Partner Engagement.

Recommendation 1: The IA requires the PPS to develop an action plan to increase partner engagement. The plan needs to provide specific details by each project for partner engagement.

Thank you for your recommendation to develop an action plan to increase partner engagement. **Partner engagement is critical to WMCHealth PPS success and we have an active and detailed plan to address it.** From the beginning of DSRIP, our partners have been involved and engaged in PPS program and projects through participation in:

- Project Advisory Quality Committee meetings,
- conferences,
- webinars and
- Focus groups.

Formal contracting around project participation began with affiliated organizations signing a **Master's Services Agreement accompanied by one or more "Schedule B"** which spelt out the commitments of both the PPS and the partner provider or agency around particular projects. Our first round of Schedule B contracts focused on threshold activity associated with project 2ai and with community outreach related to project 2di. More recently, we have executed **Implementation Contracts** starting in July 2016. Beginning with those partners with the most attributed Medicaid beneficiaries and participating in the most projects, the Implementation contracts will be rolled out to partner organizations in 5 "waves." At this time we are finishing wave 3 and beginning wave 4 of the planned 5 waves.

To **monitor** partner engagement we have developed a very detailed Quarterly Project Performance Roadmap (QPPR) Supporting Report Form to track quarterly partner activity around each project.

In addition to committee work and contracts for participation for each of the projects we have an **active engagement plan based on local "mini medical neighborhoods"**. This work is specific to each of the 7 communities where the PPS has convened hospitals, primary care, specialists, behavioral health, Health Homes, nursing homes, home health agencies and community based partners to address the clinical interoperability needed to meet project deliverables and create a more effective and efficient delivery system for Medicaid beneficiaries.

We appreciate the IA suggestion that we be able to provide details by each project for partner engagement. To facilitate that level of detailed reporting we will undertake the following steps to ensure that the full breadth and depth of provider engagement for each project is documented in the quarterly submission to NYS of engaged providers.

1- We have always included in our quarterly submission to the IA a list of meetings, conferences and trainings. Going forward we will also include participation in PPS committees and trainings as evidence of PPS participation in the provider engagement file;
2- We will ensure that when a partner organization has executed a Schedule B for project participation, all providers associated with the partner are reported in the provider engagement file;
3- We will continue to extend Implementation contracts to more partners.

To summarize, we appreciate the concern expressed by the IA. We are confident our **Partner Engagement Plan** is **detailed and active, covers all 11 projects** and will be more fully reflected in the DY2Q3 provider engagement submission.

Project 3.a.i.
Recommendation 1: The IA recommends that the PPS develop an action plan to identify and introduce opportunities for mental health professionals to partner with primary care providers. It will be important to increase the engagement of PCP and Mental Health partners in this project to ensure the project is implemented successfully and the PPS is positioned to meet the performance metrics for Domain 3a projects. The engagement of partners to successfully implement this project is further emphasized by the additional value associated with this project through the High Performance Fund, where six of the ten eligible measures are tied to Domain 3a projects.

WMCHealth PPS agrees whole heartedly that **integration of Behavioral Health (BH) with primary care is a critical component of the transformation of service delivery** that will help NY to deliver more compassionate, effective and efficient care for all Medicaid beneficiaries and will ensure better coordination of medical care with BH care for patients with serious mental illness. **From the beginning WMCHealth PPS has placed a high priority on working closely with primary care and BH providers** through Project Advisory Quality Committees, Medical Neighborhood Working Groups, and Actively Engaged Patient Reporting. WMCHealth PPS has invested in significant resources to assist primary care practices working toward Patient Centered Medical Home. Also, a number of workforce training initiatives that have been very well attended have focused on skills needed to increase integration of medical and behavioral health: 97 people from throughout the region attended an all-day WMCHealth PPS Sponsored Care Management Learning Collaborative, 76 people have been trained in Motivational Interviewing, 22 people have been trained in Mental Health First Aid, 75 attended the 3rd Annual Prevention Conference *Law Enforcement & Public Health Partnerships* in sponsored by WMCHealth PPS in collaboration with the National Council on Alcoholism & Other Drug Dependencies/Putnam (NCADD) held on October 28, 2016. For 2017 WMCHealth PPS is will continue quarterly offerings for Motivational Interviewing and Mental Health First Aid and is developing Trauma Informed Care Training an anticipated 50 persons.

WMCHealth has also **engaged both primary care and Behavioral health providers through contracted agreements with participating partner organizations**. Initial contracts for "threshold" participation were executed in DY1. Implementation contracts reflecting specific project participation are being executed in DY2. In addition to committee work and contracts for participation we have an active engagement plan based on seven local "medical neighborhoods" which include both primary care and BH organizations. WMCHealth PPS is also very aware of DSRIP Performance Measures addressing the needs of Behavioral Health patients and we have **played an active role in region-wide efforts involving all three PPSs in the Hudson Valley to create tools and resources to help providers better address the needs of patients as reflected in the BH measures**.

While we have consistently reported all meetings and trainings in quarterly reports to the DSRIP Independent Assessor, the extent of WMCHealth PPS engagement with PCPs and BH providers is not fully reflected in the Mid-Point Assessment because we have, until now, not also reported provider participation in the quarterly provider engagement file. We will be sure to do so going forward and **we are confident that the extent of engagement is much greater than what was apparent in the Mid-Point report and will continue to grow** as contracting for project implementation proceeds. We appreciate the concern expressed by the IA and acknowledge that our quarterly reporting of provider engagement has not fully reflected the excellent work of our many partners.

WMCHealth PPS acknowledges two recommendations from the DSRIP Midpoint Assessment regarding our action plan for project 2di. The goal of the 2di project is to engage, educate and integrate uninsured, and low or non- utilizing Medicaid beneficiaries into community based health care.

To date, WMCHealth PPS has worked through our partner organizations to implement project 2di. Efforts to engage network partners in the project 2di have been:

- 20 organizations are currently performing PAM surveys
- 7 organizations are in the processes PAM Implementation contract review
- As of DY2-Q3 8,472 of PAMS surveys have been completed

Recommendation 1: The IA recommends the PPS develop a strategy to assist partners in better identifying the targeted population for this project.

WMCHealth PPS will:

- Collaborate with Medicaid managed care plans to help practices identify and do outreach to engage patients who have enrolled in managed care but who have not yet been seen by their PCP.
- The vast majority of the Medicaid beneficiaries attributed to WMCHealth PPS who have not engaged with primary care are those who are not assigned to a managed care plan. WMC Health will consult with DOH about the possibility of conducting mail or phone outreach to these persons to encourage them to engage with primary care. This could be a joint project of all the PPSs doing project 2di if NYS DOH was in agreement. This proposal could not only help to make project 2di more successful but could also help with other DSRIP wide performance measures that will assess the appropriateness of utilization of care and access to primary care.
- Collaborate with WMCHealth PPS' primary care providers to address the needs of the low & non utilizing patients within their practices. Open Door Family Medical Group, Llobet Medical group and Fallsburg Pediatrics among others are currently doing the PAM surveys with their patient populations. Crystal Run Health and Community Medical and Dental Care, Inc. are going to begin in the first quarter of 2017. These practices are currently undergoing practice transformation to achieve National Committee Quality Assurance's 2014 Patient Centered Medical Home Level 3 recognition status, or have already achieved this recognition, and thus have to demonstrate meeting the PCMH Standards requirements that pertain to the target population:
    i) Standard 1 Patient Centered Access, Element A, Factor 5: Monitoring of no-show patients: Practices have to demonstrate monitoring of no-show patients for a period of time.
    ii) Standard 3 Population Health Management, Element A, Factor 13: Health Insurance. Practices have to demonstrate documenting patients' health insurance status including 'none'.
    iii) Element D, factor 4: Practice has to document outreach attempts made for patients who have not been recently seen by practice.
    iv) Standard 6, Performance Measurement and Quality Improvement Element A, factor 4: Practices have to collect data on "vulnerable groups that reflect the practice's population demographics. Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability" (AHRQ)

Through its Primary Care Workgroup, WMCHealth PPS will work with these practices to align their PAM survey efforts to the above PCMH standards.

- Promote the use of the PAM survey tool at additional new locations within the WMC Health PPS network where uninsured persons are likely to present for care, such as emergency rooms and presumptive eligibility programs. Engage additional community base providers serving the undocumented population about PAM survey support: WMCH office for diversity; local government units to reach the target population e.g. Dutchess DOH; Rockland DOH.

Recommendation 2: The IA recommends the PPS develop a plan to increase outreach and education materials to partners with respect to patient activation measures.

WMCHealth PPS will:

- Move training materials for conducting PAM surveys to the WMCHealth PPS Learning Management System.
- Provide continuous in-service to contracted network partners providing PAM surveys.
- One objective of the 2di project is to assist non-utilizing Medicaid beneficiaries to more effectively use their Medicaid benefits and to connect with primary care. To that end, the PPS developed training via Webinar & Collateral Media providing instruction for PPS partners working with low and non-utilizing Medicaid beneficiaries about how to read the Medicaid ID cards to identify the health plan and primary care provider and information on how to request changes. The purpose of this training is to help our partners to ensure that patients and clients are able to identify and/ or select a primary care physician of their choice and they will be more likely to engage with that provider for preventive care.
- In collaboration with our community engagement efforts, WMCHealth PPS will host focus sessions with vulnerable and isolated communities. For example: we have conducted a community engagement needs assessment with the Boys & Girls Club of Newburgh and they have invited us to return next year.
- All training will be available on our Learning Management System.