NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Redline (following 1st Public Comment)

The New York and Presbyterian Hospital

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Prepared by the DSRIP Independent Assessor

The New York and Presbyterian Hospital

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I. Introduction

The New York and Presbyterian Hospital (NYP) PPS serves New York (Manhattan) county. The Medicaid population attributed to this PPS for performance totals 88,886. The Medicaid population attributed to this PPS for valuation was 47,293. NYP was awarded a total valuation of $97,712,825 in available DSRIP Performance Funds over the 5 year DSRIP project.

NYP selected the following 10 projects from the DSRIP Toolkit:

Figure 1: The New York and Presbyterian Hospital 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.i.	Ambulatory intensive care units (ICUs)
2.b.iii.	ED care triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30-day readmissions for chronic health conditions
3.a.i.	Integration of primary care and behavioral health services
3.a.ii.	Behavioral health community crisis stabilization services
3.e.i.	Comprehensive strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of excellence for management of HIV/AIDS
3.g.i.	Integration of palliative care into the patient centered medical home (PCMH) Model
4.b.i.	Promote tobacco use cessation, especially among low socioeconomic status (SES) populations and those with poor mental health
4.c.i.	Decrease HIV morbidity

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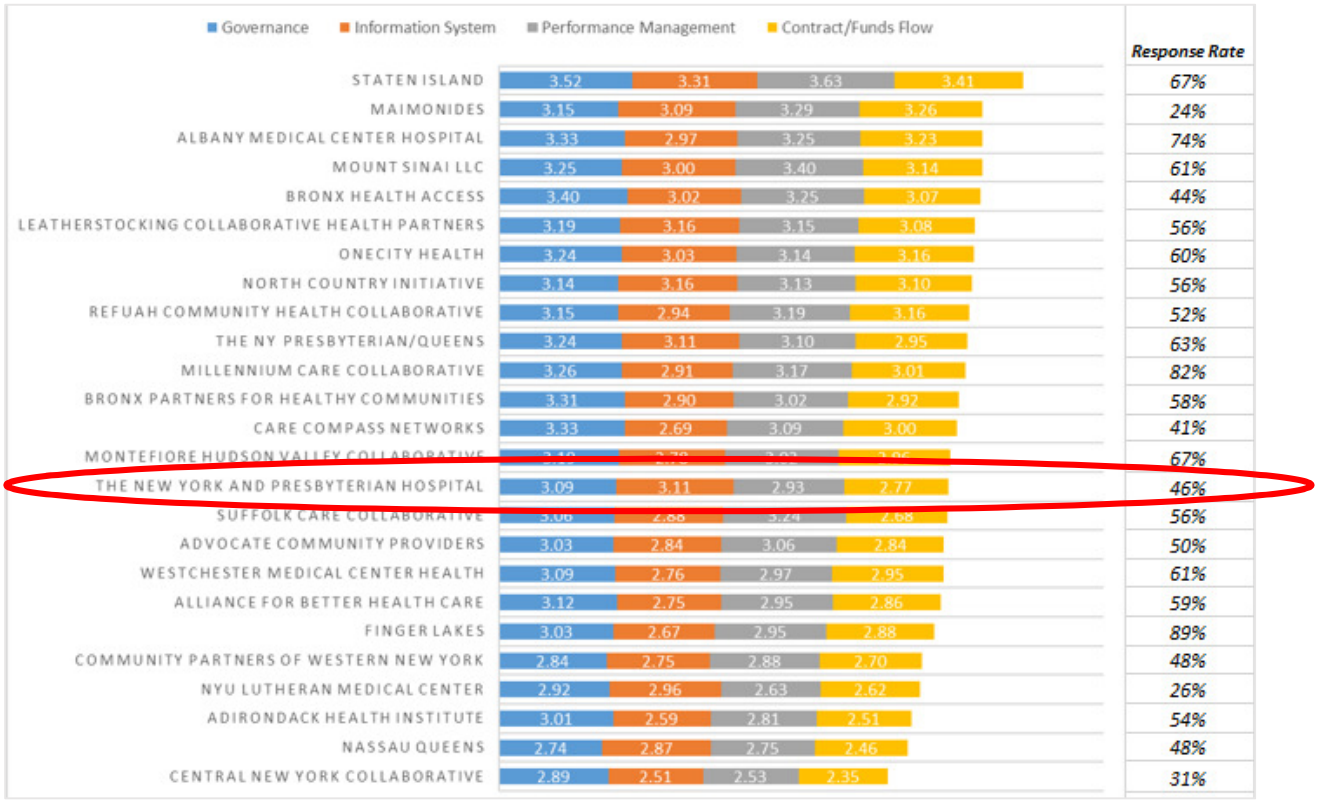
Mental Health	*2.81*		2.94	2.85	2.56	2.75
Hospice	*2.74*		2.93	2.75	2.41	2.41
Practitioner - PCP	*2.66*		2.68	2.66	2.61	2.31
Average by Organizational Area	***2.90***		**3.00**	**2.89**	**2.70**	**2.67**

Data Source: 360 Survey Results

<u>The New York and Presbyterian Hospital 360 Survey Results</u>[2]

The NYP 360 survey sample included 35 participating network partner organizations identified in the PIT; 16 of those sampled (46%) returned a completed survey. This response rate was fairly consistent with the average across all PPS (52% completed). The NYP Hospital aggregate 360 survey score ranked 15th 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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NYP Survey Results by Partner Type

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 Mental Health survey result was high (5th out of 12), which was unusual compared to all PPS' (10th out of 12). The Case Management / Health Home category was also high, which was consistent with peer PPS responses. Most negative answers were for the Contract / Funds Flow and the Performance Management questions.

Figure 4: The New York and Presbyterian Hospital 360 Survey Results by Partner Type[3]

PPS	Partner Type		Respondents over Total Surveyed
The New York and Presbyterian Hospital	Case Management / Health Home	3.67	1/2
	Practitioner - Non-Primary Care Provider (PCP)	3.50	1/2
	Hospital	3.20	1/2
	Mental Health	3.17	1/3
	Nursing Home	3.17	1/2
	Practitioner - Primary Care Provider (PCP)	3.04	7/15
	Pharmacy	2.83	1/2
	Hospice	2.70	1/1
	Substance Abuse	2.33	1/2
	Clinic	1.42	1/2
	All Other	0.00	0/1
	Community Based Organization	0.00	0/1
Grand Total			16/35

Data Source: The New York and Presbyterian Hospital 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 and may guide the PPS in its efforts to engage its partners.

[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, NYP **earned all available Organizational AVs and all Patient Engagement Speed AVs.**
- In DY1, Q4, NYP **earned all available Organizational AVs and five out of 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 PPS Governance structure includes five oversight committees and several ~~sub-committees~~workgroups responsible for monitoring ongoing DSRIP activities and the effectiveness of its governance. The primary committees are: Executive, Finance, Clinical Operations, IT/Data Governance, and Project Advisory (PAC~~),~~). The Executive, Finance, Clincal Operations, and IT/Data Governance Committees are each co-led by representatives of NYP and a representative "collaborator", a term that this PPS uses in reference to its contracted partners that are active with DSRIP projects. The PAC is chaired by the Vice President, Government & Community Relations at NYP.

The PAC is comprised of 57 members, almost half of which are invited non-PPS community representatives. Other members of the PAC are representatives from the PPS' partner network. The Finance, IT/Data Governance, and Clinical Operations Committees are each comprised of 10-11 network partner members, including two chairpersons. The Executive Committee is comprised of NYP staff who serve as the Co-chairs of the other NYP PPS Governance Committees as well as representatives from collaborator organizations. The workgroups are less rigid with regards to membership and are populated based on interest/expertise from collaborator organizations and NYP PPS staff who work in the associated programmatic areas. ~~NYP's committees and sub-committees, such as the Executive Committee, Finance, IT/Data Governance, Project Advisory and the Clinical Quality Committee, which has oversight for quality monitoring, all have 10 to 11 network partner members and two to three chairpersons. All committees~~ The Executive, Clinical Operations, IT/Data Governance, and Finance Committees follow a random-selection process with 12 ~~to 18~~ month term limits (with the exception of the initial term, which was extended to 18 months). Regular committee meetings are held bimonthly, monthly, or quarterly, in accordance with the committees' charters. Committee meetings to date have focused on providing project updates with an opportunity for feedback and guidance from Committee members as well as completion of organizational milestones and strategies. ~~These committees serve as platforms for theme based meetings as well as open discussion for questions, concerns, and idea exchange.~~

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 NYP had reported spending of $1,691,150.00 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 NYP spends $19.03 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, NYP distributed $543,638.81 to the PPS PMO out of a total of $7,149,016.33 in funds distributed across the PPS network, accounting for 7.60% 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, NYP included a list of all Community Based Organizations (CBOs) in its organization, and whether they had completed contracts. The IA found that the PPS has contracted with the CBOs necessary to meet project requirements. As projects progress, the PPS will follow its protocols to determine next steps and contract additional CBOs, if needed.

In further assessing the engagement of CBOs by NYP, the IA found that the PPS had distributed $27,026.46 or 0.38% 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

NYP PPS has adopted a patient-centered approach to cultural competency, known as the "Culture of One," which is aligned with the National Quality Forum's (NQF) Cultural Competency framework. NYP submitted its CCHL Training Strategy with its DY2, Q1 Quarterly Report. The PPS aims to provide training specific to cultural competency and health literacy for the PPS partners and staff. The training aims to educate the workforce on what cultural competency and health literacy are and why they are important concepts for all patient interactions, not just for clinical providers. The trainings will help work towards the goal of having cultural competency and health literacy embedded into the foundation of the care provided at each of the PPS partner sites.

[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.

NYP PPS has endorsed the use of Community Health Workers (CHWs) from the community to provide outreach within various facilities. The PPS also has in use, general health education materials that meet CLAS standards. NYP PPS continues efforts to develop further materials geared towards cultural competency and health literacy to meet the needs of patients under its DSRIP projects.

During the IA on-site review it was revealed that many aspects of the CCHL plan have not yet been implemented. NYP PPS has an eLearning and resource portal for cultural competency training. This portal, *Quality Interactions*-anticipated to go live in November 2016, will enable participants to register and track participation in learning modules, as well as track their progress by use of surveys and assessment tools. At the time of review, it was unclear whether NYP PPS will use information obtained from the portal in establishing best practices, and how the PPS will monitor outcomes and determine specific cultural competency needs of its partners.

Financial Sustainability and Value Based Purchasing (VBP)

The Financial Governance Committee assists the Executive Governance Body in the oversight of several areas related to finance including reporting, compliance, distribution of funds and oversight of financial performance. NYP created a survey to identify financially fragile partners. The PPS performed a baseline assessment of its partners' financial health in DY1, from which it identified one potentially fragile subsidiary partner from 60 responses out of 80 surveys that were sent.

In DY1, Q3 the PPS submitted a Financial Sustainability Strategy which articulates that organizations that are deemed financially fragile will be monitored more closely and more frequently by the NYP PPS PMO and the Finance Committee Co-Chairs. The organization may be asked to increase reporting, as appropriate. The PPS will work with the organization to develop reporting mechanisms that are not administratively burdensome, including, but not limited to, review of balance sheets and Profit and Loss Statements. Network members who are deemed financially fragile will receive advice and counsel from the NYP PPS Finance Committee Co-Chairs.

It will be important for NYP to continue assessing the financial health of its network partners throughout the life of DSRIP. This will be of particular importance as DSRIP funding shifts from pay for reporting (P4R) to pay for performance (P4P) and as partner reimbursement shifts towards Value Based Purchasing (VBP).

The PPS indicated that it is still in the early stages of implementing a VBP strategy. The PPS has completed a VBP baseline survey of its partners and is currently focused on disseminating information made available by DOH and encouraging participation in DOH-sponsored educational events such as the VBP Bootcamps. NYP intends to collaborate with many partners in implementing its VBP strategy, including DOH, trade associations, and other PPS resources. NYP indicates that its PPS PMO is closely collaborating with the New York and Presbyterian/Queens PPS on the VBP strategy. An increased focus is on developing and

implementing a VBP strategy that will move the PPS and its partners towards the established VBP goals.

Funds Flow

Through the DY2, Q2 PPS Quarterly Report, NYP's funds flow reporting indicates that it has distributed 92.83% ($7,149,016.40) of the DSRIP funding it has earned ($7,701,266.40) to date. In comparison to other PPS, the distribution of 92.83% of the funds earned ranks 3rd and places NYP above the statewide average of 56.20%.

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

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

Total Funds Available (DY1)	$7,720,654.69		
Total Funds Earned (through DY1)	$7,701,266.43 (99.75% of Available Funds)		
Total Funds Distributed (through DY2, Q2)	$7,149,016.33 (92.83% of Earned Funds)		
Partner Type	**Funds Distributed**	**NY Presbyterian (% of Funds Distributed)**	**Statewide (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%	3.9%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%	0.7%
Hospital	$6,389,654.39	89.38%	30.4%
Clinic	$146,030.00	2.04%	7.5%
Case Management/Health Home	$0.00	0.00%	1.3%
Mental Health	$0.00	0.00%	2.4%
Substance Abuse	$0.00	0.00%	1.0%
Nursing Home	$0.00	0.00%	1.2%
Pharmacy	$0.00	0.00%	0.0%
Hospice	$0.00	0.00%	0.2%
Community Based Organizations[7]	$27,026.46	0.38%	2.3%
All Other	$0.00	0.00%	5.8%
Uncategorized	$42,666.67	0.60%	0.5%
Non-PIT Partners	$0.00	0.00%	0.6%
PMO	$543,638.81	7.60%	42.0%

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

In further reviewing NYP's funds flow distributions, it is notable that the distributions are heavily directed towards the Hospital and PMO categories, with 96.98 % of the funds being directed to those two categories. The lack of funding distributions to many of the partner types, in particular the PCP and Behavioral Health (Mental Health and Substance Abuse) partners is something the PPS must address going forward. It will be important for the PPS to demonstrate efforts to distribute funding to a larger portion of the PPS network to encourage and maintain the participation of its partners outside of the hospital network.

[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 Plan

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 Plan. The IA agrees with the assessment that the largest portion of the Primary Care network is within the NYP institutional framework and that the leadership committees for the PPS have strong representation by Primary Care practitioners.

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.

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 NYP's current status in completing the project milestones within each project. Figure 6 also indicates where the required completion dates are for the milestones.

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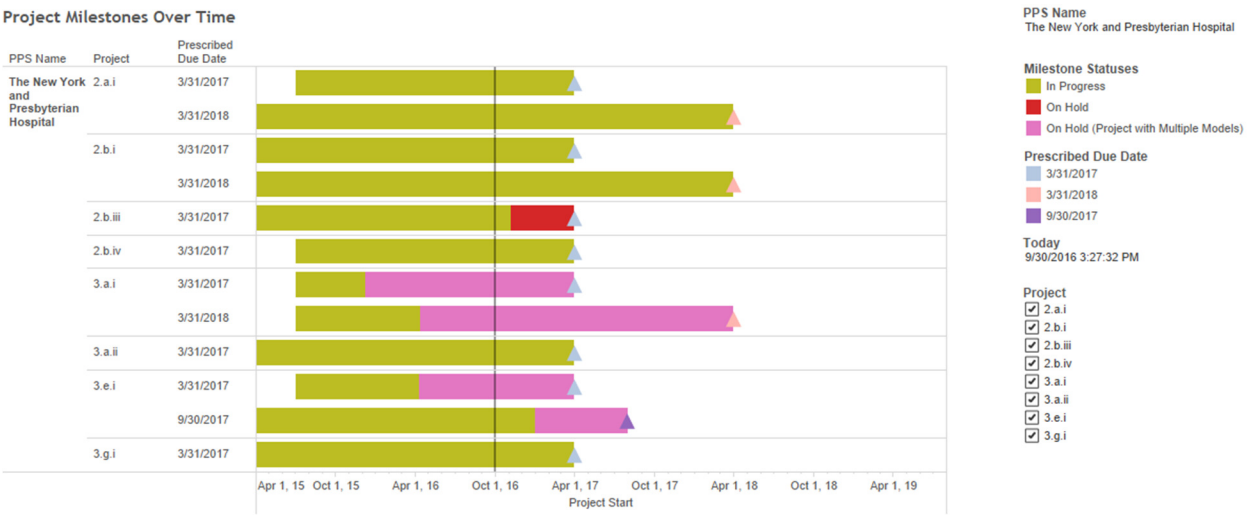
Figure 6: The New York and Presbyterian Hospital Project Milestone Status (through DY2, Q2)[8]



Data Source: The New York and Presbyterian DY2, Q2 PPS Quarterly Report

Based on the data in Figure 6 above, it appears that Projects 3.a.i and 3.e.i may be at risk due to the current status of project implementation efforts being "On Hold". This status indicates that the PPS has not begun efforts to complete these milestones by the required completion date and as such are at risk of losing a portion of the Project Implementation Speed AV for each project.

However, further assessment of the PPS project implementation status for project 3.a.i. indicates that many of the project milestones with a status of 'On Hold' are related to the PPS not pursuing Model 3 for this project. Therefore, for the models the PPS is pursuing, there is no risk of project implementation meeting the required completion dates at this time. Similarly, for project 3.e.i., the PPS is only implementing Model 3 and all milestones that have a current status of 'On Hold' are associated with Models 1 and 2. As such, the IA has not identified any risks of project implementation meeting the required completion dates at this time.

Furthermore, Project 2.b.iii may be at risk due to the current status of milestones which are due in DY2, Q4 as "On Hold". This status indicates that the PPS has not begun efforts to complete these milestones by the required completion date and as such are at risk of losing a portion of the Project Implementation Speed AV for each project.

Patient Engagement AVs

In addition to the analysis of the current project implementation status, the IA reviewed NYP's performance in meeting the Patient Engagement targets through the PPS Quarterly Reports. The IA identified three projects where the PPS has missed the Patient Engagement targets in at least one PPS Quarterly Report. Figures 7 through 8 below highlight those projects where NYP has missed the patient Engagement target for at least one quarter.

[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.

Figure 7: Project 3.e.i (Comprehensive strategy to decrease HIV/AIDS transmission) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	1,723	1,379	80.03%
DY1, Q4	3,445	2,402	69.72%
DY2, Q2[9]	1,941	3,897	200.77%

Data Source: The New York and Presbyterian PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

Figure 8: Project 3.g.i (Integration of palliative care into the PCMH model) Patient Engagement

DY1, Q4	280	0	0.00%

Data Source: The New York and Presbyterian PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

While the PPS missed the Patient Engagement target for projects 3.e.i., and 3.g.i. for at least one reporting period, through DY2, Q2, NYP is projected to have reached the Patient Engagement targets for these projects based on the data reported in the DY2, Q2 PPS Quarterly Report pending IA review and approval. Based on this data, it would appear that the PPS has addressed any issues it encountered with early Patient Engagement efforts.

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

[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.~~

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. Figures 9 through 15 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.

Figure 9: Project 2.a.i (Creating an Integrated Delivery System) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	768	0
	Safety Net	174	0
Case Management / Health Home	Total	7	7
	Safety Net	3	3
Clinic	Total	11	11
	Safety Net	11	8
Community Based Organizations	Total	18	16
	Safety Net	0	0
Hospice	Total	3	3
	Safety Net	1	2
Hospital	Total	2	3
	Safety Net	3	3
Mental Health	Total	55	37

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	Safety Net	25	19
Nursing Home	Total	11	11
	Safety Net	10	11
Pharmacy	Total	11	10
	Safety Net	8	7
Practitioner - Non-Primary Care Provider (PCP)	Total	1,417	0
	Safety Net	130	0
Practitioner - Primary Care Provider (PCP)	Total	329	116
	Safety Net	114	114
Substance Abuse	Total	10	10
	Safety Net	9	9

Data Source: The New York and Presbyterian DY2, Q2 PPS Quarterly Report

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Figure 10: Project 2.b.i (Ambulatory intensive care units (ICUs)) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	0	0
	Safety Net	174	0
Case Management / Health Home	Total	0	3
	Safety Net	3	3
Clinic	Total	0	2
	Safety Net	2	2
Community Based Organizations	Total	0	1
	Safety Net	0	0
Mental Health	Total	0	19
	Safety Net	25	19
Pharmacy	Total	0	0
	Safety Net	8	0
Practitioner - Non-Primary Care Provider (PCP)	Total	0	0
	Safety Net	130	0
Practitioner - Primary Care Provider (PCP)	Total	0	114
	Safety Net	114	114
Substance Abuse	Total	0	10
	Safety Net	9	9

Data Source: The New York and Presbyterian DY2, Q2 PPS Quarterly Report

The New York and Presbyterian Hospital

Figure 11: 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	768	0
	Safety Net	174	0
Case Management / Health Home	Total	7	7
	Safety Net	3	3
Community Based Organizations	Total	18	16
	Safety Net	0	0
Practitioner - Non-Primary Care Provider (PCP)	Total	1,417	0
	Safety Net	130	0
Practitioner - Primary Care Provider (PCP)	Total	329	114
	Safety Net	114	114

Data Source: The New York and Presbyterian DY2, Q2 PPS Quarterly Report

Figure 12: Project 3.a.i (Integration of primary care and behavioral health services) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	384	0
	Safety Net	87	0
Clinic	Total	1	1
	Safety Net	1	1
Community Based Organizations	Total	9	8
	Safety Net	0	0
Mental Health	Total	3	0
	Safety Net	0	0
Practitioner - Non-Primary Care Provider (PCP)	Total	354	0
	Safety Net	33	0
Practitioner - Primary Care Provider (PCP)	Total	164	114
	Safety Net	57	114
Substance Abuse	Total	10	10
	Safety Net	9	9

Data Source: The New York and Presbyterian DY2, Q2 PPS Quarterly Report

The New York and Presbyterian Hospital

Figure 13: Project 3.a.ii (Behavioral health community crisis stabilization services) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	0	0
	Safety Net	87	0
Case Management / Health Home	Total	0	3
	Safety Net	3	3
Clinic	Total	0	11
	Safety Net	11	8
Mental Health	Total	0	19
	Safety Net	25	19
Practitioner - Non-Primary Care Provider (PCP)	Total	0	0
	Safety Net	33	0
Practitioner - Primary Care Provider (PCP)	Total	0	114
	Safety Net	57	114
Substance Abuse	Total	0	10
	Safety Net	9	9

Data Source: The New York and Presbyterian DY2, Q2 PPS Quarterly Report

The New York and Presbyterian Hospital

Figure 14: Project 3.e.i (Comprehensive strategy to decrease HIV/AIDS transmission) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	768	1
	Safety Net	174	0
Case Management / Health Home	Total	7	7
	Safety Net	3	3
Clinic	Total	1	0
	Safety Net	1	0
Community Based Organizations	Total	18	16
	Safety Net	0	0
Mental Health	Total	55	37
	Safety Net	25	19
Pharmacy	Total	11	10
	Safety Net	8	7
Practitioner - Non-Primary Care Provider (PCP)	Total	1,417	2
	Safety Net	130	0
Practitioner - Primary Care Provider (PCP)	Total	21	5
	Safety Net	14	4
Substance Abuse	Total	10	10
	Safety Net	9	9

Data Source: The New York and Presbyterian DY2, Q2 PPS Quarterly Report

Figure 15: Project 3.g.i (Integration of palliative care into the PCMH model) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	768	0
	Safety Net	174	0
Community Based Organizations	Total	2	2
	Safety Net	2	2
Hospice	Total	18	16
	Safety Net	0	0
Hospital	Total	3	3
	Safety Net	1	2
Practitioner - Primary Care Provider (PCP)	Total	125	2
	Safety Net	130	0
Substance Abuse	Total	329	115
	Safety Net	114	114

Data Source: The New York and Presbyterian DY2, Q2 PPS Quarterly Report

As the data in Figures 9 through 15 above indicate, the PPS has engaged network partners on a limited basis across all projects. Of particular note is project 3.a.i, where NYP has not yet engaged a Mental health partner. The combination of the PPS failure to meet Patient Engagement targets and the lagging Partner Engagement across the same projects indicates an elevated level of risk for the successful implementation of project 3.e.i and 3.g.i.

PPS Narratives for At-Risk Projects

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.

- **3.e.i. (**Comprehensive strategy to decrease HIV/AIDS transmission ~~Integration of palliative care into the PCMH Model~~**):** NYP indicated that it has faced the following challenges throughout the first year of implementation: (1) due to an influx of additional resources through the acquisition of several grants, including three NYS DOH End-the-Epidemic grants, the HIV Center of Excellence (CoE) is suddenly faced with space challenges to accommodate the increasing staffing; (2) aligning new DSRIP-funded efforts with existing Medical Case Management (MCM) and other engagement-focused efforts, and (3) ensuring access to appropriate substance use treatment. The PPS has also noted various efforts to mitigate the challenges identified. The impact of these efforts will be evaluated in future quarters.

- **3.g.i. (Integration of palliative care into the PCMH Model):** The PPS recognized challenges due to (1) the speed at which the appropriate IS support could be developed,

(2) the recruitment of staff with specialized palliative care competencies to address high-risk patients, and (3) the speed at which education can be rolled out to primary care practices that are currently involved in other DSRIP- and leadership initiatives.

NYP also was challenged in recruiting a team (MD, NP, SW, RN Care Manager) with appropriate palliative care experience to support both direct service to the target population and the provision of education (webinars, case conferences, shadowing, etc.) to the primary care practices.

In rolling out generalist level education to the participating primary care practices, the 3.g.i project team, also met some resistance from front line staff around their comfort level with discussing goals of care and end of life treatment with patients, as well as challenges related to merging the new education with other GME, DSRIP-funded, or practice leadership initiatives.

IV. Overall Project Assessment

Figure 16 below summarizes the IA's overall assessment of the project implementation efforts of NYP 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 16: Overall Project Assessment

Project	Project Description	Patient Engagement	Project Milestone Status	Partner Engagement
2.a.i.	Creating an Integrated Delivery System			X
2.b.i.	Ambulatory intensive care units (ICUs)			X
2.b.iii.	ED care triage for at-risk populations		X	
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions			X
3.a.i.	Integration of primary care and behavioral health services			X
3.a.ii.	Behavioral health community crisis stabilization services			X
3.e.i.	Comprehensive strategy to decrease HIV/AIDS transmission	X		X
3.g.i.	Integration of palliative care into the PCMH model	X		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 17: Project Risk Scores

Project	Project Description	Risk Score	Reasoning
2.a.i.	Creating an Integrated Delivery System	2	This is a low risk score indicating the project is more than likely to meet intended goals but has challenges to overcome.
2.b.i.	Ambulatory intensive care units (ICUs)	2	This is a low risk score indicating the project is more than likely to meet intended goals but has challenges to overcome.
2.b.iii	ED care triage for at-risk populations	2	This is a low risk score indicating the project is more than likely to meet intended goals but has challenges to 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 challenges to overcome.
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 challenges to overcome.
3.a.ii.	Behavioral health community crisis stabilization services	2	This is a low risk score indicating the project is more than likely to meet intended goals but has challenges to overcome.
3.e.i.	Comprehensive strategy to decrease HIV/AIDS transmission	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges. The PPS has had patient and partner engagement challenges.
3.g.i.	Integration of palliative care into the PCMH model	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges. The PPS has had patient and partner engagement challenges.

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

VI. IA Recommendations

The IA's review of The New York and Presbyterian Hospital 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. The review of the PPS organizational capacity to support the successful implementation of DSRIP found no fundamental issues that would indicate that the PPS cannot successfully meet the DSRIP goals. The IA noted that the PPS has not distributed funds across many of its partners and that Partner Engagement has been limited across multiple projects. The PPS must identify opportunities to better engage its partners and to distribute funds to ensure the continued engagement of key partners in the implementation of the DSRIP projects.

The IA did also note that there were two projects where the PPS missed Patient Engagement targets and had limited Partner Engagement through DY2, Q2. The PPS will need to address the concerns associated with these two projects to ensure the successful implementation of these projects.

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

Cultural Competency and Health Literacy

Recommendation: The IA recommends the PPS implement the strategies and execute the training on CCHL as articulated in its submitted plans. The execution of this strategy needs to articulate how the PPS will measure the effectiveness of its CC/HL outreach efforts to the target population.

B. Project Recommendations

3.e.i. (Comprehensive strategy to decrease HIV/AIDS transmission):

Recommendation 1: The IA recommends that the PPS obtain long-term space for the HIV Center of Excellence (CoE) that can accommodate growth of staff and patients attributed to the program.

Recommendation 2: The PPS needs to demonstrate effective collaboration with CBOs and other resources to ensure appropriate access to substance abuse treatment

3.g.i Integration of palliative care into the PCMH model

Recommendation 1: The IA recommends that the PPS create an action plan to increase the presence of palliative team members in primary care practices in order to increase referrals, which will further improve patient engagement.

Recommendation 2: The IA recommends that the PPS develop a plan to increase outreach and education materials to partners with respect to end of life care. The plan should include ongoing support and resources with educational updates for partners and their staff.