through the PIT almost exclusively to Project 2.a.i, an artifact of our contracting process. As a result of partner contract execution completed in DY2Q3, the number of engaged partners for Project 3.a.i exceeds commitments in all but two provider categories, Clinics and Substance Abuse. The PPS has a strategy in place for meeting those targets.

Heeding the Independent's Assessor's recommendation to focus on behavioral health performance measures, WMCHealth PPS will take two action steps described above: the PPS will continue to actively participate in the cross-PPS collaboration that brings together stakeholders in the Hudson Valley around improving performance in behavioral health measures; and the PPS will convene a WMCHealth PPS Performance Measure Workgroup, including community partners, in order to develop strategic implementation and operational workflow templates targeted to track progress towards the achievement of high performance measurements. This work will begin intensely with a few pilot sites to test interventions during the closing months of DSRIP Measurement Year 3 and then expand PPS-wide for Measurement Year 4. WMCHealth PPS is confident our progress towards implementing Project 3.a.i., including partner engagement, will succeed in its DSRIP goal of integrating behavioral health services in primary care sites.

Recommendation #4: 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.

Specific action of the PPS to remedy the deficiency:

Mid Point Assessment Recommendation #4:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Offer Implementation Contracts to additional partners with a special focus on Primary Care, Clinics (Including IDD providers), Substance Use Disorder Service providers, Case Management Agencies, and other Community-Based Partners.	**6/30/2017**
Identify complete list of organizations that possess the highest attributed patient population and provider types needed for transformation agenda.	3/31/2017
Offer implementation contracts to organizations as needed to meet engagement commitments for DSRIP projects with particular attention to clinics offering specialty DD services, care management agencies providing Health Home services, additional primary care sites, additional substance abuse disorder services sites, and other community based partners.	6/30/2017
2. Hold Key Network Partner Meetings to better engage organizations with significant role or DSRIP transformation agenda.	**9/30/2017**
Develop relevant training materials/resources for partners to address challenges for achieving DSRIP milestones and performance measures.	6/30/2017
Hold network meetings with identified key partners to educate staff on updated DSRIP and PPS objectives; gather information on workflow and barriers to implementation.	9/30/2017
3. Engage additional Community-Based Partners (CBPs); Engage CBPs in local PPS implementation.	**9/30/2017**
Create detailed patient workflow template demonstrating CBP role in Medical Neighborhood Supporting Healthy Communities Model; identify additional CBPs in local PPS neighborhoods.	6/30/2017
Crosswalk PPS Network Partners with identified Port Jervis and Kingston Medical Village partners to identify opportunities to engage additional partners in the Medical Village.	6/30/2017
Hold Community-Based Partner-Specific Medical Neighborhoods Supporting Healthy Communities Meeting Series.	9/30/2017

WMCHealth has taken an aggressive and inclusive approach to partner engagement. A dedicated Network Development team has created a framework for engaging partners that focuses on unique community-centric geographies and high-need patient populations. Key Network Partner Meetings, *Medical Neighborhood Supporting Healthy Community* Meetings, a PPS-wide Primary Care workgroup and two WMCHealth Medical Villages located in Port Jervis and Kingston continue to be the primary avenue for engaging partners in PPS activities.

Initially, all PPS partners were asked to sign a Master Services Agreement. In order to trigger funds flow a "Schedule B" or vendor contract, specific to each organization's involvement in project implementation, must be executed. Contract negotiation was prioritized to first ensure the broadest possible engagement with all partners through a "Threshold Schedule B" agreement linked to Project 2.a.i. Subsequently, additional "Schedule B" agreements linked to other DSRIP projects were and continue to be rolled out sequentially, beginning with partners who possess the highest attributed patient population and the most provider types needed to meet DSRIP requirements. This approach was successful in getting some DSRIP funds to all PPS partners early, but as a result, provider

engagement at the time of the Mid-Point Assessment did not show the breadth of involvement of partners in all projects. In total, the PPS has initiated seven contracting waves with waves 5,6,7 projected to begin by the end of March 2017. A timeline illustrating each contract wave and associated project(s) is provided in Figure 4 below.

	Jul-16	Jul-16	Jun-16	Jul-16	Jul-16	Mar-17	Oct-16	Oct-16	Oct-16	Oct-16	Oct-16	Feb-17	Feb-17	Feb-17	Mar-17	Mar-17	Apr-17	Apr-17
Org Type	**Wave 1 Executed**	**Wave 1- 2ai, 2aiii, 2biv, 3aii, 3ci, 3diii**	**Wave 1 - 2aiv**	**Wave 1 - 2di**	**Wave 1 - 3ai**	**Wave 2 - 2ai, 2aiii, 2biv, 3aii, 3ci, 3diii**	**Wave 3 - Executed 2ai, 2aiii, 2biv, 3ai, 3aii, 3ci, 3diii**	**Wave 3 - Executed - 2aiv**	**Wave 3 - Executed - 2di**	**Wave 3 - 2ai, 2aiii, 2biv, 3ai, 3aii, 3ci, 3diii**	**Wave 3 - 2di**	**Wave 4 - 2ai, 2biv, 3aii, 3ci, 3diii**	**Wave 4 - 2aiii**	**Wave 4 - 3ai**	**Wave 5 - Executed 2ai, 2aiii , 2biv, 3ai , 3aii, 3ci, 3diii**	**Wave 5 - Executed - 2di**	**Wave 6 - 2ai, 2aiii, 2biv, 3aii, 3ci, 3diii**	**Wave 7 - 2ai, 2aiii, 2biv, 3aii, 3ci, 3diii**
PCP tot	491	142	44	-	90	25	15	-	-	4	4	9	8	8	-	-	2	58
PCP SN Tot	249	10	3	-	6	9	4	-	-	2	2	3	3	3	-	-	-	29
Non PCP Tot	964	686	121	-	473	7	595	-	200	99	21	117	111	111	105	43	104	168
Non-PCP SN Tot	278	29	6	-	22	-	40	-	17	3	2	30	30	30	2	1	10	47
Mental Health Tot	108	67	2	-	48	-	121	1	37	34	3	14	10	10	28	14	5	44
Mental Health SN	16	7	2	-	6	-	39	1	15	3	1	4	2	2	6	3	4	6
Hospital Tot	5	7	3	-	5	-	-	-	-	1	1	-	-	-	-	-	-	2
Hospital SN	5	5	2	2	4	-	-	-	-	1	1	-	-	-	-	-	-	2
SA Tot	4	5	2	-	4	-	7	-	2	6	3	2	1	2	-	-	4	1
SA SN	4	5	2	-	4	-	7	-	2	5	2	2	1	2	-	-	4	1
CM HH Tot	2	1	-	-	-	-	10	1	2	3	-	9	6	5	6	2	10	6
CM HH SN	2	1	-	-	-	-	7	-	2	1	-	3	3	2	3	2	3	2
Clinic Tot	11	7	3	-	5	-	2	-	-	2	1	16	14	15	-	-	2	4
Clinic SN	11	5	2	-	4	-	2	-	-	1	1	14	12	14	-	-	1	2
SNF Tot	2	2	2	-	2	-	-	-	-	-	-	1	1	1	-	-	-	22
SNF SN	1	2	2	-	2	-	-	-	-	-	-	1	1	1	-	-	-	22
CBP Tot -Manual	-	-	-	-	-	-	24	1	4	6	1	19	14	15	5	3	22	-
CBP SN	-	-	-	-	-	-												
Pharm Tot	1	1	-	-	-	-	-	-	-	1	1	-	-	-	-	-	1	-
Pharm SN	1	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-
Other Tot	906	409	86	-	284	23	56	4	4	13	5	70	62	63	9	-	86	121
Other SN	457	22	8	-	16	9	18	-	3	8	3	32	28	30	-	-	25	69
Hospice Tot	-	2	1	-	1	-	-	-	-	1	-	-	-	-	-	-	3	4
Hospice SN	-	1	1	-	1	-	-	-	-	-	-	-	-	-	-	-	1	2
Uncategorized Tot	98	71	27	-	43	1	247	-	53	193	76	9	9	8	42	2	88	48
Uncategorized SN	2	-	-	-	-	-	2	-	-	2	-	1	1	-	-	-	3	4

Figure 4.Timeline for Partner Engagement by Contracting Waves

Following the Mid-Point Assessment in DY2Q2, WMCHealth PPS made significant progress in increasing partner engagement during DY2Q3, as illustrated in each of the 9 project-specific graphs below. Each graph illustrates the number of partners by category the PPS committed to in contrast to what was reported at the time of the IA's Mid-Point Assessment. The PPS has created detailed project-specific plans for meeting the requisite partner engagement metrics which includes identifying prospective organizations not already contractually engaged in the respective project. The last column of these graphs illustrates the projected gap if all contracts in all waves are fully executed. In utilizing these projections, the PPS expects to meet or exceed all partner engagement requirements for all DSRIP projects with two exceptions: 1 clinic for Project 3.a.ii and 79 CBPs for Project 2.a.i. Contracting with "Tier One" Community-Based Partners (CBPs) has been a consistent challenge for the PPS as many CBPs are reluctant to sign a Master Services Agreement. The PPS intends to continue engaging CBPs through vendor contracts instead of MSAs in an effort to meet 2.a.i CBP partner engagement requirements.

Figures 5-14. Partner Engagement by Project

2ai Integrated Delivery System

	Committed	Contracted DY2Q2 (MPA)	Gap as reported DY2Q2	Contracted DY2Q3	Currently Under Contract	Current Gap	Projected with all Waves Executed	Projected Gap after all waves executed
PCP tot	578	13	565	675	693	-	933	-
PCP SN Tot	177	4	173	278	279	-	332	-
Non PCP Tot	1,784	119	1,665	2,667	2,693	-	3,874	-
Non-PCP SN Tot	332	17	315	383	383	-	502	-
Mental Health Tot	307	38	269	380	380	-	544	-
Mental Health SN	80	32	48	81	81	-	105	-
Hospital Tot	13	12	1	14	14	-	24	-
Hospital SN	11	10	1	12	12	-	20	-
SA Tot	26	22	4	23	23	3	41	-
SA SN	25	21	4	22	22	3	39	-
CM HH Tot	25	23	2	36	36	-	65	-
CM HH SN	16	18	-	19	19	-	29	-
Clinic Tot	40	27	13	36	36	4	67	-
Clinic SN	36	24	12	31	31	5	54	-
SNF Tot	36	22	14	32	32	4	57	-
SNF SN	35	21	14	31	31	4	56	-
CBP Tot	148	17	131		29	119	76	72
CBP SN	-	-	-	-	-	-	-	-
Pharm Tot	3	4	-	5	5	-	8	-
Pharm SN	-	2	-	2	2	-	3	-
Other Tot	1,094	137	957	1,626	1,676	-	2,398	-
Other SN	200	82	118	616	617	-	782	-
Hospice Tot	6	6	-	11	11	-	21	-
Hospice SN	-	4	-	5	5	-	9	-
Uncategorized Tot	-	19	-	787	778	-	1,188	-
Uncategorized SN	-	3	-	13	12	-	22	-

2aiii Health Home at Risk

	Committed	Contracted DY2Q2 (MPA)	Gap as reported DY2Q2	Contracted DY2Q3	Currently Under Contract	Current Gap	Projected with all Waves Executed	Projected Gap after all waves executed
PCP tot	497	-	497	485	507	-	746	-
PCP SN Tot	132	-	132	251	252	-	305	-
Non PCP Tot	950	-	950	1,591	1,630	-	2,805	-
Non-PCP SN Tot	243	-	243	311	311	-	430	-
Mental Health Tot	71	-	71	245	251	-	411	-
Mental Health SN	26	-	26	57	59	-	81	-
Hospital Tot	-	1	-	4	4	-	14	-
Hospital SN	-	1	-	4	4	-	12	-
SA Tot	8	1	7	9	9	-	26	-
SA SN	7	1	6	9	9	-	25	-
CM HH Tot	25	1	24	17	17	8	43	-
CM HH SN	16	1	15	12	12	4	22	-
Clinic Tot	23	4	19	12	12	11	41	-
Clinic SN	25	4	21	12	12	13	33	-
SNF Tot	-	-	-	2	2	-	27	-
SNF SN	-	-	-	1	1	-	26	-
CBP Tot	68	-	68		29	39	71	-
CBP SN	-	-	-	-	-	-	-	-
Pharm Tot	3	-	3	1	1	2	4	-
Pharm SN	-	-	-	1	1	-	2	-
Other Tot	280	4	276	1,094	966	-	1,680	-
Other SN	280	4	276	200	473	-	634	-
Hospice Tot	-	-	-	-	-	-	10	-
Hospice SN	-	-	-	-	-	-	4	-
Uncategorized Tot	-	-	-	-	386	-	796	-
Uncategorized SN	-	-	-	-	5	-	15	-

2aiv Medical Village

	Committed	Contracted DY2Q2 (MPA)	Gap as reported DY2Q2	Contracted DY2Q3	Currently Under Contract	Current Gap	Projected with all Waves Executed	Projected Gap after all waves executed
PCP tot		-	-	-	-	-	-	-
PCP SN Tot	73	-	73	186	186	-	189	-
Non PCP Tot		-	-	506	506	-	627	-
Non-PCP SN Tot	155	-	155	203	203	-	209	-
Mental Health Tot		1	-	67	67	-	69	-
Mental Health SN	3	1	2	12	12	-	14	-
Hospital Tot		3	-	3	3	-	6	-
Hospital SN	4	3	1	3	3	1	5	-
SA Tot		3	-	3	3	-	5	-
SA SN	2	3	-	3	3	-	5	-
CM HH Tot		-	-	2	2	-	2	-
CM HH SN	1	-	1	1	1	-	1	-
Clinic Tot		4	-	5	5	-	8	-
Clinic SN	6	4	2	5	5	1	7	-
SNF Tot		2	-	2	2	-	4	-
SNF SN	-	1	-	1	1	-	3	-
CBP Tot -Manual		-	-	-	1	-	1	-
CBP SN	-	-	-	-	-	-	-	-
Pharm Tot		1	-	1	1	-	1	-
Pharm SN	-	1	-	1	1	-	1	-
Other Tot		5	-	464	464	-	550	-
Other SN	216	5	211	350	350	-	358	-
Hospice Tot		-	-	-	-	-	1	-
Hospice SN	-	-	-	-	-	-	1	-
Uncategorized Tot		-	-	48	48	-	75	-
Uncategorized SN	-	-	-	2	2	-	2	-

Partner Engagement by Project

2biv Post Acute Care Transitions

	Committed	Contracted DY2Q2 (MPA)	Gap as reported DY2Q2	Contracted DY2Q3	Currently Under Contract	Current Gap	Projected with all Waves Executed	Projected Gap after all waves executed
PCP tot	497	0	497	480	502	-	742	-
PCP SN Tot	132	0	132	251	252	-	305	-
Non PCP Tot	950	0	950	1,590	1,629	-	2,810	-
Non-PCP SN Tot	243	0	243	311	311	-	430	-
Mental Health Tot	0		-	245	251	-	415	-
Mental Health SN	0		-	57	59	-	83	-
Hospital Tot	9	0	9	4	4	5	14	-
Hospital SN	7	0	7	4	4	3	12	-
SA Tot	0		-	9	9	-	27	-
SA SN	0		-	9	9	-	26	-
CM HH Tot	25	0	25	17	17	8	46	-
CM HH SN	16	0	16	12	12	4	22	-
Clinic Tot	0		-	12	12	-	43	-
Clinic SN	0		-	12	12	-	35	-
SNF Tot	0		-	2	2	-	27	-
SNF SN	0		-	1	1	-	26	-
CBP Tot -Manual	64		64		24	40	71	-
CBP SN	0		-	0	0	-	-	-
Pharm Tot	0		-	1	1	-	4	-
Pharm SN	0		-	1	1	-	2	-
Other Tot	415	0	415	910	962	-	1,684	-
Other SN	294	0	294	470	473	-	638	-
Hospice Tot	0		-	0	0	-	10	-
Hospice SN	0		-	0	0	-	4	-
Uncategorized Tot	0		-	378	386	-	796	-
Uncategorized SN	0		-	4	5	-	15	-

3ai Primary Care Behavioral Health Integration

	Committed	Contracted DY2Q2 (MPA)	Gap as reported DY2Q2	Contracted DY2Q3	Currently Under Contract	Current Gap	Projected with all Waves Executed	Projected Gap after all waves executed
PCP tot	95	-	95	480	502	-	604	-
PCP SN Tot	45	-	45	251	252	-	263	-
Non PCP Tot	95	-	95	1,590	1,629	-	2,312	-
Non-PCP SN Tot	32	-	32	311	311	-	366	-
Mental Health Tot	109	-	109	245	251	-	343	-
Mental Health SN	25	-	25	57	59	-	70	-
Hospital Tot	-		-	3	3	-	9	-
Hospital SN	-		-	3	3	-	8	-
SA Tot	10	1	9	9	9	1	21	-
SA SN	9	1	8	9	9	-	20	-
CM HH Tot	-		-	17	17	-	25	-
CM HH SN	-		-	12	12	-	15	-
Clinic Tot	20	3	17	11	11	9	33	-
Clinic SN	20	3	17	11	11	9	30	-
SNF Tot	-		-	2	2	-	5	-
SNF SN	-		-	1	1	-	4	-
CBP Tot -Manual	20		20		-	20	21	-
CBP SN	-		-		-	-	-	-
Pharm Tot	-		-	1	1	-	2	-
Pharm SN	-		-	1	1	-	2	-
Other Tot	190	3	187	909	961	-	1,321	-
Other SN	19	3	16	469	472	-	526	-
Hospice Tot	-		-	-	-	-	2	-
Hospice SN	-		-	-	-	-	1	-
Uncategorized Tot	-	-	-	378	386	-	630	-
Uncategorized SN	-	-		4	5	-	7	-

2di Patient Activation

	Committed	Contracted DY2Q2 (MPA)	Gap as reported DY2Q2	Contracted DY2Q3	Currently Under Contract	Current Gap	Projected with all Waves Executed	Projected Gap after all waves executed
PCP tot		3	-	200	200	-	204	-
PCP SN Tot	97	1	96	127	127	-	129	-
Non PCP Tot		35	-	825	825	-	846	-
Non-PCP SN Tot	85	9	76	263	263	-	265	-
Mental Health Tot		2	-	85	85	-	88	-
Mental Health SN	-	2	-	26	26	-	27	-
Hospital Tot		3	-	4	4	-	5	-
Hospital SN	6	3	3	4	4	2	7	-
SA Tot		6	-	8	8	-	11	-
SA SN	-	5	-	7	7	-	9	-
CM HH Tot		2	-	6	6	-	6	-
CM HH SN	-	2	-	6	6	-	6	-
Clinic Tot		7	-	9	9	-	10	-
Clinic SN	8	7	1	9	9	-	10	-
SNF Tot		2	-	2	2	-	2	-
SNF SN	-	1	-	1	1	-	1	-
CBP Tot -Manual		2	-	-	7	-	8	-
CBP SN	-	-	-		-	-	-	-
Pharm Tot		1	-	3	3	-	4	-
Pharm SN	-	1	-	2	2	-	3	-
Other Tot		24	-	481	481	-	486	-
Other SN	168	12	156	335	335	-	338	-
Hospice Tot			-	-	-	-	-	-
Hospice SN	-		-	-	-	-	-	-
Uncategorized Tot			-	198	198	-	274	-
Uncategorized SN	-		-	2	2	-	2	-

3ci Diabetes Management

	Committed	Contracted DY2Q2 (MPA)	Gap as reported DY2Q2	Contracted DY2Q3	Currently Under Contract	Current Gap	Projected with all Waves Executed	Projected Gap after all waves executed
PCP tot	497	-	497	485	507	-	747	-
PCP SN Tot	132	-	132	251	252	-	305	-
Non PCP Tot	760	-	760	1,591	1,630	-	2,811	-
Non-PCP SN Tot	182	-	182	311	311	-	430	-
Mental Health Tot	103	-	103	245	251	-	415	-
Mental Health SN	38	-	38	57	59	-	83	-
Hospital Tot	-	-	-	4	4	-	14	-
Hospital SN	-	-	-	4	4	-	12	-
SA Tot	10	-	10	9	9	1	27	-
SA SN	9	-	9	9	9	-	26	-
CM HH Tot	25	-	25	17	17	8	46	-
CM HH SN	16	-	16	12	12	4	22	-
Clinic Tot	10	-	10	12	12	-	43	-
Clinic SN	10	-	10	12	12	-	35	-
SNF Tot	-	-	-	2	2	-	27	-
SNF SN	-	-	-	1	1	-	26	-
CBP Tot -Manual	65	-	65	-	29	36	76	-
CBP SN	-	-	-	-	-	-	-	-
Pharm Tot	3	-	3	1	1	2	4	-
Pharm SN	-	-	-	1	1	-	2	-
Other Tot	454	1	453	914	966	-	1,688	-
Other SN	33	-	33	470	473	-	638	-
Hospice Tot	-	-	-	-	-	-	10	-
Hospice SN	-	-	-	-	-	-	4	-
Uncategorized Tot	-	-	-	378	386	-	796	-
Uncategorized SN	-	-	-	4	5	-	15	-

3diii Asthma Management

	Committed	Contracted DY2Q2 (MPA)	Gap as reported DY2Q2	Contracted DY2Q3	Currently Under Contract	Current Gap	Projected with all Waves Executed	Projected Gap after all waves executed
PCP tot	497	-	497	485	507	-	747	-
PCP SN Tot	132	-	132	251	252	-	305	-
Non PCP Tot	760	-	760	1,591	1,630	-	2,811	-
Non-PCP SN Tot	182	-	182	311	311	-	430	-
Mental Health Tot	-		-	245	251	-	415	-
Mental Health SN	-		-	57	59	-	83	-
Hospital Tot	-	1	-	4	4	-	14	-
Hospital SN	-	1	-	4	4	-	12	-
SA Tot	-	1	-	9	9	-	27	-
SA SN	-	1	-	9	9	-	26	-
CM HH Tot	25	1	24	17	17	8	46	-
CM HH SN	16	1	15	12	12	4	22	-
Clinic Tot	12	4	8	12	12	-	43	-
Clinic SN	12	4	8	12	12	-	35	-
SNF Tot	-		-	2	2	-	27	-
SNF SN	-		-	1	1	-	26	-
CBP Tot -Manual	35		35	-	29	6	76	-
CBP SN	-		-	-	-	-	-	-
Pharm Tot	3	-	3	1	1	2	4	-
Pharm SN	-		-	1	1	-	2	-
Other Tot	432	5	427	914	966	-	1,688	-
Other SN	333	4	329	470	473	-	638	-
Hospice Tot	-		-	-	-	-	10	-
Hospice SN	-		-	-	-	-	4	-
Uncategorized Tot	-		-	378	386	-	796	-
Uncategorized SN	-		-	4	5	-	15	-

3aii BH Crisis Stabilization

	Committed	Contracted DY2Q2 (MPA)	Gap as reported DY2Q2	Contracted DY2Q3	Currently Under Contract	Current Gap	Projected with all Waves Executed	Projected Gap after all waves executed
PCP tot		-	-	480	502	-	742	-
PCP SN Tot	177	-	177	251	252	-	305	-
Non PCP Tot		-	-	1,590	1,629	-	2,810	-
Non-PCP SN Tot	81	-	81	311	311	-	430	-
Mental Health Tot		-	-	245	251	-	415	-
Mental Health SN	44	-	44	57	59	-	83	-
Hospital Tot		-	-	4	3	-	13	-
Hospital SN	10	-	10	4	3	7	11	-
SA Tot		-	-	9	9	-	27	-
SA SN	25	-	25	9	9	16	26	-
CM HH Tot		-	-	18	18	-	47	-
CM HH SN	10	-	10	13	13	-	23	-
Clinic Tot		-	-	12	12	-	43	-
Clinic SN	36	-	36	12	12	24	35	1
SNF Tot		-	-	2	2	-	27	-
SNF SN	-	-	-	1	1	-	26	-
CBP Tot -Manual		-	-	-	-	-	47	-
CBP SN	-	-	-	-	-	-	-	-
Pharm Tot		-	-	1	1	-	4	-
Pharm SN	-	-	-	1	1	-	2	-
Other Tot		-	-	910	962	-	1,684	-
Other SN	285	-	285	470	472	-	637	-
Hospice Tot		-	-	-	-	-	10	-
Hospice SN	-	-	-	-	-	-	4	-
Uncategorized Tot		-	-	378	386	-	796	-
Uncategorized SN	-	-	-	4	5	-	15	-

Recommendation #5: PAOP Modification

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.

1) A detailed plan for engaging partners, consistent with Speed & Scale commitments, across all projects with specific focus on Primary Care, Mental Health and Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline of engagement.

WMCHealth PPS has a robust partner engagement plan which includes Primary Care, Mental Health, Substance Use Disorder Providers, as well as Community-Based Partners (CBPs). Each of WMCHealth PPS's contracted partners are meaningfully engaged in PPS work through a series of agreements and/or vendor contracts specific to the type(s) of projects and workstreams the organization participates in. As described in Recommendation #4, the timeline for contracting with each organization type varies by the nature of services offered by that organization in addition to their level of project participation. The result is a complex contracting strategy that recognizes the unique role of each organization in DSRIP transformation. Table 15 below illustrates which partner categories are included in each contracting wave in addition to their contract type. Further detail, including a summary of the various contract types, entailing partner roles in implementation, can be found in Figure 16 on page 11 and a full list of partners associated with each contract wave will be made available upon request.

Schedule B Contract Waves	Partner Types Included in Contracting Wave	Estimated Period for Contract Distribution
Wave 1	Hospitals, FQHC's, Multi-Specialty Medical Groups, Primary Care Physician Groups	July 2016
Wave 2	Primary Care Practices needed PCMH Assistance	March 2017
Wave 3	Mental Health	October 2016
Wave 4	Specialty DD Service Provides	February 2017
Wave 5	Care Management Agencies with 3.a.i and 2.a.i.i.i deliverables	March 2017 *(projected)*
Wave 6	Specialty DD Service Providers, Skilled Nursing Facilities and Community-Based Partners	March 2017 *(projected)*
Wave 7	Specialty DD Service Providers, Skilled Nursing Facilities and Community-Based Partners	March 2017 *(projected)*

Figure 15. Contracting Waves by Partner Type

The PPS has a detailed plan, by project, for engaging partners to meet Speed & Scale commitments. As demonstrated in the Partner Engagement figures 5-14, the PPS has made significant progress since DY2Q2 in contracting with partners including Primary Care, Mental Health, Substance Use Disorder providers and Community-Based Partners.

Currently, project implementation is facilitated through oversight and deployment of resources within the framework of 7 naturally occurring *Medical Neighborhoods Supporting Healthy Communities.* WMCHealth PPS *Medical Neighborhoods Supporting Healthy Communities* (Medical Neighborhoods) operate as "hubs" which highlight and strengthen the connections between primary care clinicians and the constellation of providers such as Primary Care, Mental Health, Substance Use Disorder providers, Hospitals, and Community-Based Partners, that support the delivery of integrated, patient-centered care.

Since September 23rd 2016, the PPS has held 9 Medical Neighborhood meetings across the region in accordance with the WMCHealth PPS Primary Care Plan. The goal of each is to convene diverse provider groups to define challenges to creating an integrated system of care while identifying solutions to support the further development of IT infrastructure, population health and performance management tools. Medical Neighborhood meetings not only operate as a forum for convening local partners such as Primary Care, Mental Health, Substance Use Disorder, and Community-Based Partners but also provide a platform for the PPS to provide technical assistance and disseminate resources for implementation requirements such as PCMH, QE connectivity, and Meaningful Use.

A key outcome of Medical Neighborhood meetings has been the collaborative creation of patient workflows unique to each Medical Neighborhood. Each workflow details the location-specific process for transitioning patients while providing vital wrap-around

supports and services. WMCHealth understands the important role Community-Based Partners play on both ends of a patient's journey from the community to the hospital to post-acute settings before placement back in community settings. In the Middletown Medical Neighborhood, community-based providers Access Supports for Living (Access) and Rehabilitation Support Services Inc. (RSS) have been intimately involved in the development of improved patient workflows that take into account the unique contribution Community-Based Partners can make in enhancing the experience of care for patients along the healthcare continuum.

Now that this foundation has been laid, the PPS seeks to expand the role of Community-Based Partners in Medical Neighborhood meetings by launching a series of meetings specific to a CBP audience, and conscientiously targeting additional CBPs for involvement in broader Medical Neighborhood activities. In doing so, the PPS intends to identify and incorporate CBP services in the patient workflow for their respective Medical Neighborhood. Plans to develop the CBP-specific Medical Neighborhood meetings are underway and the PPS expects to conclude the meeting series by September 30th, 2017.

Similarly, WMCHealth PPS plans to widen its network contracting scope and deepen existing network partner engagement through deployment of the Medical Village project across a spectrum of provider categories. WMCHealth has invested nearly $175 million, including $113 million in NYSDOH funding, into two hospitals: HealthAlliance in Kingston and Bon Secours Community Hospital in Port Jervis, to convert existing hospital space into state of the art Medical Villages. Further, Medical Villages allow the PPS to attract and diversify participation in broader DSRIP initiatives (e.g. diabetes, behavioral health, cardiology, respiratory disease etc.) by engaging partners slated to participate in the Medical Village project.

While plans for converting facilities to allow for the eventual co-location of hospital and partnering providers are underway, WMCHealth PPS is exploring deployment of a "Virtual Medical Village" strategy. The Virtual Medical Village provides an infrastructure for prospective community partners to communicate and participate in shared care management/care transition processes in order to accelerate the development of systems and operational protocols that will define the respective Medical Village campuses. WMCHealth PPS is in the process of identifying appropriate community based partners for engagement in the Kingston and Port Jervis Virtual Medical Village and expects to complete this process by September 30th, 2017.

In addition to the Medical Village and Medical Neighborhood framework, Primary Care, Mental Health, Substance Use Disorder, Community-Based Partners, and other PPS partners are engaged through Key Network Partner Meetings. Key Network Partner meetings take place with partners possessing the highest number of PPS attributed lives and related transformation agenda. Meetings allow core PPS and partner staff to meet around DSRIP projects and deliverables. A series of Key Network Partner Meetings will take place in DY3 in order to discuss partner-specific milestones and performance goals associated with DSRIP projects in addition to the education and resources the PPS will provide to support their achievement. The PPS expects the current series of Key Network partner meetings to conclude by September 30th, 2017.

2) A description of the PPS funds flow strategy for project implementation and performance incentives to partners throughout the term of the DSRIP program including projected budget percentages of total PPS budget to be provided in the funds flow template.

As detailed on Pages 6-7 within the Recommendation #4 response, partner contracting commenced by engaging all partners through a Masters Services Agreement. Subsequent Schedule B contracts are executed contingent on each partner's DSRIP project involvement. The first and broadest category of Schedule Bs to be executed was the "Threshold Schedule B" which incentivized partner participation by providing baseline compensation to organizations that completed a survey or participated in a PPS committee.

The majority of funds flowed, 53%, have been made through "Implementation Schedule B (Implementation)" contracts. Implementation contracts provide direct resources to providers to support DSRIP project implementation. Schedule B Contracting is occurring in seven waves in accordance with categories of provider organization types. These contracting waves ensure adequate alignment with DSRIP speed and scale requirements, facilitating the timely achievement of DSRIP milestones. Table 16 below illustrates each contract type and the associated amount of funds flow distributed to date.

The PPS is currently developing additional methodologies to distribute performance incentive payments in a way that maximizes the impact of the funds towards achievement of DSRIP performance goals.

PPS Total Funds Flow ($) as of December 31, 2016	TYPE OF CONTRACTS	DESCRIPTION	SUMMARY
$ 529,250	Threshold	Threshold WMC PPS Participation	DSRIP support for completion of DSRIP readiness assessment, support and guidance.
$121,390	PAM	Patient Activation Measure Survey	DSRIP support for completion of Patient Activation Measure Survey for DSRIP Project 2.d.i. (Survey results and coaching materials are shared to enhance provider management of clients/patients.)
$15,770	AEP/P4R	Actively Engaged Patient/Pay for Reporting	DSRIP support for data submissions on actively engaged patients.
$618,364	MAX	Medicaid Accelerated Exchange (MAX) Series Program/Revenue Loss	DSRIP support to qualifying Emergency Department's frequented by Super Utilizers who are engaged in the MAX Program.
$1,583,250	Implementation	Implementation Project Activities	DSRIP resource support to assist in the successful completion of DSRIP project implementation activities, milestones and deliverables.
$72,500	Committee Leadership	Committee Chairs, Co-Chairs, Co-Vice Chairs	DSRIP support for engagement in committee leadership activities critical to WMCHealth PPS's success.
$25,366	Training/ Service Agreements		
$2,965,890	**TOTAL CONTRACTED PROVIDER PAYMENTS As of December 31st 2016**		

Figure 16. Type of Contracts and Associated Funds Flow

WMCHealth PPS completed the Mid-Point Assessment Funds Flow template by evaluating payments made at the organizational level (e.g. Legal Entity w/Tax ID#). The PPS allocates payments only to "Tier 1" entities that make up the organization, which are determined by comparing and selecting the identification #'s that most closely matches the organization's name (Tier 1 definition). In most cases, the PPS was able to allocate dollars to Entity IDs that reflects Tier 1 level of an organization. However, in some cases where no Tier 1 Entity ID was available for that organization, funds were allocated to Tier 1 NPI's of an organization. Organizations with no information on Tier 1 Entity ID's and NPI's were reported in the "Additional Providers" category. In many cases, identification numbers associated with an organization span across multiple provider types. Payments may be for one project or may span several projects contingent upon what projects the organization was contracted for at the time of payment.

The PPS currently tracks Community-Based Partner engagement by identifying partners that meet criteria for one of the following three CBP definitions provided by the State: Non-profit, non- Medicaid billing community-based social and human service organizations; Non-profit, Medicaid billing, non-clinical service providers (e.g., transportation, care coordination); Non-profit, Medicaid billing, clinical and clinical support service providers licensed by DOH, OMH, OPW or OASAS. Because partners that meet this criterion typically fall into another partner category, and because the nature of services offered by some Community-Based Partners meet criteria for a CBP definition but not the CBP Tier One definition, funds allocated to Community-Based Partners may not be accurately reflected in the template provided in Figure 17 below. As of January 2017, WMCHealth PPS has given $379,137.93 funds to 97 community-based partners. These Community-Based Partners were included in the Appendix of the WMCHealth PPS PAOP presentation and can be made available upon request.

Funds flowed to partners through DY2, Q3 in addition to projected percentage distributions through DY5 can be found in Figure 17 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	$ 4,945	$ 4,965	0.2%	0.4%
Practitioner - Non-Primary Care	$ 37,665	$ 38,040	0.0%	0.0%
Hospital - Inpatient/ED	$ 976,922	$ 997,031	0.2%	0.5%
Hospital - Ambulatory	$ 976,922	$ 997,031	0.2%	0.5%
Clinic	$ 2,472,624	$ 2,806,446	1.9%	3.9%
Mental Health	$ 1,860,092	$ 1,942,283	2.3%	4.7%
Substance Abuse	$ 1,806,989	$ 1,833,342	0.3%	0.7%
Case Management	$ 140,657	$ 212,692	0.5%	1.1%
Health Home	$ 140,657	$ 212,692	0.5%	1.1%
Community Based Organization (Tier 1)	$ 84,490	$ 93,780	0.3%	0.5%
Nursing Home	$ 33,122	$ 35,747	0.1%	0.1%
Pharmacy	$ 4,899	$ 4,917	0.0%	0.0%
Hospice	$ 10,256	$ 11,194	0.0%	0.0%
Home Care		$ -	0.0%	0.0%
Other (Define)-All Other & TBD For DY3 to DY5	$ 2,654,547	$ 3,208,287	58.5%	52.8%
Other (Define)-Additional Providers	$ 482,120	$ 500,742	3.4%	6.8%
Other (Define)-Uncategorized	$ 27,457	$ 43,207	0.5%	1.0%
Other (Define) -PMO & Provider Support Vendors	$ 34,459,655	$ 41,678,793	31.0%	26.0%
Total	$ 46,174,021	$ 54,621,189.00	100.0%	100.0%

Figure 17. PPS Funds Flow through DY2, Q3 and Project Funds Flow

3) 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.

WMCHealth PPS ensures successful project implementation through the tracking and execution of DSRIP project and workstream milestones; reporting of actively engaged patients; and achievement of DSRIP performance measures. In order to adequately track project implementation efforts, a comprehensive Quarterly Project Performance Roadmap (QPPR) report was created to track and monitor partner organization's project participation.

This tool allows the organization and the PPS to monitor project performance, identify risks, and mitigate challenges as necessary. In response to partner feedback, WMCHealth PPS launched an online Partner Portal, February 22nd 2017, in order to provide easy and consistent access to each organization's contracts, required surveys, demographic information in addition to a tool to complete a condensed online version of their QPPR.

The QPPR will also be used to ensure sufficient funds flow and resources are directed towards completing strategies that address projects identified as being at risk. Further detail regarding the PPS's strategy towards remedying deficiencies noted by the IA can be found in the project-specific recommendation narratives for Projects 2.d.i and 3.a.i.

Actively engaged patients are reported by select partners who receive compensation for accurately reporting these metrics on an ongoing basis. These partners are engaged through an AEP Schedule B Contract.

Performance measures are calculated by New York State based on claims data. In addition to ongoing work with the Cross-PPS Committee to address high performance measures, The PPS has deployed several strategies to educate partners on the performance measures and how to impact them. Medical Neighborhoods, PPS Committees, and Key Network Partner meetings continue to be a forum for educating appropriate partner staff on DSRIP performance measures. The PPS has developed distinct strategies to impact performance measures for both Projects 2.d.i and 3.a.i which were identified as being "at-risk" and further detail can be found within each recommendation narrative.

WMCHealth PPS has developed the infrastructure to ensure successful project implementation. Investments in internal and external information technology systems such as the Partner Portal and Learning Management System; a robust and committed network of partner organizations; and a skilled workforce providing both subject matter and project management expertise comprise the foundation of an enterprise equipped to create and sustain healthcare system delivery transformation for DSRIP and beyond.

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Mid-Point Assessment Action Plan - Implementation Plan

Mid-Point Assessment Recommendation #1:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Recruit and train additional 2.d.i participating partner organizations as necessary to ensure that PAM © surveys are being collected in all high-priority zip codes for the target population.	***9/30/2017***
Geomap current participating PAM © partner organizations against WMCHealth PPS's 9 priority zip codes.	3/31/2017
Analyze results and identify potential new partners and/or new sites to help close gaps in coverage.	6/30/2017
Engage and train additional organizations and/or sites to better identify the targeted population for this project and conduct PAM ©surveys in identified high-priority zip codes.	9/30/2017
Mid-Point Assessment Recommendation #2:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Launch Webinar Series to instruct partner organization staff on how to help low and non-utilizing Medicaid beneficiaries to identify their health coverage information and engage with primary care services.	***3/31/2017***
Contract with appropriate vendor to develop training materials and resources for use by partner organizations to help partners to help clients/patients effectively connect with their MCO and/or PCP.	*2/14/2017*
Conduct webinar trainings for select partner organization staff.	*3/31/2017*
Place webinar training materials on PPS Learning Management System for ongoing partner access.	*3/31/2017*
2. Launch CG-CAHPS Improvement Collaborative	***9/30/2017***
Meet with pilot site FQHC and CG-CHAPS vendor to review terms of proposed contract.	*4/30/2017*
Begin sampling of uninsured patients for Measurement Year 3.	*5/30/2017*
Identify additional potential partners to participate in CG-CAHPS Improvement Collaborative.	*6/30/2017*
Convene CG-CAHPS Improvement Collaborative with FQHC participants.	*9/30/2017*
Mid-Point Assessment Recommendation #3:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Convene the Behavioral Health Project Advisory Quality Committee comprised of the Behavioral Health Primary Care (BH-PC) Integration Subcommittee and the BH Crisis Sub-Committee to review the progress on Projects 3.a.i and 3.a.i.i	***6/30/2017***
Review membership and participation in both the BH-PC Integration Subcommittee and the BH Crisis Subcommittee for inclusion of appropriate stakeholders.	*4/30/2017*
Recruit additional committee participants as indicated.	*6/30/2017*
Convene the Behavioral Health Project Advisory Quality Committee comprised of the BH-PC Integration Subcommittee and the BH Crisis Subcommittee to review the progress on Projects 3.a.i and 3.a.i.i.	*6/30/2017*
2. Complete the MY3 cross-PPS work through the Hudson Region DSRIP Clinical Council (HRDCC) to improve outcomes for actionable Behavioral Health performance measures.	***6/30/2017***
Report to the WMCHealth Quality Steering Committee the findings of the HRDCC Clinical Council advisory work group regarding clinical standards for management of patients on anti-psychotic medications.	*3/31/2017*
Reconvene cross PPS BH stakeholder group to review use to date of the PSYKES database for identification of patients whose care is not compliant with performance measures and to address concerns identified by BH providers and other partners on efforts to date to address DSRIP BH performance measures. (HRDCC has previously hosted webinars for partners on the use of the PSYKES data and made materials on use of PSYKES available via learning platform.)	*5/30/2017*
Based on feedback, revise and redistribute educational materials describing how to use PSYKES & other data sources to improve BH performance measures.	*6/30/2017*

3. Establish WMCHealth PPS Performance Measure Workgroups to address actionable Behavioral Health improvement performance measures.	***9/30/2017***
Identify existing primary care and behavioral health partners to participate as initial (pilot site) workgroup.	*3/31/2017*
Create initial strategic implementation and operational templates to evaluate site-specific workflow and projected strategy to improve high-performance measures at each pilot site(s).	*4/30/2017*
Review first round PDSA results from initial pilot site(s) and modify protocols as appropriate.	*6/30/2017*
Assess gaps in workgroup membership to ensure adequate representation from primary care, mental health, substance use disorder, and community based providers as needed for impact on the performance measures.	*6/30/2017*
Recruit additional workgroup participants as needed.	*8/30/2017*
Convene workgroup and create strategic implementation and operational templates to evaluate site-specific workflow and projected strategy to improve performance on measures in each participating organization.	*9/30/2017*
Mid-Point Assessment Recommendation #4:	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Offer Implementation Contracts to additional partners with a special focus on Primary Care, Clinics (Including IDD providers), Substance Use Disorder providers, Case Management Agencies, and other Community-Based Partners.	***6/30/2017***
Identify complete list of organizations with highest attributed patient population and provider types needed for transformation agenda.	*3/31/2017*
Offer implementation contracts to organizations as needed to meet engagement commitments for DSRIP projects with particular attention to clinics offering specialty DD services, care management agencies providing Health Home services, additional primary care sites, additional Substance Abuse services sites, and other community-based partners.	*6/30/2017*
2. Hold Key Network Partner Meetings to better engage organizations with significant role or DSRIP transformation agenda	***9/30/2017***
Develop relevant training materials/resources for partners to address challenges for achieving DSRIP milestones and performance measures.	*6/30/2017*
Hold network meetings with identified key partners to educate staff on updated DSRIP and PPS objectives; gather information on workflow and barriers to implementation.	*9/30/2017*
3. Engage additional Community Based Partners (CBPs); Engage CBPs in local PPS implementation	***9/30/2017***
Create detailed patient workflow template demonstrating CBP role in Medical Neighborhood Supporting Healthy Communities Model; identify additional CBPs in local PPS neighborhoods.	*6/30/2017*
Crosswalk PPS Network Partners with identified Port Jervis and Kingston Medical Village providers to identify opportunities to engage additional partners in the Medical Village.	*6/30/2017*
Hold Community-Based Provider-Specific Medical Neighborhoods Supporting Healthy Communities Meeting Series.	*9/30/2017*

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Mid-Point Assessment Action Plan - Partner Engagement

		Partner Engagement										
Partner Category		***Project 2.a.i.***	***Project 2.a.iii***	***Project 2.a.iv***	***Project 2.b.iv***	***Project 2.d.i***	***Project 3.a.i***	***Project 3.a.ii***	***Project 3.c.i***	***Project 3.d.iii***	***Project 4.b.i***	***Project 4.b.ii***
Practitioner - Primary Care		933	746	189	742	204	604	742	747	747	742	742
Practitioner - Non-Primary Care		3874	2805	627	2810	846	2312	2810	2811	2811	2810	2810
Hospital - Inpatient/ED		24	14	6	14	5	9	13	14	14	14	14
Hospital - Ambulatory*		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Clinic		67	41	8	43	10	33	43	43	43	43	43
Mental Health		544	411	69	415	88	343	415	415	415	415	415
Substance Abuse		41	26	5	27	11	21	27	27	27	27	27
Case Management		65	43	2	46	6	25	47	46	46	46	46
Health Home**		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Community Based Organization***		76	71	1	71	8	29	47	76	76	47	47
Nursing Home		57	27	4	27	2	2	27	27	27	27	27
Pharmacy		8	4	1	4	4	2	4	4	4	4	4
Hospice		21	10	1	10	N/A	2	10	10	10	10	10
Home Care*		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other "Uncategorized"		1188	796	75	796	274	630	796	796	796	796	796
Other		2398	1680	550	1684	486	1321	1684	1688	1688	1684	1684

All totals include all providers in waves 1-7, regardless of current contract status, except as follows:
2.a.iv - includes only the 7 contracted members within the geographic Medical Villages
2.d.i - includes only orgs with active PAM contracts
* We have not used the partner categories of Hospital Ambulatory, or Home Care
**Commitments for Health Home partners based on the combined CM/HH category
***Commitments for CBPs were made based on combined tiers

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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		$ 4,945	$ 4,965	0.2%	0.4%
Practitioner - Non-Primary Care		$ 37,665	$ 38,040	0.0%	0.0%
Hospital - Inpatient/ED		$ 976,922	$ 997,031	0.2%	0.5%
Hospital - Ambulatory		$ 976,922	$ 997,031	0.2%	0.5%
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Hospice		$ 10,256	$ 11,194	0.0%	0.0%
Home Care			$ -	0.0%	0.0%
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