Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Final Report

Mount Sinai PPS

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Prepared by the DSRIP Independent Assessor

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Mount Sinai LLC PPS -

I. Introduction

Mount Sinai LLC PPS serves three counties in the Greater New York City Area: Kings (Brooklyn), New York (Manhattan), and Queens. The Medicaid population attributed to this PPS for performance totals 364,804. The Medicaid population attributed to this PPS for valuation was 136,370. Mount Sinai was awarded a total valuation of $389,900,648 in available DSRIP Performance Funds over the five year DSRIP project.

Mount Sinai selected the following 10 projects from the DSRIP Toolkit:

Figure 1: Mount Sinai DSRIP Project Selection

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

II. 360 Survey Results: Partners' Experience with the PPS

Survey Methodology and Overall PPS Average Results

The Independent Assessor (IA) developed a 360 survey to solicit feedback from the partners of each PPS regarding engagement, communication, and effectiveness. The survey consisted of 12 questions across four PPS organizational areas: Governance, Performance Management, Information Systems, and Contracting/Funds Flow. The Independent Assessor selected a sample of PPS network partners to participate via a sample generator from the PPS Provider Import/Export Tool (PIT)[1] report. A stratified sampling methodology was used to ensure that each category of network partner was included in the surveyed population. This was done to ensure a cross-section of the partner types in the PPS network. The IA used 95% confidence interval and 5% error rate to pull each sample. For the 25 PPS the IA sent out a total of 1,010 surveys, for an average of 40 surveys per PPS partner. The response rate overall was 52%, or 523 total respondents, for an average of approximately 21 responses per PPS.

360 Survey by Partner Category for All PPS

An analysis of the average survey scores by partner category for all PPS identifies some key trends. The two most favorable survey results were from Hospitals and Nursing Homes. The least favorable survey results came from the Mental Health, Hospice, and Primary Care Providers. These results reflect (generally) a high approval rating of PPS' engagement, communication, and effectiveness by institutional providers and a low approval rating of PPS' engagement, communication, and effectiveness by non-institutional/community based providers. A more thorough review of the four PPS organizational areas demonstrated that all partners perceived Contracting/Funds Flow and Information Systems as the least favorable rankings (compared to Governance and Performance Management).

Figure 2: All PPS 360 Survey Results by Partner Type and Organizational Area

Partner Type	*Average Score*	Governance	Performance Management	IT Solutions	Funds Flow
Hospital	*3.32*	3.42	3.39	3.04	3.28
Nursing Home	*3.06*	3.15	2.93	2.93	2.79
Community Based Organization	*3.00*	3.17	3.04	2.73	2.97
Case Management / Health Home	*2.93*	2.98	2.87	2.81	2.75
Practitioner - Non-PCP	*2.93*	3.03	2.80	2.64	2.40
Clinic	*2.92*	2.96	3.03	2.75	2.66
Substance Abuse	*2.91*	3.08	2.96	2.78	2.82
Pharmacy	*2.87*	3.00	2.84	2.31	2.25
All Other	*2.84*	2.92	2.83	2.63	2.69

[1] The Provider Import/Export Tool (PIT) is used to capture the PPS reporting of partner engagement, as well as funds flow for the PPS quarterly reports. All PPS network partners are included in the PIT and are categorized based on the same logic used in assigning the partner categorization for the Speed & Scale commitments made during the DSRIP Project Plan Application process.

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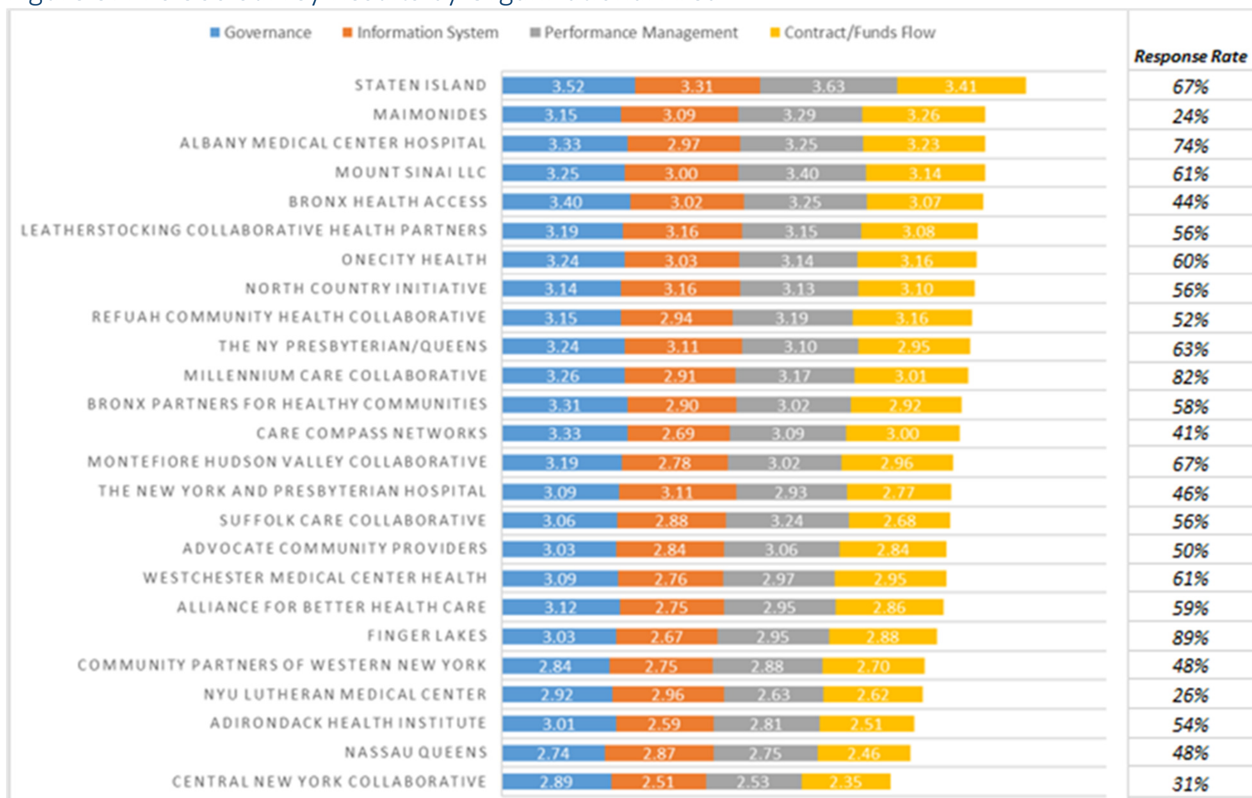
Mental Health	*2.81*		2.94	2.85	2.56	2.75
Hospice	*2.74*		2.93	2.75	2.41	2.41
Practitioner - PCP	*2.66*		2.68	2.66	2.61	2.31
Average by Organizational Area	***2.90***		**3.00**	**2.89**	**2.70**	**2.67**

Data Source: 360 Survey Results

Mount Sinai LLC 360 Survey Results[2]

The Mount Sinai 360 survey sample included 31 participating network partner organizations identified in the PIT; 19 of those sampled (61%) returned a completed survey. This response rate was fairly consistent with the average across all PPS (52% completed). The Mount Sinai aggregate 360 survey score ranked 4th out of 25 PPS (Figure 3).

Figure 3: PPS 360 Survey Results by Organizational Area



Data Source: 360 Survey Data for all 25 PPS

[2] PPS 360 Survey data and comments can be found in the "Appendix 360 Survey."

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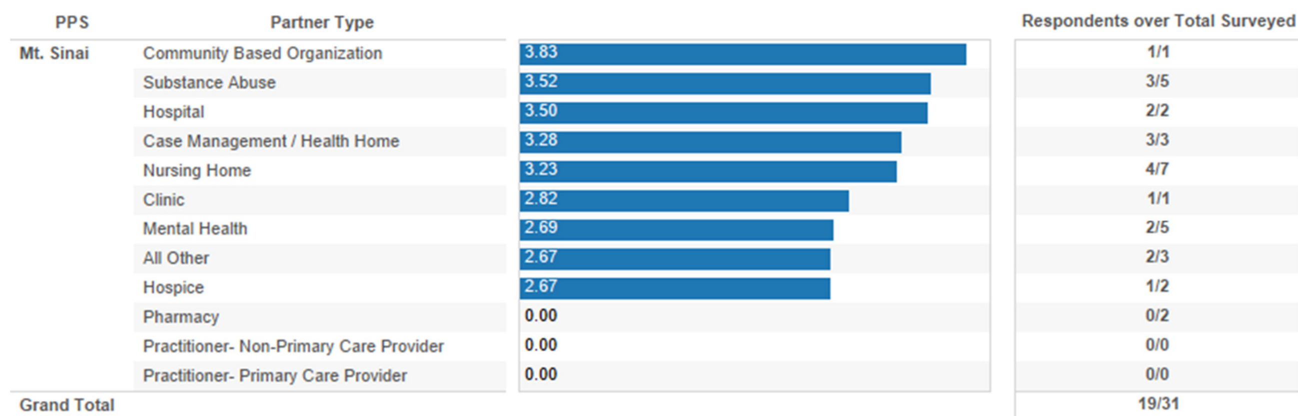
<u>Mount Sinai 360 Survey Results by Partner Type</u>

The IA analyzed the survey response by partner category to identify any trends by partner type. Figure 4 below identifies and ranks the average survey responses. The Hospice survey result was low (9th out of 12), which was consistent with all PPS' (11th out 12). Mental Health and Practitioner – Primary Care Provider categories were also low, which was consistent with peer PPS responses.

Figure 4: Mount Sinai 360 Survey Results by Partner Type[3]



PPS	Partner Type	Score	Respondents over Total Surveyed
Mt. Sinai	Community Based Organization	3.83	1/1
	Substance Abuse	3.52	3/5
	Hospital	3.50	2/2
	Case Management / Health Home	3.28	3/3
	Nursing Home	3.23	4/7
	Clinic	2.82	1/1
	Mental Health	2.69	2/5
	All Other	2.67	2/3
	Hospice	2.67	1/2
	Pharmacy	0.00	0/2
	Practitioner- Non-Primary Care Provider	0.00	0/0
	Practitioner- Primary Care Provider	0.00	0/0
Grand Total			19/31

Data Source: Mount Sinai 360 Survey Results

While the data from the 360 Survey alone does not substantiate any specific recommendations at this time, it serves as an important data element in the overall assessment of the PPS through the first five quarters of the DSRIP program.

[3] For the survey results, while the CBO category appears to have returned zero results, the IA found that CBO entities may have also been identified as part of the All Other partner category.

III. Independent Assessor Analysis

The Independent Assessor (IA) has reviewed every Quarterly Report submitted by the PPS covering DY1, Q1 through DY2, Q2[4] and awarded the Achievement Values (AVs) for the successful completion of milestones, as appropriate.

- In DY1, Q2, Mount Sinai **earned all available Organizational AVs and earned seven of a possible seven Patient Engagement Speed AVs.**
- In DY1, Q4, Mount Sinai **earned four of five available Organizational AVs and earned seven of a possible seven Patient Engagement Speed AVs.** The PPS failed the Workforce organizational AV due to a failure to report the Workforce spend as required in DY1, Q4.

In addition to the PPS Quarterly Reports the PPS were required to submit narratives for each of the projects the PPS is implementing and a narrative to highlight the PPS organizational status. These narratives were required specifically to support the Mid-Point Assessment and were intended to provide a more in-depth update on the project implementation efforts of the PPS.

Lastly, the IA conducted site visits to each of the 25 PPS during October 2016. The site visits were intended to serve a dual purpose: as an audit of activities completed during DY1, including specific reviews of Funds Flow and Patient Engagement reporting, and as an opportunity to obtain additional information to support the IA's efforts related to the Mid-Point Assessment. The IA focused on common topics across all 25 PPS including Governance, Cultural Competency and Health Literacy, Performance Reporting, Financial Sustainability, and Expanding Access to Primary Care.

The IA leveraged the data sources available to them, inclusive of all PPS Quarterly Reports, AV Scorecards, the PPS Narratives, and the On-Site Visits to conduct an in-depth assessment of PPS organizational functions, PPS progress towards implementing their DSRIP projects and the likelihood of the PPS meeting the DSRIP goals. The following sections describe the analyses completed by the IA and the observations of the IA on the specific projects that have been identified as having varying levels of risk.

A. Organizational Assessment

The first component of the IA assessment focused on the overall PPS organizational capacity to support the successful implementation of DSRIP and in meeting the DSRIP goals. As part of the quarterly reports, the PPS are required to submit documentation to substantiate the successful completion of milestones across key organizational areas such as Governance, Cultural

[4] At the time of this report, the IA was reviewing the PPS Quarterly Report submissions for DY2, Q2 and had not issued final determinations on PPS progress. However, items not subject to remediation such as engagement numbers and funds flow data were necessary to provide for the most recent and comprehensive IA analysis.

Competency and Health Literacy, Workforce, Financial Sustainability, and Funds Flow to PPS partners. Following the completion of the defined milestones in each of the key organizational areas, the PPS are expected to provide quarterly updates on any changes to the milestones already completed by the PPS. The following sections highlight the IA's assessment on the PPS efforts in establishing the organizational infrastructure to support the successful implementation of the PPS DSRIP plan.

PPS Governance

The PPS governance structure includes a PPS Board of Managers which reports to the PPS lead, Mount Sinai. Reporting to this Board are the following committees: Workforce, Finance, Clinical Quality, IT, and Compliance. A Cultural Competency and Health Literacy (CCHL) Workgroup reports to the Workforce committee. Four Cross-Functional Workgroups report to the Clinical Quality committee: Bed Complements and Utilization, Stakeholder Engagement, Patient Centered Medical Home, and Care Coordination. The PPS has established a Project Management Office (PMO) to facilitate the work of the committees and workgroups. Notably, the PPS has appointed both a Medical Director and Behavioral Health Medical Director to prominent roles within the PMO.

The PPS has also added a full-time Communications Director to enhance community and partner outreach. The PPS newsletter is distributed internally and to partners every three weeks.

PPS Administration and Project Management Office (PMO)

The IA also reviewed the PPS spending through the DY2, Q2 PPS Quarterly Reports related to administrative costs and funds distributed to the PPS PMO. It should be noted that PPS administrative spending will vary due to speed of staffing up the PMO, size of the PMO, the type of centralized services provided and the degree of infrastructure investment such as IT that it may find necessary to support the PPS partners to achieve project goals.

In reviewing the PPS spending on administrative costs, the IA found that Mount Sinai had reported spending of $5,198,160.00 on administrative costs compared to an average spend of $3,684,862.24 on administrative costs for all 25 PPS. As each PPS is operating under different budgets due to varying funding resources associated with the DSRIP valuations, the IA also looked at spending on administrative costs per attributed life[5], relying on the PPS Attribution for Performance figures[6]. The IA found that Mount Sinai spends $14.25 per attributed life on administrative costs compared to a statewide average spend of $23.93 per attributed life on administrative costs.

Looking further at the PPS fund distributions to the PPS PMO, Mount Sinai PPS distributed $11,495,401.00 to the PPS PMO out of a total of $14,641,731.18 in funds distributed across the

[5] Attribution for Performance was used as a measure of the relative size of each PPS to normalize the administrative spending across all 25 PPS.

[6] The Attribution for Performance figures were based on the data included on the individual PPS pages on the NY DSRIP website.

PPS network, accounting for 78.51% of all funds distributed through DY2, Q2. Comparatively, the statewide average for PPS PMO distributions equaled $5,966,502.64 or 42.85% of all funds distributed.

The data on the administrative costs and PMO funds flow distributions present a point of comparison across PPS, however do not alone provide enough information from which the IA can assess the organizational capacity of the PPS to support the implementation of DSRIP. It is important for the PPS to invest in the establishment and maintenance of an organizational infrastructure to support the PPS through the implementation of the DSRIP projects to ensure the PPS' success in meeting its DSRIP goals.

Community Based Organization Contracting

As part of the DY1, Q4 PPS Quarterly Report, Mount Sinai included a list of all Community Based Organizations (CBO) in its organization, and whether they had completed contracts. The IA found that the PPS has contracted with most but not all of the CBOs they have listed as participating in their project and that a large number of them will be compensated for services rendered.

As indicated in the analysis of the funds flow distributions through DY2, Q2, CBOs received 0.59% or $85,951.84 of funds distributed to date by the PPS. The PPS should identify opportunities to distribute DSRIP funds to these partners to ensure their continued engagement in the implementation efforts of the PPS.

Cultural Competency and Health Literacy

The Mount Sinai approach to Cultural Competency and Health Literacy (CCHL) was informed by their Community Needs Assessment (CNA) as well as a partner survey of 192 partners to assess the current state of CCHL awareness. The PPS has formally adopted the CLAS standards as its best practices to guide their CCHL strategy. The CCHL workgroup, which reports to the Workforce committee, was developed to formulate a strategy to improve patient care and educate clinicians as well as other segments of the workforce. Membership is geographically representative of the continuum of care within the PPS. CCHL is included in every project and each partner is required by contract to have a CCHL champion. The PPS recently held a launch event for the CCHL site champions for each partner to provide an overview of the expectations and responsibilities of this role.

The PPS developed a training strategy addressing the drivers of health disparities beyond the availability of language appropriate material. The PPS plans to leverage the Mount Sinai Health Systems learning management system and other web-based platforms to assist in training. The PPS also plans to use CBOs to provide CCHL trainings where applicable.

Financial Sustainability and Value Based Purchasing (VBP)

The PPS established a Finance Committee which reports to the Board of Managers. The Finance Committee conducted a Partner Financial Sustainability Survey to assess partner financial health and current managed care participation. The PPS will conduct an annual survey to assess partner

financial health as well as a quarterly “check-in” with financially fragile partners. The PPS plans to track the financial health of its partners using the baseline data and the annual surveys. Once partners are identified as financially fragile, the Finance Committee leads will call or meet with the partner’s CFO to review the partner’s survey responses and to determine the nature of the financial risk. Where appropriate, specific Corrective Action Plans will be developed.

As part of the initial assessment survey, the PPS included questions regarding the partner’s readiness for VBP. The PPS has begun to discuss the components necessary to model current revenue for the PPS and how the transition to VBP over the next three years will impact overall revenue, provider types, long term sustainability of centralized services, and what contracting/financial alignment models may be necessary to cover required services and infrastructure post-DSRIP.

Funds Flow

Through the DY2, Q2 PPS Quarterly Report, Mount Sinai’s funds flow reporting indicates they have distributed 67.82% ($14,641,731.18) of the DSRIP funding it has earned ($21,590,064.22) to date. In comparison to other PPS, the distribution of 67.82% of the funds earned ranks 8th among the 25 PPS compared to the statewide average of 56.20%.

Figure 5 below indicates the distribution of funds by Mount Sinai across the various Partner Categories in its network.

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Figure 5: PPS Funds Flow (through DY2, Q2) -

Total Funds Available (DY1)	$21,976,835.72		
Total Funds Earned (through DY1)	$21,590,064.22 (% of Available Funds)		
Total Funds Distributed (through DY2, Q2)	$14,641,731.18 (67.82% of Earned Funds)		
Partner Type	Funds Distributed	Mount Sinai (% of Funds Distributed)	Statewide (% of Funds Distributed)
Practitioner - Primary Care Physician (PCP)	$20,559.28	0.14%	3.89%
Practitioner - Non-Primary Care Physician (PCP)	$54.58	0.00%	0.73%
Hospital	$363,834.32	2.48%	30.41%
Clinic	$851,053.59	5.81%	7.54%
Case Management/Health Home	$136,838.86	0.93%	1.31%
Mental Health	$378,585.66	2.59%	2.43%
Substance Abuse	$103,040.71	0.70%	1.04%
Nursing Home	$15,055.72	0.10%	1.23%
Pharmacy	$85,959.69	0.59%	0.04%
Hospice	$86,491.28	0.59%	0.16%
Community Based Organizations[7]	$85,951.84	0.59%	2.30%
All Other	$959,208.33	6.55%	5.82%
Uncategorized	$37,677.03	0.26%	0.53%
Non-PIT Partners	$22,019.31	0.15%	0.58%
PMO	$11.495,401.00	78.51%	41.99%

Data Source: PPS Quarterly Reports DY1, Q2 – DY2, Q2

In further reviewing the Mount Sinai PPS funds flow distributions, it is notable that the distributions it has made are primarily directed toward its PPS PMO, which represent 78.51% of the funds being directed to these partner categories. This is higher than the statewide average of 42% for this category.

While the PPS has distributed funds across all of the partner categories, the amount of funds distributed to the PCPs, in particular, has been limited through DY2, Q2. The PPS should identify opportunities to increase its funding distributions to this key partner category to ensure their continued engagement in the implementation of the PPS' DSRIP projects.

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

Primary Care Plans

The IA reviewed the executive summaries of the Primary Care Plan submitted by DOH during the public comment period. The IA review focused on the completeness and the progress demonstrated by the PPS in the Primary Care Plan. DOH identified some weaknesses in the Mount Sinai Primary Care Plan, citing that the "plan seems overall vague and future oriented, suggesting the PPS is behind in its Primary Care activities."

B. Project Assessment

In addition to the assessment of the overall organizational capacity of the PPS, the IA assessed the PPS progress towards implementing the DSRIP projects the PPS selected through the DSRIP Project Plan Application process. In assessing the PPS progress towards project implementation, the IA relied upon common data elements across various projects, including PPS progress towards completing the project milestones associated with each project as reported in the PPS Quarterly Reports, PPS efforts in meeting patient engagement targets, and PPS efforts in engaging network partners in the completion of project milestones. Based on these elements, the IA identified potential risks in the successful implementation of DSRIP projects. For each project identified as being at risk by the IA, this section will indicate the various data elements that support the determination of the IA and that will ultimately result in the development of the recommendations of the IA for each project.

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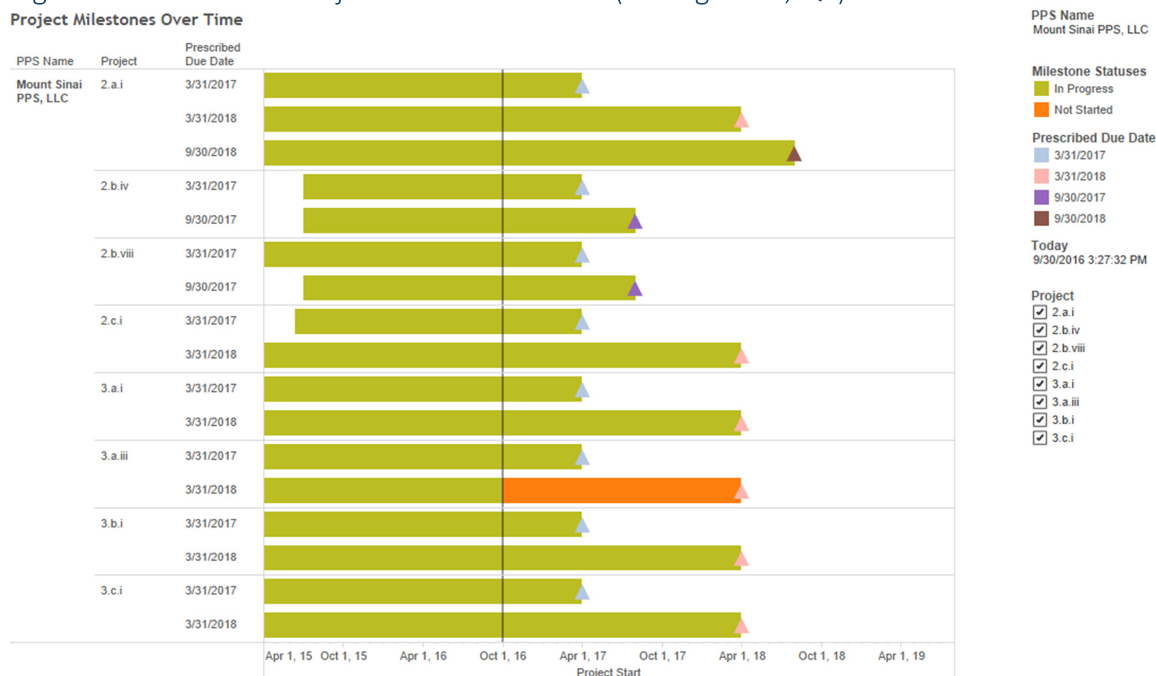
PPS Project Milestone Status

The first element that the IA evaluated was the current status of the PPS project implementation efforts as indicated through the DY2, Q2 PPS Quarterly Reports. For each of the prescribed milestones associated with each Domain 2 and Domain 3 project, the PPS must indicate a status of its efforts in completing the milestone. The status indicators range from 'Completed' to 'In Progress' to 'On Hold'. Figure 6 below illustrates Mount Sinai's current status in completing the project milestones within each project. Figure 6 also indicates where the required completion dates are for the milestones.

Figure 6: Mount Sinai Project Milestone Status (through DY2, Q2)[8]



Data Source: Mount Sinai DY2, Q2 PPS Quarterly Report

Based on the data in Figure 6 above, the IA identified one project that is at risk due to the current status of project implementation efforts: project 3.a.iii has a milestone with a required completion date of DY3, Q4 that currently shows a status of 'Not Started.' This status indicates that the PPS has not begun efforts to complete these milestones by the required completion date and as such is at risk of losing a portion of the Project Implementation Speed AV for each project.

The IA review of the Quarterly Reports reveals that the PPS has not yet started one of the four milestones for project 3.a.iii.: "Coordinate with Medicaid Managed Care Plans to improve

[8] Note that this graphic does not include Domain 4 projects as these projects do not have prescribed milestones and the PPS did not make Speed & Scale commitments related to the completion of these projects.

medication adherence." Additionally, in the Quarterly Reports, the PPS indicates that it has not started any of the tasks needed to complete this milestone.

Patient Engagement AVs

In addition to the analysis of the current project implementation status, the IA reviewed Mount Sinai's performance in meeting the Patient Engagement targets through the PPS Quarterly Reports. The PPS earned all available Patient Engagement Speed AVs for DY1. The Patient Engagement numbers reported by the PPS in DY2, Q2 appear to meet their targets but are still subject to IA review and validation. As such, the Patient Engagement reporting does not indicate a level of risk for any of the projects being implemented by Mount Sinai.

Partner Engagement

The widespread engagement of network partners throughout the PPS service area is important to the overall success of DSRIP across New York State. Engagement of partners in isolated portions of the PPS service area will not support the statewide system transformation, improvement in the quality of care, and reduction in costs that are expected as a result of this effort. It is therefore important to the success of the PPS and to the overall DSRIP program that the PPS engage network partners throughout their identified service area.

In continuing to further assess the project implementation efforts of the PPS and to identify the potential risks associated with project implementation, the IA also assessed the efforts of the PPS in engaging their network partners for project implementation relative to the Speed & Scale commitments made for partner engagement as part of the DSRIP Project Plan Application.

The IA paid particular attention to the PPS engagement of Practitioner – Primary Care Provider (PCP) and of behavioral health (Mental Health and Substance Abuse) partners given the important role these partners will play in helping the PPS to meet the quality improvement goals tied to the Pay for Performance (P4P) funding. The engagement of PCPs and behavioral health partners is especially important across Domain 3 projects where six out of ten High Performance Funding eligible measures fall.

As part of this effort, the IA reviewed all projects with a specific focus on those projects that were identified as potential risks due to Project Milestone Status and/or Patient Engagement performance. Figures 7 through 13 illustrate the level of partner engagement against the Speed & Scale commitments for all projects based on the PPS reported partner engagement efforts in the DY2, Q2 PPS Quarterly Report. The data included in the tables is specifically focused on those partner categorizations where PPS engagement is significantly behind relative the commitments made by the PPS.

The data presented in the partner engagement tables in the following pages includes the partner engagement across all defined partner types for all projects where the PPS is lagging in partner engagement. The PPS reporting of partner engagement, as well as funds flow, is done through the Provider Import Tool (PIT) of the PPS Quarterly Reports. All PPS network partners are included

in the PIT and are categorized based on the same logic used in assigning the partner categorization for the Speed & Scale commitments made during the DSRIP Project Plan Application process.

In many cases, PPS did not have to make commitments to all partner types for specific projects, as indicated by the '0' in the commitment columns in the tables, however PPS may have chosen to include partners from those partner categories to better support project implementation efforts. It is therefore possible for the PPS to show a figure for an engaged number of partners within a partner category but have a commitment of '0' for that same category.

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Figure 7: Project 2.a.i (Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	3,296	130
	Safety Net	1,954	90
Case Management / Health Home	Total	36	30
	Safety Net	20	13
Clinic	Total	37	32
	Safety Net	36	27
Community Based Organizations	Total	30	35
	Safety Net	0	1
Hospice	Total	3	6
	Safety Net	1	5
Hospital	Total	4	3
	Safety Net	7	3
Mental Health	Total	336	35
	Safety Net	166	30
Nursing Home	Total	31	27
	Safety Net	33	27
Pharmacy	Total	26	5
	Safety Net	11	4
Practitioner - Non-Primary Care Provider (PCP)	Total	5,357	5
	Safety Net	2,225	0
Practitioner - Primary Care Provider (PCP)	Total	1,381	1
	Safety Net	763	1
Substance Abuse	Total	29	25
	Safety Net	34	24
Uncategorized	Total	0	23
	Safety Net	0	6

Data Source: Mount Sinai DY2, Q2 PPS Quarterly Report

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Figure 8: Project 2.b.iv (Care transitions intervention model to reduce 30 day readmissions for chronic health conditions) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	824	93
	Safety Net	486	60
Case Management / Health Home	Total	32	19
	Safety Net	19	6
Clinic	Total	0	16
	Safety Net	0	13
Community Based Organizations	Total	10	15
	Safety Net	0	1
Hospice	Total	0	5
	Safety Net	0	4
Hospital	Total	3	3
	Safety Net	7	3
Mental Health	Total	0	15
	Safety Net	0	12
Nursing Home	Total	0	25
	Safety Net	0	25
Pharmacy	Total	0	2
	Safety Net	0	1
Practitioner - Non-Primary Care Provider (PCP)	Total	1,073	0
	Safety Net	505	0
Practitioner - Primary Care Provider (PCP)	Total	690	1
	Safety Net	381	1
Substance Abuse	Total	0	8
	Safety Net	0	7
Uncategorized	Total	0	13
	Safety Net	0	3

Data Source: Mount Sinai DY2, Q2 PPS Quarterly Report

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Figure 9: Project 2.b.viii (Hospital-Home Care Collaboration Solutions) Partner Engagement -

Partner Type		Committed Amount	Engaged Amount
All Other	Total	0	45
	Safety Net	291	36
Case Management / Health Home	Total	0	8
	Safety Net	0	3
Clinic	Total	0	12
	Safety Net	0	11
Community Based Organizations	Total	0	10
	Safety Net	0	1
Hospice	Total	0	5
	Safety Net	0	4
Hospital	Total	0	2
	Safety Net	6	2
Mental Health	Total	0	6
	Safety Net	82	6
Nursing Home	Total	0	8
	Safety Net	8	8
Pharmacy	Total	0	2
	Safety Net	5	1
Practitioner - Non-Primary Care Provider (PCP)	Total	0	0
	Safety Net	630	0
Practitioner - Primary Care Provider (PCP)	Total	0	1
	Safety Net	381	1
Substance Abuse	Total	0	4
	Safety Net	0	4
Uncategorized	Total	0	9
	Safety Net	0	3

Data Source: Mount Sinai DY2, Q2 PPS Quarterly Report

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Figure 10: Project 3.a.i (Integration of primary care and behavioral health services) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	6	69
	Safety Net	0	41
Case Management / Health Home	Total	0	18
	Safety Net	0	8
Clinic	Total	8	24
	Safety Net	9	22
Community Based Organizations	Total	10	10
	Safety Net	0	1
Hospice	Total	0	1
	Safety Net	0	1
Hospital	Total	0	2
	Safety Net	0	2
Mental Health	Total	24	25
	Safety Net	19	21
Nursing Home	Total	0	0
	Safety Net	0	0
Pharmacy	Total	0	1
	Safety Net	0	1
Practitioner - Non-Primary Care Provider (PCP)	Total	191	5
	Safety Net	140	0
Practitioner - Primary Care Provider (PCP)	Total	258	1
	Safety Net	156	1
Substance Abuse	Total	8	18
	Safety Net	9	17
Uncategorized	Total	0	9
	Safety Net	0	2

Data Source: Mount Sinai DY2, Q2 PPS Quarterly Report -

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Figure 11: Project 3.a.iii (Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	0	34
	Safety Net	138	23
Case Management / Health Home	Total	0	14
	Safety Net	0	5
Clinic	Total	0	12
	Safety Net	8	11
Community Based Organizations	Total	0	18
	Safety Net	0	1
Hospice	Total	0	2
	Safety Net	0	2
Hospital	Total	0	2
	Safety Net	6	2
Mental Health	Total	0	15
	Safety Net	13	12
Nursing Home	Total	0	00
	Safety Net	0	0
Pharmacy	Total	0	5
	Safety Net	4	4
Practitioner - Non-Primary Care Provider (PCP)	Total	0	0
	Safety Net	66	0
Practitioner - Primary Care Provider (PCP)	Total	0	1
	Safety Net	218	1
Substance Abuse	Total	0	11
	Safety Net	6	10
Uncategorized	Total	0	6
	Safety Net	0	2

Data Source: Mount Sinai DY2, Q2 PPS Quarterly Report -

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Figure 12: Project 3.b.i (Evidence-based strategies for disease management in high risk/affected populations (adult only)) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	329	44
	Safety Net	194	34
Case Management / Health Home	Total	14	10
	Safety Net	8	2
Clinic	Total	7	16
	Safety Net	6	14
Community Based Organizations	Total	3	9
	Safety Net	0	1
Hospice	Total	0	3
	Safety Net	0	3
Hospital	Total	0	2
	Safety Net	0	2
Mental Health	Total	95	10
	Safety Net	46	10
Nursing Home	Total	0	7
	Safety Net	0	7
Pharmacy	Total	9	2
	Safety Net	3	1
Practitioner - Non-Primary Care Provider (PCP)	Total	1,192	0
	Safety Net	561	0
Practitioner - Primary Care Provider (PCP)	Total	1,243	1
	Safety Net	687	1
Substance Abuse	Total	2	5
	Safety Net	2	5
Uncategorized	Total	0	7
	Safety Net	0	2

Data Source: Mount Sinai DY2, Q2 PPS Quarterly Report -

Figure 13: Project 3.c.i (Evidence-based strategies for disease management in high risk/affected populations (adults only)) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	329	60
	Safety Net	194	34
Case Management / Health Home	Total	14	12
	Safety Net	8	3
Clinic	Total	7	15
	Safety Net	6	12
Community Based Organizations	Total	33	8
	Safety Net	0	1
Hospice	Total	0	3
	Safety Net	0	3
Hospital	Total	0	2
	Safety Net	0	2
Mental Health	Total	166	10
	Safety Net	81	10
Nursing Home	Total	0	8
	Safety Net	0	8
Pharmacy	Total	14	5
	Safety Net	5	4
Practitioner - Non-Primary Care Provider (PCP)	Total	1192	0
	Safety Net	561	0
Practitioner - Primary Care Provider (PCP)	Total	1,243	1
	Safety Net	687	1
Substance Abuse	Total	8	4
	Safety Net	9	4
Uncategorized	Total	0	9
	Safety Net	0	3

Data Source: Mount Sinai DY2, Q2 PPS Quarterly Report

As the data in Figures 7 through 13 above indicate, the PPS has engaged network partners on a limited basis for each of the seven projects highlighted. Project 3.a.iii was also highlighted as the Project Milestone Status indicates that one of the required project milestones remains in a ‘Not Started’ status. The limited engagement of partners across projects presents a risk to the ability of the PPS to successfully implement the DSRIP projects and meet the DSRIP performance goals.

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The IA specifically notes the limited engagement of PCPs across the projects highlighted above. For example, in project 2.a.i, the PPS committed to engaging 1,381 PCPs; however, the Partner Engagement reporting through DY2, Q2 indicates that they have only engaged one PCP. It will be important for the PPS to demonstrate expanded Partner Engagement across all partners and PCPs in particular to ensure the success of their DSRIP projects.

PPS Narratives for Projects at Risk

For those projects that have been identified through the analysis of Project Milestone Status, Patient Engagement AVs and Partner Engagement, the IA also reviewed the PPS narratives to determine if the PPS provided any additional details that would indicate efforts by the PPS to address challenges related to project implementation efforts.

3.a.iii (Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance)

The PPS states that they have challenges standardizing and scaling the intervention and documentation of self-management goals across multiple providers.

IV. Overall Project Assessment

Figure 14 below summarizes the IA's overall assessment of the project implementation efforts of Mount Sinai based on the analyses described in the previous sections. The 'X' in a column indicates an area where the IA identified a potential risk to the PPS' successful implementation of a project.

Figure 14 Overall Project Assessment

Project	Project Description	Patient Engagement	Project Milestone Status	Partner Engagement
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management			X
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions			X
2.b.viii.	Hospital-Home Care Collaboration Solutions			X
2.c.i.	Development of community-based health navigation services			
3.a.i.	Integration of primary care and behavioral health services			X
3.a.iii.	Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance		X	X
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)			X
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only)			X

V. Project Risk Scores

Based on the analyses presented in the previous pages the IA has assigned risk scores to each of the projects chosen for implementation by the PPS. The risk scores range from a score of 1, indicating the Project is On Track, to a score of 5, indicating the Project is Off Track.

Figure 15: Project Risk Scores

Project	Project Description	Risk Score	Reasoning
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
2.b.viii.	Hospital-Home Care Collaboration Solutions	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
2.c.i.	Development of community-based health navigation services	1	This is the lowest risk score indicating the project is on track and more than likely to meet intended goals.
3.a.i.	Integration of primary care and behavioral health services	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
3.a.iii.	Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges.
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only)	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.

****Projects with a risk score of 3 or above will receive a recommendation.***

VI. IA Recommendations

The IA's review of Mount Sinai covered the PPS' organizational capacity to support the successful implementation of DSRIP and the ability of the PPS to successfully implement the projects the PPS selected through the DSRIP Project Plan Application process. Mount Sinai has achieved many of the organizational and project milestones to date in DSRIP. The PPS has made strategic decisions, such as including the Medical Director and a Behavioral Health Medical Director to prominent positions in the PPS PMO.

The IA does have some concerns regarding Mount Sinai's project implementation however. There appears to be limited Partner Engagement reported in the individual projects, notably in the area of Primary Care Practitioners. Primary Care Provider (PCP) and behavioral health (Mental Health and Substance Abuse) partners are critically important given the important role these partners will play in helping the PPS to meet the quality improvement goals tied to the Pay for Performance (P4P) funding. The engagement of PCPs and behavioral health partners is especially important across Domain 3a projects where six out of ten High Performance Funding eligible measures fall. The IA also identified that the PPS has not started its efforts in completing one of the four required project milestones for project 3.a.iii. It will be important for the PPS to address the limited Partner Engagement efforts and the delayed initiation of efforts related to project 3.a.iii.

The following recommendations have been developed based on the IA's assessment of the PPS' progress and performance towards meeting the DSRIP goals. For each recommendation, it is expected that the PPS will develop a Mid-Point Assessment Action Plan (Action Plan) by no later than March 2, 2017. The Action Plan will be subject to IA review and approval and will be part of the ongoing PPS Quarterly Reports until the Action Plan has been successfully completed.

A. Organizational Recommendations

Partner Engagement

Recommendation 1: The IA recommends that the PPS develop a strategy to increase partner engagement across all projects being implement and across all partner categories with a specific focus on increasing the engagement of Primary Care Practitioners.

Primary Care Plan

Recommendation 1: The IA recommends that the PPS develop a detailed action plan with specific dates and deliverables for the various Primary Care Plan strategies.

B. Project Recommendations

3.a.iii Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance

Recommendation 1: The IA recommends the PPS review its current plan for implementing this project and develop a plan to initiate efforts on all required project milestones.