Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Redline (following 1st Public Comment)

Montefiore Hudson Valley Collaborative

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Prepared by the DSRIP Independent Assessor

Montefiore Hudson Valley Collaborative (MHVC)

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I. Introduction

Montefiore Hudson Valley Collaborative (MHVC) Performing Provider System (PPS) serves seven counties in Southern New York: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester. The Medicaid population attributed to this PPS for performance totals 229,654. The Medicaid population attributed to this PPS for valuation was 105,752. MHVC was awarded a total valuation of $249,071,149 in available DSRIP Performance Funds over the five year DSRIP project.

MHVC selected the following 10 projects from the DSRIP Toolkit:

Figure 1: MHVC DSRIP Project Selection

Project	Project Description
2.a.i.	Create integrated delivery systems that are focused on evidence-based medicine / population health management
2.a.iii.	Health home at-risk intervention program: proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.a.iv.	Created a medical village using existing hospital infrastructure
2.b.iii.	ED care triage for at-risk populations
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral health community crisis stabilization services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (cardiovascular health)
3.d.iii.	Implementation of evidence- based medicine guidelines for asthma management
4.b.i.	Promote tobacco use cessation, especially among low socioeconomic status populations and those with poor mental health
4.b.ii.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings

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

<u>Survey Methodology and Overall PPS Average Results</u>

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 a 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.

<u>360 Survey by Partner Category for All PPS</u>

An analysis of the average survey scores by partner category for all PPS identified 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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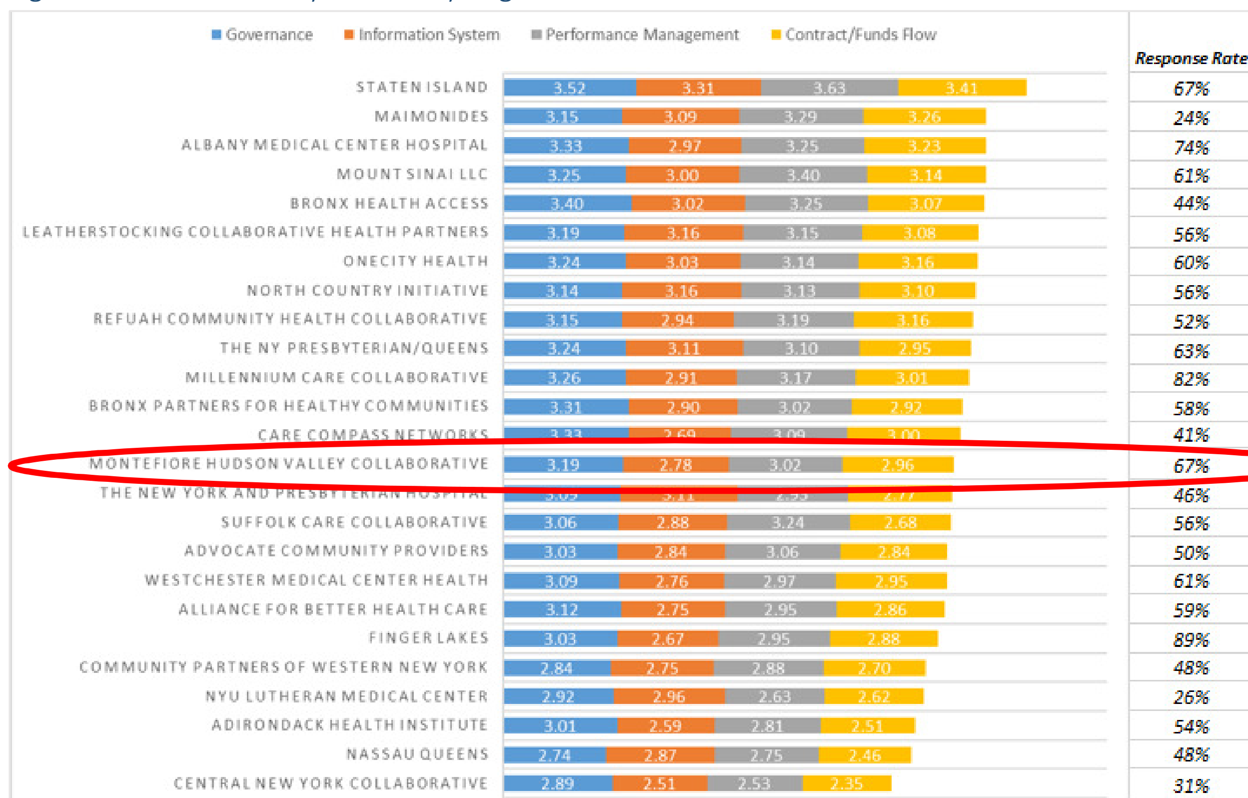
Mental Health	*2.81*		2.94	2.85	2.56	2.75
Hospice	*2.74*		2.93	2.75	2.41	2.41
Practitioner - PCP	*2.66*		2.68	2.66	2.61	2.31
Average by Organizational Area	***2.90***		**3.00**	**2.89**	**2.70**	**2.67**

Data Source: 360 Survey Results

Montefiore Hudson Valley Collaborative 360 Survey Results[2]

The MHVC 360 survey sample included 21 participating network partner organizations identified in the PIT; 14 of those sampled (67%) returned a completed survey. This response rate was fairly consistent with the average across all PPS (52% completed). The MHVC aggregate 360 survey score ranked 14th 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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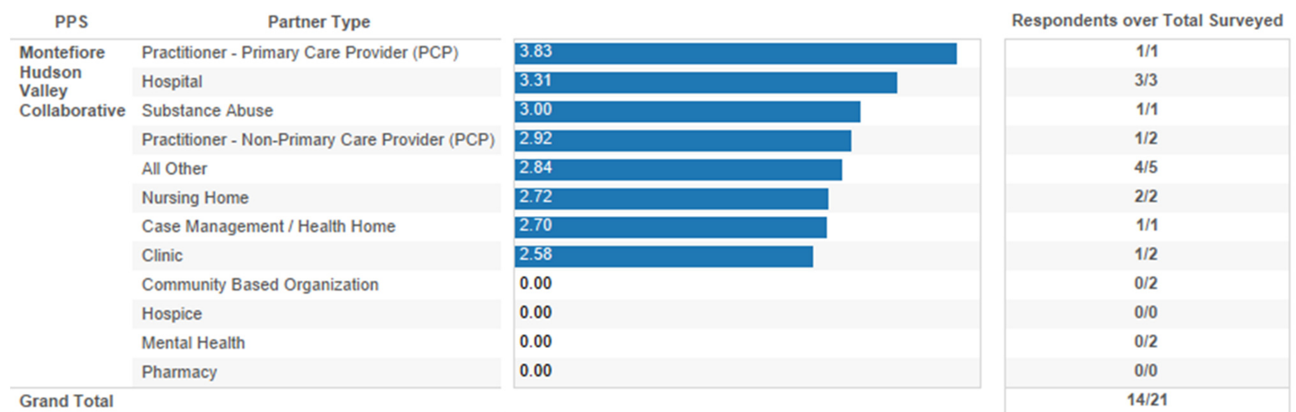
<u>MHVC PPS 360 Survey Results by Partner Type</u>

The IA then 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 Case Management/Health Home survey result was low (7th out of 12), which was unusual compared to all PPS (4th out 12). Pharmacy, Hospice, and Mental Health categories were also low, which was consistent with peer PPS responses. Primary Care Providers had the highest rank of partners, while across all PPS, PCPs were the lowest ranked partner. Most negative answers were for the Contracting / Funds Flow and the IT Solutions questions.

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



PPS	Partner Type		Respondents over Total Surveyed
Montefiore Hudson Valley Collaborative	Practitioner - Primary Care Provider (PCP)	3.83	1/1
	Hospital	3.31	3/3
	Substance Abuse	3.00	1/1
	Practitioner - Non-Primary Care Provider (PCP)	2.92	1/2
	All Other	2.84	4/5
	Nursing Home	2.72	2/2
	Case Management / Health Home	2.70	1/1
	Clinic	2.58	1/2
	Community Based Organization	0.00	0/2
	Hospice	0.00	0/0
	Mental Health	0.00	0/2
	Pharmacy	0.00	0/0
Grand Total			14/21

Data Source: MHVC 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 been also been identified as part of the All Other partner category.

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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, MHVC **earned all available Organizational AVs and earned three of a possible seven Patient Engagement Speed AVs.**
- In DY1, Q4, MHVC **earned all available Organizational AVs and earned six of a possible seven Patient Engagement Speed AVs.**

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 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

[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.

efforts in establishing the organizational infrastructure to support the successful implementation of the PPS DSRIP plan.

PPS Governance

The MHVC has over 250 partners. Its governance structure is comprised of one primary committee, the Steering Committee, which has 20 members represented by PPS partners and provides general governance oversight. Multiple sub-committees also provide oversight and project responsibilities specific to: Finance and Sustainability, Legal and Compliance, Clinical Quality, Workforce, and Information Technology. Each sub-committee is comprised of 10-12 partner representatives and includes two (2) partner co-chairs.

Committee and subcommittees have regular meetings bimonthly, monthly, or quarterly, in accordance with committee and sub-committee charters. Ad hoc meetings are held out of necessity to address urgent concerns and meet targets; they also serve as platforms for open discussion, idea exchange and partner support systems.

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 MHVC had reported spending of $1,242,111.00 on administrative costs compared to an average spend of $~~3,758,965.56~~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 MHVC spent $5.41 per attributed life on administrative costs compared to a statewide average spend of $~~24.23~~23.93 per attributed life on administrative costs.

Looking further at the PPS fund distributions to the PPS PMO, MHVC distributed $8,046,108.00 to the PPS PMO out of a total of $15,958,360.00 in funds distributed across the PPS network, accounting for 50.42% 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.

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[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

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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, MHVC included a list of all Community Based Organizations (CBOs) in its network, and whether they had completed contracts. The IA found that the PPS has contracted with the CBOs as reported.

In further assessing the engagement of CBOs by MHVC, the IA found that the PPS had distributed $8,650.25 or 0.05% of the funds distributed to its CBO partners through DY2, Q2. It will be important for the PPS to expand its fund distributions across all of its CBO partners to maintain engagement of these key partners.

Cultural Competency and Health Literacy

The MHVC approach to Cultural Competency and Health Literacy (CCHL) was informed by their Community Needs Assessment (CNA), a review of hot spots, an assessment of the existing resources and ongoing activities in the PPS, as well as the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards). In addition, the PPS conducted focus groups and in-depth interview with clients and community-based providers, and attended community forums. The PPS formed a CCHL Workgroup in December 2015. This workgroup is an extension of the workforce subcommittee and serves to guide the implementation of the CCHL strategy, develop and guide a CCHL training strategy, provide support and information to the partner organizations, and ensure that CCHL is present and integrated throughout the work of MHVC. This workgroup meets monthly at rotating locations throughout the region with activities divided into three categories: data collection, organization, and community engagement.

Their approach to community outreach includes:

- Linking to faith-based organizations
- Engaging in two-way communication
- Emphasizing prevention services
- Working with priority groups such as
  - Individuals with limited English proficiency
  - Individuals needing mental health services which includes mobile crisis and peer supports
  - Chronic disease sufferers in the self-management of their illness

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The CCHL workgroup developed a training strategy for the PPS. Training is focused on health literacy, cultural competency, and language assistance services *in Context.* Training integrates key principles of CCHL throughout general and prioritized projects and community forums. The CCHL strategy also includes the "universal precautions approach" to health literacy that builds opportunities to strengthen the foundation for the provision of equitable health care, recognizes the importance of participant / client / member safety, and drives outcomes and cost efficiency. The workgroup has identified targeted partner employees and network staff that would need training. They have provided a centralized training approach due to the need to integrate various key functions and provide ongoing support to its partners.

MHVC has been working to engage CBOs in addition to its community collaboration with the Westchester and Refuah PPS. The collaborative and extensive outreach will enable the PPS to broaden its ability to provide appropriate health literacy materials, health education programs and services to improve access to care. Through a train-the-trainer approach, integrated workforce trainings, and various other training channels across the network, MHVC has demonstrated the ability to effectively execute its CCHL strategy.

Financial Sustainability and Value Based Purchasing (VBP)

MHVC distributed its first round of financial sustainability surveys to PPS network partners in DY1 to establish a baseline for monitoring the financial status of partner organizations. The PPS completed an extensive partner survey and financial analysis process using internal and external counsel, as well as a consulting firm to compile, evaluate and report on the data.

If a partner is deemed to be financially fragile, the partner will be asked to provide supplemental information that provides further detail into the financial sustainability of the partner. After reviewing supplemental financial documents, the Financial Sustainability Subcommittee will determine which partners should retain their At Risk status. For partners with this designation a distressed provider plan may be required to be completed and reviewed, in conjunction with the financially distressed partner, with the Financial Sustainability Subcommittee, to determine alternative actions to ensure the DSRIP project integrity.

MHVC has plans to continue monitoring at risk partners with bi-annual surveys.

MVHC has been on the forefront of VBP arrangements for more than two decades and has been recognized as a national leader in the drive for value over volume. They intend to leverage their extensive knowledge base of their Care Management Organization and their strong MCO relationships to lay groundwork for a VBP future for Westchester and the Hudson Valley.

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Funds Flow

Through DY2, Q2, MHVC distributed 82.61% ($15,958,360.00) of funds it had earned ($19,316,833.14) through the end of DY1, Q4, compared to an average of 42.50% for all 25 PPS. In comparison to other PPS, the distribution of 82.61% of the funds earned ranks 6th and places MHVC well above the statewide average of 56.20%.

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

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

Total Funds Available (DY1)	$19,492,399.00		
Total Funds Earned (through DY1)	$19,316,833.14 (% of Available Funds)		
Total Funds Distributed (through DY2, Q2)	$15,958,360.00 (82.61% of Earned Funds)		
Partner Type	**Funds Distributed**	**Montefiore (% of Funds Distributed)**	**Statewide (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$999,683.27	6.26%	3.89%
Practitioner - Non-Primary Care Physician (PCP)	$165,628.83	1.04%	0.73%
Hospital	$1,677,997.80	10.51%	30.41%
Clinic	$1,895,323.52	11.88%	7.54%
Case Management/Health Home	$339,816.68	2.13%	1.31%
Mental Health	$1,400,895.13	8.78%	2.43%
Substance Abuse	$1,013,922.25	6.35%	1.04%
Nursing Home	$32,962.65	0.21%	1.23%
Pharmacy	$6,532.00	0.04%	0.04%
Hospice	$258.38	0.00%	0.16%
Community Based Organizations[7]	$8,650.25	0.05%	2.30%
All Other	$370,581.24	2.32%	5.82%
Uncategorized	$0.00	0.00%	0.53%
Non-PIT Partners	$0.00	0.00%	0.58%
PMO	$8,046,108.00	50.42%	41.99%

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

In further reviewing the MHVC funds flow distributions, it is notable that the distributions are heavily directed towards the PPS PMO, with 50.42% of the funds being directed there. MHVC has

[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

flowed significant funds to the Clinic, Mental Health, Substance Abuse, and PCP provider categories compared to the average PPS. It will be important for MHVC to continue distributing funds across all network partners to ensure their continued engagement in the implementation of DSRIP projects.

Primary Care Plans

The IA reviewed the executive summaries of the Primary Care Plans 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 Plans. The IA agrees with the assessment that Montefiore produced an "extensive and thorough PC Plan." The IA also agrees that the PPS has a strong commitment to the PCMH model, and a sound plan for IDS and behavioral health integration. PCPs are involved in the PPS' governance and other committees.

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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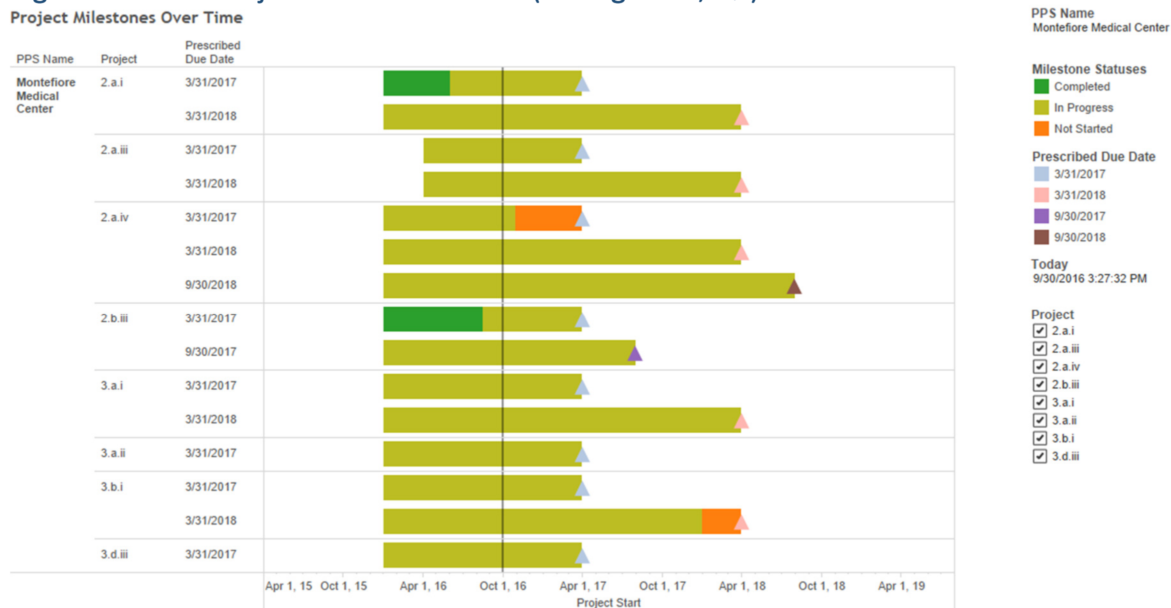
PPS Project Milestone Status

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 MHVC'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: MHVC Project Milestone Status (through DY2, Q2)[8]



Data Source: MHVC DY2, Q2 PPS Quarterly Report

Based on the data in figure 6 above, the IA did not identify projects at risk. All project milestones have either been completed or are in progress. This indicates that the PPS has been successful with milestone completion efforts to date and as such, earned Project Implementation Speed AVs for each project.

[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.

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Patient Engagement AVs

In addition to the analysis of the current project implementation status, the IA reviewed MHVC's performance in meeting the Patient Engagement targets through the PPS' Quarterly Reports. The IA identified four projects where the PPS had missed the Patient Engagement targets in at least one PPS Quarterly Report. This is detailed in figures 7 through 10 below:

Figure 7: 2.a.iii (Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	5,044	468	9.28%
DY1, Q4	8,125	1,003	12.34%
DY2, Q2[9]	16,141	~~137~~107	~~0.85%~~0.66%

Data Source: MHVC PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

Figure 8: 2.b.iii. (ED care triage for at-risk populations) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	252	152	60.32%
DY1, Q4	505	478	94.65%
DY2, Q2[10]	1,262	~~1,958~~967	~~155.15~~76.62%%

Data Source: MHVC PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

Figure 9: 3.a.ii (Integration of primary care and behavioral health services) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	1,895	654	34.51%
DY1, Q4	2,167	3,064	141.39%
DY2, Q2[11]	3,791	~~3,818~~3,692	~~100.71%~~97.39%

Data Source: MHVC PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

Figure 10: 3.d.iii (Implementation of evidence-based medicine guidelines for asthma management) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	1,401	40	2.86%
DY1, Q4	2,002	2,223	111.04%
DY2, Q2[12]	4,003	~~3,537~~3,424	~~88.36%~~85.54%

Data Source: MHVC PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

~~[9] The DY2, Q2 Patient Engagement figures reflect 'As Submitted' data by the PPS and have not been validated by the IA at the time of this report.~~

~~[10] The DY2, Q2 Patient Engagement figures reflect 'As Submitted' data by the PPS and have not been validated by the IA at the time of this report.~~

~~[11] The DY2, Q2 Patient Engagement figures reflect 'As Submitted' data by the PPS and have not been validated by the IA at the time of this report.~~

~~[12] The DY2, Q2 Patient Engagement figures reflect 'As Submitted' data by the PPS and have not been validated by the IA at the time of this report.~~

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All projects have met Patient Engagement targets by DY1, Q4 except project 2.a.iii, where the PPS has missed the Patient Engagement targets through DY2, Q2. The missed Patient Engagement targets for these projects do not alone place these projects at risk, however, it is an important data element in assessing the overall potential for the successful implementation of these projects.

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 3a 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. 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.

Through this review, the IA did not identify any limited partner engagement efforts relative to the commitments made by the PPS during the DSRIP Project Plan Application. The IA will continue to monitor the engagement of network partners as the PPS completes its project implementation efforts.

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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 for additional details provided by the PPS that would indicate efforts to address challenges related to project implementation.

2.a.iii. (Health home at-risk intervention program: proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services): The PPS identified a number of challenges it has experienced in implementing this project. Among these challenges are:

- Financial sustainability modeling-partners have raise short and long term concerns about future funding for the care management services required for these patients.
- Actively engaged reporting-overly ambitious patient engagement targets would strain central resources necessary to provide quality care management services.
- Delays in claims data-has hindered the ability to stratify the population and identify targeted patients for this project. This has also impeded the ability to track and monitor performance and measure the impact of service.
- IT Challenges-lack of standardized care planning and partner integration has created an obstacle in appropriately documenting and sharing relevant patient information.
- Cost of Health Information Exchange connections-high Exchange costs with the number of patients and providers to be engaged has been prohibitive.
- Partner engagement-many providers may not be able to meet Patient Centered Medical Home requirements in the early years, if at all. Managed Care Organizations and Health Homes may be too overwhelmed, uninterested or too understaffed to become engaged.

IV. Overall Project Assessment

Figure 19 below summarizes the IA's overall assessment of the project implementation efforts of MHVC based on the analyses described in 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 19: 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			
2.a.iii.	Health home at-risk intervention program: proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.	X		
2.a.iv.	Created a medical village using existing hospital infrastructure			
2.b.iii.	ED care triage for at-risk populations			
3.a.i.	Integration of primary care and behavioral health services			
3.a.ii.	Behavioral health community crisis stabilization services			
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (cardiovascular health)			
3.d.iii.	Implementation of evidence-based medicine guidelines for asthma management			

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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 20: 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	1	This the lowest risk score indicating the project is more than likely to meet intended goals
2.a.iii.	Health home at-risk intervention program: proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.	2	This is a low risk score indicating the project is more than likely to meet intended goals.
2.a.iv.	Created a medical village using existing hospital infrastructure	1	This the lowest risk score indicating the project is more than likely to meet intended goals
2.b.iii.	ED care triage for at-risk populations	1	This the lowest risk score indicating the project is more than likely to meet intended goals
3.a.i.	Integration of primary care and behavioral health services	1	This the lowest risk score indicating the project is more than likely to meet intended goals
3.a.ii.	Behavioral health community crisis stabilization services	1	This the lowest risk score indicating the project is more than likely to meet intended goals
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (cardiovascular health)	1	This the lowest risk score indicating the project is more than likely to meet intended goals
3.d.iii.	Implementation of evidence- based medicine guidelines for asthma management	1	This the lowest risk score indicating the project is more than likely to meet intended goals

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

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VI. IA Recommendations

The IA's review of the Montefiore Hudson Valley Collaborative PPS 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. MHVC has achieved many of the organizational and project milestones to date in DSRIP. The PPS has made positive strides to develop the infrastructure to run a successful PPS in their region. For example, the 360 survey revealed that the Hospital, PCPs, and Practitioner non-PCPs all had positive experience with the PPS. Furthermore, the PPS has achieved all Organizational and Project milestones to date. It appears that the PPS is engaging partners and implementing projects successfully.

There are a few areas of improvement that the PPS could focus on. First, the CBO funds flow was limited compared to peer PPS. Although community partners make up a fair percentage of the PPS network of partners, the funds flow chart, figure 5, shows that CBOs have received only 0.05% of funds flown through DY2Q2. MHVC has expressed plans to increase engagement and funds flow activity in upcoming quarters as the PPS continues to engage its CBO network and collaborate with partners in developing a funds flow methodology that supports and demonstrates success.

One other area of focus is project 2.a.iii. The PPS identified some issues implementing the project in the PPS narrative submitted. Of note is the difficulty recruiting and engaging the Case Managers/Health Homes for the project. MHVC should continue to monitor the project against the existing plans.

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

The IA does not have any organizational recommendations for the PPS at this time.

B. Project Recommendations

Although there are some concerns to be address in project 2.a.iii discussed above, the PPS has outlined strategic plans to address those concerns. The IA will continue to monitor and further assess the PPS' progress through upcoming quarters.