NYS DSRIP Final PPS Profile Report

New York State Department of Health

DECEMBER 2020

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INTRODUCTION

New York's Delivery System Reform Incentive Payment (DSRIP) program has been a remarkable five-year demonstration from 2015-2019 in transforming the Medicaid delivery system and the care received by Medicaid members across the state. Twenty-five (25) Performing Provider Systems (PPS) of local collaborative safety net provider partnerships were awarded opportunities to earn performance payments from a pool of $6.4 billion to move the needle on reducing avoidable admissions and achieving clinical outcomes. A primary goal of this initiative was to transform the delivery system that was focused on volume-based care to that of outcomes-based where providers would be financially rewarded under value-based payment arrangements. New partners were identified and recruited to design strategies that could more effectively engage patients and impact key measures. New relationships were built spanning not only physical and behavioral health but also with other sectors of social services, housing, law enforcement, criminal justice, schools and prisons. In focusing on the performance outcomes to earn the incentive payments, PPS partners shared their mutual expertise and learned from each other and strengthened a collaborative community network infrastructure representing multiple sectors. These efforts are reflected in companion publications – DSRIP Stories of Meaningful Change in Patient Health and DSRIP Promising Practices by the United Hospital Fund.

A key goal of New York's DSRIP demonstration was to reduce avoidable hospital use by 25%. New York is proud of the final statewide performance results of a 26% reduction in Potentially Preventable Admissions (PPAs) that are attributed to the collective efforts of the 25 PPS local partnerships and innovation to reach the performance targets of improving patient-centered care.

This report provides a profile of all 25 PPS and qualitative aspects of their characteristics and performance as well as highlights from the DSRIP demonstration. A more in-depth review of DSRIP and PPS performance measurement will be presented in the Independent Evaluation Summative Report to be submitted to the Centers of Medicare and Medicaid Services (CMS) in the summer of 2021.

BACKGROUND

The Medicaid Redesign Team (MRT) efforts initiated in 2011 launched many immediate cost-saving initiatives as well as longer term reforms to help bring the Medicaid budget under control. The MRT provided savings to both the state and federal governments. On April 14, 2014 Governor Andrew M. Cuomo announced that New York had finalized the Special Terms and Conditions (STCs) with the federal government for a groundbreaking waiver to allow the New York State Department of Health (DOH) to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms.

The MRT waiver amendment addressed critical issues throughout the state and allowed New York to invest $6.4 billion for comprehensive transformation of the Medicaid program through the five-year Delivery System Reform Incentive Payment (DSRIP) demonstration. The demonstration sought to transform the health care system, bend the Medicaid cost curve and assure access to quality care for all Medicaid members. The New York DSRIP program promoted community-level collaborations focused on health care transformation, specifically a goal to

achieve a 25 percent reduction in avoidable inpatient and emergency department hospital use over five years, and to use incentives to drive system integration, and improvements in clinical management and population health. The demonstration sought to restructure the Medicaid delivery system financial incentives away from volume-driven care to that based on clinical outcomes that could be rewarded under a value-based payment system.

DSRIP PROGRAM PRINCIPLES

The design of the DSRIP program, projects, the project requirements and the application requirements reflected the following principles.

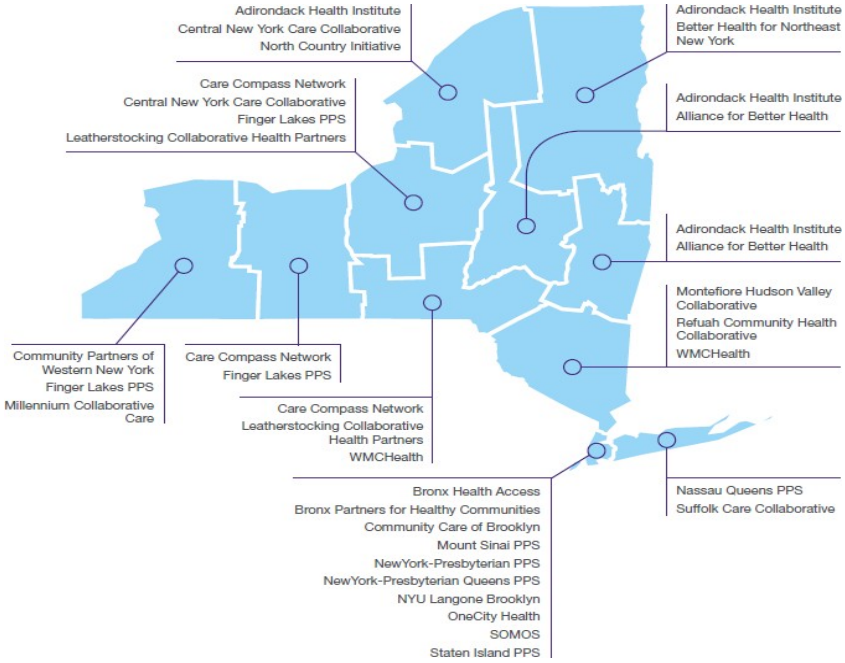
Figure 1. NY DSRIP Program Principles

PERFORMING PROVIDER SYSTEMS (PPS)

DSRIP was implemented at the local level relying on the collaboration of providers across the continuum of care in order to integrate services for patient-centered care and attain performance at a population health level. Local health care partnerships led by safety net providers were selected to become Performing Provider Systems (PPS) who demonstrated prior collaborative experience, leadership and administrative capabilities, and financial stability, necessary qualities for transforming the delivery system. The PPS were required to include community providers representing diverse partner types, including hospitals, health homes, skilled nursing facilities, federally qualified health centers, behavioral health providers, and community-based organizations. The inclusion of an array of partners, including providers of supportive services such as housing, was intended to address the entire continuum of care including the social determinants of health.

Twenty-five (25) PPS were selected through a project application and independent approval process. The PPS are located across the state (see Figure 3), covering each of the 62 counties across New York. In New York City and Long Island, some PPS covered only one county and ten PPS served the five boroughs with some overlap. In contrast, the PPS in upstate New York regions served multiple counties that covered a larger and more diverse geographic area but with a lower population density and there may have been only one PPS covering the county.

Figure 3. Geographic distribution of New York's Performing Provider Systems across the 11 DSRIP planning regions



Source: New York State Department of Health. (n.d.) DSRIP Performing Provider Systems (PPS): PPS by County. Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/index.htm

DSRIP GOALS AND PROJECT IMPLEMENTATION

Among DSRIP's key performance goals in system transformation was to reduce avoidable hospital admissions by 25% by the end of the five-year period. Implementation strategies were structured into four domains that would facilitate delivery transformation and improve quality of care.

The four domains were:

Domain 1 - Organizational transformation competencies (IT/population health data analytics, workforce and training, cultural competency/health literacy),

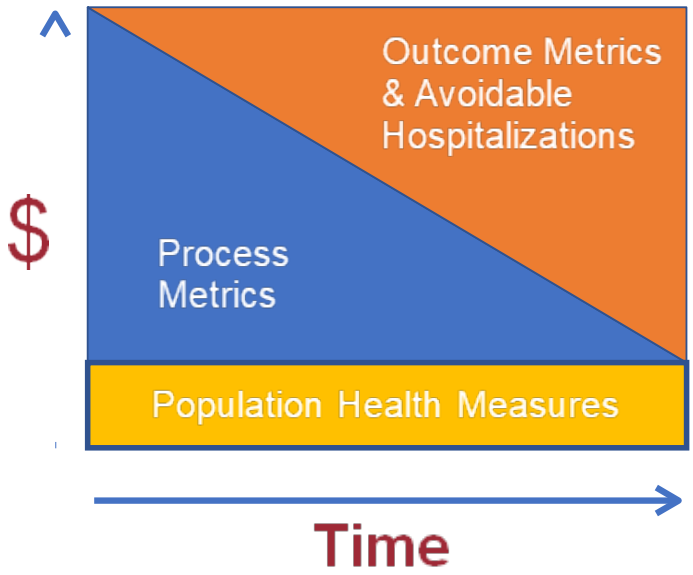
Domain 2 – Delivery system integration, care coordination and transitional care programs, connecting settings, and "patient activation" to expand access to community-based care

Domain 3 – Clinical improvement in major chronic disease and the integration of primary care and behavioral health

Domain 4 - Population health projects that aligned with the state's public health "Prevention Agenda" to address local community health needs.

Another critical goal was to move PPS and their partners towards pay for performance (see Figure 2) and position providers for future value-based payment arrangements.

Figure 2. NY DSRIP Key Performance Goals



Forty-four (44) projects in total were available for the PPS to select to meet their local community health needs as evidenced by their community needs assessment. Each project had a point score that would be further enhanced by the projected start date (speed) and the projected number of providers and patients (scale) that the PPS committed to in their project application. The resulting project application score was multiplied by the Attribution for Valuation number of Medicaid lives as determined by the PPS provider network to determine the maximum funding pool or valuation for the PPS.

PPS PROJECT SELECTION

New York's DSRIP program offered a defined list of 44 projects outlined in the Project Toolkit that were based on evidence-based practices and designed to meet the core DSRIP program goals of reducing avoidable hospital use and transforming the New York health care system into a financially viable, high performing system. All projects had performance measures initially for pay for reporting (P4R) on process and transitioned to pay for performance (P4P) on outcomes.

All PPS had to satisfy the organizational requirements in Domain 1 for foundational competencies necessary for transformation and project implementation. where PPS could choose a minimum of five and up to ten projects with specific required minimum numbers of projects in Domains 2,3, and 4 to address health issues as defined in their community needs assessments. An optional eleventh project to additionally engage the low-utilizing Medicaid members and the uninsured was also available to eligible PPS. A main priority for the state's DSRIP program was the integration of primary care and behavioral health and all PPS were required to select the project 3.a.i with this focus for implementation. Figure 4 lists the NY DSRIP Project Names, and the total number of PPS who selected each project.

Figure 4. PPS Project Names, and Number of PPS Selecting the Project

Project Number	Project Description	Total No. of PPS Selecting
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	22
2.a.ii	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))	5
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	10
2.a.iv	Create a medical village using existing hospital infrastructure	4
2.a.v	Create a medical village/alternative housing using existing nursing home infrastructure	1
2.b.i	Ambulatory Intensive Care Units (ICUs)	2
2.b.ii	Development of co-located primary care services in the emergency department (ED)	1
2.b.iii	ED care triage for at-risk populations	13
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	17
2.b.v	Care transitions intervention for skilled nursing facility (SNF) residents	1
2.b.vi	Transitional supportive housing services	1
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	7
2.b.viii	Hospital-Home Care Collaboration Solutions	7
2.b.ix	Implementation of observational programs in hospitals	2
2.c.i	Development of community-based health navigation services	5
2.c.ii	Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services	1

Project Number	Project Description	Total PPS Selection
2.d.i	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care	14
3.a.i	Integration of primary care and behavioral health services	25
3.a.ii	Behavioral health community crisis stabilization services	11
3.a.iii	Implementation of evidence-based medication adherence programs (MAP) in community-based sites for behavioral health medication compliance	2
3.a.iv	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs	4
3.a.v	Behavioral Interventions Paradigm (BIP) in Nursing Homes	1
3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)	15
3.b.ii	Implementation of evidence-based strategies in the community to address chronic disease – primary and secondary prevention projects (adult only)	0
3.c.i	Evidence-based strategies for disease management in high risk/affected populations (adults only)	10
3.c.ii	Implementation of evidence-based strategies to address chronic disease – primary and secondary prevention projects (adults only)	1
3.d.i	Development of evidence-based medication adherence programs (MAP) in community settings– asthma medication	0
3.d.ii	Expansion of asthma home-based self-management program	7
3.d.iii	Implementation of evidence-based medicine guidelines for asthma management	6
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	1
3.f.i	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse- Family Partnership)	4
3.g.i	Integration of palliative care into the PCMH Model	9
3.g.ii	Integration of palliative care into nursing homes	2
3.h.i	Specialized Medical Home for Chronic Renal Failure	0
4.a.i	Promote mental, emotional and behavioral (MEB) well-being in communities	2
4.a.ii	Prevent Substance Abuse and other Mental Emotional Behavioral Disorders	1

Project Number	Project Description	Total PPS Selection
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems	13
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.	11
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	11
4.c.i	Decrease HIV morbidity	1
4.c.ii	Increase early access to, and retention in, HIV care	7
4.c.iii	Decrease STD morbidity	0
4.c.iv	Decrease HIV and STD disparities	0
4.d.i	Reduce premature births	2

STATEWIDE PERFORMANCE AND LEARNING COLLABORATIVES

The federal STCs for New York's DSRIP program also required an overall statewide performance improvement on select key outcomes and performance measures for demonstration years 3, 4 and 5 for the state and the PPS in order to earn the performance incentive payments in full. This further incentivized the transformation efforts of all PPS to collectively change the Medicaid delivery system and spawned collaborative efforts across PPS formally and informally on project implementation, community prevention strategies and other improvement activities. New York met the statewide test for key outcomes and project performance measures for the 3 years.

The DSRIP Learning Collaborative was an integral strategy to promote and support the continuous environment of learning and sharing based on data transparency in an effort to bring meaningful improvement to the landscape of healthcare in New York. The Learning Collaborative included both virtual and in- person collaboration that created and fostered relationships and facilitated project analysis and measurement. The Learning Collaboratives included the following:

1. Sharing of DSRIP project development including data, challenges, and proposed solutions based on the PPS quarterly progress reports
2. Collaborating based on shared ability and experience
3. Identification of best practices
4. Provide updates on DSRIP program and outcomes
5. Encourage the principles of continuous quality improvement cycles

Annual DSRIP Learning Symposiums

Each year DOH convened a statewide Learning Symposium to take stock on PPS progress, share and learn together, and accelerate the system-wide transformation. The Learning Symposium was designed to showcase DSRIP program successes and most promising practices to date and support all who attend in their transformational journey. Themes of each event varied given where PPS were in the implantation of their projects, but often included:

- **Celebrate**: Showcase what works and encourage the adoption of effective strategies
- **Inspire**: Motivate and encourage continued commitment, progress, and innovation
- **Challenge**: Highlight innovators and innovations and challenge "business as usual"
- **Empower**: Deepen our learning with new tools, skills, and actionable change ideas
- **Spread**: Harvest and reflect on the learning across PPS and stakeholders.

The symposiums provided a forum to share the perspectives and insight of the DSRIP PPS, as well as their network partners of Physical and Behavioral Health Providers, Managed Care Organizations (MCOs), and community-based organizations (CBOs) addressing the Social Determinants of Health. Presentations and themes for each event were tailored to be responsive to PPS implementation efforts and the overall DSRIP timeline. Offerings from the events included:

- Keynote addresses from renowned speakers such as Dr. Don Berwick, Former Administrator, Centers for Medicare and Medicaid Services and Founding CEO, Institute for Healthcare Improvement, and Dr. Sandro Galea, Dean and Robert A. Knox Professor, Boston University School of Public Health, offering inspiration and empowerment in support of progress, change and sustainability for healthcare transformational efforts.
- Multidisciplinary panel presentations and breakout sessions highlighting DSRIP program successes and promising practices, innovative partnerships, lessons learned, tools and strategies for adoption and spread, and approaches to building sustainable models for the future in reforming service delivery.
- Hands–on, interactive workshops that addressed real-time challenges such as managing the opioid epidemic, supporting care transitions, advancing cross–sector partnerships, maintaining the high–performance energy, partnering for sustainable transformation, and advancing health literacy.
- Poster presentations showcasing DSRIP program successes, promising practices, and lessons learned from presenters in their work towards more integrated, innovative, and effective approaches to address theneeds of Medicaid consumers, shown in measurable improvements across a variety of health outcomes.

The last scheduled annual Learning Symposium was the NY Medicaid Population Health Symposium that took place on November 18–19, 2019 in New York, NY. Nearly 800 leaders and stakeholders of the DSRIP program were convened for two days to acknowledge the transformational work accomplished under the DSRIP demonstration and recognize the critical roles of community providers, behavioral health providers, traditional medical providers, and payers in their efforts for population health activities as part of the transition to VBP. Participants included representatives from the 25 PPS, CBOs, MCOs, the New York State agency staff, as well as consumer advocates, national health care reform experts, and other public health officials from within and beyond NY. The symposium´s conference guide provides detailed information on the content of the event and can be viewed here: NY Medicaid 2019 Population Health Symposium Conference Guide. Additional information on the Learning Symposiums, including

the conference guides, presentation materials, and details on past events can be found on the dedicated website established for the event: http://www.dsriplearning.com/.

Medicaid Accelerated eXchange (MAX)

DOH launched its approach to Rapid Cycle Continuous Improvement (RCCI) as the Medicaid Accelerated eXchange (MAX) program in 2015 to support PPS and their provider partners in their efforts to redesign the way healthcare is delivered. The key objective of the MAX program was to support interdisciplinary PPS provider teams to accelerate their ability to achieve sustainable reductions in hospital admission and emergency department use. The focus was to address multi-visit patients (MVPs), previously described as high utilizing patients. Front-line teams of clinicians and operations staff were recruited from emergency and inpatient units to engage in three full days of in-person workshop sessions over a 6-month period. Community partners were identified and incorporated into the Action Teams as workflows were redesigned to address the "drivers of utilization" for each patient. Action Teams were challenged to drive change, and to accelerate results throughout three workshops and action periods made up of Plan-Do-Study-Act (PDSA) cycles. Action Teams generated and prioritized improvement ideas, developed concrete action plans, and implemented, tested, measured, and adjusted localized processes for whole-person care delivery for the target population. Team participants reported high rates of job satisfaction in approaching patients in a different way and working with community partners to address non-medical underlying issues.

The program started with six Action Teams and after three years, there were more than 90 Action Teams. Through offering a series of RCCI workshops focused on improving care, the MAX program supported the goal of transforming the system by directly providing quality improvement tools to frontline providers, strengthening care collaborations at the local level and getting patients the right care at the right time. By understanding the drivers of high utilization, patients were directed to appropriate community providers and resources while promoting the more efficient use of hospitals for emergent and acute level services. More information regarding the MAX program can be found on the DOH website: Medicaid Accelerated eXchange (MAX) Series and MAX Training Program.

COVID-19 RESPONSE in 2020:

The end of DSRIP Demonstration Year 5 was March 31st, 2020 and should otherwise have been a time to celebrate a remarkable period of accomplishments by the 25 PPS statewide. Instead, an unimaginable pandemic was surging in New York and impacting all communities and colleagues, professionally and personally. DSRIP's greatest success and legacy may be the foundation of the strong community collaborations the 25 PPS built to mobilize to help meet the challenge. Investments in workforce capacity and partnerships with community-based organizations (CBOs) helped to meet local needs and address social needs for more holistic care. PPS, in collaboration with their partners, demonstrated the innovation and nimbleness for local solutions during DSRIP and did so again in response to the COVID-19 crisis as the following examples show:

- Rapid deployment of telehealth capabilities (software, equipment, technical assistance) to community-based clinical partners
- Provision of electronic applications to support behavioral health providers and patients

to maintain relationships for recovery

- Provisioning of funding, equipment and tools to CBO partners to enable staff to work remotely
- Leveraging population health platforms for timely outreach to high-risk patients for tele-visits
- Organizing community-based multi-lingual Covid-19 test sites and patient hotlines
- Advancing payments and funding to stem revenue loss for safety net providers
- Workforce training for non-clinical essential staff working in shelters and transportation
- Managing updated community resource hubs and apps for patients, providers and CBOs on newly issued emergency regulations, information and latest location of essential services such as food pantries
- Aggregation and distribution of PPE, cleaning supplies and thermometers early in the surge
- Providing marketing/communication assistance to local counties for public health messaging

The cited efforts by the PPS leveraged a community infrastructure built on the DSRIP collaborations and partnerships across sectors, institutions and agencies to meet their community needs at a time of extreme crisis. The role of the PPS as trusted regional conveners to improve population health is affirmed by these types of efforts.

PPS PROFILE OVERVIEW

SUMMARY

The purpose of this report is to document the lasting impact of DSRIP in NY State. It includes a description of the key features and accomplishments of each PPS, prepared by the Independent Assessor (IA), followed by a description of the PPS impact in their community, from the PPS own perspective. PPS and its community partners went about accomplishing DSRIP goals in unique ways that were best suited to their own members and communities. To that end, each PPS had a distinct and lasting transformation on health care in their respective region and community.

PPS OVERVIEW

Within each PPS Profile, a PPS Overview is provided first that contains the basic characteristics of the PPS including the counties served, projects implemented, and funding. Below is a description of each of the data elements provided as part of this overview.

- *Total Patients Attributed for Valuation:* The number of Medicaid and uninsured lives that were used in the calculation of the maximum funding that a PPS could receive over its DSRIP duration. Attribution for valuation was based on membership on December 1, 2014; this fixed amount does not change even if the PPS dropped or added partners over time.
- *Total Patients Attributed for MY5 Performance:* The number of beneficiaries that were assigned to a PPS which formed the basis of metric denominators used in performance measurement for Measurement Year 5. Attribution for performance adjusted annually and reflects the number of attributed Medicaid members based on the partners in the PPS performance networks.
- *% Statewide Attribution for Valuation:* The percent based on the total number of the PPS' attributed population for valuation compared to the total attributed population for valuation for NYS DSRIP.
- *% of Statewide Attribution for MY5 Performance:* The percent based on the total number of the PPS' attributed population for Measurement Year Performance compared to the total attributed population for performance for MY5 of NYS DSRIP.
- *Total Network Partner Types:* The total number of partners that were included in the PPS's reported partner engagement as of DY5Q4 for the NY DSRIP program. This count may contain duplicates based on the categorization of a partner across multiple partner types. For example, an organization may be categorized and counted as both a hospital and as a primary care entity.
- *Total PCMH and APC Recognized Providers:* The total number of providers in the PPS provider network that met 2014 NCQA Level 3 Patient Centered Medical Home (PCMH) and/or Advanced Primary Care (APC) standards as of DY3Q4.
- *Total Primary Care Providers and Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i:* The total number of PPS primary care and mental health providers that participated in the PPS's Project 3.a.i (Primary Care

and Behavioral Health Integration) and were engaged in primary care and behavioral health integration.

- *Total Funds Earned Through DY5:* The total DSRIP funds that were earned by the PPS (pay-for-reporting and pay-for-performance) for Demonstration Year 1 through Demonstration Year 5.
- *Total Active Patient Engagements:* The total number of patients that satisfied the specific active engagement criteria for each project in each Demonstration Year. Please note that patient engagement counts were not required and reported in DY5.

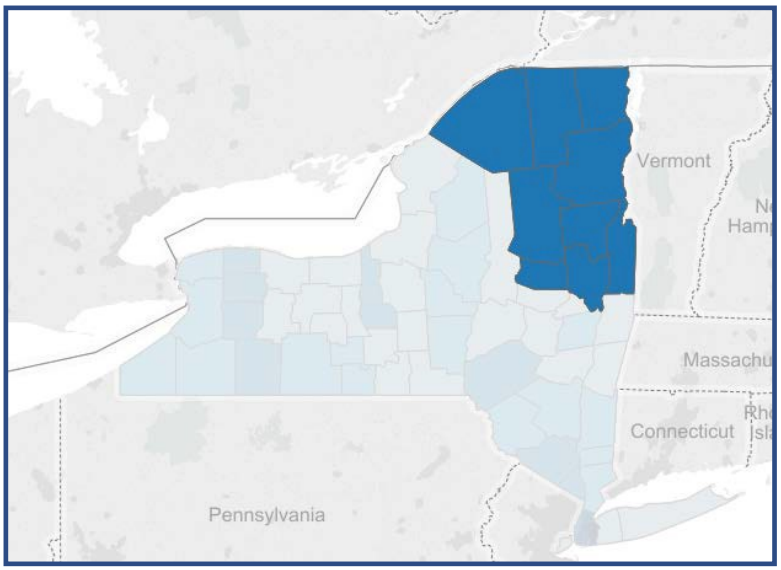
PPS NARRATIVES

Following the PPS Overview is the PPS Narrative. This narrative was written by individual PPS to describe the most impactful ways in which DSRIP funded activities drove sustainable transformations in health care and the lasting ways the PPS and DSRIP has transformed health care in the PPS region and community. Each PPS was given 500 words to respond to the question: "In what lasting ways has the PPS/DSRIP transformed health care in your region/community?". Each PPS Narrative provides the PPS their voice on the specific changes inspired by the PPS collaborative efforts and what their legacy on health care in their respective region and community will be.

Adirondack Health Institute

https://ahihealth.org/

The AHI Performing Provider System, a partnership of more than 120 organizations collaborated over a five-year period to re-imagine and significantly restructure the health care delivery system in the nine-county Adirondack region.



Counties Served: Saratoga, Hamilton, Franklin, Clinton, St. Lawrence, Fulton, Essex, Warren, Washington

11 total projects

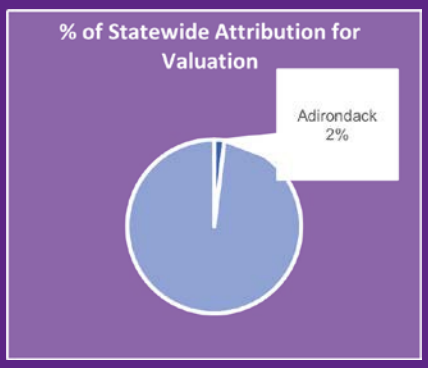
2.a.i	Integrated Delivery Systems
2.a.ii	PCMH/APC
2.a.iv	Medical Village-Hospital
2.b.viii	INTERACT
2.d.i	Patient Activation (PAM)
3.a.i	Primary Care and Behavioral Health Integration
3.a.ii	Crisis Stabilization
3.a.iv	Withdrawal Management & Abstinence Services
3.g.i	Integration of Palliative Care into PCMH
4.a.iii	Strengthen MHSA Infrastructure
4.b.ii	Preventative Care/Management

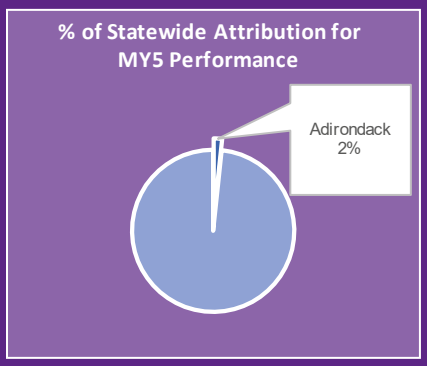
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Integration Models	0	26,853	37,406	38,383
Total Active Engagements of Patients	5,630	58,642	80,331	45,099

BY THE NUMBERS

- **143,640** Total Patients Attributed for Maximum Valuation
- **92,282** Total Patients Attributed for MY5 Performance





- **1,859** Total Network Partner Types
- **246** Total PCMH and APC Recognized Providers
- **268** Total Primary Care Providers and **137** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$186,606,578** Total Funds Earned Through DY5

Adirondack Health Institute

Lead Empower Innovate

AHI PPS Profile

The Adirondack Health Institute achieved population health goals through the lens of collaboration, communication and engagement of all health-related sectors, both clinical and community-based. The AHI PPS created the community infrastructure needed to ensure optimal health and well-being for all residents of an eleven thousand square mile region through targeted, sub-regional networks that shared common goals and communicated lessons and learnings between and among one another. Bridge-building, communications, community engagement and trust are the legacy which will continue through these coalitions to address and promote the health of the Adirondacks well into the future.

- **Community-Based Multi-Sector Networks**
  The AHI PPS established five region-specific networks of clinical and community service providers to collaborate on Delivery System Reform Incentive Payment (DSRIP) Program projects and metrics. Each network served as a distinct point of contact for program activities and involved a physician champion, hospital administrator, and community-based organization administrator, supported by dedicated AHI staff.

- **Cross-Sector Collaboration**
  Bringing together diverse provider types to collectively address health and well-being has been a hallmark of AHI's DSRIP experience. Examples include (1) behavioral health and primary care integration; (2) expansion of the crisis respite support infrastructure (e.g. mobile substance use disorder services, community centers, crisis hotlines, and peer services); and (3) justice system collaboration with health care. The justice system effort involved identifying gaps in health care services for people at risk of incarceration. The plan resulted in ongoing collaboration, crisis intervention training for law enforcement, and post-release care management services for formerly incarnated individuals.

- **Right Care, in the Right Place, at the Right Time**
  The PPS built and strengthened connections between the health care system and community resources. Several community health navigator programs were established to screen and link eligible individuals with Health Homes and other care management services. Navigators were placed in emergency departments to support individuals with chronic conditions and health-related social needs, to improve well-being and reduce avoidable hospital use. Programs focused on multiple needs, including transportation and food insecurity.

- **Expanded Technology and Use of Data Analytics**
  To drive PPS performance and support improved care delivery, quality, and coordination, the PPS

developed data analytics capabilities, producing partner-specific dashboards designed to support decision-making and performance improvement strategies. The implementation and/or expansion of access and utilization of Health

Information Exchange (HIE) and Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) databases provided real-time, actionable information.

- **Transformed Primary Care**

  The PPS leveraged DSRIP resources to support practice transformation efforts across the region. These investments strengthened primary care providers' capacity to manage patients with complex medical needs and chronic conditions and furthered their preventive care efforts. Over two years, AHI successfully assisted approximately 50 practice organizations with more than 100 practice sites, through the National Committee for Quality Assurance Patient-Centered Medical Home (NCQA PCMH) recognition process. The integration of primary care and behavioral health led to an increase in behavioral health follow-through. The DSRIP Waivers that permitted this union, allowed both areas to support their attributed lives with additional on-site services.

- **Workforce Capacity Building**

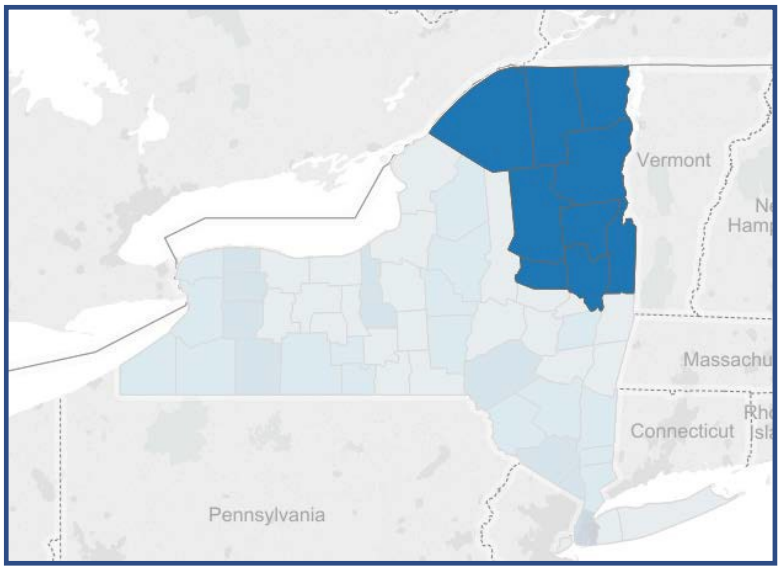
  The AHI PPS built workforce capacity through enhanced and expanded training, retention, and recruitment efforts to meet regional medical, behavioral, and social need. Service providers across clinical and non-clinical sectors within the PPS participated. The PPS provided valuable data, administrative support, and targeted funding streams to ensure PPS partners were well-positioned for success in a population health-driven, value- based care environment.

- **Sustainability Plan**
  - PPS functions and activities will be integrated into AHI ACO structure and other AHI programs
  - Continue care coordination, care management, care transitions initiatives and cross-sector collaborations including those addressing social determinants of health
  - Explore opportunities to continue regional population health networks (PHNs) to ensure community involvement
  - Pursue diverse funding streams to advance successful programs valued by partners

Alliance for Better Health

https://abhealth.us/

Established in 2015, Alliance for Better Health and its daughter organization Healthy Alliance IPA, collaborate with community partners to address social needs before they turn into costly, medical problems. With more than 100 partners in New York's Tech Valley and Capital Region, Alliance prioritizes building health equity for all.



Counties Served: Saratoga, Hamilton, Franklin, Clinton, St. Lawrence, Fulton, Essex, Warren, Washington

11 total projects

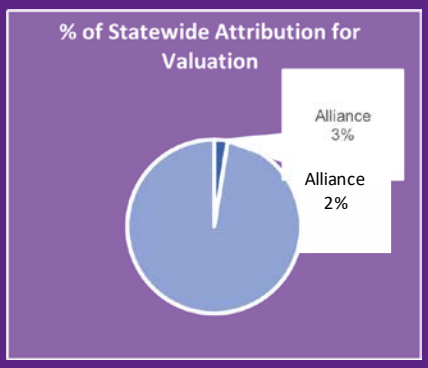
- 2.a.i Integrated Delivery Systems
- 2.b.iii ED Care Triage
- 2.b.iv Care Transitions – Chronic Disease
- 2.b.vii Hospital-Home Care Collaboration
- 2.d.i Patient Activation (PAM)
- 3.a.i Primary Care and Behavioral Health Integration
- 3.a.iv Withdrawal Management & Abstinence Services
- 3.d.ii Integration of Palliative Care into PCMH
- 4.a.iii Strengthen MHSA Infrastructure
- 4.b.i Tobacco Cessation

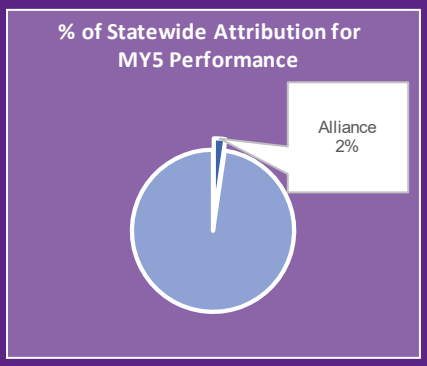
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	9,675	16,978	19,625	28,379
Total Active Engagements of Patients	21,825	42,335	81,303	72,154

BY THE NUMBERS

- **193,150** Total Patients Attributed for Maximum Valuation
- **127,836** Total Patients Attributed for MY5 Performance





- **705** Total Network Partner Types
- **390** Total PCMH and APC Recognized Providers
- **201** Total Primary Care Providers and **5** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$219,429,744** Total Funds Earned Through DY5

Alliance for Better Health (Alliance) exists today because the PPS continues to foster real change at the community-level. Together, with partners, the PPS nurtured a shared vision of building health equity for the ~200,000 Medicaid and uninsured community members served across Albany, Fulton, Montgomery, Rensselaer, Saratoga, and Schenectady counties. The Alliance worked to improve health by:

- *Creating a regional high-performing network to address the social determinants of health (SDoH)*: Alliance's long-term sustainability activity, Healthy Alliance IPA, has evolved into a regionally-shared network of more than 50 organizations that provide social services – food pantries, benefits navigators, shelters, etc. – to the underserved. Alliance's role remains a community convener, bringing together providers of all kinds to contract with health plans. Healthy Alliance IPA executed four contracts with three local health plans, across 18 partners over four years. Fundamental to these partnerships is the common belief that no individual should fall through the cracks and that together, partners can cultivate community solutions that *better health*.

- *Optimizing community-wide infrastructure for SDoH:* Alliance's closed-loop referral platform, Healthy Together powered by Unite Us, connects social, medical, and behavioral health providers – so that all basic human needs (not just medical ones) are addressed. Healthy Together, with its partner network ADK Wellness Connections in the Adirondacks, has connected over 5,000 community members with SDoH needs to a shared network of over 450+ organizations providing these critical social services.

- *Funding community initiatives that sustain better health: a*s a firm believer in getting the *right* things done, Alliance created an Innovation Fund set aside to support community initiatives that are collaborative in nature, sustainable, and most importantly, improve health by addressing a community need. Alliance has invested in 47 organizations over three years, for projects like:
    a. The Living Room: a crisis diversion program addressing the lack of alternative services for individuals experiencing mental health crises, proving to lower the number of *avoidable, costly* hospital admissions.
    b. Food Farmacy: a program that delivers medically tailored meals for home-bound, critically, or chronically ill patients discharged with specific nutritional needs, aiming to improve health through nutritious, accessible food.
    c. IPH Medical Respite: provides emergency respite shelter and care coordination to homeless individuals discharged from inpatient hospitalizations and/or have a history of improper use of emergency services due to chronic health conditions and/or illnesses.

- *COVID-19 relief efforts:* Recognizing that continuity of SDoH services is instrumental to keeping the community's most vulnerable safe and healthy

during (and after) this pandemic, Alliance made significant investments into the community, such as:

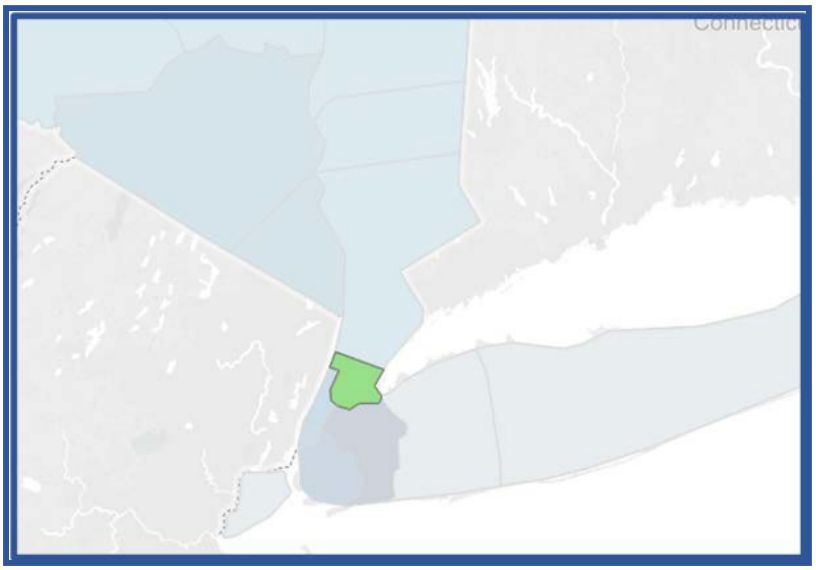
a. Procuring and distributing ~7,000 Kinsa smart thermometers to the community, Alliance partners, and the essential workforce with the goal of helping people understand and track their symptoms sooner for more proactive isolation procedures, while providing insight to public health professionals about emerging COVID-19 hotspots.
b. Purchasing and donating 425+ Zoom licenses and over 40 laptops for community partners to enable continuity and coordination of social services across the community.
c. Securing ~20,000 surgical masks for 26 partner organizations unable to locate a viable vendor.

- *Sustainability Plan:*
  a. Continue to fund regional partners to support VBP initiatives in first quarter of 2021.
  b. Form a network of SDH Providers/CBOs under the structure of an IPA explicitly focused on curating and managing a high-performing and regionally shared network of accountable CBOs.
  c. Help CBOs migrate toward VBP through the execution of risk-sharing arrangements and facilitation of referrals and would provide MSO services such as process optimization assistance, group purchasing, and back-office assistance.
  d. Incorporate additional community-based services in the IPA and its network depending on payor support.

Bronx Health Access

https://www.bronxhealthaccess.org/

The Bronx Health Access network includes over 200 doctors, specialist, pharmacies, mental health providers, substance abuse providers, home health agencies, housing, social service agencies, and community-based organizations.



Counties Served: Bronx County

10 total projects

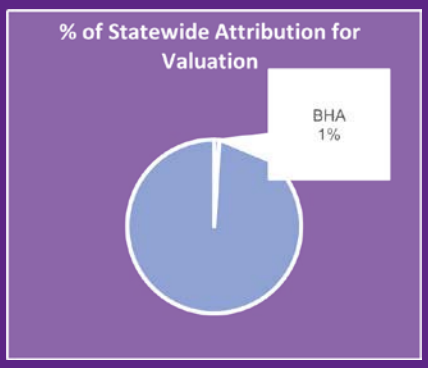
- 2.a.i Integrated Delivery Systems
- 2.a.iii Health Home At-Risk
- 2.b.i Ambulatory ICUs
- 2.b.iv Care Transitions – Chronic Disease
- 3.a.i Primary Care and Behavioral Health Integration
- 3.c.i High-Risk Disease Management – Diabetes
- 3.d.ii Asthma Home-Based Self-Management
- 3.f.i Maternal and Child Support Programs
- 4.a.iii Strengthen MHSA Infrastructure
- 4.c.ii Increase Access/Retention of Care

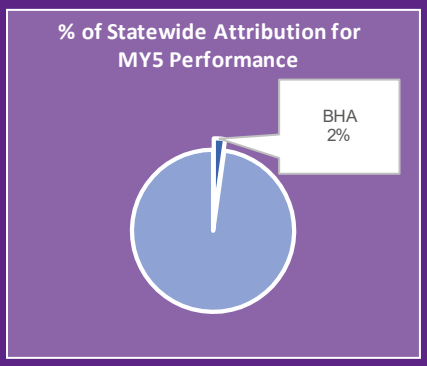
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	49,698	57,706	61,084	57,648
Total Active Engagements of Patients	77,738	100,264	112,145	87,792

BY THE NUMBERS

- **70,861** Total Patients Attributed for Maximum Valuation
- **123,489** Total Patients Attributed for MY5 Performance





- **4,554** Total Network Partner Types
- **297** Total PCMH and APC Recognized Providers
- **386** Total Primary Care Providers and **155** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$144,510,909** Total Funds Earned Through DY5

Bronx Health Access PPS

More than any other project that the Bronx Health Access PPS has done, the three projects below exemplify the outreach, collaboration and culture-change that came about in the health system as well as in the community from delivery system reform efforts. Each one of the projects below shows what can be done when dedicated caregivers are challenged to reimagine how health can be delivered and then given the resources to do it.

- ***Centering Program***
  BronxCare's Centering Program, the only Centering Program in the Bronx recognized by the Centering Health Institute, was expanded and improved under the DSRIP program. After further initiatives were implemented, the program saw measurable improvements in the number of groups and patients participating, the rate of preterm births, and cesarean section rate as well as the percentage of mothers' breast feeding and post-partum visits. This program was instrumental in reducing the low birth weight incidence for the PPS's attributed population in the South Bronx, an area that historically had the highest low birth weight in the nation. The Centering Program is now an integrated component of the OB/GYN department in which health, social and mental care is now bundled and coordinated rather than segmented.

- ***Collaborative Care***
  With the high rates of mental illness in the Bronx, the integration of primary care with behavioral health was critical in addressing the needs of this vulnerable group. This group can now count on a coordinated primary care/behavioral health approach, resulting from a cultural shift in the way health care providers traditionally performed their role. Lasting efforts are assured as these new processes are now the norm, taught to physician residents, and part of the routine delivery of care by both primary care and behavioral health physicians and other care givers, including PPS partners specializing in behavioral health.

  A similar approach is used for high-need, high-cost patients in ambulatory care. Staff and residents from multiple disciplines participate in enhanced treatment planning. Seeing improved outcomes, both physically and socially, give evidence to the success of this type of coordinated care. This evidence of success means that it becomes part of repertoire of treatment planning for the diverse disciplines.

- ***Care Transitions***
  The Care Transitions brings together elements of the integration of primary care and behavioral health with enhanced treatment planning. The defining element of this approach is the use of a Mobile Crisis Team, with dedicated transportation, that engages patients post-discharge at their own residence. Besides the Mobile

Crisis Team, members of the entire Care Transition include Community Health Workers (CHW) and Peer Specialists with the goal of improving care transitions for mental health and behavioral health patients as they return to the community after a period of inpatient hospitalization. This approach has increased the engagement and improved the care experience of these patients while at the same time decreasing unnecessary readmissions and ED visits.

- ***Sustainability Plan***

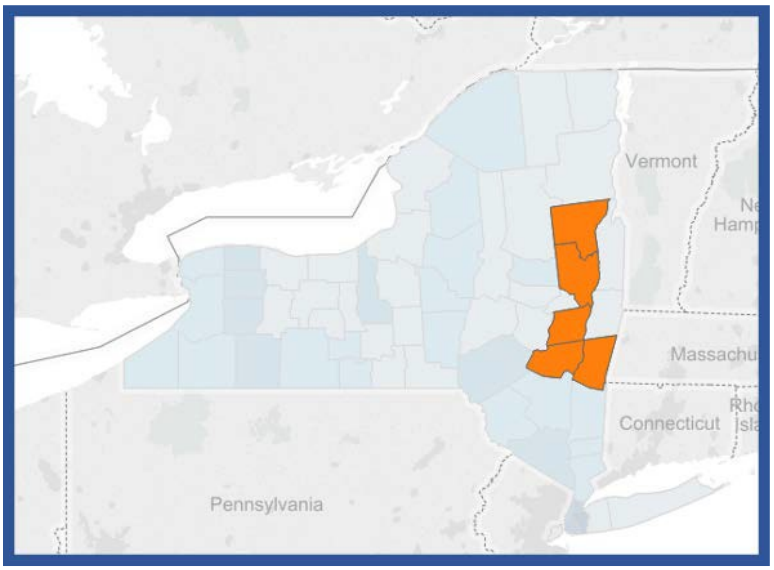
  The DSRIP program has created or enhanced existing workflows among the PPS partners. Those programs that align with DSRIP goal will continue to the extent that PPS partners have or continue to fund them. At the Bronx Care Health System, for example, the Centering Program, identified as one of the Best Practices in the Promising Practices report by the DOH, will continue to operate and be funded by the Health System. Other programs would be the Care Coordination and the BH/PC Coordination that were expanded during DSRIP.

  The PPS relationship with the Bronx RHIO was one of the best throughout the State, and this relationship will continue. The PPS centralized the analytics, data warehousing, and data visualization at the Bronx RHIO, which is a regional, shared resource among PPS members, Hospitals, CBOs, and FQHCs. This centralized development was done so all members will have the ability to contract with and use the platform post-DSRIP

Better Health for Northeast New York

http://www.bhnnypps.org/

Better Health for Northeast New York (BHNNY) is a regional network of healthcare and community health partners working as an Integrated Delivery System (IDS) to enhance the value of healthcare and improve population health outcomes in New York's Capital District.



Counties Served: Albany, Columbia, Greene, Saratoga, Warren

11 total projects

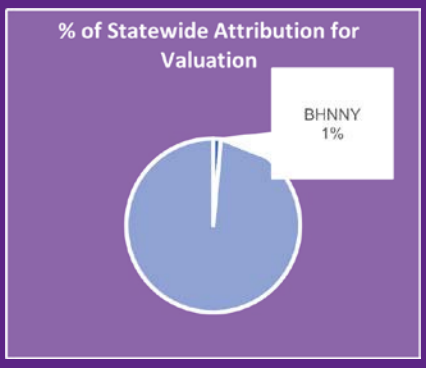
2.a.i	Integrated Delivery Systems
2.a.iii	Health Home At-Risk
2.a.v	Medical Village-Nursing Home
2.b.iii	ED Care Triage
2.d.i	Patient Activation (PAM)
3.a.i	Primary Care and Behavioral Health Integration
3.a.ii	Crisis Stabilization
3.b.i	High-Risk Disease Management – Cardio
3.d.iii	Evidence-Based Guidelines for Asthma Management
4.b.i	Tobacco Cessation
4.b.ii	Preventative Care/Management

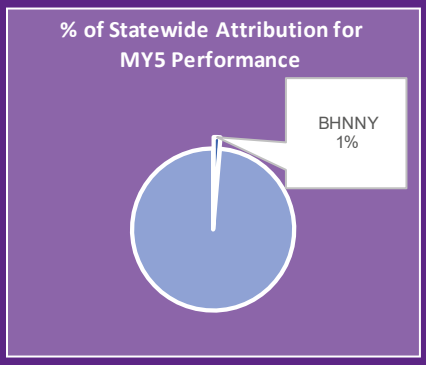
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	8,997	7,995	10,399	10,999
Total Active Engagements of Patients	22,288	31,875	22,258	22,583

BY THE NUMBERS

- **107,781** Total Patients Attributed for Maximum Valuation
- **73,313** Total Patients Attributed for MY5 Performance





- **4,589** Total Network Partner Types
- **303** Total PCMH and APC Recognized Providers
- **623** Total Primary Care Providers and **157** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$137,692,442** Total Funds Earned Through DY5

Better Health for Northeast New York
A Partnership for Better Health

Better Health for Northeast New York (BHNNY) is a regional network of healthcare and community health partners working as an Integrated Delivery System (IDS) to enhance the value of healthcare and improve population health outcomes in New York's Capital District. Supporting a shift in care from one focused on illness to one focused on wellness, BHNNY has strengthened the regional delivery system through investments and program development in enhanced primary care services, primary care and behavioral health services integration, transitional care management, and data and technology integration and optimization. Through the coordination, collaboration, innovation, and continuous improvement of aligned goals, strategic investments, integrated technologies, and shared incentives and performance measurements, the BHNNY network has established a sustainable system to support targeted population health management interventions in response to the continually changing needs of both the regional population and the regional health system.

Shifting the focus from Illness to Wellness through Enhanced Prevention and Primary Care

The most significant transformation was the change in focus from illness to wellness by the Integrated Care Delivery System developed by BHNNY. This transformation was achieved by recognizing the unmet community need for primary care services and addressing it by providing support to expand access to primary care services, expanding the scope of services provided at the primary care sites, and helping them improve the quality of their services as demonstrated by achieving Patient Centered Medical Home (PCMH) accreditation. It also included the coordination and expansion of community resources to expand crisis stabilization support and decrease inappropriate use and cost of emergency room service. Temporary respite care/housing after an acute inpatient discharge and transportation for non-medical needs such as benefits, food, housing, and prescriptions also contributed to a decrease in inappropriate Emergency Department (ED) use or readmissions.

Transitional Care Management

Another transformation was the identification of the need for care coordination across the continuum of care rather than the previous

siloed, episodic approach. The development and implementation of BHNNY Cares, a comprehensive care coordination care management program provided access to care coordination services across care providers and community health partners. It provides short term care management, on average a 2-3-month engagement, focusing on stabilization, transitions of care, and implementation of wrap around services prior to warm hand-off to long term care management programs. It is staffed by registered nurses, social workers, care coordinators and a pharmacist to offer a truly dynamic multi-disciplinary team approach and has demonstrated a significant return on investment (ROI) by reducing readmission and avoidable ED visits.

Integrating Primary Care and Behavioral Health

The BHNNY incentivized 10 partner organizations to co-locate behavioral health services at 32 separate primary care sites. Two partner organizations implemented the "Improving Mood –

Promoting Access to Collaborative Treatment" (IMPACT) model of depression management at primary care sites. The key initiative has allowed partner organizations to identify and begin treating behavioral health conditions early, ensure that treatments for behavioral health conditions are compatible and do not cause adverse effects, and destigmatize treatment for behavioral health conditions.

Data and Technology to Drive Enhancements in Care and Improve Outcomes

The BHNNY leveraged the data-sharing capabilities of Hixny, the area's Regional Health Information Organization (RHIO) to support Data Analytics and Care Management Programs. The need for a platform all partners could use to coordinate care was critical. The BHNNY implemented Medecision's GSI Health Coordinator to support BHNNY's Community Care Coordination Program and developed a multidisciplinary Community Care Plan that is now being shared via Hixny, making it available to all providers. BHNNY also developed an Enterprise Data Warehouse (EDW). Information developed from this "Big Data" source allowed BHNNY to produce monthly, quarterly and ad-hoc reports enhancing overall performance. Data sources included: Medicaid final and pre-adjudicated claims, Hixny clinical data, GSI Care Coordination data, and partner program data.

Sustainability Plan

- Continue to fund quality improvements made by clinical partners, support

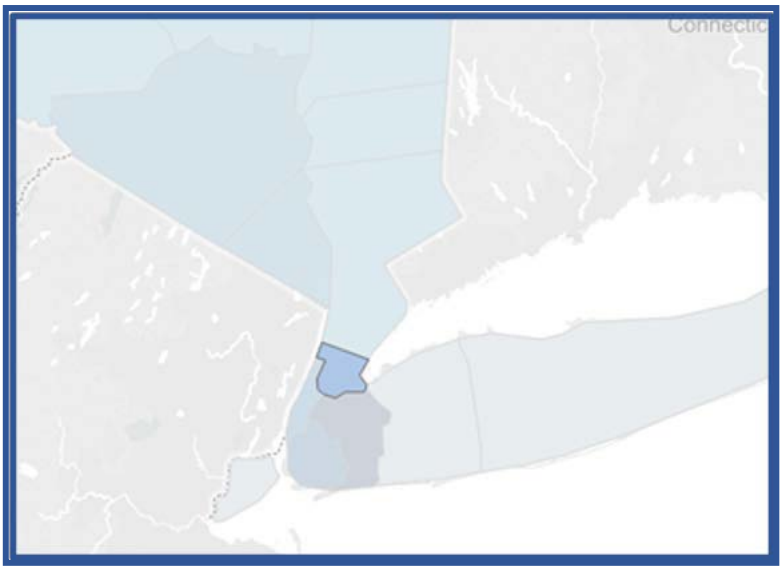
increase in access
and transitions of care, and various behavioral health and substance abuse program

- Evaluate Return on Investment, and sustainability of programs in MCO agreements
- Work with local community colleges to standardize the education and competency validation
  as well as training for community health workers (CHWs)
- Maintain engagement with CBOs to fund screening and remediation of Social Determinants of Health needs a well as enrollment in managed care plans

Bronx Partners for Healthy Communities

http://www.bronxphc.org/

Bronx Partners for Healthy Communities is a partnership of 240 health and social service providers working together to build an integrated healthcare system that is coordinated, patient-focused and addresses the communities' health disparities.



Counties Served: Bronx County

11 total projects

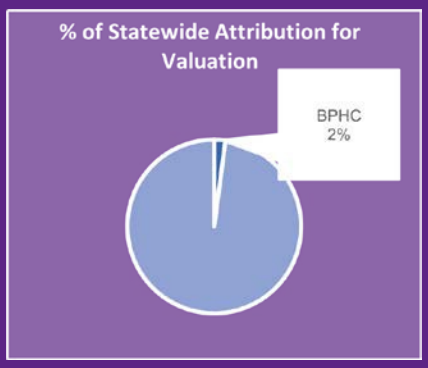
- 2.a.i Integrated Delivery Systems
- 2.a.iii Health Home At-Risk
- 2.b.iii ED Care Triage
- 2.b.iv Care Transitions – Chronic Disease
- 3.a.i Primary Care and Behavioral Health Integration
- 3.b.i Disease Management – Cardio
- 3.c.i High-Risk Disease Management – Diabetes
- 3.d.ii Asthma Home-Based Self-Management
- 4.a.iii Strengthen MHSA Infrastructure
- 4.c.ii Increase Access/Retention of Care

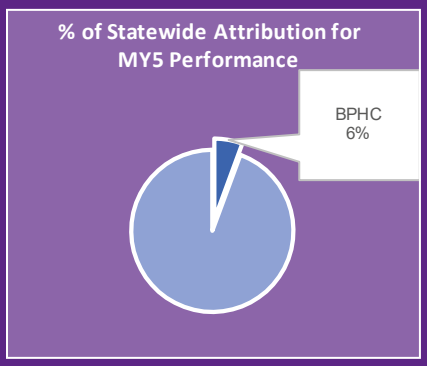
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	41,551	88,253	89,802	108,556
Total Active Engagements of Patients	77,657	157,543	197,995	220,611

BY THE NUMBERS

- **159,201** Total Patients Attributed for Maximum Valuation
- **323,385** Total Patients Attributed for MY5 Performance





- **8,568** Total Network Partner Types
- **518** Total PCMH and APC Recognized Providers
- **699** Total Primary Care Providers and **438** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$280,713,381** Total Funds Earned Through DY5

BRONX PARTNERS FOR
HEALTHY COMMUNITIES

Bronx Partners for Healthy Communities (BPHC)

Bronx Partners for Healthy Communities convened 240 Bronx providers across the care continuum to build an integrated healthcare delivery system. The PPS provided the support, training, and technology to enable network members to coordinate patient care, address the spectrum of the communities' health and social needs, and deliver outcome-driven care.

Emphasis was placed on building trust and productive partnerships among organizations, establishing communities of practice, and developing competencies that would establish a solid and sustainable
foundation for working together beyond DSRIP. Members learned to align with shared goals, adopt best practices, and work with standardized measures to succeed in a value-based environment.

Transformation of primary care
Nearly all (~95%) of primary care providers in BPHC have achieved NCQA Patient-Centered Medical Home designation with behavioral health successfully integrated with primary care at roughly 96 sites. Providers have the standardized processes, technology, and capacity to coordinate their patients' care and address care gaps. Today, patients can be screened for primary care or behavioral health needs in either a provider setting or be seamlessly connected to the care they need.

Care coordination programs improve patient health and reduce hospitalizations
New care coordination programs reach patients with complex medical and social needs when they are in the hospital, emergency room, shelter, nursing home, and other care settings. Care models, like Hospital to Home, Critical Time Intervention (hospital to community), and Transitional Care Coordination (prison to community), transition patients from institutional care to their homes and community. Care coordinators identify the range of patients' needs, provide the critical link to care and services, and keep patients engaged in their care. Preventable hospitalizations for high-risk patients have decreased substantially.

Clinical and social service partnerships address patients' social needs
Strong and enduring collaborations are in place between community-based organizations (CBOs) and health providers. The CBOs partner with hospitals and providers offering patients wrap-around services that address food insecurity, transportation, housing instability, and housing quality. They give patients the skills and knowledge to self-manage their chronic conditions like diabetes, asthma, cardiovascular disease, and HIV, and they empower and educate patients on nutrition, health literacy, and benefit eligibility.

Providers have the training and technology to deliver outcome-driven care
Providers acquired the platforms to share patient medical information, identify care gaps, coordinate care among each other, and operationalize performance improvement. Across the consortium, participants capture, mine, and use data to measure performance outcomes and practice change management, Lean process improvement, and goal setting. Participants now have the toolkits for managing population health with accountability and the competencies to demonstrate their

contribution to Value-Based arrangements.

Introducing a new culture of "health": SBH Health and Wellness Center

The new SBH Health and Wellness Center is a culmination of BPHC's work to achieve the community stakeholders' aspirational vision of all-inclusive health. Opening in summer 2020, the Center offers medical and behavioral health care complemented by fitness, mind-body, cooking, and nutritional programming. It is a testament to DSRIP's goal to transform the healthcare system from "illness care" to "well care" and provide the community with comprehensive, community-based health and wellness support.

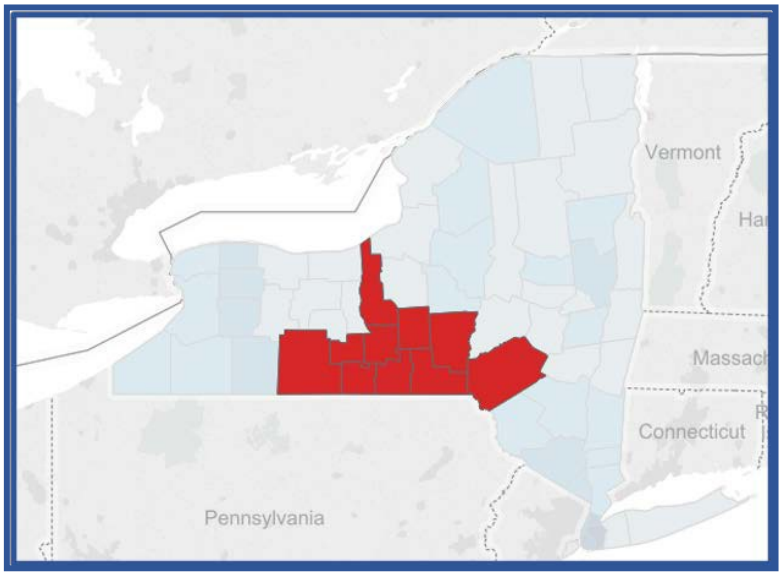
Sustainability Plan

- Continue the PPS-led transformation effort
- Establish and continue a post-2020 plan for sustaining DSRIP goals and transformation
- Identifying other revenue sources
- Collaborate with health plans to evaluate selected "Promising BPHC Practices"
- Continue investment in workforce development
- Coordinate population health management with SDH Networks for social interventions

Care Compass Network

https://carecompassnetwork.org/

Care Compass Network convenes and collaborates with over 180 partner organizations, which include hospital systems, community-based organizations, nursing homes, behavioral health and substance use disorder programs, social services agencies, and similar entities.



Counties Served: Broome, Chemung, Chenango, Cortland, Delaware, Schuyler, Steuben, Tioga, Tompkins

11 total projects

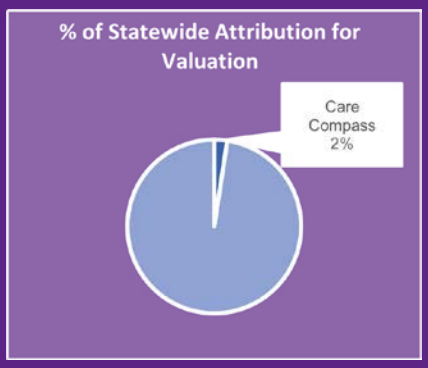
- 2.a.i Integrated Delivery Systems
- 2.b.iv Care Transitions – Chronic Disease
- 2.b.vii INTERACT
- 2.c.i Community-Based Health Navigation
- 2.d.i Patient Activation (PAM)
- 3.a.i Primary Care and Behavioral Health Integration
- 3.a.ii Crisis Stabilization
- 3.b.i High-Risk Disease Management – Cardio
- 3.g.i Integration of Palliative Care into PCMH
- 4.a.iii Strengthen MHSA Infrastructure Preventative
- 4.b.ii Care/Management

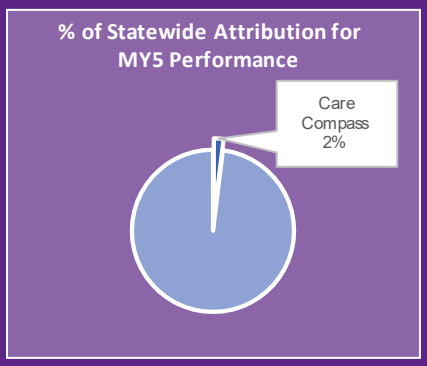
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	0	5,451	26,084	28,904
Total Active Engagements of Patients	240	49,373	105,894	105,837

BY THE NUMBERS

- **186,101** Total Patients Attributed for Maximum Valuation
- **107,094** Total Patients Attributed for MY5 Performance





- **2,224** Total Network Partner Types
- **353** Total PCMH and APC Recognized Providers
- **312** Total Primary Care Providers and **26** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$212,412,216** Total Funds Earned Through DY5

CARE COMPASS NETWORK

Care Compass Network convenes and collaborates with over 180 partner organizations, which include hospital systems, community-based organizations, nursing homes, behavioral health and substance use disorder programs, social services agencies, and similar entities.

- **Collaboration**
  Care Compass Network ("CCN") formed as a new entity to administer DSRIP in the Southern Tier of upstate New York. The CCN's engagement approach was simple, if your organization works with the Medicaid population, the PPS wants to work with you. This open engagement model resulted in partnerships that spanned a wide variety of organization types and services as well as front line employed and independent clinicians. In its convening role, CCN advocated for needs of the Medicaid member, prompting innovation and change among community organizations and healthcare providers. The lasting result was the integration of community agencies to both the care continuum of health systems as well as clinicians and vice versa. The Delivery System Reform Incentive Payment (DSRIP) program amplified the concept of social determinants of health ("SDOH") which was previously missing from view of healthcare providers and supported the integration of effort to address SDOH between community organizations and healthcare providers. The CCN partners have benefited from tapping into the breadth of resources inherent to the community and leveraged CCN as a facilitator of collaboration, resulting in the advancement of core competencies and lasting relationships that are now being used to manage networks and collect meaningful data for assessment and outcome delivery.

- **Regional Infrastructure**
  The CCN implementation plans had deep requirements for advancement of regional infrastructure. The PPS helped administer new IT technologies to both clinical and non-clinical partners which served as a backbone for sustainable collaboration to occur. The Southern Tier has also integrated disparate technology platforms allowing organizations to track, monitor, and measure impact in ways previously not possible. Further, the region leveraged the PPS's collaborative backbone which resulted in regional standards being adopted, including clinical guidelines and screening tools for SDOH. Workforce training reached many and increased the presence of master trainers for several initiatives positioning the region for training sustainability. Overall, the advanced regional infrastructure compliments consumer navigation of care and better equips organizations to manage more complex value based and grant programs.

- **Population Health**
  Building upon the collaborative efforts referenced above, DSRIP brought recognition of population health to entities large and small. The Care Compass Network's integrated delivery system model required the development of population health and care management resources. These systems were tailored to the existing infrastructure of the Southern Tier and have been leveraged to assess outcomes related to DSRIP programs as well as supported partner organizations' ability to access to data for grant or other purposes. The PPS has leveraged these tools to perform detailed regression analysis to

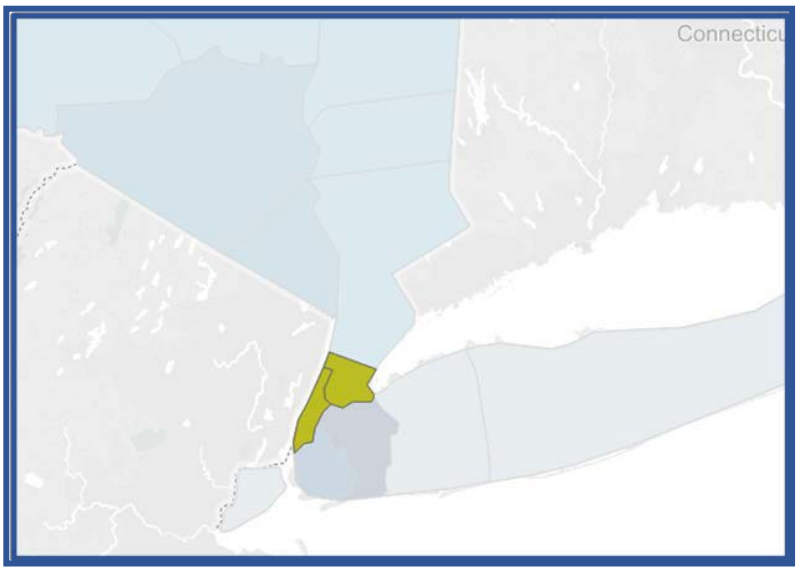
identify where statistical correlation exists between DSRIP program efforts and positive health and wellness improvement. In networks established through the CCN Cohort program, population health resources were integrated to where key decisions are being made, including networks of organizations working together to provide person centered care to produce real time actionable information. These tools have already assisted individual organizations, networks, and IPAs. The power of this new community resource has just begun to evolve and will help inform and impact how individuals are engaged and how care models are developed and managed into the future.

- **Sustainability Plan**
  - Implement "Vision 2025" strategic plan to shift infrastructure beyond DSRIP and the CRFP grant (ending 2023).
  - Maintain role as a convener to promote collaboration, create forum for innovation, and support progression of VBP in the region.
  - Continue the implementation of key "Promising Practices" to deliver value and outcomes
  - Implement a "Continuation Funding" program for DSRIP and workforce retention
  - Evaluate whether a 501(c)(6) corporate structure remains effective for the Mission & Vision 2025 strategy

Community Care of Brooklyn

https://www.ccbrooklyn.org/

The CCB is the largest Brooklyn PPS, with 4,600+ physicians across 7 hospitals, 10 FQHCs, and 500 independent practices, plus hundreds of social service organizations, CBOs, and other providers involved in the care continuum.



Counties Served: Brooklyn and parts of Queens

10 total projects

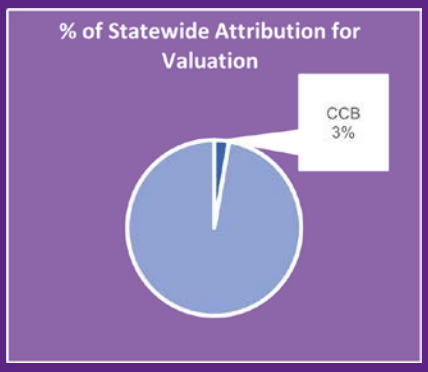
- 2.a.i Integrated Delivery Systems
- 2.a.iii Health Home At-Risk
- 2.b.iii ED Care Triage
- 2.b.iv Care Transitions – Chronic Disease
- 3.a.i Primary Care and Behavioral Health Integration
- 3.b.i High-Risk Disease Management – Cardio
- 3.d.ii Asthma Home-Based Self-Management
- 3.g.i Integration of Palliative Care into PCMH
- 4.a.iii Strengthen MHSA Infrastructure
- 4.c.ii Increase Access/Retention of Care

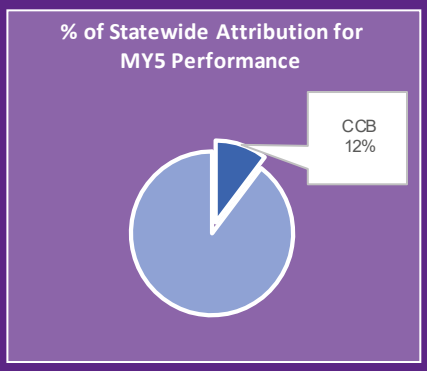
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	14,262	57,020	82,929	87,141
Total Active Engagements of Patients	22,930	120,530	159,184	141,611

BY THE NUMBERS

- **212,586** Total Patients Attributed for Maximum Valuation
- **626,435** Total Patients Attributed for MY5 Performance





- **8,460** Total Network Partner Types
- **429** Total PCMH and APC Recognized Providers
- **1,215** Total Primary Care Providers and **530** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$337,587,938** Total Funds Earned Through DY5

COMMUNITY CARE OF BROOKLYN

Community Care of Brooklyn (CCB) is a large, diverse network of health and social service providers that have worked together to transform the health of communities across Brooklyn. Below are examples of what we've accomplished together thus far.

- **Transforming Primary Care and Integrating Behavioral Health**: CCB worked with practices to strengthen primary care resources, improve quality preventive services, integrate behavioral health screening/follow-up, and help patients manage chronic conditions. The PPS helped partners achieve Patient Centered Medical Home (PCMH) recognition across 158 sites, deploying health coaches to 71 practices to improve patient engagement and chronic disease self-management, and assisted with electronic health record and workflow optimization. The CCB engaged mental health partners in strategies to ensure access and improve population health, including use of patient registries and implementation of daily huddles, and trained over 150 primary care providers on trauma-informed care.

- **Improving Care Transitions through Collaboration and Care Management**: CCB reduced potentially preventable readmissions and emergency department visits by implementing an innovative, interdisciplinary transitional care model at network hospitals, where transitional care nurses and care managers followed at-risk patients in the hospital and post-discharge. The PPS integrated and streamlined referrals among transitional care teams, health coaches, peers, and Health Home community-based care management to help patients connect to primary care, behavioral health services, and community-based resources.

- **Engaging the Community to Address Disparities**: CCB conducted student-led participatory action research (PAR) projects in underserved neighborhoods to better understand community concerns, build relationships, and support community engagement, guided by CCB's Community Action and Advocacy Workgroup. The PPS partnered with CBOs to address the priorities identified through PAR, including improving access to healthy food, mental health, and advocacy services. In 2019, CCB established and secured 501(c)(3) designation for **Brooklyn Communities Collaborative**, leveraging the commitment of anchor institutions to address housing, workforce development, and economic issues affecting the health and well-being of individuals and communities.

- **Investing in Workforce to Sustain the Transformation**: CCB partnered with 1199SEIU Training and Education Fund to develop and provide in-person and online CME-eligible trainings for over 1,500 staff from across the CCB network. The PPS collaborated with CUNY to create a credit-granting health coach training program for 242 medical assistants employed at FQHCs and primary care practices. Additionally, the PPS provided support for training, certification, and integration of innovative new care team roles, including health coaches, substance use recovery and mental health peers, transitional care nurses,

and care managers.

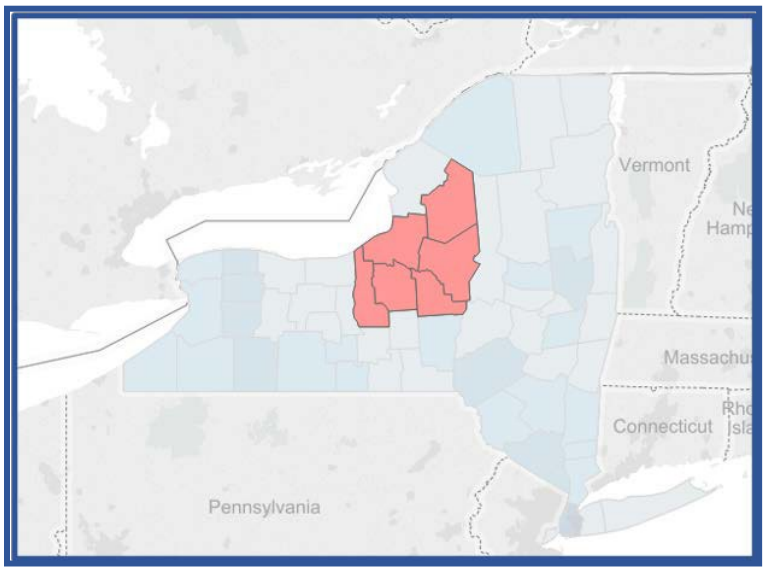
- **Supporting the Transition to Value-based Care**: CCB supported quality measurement, contracting, and funds flow for four VBPQIP hospital partners, strengthening relationships with MCO partners and informing refinement of CCB's sustainability plans. In 2018, the Community Care of Brooklyn created the **CCB IPA**--a network of hospitals, FQHCs, primary care and specialty physicians, CBOs, and others--to negotiate and implement value-based contracts, leveraging DSRIP investments to achieve quality and spending goals. The CCB IPA has implemented VBP agreements with five MCOs, convened 6 hospital partners to participate in a Medicare bundled payment program that resulted in shared savings, and launched participation in the Medicare Shared Savings Program.

- **Sustainability Plan**:
    - Maintain infrastructure created with DSRIP funds to support ongoing work with partners, Brooklyn Communities Collaborative (BCC) and CCB IPA, and the provision of management Services.
    - Use DSRIP funds to advance the clinical, care management and information technology infrastructure developed to support the integration of services.
    - Allocate funds to further develop high-functioning primary care practices serving Medicaid beneficiaries; implement hospital-based care transitions programs; support innovative behavioral health interventions; provide workforce training programs.
    - Convene and support BCC stakeholders to inform the policies and practices that most affect health and well-being.

Central New York Care Collaborative

https://cnycare s.org/

The Central New York Care Collaborative connects over 2,000 healthcare and community-based service providers to address the physical, behavioral, and social needs of patients across the Central New York region.



Counties Served: Cayuga, Lewis, Madison, Oneida, Onondaga, Oswego

11 total projects

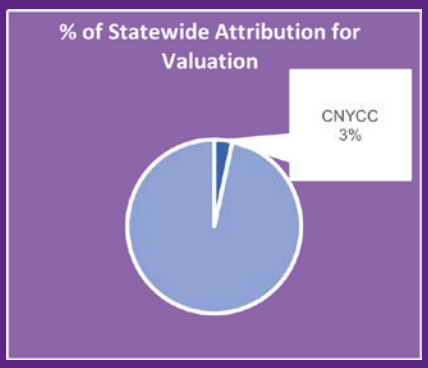
- 2.a.i Integrated Delivery Systems
- 2.a.iii Health Home At-Risk
- 2.b.iii ED Care Triage
- 2.b.iv Care Transitions – Chronic Disease
- 2.d.i Patient Activation (PAM)
- 3.a.i Primary Care and Behavioral Health Integration
- 3.a.ii Crisis Stabilization
- 3.b.i High-Risk Disease Management – Cardio
- 3.g.i Integration of Palliative Care into PCMH
- 4.a.iii Strengthen MHSA Infrastructure
- 4.d.i Reduce Premature Births

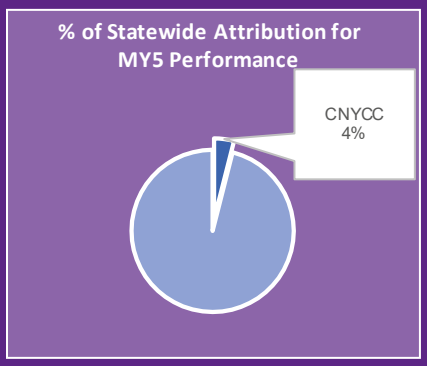
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	8,116	26,730	34,678	31,776
Total Active Engagements of Patients	22,762	64,106	74,571	68,714

BY THE NUMBERS

- **262,144** Total Patients Attributed for Maximum Valuation
- **224,274** Total Patients Attributed for MY5 Performance





- **3,851** Total Network Partner Types
- **361** Total PCMH and APC Recognized Providers
- **397** Total Primary Care Providers and **136** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$328,424,194** Total Funds Earned Through DY5

CNY Cares PPS Profile Narrative

The Central New York Care Collaborative (CNY Cares) launched with the goal to serve the local community by creating an overall better system of care. The CNY Cares PPS and its network partners worked together to create lasting improvements for the community's most vulnerable populations. The organization's legacy includes:

Supporting Members in Crisis

The mobile crisis teams & peer-run crisis respite programs were instrumental in CNY Care's success reducing potentially preventable emergency department visits (PPVs) among individuals with behavioral health conditions. The impact of these services delivered by network partners in each of CNY Care's six counties is illustrated by the work of AccessCNY's Berkana Center and Liberty Resource's regional mobile crisis response programs.

Advancements in Primary Care and Behavioral Health Care

CNY Cares' most effective primary care-based projects included the achievement of 2017 Patient-Centered Medical Home or Advanced Primary Care recognition for nearly one-hundred primary care practitioners which contributed to the improvement of many of the ambulatory outcome measures, with one example being the achievement of this milestone by Christian Health Services of Syracuse. Additionally, integration of behavioral health into primary care achieved broad adoption including Mohawk Valley Health System's 2017 expansion of access to behavioral health services across sixteen sites throughout the Mohawk Valley region.

Reducing Avoidable Visits

The CNY Care's hospital-based projects were adopted across all eleven hospitals in the CNY Cares network. The effectiveness of ED care triage was demonstrated by the improvement in PPVs and is highlighted by the work of Oneida Healthcare. Care Transitions teams working with network partners in the community contributed to the improvement in potentially preventable readmissions (PPRs), as did MAX series participation by four of CNY Cares' partner hospitals.

Innovation Fund

The CNY Cares' Innovation Fund was set up to provide funding for creative approaches that address physical, social, and mental health needs to improve care for Medicaid and uninsured patients while fostering cross-sector partnerships throughout the region. Since its inception, the Innovation Fund has distributed $12.8 million dollars to sixteen lead network partners to make significant improvements and provide invaluable services to some of the most vulnerable populations. Among the many successful projects awarded funding in 2018 and 2019is Catholic Charities of Onondaga County's Comprehensive Services for the Homeless and Housing Vulnerable Program, which provided access to critical on-site services that significantly improved outcomes for clients of the men's shelter, improved health and reduced unnecessary ambulance & hospital utilization.

Addressing the Social Determinants of Health

In May of 2020, CNY Cares along with Unite Us, a data platform that builds coordinated care networks of health and human service providers, launched the CNY Cares Referral Network. The network enables providers across sectors to send and receive secure electronic referrals, track every person's total health journey, and report on tangible outcomes across a range of services in a centralized platform. More than four-hundred users from over one-hundred organizations–including primary care, behavioral health, nursing home, specialty care, community-based organizations, and local hospitals are anticipated to utilize the network.

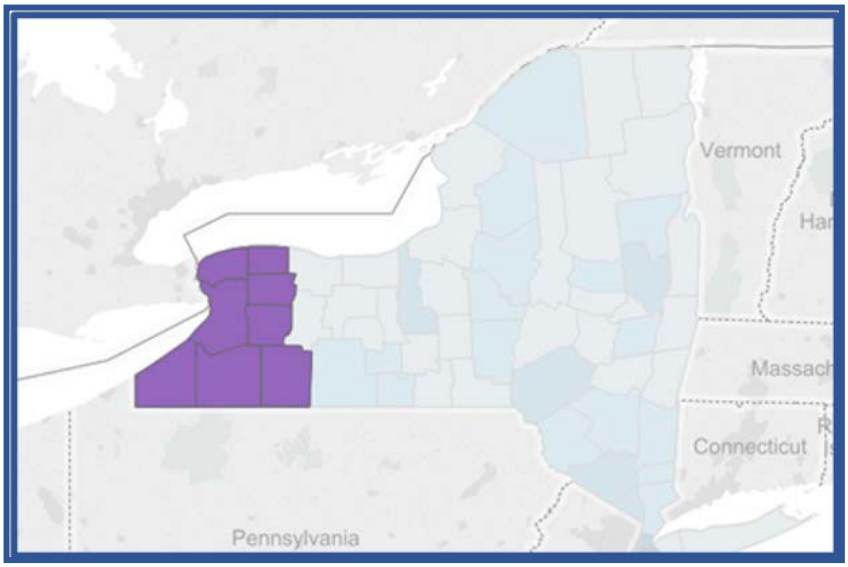
Sustainability Plan

- CNYCARES to wind down DSRIP activities and dissolve the organization while taking steps to preserve the essential assets that will most benefit our community in the future.
- Support partner organizations to leverage the Promising Practices funded through DSRIP to meet the care delivery & coordination challenges posed by the crisis.
- Accelerate the flow of funds to partners that have been significantly financially impacted by the pandemic under the PPS Financially Fragile Partner Policy.

Community Partners of Western New York

http://wnycommunitypartners.org/

Community Partners of WNY is a network of more than 100 health, human service, and educational organizations; the Catholic Health System plus five community hospitals; and over 1,000 physicians from across the region that focus on transforming the delivery of healthcare in Western New York. This community-wide effort is governed by a representative board established by the lead organization, Sisters of Charity Hospital, and supported by the project management team at Catholic Medical Partners. Primary care and transformation work in the southern part of the PPS includes efforts by the Chautauqua Health Network and UPMC Chautauqua.



Counties Served: Chautauqua, Erie, Niagara

10 total projects

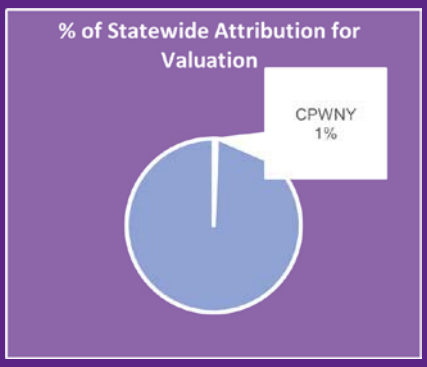
2.a.i	Integrated Delivery Systems
2.b.iii	ED Care Triage
2.b.iv	Care Transitions – Chronic Disease
2.c.ii	Telemedicine in Underserved Areas
3.a.i	Primary Care and Behavioral Health Integration
3.b.i	High-Risk Disease Management – Cardio
3.f.i	Maternal and Child Support Programs
3.g.i	Integration of Palliative Care into PCMH
4.a.i	Promote MEB Well-Being
4.b.i	Tobacco Cessation

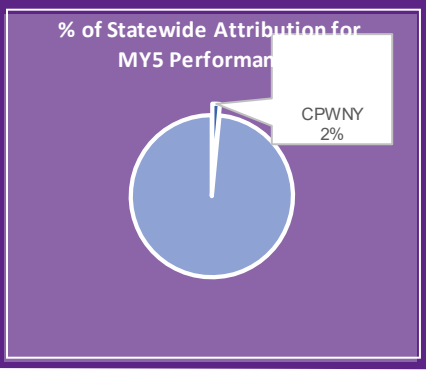
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	20,061	26,111	29,190	32,653
Total Active Engagements of Patients	41,674	54,083	57,863	59,435

BY THE NUMBERS

- **43,375** Total Patients Attributed for Maximum Valuation
- **83,221** Total Patients Attributed for MY5 Performance





- **3,604** Total Network Partner Types
- **284** Total PCMH and APC Recognized Providers
- **280** Total Primary Care Providers and **53** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$77,582, 914** Total Funds Earned Through DY5

COMMUNITY PARTNERS OF WNY

Performing Provider System

CPWNY PPS PROFILE

The Delivery System Reform Incentive Payment (DSRIP) program and CPWNY, a Performing Provider System (PPS), have transformed healthcare in the Western New York Region. The CPWNY has demonstrated this transformation by being intentional in piloting and implementing programs that support an integrated, patient-centered delivery system and prepared network partners for the future of value-based care. It has also leveraged established and existing structures in its organizational framework that will have transformed healthcare and will also continue after DSRIP.

A few lasting ways CPWNY has transformed healthcare in the region are as follows:

1. **Buffalo Urban League (BUL) Community Health Worker (CHW) Program:** This program has grown from one CHW at an OB/GYN Article 28 clinic in 2017 to eight CHWs and a supervisor at six Article 28 clinics and one hospital emergency department. As a recipient of Value Based Payment (VBP) Innovation funding, BUL moved from a paper-based system with no connectivity to health providers into one with a data platform, refined a qualitative and quantitative evaluation plan, and polished their value proposition.

2. **CPWNY's Primary Care Clinical Partnership with Catholic Health System (CHS) and Buffalo's D'Youville College:** These partners have built and will sustain a brand-new primary care program in the West Side of the City of Buffalo. The program is a collaborative training and clinical program that will change the face of Buffalo's West Side community's health care environment.

3. **Care Management Redesign Efforts in CHS:** CPWNY supported the initiation of care management redesign efforts in the acute care setting across the Catholic Health System. Master's prepared social workers are placed in each of the emergency departments to provide better care coordination of patients with psychosocial issues and/or poorly controlled chronic conditions. Further, acute care redesign efforts will strengthen safe transitions across the continuum of care, increase connectivity to ambulatory care and address social determinants of health.

4. **Performance Improvement Initiative Program (PIIP):** The PIIP Program sparked collaborated efforts among clinical and service providers and led to improvement in priority metrics. The program was aligned with other quality improvement programs, i.e., clinical integration programs and shared savings initiatives. Dashboards and reports were created to improve patient list management and monitor performance, producing actionable data. Further, PIIP supported regional collaboration among an emerging behavioral health IPA, RHIO, partner DSRIP PPS, local government organizations, etc.

5. **Telemedicine:** Telemedicine has transformed healthcare delivery by the way services are delivered and received by patients. Patients are now able to receive fast and efficient care because of the convenience of using technology.
    - People Inc. led a Telemedicine Initiative for individuals from People Inc. group homes or day habilitation programs located in Erie and Niagara counties who required non-emergent incidental care. This program has continued, is sustainable, and has transformed future healthcare for the developmentally disabled population.

    Integration of primary care (PC) and behavioral health (BH) services has transformed healthcare by reducing the stigma associated with mental illness. Offering PC and BH services under one roof has increased patient show rates for their BH appointments.
    - The Hope Center, collaboration between Endeavor BH Services and Inspired Medical Group is now self-sustainable and has impacted the lives of their patients. This Center has made it easier for patients to see their BH and PC provider at just one appointment.
    - Niagara County Department of Mental Health (NCDMH) implemented a satellite clinic at Dr. Laurri's Primary Care Practice. These committed partners worked together to design a seamless clinical workflow between PC and BH providers, including adapting the respective electronic medical record systems to reduce duplication of effort and provide the right information to the right provider.

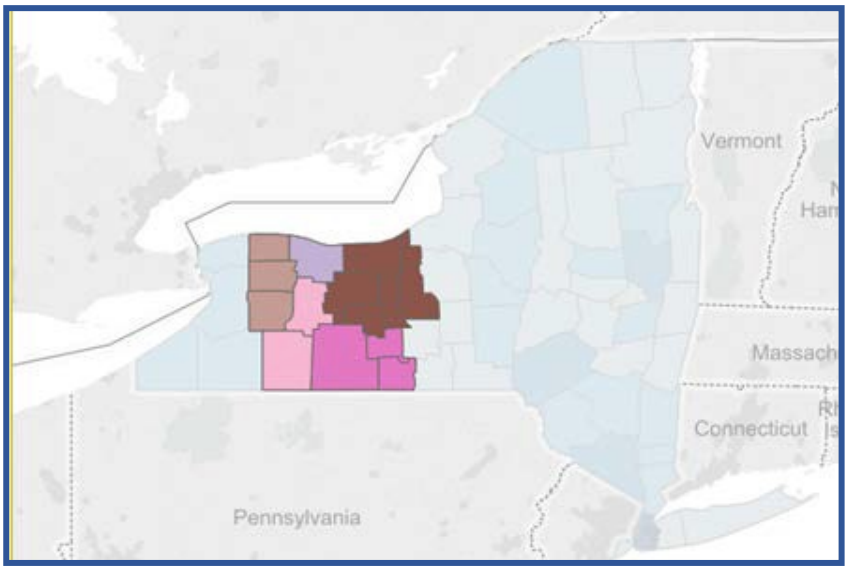
6. **Sustainability Plan:**

    - Continue programs that support and integrated, patient-centered delivery system and prepare network partners for the future of value-based care.
    - Enhance a financially viable independent practice association (IPA)
    - Advance efforts of the rural health network
    - Leverage resources from existing health systems

Finger Lakes PPS

http://flpps.org/

The Finger Lakes Performing Provider System (FLPPS) is a partnership comprised of 19 hospitals, 6,700 healthcare providers, and hundreds of healthcare and community-based organizations in a 13-county region.



Counties Served: Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates

11 total projects

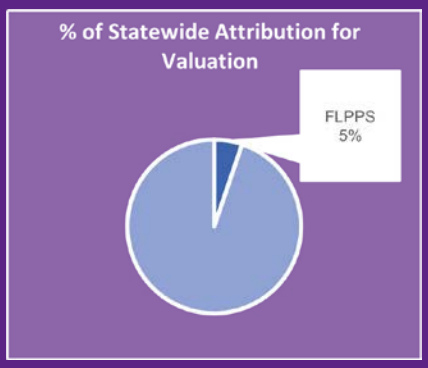
2.a.i	Integrated Delivery Systems
2.b.iii	ED Care Triage
2.b.iv	Care Transitions- Chronic Disease
2.b.vi	Transitional Supportive Housing
2.d.i	Patient Activation (PAM)
3.a.i	Primary Care and Behavioral Health Integration
3.a.ii	Crisis Stabilization
3.a.v	Behavioral Intervention Paradigm in Nursing Homes
3.f.i	Maternal and Child Support Programs
4.a.iii	Strengthen MHSA Infrastructure
4.b.ii	Preventative Care/Management

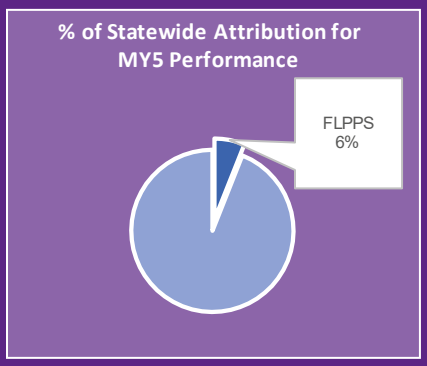
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	17,151	35,674	63,174	66,259
Total Active Engagements of Patients	38,418	94,110	150,364	144,399

BY THE NUMBERS

- **413,289** Total Patients Attributed for Maximum Valuation
- **347,089** Total Patients Attributed for MY5 Performance





- **4,195** Total Network Partner Types
- **279** Total PCMH and APC Recognized Providers
- **761** Total Primary Care Providers and **343** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$449,331,456** Total Funds Earned Through DY5

The Finger Lakes Performing Provider System (FLPPS) is a partnership comprised of 19 hospitals, 6,700 healthcare providers and hundreds of healthcare and community-based organizations in a 13-county region.

1) Keeping Care Local

With a region of over 10,000 square miles, the Finger Lakes PPS is the largest, most geographically diverse PPS in NY State with both urban and rural areas. To effectively improve care delivery, the PPS divided the large region into sub-regions representing local care patterns. These subregions became the naturally occurring care networks (NOCN) which include Finger Lakes, Monroe, Southeastern, Southern and Western. Each NOCN represents the full continuum of care and is led by a workgroup of healthcare and community-based leadership within a shared geographic service area. The NOCN workgroups successfully operationalized DSRIP projects and continue to identify gaps in care for their region.

2) Connecting Social Determinants of Health and Clinical Care

Over the course of DSRIP, FLPPS has bridged partnerships between clinical and social service providers in many ways. Through Medicaid Accelerated eXchange (MAX) action teams composed of hospital clinical staff, social workers, CBO representatives, behavioral health and primary care providers have redesigned the way care is delivered to high-utilizing patients. The teams focus on understanding a patient's drivers of hospital utilization and meeting his or her unique medical, behavioral and social needs. In the Finger Lakes, the high-utilizer population accounts for approximately 1 in 5 of all Medicaid inpatient admissions.

The FLPPS Community Navigation Program supports the sustainability of non-clinical community health workers who assess an individual's immediate needs and provide coordination of basic needs. The FLPPS has assembled a set of best practices which address county-level coordination, telehealth response, social determinant of health support and screening, and health home outreach. Partners are provided with data analytics dashboards to track performance. The FLPPS is collaborating with regional independent practice associations (IPAs) to establish a clinical outcome measure set to evaluate performance.

3) Capturing Quality Improvement with Behavioral Health Integration

Through DSRIP, the FLPPS seized the opportunity to look beyond the traditional and expand care teams to include historically undervalued services. In 2018, the regional FQHCs, a group of behavioral health providers, and a rural health organization of county public health departments allied to create the Finger Lakes Independent Provider Association (FLIPA). The PPS supported FLIPA with resources to begin quality and clinical outcome improvement initiatives inclusive of their behavioral health members, which resulted in significant outcome improvement. Through the System Transformation Initiative, FLPPS also supported the creation and development of outcome performance

dashboards and a peer engagement model of intervention, focusing on engagement and retention of patient participation in care for chronic conditions. Through common efforts and partner support, FLPPS has demonstrated the value of behavioral health providers and peers in the delivery and coordination of care.

4) Integrating DSRIP and Health Homes Care Management

Health h and care management services have been integral to the success of DSRIP by linking community resources to clinical services, improving collaboration and coordination among providers, and reducing unnecessary hospitalizations. In 2018, FLPPS embraced the opportunity to integrate the work with one of the local health homes and acquired the Greater Rochester Health Home Network. This integration has resulted in operational efficiencies, including a streamlined on-line referral system and universal training for all care management agencies (CMA). The FLPPS infrastructure has expanded CMA ability to increase enrollment and enhance data analytics capabilities resulting in increased collaboration to provide optimal care. The FLPPS and GRHHN are also providing gap-in-care information to local MCOs.

In the Finger Lakes region, these types of initiatives improve outcome performance, but more importantly, they are changing lives for the better. In the Finger Lakes, FLPPS is redefining healthcare.

5) Sustainability Plan

The Partners in the PPS will continue the DSRIP work and activities built under the DSRIP 1.0 program. The Partners in the PPS will continue to deploy the promising practices in an effort to improve health outcomes for patients in the region and remaining DSRIP funds will be utilized to support sustainability of these activities. FLPPS investment in System Transformation and Community Initiatives will address the following goals:

- Identify high-cost and high-utilizer populations and invest in transformative practices across DSRIP domains (behavioral health and substance abuse, maternal and child health, social determinants of health, telehealth, workforce, etc.).
- Scale investments to result in a sustainable model of care that improves health outcomes and lowers cost of care.
- Ensure collaboration amongst all providers in the PPS (both clinical and non-clinical) to ensure alignment and eliminate duplication of resources.

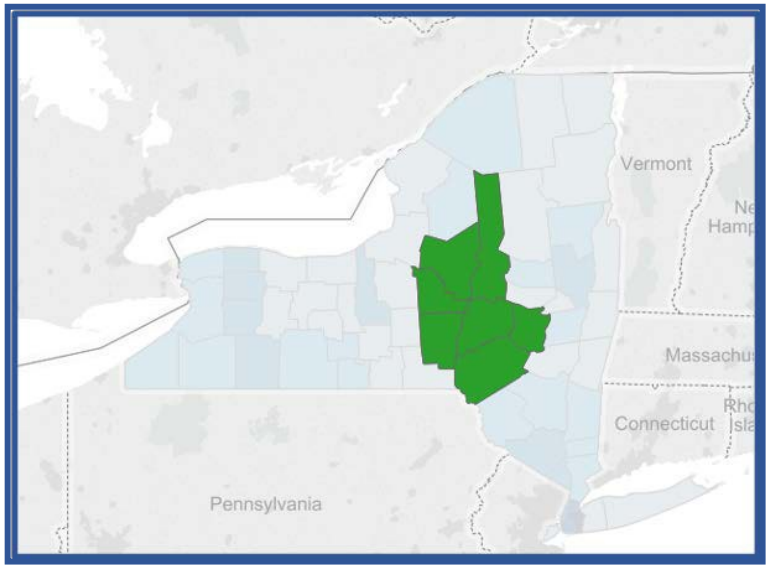
In order to support Partners and ensure success of transformation initiatives, FLPPS will provide partners with implementation and transformation support services in the form of project management, subject-matter expertise and consultation, and data analytics. FLPPS will utilize its resources and infrastructure to support the partnership in its continued transformation, and FLPPS will sustain these services for the community post-DSRIP.

In addition, FLPPS will focus on sustaining the critical mission of the Greater Rochester Health Home Network (GRHHN). The GRHHN provides health home care management services to patients in Monroe County and the value generated from the GRHHN's activities are critical to supporting high-cost, high-utilizer patients. GRHNN's infrastructure and resources will be leveraged to support population health improvement post-DSRIP.

Leatherstocking Collaborative Health Partners

http://leatherstockingpartners.org/

Bassett Healthcare Network led the formation of Leatherstocking Collaborative Health Partners (LCHP), a collaboration of 90 diverse health care and community service partners in rural central New York.



Counties Served: Delaware, Herkimer, Madison, Otsego, Schoharie

11 total projects

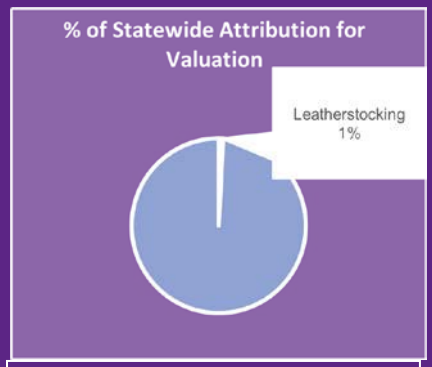
2.a.ii	PCMH/APC
2.b.vii	INTERACT
2.b.viii	Hospital-Home Care Collaboration
2.c.i	Community-Based Health Navigation
2.d.i	Patient Activation (PAM)
3.a.i	Primary Care and Behavioral Health Integration
3.a.iv	Withdrawal Management & Abstinence Services
3.d.iii	Evidence-Based Guidelines for Asthma
3.g.i	Integration of Palliative Care into PCMH
4.a.iii	Strengthen MHSA Infrastructure
4.b.i	Tobacco Cessation

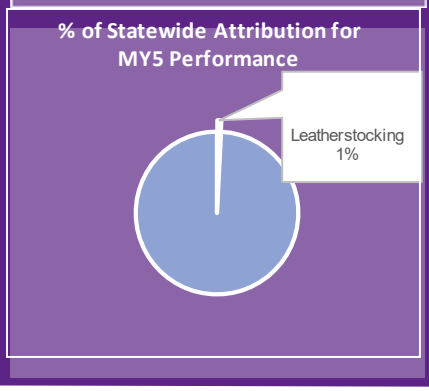
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	6,297	11,166	9,329	5,719
Total Active Engagements of Patients	25,278	38,000	42,595	38,801

BY THE NUMBERS

- **62,043** Total Patients Attributed for Maximum Valuation
- **43,680** Total Patients Attributed for MY5 Performance





- **949** Total Network Partner Types
- **190** Total PCMH and APC Recognized Providers
- **223** Total Primary Care Providers and **36** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$63,012,089** Total Funds Earned

Over the course of DSRIP, Leatherstocking Collaborative Health Partners (LCHP) worked to provide innovative programming to transition health care toward patient centered care, collaboration, improved access, and reduced health care costs. Four areas, in particular, demonstrate how this change was affected in a sustainable, meaningful manner:

Medication Assisted Treatment

- Using buprenorphine for management of opioid addiction is a well-supported approach to treatment, and Bassett Medical Center's Medication-Assisted Treatment (MAT) program has demonstrated that this treatment can be effectively and safely delivered from a primary care setting. Through collaboration with the University of Massachusetts Medical School and with support of DSRIP funding, the project has brought evidence-based treatment to a population in great need. This project has successfully built onto existing infrastructure (i.e., primary care clinics) to make evidence-based treatment more accessible to patients who have historically been underserved. It has treated over 700 patients with buprenorphine for opioid addiction. Of these, approximately two-thirds were either covered by Medicaid or uninsured. Bassett has 53 primary care clinicians who have obtained their Drug Addiction Treatment Act (DATA) waivers (often called "X-licenses"), an increase of over 96% since training was initiated. There is now a total of 79 clinicians with X- licenses across all specialties.

  In 2019, NYS DSRIP leadership recognized the project in their "DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid" report of the most impactful projects to emerge from the first four years of DSRIP. Plans are for the project to expand into emergency departments and in-patient units in the future.

Community Health Navigation

- One program which has fundamentally changed the way in which services are provided to patients is community health navigation. With average caseloads of 40-45 individuals, navigators, embedded within hospitals and community-based organizations, identify individuals who can benefit from this type of comprehensive service. Following an in-depth screening process, individual care plans are established, ensuring members are educated about their chronic conditions and have access to necessary health care and follow up with social support services. While these services impact the DSRIP goals of reduced emergency department (ED) visits and readmissions, community health navigators deeply touch the lives of patients and their families every day, advocating for them, establishing trust, and facilitating lasting change. As one patient put it, "when community health navigation came into our lives, I was indifferent, but I must say they have done a wonderful job for my wife and me in getting things we need such as scheduling appointments, rides, and overall helping in general."

Leatherstocking Collaborative Health Partners

County Hub Steering Committees

- In DSRIP Year 2, LCHP recognized that while the five counties in the performing provider system (PPS) had many things in common, it was also clear that each possessed its own particular character, assets, opportunities and challenges. In order to address these unique differences, county hub steering committees were organized, with a PPS partner/leader appointed as "Champion" and including a committee membership comprised of diverse partners. For many, it was the first time working collaboratively with "competing" organizations. Using data supplied by LCHP and other county resources, each hub identified specific issues faced by Medicaid members in their county. Informed by DSRIP goals and objectives, they collectively formulated and executed plans to address the problems. For example, Schoharie County identified their high ED utilizers. By educating patients about other available options for non-emergent needs, they substantially reduced potentially avoidable ED visits. The education tool they developed for this initiative continues to be effectively used by navigators embedded in the ED. The county hubs will continue to meet to address local issues and share best practices.

Telehealth

- With the help of DSRIP funds, LCHP's lead partner, Bassett Medical Center, has developed a comprehensive telemedicine program which positively impacts ED utilization, and, in the surrounding rural counties, improved access to both primary and specialty care. These benefits have been particularly striking during the COVID-19 crisis, when, with the exception of emergencies, in-person visits to the Medical Center have been curtailed. Telemedicine allows for seamless, electronic medical record-integrated video consults among Bassett's affiliated hospitals and primary care centers, providing ambulatory telehealth visits and specialty consults. Patient and provider satisfaction are high, and all signs indicate this inclusive approach to telemedicine will become part of the "new normal," positively influencing the way care is delivered in the region for years to come.

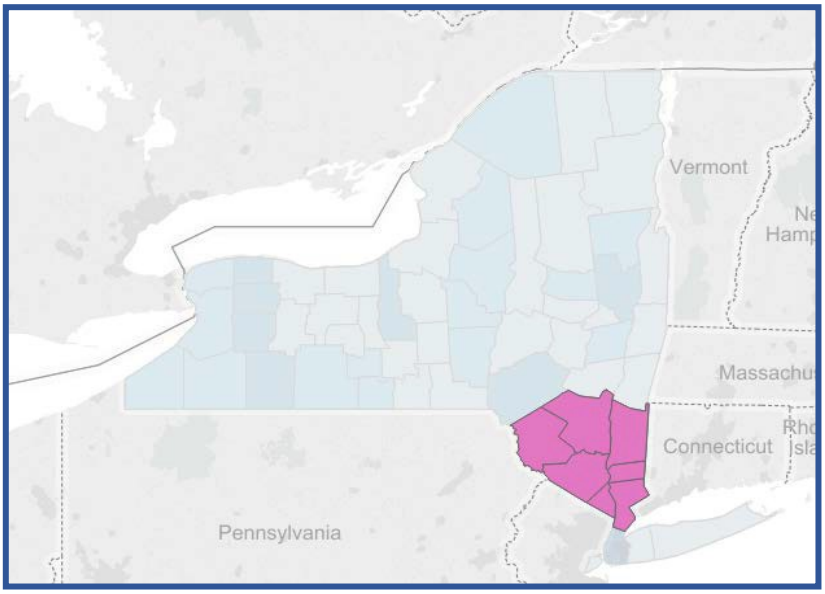
Sustainability Plan

- Extension renewal of the waiver would enable LCHP to not only continue its current best-practices but to pursue additional projects and innovations, as well. New initiatives to address the social determinants of health, behavioral health, and workforce issues would be explored; efforts to increase CBO engagement and cross-sector collaboration would be supported. Expanding this work would also enhance partners' ability to collect data and information which would strategically improve their ability to negotiate Value Based Payment arrangements in the future. The PPS will support and oversee non-clinical coordination programs in region as well as maintain and strengthen the established county hub/CBO infrastructure. Additionally, the LCHP will create, expand and maintain interventional initiatives aimed at specific populations and scale up current VBP model to multiple MCOs.

Montefiore Hudson Valley Collaborative

https://montefiorehvc.org/

Montefiore, renowned for its long-standing commitment to community-based healthcare, led a group of nearly 250 healthcare providers, community-based organizations and more, from across the Hudson Valley, to form the Montefiore Hudson Valley Collaborative.



Counties Served: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester

10 total projects

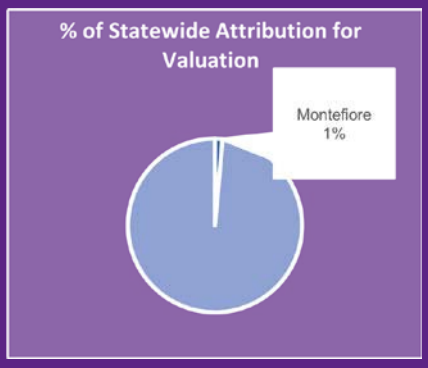
2.a.i	Integrated Delivery Systems
2.a.iii	Health Home At-Risk
2.a.iv	Medical Village-Hospital
2.b.iii	ED Care Triage
3.a.i	Primary Care and Behavioral Health Integration
3.a.ii	Crisis Stabilization
3.b.i	High-Risk Disease Management- Cardio
3.d.iii	Evidence-Based Guidelines for Asthma Management
4.b.i	Tobacco Cessation
4.b.ii	Preventative Care/Management

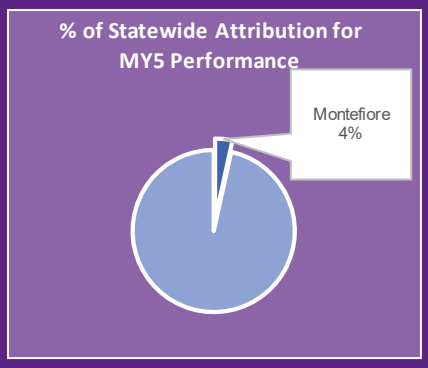
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	15,122	39,553	38,464	26,424
Total Active Engagements of Patients	35,195	91,603	71,251	57,429

BY THE NUMBERS

- **105,752** Total Patients Attributed for Maximum Valuation
- **194,117** Total Patients Attributed for MY5 Performance





- **10,921** Total Network Partner Types
- **257** Total PCMH and APC Recognized Providers
- **1,157** Total Primary Care Providers and **326** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$203,449,590** Total Funds Earned Through DY5

Montefiore HUDSON VALLEY COLLABORATIVE

MHVC PPS Profile May 29, 2020

Montefiore Hudson Valley Collaborative's (MHVC) journey began with an emphasis on key foundational elements of transformation and evolved into an interactive model emphasizing community and provider co- design principles within regional forums. Throughout, providers were encouraged to consider how the Institute for Healthcare Improvement's (IHI) framework of "What Matters to You?" (WMTY) could empower patient and community experience and workforce engagement initiatives. The network's regional legacy can be framed as three interrelated areas of focus:

1. Building a Foundation of Provider Networks: Since inception, MHVC contracts incentivized accountability to process improvements, network outcomes and community connection. This built engagement across partners and provided experience for MHVC members that were new to value-based contracting. Through the course of DSRIP, three new provider contracting entities emerged and another increased in size by four-fold. By DY5, ~75% of MHVC contracted partners participated in the newly formed Hudson Valley IPA - HVIPA (as direct members, network partners, or affiliates) or through IPA-to-IPA contracts. Additionally, MHVC's emphasis on using data to drive partner engagement and contracting models helped to give rise to a joint venture entity, Analytics for Risk Contracting (ARC),a data analytics platform that empowers provider networks, including the HVIPA, to understand the financial impact of targeted care improvement, population health management and provider engagement initiatives.

2. Investing in the Workforce of the Future: Using interactive learning collaboratives and multimedia formats, MHVC empowered network partners with tools related to: change management, behavioral health integration, embracing diversity and inclusion, provider and patient engagement, and social determinants of health (SDH). To support emerging roles, MHVC provided direct underwriting for the cost of training programs (community health workers, peers, care managers and Nurse Practitioner residents) and actively worked with area colleges and accredited training programs to build future programs that enable flexibility in class location, college credits (when applicable) and embrace the needs of full time workers. A unique aspect of the training has been the commitment to include the WMTY framework across all curriculum, to foster patient engagement and address how providers can build resiliency to combat staff burnout.

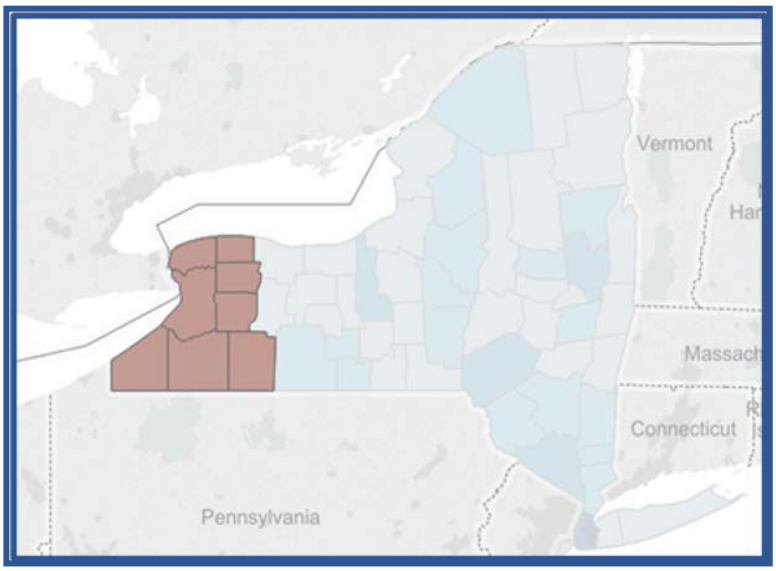
3. Research Roadmap: The MHVC Research Roadmap is a living evolving vehicle for the continued path toward an integrated delivery system. The community networks built over the life of MHVC are resources for grant seeking, coalition building and adoption/measurement of new models of care and SDH interventions. They form a strong foundation for current and future research collaborations with Einstein and Montefiore researchers, Hudson Valley stakeholders and local government, and other academic institutions. For example, MHVC's model of community engagement is a cornerstone within the $85M National Institutes on Drug Abuse (NIDA) Healing Communities Study (HCS) being deployed across New York State. To deepen the network's legacy, MHVC has funded a post -doctoral research fellowship and a medical student public health fellowship. Together these activities are helping tobuild a research pipeline focused on SDH and health disparities.

4. Sustainability Plan:
    - Key PPS governance committees, such as Board of Managers and Audit and Compliance Committee, will remain active due to ongoing payment distributions through end of CY2020
    - Transitioned Tier 1 CBO-based and SDoH-focused pilots to a PPS partner to directly service their value-based lives; these pilots allow the CBO partners to serve as care management extension arm, initiate technical integration with the Partner's systems, and allow for a contractual relationship through the partner's IPA member network.
    - PPS solutions such as community resource guide and eConsults have been successfully utilized and will
      continue to be leveraged post-CY2020.
    - PPS has transitioned the behavioral health-focused pilot: Crisis Respite for behavioral health patients, Care Management for High Utilizing behavioral health patients, Permanent Housing Placement Support for unstably housed behavioral health patients, and Medical Respite for all patients to continue the program post-CY2020 to allow for involved partners to collect and analyze the necessary data to demonstrate value beyond DSRIP funding.
    - Transitioning of Clinical Integration Learning Center (CILC), the PPS' learning management system, to a PPS Partner with a large IPA and CIN membership network. The transition accounts for business and technical workflows, platform integration, and course content transfer between the PPS and Partner.

Millennium Collaborative Care

https://millenniumcc.org/

Millennium Collaborative Care, led by Erie County Medical Center, represented more than 270,000 Medicaid beneficiaries across eight counties in Western New York. Through DSRIP, Millennium ignited and sustained unprecedented collaboration among healthcare partner organizations and community-based organizations, ultimately improving the quality and efficiency of care.



Counties Served: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

11 total projects

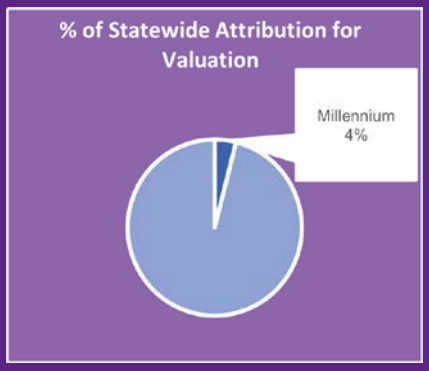
- 2.a.i Integrated Delivery Systems
- 2.b.iii ED Care Triage
- 2.b.vii INTERACT
- 2.b.viii Hospital-Home Care Collaboration
- 2.d.i Patient Activation (PAM)
- 3.a.i Primary Care and Behavioral Health Integration
- 3.a.ii Crisis Stabilization
- 3.b.i High-Risk Disease Management – Cardio
- 3.f.i Maternal and Child Support Programs
- 4.a.i Promote MEB Well-Being
- 4.d.i Reduce Premature Births

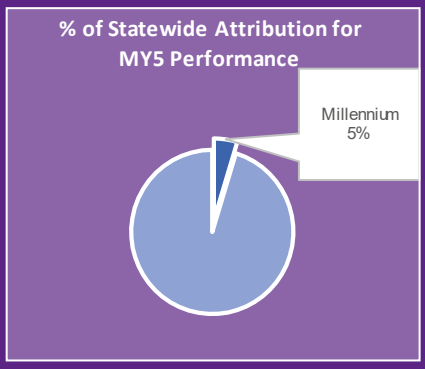
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health 5sIntegration Models	5,147	31,539	51,766	53,896
Total Active Engagements of Patients	39,714	102,815	116,498	118,407

BY THE NUMBERS

- **309,457** Total Patients Attributed for Maximum Valuation
- **266,675** Total Patients Attributed for MY5 Performance





- **2,317** Total Network Partner Types
- **454** Total PCMH and APC Recognized Providers
- **140** Total Primary Care Providers and **117** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$257,198,303** Total Funds Earned Through DY5

Millennium
COLLABORATIVE CARE
Igniting Healthcare Change in WNY

PPS Profile

, The Millennium Collaborative Care (MCC) improved quality and efficiency of care for more than 270,000 Medicaid beneficiaries across Western New York by initiating and sustaining unprecedented collaboration with hundreds of healthcare partner organizations, supported by its lead entity, the Erie County Medical Center Corporation (ECMCC) to accomplish innovative system transformation. Among its achievements are:

Addressing the complex physical and social needs of high utilizers of emergency care was a major focus. Millennium flattened this curve—and changed lives—by transforming care coordination, management, and transitions. The MCC deployed community health workers and mobilized a team to link high utilizers to social care. Avoidable emergency department (ED) use is trending downward thanks to programs including the ECMCC Re-Engineering Discharge program; the Oishei Children's Hospital and Kaleida Primary Care's asthma initiative; the Olean General Hospital behavioral health care transition medication management program; the Niagara Falls Memorial Medical Center (NFMMC) Hot Spotter program; the People Inc., BestSelf, Horizon, and Endeavor telehealth programs; and numerous efforts by the Safety Net Association of Primary Care Affiliated Providers of WNY IPA.

Further supporting these efforts are a new legacy of **cross-sector collaborations with members of Millennium's Community-Based Organization Network**. Millennium unleashed the transformative powers of CBOs by providing value-based payment readiness skill-building and cultural competency/health literacy training to over 5,500 individuals. Additionally, MCC supported formation of lasting partnerships through initiatives such as the NFMMC 'Connect 4U' coalition, ECMCC's support for the new Buffalo Center For Health Equity, Crisis Services' crisis intervention training, and Endeavor's licensed clinical social worker police ride-along program. The ultimate result? A veritable "village of care" is replacing avoidable ED visits for so many.

Millennium also supported **initiatives to transform primary care**. From the Evergreen Health THRIVE wellness program, to The Chautauqua Center chronic obstructive pulmonary disease medical neighborhood, to the Rapha Family Wellness diabetes prevention program, Medicaid clients benefit from primary care innovations leading to brighter tomorrows. The MCC supported Centering Pregnancy Programs including NFMMC P3 Center for Teens, Moms & Kids. Additionally, the PPS helped integrate behavioral health by supporting a host of initiatives including BestSelf/UB Family Medicine primary care/behavioral health integration, Urban Family Practice/Endeavor mobile health clinic program, Erie County Anti-Stigma Coalition, ClubWest@BestSelf crisis respite center, ECMCC/BestSelf/Horizon peer bridger program, "Just Tell One" mental health public awareness campaign, and the ValueNetwork transportation partnership with Uber Health. These are but a few of the lasting ways Millennium PPS/DSRIP has transformed healthcare in the region/community.

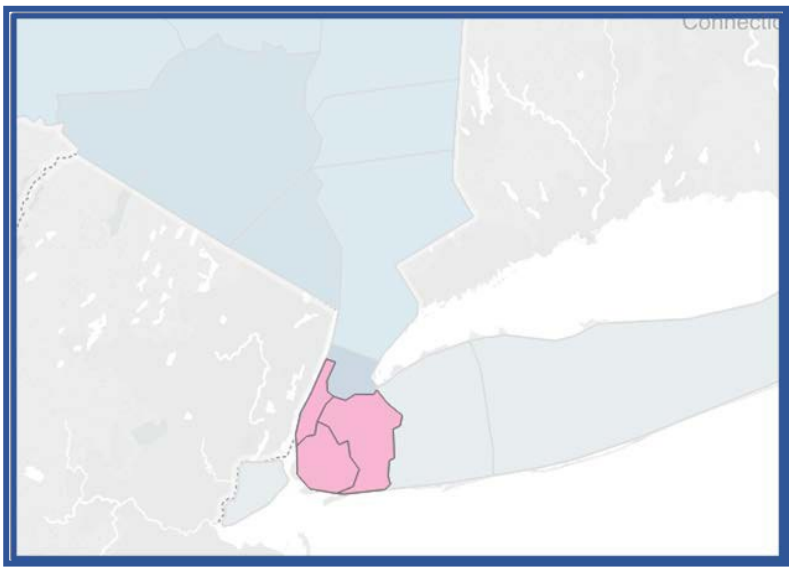
Sustainability Plan

Millennium has worked with its partners on the establishment of a regional Medicaid IPA and application for a Medicaid ACO in order to manage attributed lives through its network, built on the partnerships established throughout DSRIP. The objective is formation of an entity that can engage together collectively with MCOs, providers, and CBOs in risk-based contracts that drive value by improving health outcomes while generating shared savings that support ongoing population health and high-value promising practices.

Mount Sinai PPS

https://partner.mountsinai.org/

The Mount Sinai Performing Provider System (MSPPS), sponsored by Mount Sinai Hospital, partners with medical and behavioral health providers, care coordination agencies, and community-based organizations throughout Manhattan, Brooklyn, and Queens to implement clinical initiatives that support DSRIP goals of establishing a sustainable, seamless, population-health driven system to deliver high quality care to patients, while reducing high-cost avoidable emergency department (ED) and inpatient care.



Counties Served: Manhattan County, Queens County, Brooklyn County

10 total projects

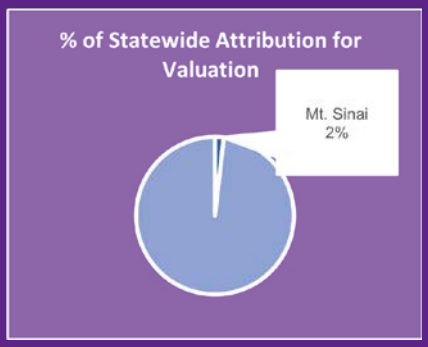
- 2.a.i Integrated Delivery Systems
- 2.b.iv Care Transitions – Chronic Disease
- 2.b.viii Hospital-Home Care Collaboration
- 2.c.i Community Health Navigation
- 3.a.i Primary Care and Behavioral Health Integration
- 3.a.iii Evidence-Based Medication Adherence – BH
- 3.b.i Disease Management – Cardio
- 3.c.i High-Risk Disease Management – Diabetes
- 4.b.ii Preventative Care/Management
- 4.c.ii Increase Access/Retention of Care

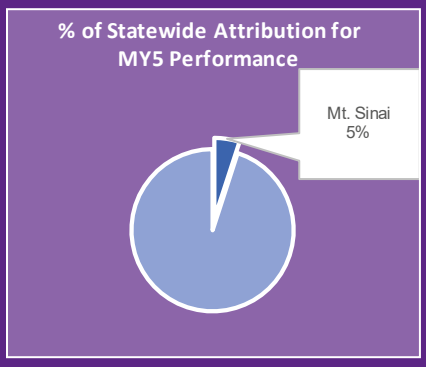
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	37,614	47,440	24,389	46,010
Total Active Engagements of Patients	124,756	223,604	94,599	218,383

BY THE NUMBERS

- **136,370** Total Patients Attributed for Maximum Valuation
- **286,656** Total Patients Attributed for MY5 Performance





- **6,075** Total Network Partner Types
- **428** Total PCMH and APC Recognized Providers
- **1,230** Total Primary Care Providers and **37** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$315,728,330** Total Funds Earned Through DY5

The Mount Sinai Performing Provider System (MSPPS), sponsored by Mount Sinai Hospital, partners with medical and behavioral health providers, care coordination agencies, and community-based organizations throughout Manhattan, Brooklyn, and Queens to implement clinical initiatives that support DSRIP goals of establishing a sustainable, seamless, population-health driven system to deliver high quality care to patients, while reducing high-cost avoidable emergency department (ED) and inpatient care. In partnership with a vast network of providers, while serving over 300,000 patients with a high attribution churn rate, MSPPS has strategically implemented clinical improvement strategies that successfully achieved high value in performance as well as remuneration while improving patient quality and outcomes as well as their care experience.

Additionally, MSPPS transformed its provider landscape by supporting partners with sustainable unique clinical programming, Tier 1 Community Based Organizations (CBO) service integration as well as innovative technical initiatives and solutions.

1. Coordinated Behavioral Care Behavioral Health High Utilizer Program

The MSPPS incentivized the Coordinated Behavioral Care (CBC) IPA to provide a person-centered intensive care management intervention for medically, behaviorally, and socially complex patients who are high utilizers of avoidable ED and hospital services. A 6-month intervention with a multi-disciplinary team, of a registered nurse, social workers and case managers, focused on providing patients with a customized program to address their behavioral, medical, and social service needs. Recognizing the importance of care coordination, the team worked collaboratively with patient's care team members while providing frequent in-person, telephonic, and telehealth contact for 24/7 coverage.

2. Community Paramedicine Program

The MSPPS funded the Community Paramedicine Program, which provided personalized and coordinated care via a paramedic visit, in the patient's home, while communicating in real-time with the patient's physician via phone or video teleconference technology to provide appropriate and timely treatment. The program expanded beyond Manhattan and is offered 24/7/365 in four boroughs to continue to provide in home screening and treatment to avoid unnecessary ED and hospital admissions.

3. Addressing Homelessness with Respite Care

The MSPPS funded partners ACMH Inc., Institute for Community Living (ICL), and Comunilife to provide temporary housing to unstably housed patients with complex medical, behavioral, and social health while providing care management support with the goal of reengaging in needed care and securing or maintaining permanent housing.

4. Tier 1 CBO Integration with Clinical Providers

The MSPPS supported Tier 1 CBOs with integrating social services into clinical partner operations to improve patient outcomes. Through DSRIP funding, New York Common Pantry expanded its Project Dignity Program, Choice Pantry Program and Help 365 Program and with dedicated funding during COVID to expand their core programs of Choice Pantry, Hot Meals/Brown Bags. The New York Legal Assistance Group (NYLAG) collaborated with MSPPS federally qualified health centers (FQHC) partners in East Harlem and Upper West Side to address socioeconomic and healthcare disparities through legal counseling via weekly legal sessions and training FQHC staff to support non-legal needs and appropriate legal referrals.

The MSPPS funded City Health Works to provide self-management and coaching support, health education, and care coordination for patients with chronic conditions with locally hired health coaches. Similarly, AIRnyc received funding to provide home-based asthma assessment, self-management, and pest management services to underserved patients with persistent and uncontrolled asthma. During COVID, both programs transitioned to providing telephonic outreach for at-risk patients with a focus on SDH needs, medication refills, and triaging to appropriate resources.

5. Consent Program to Enhance Hospital: Community Relationship

The impact of the Enterprise Information Exchange Consent program on enhanced patient clinical data sharing across organizations is important during the COVID-19 crisis. With a centralized site for forms, training, and education materials for Mount Sinai Health System (MSHS) staff and community partners who participated in this program, and an operational dashboard to monitor consent collection across the patient population, this program supports sustainable care coordination across the community.

6. Solutions to Optimize Primary Care

The MSPPS supported its FQHC partners with short-term and long-term eConsult solution resource for primary care physicians (PCPs) to determine the appropriateness of specialty care and coordination of timely specialty visits to the appropriate specialist with the goal of improving health outcomes and reducing preventable ED hospitalizations. The PPS also funded efforts to address SDH needs including the implementation of electronic community resource guides, closed-loop social referrals, and standardization of SDH data capture.

7. Sustainability Plan

- Transitioned Tier 1 CBO-based and SDoH-focused pilots to a PPS partner to directly service their value-based lives; these pilots allow the CBO partners to serve as care management extension arm, initiate technical integration with the Partner's systems, and allow for a contractual relationship through the partner's IPA member network.
- PPS solutions such as community resource guide and eConsults have been successfully utilized and will continue to be leveraged post-CY2020.
- PPS has transitioned the behavioral health-focused pilot: Crisis Respite for behavioral health patients, Care Management for High Utilizing behavioral health patients, Permanent Housing Placement Support for unstably housed behavioral health patients, and Medical Respite for all patients to

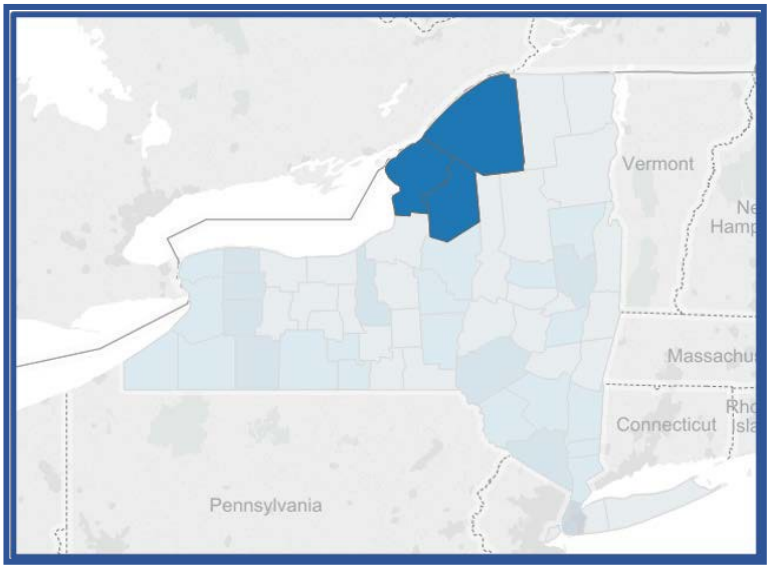
continue the program post-CY2020 to allow for involved partners to collect and analyze the necessary data to demonstrate value beyond DSRIP funding.

- Conversion of Clinical Integration Learning Center (CILC), the PPS' learning management system, to a PPS Partner with a large IPA and CIN membership network. The transition accounts for business and technical workflows, platform integration, and course content transfer between the PPS and Partner.

North Country Initiative

https://northcountryinitiative.org/

The North Country Initiative, established in 2014, is a partnership encompassing entities from across the health care continuum with nearly 150 sites among over 80 partners governed by a physician-led Board of Directors.



Counties Served: Jefferson, Lewis, St. Lawrence

11 total projects

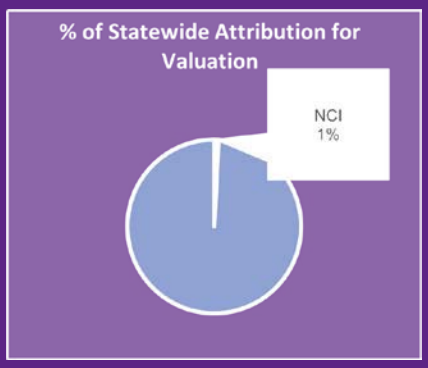
- 2.a.i Integrated Delivery Systems
- 2.a.ii PCMH/APC
- 2.a.iv Medical Village-Hospital
- 2.b.iv Care Transitions – Chronic Disease
- 2.d.i Patient Activation (PAM)
- 3.a.i Primary Care and Behavioral Health Integration
- 3.b.i High-Risk Disease Management – Cardio
- 3.c.i High-Risk Disease Management – Diabetes
- 3.c.ii Chronic Disease Prevention – Diabetes
- 4.a.iii Strengthen MHSA Infrastructure Preventative
- 4.b.ii Care/Management

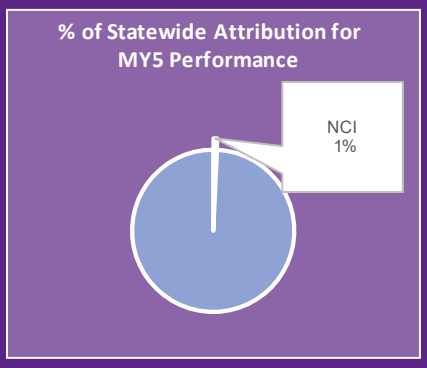
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	1,857	8,576	12,048	12,565
Total Active Engagements of Patients	11,677	29,741	45,254	47,913

BY THE NUMBERS

- **61,994** Total Patients Attributed for Maximum Valuation
- **40,965** Total Patients Attributed for MY5 Performance





- **745** Total Network Partner Types
- **85** Total PCMH and APC Recognized Providers
- **59** Total Primary Care Providers and **24** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$75,087,683** Total Funds Earned Through DY5

The North Country Initiative's work is grounded in the goals of the triple aim, improving the quality of care for rural, underserved population, improving population health, and lowering healthcare costs by reducing avoidable hospitalizations, with an overarching goal to improve access to healthcare for all. NCI and its partners have successfully implemented the following strategies for meaningful transformation to better serve the community:

- Building Upon Workforce Initiatives within a Comprehensive Delivery System: The North Country Initiative (NCI) approached lasting health care transformation by first building a regional network on a foundation already in place due to the work of the Fort Drum Regional Health Planning Organization (FDRHPO). The NCI is a clinically integrated network, whose governance and committee structures bring together representatives of the region's physicians, FQHCs, hospitals, behavioral health providers, community-based organizations, and other stakeholders. These stakeholders have worked in a committee structure that included behavioral health, population health, EMS, health IT, and workforce since 2008 and with DSRIP, expanded to include medical management, care coordination, health literacy/cultural competency, value- based payment/finance, and compliance. The Delivery System Incentive Payment (DSRIP) program also expanded the North Country health workforce through the partnership with FDRHPO by further developing the workforce pipeline and enhancing the regional workforce by recruiting and providing career growth opportunities to over 90 professionals. This has resulted in the creation of an inclusive integrated delivery system, resulting in improved access, coordination and quality of care across the system.
- Care Coordination, Care Management & Care Transitions: Care management infrastructure was established across the delivery system, including clinical care management in the hospital and primary care settings as well as non-clinical care coordination in the community organization setting. Care teams were developed to include clinical care managers, diabetes educators, peer supports, health home care managers, and more to support the individualized needs of each patient to include clinical needs such as chronic care management as well as social needs such as housing assistance or access to food. Furthermore, protocols have been implemented to standardize and improve the transition of care from an inpatient hospitalization setting to outpatient care, including a warm hand-off to those on the individual's care team.
- Integration & Access to Care: In an effort to enhance coordination of care and ensure access to care, the NCI network also (1) integrated behavioral health and primary care services and (2) developed six medical villages where patients can access multiple services in one convenient location, such as, integrated primary care and behavioral health, cardiology, Ob/Gyn, laboratory & imaging, and more.
- Patient-Centered Medical Home (PCMH) Model of Care: Each primary care partner in the NCI network achieved and maintains the latest patient-centered

medical home recognition demonstrating the ability to coordinate patient care from prevention to treatment while maintaining timely access to care, availability of same-day appointments, electronic access to health information, and effective coordination among the patient's care team. This enables patients to receive the right care, in the right place, at the right time.

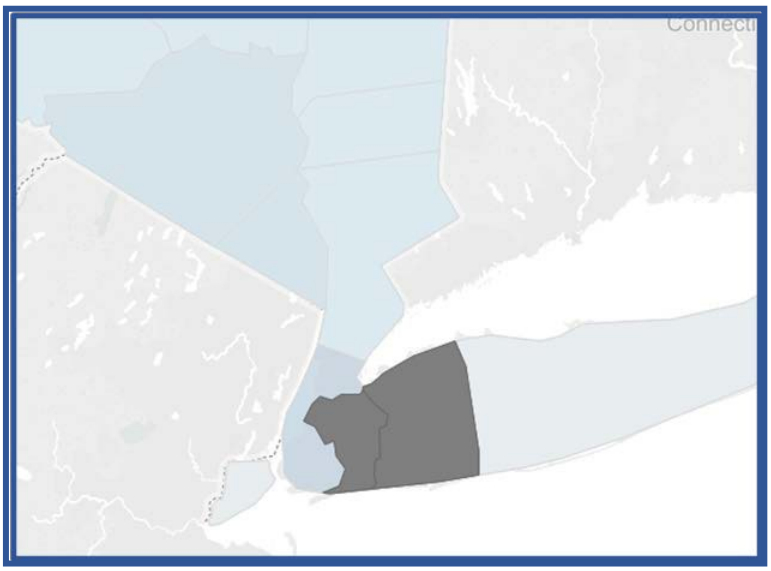
- Connectivity & Patient Engagement: 100% of DSRIP partners are now connected to the Regional Health Information Organization (RHIO), which has allowed the network to securely and effectively coordinate care across the care continuum, by allowing for exchange of information and referrals. Patients are further engaged in a number of ways to include, (1) providing four types of evidence- based community chronic disease programs to promote disease self-management, (2) leveraging the Bridges out of Poverty framework to bring together people from all backgrounds and socioeconomic classes to build resources and improve outcomes, (3) outreach using peer organizations to support individual's wellness goals, and (4) utilizing the "What Matters to You" framework to encourage and support meaningful conversation with patients.
- Sustainability Plan

  DSRIP has impacted the way care is delivered in the region by focusing on care management, whole-person and patient centered care, social determinants of health, patient engagement, an inclusive health care continuum, among so many others. Each initiative has significantly improved the health care system for the patient and community. In doing this, NCI took great care to ensure the investments would be sustainable long-term. For example, standardization and improvements in workflow, clinical protocols, connectivity and enhanced workforce skills demonstrate advances that will continue to have a positive impact on the community long after DSRIP has concluded. NCI has also expanded its organizational structure to include an Independent Practice Association (IPA) that will serve as the vehicle for further progress towards value-based arrangements and our region's ability to continue to focus on improved quality, reduced cost, and addressing social determinants of health.

Nassau Queens PPS

https://www.nqpps.org/

Nassau Queens Performing Provider System (NQP) is a partnership between Nassau University Medical Center (NUMC), Northwell's Long Island Jewish and Catholic Health Services working together with more than 8,400 partner organizations to transform the health status of communities in Nassau and eastern Queens.



Counties Served: Nassau, Queens

11 total projects

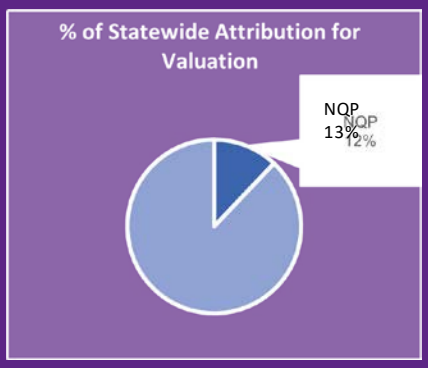
2.a.i	Integrated Delivery Systems
2.b.ii	Primary Care in ED
2.b.iv	Care Transitions – Chronic Disease
2.b.vii	Transfer Avoidance – SNF
2.d.i	Patient Activation (PAM)
3.a.i	Primary Care and Behavioral Health Integration
3.a.ii	Community Crisis Stabilization
3.b.i	Disease Management – Cardio
3.c.i	Chronic Disease Prevention – Diabetes
4.a.iii	Strengthen MHSA Infrastructure
4.b.i	Tobacco Cessation

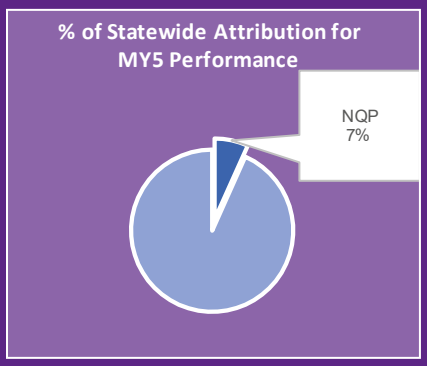
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	19,156	31,387	77,220	53,577
Total Active Engagements of Patients	126,185	175,899	227,939	199,672

BY THE NUMBERS

- **1,030,400** Total Patients Attributed for Maximum Valuation
- **389,057** Total Patients Attributed for MY5 Performance





- **2,157** Total Network Partner Types
- **424** Total PCMH and APC Recognized Providers
- **845** Total Primary Care Providers and **324** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$566,233,667** Total Funds Earned Through DY5

The Nassau Queens Performing Provider System (NQP) is a partnership led by Nassau University Medical Center (NUMC), in alliance with Northwell Health's Long Island Jewish Medical Center and Catholic Health Services of Long Island, and consists of more than 8,400 partner organizations that have come together to better serve the health needs of the community through the Delivery System Reform Incentive Payment (DSRIP) program. The NQP is responsible for overseeing the successful implementation of 11 DSRIP program projects with a goal to redesign the way health care is delivered to people with Medicaid in our community by closing critical gaps in the continuum of care and reducing avoidable hospital use.

Through our 11 DSRIP projects, we strove to increase access to primary care and community-based resources, integrate behavioral and medical services, and create better care coordination through shared technology.

The NQP has listed below several lasting ways in which the PPS/DSRIP has transformed health care in the region/community:

Healthcare Systems Working Together

- NQP's Hub structure (Catholic Health Services of Long Island [CHS], LIJ/Northwell Health [LIJ] and Nassau University Medical Center [NUMC]) enabled geographically intermingled health systems to work collaboratively on population health strategies. Competitors working as partners helped manage a dense population of patients who use multiple entry points for care.

Expanding Transitions of Care

- Hospitals expanded transitions of care programs and support for discharged patients to ensure that clinical directions are understood.
    - St. John's Episcopal Hospital launched an *Emergency Room Navigation Program*, for patients who repeatedly utilize the ER for conditions more efficiently managed by community providers. Navigators reinforce discharge instructions, recommend a primary care provider for follow-up, check compliance, and address any social issues that might present barriers to compliance. The result: unnecessary emergency department (ED) utilization reduced over 50% in the most vulnerable populations.
    - The NUMC established a *Care Transitions Intervention* program that utilized in-house staff (Licensed Clinical Social Workers [LCSW]and care navigators), as well as staff from partner behavioral health community benefit organizations (CBOs) (certified peer recovery advocates, certified peer specialists, and LCSWs), to work directly with NUMC's discharge planners in a closed-loop referral process. The program, which initially targeted high utilizers but expanded to all behavioral health patients, created definitive timely linkages to follow-up care that improved patient outcomes and reduced behavioral health re-admissions and ED visits.

Importance of Social Determinants of Health in Accessing Healthcare

- The DSRIP highlighted that all communities have underserved people in need with social determinants of health issues.

    - The LIJ established the *Food as Health* Program to address food insecurity experienced by 1.4 million community residents, by coordinating healthy, affordable food for patients in need. The program has decreased the risk of chronic disease, shortened hospital stays, and reduced the likelihood of future hospital readmissions.

    - The CHS partnered with Island Harvest and Family & Children's Association to offer food insecurity screening to all clients at two BH clinics and fresh food/nutritional services to those screening positive

Renewed Focus on Behavioral Health

- Greater acceptance of behavioral health as a key component in addressing the region's population health needs.

The adult and pediatric behavioral health urgent care centers at LIJ provided 14,000 children and adults experiencing an urgent/emergent behavioral health issue with same-day access to psychiatric care, an alternative to the emergency department.

- The CHS implemented SBIRT (Screening, Brief Intervention and Referral to Treatment) in the ED/Inpatient units at their three Nassau County hospitals

- The NUMC implemented several initiatives with behavioral health CBOs that augmented community crisis stabilization services and strengthened the mental health and substance use infrastructure in Nassau County:
    - In partnership with Family & Children's Association, funded a recovery support services center that provides SBIRT and support services for patients in the SUD recovery process.
    - Partnered with Mental Health Association of Nassau County to create a peer- supported crisis/respite hospital diversion program in a self-contained home environment for individuals in crisis.

Workforce Training-Investing in the Future

- Importance of training and development to workforce goals

    - The NQP developed robust workforce capabilities, primarily through training and college Outreach. Over 36,000 people learned various job-enhancing skills. College outreach yielded lasting relationships with Hofstra, Nassau Community, Adelphi, and York, producing career fairs, internships, job training, and curriculum development for the healthcare workforce.

    - The LIJ's *From the Community, For the Community* trained jobseekers from traditionally disenfranchised communities to prepare them

community health workers (CHWs) to help community members adopt healthy behaviors and overcome access to care barriers. The CHWs developed meaningful relationships with healthcare workers from their communities to facilitate better patient outcomes with lower costs.

Sustainability Plan

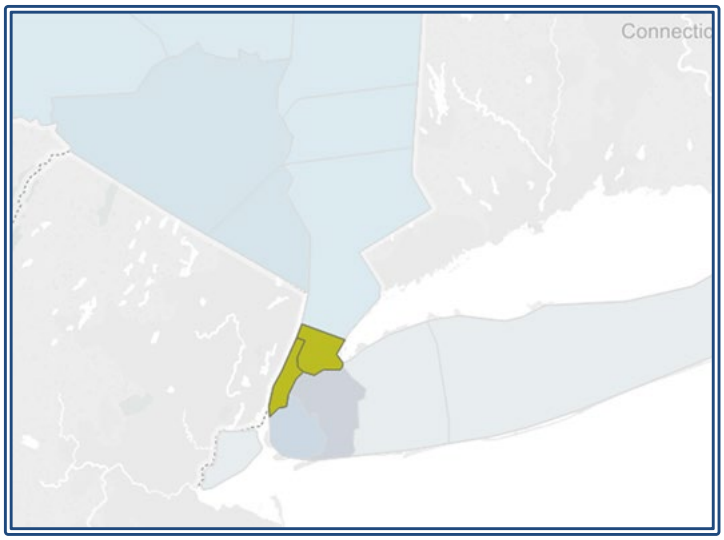
- NQP was structured as a three-member partnership consisting of Long Island Jewish Medical Center (Northwell), Catholic Health Services of Long Island, and Nassau University Medical Center. These three health system members developed their hubs to focus on the initiatives within their health systems and to coordinate the improvements on which the Performing Provider System has focused. Post-DSRIP, these hubs, utilizing staff and resources put in place within the organizations as part of DSRIP, can continue the initiatives started, including care management, care coordination, Community Based Organization, and Behavioral Health Organization partnerships, and value-based arrangements. The value-based
  arrangements include quality measures, and most, if not all, were part of the measurements used under DSRIP. These measures will be used to measure the achievement of the individual system under
  their Value-Based Pricing (VBP) contract.

- In addition, based on the work of the members in developing "Promising Practices," the work will continue as long as outcomes show positive results and budgets can continue to support the initiative. Two Promising Practices examples of the significant outcomes from the DSRIP work done by the three partners:
  1) Crisis Stabilization: Preventing Unnecessary Behavioral Health Hospitalizations and
  2) Integration: Embedding Nutrition Assistance Within Health Care Settings

New York and Presbyterian Hospital PPS

https://www.nyp.org/pps

The New York-Presbyterian Performing Provider System (NYP PPS) is a network of approximately 90 providers and community collaborators jointly committed to addressing the major drivers of poor health outcomes and avoidable utilization



Counties Served: Manhattan – Bronx and Manhattan

10 total projects

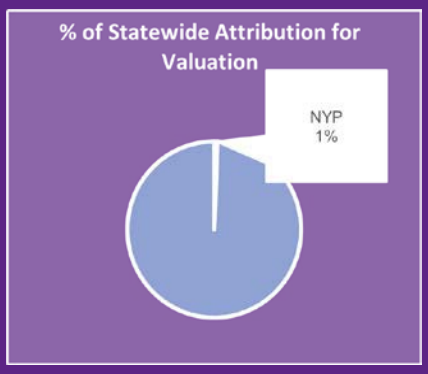
- 2.a.i Integrated Delivery Systems
- 2.b.i Ambulatory ICUs
- 2.b.iii ED Care Triage
- 2.b.iv Community Health Navigation
- 3.a.i Primary Care and Behavioral Health Integration
- 3.a.ii Crisis Stabilization
- 3.e.i Strategy to Decrease HIV/AIDS Transmission
- 3.g.i Integration of Palliative Care into PCMH
- 4.b.i Tobacco Cessation
- 4.c.i Decrease HIV Morbidity

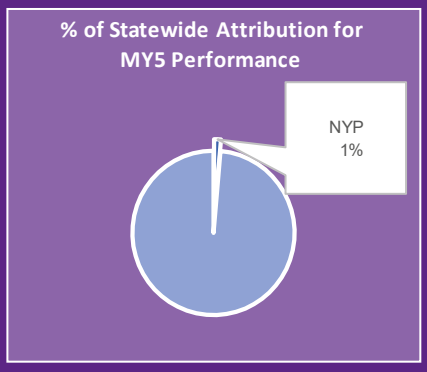
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	79	362	278	223
Total Active Engagements of Patients	15,866	24,108	30,024	32,263

BY THE NUMBERS

- **47,293** Total Patients Attributed for Maximum Valuation
- **75,193** Total Patients Attributed for MY5 Performance





- **224** Total Network Partner Types
- **171** Total PCMH and APC Recognized Providers
- **114** Total Primary Care Providers and **0** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$87,543,659** Total Funds Earned Through DY5

NewYork-Presbyterian
Performing Provider System

The New York-Presbyterian Performing Provider System (NYP PPS) is a network of approximately 90 providers and community collaborators jointly committed to addressing the major drivers of poor health outcomes and avoidable utilization. The following are three examples of collective impact to improve the health and wellbeing of the communities served.

- SKATE- Special Kids Achieving Their Everything
  In partnership with three community-based organizations (CBOs), the SKATE team works together to address the needs of Children of Special Healthcare Needs (CSHCN). Adaptations to the EMR support risk stratification of CSHCN (L. Adriana Matiz, Laura Robbins-Milne & John A. Rausch; *Maternal and Child Health Journal*, 23 (1) 1-130, 2019). Nurse care managers direct pre-visit planning, coordinate n practitioners perform short-term counseling, long-term medication management as well as family psychiatric counseling. CBO-based community health workers (CHWs) assess the home environment, link to community resources, and coordinate with the medical home team. Between July 2016 and June 2018, 365 caregivers of CSHCN received SKATE support. In a retrospective analysis, there was significant improvement in caregiver distress scores ($P < .001$) and in understanding of their children's diagnoses ($P < .001$). Furthermore, the number of caregivers reporting food or housing issues was significantly reduced ($P < .01$ and $P < .01$, respectively) (LA Matiz, MA, et.al., *Clinical Pediatrics*, 58 (11-12) 1315-1320, May 25, 2019)

- Ending the AIDS Epidemic
  In 2015, New York-Presbyterian (NYP), in collaboration with six CBOs, formed the REACH Collaborative (Ready to End AIDS and Cure Hepatitis C). Institutional HIV Care Cascades submitted quarterly to the NYS AIDS Institute, along with real-time panel management, helped guide targeted interventions. The REACH Collaborative community health workers, HIV peers and health home care managers were integrated across three HIV Centers of Excellence to address care coordination, behavioral health and social determinant of health needs and facilitate linkages to critical clinical and social services. By the end of 2018, a net increase of 1,359 people living with HIV or Hepatitis C were engaged in care and 1,553 additional patients were prescribed PrEP, making NYP the second largest PrEP provider in the state. The REACH Collaborative model was featured in the United Hospital Fund Report, *DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid*.

- Emergency Department Patient Navigation Program
  The goal of the Patient Navigator program is to help patients presenting to the ED who do not have a primary care doctor, are uninsured-underinsured, and need assistance in overcoming barriers they may encounter in navigating the health care system. With DSRIP funding, the NYP PPS expanded the existing program at the Columbia University Medical Center to include Weill Cornell and Lower Manhattan emergency departments. By the end of March 2019, out of a total of 50,135 patients assessed by patient navigators, 16,899 were scheduled for Pprimary care appointments of which

13,060 (77%) attended. This program has been critical to improving access to primary care services for some of the most vulnerable members of the communities served.

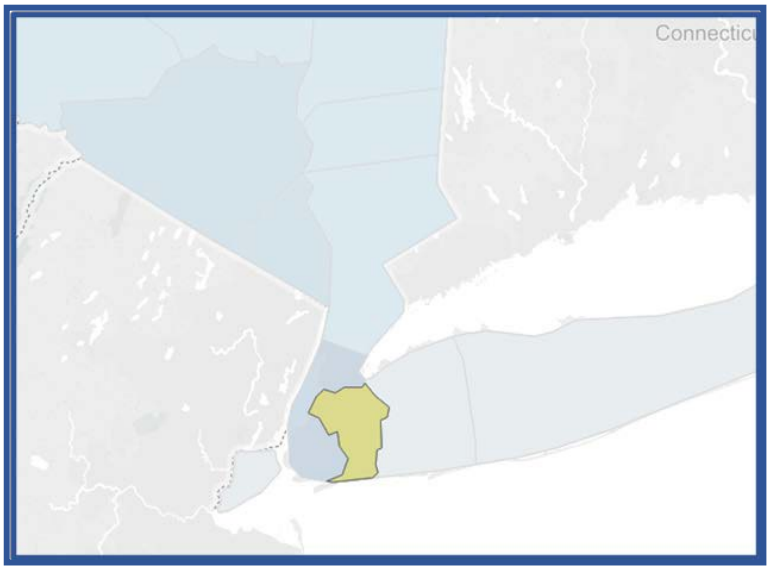
- Sustainability Plan

    - The NYP-PPS will sustain the components of the legacy DSRIP interventions (that demonstrated impact in a 6-month comprehensive project assessment completed in 2019) through existing DSRIP funds and rapid transition of funding by leveraging a combination of NYS Health Home revenue, third party payment, grant funding, and value-based incentives.
    - The PPS is actively exploring business plans for other DSRIP funded interventions that are in alignment with evolving priorities
    - The framework for allocated of DSRIP funding will be shifted to be in alignment with the New York Prevention Agenda 2019 – 2024 with particular focus on priorities set by The NYP 2019-2021 Community Health Needs Assessment:
    - Workflows, services and collaborations will likely undergo on-going modification in order to respond to evolving community needs in the face of the COVID-19 pandemic (e.g., rapidly rising food insecurity, unstable mental health and substance use, significantly reduced access to in-person care for the management of chronic conditions).

New York-Presbyterian/Queens PPS

https://www.nyp.org/

The NYPQ PPS is a collaborative coordination of partners across Queens County who are focused on breaking down silos in healthcare and improving access and coordination across the continuum.



Counties Served: Queens

9 total projects

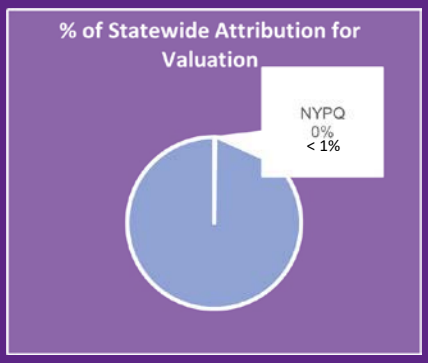
- 2.a.ii PCMH/APC
- 2.b.v Care Transitions- Nursing Facility
- 2.b.vii INTERACT
- 2.b.viii Hospital-Home Care Collaboration
- 3.a.i Primary Care and Behavioral Health Integration
- 3.b.i Crisis Stabilization
- 3.d.ii Asthma Home-based Self-Management
- 3.g.ii Integration of Palliative Care into Nursing Homes
- 4.c.ii Increase Access/Retention of Care

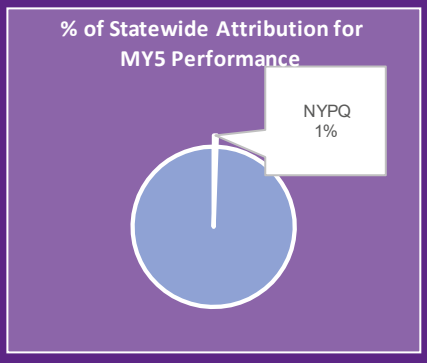
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	8,483	5,045	3,245	3,299
Total Active Engagements of Patients	25,573	26,030	25,998	24,752

BY THE NUMBERS

- **12,962** Total Patients Attributed for Maximum Valuation
- **30,737** Total Patients Attributed for MY5 Performance





- **581** Total Network Partner Types
- **72** Total PCMH and APC Recognized Providers
- **11** Total Primary Care Providers and **87** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$28,904,130** Total Funds Earned Through DY5

In what lasting ways has the PPS/DSRIP transformed health care in your region/community?

The NYS DSRIP program offered numerous opportunities for healthcare leaders in Queens County to focus to the highest needs of our community, maximize access to care, improve quality outcomes, and decrease avoidable hospital utilization. The NYPQ PPS is a collaborative model consisting of providers from all sectors of the healthcare delivery system; the PPS bridged silos that are seen in healthcare, bringing together stakeholders across the continuum to focus to patient needs. Through this process, the PPS funded the use of IT platforms including Healthix (RHIO), Curatur for real time patient notifications, and quality measure dashboards. Additionally, the PPS provided numerous trainings for providers and partner organizations, funded innovative initiatives to improve patient care and outcomes, and foster partnerships and collaborations across the provider continuum:

- Access to Center to Advance Palliative Care (CAPC) trainings and resources and Education in Palliative & End-of-Life Care (EPEC) certification
- Pediatric focused asthma trainings, by the Asthma Coalition for ED, PCPs, and nurses in school-based clinics that included asthma action plans, asthma triggers, and how to utilize home care services to prevent avoidable hospitalizations
- INTERACT training for SNF partners to identify patient needs through early identification and interventions with the entire care team, both clinical and non-clinical
- Education and ongoing support for pediatricians on managing ADHD medications and patient needs to help keep patients in the primary care setting as opposed to specialty care
- PCP Training on motivational interviewing and other effective methods to screen for substance abuse which were conducted by an OASAS partner
- Value based payment (VBP) educational symposiums specific to finance, quality measures, organizational value proposition, and NYS VBP Roadmap
- Support to transform participating practices to NCQA/NYS patient -centered medical home (PCMH) and provide support to complete the application for certification
- Ongoing root cause analysis quarterly meetings with long term care and home care providers to identify areas of opportunity in treating patients in place
- Fund CBOs to hire and train peer leaders to educate at risk communities on early access to HIV care and importance of maintaining viral load suppression
- Fund and collaborate with St. Mary's Home Care and Asthma Coalition on utilizing blue tooth equipped inhalers to monitor utilization of rescue medication by pediatric asthma patients

Alongside the focus to providers, the PPS utilized the waiver to transform access to care and develop tools for the community-based organization partners to implement best practices or rising practices that leveraged technology and cross continuum of care aspects. The NYPQ PPS completed 9 projects focused to improving patient's health and engaging patients to get the right care in the right setting at the right time. Along with education, the network was able to bring new technology to the community through the pediatric asthma project. By partnering with the Asthma Coalition of Queens and St. Mary's Home Care teams Bluetooth inhalers were provided to high risk pediatric asthmatic patients complimented by home assessments, care management, and pharmacy care management to maximize the use of technology.

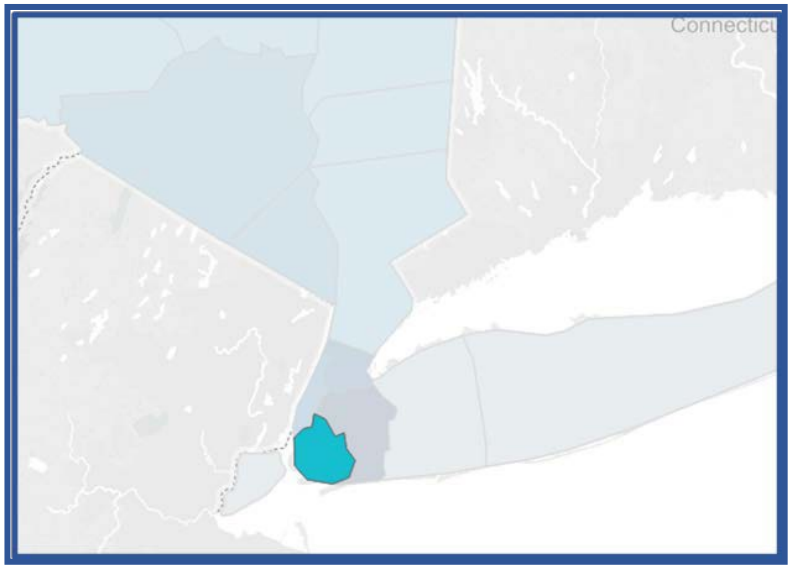
Sustainability Plan: The PPS will sunset and the governing structure will be absorbed by the lead hospital, NYPQ.

- The PPS will continue to support these initiatives with patient recruitment, data collection and analytics, and collaborative leadership to determine any relevant next steps.
- Foster collaborations to enhance long-term care projects.
- Maintain relationships with CBOs and providers to enhance programs targeted to at risk populations.
- Partner with staff to support and strengthen care management efforts
- Continue to use quality process improvement to drive change

NYU Langone Brooklyn PPS

https://nyulangone.org/

With approximately 120,000 attributed lives and 217 network partners, the NYU Langone Brooklyn PPS provides clinical care and aims to improve population health for Medicaid patients across all New York City boroughs.



Counties Served: Brooklyn (partners are also located in Manhattan and Queens)

9 total projects

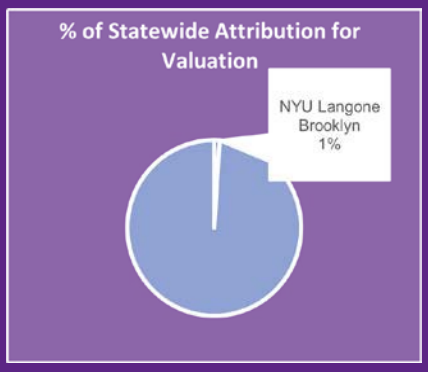
- 2.a.i Integrated Delivery Systems
- 2.b.iii ED Care Triage
- 2.b.ix Hospital Observational Programs
- 2.c.i Community-Based Health Navigation
- 3.a.i Primary Care and Behavioral Health Integration
- 3.c.i Crisis Stabilization
- 3.d.ii Asthma Home-Based Self-Management
- 4.b.i Tobacco Cessation
- 4.c.ii Increase Access/Retention of Care

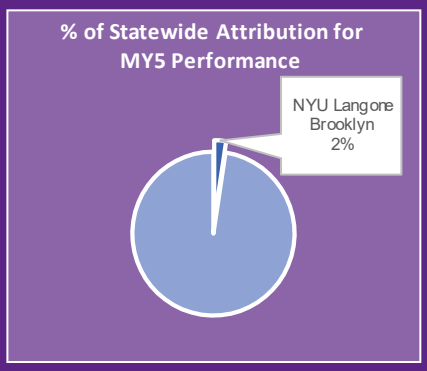
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	4,946	20,354	26,768	27,410
Total Active Engagements of Patients	10,261	46,081	64,633	62,860

BY THE NUMBERS

- **74,326** Total Patients Attributed for Maximum Valuation
- **132,110** Total Patients Attributed for MY5 Performance





- **2,954** Total Network Partner Types
- **314** Total PCMH and APC Recognized Providers
- **125** Total Primary Care Providers and **131** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$128,323,097** Total Funds Earned Through DY5

NYU Langone Health

NYU Langone Brooklyn PPS

Through DSRIP, the NYU Langone Brooklyn PPS transformed health care in the community in critical ways, reshaping how care is delivered through new partnerships, sharing of resources, funding vital healthcare positions, and improving data collection, guiding the understanding of true community needs and leading to demonstrably healthier and happier patients.

- **Utilizing an interdisciplinary team to reduce potentially preventable hospitalizations in a high-risk patient population.** NYU Langone Brooklyn PPS substantially reduced potentially preventable readmissions (PPR) over the five-year DSRIP measurement period. Building on this success, the MAX High Utilizer team began combining efforts with the ED Care Triage Community Health Worker program in September 2019 to continue post-DSRIP transition to value based care. The two teams are collaborating to further reduce PPR in a pre-determined high-risk population. The intervention is conducted by a palliative care specialist, nurse, social worker and community health worker team and involves both proactive and reactive engagement. Proactive engagement includes telephonic and face to face outreach in the community, chart and case reviews, and provider engagement. The reactive engagement component is employed when a patient is hospitalized either in the emergency department or an inpatient setting. The team addresses identified social determinants of health and other challenges patients may have in addressing biopsychosocial issues including navigation support to providers. In this way, the PPS has transformed the way high risk patient populations are cared for in our community.

- **Focusing on the integration of behavioral health services into primary care.** Bridging DSRIP accomplishments and endeavoring further transformation, the NYU Langone Brooklyn PPS will continue: 1) partnering with vital healthcare partners across the community to build upon behavioral health (BH) services that are culturally competent, sharing knowledge and resources in new ways to help provide BH care to those who would not have otherwise been reached, 2) expanding access to BH services for critical populations who did not previously have BH services readily available, particularly at pediatric and women's health primary care locations, 3) increasing access to essential psychiatric consultation services/ psychiatric medications within primary settings for those in need but frequently forego psychiatric visits due to stigma, and 4) pioneering the use of community health workers, who provide help to over 500 psychiatric patients annually, all of whom struggle with adhering to medications recommended by their doctor or needed support to engage in follow-up care after experiencing a psychiatric crisis.

- **Developing a robust workforce training and development program charting a pathway for future success.** During DSRIP, the NYU Langone Brooklyn PPS created specific clinical and non-clinical role-based curriculums for chronic disease management, behavioral health, community health workers, population health management, and value-based payments. Training rollout occurred using a phased approach via electronic learning and in-person instructor led training. While these trainings were beneficial for the PPS network during the five-year DSRIP timeframe, the availability of these trainings will continue to add value in a post-DSRIP environment.

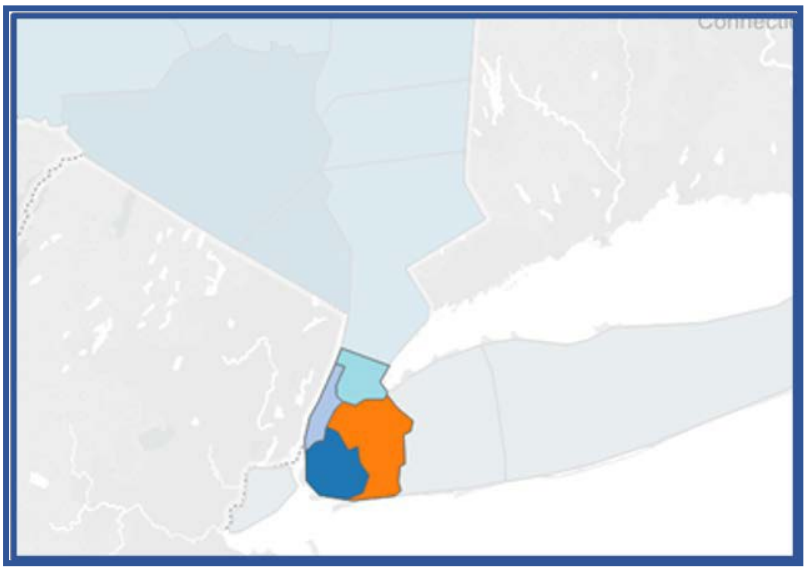
- **Sustainability Plan**: In alignment with DSRIP promising practices, the NYU Langone Brooklyn PPS has laid the foundation for sustainability through the development of a performance network- the NYU Langone

IPA, the expansion of analytical and technological capabilities via tools that assist with patient risk stratification and a robust population health management platform to help manage patients and provider workflows, and a continued focus on serving our high risk patient population utilizing community health workers and care coordination. The NYU Langone Brooklyn PPS is positioned to use the momentum developed through the 5 years of DSRIP as it continues towards establishing value-based payment (VBP) models with Medicaid managed care organizations (MCOs) and community partners.

OneCity Health

https://www.onecityhealth.org/

OneCity Health is New York's largest performing provider system and sponsored by the NYC Health + Hospitals, the nation's largest municipal healthcare system.



Counties Served: Manhattan County, Brooklyn County, Bronx County, Queens County

11 total projects

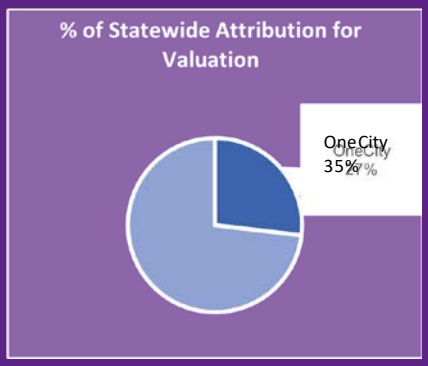
- 2.a.i Integrated Delivery Systems
- 2.a.iii Health Home-At-Risk
- 2.b.iii ED Care Triage
- 2.b.iv Care Transitions – Chronic Disease
- 2.d.i Patient Activation (PAM)
- 3.a.i Primary Care and Behavioral Health Integration
- 3.b.i Disease Management – Cardio
- 3.d.ii Asthma Home-Based Self-Management
- 3.g.i Palliative in PCMH
- 4.a.iii Strengthen MHSA Infrastructure
- 4.c.ii Increase Access/Retention of Care

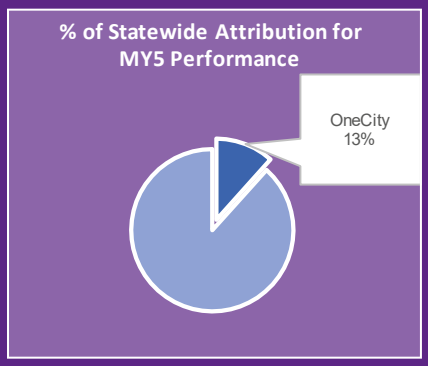
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patient Engaged through Primary Care and Behavioral Health Integration	19,832	109,225	123,881	156,486
Total Active Engagements of Patients	36,993	211,396	286,210	319,167

BY THE NUMBERS

- **2,760,602** Total Patients Attributed for Maximum Valuation
- **715,563** Total Patients Attributed for MY5 Performance





- **20,008** Total Network Partner Types
- **1,338** Total PCMH and APC Recognized Providers
- **2,183** Total Primary Care Providers and **1,117** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$940,632,663** Total Funds Earned Through DY5

Introduction

OneCity Health is New York's largest performing provider system (PPS) and sponsored by the NYC Health + Hospitals, the nation's largest municipal healthcare system. To help close critical gaps in the continuum of care, OneCity Health has focused on preventive primary care by engaging in partnerships with hundreds of community-based healthcare providers and organizations, as well as NYC Health + Hospitals' network of acute care hospitals, nursing homes, community clinics, and home-care services. By leveraging NYC Health + Hospitals' considerable experience in managing value-based payment models, OneCity Health has been able to promote and implement value-based approaches across its PPS network.

OneCity Health:

1. **Helped New York City's health care safety net transition from an inpatient focused system to a system focused on addressing patients' physical and behavioral health needs outside the four walls of the hospital.** From driving new models of primary care and outpatient behavioral health care; to creating ExpressCare clinics (NYC Health + Hospital's line of urgent care clinics) that improve access, reduce unnecessary emergency department visits and connect patients to primary care; to programs that link patients leaving the hospital to the social, behavioral health, and medical supports they needed to stay healthy; OneCity Health and DSRIP made the largest safety net health system in NYC stronger and more effective at meeting its patients ongoing needs.

2. **Built strong bonds between 'traditional' health providers and Community-Based Organizations (CBOs).** Building on initial investments in building CBO capacity and formal hospital community partnerships to boost linkages to community resources, multiple PPS partner hospitals have CBOs embedded in their facilities to provide connections to key social services. Partnerships ranging from multidisciplinary care transition services, medical respite, to housing navigation, to community-based asthma management services led by community health workers (CHWs) will endure long beyond DSRIP. In fact, many of these relationships were so strong, OneCity partners were willing to rapidly adjust the scope of their contracts to address the unique needs of patients and the incredibly challenging circumstances of the COVID-19 pandemic. Facility based services like food navigation became mobile and community based, housing and respite programs accelerated admissions, and PPS partners moved to support alternative care sites like hotels. The CHWs pivoted to telephonic remote outreach to asthma and COPD patients, assessing their symptoms, pharmacy needs, medication refills, and adherence statuses, and escalated to providers, thereby reducing the burden on facility staff.

3. **Strengthened the commitment to value-based payment and addressing social needs of patients.** OneCity Health developed a capacity building and technical assistance program for CBOs to build a strong network of partners focused on 1) financial stability, 2) data collection

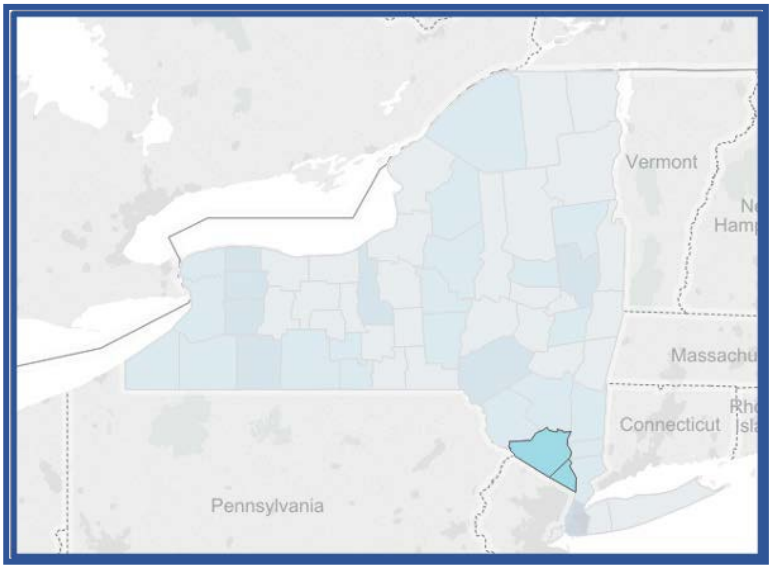
and tracking, 3) program design, and 4) operations and organizational culture. These practices, along with investments in a robust data and analytics infrastructure, allowed PPS partners to improve the quality of care they provided and to track that improvement, so they were prepared for success in value-based payment. While many thought it impossible to reduce avoidable hospital utilization, and particularly emergency department use, OneCity Health and PPS partners succeeded in reducing avoidable hospitalization and ED utilization. Success on major hospital-based measures was paired with dramatic improvements on diabetes control, asthma management, follow up care after behavioral health admissions, and access to key screenings and preventive care. Those improvements, and the culture change behind them, position OneCity Health's partners to succeed in value-based payment over the long term.

4. **Sustainability Plan:**
   - Continue investments that improve quality and financial performance in existing contracts; investments that reduce system costs and reliance on fixed and fee-for-service revenue streams
   - Build infrastructure to support more PPS partners through value-based contracts (e.g., Independent PPS partners, and safety net resources on practice association)
   - Develop next level VBP arrangements with New York State DOH to focus NYC Health + Hospitals, PPS partners, and safety net resources on specific vulnerable populations

Refuah Community Health Collaborative

https://refuahhealth.org/

Refuah Community Health Collaborative is a Federally Qualified Health Center led network of 55 partner agencies working together to serve over 45,000 Medicaid beneficiaries in Rockland and Orange counties.



Counties Served: Orange and Rockland

7 total projects

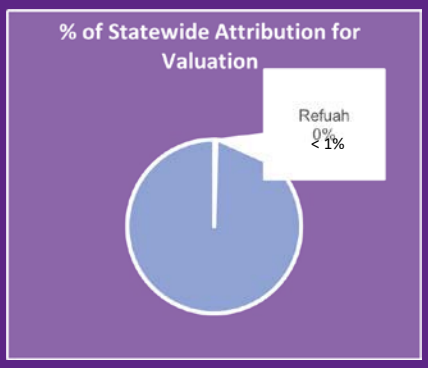
- 2.a.i Integrated Delivery Systems
- 2.a.ii PCMH/APC
- 2.c.i Community-Based Health Navigation
- 3.a.i Primary Care and Behavioral Health Integration
- 3.a.ii Crisis Stabilization
- 3.a.iii Evidence-Based Medication Adherence – BH
- 4.b.i Tobacco Cessation

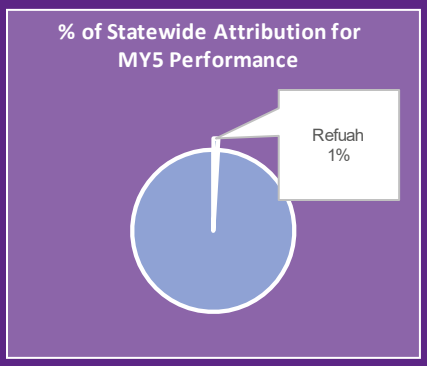
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patient Engagement through Primary Care and Behavioral Health Integration Models	5,490	6,564	7,631	8,160
Total Active Engagements of Patients	20,202	30,034	38,787	34,819

BY THE NUMBERS

- **26,804** Total Patients Attributed for Maximum Valuation
- **51,850** Total Patients Attributed for MY5 Performance





- **1,459** Total Network Partner Types
- **102** Total PCMH and APC Recognized Providers
- **67** Total Primary Care Providers and **29** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$43,889,758** Total Funds Earned Through DY5

As the only Federally Qualified Health Center (FQHC)-led performing provider system (PPS), Refuah Community Health Collaborative (RCHC) likes to say it has been "DSRIP'ing before DSRIP." Addressing individual and community needs and social barriers to health has been a cornerstone of Refuah's mission from its inception. The DSRIP program has allowed Refuah to realize that mission on a scale that would not have been otherwise possible. Three of the most impactful areas of transformation include the following:

- Integrated Care: Through DSRIP, the Refuah Community Health Collaborative (RefuahCHC) has developed multiple strategies to advance the integration of primary medical care and behavioral health services. Operationally, RefuahCHC has invested in supporting integration through workforce expansion, hiring dozens of mental health professionals to respond to positive mental health screening in the primary care space via "warm hand offs." The PPS has also developed and assessed "Core Protocols" for all of its providers, asking if practices have certain standards in place for BH care–such as procedures to ensure outpatient follow- ups within seven days of discharge for mental health hospitalizations or to ensure that every patient on antipsychotics is screened for diabetes. RefuahCHC has also implemented workflows and delivery models within the primary care setting that achieve true integration including: the introduction of the AIMS consultative psychiatry model to empower primary care providers to manage anxiety, depression and ADHD themselves with the support of a mental health team; over 1,600 mental health "warm hand-offs" across all departments including women's health, dental, physical therapy, etc.; capital renovation project to integrate BH providers within primary care and OB/GYN departments. Currently Refuah Health Center, the lead agency of RefuahCHC, has no wait list for therapy and psychiatry.

- Patient Center Medical Home: As a result of DSRIP, RefuahCHC recognizes the transformative power and cost efficiencies achieved through participation of primary care providers in the PCMH program. As part of the DSRIP program, every PPS primary care partner became PCMH certified. Outlays by primary care providers with PPS support including increased patient support staff (e.g. care coordinators, care managers, patient navigators) and new workflows(e.g. screening for social determinants of health that may pose a barrier to care, medication coordination), positively impacted multiple quality outcomes and resulted in high achievement for the PPS. For example, under DSRIP, the PPS hired an army of patient navigators to screen for and address the many social determinants that impact a patient's health (i.e., housing, food insecurity, transportation etc.). In the past, these areas were not typically addressed in the "medical" office. Under PCMH integration, providers have evolved into a more comprehensive "medical home". The PCMH resources generate benefits to patients in the form of improved outcomes and cost-savings in the form of reduced avoidable hospitalizations. RefuahCHC believes that the PCHM program directly contributes to lowering Medicaid costs in other areas and believes that continued investment in the PCMH program will only yield more cost efficiencies in the long term.

- Enhanced Data: DSRIP's push to Value Based Payment contracting encouraged each

DSRIP participant to harness the value of robust data while simultaneously providing funding to successfully develop enhanced analytics. Data, measurement, and reporting were cornerstones of the DSRIP program from the outset. Because of the high bar set by DSRIP, Refuah reevaluated the use of internal data and externally available sources and invested substantial resources (both human and financial) in the development of an internal data warehouse, that assimilates quality, utilization and financial data across all sources.

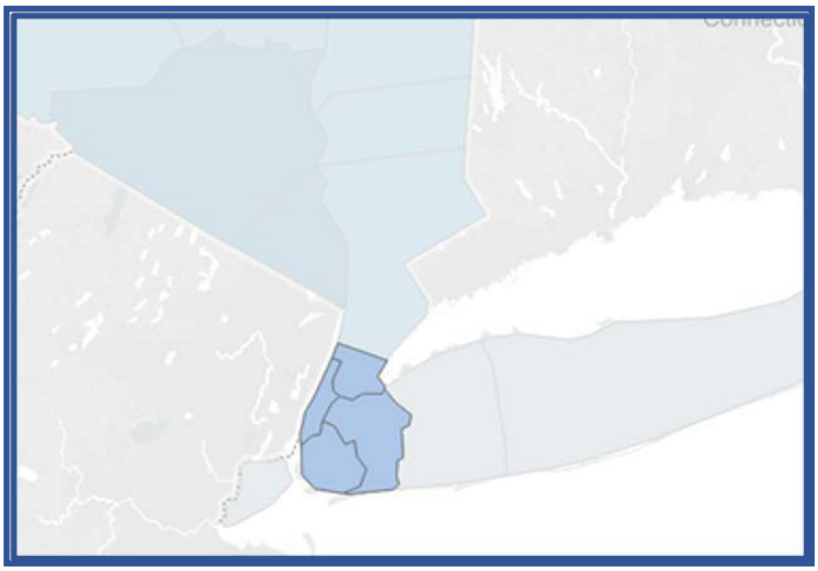
- Sustainability Plan:

  - RCHC will leave in place its current governance and organizational structure until all DSRIP funds
    have been distributed
  - Partner organizations are well-positioned to continue to sustain many of the workflows and processes that were put into place over the past 5 years.
  - Partners will continue to exchange ideas and provide support through the relationships and open flow of communication that have evolved through the DSRIP collaborative process.
  - Specific programs and processes that RCHC anticipates will remain in place are: PCMH certification for RCHC health centers, primary-care behavioral health integration, and data-analytics platforms and workflows.

SOMOS Healthcare

https://somoscommunitycare.org/

SOMOS is a physician-led organization of 2500 providers, mainly minorities, working to increase the quality of care for >650,000 persons in under-served communities of Manhattan, Bronx, Brooklyn, Queens.



Counties Served: Bronx County, Brooklyn County, Queens County, Manhattan County

10 total projects

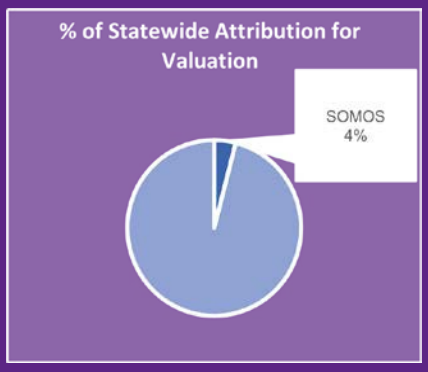
- 2.a.i Integrated Delivery Systems
- 2.a.iii Health Home-At-Risk
- 2.b.iii ED Care Triage
- 2.b.iv Care Transitions – Chronic Disease
- 3.a.i Primary Care and Behavioral Health Integration
- 3.b.i Disease Management – Cardio
- 3.c.i High-Risk Disease Management – Diabetes
- 3.d.iii Evidence-Based Guidelines for Asthma Management
- 4.b.i Tobacco Cessation
- 4.b.ii Preventative Care/Management

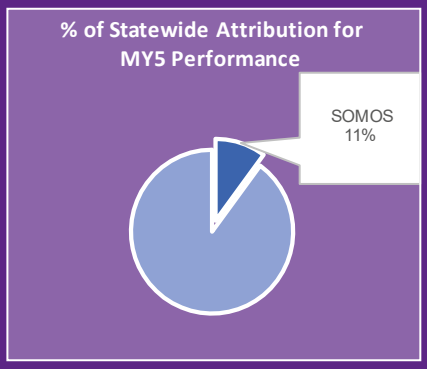
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patient Engagement through Primary Care and Behavioral Health Integration Models	134,565	217,353	334,044	425,470
Total Active Engagements of Patients	433,713	1,104,905	1,039,964	1,185,640

BY THE NUMBERS

- **312,623** Total Patients Attributed for Maximum Valuation
- **610,530** Total Patients Attributed for MY5 Performance





- **3,271** Total Network Partner Types
- **646** Total PCMH and APC Recognized Providers
- **921** Total Primary Care Providers and **360** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$603,289,679** Total Funds Earned Through DY5

THE FUTURE OF MEDICAL CARE.

SOMOS Community Care Comprehensive Final Report June 1, 2020

SOMOS Community Care PPS is a physician-led organization of 2500 providers, mainly minorities, working to increase the quality of care for >650,000 persons in underserved communities of Manhattan, Bronx, Brooklyn, Queens.

SOMOS has:

Changed the way independent medical practices operate: SOMOS built a comprehensive Integrated Delivery System providing independent practices that have traditionally worked in silos, the ability to access modern technology to further improve quality of care. SOMOS built a centralized IT platform that connects independent providers and facilitates centralized data exchange allowing small practices to thrive, interconnect, and thereby improve population health. SOMOS's practices can access and exchange clinical information, event notification and treatment plans. SOMOS brought together different EMRs and systems forming a central, uniform, efficient technology where providers can identify and address care gaps. Through SOMOS support, over 600 practices with nearly a million patients are part of population health platforms. SOMOS connected nearly 1,800 providers and over 600 practices to the Bronx RHIO, allowing independent practices to share real-time data among providers. Availability of advanced patient-centered care was strengthened with more than 900 providers achieving NCQA PCMH level 3 certification, a level that requires more behavioral health integration and care coordination competencies.

Developed a Centralized Telehealth Platform supporting individual providers or as centralized telehealth, allowing for virtual office visits, e-prescribing and patient consultations. The central telehealth service is connected with all of our practices and covers all SOMOS practices. Each practice has its own login for portal use in performing telehealth visits, but it is also covered centrally during hours when the practice is not available. Patients are able to easily dial one number or utilize the website to connect with SOMOS and request a telehealth visit and a team of multilanguage providers will be available for the patient. Service is available for patients of all ages.

Changed how patients engage in their health: SOMOS developed new forms of patient outreach and health education, informed by our unique lens of cultural likeness with the communities we serve.

Patients are engaged through several initiatives, including Behavioral Health Integration where patients can receive behavioral health screenings and services in the privacy and comfort of their PCP's office, chronic disease management, and lifestyle modification. Combining modern technologies, such as the MiSOMOS App, with on-the-ground personal interaction with enhanced community health workers (CHWs) have increased compliance with treatment

regimens, improved health literacy, promoted healthy habits, and addressed SDH needs through connections with CBOs.

Care Transitions and Care Management: SOMOS implemented centralized Care transitions and Care Management successfully decreasing hospital use and readmissions thus reducing costs and increasing care quality and wellbeing. Patients are provided the benefit of having a care transitions team of care coordinators, care managers and medical providers who are available to help them.

They provide comprehensive care from medical care at home to assistance with obtaining medications and addressing social determinants of health when they leave the hospital and integrate into the community. Patients also receive care coordination and care management to help them better understand how to manage chronic illnesses and navigate through the health system ensuring that they get timely appointments, manage their medications and even maintain their insurance coverage. Care managers and care coordinators establish a rapport with the patients, their families and caregivers to increase compliance and assist with social determinants. Patients are never left alone.

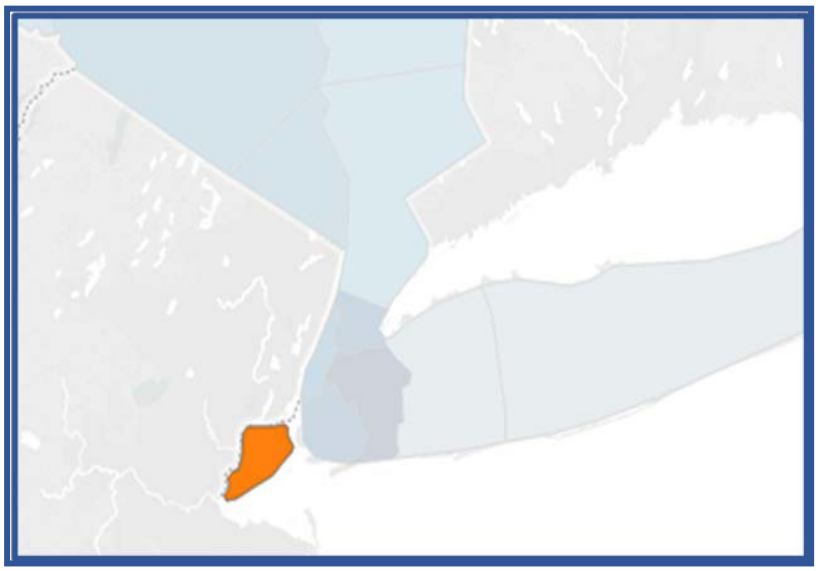
Changed the ability of the system to respond: As the COVID-19 crisis demonstrates the assets deployed, and the trust built by the PPS have become more critical in a public health emergency. The SOMOS community and provider network engagement, built on culturally competent and community-invested staff, allowed the PPS to immediately understand the needs and challenges, bring people together, and implement urgent new strategies for response.

Prepared the system for the next step: SOMOS successfully piloted Value based care that is sustainable throughout the Healthcare system. We have successfully implemented VBP contracts in independent small to large practices at increasing levels of risk arrangements.

Staten Island PPS

https://www.statenislandpps.org/

Co-led by Staten Island University Hospital and Richmond University Medical Center, Staten Island PPS's network of over 70 partners includes a wide range of community-based clinics, nursing homes, behavioral health organizations, social service agencies, and primary care practices across the Island.



Counties Served: Staten Island

11 total projects

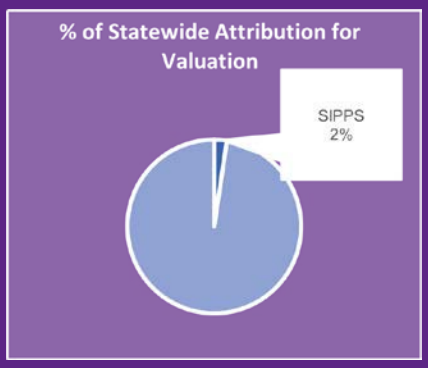
- 2.a.iii Health Home At-Risk
- 2.b.iv Care Transitions – Chronic Disease
- 2.b.vii Transfer Avoidance – SNF
- 2.b.viii Hospital-Home Care Collaboration
- 2.d.i Patient Activation (PAM)
- 3.a.i Primary Care and Behavioral Health Integration
- 3.a.iv Withdrawal Management & Abstinence Services
- 3.c.i High-Risk Disease Management – Diabetes
- 3.g.ii Integration of Palliative Care into Nursing Homes
- 4.a.iii Strengthen MHSA Infrastructure
- 4.b.ii Preventative Care/Management

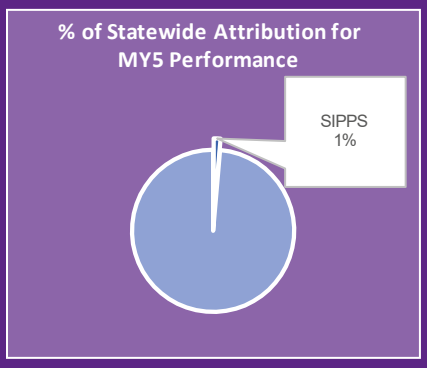
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patients Engaged through Primary Care and Behavioral Health Integration Models	6,726	10,742	15,217	17,269
Total Active Engagements of Patients	24,722	48,771	75,814	93,640

BY THE NUMBERS

- **180,268** Total Patients Attributed for Maximum Valuation
- **75,062** Total Patients Attributed for MY5 Performance





- **595** Total Network Partner Types
- **85** Total PCMH and APC Recognized Providers
- **67** Total Primary Care Providers and **76** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$227,937,356** Total Funds Earned Through DY5

Collaboration, innovation and trust have been the foundation of the SI PPS mission to transform the health and wellness of our community. From the start, SI PPS engaged community partners and stakeholders, leveraging existing partnerships and coalitions to help inform the strategy and goals of improving population health for underserved Staten Islanders. The following systems of care and approaches have become regional models for achieving success:

- Focus on Social Determinants of Health: Population health partnerships and social determinant of health (SDOH) programs are one of the most enduring aspects of DSRIP. Both durable and sustainable, many partners are engaging with MCOs to deliver services addressing food insecurity, social isolation, and faith- based outreach. Using technology, the PPS designed its own innovative SDOH app called "WeSource". Over 20,000 Staten Islanders had over 30,000 SDOH factors addressed through closed loop referrals by community-based partners. Multiple partners are still funded post DSRIP through this effort. The safety net funding rule hampered the engagement and funding for CBOs, however, that did not deter SI PPS from early year engagement and capacity-building with CBOs and community-based clinical partners like FQHCs and recovery centers.
- Prioritization of Diversity, Equity, and Inclusion: Identified as a priority in the community, SI PPS made health literacy and cultural competency trainings and workshops available to over 50 partner organizations. The SI PPS contracted with organizations addressing LGBTQ+, military, interreligious and people with disabilities cultural awareness, who delivered training to the community. Over 12,000 individuals have received training through CC/HL classes, boot camps and provider communication trainings. The impact and effectiveness of SI PPSs CC/HL training strategy is evidenced by year over year improvements in health literacy performance measures.
- Workforce Transformation: Workforce investments have led to greater than 70,000 hours of training across over 50 partner organizations. Relationships with the United States Department of Labor yielded the first federally approved apprenticeship program for certified nursing assistants and certified peer recovery advocates (CRPA) in New York State. Staten Island is the only PPS in New York to have received a 3-year grant from the Health Resources and Services Administration (HRSA) to train 240 CRPAs and community health workers based on its innovative and durable training programs. The SI PPS workforce models are being sustained through grants and city-wide partnerships with institutes of higher education, producing new initiatives in the coming year enhancing workforce programs and expansion of key programs to other areas.
- Building Infrastructure to Address Behavioral Health: Once the epicenter of the addiction crisis, Staten Island has seen a continuous reduction in overdose mortality since 2016, with significantly fewer deaths in the last year. Thousands of individuals are receiving addiction treatment through modalities like medication assisted treatment (MAT), harm reduction and residential programs. Dozens of practitioners have obtained MAT waivers to care for patients with substance use disorders and Staten Island has seen a marked increase in the number of people accessing MAT. The EDs have hired CRPAs educated through the PPS funded program, available 24/7 in many community settings. The partnership on the HOPE Program with the Office of the Richmond County District Attorney is a hallmark of innovation, becoming sustainably funded based on its effectiveness and impact as evidenced by over 1,000 individuals being engaged and over 90% being redirected from criminal justice settings to treatment and recovery services. The program is now in use throughout NYC and many counties in the state.
- Achieving Quality through Analytics and Business Intelligence: Staten Island has become a model

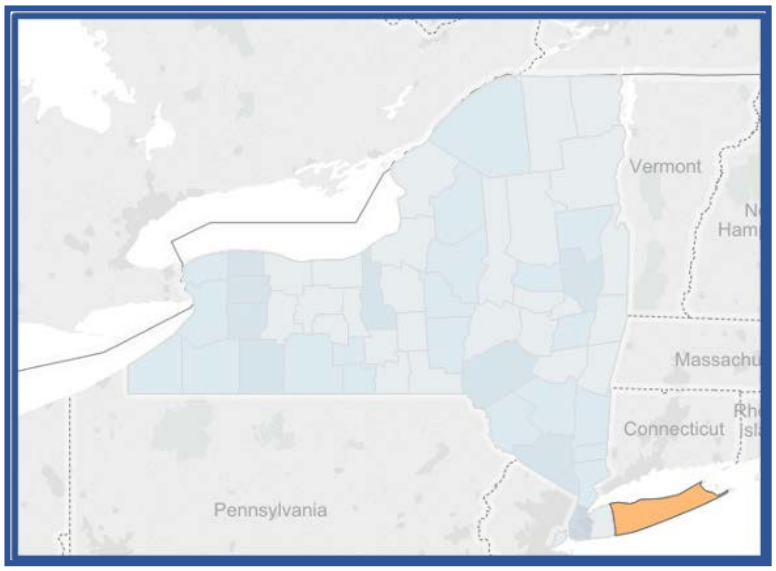
for how to use business intelligence to drive decision making through multi-agency collaboration, reducing costs, and improving population health. This led to targeted and innovative programming using patient facing technology, the SDOH app, "WeSource"

- Sustainability Plan: An agreement is in final stages with Capitol District Physician Health Plan (CDPHP) to introduce a Medicaid product to be called the "Staten Island Health Plan" to the community. The PPS will provide MSO services and population health management under contract to CDPHP. Other revenue streams from grants, technology and consulting will support the organization.

Suffolk Care Collaborative

https://suffolkcare.org/

Suffolk Care Collaborative is an alliance of healthcare providers established to improve county-wide health by addressing barriers to wellness, improving access and reducing costs by decreasing unnecessary hospital utilization.



Counties Served: Suffolk County

11 total projects

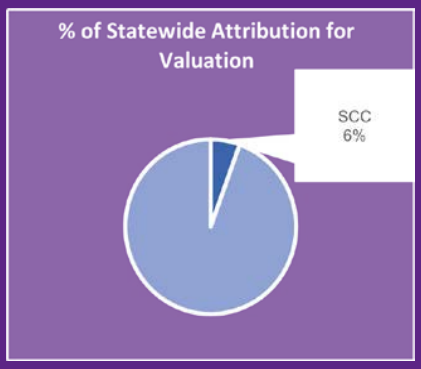
2.a.i	Integrated Delivery Systems
2.b.iv	Care Transitions – Chronic Disease
2.b.vii	INTERACT
2.b.ix	Hospital Observational Programs
2.d.i	Patient Activation (PAM)
3.a.i	Primary Care and Behavioral Health Integration
3.b.i	Disease Management – Cardio
3.c.i	High-Risk Disease Management – Diabetes
3.d.ii	Asthma Home-Based Self-Management
4.a.ii	Prevent MHSA Disorders
4.b.ii	Preventative Care/Management

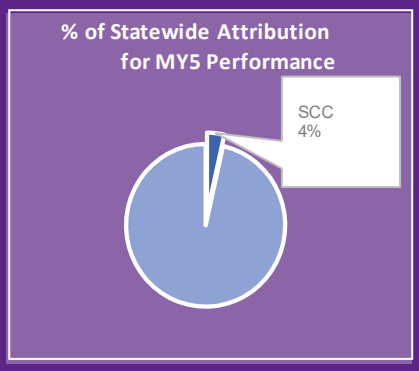
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patient Engagement through Primary Care and Behavioral Health Integration Models	15,541	31,440	42,928	34,449
Total Active Engagements of Patients	78,407	119,176	125,488	132,597

BY THE NUMBERS

- **437,896** Total Patients Attributed for Maximum Valuation
- **197,402** Total Patients Attributed for MY5 Performance





- **3,924** Total Network Partner Types
- **508** Total PCMH and APC Recognized Providers
- **453** Total Primary Care Providers and **444** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$269,695,200** Total Funds Earned Through DY5

Initiatives undertaken by the Suffolk Care Collaborative (SCC) and its partners to support the transformation of healthcare in Suffolk County include:

- **Cultural Competency and Health Literacy (CCHL)**

The Cultural Competency and Health Literacy (CCHL) Program, provided through a collaboration of the SCC, Nassau-Queens PPS, Long Island Health Collaborative, and curriculum creator Dr. Martine Hackett, Assistant Professor at Hofstra University, is a self-perpetuating Cultural Competency and Health Literacy train-the-trainer program, where 1,810 individuals were trained (355 master facilitators and 1,455 workforce). The objectives of the CCHL program is to advance cultural and linguistic competency, promote effective communication to eliminate health disparities and enhance patient outcomes. Participants interactively learn concepts of regional health equity data, unconscious bias, social determinants of health, cultural competency and humility, National Culturally and Linguistically Appropriate Services (CLAS) Standards, health literacy barriers and strategies, and the Teach-Back Method.

- **Practice Transformation**

The SCC successfully developed and executed a practice transformation plan for primary care practices to achieve NCQA 2014 PCMH Level 3 or APC Gate 2 recognition. The plan included contracts with technical agents (TA) and two SCC staff PCMH-certified content experts (CCE) to support and facilitate practices through the transformation process. The SCC supported 550 primary care providers to achieve PCMH / APC practice transformation exceeding the commitment of 511. The SCC continued to support partners to sustain, transition, and/or prepare new applications for NYS PCMH through sharing of best practices and experiences and coaching partners through challenges and areas of opportunities for improvement.

- **Primary Care/Behavioral Health (PCBH) Program**

An essential goal for SCC was building infrastructure to support increased access and coordination to mental health and substance use disorder treatment. Primary care (PC) and behavioral health (BH) integration was accomplished by supporting partnerships between PC and BH providers, accounting for 100 integrated sites. The strategy included technical assistance to evaluate readiness/current state of integration with ongoing support tailored to fit the individual needs of each partner. To facilitate achievement of an integrated model of care, SCC's assistance included onsite assessments, performance metrics goal setting, coaching to achieve performance targets and action planning process for partners not achieving performance targets.

- **Performance Improvement**

The SCC developed a performance improvement program for the provider network by adopting the Institute for Healthcare Improvement model for improvement framework and adapting and integrating the NYS DOH Medicaid Accelerated eXchange (MAX) program methodology into community providers' performance improvement activities. The goal was to deploy structured performance improvement initiatives and enhance continuous quality improvement (CQI) skillsets among SCC community-based providers.

- **Transitions of Care**

SCC established care management/care coordination processes with a focus on social

determinants of health and building partnerships with community-based organizations (CBOs) by:

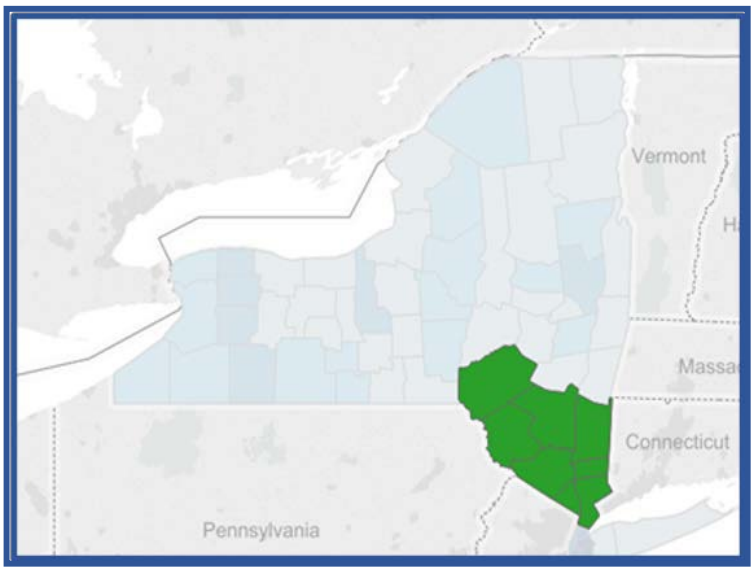
- Creating transitions of care workflows to ensure communication across the continuum of care and connections to community-based resources.
- Implementation and utilization of a screening tool to identify barriers to care and social determinants of health.
- Convening subject matter experts to inform and add to an online directory to connect resources to identified needs utilizing HITE.

- **<u>Sustainability Plan</u>**
  - The current PPS organizational structure will no longer be relevant post-DSRIP and will be dissolved.
  - Catholic Health Services of Long Island (CHSLI) hub is actively working with other managed Medicaid plans to establish value-based contracts.
  - Northwell Health hub, Southside will continue to support its care management efforts and invest in value-based care competencies to support our Population Health strategy around Medicaid patients.
  - Stony Brook Medicine (SBM) hub expanding care algorithm to support Medicare beneficiaries through SBM) as an Accountable Care Organization as well as the CMS Bundled Payments for Care Improvement Advanced Model (BPCIa).
    - SBM is building on and expanding the collaborative network of partners (clinicians, CBOs, acute care facilities, Skilled Nursing Facilities, Homecare Agencies, etc) to improve access to care.
    - investing substantial resources and capital into building a referral management solution to assist clinicians and patients in facilitating scheduling of appointments and clinical services throughout the system.

WMCHealth

http://www.crhi-ny.org/

Since 2015, WMCHealth PPS has collaborated with 5,600 clinical providers in 207 organizations throughout eight counties in the Hudson Valley, including primary and specialty care, behavioral health, and agencies addressing special populations or social needs.



Counties Served: Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester

11 total projects

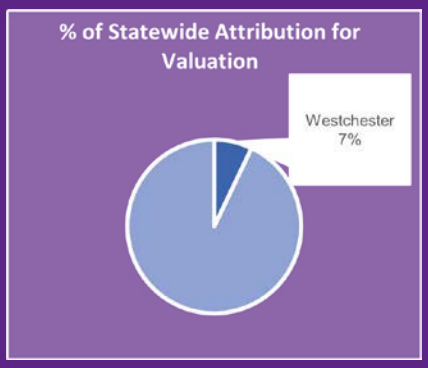
- 2.a.i Integrated Delivery Systems
- 2.a.iii Health Home At-Risk
- 2.a.iv Medical Village-Hospital
- 2.b.iv Care Transitions – Chronic Disease
- 2.d.i Patient Activation (PAM)
- 3.a.i Primary Care and Behavioral Health Integration
- 3.a.ii Crisis Stabilization
- 3.c.i High-Risk Disease Management – Diabetes
- 3.d.iii Evidence-Based Guidelines for Asthma Management
- 4.b.i Tobacco Cessation
- 4.b.ii Preventative Care/Management

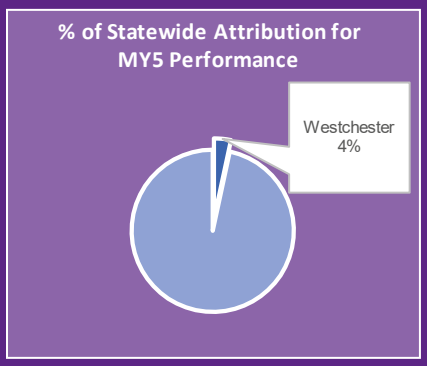
Annual Active Patient Engagements

	DY1	DY2	DY3	DY4
Patient Engagement through Primary Care and Behavioral Health Integration Models	12,223	15,160	13,302	22,857
Total Active Engagements of Patients	27,032	48,897	57,586	94,392

BY THE NUMBERS

- **573,393** Total Patients Attributed for Maximum Valuation
- **188,803** Total Patients Attributed for MY5 Performance





- **5,505** Total Network Partner Types
- **357** Total PCMH and APC Recognized Providers
- **480** Total Primary Care Providers and **245** Total Mental Health Providers engaged in Primary Care and Behavioral Health Integration through project 3.a.i

- **$240,603,451** Total Funds Earned Through DY5

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The impact of the WMCHealth PPS has been apparent in the resiliency of partner organizations facing the COVID-19 crisis.

- Creating an Integrated Delivery System: DSRIP supported work to integrate the 10 hospitals that comprise WMCHealth Network. Implementation of shared data platforms and expansion of telehealth capabilities laid the basis for the eight-county system to respond to the COVID crisis in an orderly and synchronized manner: sharing the expertise of the tele-Intensive Care Unit, and shifting staff, equipment, and patients as required. As the leading hospital system in the Hudson Valley, through June 2020, WMCHealth Network cared for and successfully discharged over 1350 COVID patients. As WMCHealth hospitals shift to post-COVID status, DSRIP support will enable the consolidation of lessons learned and the strengthening of WMCHealth Network hospitals' links with primary care, behavioral-health and social service agencies.

- Enabling Organizations to Serve Patients, Clients, and Communities More Effectively: Partners used DSRIP resources to upgrade staff skills, to enable electronic exchange of health information, and to create new umbrella organizations for independent agencies to coordinate their work. Partner organizations targeted populations of complex patients while accelerating the focus on social determinants of health, such as food insecurity or inadequate housing and expanding patients' engagement with mental health and substance use treatment. Community engagement programs linked medical students to community internships, raised awareness of racial disparities in perinatal care and outcomes, and facilitated smoking cessation for residents of public housing. Peer wellness coaches deployed in Port Jervis, Suffern, and Poughkeepsie assisted patients discharged from in-patient psychiatry units. Peers have lived experience with mental illness or addiction and offer empathetic support to patients facing the challenge of the transition to community care after a hospital stay.

- Investing in Workforce: Over eleven thousand individuals in 449 organizations benefitted from workforce development supported by WMCHealth PPS; 500 primary care physicians achieved NCQA Patient Centered Medical Home (PCMH) recognition; 350 attendees from agencies and practices took advantage of "Blueprint for Health" sensitivity training to deepen their understanding of the social determinants of health. The PPS supported training and pilot program jobs for peer coaches, for emergency department care navigators in partner hospitals in Dutchess, Orange, Rockland, and Ulster counties, and for health home care to work in primary care practices in Kingston, Middletown, Hawthorne, and White Plains. A particularly effective program enabled staff to deliver diabetes self-management training to persons with severe and persistent mental illness who are at greater risk of diabetes because of the effects of anti-psychotic medications.

- Building Healthy Communities: Many organizations have developed ongoing collaborations to benefit patients after meeting in "Medical Neighborhoods" convened by WMCHealth PPS. These

investments in community initiatives, particularly among agencies providing social services and those providing medical and behavioral health care, facilitated a shift to virtual delivery of services when COVID suddenly required social distancing and will enhance the transition after the pandemic to a more integrated health system rooted in the communities served. These promising practices will be the legacy of the WMCHealth PPS.

- Sustainability Plan:
  - WMCHealth PPS Project Management Office and the WMCPPS Executive Committee will be dissolved post-DSRIP.
  - The PPS will set aside funds to create the Transitioning Promising Practices Fund (TPPF) to assist WMCHealth PPS partners to scale, consolidate and sustain their DSRIP "promising practices" for sustainability after DSRIP.
  - One-third of partners will have sustained activities resulting from their DSRIP work.