



**To:** New York State Department of Health  
**From:** AHI PPS (ID #23)  
**Subject:** AHI PPS Mid-Point Assessment Narratives and Action Plans: **Executive Summary**  
**Date:** March 10, 2017

The AHI PPS is pleased to provide this packet of narratives and action plans in response to recommendations received during the recent DSRIP Mid-Point Assessment (MPA).

This process has provided us a welcomed opportunity to not only reflect on the significant progress we’ve made since the mid-point assessment period, but more importantly, a chance to articulate the planful, proactive strategies we’re marshalling within the structure of the DSRIP program to create a sustainable, integrated delivery system that will have a tangible positive impact on the health of individuals and families in our communities.

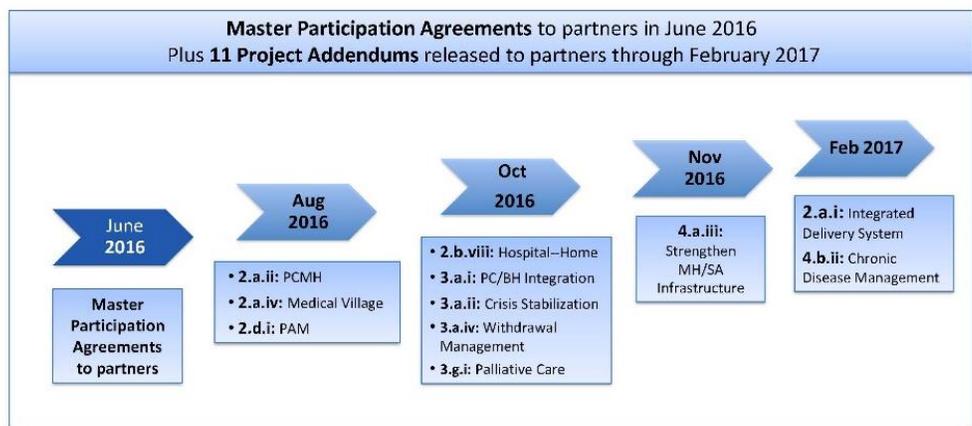
While this document provides detailed strategies to address the 13 areas identified by the Independent Assessor as areas for improvement, there are four overarching areas of focus we have identified that will serve as a compass for successfully reaching our DSRIP goals.

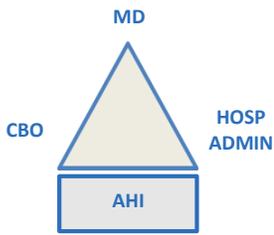
### Partner Engagement Across All Projects

Engaging partners across all projects is a crucial component of program success. It is particularly important to engage non-acute care providers and community-based organizations who may not have traditionally had a seat at the table and their voice heard.

We are utilizing effective contracting processes to confirm and secure partners’ participation via our Master Participation Agreement (MPA) and associated project addendums.

By restructuring our PPS geographically with the formation of five regional Population Health Networks (PHN’s), we have gained significant traction in our health system transformation efforts. The PHNs have positioned us to better identify and address the unique needs of the individual communities we serve.

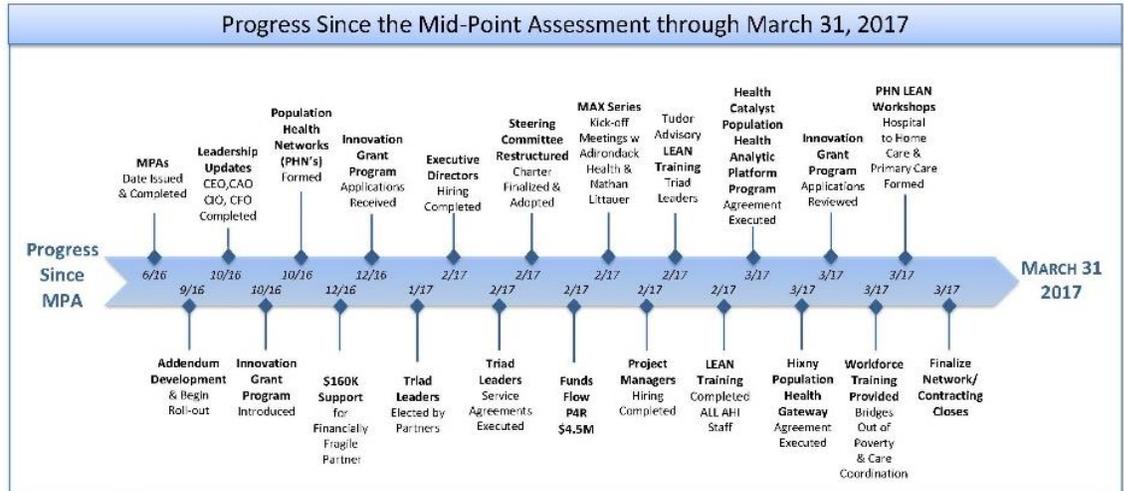




**PHN Triad Leadership**

We have established a Triad Leadership Structure for each PHN, comprised of a physician, hospital executive and community-based organization representative with formalized roles and responsibilities outlined in a Triad Leader Support Agreement. Each Leadership Triad is supported by an AHI Executive Director who serves as a liaison for coordinating project management support. The Triad Leaders, well-known and respected in their respective regions, are uniquely qualified to serve as project leads because of their relationships and in-depth familiarity with the needs and available resources in their communities. We have established an optimized PPS Operating Model based on LEAN continuous rapid cycle improvement principles.

Utilizing available data and analytics along with DSRIP program deliverables, we are able to more easily identify improvement priorities. Each Triad Leader and their partners has attended LEAN training sessions, incorporating its principles as standard practice for project activities. Work teams, comprised of a myriad of community stakeholders across the care continuum, have also been established to maintain forward momentum.



AHI provides project-specific management support to maintain engagement with providers in each PHN to assist them in understanding and achieving DSRIP goals and deliverables.

Partner participation will be tracked via a scorecard designed to assess work group participation and monitor performance results.

**Meaningful Engagement Timeline**

The AHI PPS has developed a detailed, well-thought-out timeline for accomplishing truly meaningful partner engagement. We are pleased to share the particulars with you:

**April 2017**

- Triad Leaders are meeting with Executive Directors twice monthly to oversee the development and implementation of performance quality and cost initiatives throughout each PHN.
- PHNs each establish LEAN work teams that result in the reduction of preventable hospital utilization by closing care gaps.
- The first round of Innovation Grants, that align with and accelerate IDS formation and DSRIP goal achievement, will be awarded and funded.

- Funds flow to partners in the P4R phase continues to provide much-needed resources to partners to spur further implementation of DSRIP projects.
- The PPS initiates a Care Management Feasibility Needs Survey.
- Triad Leaders continue to monitor DSRIP milestones and metrics performance.
- Steering Committee meets monthly to provide strategic leadership and general oversight of the five PHNs with the objective of achieving DSRIP program goals and developing a sustainable integrated delivery system.
- Ongoing cultural competency and health literacy (CCHL) training is provided to a myriad of partners from diverse sectors.

### May 2017

- P4R Cycle 4 funds flow will distribute earned funds to partners, fueling the continuation of implementation efforts.
- PHN LEAN work groups meet and report every two weeks on initiatives to reduce preventable hospital utilization and close care gaps.
- The PPS will issue a second Innovation Grant Request for Proposal (RFP) designed to align and accelerate integrated delivery system (IDS) formation and DSRIP goal achievement.
- Implement a comprehensive PPS workforce training plan to recruit, retain, train and re-train qualified practitioners.

### June 2017

- AHI's Medicaid Accelerated eXchange (MAX) Series Train-the-Trainers will launch three new improvement projects focused on reducing preventable utilization.
- Triad Leaders will review and score second round Innovation Grant applications for alignment with DSRIP program goals.
- PHN work groups continue Rapid Improvement Cycles to close care gaps and reduce preventable utilization.

### July 2017

- Steering Committee will report PHN progress to AHI Board of Directors.
- MAX Series workshops and PHN LEAN work groups continue Rapid Improvement Cycles to further DSRIP goals.

### August 2017

- P4R Cycle 5 funds flow will distribute earned funds to partners spurring continued engagement.
- Steering Committee and Independent Auditor (IA) will approve grant awards.
- Second round Innovation Grants will be funded and work initiated furthering innovation.
- PHN Rapid Cycle work groups continue, furthering progress on addressing care gaps.

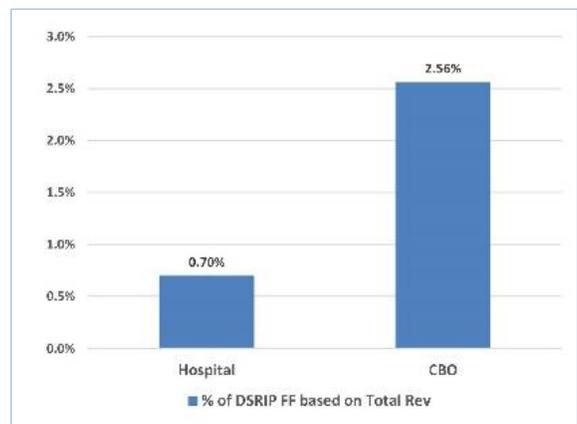
### September 2017

- MAX Series projects mark initial program success at Adirondack Health and Nathan Littauer Hospital.
- AHI hosts 9<sup>th</sup> Annual Summit to improve on rural population health.
- Three MAX Series projects led by newly-minted AHI Train-the-Trainers continue to drive improvements.
- The PHN scorecard documents and directs progress of Rapid Cycle Improvement work groups.
- Corrective Action Period closes; projects are on target to meet or exceed goals and expectations.

CBO Average Funds Flow	
CBO AVERAGE TOTAL REVENUE:	\$1,225,630
CBO AVERAGE DSRIP FF THROUGH FEB 2017:	\$31,396
CBO % OF DSRIP FF BASED ON TOTAL REVENUE:	2.56%

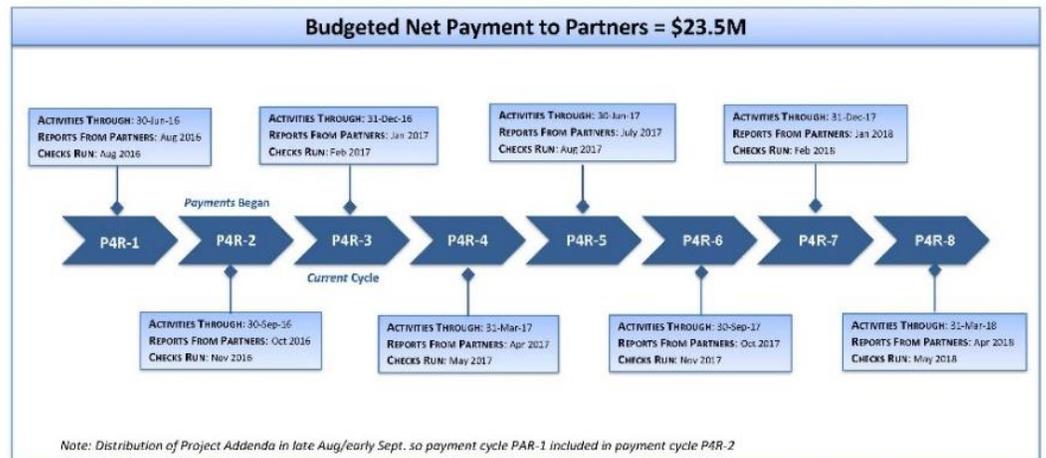
  

Hospital Average Funds Flow	
HOSPITAL AVERAGE TOTAL REVENUE:	\$123,540,47
HOSPITAL AVERAGE DSRIP FF THROUGH FEB 2017:	\$861,672
HOSPITAL % OF DSRIP FF BASED ON TOTAL REVENUE:	0.7%



## Funds Flow to Partners Ensures DSRIP Success

Our funds flow strategy is designed in two major phases – pay-for-reporting (P4R) and pay-for-performance (P4P). The systematic components below will help the process remain seamless, consistent and equitable for all partners.



- Partner funds flow in the P4R phase is driven by the completion of payment activities by the PPS partners. Each project addenda defines the threshold for payment for each payment activity. Completion of payment activities drives funds flow for the partners and were created to ensure the advancement of DSRIP projects.
- Quarterly P4R payment cycles ensure orderly cash flow to partners.
- The P4P phase of the funds flow plan will align partner funds flow with performance outcomes.

## Successful Implementation of At-Risk Projects

The AHI PPS will ensure successful project implementation for projects identified by the IA as being at risk in a number of ways:

- Funding incentives, as outlined in contracting vehicles and agreed to by partners, provide substantial motivation and support for innovations and efforts required to deliver sustainable results.
- Triad Leader roles, as specified and agreed upon in the Triad Leader Support Agreement, are designed to oversee the development, implementation and performance of initiatives, including monitoring network performance.
- MAX Series and LEAN improvement initiatives, including active partner participation and scorecard results, will be monitored on regular basis by Project Managers, Executive Directors, Triad Leaders, PPS Leadership, Governance Committees, and the AHI Board of Directors.
- Quarterly DSRIP reporting on milestones, metrics and deliverables compel partners to stay engaged and implement plans that will deliver results.



More compelling than all of the above external drivers is the shared desire of PPS partners to meet the pressing needs of the most vulnerable in our community, including those with cultural competency and health literacy challenges, while optimizing the unique opportunity that DSRIP offers toward creating a sustainable integrated delivery system. We look forward to successfully completing the overarching goals of the DSRIP program.



Adirondack Health Institute

For more information, visit [www.ahithealth.org/ahipp](http://www.ahithealth.org/ahipp)

## PPS Action Plan Narrative

Project Number: **2.b.viii**

Project Name: **Hospital-Home Care Collaboration Solutions**

### I.A. Recommendation #1

*The IA recommends the PPS develop an education strategy to address the patient lack of knowledge regarding the role of various caregivers in this project and to more effectively engage patients regarding the benefits for their care.*

#### Action Plan

The Hospital-to-Home Care Collaboration Solutions project calls for the implementation of an INTERACT-like (Interventions to Reduce Acute Care Transfers) model in the home care setting to reduce the risk of re-hospitalization of high-risk patients. Directly and effectively engaging and educating patients is a project success component that cannot be underestimated. We are pleased to provide you with strategies we will implement to address this deficiency.

#### Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation:

- Rapid Response Teams consisting of hospital and home care agency personnel have been mobilized in the AHI PPS Population Health Network (PHN) region to tackle this issue. The hospitals collaborated directly with the twelve home care agencies in the region to establish guidelines, a roadmap for organizational information exchange, communications and outlined specific roles, with a strong focus on providing more effective patient education.
- LEAN process improvement methodologies have been incorporated into the daily work of project teams. The Queensbury/Glens Falls Region Population Health Network (PHN) team has been diligently working on a communication process improvement initiative, as an example. The team is developing guidelines for hospital care managers to use as a tool during the discharge planning process. The guidelines will ensure patients/families are educated in a manner that they fully understand the patient's condition, the discharge process, and the care the patient will receive post-discharge.
- Work is well underway with the Home Care Association of New York State (HCA) on developing a far-reaching public awareness campaign regarding the numerous benefits of home care services. There are a large number of individuals in the region who are hesitant or outright refuse to utilize services and the group is developing the campaign to specifically address this issue. Materials have been shared by HCA for dissemination to the providers participating in this project, to allow for better patient education regarding the role of various caregivers during care transition.

#### Timeline for actions:

- Care transitions teams were established in September 2016, and each Rapid Response Team was leveraged from those teams in December 2016.

- The second LEAN initiative in the Queensbury/ Glens Falls Region PHN related to hospital-to-home care handout preparation will begin in April 2017.
- In February, 2017, AHI and the Home Care Association began discussions regarding development of a public awareness campaign around the many benefits of home care services. Materials will be disseminated to providers for patient education.

### How the PPS will track progress in executing the actions:

- Progress will be closely monitored and reviewed at monthly project team meetings and regional team meetings with partners. AHI Provider Engagement Managers, with support from the Executive Directors, will provide project management oversight through DSRIP operations and Integrated Delivery System meetings.
- Action plan progress will be reviewed at the AHI Board of Directors meetings.

### How these actions reflect the PPS overall strategy for meeting its DSRIP goals:

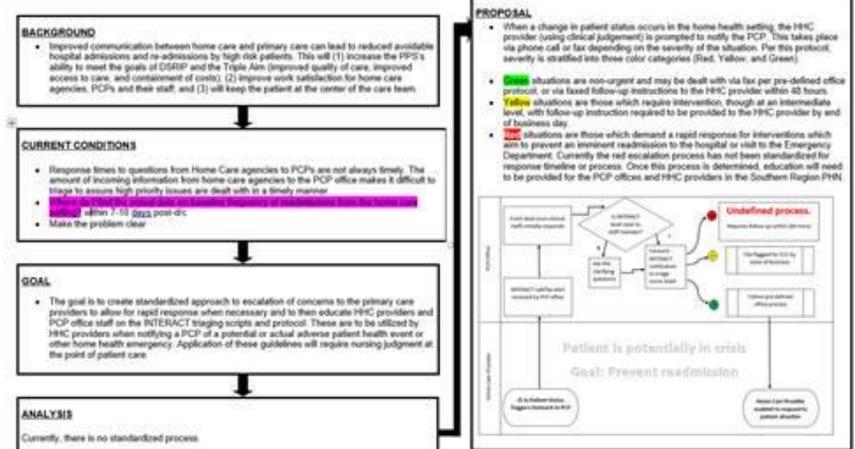
- Establishing cross continuum partnerships (the Rapid Response Teams) is essential to (1) improving communication; (2) ensuring the appropriate services are in place for high-risk Medicaid patients post-discharge; and (3) assisting with strengthening the infrastructure needed to create integrated delivery systems. This will help decrease potentially-avoidable hospital admissions and readmissions.
- The use of LEAN methodologies will assist in focusing action in areas identified as having opportunities to improve on meeting targets, as well as facilitating rapid cycle process improvement.
- Leveraging partner relationships to assist in creating a broader awareness of the benefits of home care services, in addition to creating materials and other resources for providers to educate their patients, will increase knowledge of community resources available to both individuals and providers. Providers will be able to better educate, motivate, and influence healthy behaviors for their patients, resulting in patients feeling empowered and better equipped to make those choices. Utilization of the appropriate caregivers/services will help decrease potentially-preventable hospital admissions and readmissions.

## Implementation Success

- Since the mid-point assessment, AHI staff and PPS Partners have undergone LEAN training. This has greatly helped the project teams implement rapid cycle improvement, and most recently, the communication and escalation of specific issues from home care to primary care providers to allow for more immediate response, when necessary. This will reinforce for PCPs the benefits of home care services for the good of the patient community, and assist in providing patient education in this capacity.
- The PPS has executed contracts to solidify home care engagement and participation with home care agencies in our PPS. All but one agency has an executed contract; the last will be completed by 3/31/17.

Title: INTERACT Triaging Scripts and Protocol (Education/Training)

Doc: 45242817	Owner: Terese Martin
Approval Date: TBD	Manager Approval: TBD



- The PPS has built strong relationships with subject matter experts among the PPS Partner membership and in the community, in order to promote evidence-based practices and collaboration. The PPS has done this through identifying a project champion as well as working with the HCA on a public awareness campaign.
- The PPS is broadening the plan for workforce training, including sponsoring an Evidence-based Health Coaching with Motivational Interviewing (MI) training, which will play a key role in educating direct care staff to more effectively coach, motivate, and influence patients to make healthy choices and receive appropriate services, including home care and other caregiver support. The target audience for this training includes anyone with patient contact and has the ability to impact change, including, but not limited to: primary care, home care, and hospital care managers.

## PPS Action Plan Narrative

**Project Number: 2.d.i**

**Project Name: Implementation of Patient Activation Activities**

### I.A. Recommendation #2

*The IA recommends the PPS develop a strategy to educate the CBOs about their role in DSRIP, the PPS and their role in this project for improved partner engagement in project implementation.*

#### Action Plan

This project focuses on identifying and engaging the uninsured and low-/non-utilizing Medicaid beneficiaries for the purpose of connecting them to primary/preventative care and community resources. Individuals who are disengaged from the health care system often have lower levels of activation as it relates to self-management of their health and wellness. Community-based organizations (CBOs) have trusted relationships with the individuals they serve which can be leveraged to build linkages between community members and health care providers.

It is imperative the role of CBOs in engaging underserved populations and developing an integrated system of care delivery is understood and supported by all PPS partners. What follows is our plan to further inform and educate CBOs and other PPS network partners to facilitate this understanding.

#### Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation:

- Since 6/30/16, Community Engagement staff have increased their outreach and education efforts to raise awareness of the vital role of CBOs in the PPS, as well as to encourage CBO partners to join the PPS. Thirty PPS partner organizations have signed an addendum for Project 2.d.i since 8/30/2016 and 22 of these are community-based organizations or community-based providers. The prevalence of CBO participation in this project speaks to the effectiveness of initiatives intended to improve CBO engagement. Community Engagement staff will continue to increase their targeted communication and direct outreach efforts to CBO partners to ensure understanding of their role in achieving both project-specific and PPS-wide goals.
- Community Engagement staff are in the process of enhancing PAM® trainings to include more detailed information regarding the roles of organizations in different sectors, including CBOs, in project 2.d.i, the PPS, and DSRIP.
- The Community and Beneficiary Engagement Committee has recently identified increasing awareness of regional CBO resources and capacity as a priority for future Committee initiatives, making the revision of the Community Engagement Plan to address the IA's recommendation synergistic to the Committee's larger goals.
- Community Engagement staff are working with AHl's Communications team to develop materials and vehicles for informing and educating CBOs about their role in DSRIP and project 2.d.i.
- Community Engagement staff are working with AHl Executive Directors and the PHN Triad CBO Leads to develop a plan to increase awareness within their PHN region of the role of CBOs in DSRIP and 2.d.i.

### **Timeline for actions:**

- Since 6/30/16, Community Engagement staff have increased outreach and awareness efforts, resulting in 30 signed project addenda.
- As a result of the retraining provided by Insignia Health in 2016, as well as best practices and lessons learned through project implementation, PAM®/CFA® training provided by Community Engagement staff has already been improved upon since its initial rollout. Additional enhancements, in light of IA recommendations, are being incorporated and will be completed and validated by 6/30/17.
- Revisions to the Community Engagement plan will be completed and validated by 6/30/17.
- Collateral marketing materials focusing on PAM®, CFA®, and DSRIP in general have been designed and are in the process of being produced. They will be distributed to target audiences by 6/30/17.
- Utilizing updated training and marketing materials, along with the revised Community Engagement plan, Community Engagement staff and AHI Executive Directors are in the process of developing and implementing a plan to increase awareness in each PHN region of the role of CBOs in 2.d.i and DSRIP. This will be completed and validated by 9/30/17.

### **How the PPS will track progress in executing these actions:**

- Monitoring the number of CBOs involved in project 2.d.i as evidenced by signed project addenda.
- Monitoring the depth of CBO participation in 2.d.i activities by tracking the number of PAM® surveys administered and individuals served by CBOs through other project activities.
- Annual review of the Community Engagement Plan by the Community and Beneficiary Engagement Committee.
- Utilization of the DOH Community Engagement template, completed and submitted for PPS quarterly reporting, to document partner engagement efforts.

### **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

- Educating PPS partners about the role of CBOs in addressing social determinants of health, particularly by offering culturally-sensitive care and expertise to vulnerable populations, will increase general knowledge of community resources available to both individuals and health care professionals. Utilization of services and resources offered by CBOs can lead to prevention of chronic illness or other health crises, as well as ameliorate the adverse impact of certain social factors on health outcomes.
- Building partnerships between CBOs and clinical providers, in part through integrating CBOs into PPS-wide and project-specific activities, leads to better use of available resources and improved continuity of care. It also promotes more effective communication across care teams and leads to coordinated care management and a holistic approach to population health.
- Leveraging the Executive Directors and Triad Leaders to raise awareness about the important role of CBOs aligns with the PPS overall strategy of a regionalized approach to population health management.

### **Partner Engagement (per I.A Recommendation #2)**

- There are currently 30 partner organizations with signed Project 2.d.i addenda.
- Across these organizations, more than 200 employees have been trained to administer the PAM® survey.
- Primary care and specialty providers will be engaged in the project through facilitation of collaboration with MCOs to reconnect beneficiaries to their assigned PCPs, as well as through efforts by coaches/navigators to connect project beneficiaries to care. Several project partners provide primary care as part of other services offered in a clinic setting, such as Hudson Headwaters Health Network, Community Health Center of the North Country, and Planned Parenthood.

Partner Category	# Partners with signed 2.d.i addendums
Practitioner - Primary Care	0
Practitioner - Non-Primary Care	0
Hospital - Inpatient/ED	2
Hospital - Ambulatory	3
Clinic	5
Mental Health	4
Substance Abuse	2
Case Management	2
Health Home	1
Community Based Organization (Tier 1)	5
Nursing Home	0
Pharmacy	0
Hospice	0
Home Care	1
Uncategorized	0
Uncategorized-County Agency	5
Other (Define)	0

- Behavioral health and substance abuse treatment providers engaged in 2.d.i as part of the AHI PPS include Behavioral Health Services North (BHSN), The Family Counseling Center, Citizen Advocates, St. Joseph’s Rehabilitation Center, Champlain Valley Treatment Center, the Mental Health Association of Franklin County, the Clinton County Community Services Board, and the Alliance for Positive Health.

- Multiple Tier 1 CBOs, including the Open Door Mission, the Moreau Community Center, Plattsburgh Housing Authority, Family Services Association

of Glens Falls, and public agencies like the Clinton County Office for the Aging and Essex County Office for the Aging, are actively involved.

- Providers in the categories of pharmacy and hospice may be engaged in the future, but their participation, or lack thereof, in this project would have a nominal impact on project outcomes.

**How engagement strategy ties to the PPS Primary Care Plan:**

- Our engagement with a full complement of organizations, including behavioral health providers, Health Homes, care coordination agencies, FQHCs, and non-traditional primary care providers support connection of the low-utilizing, non-utilizing, and uninsured populations to community-based care.

**Provide a detailed timeline for engagement:**

- At this time, there are no significant gaps in partner engagement. If engagement of any additional partner organizations is needed for project success, then such engagement will be completed by 9/30/17.
- Community Engagement staff are in the process of completing training for designated employees in project partner organizations on PAM® administration, Coaching for Activation®, and tools for Community Navigation. This training will be completed and validated by 9/30/17.
- Community Engagement staff are continuing to work with partners on site to embed project activities into their existing workflow. At least one site visit to each participating partner organization will be conducted by Community Engagement staff by 9/30/17.
- At least one additional PPS-wide 2.d.i project team meeting will be held by 9/30/17.
- PPS partner employees designated as coaches or community navigators participated in a Community Navigator Learning Symposium on 3/28/17. There are two additional quarterly learning collaborative meetings scheduled and these will be held by 9/30/17.

**Project Number: 2.d.i**

**Project Name: Implementation of Patient Activation Activities**

### I.A. Recommendation #3

*The IA recommends the PPS provide further orientation and develop education materials for partners that are hesitant to conduct PAM® surveys.*

#### Action Plan

This project focuses on increasing patient activation related to health care paired with increased resources that can help uninsured and low-/non-utilizing Medicaid beneficiaries gain access to and utilize the benefits associated with DSRIP projects, particularly primary and preventative services. The PAM® survey is a reliable tool for predicting future ED visits, hospital admissions and readmissions, medication adherence and more. Capturing consumers' health characteristics, motivators, attitudes and behaviors, supports restructuring the health care delivery system to better suit their care needs. Some partners, to date, have been reticent to administer the survey, for a variety of reasons. What follows is our strategy to further orient and develop education materials to alleviate partner hesitancy in using this tool.

#### Specific actions that the PPS has taken or will take to remedy the deficiency noted in the recommendation

- To date, more than 200 employees of PPS Partners have been trained to administer the PAM® survey and utilize Coaching for Activation®.
- Approximately 5,000 PAM® surveys have been administered to date for eligible beneficiaries.
- Of the 30 PPS partners which have signed 2.d.i addendums, 20 organizations are actively administering the PAM® survey. The remaining partners are in the process of training staff and preparing to integrate PAM® and other 2.d.i activities into their existing work flow and this effort has an anticipated completion date of 9/30/17.
- Community Engagement staff are in the process of educating the AHI PPS regional PHN leaders about the purpose of 2.d.i, key project goals and the criticality of PAM®. The PHN leaders are critical resources for increasing knowledge and helping to implement strategies regionally.
- Community Engagement staff are working with AHI's Communications team to develop and distribute education materials tailored to partners' hesitance to conduct PAM® surveys. These materials will highlight the benefits of the PAM® survey, citing success stories.
- Community Engagement staff are monitoring progress quarterly by reviewing the number of PAM® surveys conducted and the number of project partners (as evidenced by signed 2.d.i addendum) by PHN region. Executive Directors have been engaged to intervene in their assigned PHN as needed.

#### Timeline for actions:

- Community Engagement staff and Executive Directors are developing a plan for educating and orienting PHN leaders about 2.d.i and PAM®. This work will be completed and validated by 6/30/17.
- Informational materials related to PAM® have been developed and are in production. All communication materials necessary to address this recommendation will be created and distributed by 6/30/17.
- The 10 PPS Partners who have executed 2.d.i addenda but have not begun administering PAM® surveys will do so by 9/30/17.

- Quarterly reviews of completed PAM® surveys by partner will be reviewed with Executive Directors by 4/30/17 so that deficiencies can be addressed.

#### **How the PPS will track progress in executing these actions:**

- Progress will be tracked through the following mechanisms:
  - Monitoring the number of individuals across the PPS trained to administer the PAM® survey and measured against actively engaged targets.
  - Monitoring the number of PAM® surveys administered both PPS-wide and per PHN region.
  - Monitoring the change in PAM® cohort scores over time.

#### **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

- Improved patient activation and engagement leads to better health outcomes and lower costs. The PAM® survey allows health care and human service professionals to tailor interventions to an individual's needs, making progress toward positive changes in health behaviors.

### **Implementation Success**

- All 17 milestones associated with Project 2.d.i are either completed or on track to be completed by 3/31/17.
- Project team meetings took place in August and December 2016. Representatives from the 30 PPS partner organizations participating in 2.d.i were invited to these forums to share best practices.
- August's meeting focused on PAM® administration, promoting use of primary and preventative care, and ideas for addressing barriers to care coordination and optimal resource utilization.
- December's meeting addressed progress with implementation to date, hot-spotting data, as well as performance metrics associated with the project.
- A Community Engagement Manager who functions as the 2.d.i project manager, two Community Engagement Facilitators, and a Community Engagement Coordinator, work as a team to ensure project outcomes are achieved and project activities to support DSRIP and project-specific goals are sufficient.
- The Community Engagement team receives supervision and guidance from the Executive Director of Community Engagement and Workforce initiatives. In addition, Community Engagement staff are working closely with Workforce staff on training and education initiatives, as well as Communications staff on materials and vehicles for improved partner engagement.
- AHI's IS and Data Analytics team is assisting with project requirements related to population health management and building IT infrastructure for better cross-sector communication.
- AHI Enrollment Assistance Services and Education (EASE) staff are educating community navigators on connectivity to health insurance enrollment and health care resources.
- An external content expert is being resourced for MCO-related project components.

## PPS Action Plan Narrative

Project Number: **3.a.i**

Project Name: **Integration – Primary Care and Behavioral Health Services (Models 1 and 2 only)**

### I.A. Recommendation #4

*The IA requires the PPS develop a comprehensive action plan to address the implementation of this project in consultation with the Project Advisory Committee (PAC) that must be reviewed and approved by the AHI Board of Directors.*

#### Action Plan

Integration of behavioral health and primary care services to ensure coordination of care is the focus of this project. Identifying behavioral health needs early, ensuring treatments for medical and behavioral health conditions are compatible, and destigmatizing treatment for behavioral health needs are key components of this effort. Creating a more robust and impactful action plan, with the help of the Project Advisory Council, will greatly improve our project efficiency and efficacy. We are pleased to share with you our plan.

#### Specific actions and action plan the PPS has taken or will take to remedy the deficiency noted in the recommendation:

- A dedicated Project Manager was hired on 1/23/17 to manage the 3.a.i Integration project.
- Partners who expressed initial interest in this project were contacted to ascertain continued interest and to execute the addenda.
  - Thirteen 3.a.i Model 1 partners were issued addenda, ten executed to date. The participating partners represent the majority of primary care practices within the PPS.
  - All 3.a.i Model 2 partners have executed addenda as of 1/31/17; this represents the vast majority of behavioral health provider volume in the region.
- One-on-one meetings between the Project Manager and each participating partner in this project to strategize overcoming obstacles, and provide resources have begun as of the week of 2/27/17 and will continue through the project lifecycle.
- Monthly Integration meetings have been conducted since late 2014 with partners in Warren and Washington Counties and have generated warm transfer processes and information-sharing.
- To address the shortage of behavioral health practitioners, AHI has made efforts to augment staff including leveraging recruitment and retention workforce dollars, supporting integration partner collaborations regarding efficiencies and strategies, and facilitating telehealth.
- Population Health Network (PHN) leadership is tasked with meeting both DSRIP project and performance goals.
- Project progress is reported at monthly Board meetings.

#### Timeline for actions:

- Each PPS partner with a 3.a.i addendum (Model 1 and/or Model 2) was contacted by the Project Manager to collaborate and leverage best practices for:
  - Billing strategies for integrated services.
  - Evidence-based care protocols.
  - Documentation of staff trainings on evidence-based protocols and “warm transfer” processes.

- Documented processes for “warm transfers” and supporting EHR evidence.
- Processes for ongoing monitoring of screening and “warm transfer” process.
- A PPS-wide 3.a.i Integration – Primary Care and Behavioral Health meeting is scheduled for 3/20/17 to:
  - Determine differences in protocols across organizations providing integrated care.
  - Refine and share best practices.
  - Finalize PPS-wide evidence-based practice guidelines, policies, and procedures.
  - Begin the process of partner documentation of availability and schedules of behavioral health services and providers/primary care services.
- The Project Manager is working with remaining Model 1 partners to finalize addenda execution by 3/31/17.
- The Project Manager is compiling the following information from each participating partner in this project Model 1 and Model 2), this will be consolidated and shared with each partner by 3/31/2017:
  - EHR and/or other technical platform(s) each partner is using for tracking.
  - Gaps noted and modifications needed to systems to ensure required data is captured.
  - The process flow for capturing data, including each team member responsible for each aspect.
  - Documentation of staff training including agendas, staff trained, and training schedule(s).
  - Processes for quality review and improvement.
- Evidence-based Health Coaching by the National Society of Health Coaches (NSHC) will be conducted on 3/22/17 and 3/23/17.
- Motivational Interviewing training will occur in April and May across our PPS. The training will play a key role in educating direct care staff to more effectively coach, motivate, and influence patients to make healthy choices and receive appropriate services, including home care and other caregiver support.
- Action plan for project success was reported at the Board meeting and progress will continue to be reported at monthly meetings.

#### **How the PPS will track progress in executing the actions:**

- PHN leadership are updated on project status as it relates to their service area:
  - PHN leaders are identifying regional partners for work teams to remove integration obstacles to success
- A centralized system for meetings, agendas, minutes, communication/distribution and ongoing monitoring and updating of the Integration plan is in place:
  - Senior management has access to this centralized system for additional oversight.
- Meetings with senior management occur weekly to discuss implementation, successes and risks.
- At least 90 percent of patients aged 12 and up receive screenings (PHQ2/9 and/or SBIRT) at the practice site will be documented via a log (list/inventory) demonstrating number of screenings completed by 6/30/17.
  - All PPS Integration Project partners will meet to discuss strategies to verify appropriate screenings are taking place The meeting will be scheduled by 4/1/17 to take place no later than 5/31/17.

#### **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

PPS-wide data reflect those with behavioral health needs as the community members who drive a significant portion of Potentially Preventable Visits. By integrating primary care into behavioral health settings, community members who would go unserved medically can now receive primary care in a comfortable setting. Conversely, integrating behavioral health into primary care allows providers to identify behavioral health issues earlier to prevent major episodes. It also allows for smoother handoffs across settings. This initiative supports the PPS becoming an Integrated Delivery System.

## **Implementation Success**

#### **Additional tasks the PPS will implement to achieve milestones:**

- Project Managers will communicate via phone, email, and in-person with each partner to ensure project goals are understood and initiatives are being implemented to drive achievement. This strategy runs throughout each milestone including those that have been completed to ensure partners are optimizing their efforts.

### **New approaches to provider engagement:**

- The first PPS-wide behavioral health-primary care integration meeting will take place on 3/20/17 with the goal of fostering cross-agency collaboration, learning and best practices. These will take place quarterly, or more frequently based on provider interest/need.

### **PPS Staffing or Management Strategies:**

- A Project Manager, dedicated full-time to this project, was hired in January.
- The Executive Director is responsible for overseeing project implementation and success.
- Each PHN Triad Leadership team is held accountable for successful achievement of project deliverables and outcomes.
- Project progress is routinely reported to the AHI Board during monthly meetings.
- Primary Care Providers and Behavioral Health Providers were identified as key areas in need of training to ameliorate shortages of key providers.
- Region-wide training on Motivational Interviewing and Health Coaching, two areas of need related to this project, will be held in spring 2017 to teach direct care staff to more effectively coach, motivate, and influence patients to make healthy choices and receive appropriate services.
- The PPS-wide Learning Management System, set to go live in Q2 of 2017, will provide training modules specifically related to integrating behavioral health into primary care, and behavioral health screenings beyond PHQ2/9.

## PPS Action Plan Narrative

Project Number: **3.g.i**

Project Name: **Integration of Palliative Care into PCMH Model**

### I.A. Recommendation #5

*The IA recommends the PPS develop a training strategy to inform the targeted population of the role of palliative care services and the distinction between hospice care.*

#### Action Plan

Increasing access to palliative care programs for people with serious illnesses and those at end of life can help ensure care and end-of-life planning needs are understood, addressed and met prior to decisions to seek further aggressive care or enter hospice. Patients often turn first to their primary care physician to discuss a new diagnosis or issues related to advanced care planning, grief and bereavement. PCPs have the opportunity to facilitate early palliative care interventions and consults, and can also identify community resource referrals. Oftentimes, there is a lack of understanding of the distinction between palliative care, which may be provided at any time, and hospice care, which is end-of-life care. The following plan outlines our tactics to educate targeted populations about the differences.

#### Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation:

- PPS Partners have attended trainings that are increasing role-appropriate competence in palliative care skills. Some of these trainings include, but are not limited to: End-of-Life Nursing Consortium (ELNEC) Core Train-the-Trainer, Palliative Care Leadership Centers for Community Centers, and community screenings of the film, “Being Mortal.”
- One of the primary care provider groups participating in this project is bringing the innovative Respecting Choices® Advance Care Planning Program to the PPS region. It is an evidence-based model of advance care planning, and there will be provider and community facilitators trained to have conversations with patients.
- The PPS provides the Center to Advance Palliative Care (CAPC) membership to the PPS Partners participating in this project. CAPC provides training modules that include, but are not limited to: Pain/Symptom Management and Advance Care Planning. Moving forward, the PPS will continue to proactively promote utilization of this membership to increase expertise in palliative care supports and services.
- PPS Policies and Procedures were developed for palliative care services and eligibility, advance care planning, and end-of-life. These PPS-wide guidelines provide an overview of (1) Palliative Care; (2) Advance Directives; and (3) End-of-Life Planning. These guidelines have been reviewed and approved by the PPS Clinical Governance and Quality Committee and will be disseminated for provider education and utilization.
- Hospice and Palliative Care agencies have entered into contractual agreements with the PPS. These agencies are establishing partnerships with primary care and non-primary care practitioners to help bring palliative care supports and services into the practice. The organizations are assessing and educating providers about the subset of patients who would greatly benefit from hospice and palliative services.
- In conjunction with the AHI PPS Workforce group, a palliative care training plan has been developed. This plan will be enhanced annually to address additional training needs and further narrow gaps.

## **Timeline for Actions:**

- Palliative Care Training for PPS Partners began in July 2016. Trainings needs were identified through the palliative care work teams supplemented by palliative care experts. The 2017 Training Plan includes palliative care training prioritized by these teams.
- A PPS Partner signed a contract with Gunderson Health System for implementation of its Respecting Choices® program in July 2016. Additionally, a Steering Committee was assembled in January 2017 to provide management oversight supported by the dedicated AHI Provider Engagement Manager). Facilitators are being trained to have these “conversations” with patients in primary care centers and the community.
- The PPS obtained CAPC membership in November 2016 and providers are continuing to access CAPC’s training, tools, best practices, and other resources to assist in building their palliative care programs and services. The PPS will continue to promote membership to increase utilization by PPS Partners.
- Palliative Care, Advance Care Planning, and End-of-Life Planning policies and procedures were developed in June 2016 and reviewed and approved by the CG&QC in August 2016.
- Hospice and Palliative Care agencies have executed contracts with the PPS.
- Assessing workforce knowledge of palliative care/hospice care to identify specific training needs will be completed by March 2017. Developing a Palliative Care/Hospice Care Training Plan for providers and patients will be completed by April 2017. Delivering training for providers and patients will be ongoing through September 2017. Training needs will be reevaluated annually.

## **How the PPS will track progress in executing the actions:**

- Progress will be discussed and monitored at both monthly project team meetings and regional team meetings. A comprehensive monitoring and review of Mid-Point Action Plans is reported at the bimonthly AHI Integrated Delivery System (IDS) leads meeting to ensure project progress. This meeting includes AHI Leadership and Project Management, as well as Finance/Contracts, Compliance, IT/Data Analytics, Community Health Services/Population Health, Health Home, Workforce, and Performance Improvement Specialists.
- Progress on action plans developed for Mid-Point recommendations will be regularly reported to the AHI Board of Directors.

## **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

- Training providers and patients on palliative and hospice care, and highlighting the difference between the two, will help ensure care and end-of-life planning needs are understood, addressed and met prior to decisions to seek further aggressive care or hospice entry. This will safeguard pain and other comfort issues are managed and further health changes can be planned. This will help prevent avoidable hospital admissions and readmissions, improve access to care, and contain costs.

## **Implementation Success**

- The PPS has greatly enhanced the overall training plan and is including palliative care training to better integrate it into a broader provider population.
- The PPS is sponsoring an Evidence-Based Health Coaching with Motivational Interviewing (MI) training, which plays a key role in training. Additionally, the PPS is sponsoring a powerful training on Cultural Competency and Health Literacy. This will help patients better navigate an increasingly-complex health care delivery system.

## PPS Action Plan Narrative

Project Number: **3.g.i**

Project Name: **Integration of Palliative Care into the Patient-Centered Medical Home (PCMH) Model**

### I.A. Recommendation #6

*The IA recommends the PPS develop a workforce strategy to increase the number of board certified palliative care professionals to assist with training PCPs or to consider other options such as telehealth for consultation.*

#### Action Plan

Increasing access to palliative care programs for persons with serious illnesses and those at end of life can help ensure care and end-of-life planning needs are understood, addressed and met. This can assist with ensuring pain and other comfort issues are managed and further health changes can be planned for. Primary care providers are optimally positioned to address the initial palliative care needs of many patients and families. Understanding patients' goals for care and relieving suffering in all its forms are fundamental to any practice of health care and inherent in a "patient-centered medical home" design. Below is our plan which outlines planned activities to increase access to palliative care professional services.

#### Specific actions the PPS has already taken or will take to remedy the deficiency noted in the recommendation:

- The AHI Provider Engagement Manager is working in conjunction with the PPS Workforce Committee to update the existing assessment of the number of board-certified palliative care professionals who are available to assist training PCPs or other health care providers on palliative care services. Additionally, applications for Workforce funds will be reviewed to identify specific trainings that result in palliative care certification.
- After completion of the updates, a gap analysis will be performed. Research will be performed to identify certification/credentialing opportunities for PPS Partners, with specific focus on Physicians, RNs, LPNs, APRNs, Nurse Aides, Administrators, Hospice Medical Directors, and Social Workers. The PHN Triad Leaders will assist in this gap analysis.
- The Adirondack Rural Health Network (ARHN) has been leveraged to assess provider utilization of telemedicine/telehealth for potential palliative care consultation. Additionally, a monthly Telehealth Collaborative and an Annual Telehealth Conference have been established (the next of which will be held in November 2017).
- Stability has greatly improved for a PPS Partner (a hospice and palliative care agency) that was previously identified as financially fragile. This partner is now positioned, via the PPS sustainability funding program, to expand their palliative care capacity and train/certify staff to provide these services.

### **Timeline for actions:**

- The update to the workforce assessment, will be completed by the end of May 2017 and the gap analysis by July 2017. Filling identified gaps and increasing board-certification for palliative care will be ongoing through September 2017.
- The Adirondack Rural Health Network started assessing provider interest and capacity in telemedicine/telehealth since July 2016.

### **How the PPS will track progress in executing the actions:**

- Progress is monitored and discussed at both monthly project team and regional team meetings. These meetings serve as a forum for information exchange/updates, identifying areas for continued improvement, and evaluation of goals. AHI Provider Engagement Managers, with support from the Executive Directors, provide project management oversight. Additionally, a comprehensive review of Mid-Point Action Plans is conducted and monitored regularly at the bimonthly AHI Integrated Delivery System (IDS) Leads meeting to ensure project progress and success. This meeting includes representation from AHI Leadership, Project Management, Finance/Contracts, Compliance, IT/Data Analytics, Community Health Services/ Population Health, Health Home, Workforce, and Performance Improvement.

### **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

- Increasing the number of board-certified palliative care professionals will greatly improve the knowledge of palliative care supports and services for patients in the community. Professionals who are already board-certified in palliative care will be able to assist in training primary care practitioners and others on the benefits of palliative care for their patients. Training will ensure that everyone reaches a comfort level for discussing near-end-of-life and end-of-life care with patients, as well as better integrating palliative care into the PCMH primary care sites.
- PPS partner training and project teams foster collaborative relationships that will lead to improved knowledge and use of available resources.
- Implementing the use of telehealth for palliative care consultation closely aligns with the PPS's plan to monitor chronically-ill patients/avoidance of hospital admissions and readmissions. It will also strengthen care transition services and increase specialty expertise in PCPs.

## **Implementation Success**

- AHI will utilize the PHN structure to complete the assessment for both providers and telehealth.
- The restructuring of AHI will allow us to better leverage work being done by other AHI programs. For example, the Adirondack Rural Health Network (ARHN) can assist with assessment and training of staff and providers, and in the telehealth initiative.
- The primary care groups participating in this project are associated with the hospitals in our region that have, or will have, an established telemedicine/telehealth program. Services that are presently being offered by hospitals include, but are not limited to: Tele-neurology, tele-counseling, tele-oncology, and tele-ED support, with plans to integrate telehealth into the primary care practices for possible palliative care consultation. As the need and interest in providing telehealth services by PPS Partners increased, AHI formed a Telehealth User Collaborative to expand the PPS region's telehealth knowledge and resource awareness. The organization will also co-host the Annual North Country Telemedicine Conference.

## PPS Action Plan Narrative

### Work Stream: **Cultural Competency and Health Literacy (CCHL)**

#### I.A. Recommendation #7

*The IA recommends that the PPS develop a strategy to address how it will measure the effectiveness of their CCHL outreach efforts across the PPS network.*

#### Action Plan

Our strategy is to align the skills and capacities of PPS partners with the health and social needs of the communities we serve. The Medicaid population of the AHI PPS is characterized by low socio-economic status, prevalence of behavioral health challenges and disproportionate representation of aging and disabled adults. These disparities are compounded by the difficulty of accessing resources in a largely rural region.

In collaboration with our partners and utilizing the skills of a nationally-recognized CCHL subject matter expert and consultant, we've developed meaningful metrics and a strategy to evaluate the effectiveness of PPS CCHL related outreach, initiatives, and trainings on both a partner and beneficiary level. We are populating a dashboard with specific targets and metrics for each of the following items.

#### Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation:

- Continue collaboration with the Albany Med PPS and Alliance's CCHL leads and participation in the statewide CCHL work group to learn and share best practices and standards for measuring and assessing CCHL Strategy implementation progress.
- Leverage expertise within our Community and Beneficiary Engagement Committee, as well as that of subject matter experts and information gained from cross-PPS collaboration, to enhance AHI PPS CCHL training strategy.
- Update AHI PPS CCHL Strategy to include revised tactics for measurement and evaluation. Ensure PPS partners are aware of revisions to strategy. Roll out strategy updates to PPS partners to further engage and enhance skills and practices across the PPS.

#### Timeline for actions

- Conduct an annual partner needs assessment to further refine our understanding of resources needed within the PPS to better serve health disparity priority groups, and identify existing capabilities within organizations.
- Customized PPS-wide training to address identified community and partner needs.
- We are measuring the effectiveness of training based on improvements from the baseline.
- The AHI PPS CCHL lead is currently working with a subject matter expert to develop metrics to measure the effectiveness of CCHL outreach, initiatives, and training. Metrics and other evaluation strategies suggested by

the consultant and the Community and Beneficiary Engagement Committee are being incorporated into revisions to the AHI PPS CCHL strategy. This work will be completed and validated by 6/30/17.

- Cross-PPS collaboration on CCHL implementation and evaluation is occurring at present. The AHI PPS CCHL Training Strategy is being updated to incorporate outcomes of these efforts which are relevant to this IA recommendation and this effort will be completed by 9/30/17.

#### **How the PPS will track progress in executing the actions:**

- The PPS utilizes the AHI PPS CCHL Partner Needs Assessment Annual Survey to track the number of partners engaged through outreach efforts based on the number of survey respondents. In working through our PHN structure and work groups designed to improve access to care, we will measure progress based on ongoing feedback.
- The Community and Beneficiary Engagement Committee is reviewing the AHI PPS CCHL Strategy to be inclusive of new methods for measuring effectiveness of engagement, as well as any notable outcomes.

#### **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

- Ensuring that CCHL outreach efforts and other CCHL initiatives are effective at a partner level supports improved person-centered care delivery and promotes an increase in utilization of care and services.

## PPS Action Plan Narrative

### Work Stream: **Cultural Competency and Health Literacy (CCHL)**

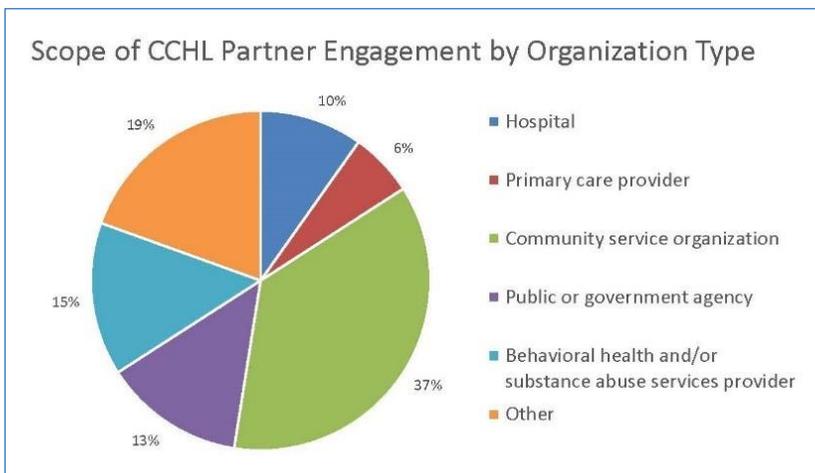
#### I.A. Recommendation #8

*The IA recommends that the PPS develop a strategy to better address the effectiveness of the CCHL training of its partners.*

#### Action Plan

As part of our culture of continuous rapid cycle improvement, we will continue to refine our approach to training to reach our stated goals. CCHL course effectiveness is measured via a pre- and post-test and the results of a course evaluation. Course content and delivery is then modified accordingly.

#### Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation:



- In collaboration with the AHI Workforce team we are updating the partner needs assessment to build upon prior results to continue to push and refine results.

- In collaboration with PPS partners, we will designate CCHL Champions responsible for monitoring and evaluating the organizational effectiveness of CCHL training efforts on an ongoing basis. We are collaborating with Albany Med PPS and the Alliance for Better Health Care on cross-training of CCHL Champions in partner organizations with overlap between the PPSs.

- Update the AHI PPS CCHL Training materials with the revised training evaluation strategy and clarified roles of CCHL Champions in measuring progress within their organizations. Based on our progress, we continually refine training materials to better address training objectives.

#### Timeline for actions:

- A course evaluation has been developed with assistance from Workforce staff members to be given to training participants at the end of each CCHL training session. It was implemented in January 2017. Results from the assessment were shared with the trainers to help improve future training effectiveness. Further collaboration with Workforce staff on training evaluation, as well as any proposed revisions to the annual AHI PPS CCHL Partner Needs Assessment, will be completed and validated by 6/30/17.
- Cross-PPS collaboration on training of CCHL Champions will be completed and validated by 6/30/17.

- Pre- and post-tests on the content of the trainings are being refined with input from the consultants. This work will be completed and validated by 6/30/17.
- CCHL Champions are being designated and given clear expectations regarding monitoring and evaluating their organization's progress. This work will be completed and validated by 6/30/17.
- The AHI PPS CCHL Training Strategy is being revised to address this IA recommendation, including incorporating feedback from PPS partners, CCHL Champions, the Community Advisory Council and the Community and Beneficiary Engagement Committee. This work will be completed and validated by 9/30/17.

 **How the PPS will track progress in executing the actions:**

**96% of AHI PPS CCHL training series attendees replied “Agree” or “Strongly Agree” when asked if the training enabled them to fulfill the following objectives:**



-  **Define the terms “Culture” & “Cultural Competency”**
-  Define the term “Social Determinants of Health”
-  **Discuss the challenges involving social determinants of health and barriers present in accessing care**
-  Develop strategies to address challenges in creating a culturally competent environment
-  **Develop strategies to address challenges experienced by individuals with low socio-economic status when accessing health care and social services**

- Progress will be tracked monthly via a dashboard which is shared with the Community and Beneficiary Engagement Committee and PHN Triad Leaders. Included in the dashboard is the number of PPS employees attending CCHL trainings, by PHN region. PHN leadership is notified of engagement levels so they can intervene, as needed, to develop solutions to meet stated goals.
- AHI is implementing an online Learning Management System (LMS), with the support of the Workforce team, to aid training efforts. Cross-PPS collaboration on the LMS modules is underway. LMS training will be assessed to ensure the appropriate number of partners are being trained.

 **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

- Effective and meaningful CCHL training provides partners with tools and strategies to support improved interactions with patients. Better communication between patients and providers contributes to increased patient satisfaction, higher quality care and, ultimately, improved health outcomes.

## PPS Action Plan Narrative

Work Stream: **Cultural Competency and Health Literacy (CCHL)**

### I.A. Recommendation #9

*The IA recommends that the PPS establish metrics that it will use to demonstrate the extent to which it is reaching and engaging Medicaid beneficiaries and the uninsured.*

#### Action Plan

The ability of Medicaid beneficiaries and the uninsured to communicate effectively with health care providers and serve as self-advocates correlates to their health outcomes and the quality of the care they receive. Following is our plan to establish reliable metrics to gauge our effectiveness in engaging our targeted population.

#### **Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation:**

- Utilize a CCHL subject matter expert and consultant, as a resource for developing meaningful metrics and a strategy to evaluate the effectiveness of PPS CCHL-related outreach, initiatives, and trainings on both a partner and beneficiary level.
- Engage PPS partners, particularly CCHL Champions, in developing methods and metrics to measure their organization's scope and impact in terms of reaching and engaging Medicaid beneficiaries and the uninsured.
- Work with partner organizations to develop health-literate and culturally-sensitive health promotion and patient education materials, with an emphasis on the benefits of primary and preventative care and available community resources to address social determinants of health. The quantity of materials being distributed will be tallied to provide an indication of which community members find the most helpful.

#### **Timeline for actions:**

- The AHI PPS CCHL lead is currently working with a consultant to develop metrics for assessing the impact of its CCHL efforts at the beneficiary level. A definitive plan will be completed and incorporated into the AHI PPS CCHL Training Strategy by 6/30/17.
- The Community Advisory Council, Community and Beneficiary Engagement Committee, PPS partners, and CCHL Champions have been engaged in efforts to address this IA recommendation, including incorporating their feedback into a revised AHI PPS CCHL Training strategy, which will be completed and validated by 9/30/17.
- Tracking of health promotion material utilization will occur by 6/30/17.

#### **How the PPS will track progress in executing the actions:**

- Progress is being tracked by the PPS CCHL lead and Executive Director, and reported at DSRIP Operation and Integrated Delivery System meetings in accordance with metrics being developed in collaboration with CCHL

consultants, partners, and beneficiaries.

- Partners choosing to designate a CCHL Champion are being engaged to develop and track beneficiary engagement at their sites and report on progress quarterly.
- The PPS continues to document, review, and share feedback gathered at community forums held throughout the PPS as well as discussions held at the Community Advisory Council and Community and Beneficiary Engagement Committee meetings. This information is being included in appropriate narratives and templates with quarterly reporting.

 **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

- Increasing health literacy and engagement of beneficiaries throughout the PPS will lead to improved health outcomes, increased utilization of primary and preventative care, and improved quality of care as a result of better communication between patients and providers.

## PPS Action Plan Narrative

Project Number: **Organizational**

Project Name: **Financial Sustainability and VBP**

### I.A. Recommendation #10

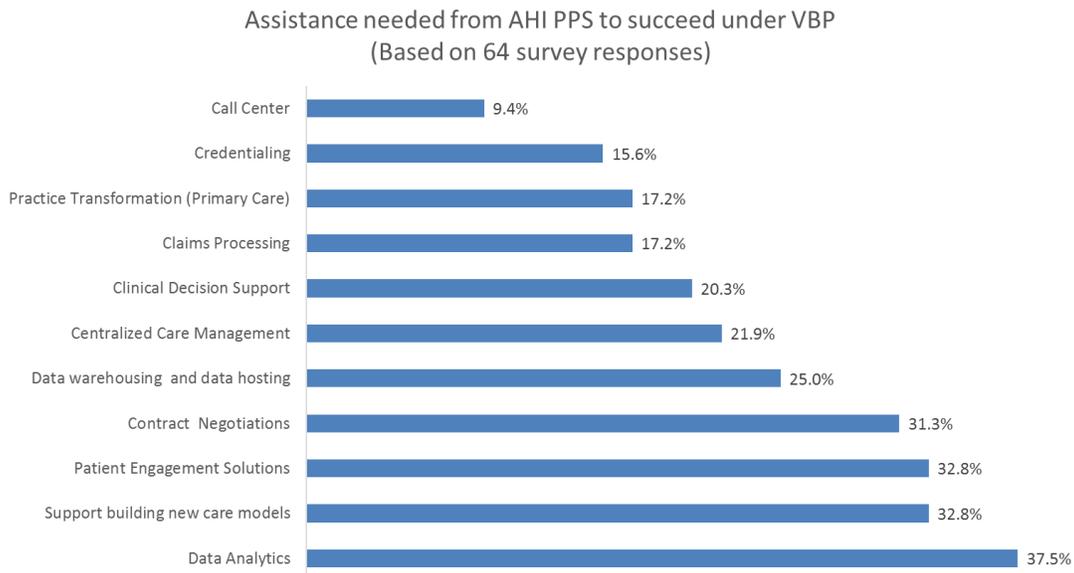
The IA recommends that the PPS establish a plan to further educate and support their partners' move toward VBP arrangements.

#### Action Plan

One of the overarching goals of the DSRIP program is to prepare providers for transitioning to a Value-Based Payment (VBP) system. To assess partner readiness, our approach included surveying partners to identify their needs. Based on needs identified through a formal Value Needs Assessment (VNA) survey and through the VBP Workgroup, education and training topics related to VBP will be identified, especially those geared toward behavioral health and community-based organizations (CBOs).

#### Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation:

- The PPS will use a combination of vendors and consultants to obtain existing training materials for education sessions for PPS partners. A Learning Management System, Healthstream, will also be leveraged to provide easily-accessible training opportunities for partners. The Healthstream LMS is currently being implemented for use by PPS partners under the workforce work stream.
- More than 60 percent of PPS partners responded to the survey with results summarized below.



- The next step in our strategy will be to re-issue the VNA survey to partners who did not previously respond and results will be updated accordingly.
- Our strategy also involves utilizing a VBP workgroup, consisting of members of the PPS Finance Committee, to develop a comprehensive implementation plan to address needs that are identified in the VNA.
- The PPS is currently finalizing negotiations with the Adirondacks ACO to enter into a shared services agreement where the PPS will support partial FTE allocation for positions at the ACO including the roles of CMO, VP of Operations, Senior Director of Finance and Contracting, and Director of QI. This relationship builds upon the Adirondack Medical Home Initiative (AMHI) which began in 2010. Participants within the AMHI include nine payors and more than 100,000 attributed lives. The governance model of the AMHI includes leadership from AHI, participating physicians, and payors. The experience gained through the AMHI to date and the PPS support of continued resource development will serve as critical building blocks for transitioning providers within our region to VBP.

#### **Timeline for actions:**

- Reissuance of VNA survey to PPS partners who did not previously respond will be completed by 3/31/17. Updated results of the VNA will be presented to the PPS Finance Committee by 4/30/17.
- Meeting schedule for the VBP workgroup will be established by 3/31/17.
- Identifying training topics and methods for delivering education to PPS partners will be completed by 6/30/17.
- Finalizing and submitting a comprehensive VBP implementation plan geared toward addressing the needs identified within the VNA will be completed by 6/30/17, as required in the updated Financial Stability Milestone #5.

#### **How the PPS will track progress in executing the actions:**

- The PPS will conduct evaluation surveys to gauge the effectiveness of VBP education and training sessions.

#### **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

- The actions outlined above will advance the PPS in developing the unique milestones that will be determined by the PPS and IA upon completion and review of the comprehensive VBP implementation plan.

## PPS Action Plan Narrative

Project Number: **Organizational**

Project Name: **Governance Recommendation (1 of 2)**

### I.A. Recommendation #11

*The IA recommends that the PPS develop and provide a strategy to increase oversight and accountability of the PHNs to ensure that projects are being implemented in a timely manner.*

#### Action Plan

AHI has successfully implemented a governance strategy that provides oversight and consistency across the PPS in each PHN and across projects and work streams. The organizational structure of AHI provides leadership through the Executive Directors (EDs) and project management team. Each ED is the support and facilitator for each PHN Triad lead team.

A Steering Committee comprised of PHN Triad Leaders from each of the five PHNs, along with the ED and executive leadership team monitors progress. A concise score card is in development to further refine this process. Progress is reported to the AHI Board of Directors on a regular basis.

#### Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation:

- The Steering Committee was formed to provide for oversight, directing and reporting of PHN progress. The oversight function of the PHNs was outlined in the introductory document. The Steering Committee meets monthly to provide strategic leadership and general oversight of the five PHNs with the objective of achieving DSRIP program goals and developing a sustainable integrated delivery system.
- A Steering Committee Charter was developed and meetings for 2017 were scheduled to define clear roles and responsibilities. Each PHN Triad Leader executed the scope of service agreement to further assure accountability.
- Complete development of a scorecard to monitor each PHN's progress. This includes P4P results, partner engagement, patient engagement, and LEAN workgroup tracking.
- Progress to action plan is reviewed weekly in ED meeting.
- Reporting PHN progress/results to Steering Committee monthly.
- Reporting PHN progress/results to the AHI Board of Directors quarterly.
- Each PHN report of progress will be shared at an annual summit of the steering committee.
- PHN leadership (Hospital lead, Medical lead, CBO lead, and AHI Executive Director) will initiate regional work teams as data dictates. These work teams will focus on high-risk patient populations identified via data analysis of the PPS (behavioral health, asthma, cardiac disease/HTN, diabetes, high utilizers of ED), with a focus on the

impact of different provider types on patient outcomes and overall cost of care (PCP, behavioral health, CBO, hospitals and home care).

### **Timeline for actions:**

- The Steering Committee held a two-day LEAN training the first week in February. The Triad Leader Scope of Service Agreements are fully executed. The steering committee charter has been completed and adopted.
- An overall scorecard is being developed to assist in monitoring progress toward patient engagement, P4P results and project/work team results, and will be completed, tested and part of our culture of rapid cycle improvement by July 2017.
- PHN Triad Leader progress is tracked and reported every two weeks to the Integrated Delivery System Leads meeting. Performance is reviewed by the Steering Committee monthly. Progress has been reported to the AHI Board of Directors monthly since November 2016. Annually there will be a Steering Committee Summit to share progress, successes and opportunities.
- Each PHN has assigned work teams to improve performance toward goals using LEAN methodologies. While the scorecard is in development, the PPS is utilizing established reports to track progress. They include:
  - contract grid is updated weekly to monitor contract execution progress
  - patient engagement tracking grid
  - gap to goal quality measure review
  - project workplans
  - innovation grant tracking document

### **How the PPS will track progress in executing the actions:**

- PHN progress toward this action plan is discussed weekly at the Executive Directors meeting. This facilitates implementation of best practices and sharing of strategies across PHNs. This action plan was discussed at the Board of Directors' committee meeting in February and the complete plan will be shared with the board in March. The plan will be updated and presented as milestones are met.

### **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

- The PHN structure is focused on building an Integrated Delivery System by including all categories of partners including CBOs, public health organizations and more traditional care providers. The use of LEAN methodologies will assist in focusing action in areas that are identified to have opportunities to improve on meeting targets. As part of the implementation process, we have completed in-depth action plans for each project and discussed them across project teams to share ideas and challenge assumptions. This process proved extremely helpful in generating strategies that leverage commonalities across projects and work streams. This self-evaluation process, sustained as part of our culture of continuous rapid cycle improvement, assures accountability and the success of our DSRIP program.

## **Implementation Success**

- In 2016, the PPS restructured into five PHNs across our nine-county, 11,000-square-mile PPS. This enables us better serve the broad geographic area we cover as we strive to achieve DSRIP goals.
- AHI has on-boarded and promoted several talented staff members. We are better equipped to meet the challenges we'll face moving forward under the direction of our new CEO.
- Our contract and addendum processes have been defined and implemented, and as a result, significant funds are flowing to partners. We are well on our way to correcting the areas of concern identified at the Mid-Point

Assessment. AHI has always had a strong relationship with community partners, and building on that through our new defined structure will assure our collective success.

## PPS Action Plan Narrative

Project Number: **Organizational**

Project Name: **Governance Recommendation (2 of 2)**

### I.A. Recommendation #12

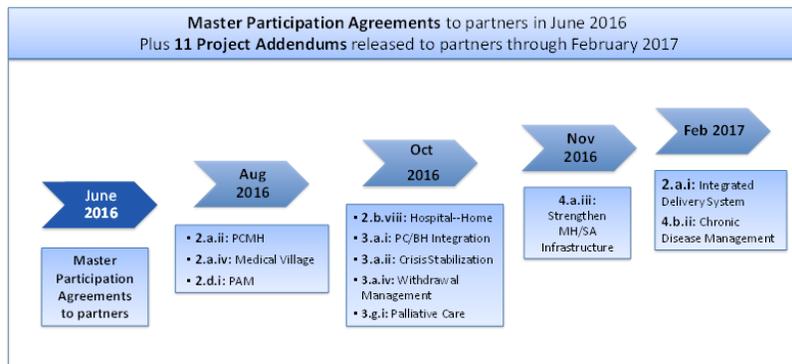
The IA recommends that the PPS develop a plan to ensure that all partners engaged in the project implementation efforts have an executed contract by the end of DY2, Q4 to ensure the PPS is able to successfully meet project milestones, Patient Engagement targets, and the performance goals of the DSRIP program.

### Action Plan

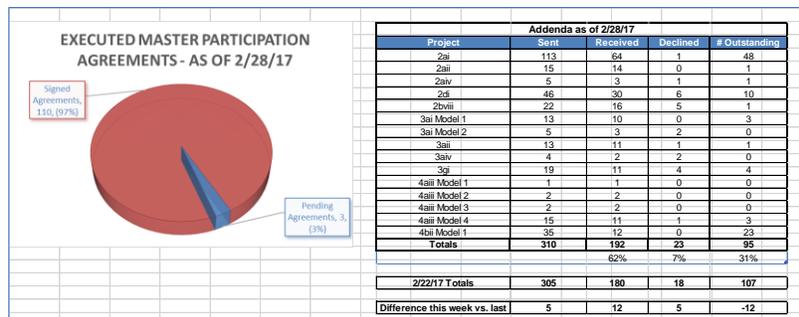
The DSRIP program offers the Adirondack region the unique opportunity to substantially transform the way health care is delivered, through the development of an Integrated Delivery System. To attain this lofty goal, the PPS must engage partners from all sectors. Below is an outline of our plan designed to engage partners in this endeavor.

#### Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation:

- Our goal is to complete the contracting process by the end of DY2, Q4 is illustrated in the timeline below. The timeline reflects progress made in the contracting process since the mid-point assessment review;



- Obtaining executed Master Participation Agreements (MPAs) from all PPS partners is nearly completed as illustrated in the chart below. Also illustrated below is the current status of the project addenda;



- Contract addendums for projects 2.a.i and 4.b.ii were released to partners in February, 2017, finalizing the development of addendums for all eleven DSRIP projects.
- Our strategy of developing a PHN structure has greatly improved communications within the partner network allowing regional focus on obtaining outstanding contract agreements.
- The PHN structure is also serving as the forum to identify and discuss new partners needed to close gaps by provider type to ensure success of the DSRIP projects.

#### **Timeline for actions:**

- The PHN leads are contacting the remaining few partners who have not completed the addenda process to complete the execution by March 31, 2017.

#### **How the PPS will track progress in executing the actions:**

- PHN progress toward this action plan is discussed weekly at the Executive Directors and Integrated Delivery System (IDS) meetings. A detailed schedule of contracting status by project at the partner level, is reviewed weekly to facilitate these discussions. This opportunity allows for sharing strategies across PHNs. Contracting status is also reviewed at the Board of Directors' and Finance Committee meetings on a monthly basis.

#### **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

- Securing executed agreements from partners is a critical factor in ensuring the PPS meets DSRIP goals. Activities defined in the project addendums align the work of partners to DSRIP objectives at the project level. Completion of the activities also drive funds flow to partners, providing resources needed to implement project deliverables.

## **Implementation Success**

- In 2016, the PPS restructured into five PHNs across our nine-county, 11,000-square-mile PPS. This enables us better serve the broad geographic area we cover as we strive to achieve DSRIP goals.
- AHI has on-boarded and promoted several talented staff members. We are better equipped to meet the challenges we'll face moving forward under the direction of our new CEO.
- Our contract and addendum processes have been defined and implemented, and as a result, significant funds are flowing to partners. We are well on our way to correcting the areas of concern identified at the Mid-Point Assessment. AHI has always had a strong relationship with community partners, and building on that through our new defined structure will assure our collective success.

## **Partner Engagement**

- The PHN structure will be focused on building an Integrated Delivery System by including all categories of partners including CBOs, public health organizations and the more traditional care providers.
- Developing an Integrated Delivery System, covering nine counties and 11,000 square miles, brings unique challenges for the PPS. The PHN structure will address community IDS needs at the regional level given the broad geography of the PPS.
- Primary care engagement for the PPS includes stand-alone primary care practices, hospital owned primary care sites and primary care clinics. Included in the primary care clinics engagement is Hudson Headwaters Health Network, a multi-site Federally Qualified Health Center as well as several Planned Parenthood sites, both critical in serving the Medicaid population.
- The PPS also has engaged more than 30 tier one CBOs and 20 organizations who focus on mental health and substance abuse disorders.

- Partner engagement across provider types by project is illustrated in the Mid-Point Assessment Action Plan Template-Partner Engagement. Engagement in this template has been reported at the partner contracting entity level.

## PPS Action Plan Narrative

Project Number: **Organizational**

Project Name: **Summary**

### I.A. Recommendation #13

*The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Use Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement. The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP.*

#### Action Plan

Our goal as a PPS is to meaningfully engage partners from all sectors in our quest to develop a fully-functional integrated delivery system to assure the success of the DSRIP program. Below is an outline of how we've structured our PPS to achieve this meaningful engagement.

#### Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation:

To better engage partners, we structured our PPS into five Population Health Networks (PHNs). The leadership of each PHN employs a Triad model comprised of a physician, hospital executive and community-based organization representative. Each Triad is supported by an AHI Executive Director.

Our first objective of the PHN Triad team was to reassess the provider network in their region to identify any provider gaps that may hinder their region from reaching DSRIP program goals. We are presently finalizing contracting with Triad-identified providers to fill the gaps.

To support the PHNs, we have optimized the PPS operating model based on LEAN continuous rapid cycle improvement principles. Each Triad Leader and AHI support staff have completed LEAN training. Each PHN is forming work teams to address identified needs to achieve project milestones and outcomes. Results of the early efforts of LEAN rapid cycle work groups has proven to be very successful in driving change.

The PPS dramatically increased funds flow to partners since the mid-point assessment, releasing more than \$4.5 million to partners in February 2017. Partner funds flow is driven by the completion of payment activities by the partners.

In addition to AHI internal monitoring, status updates on partner achievement and funds flow are reported each month to our governance structure, including the Steering Committee, PPS and AHI Finance Committee and AHI Board of Directors. See the white paper executive summary and recommendation #10 response document for more details.

#### Timeline for actions:

Accompanying Action Plans provide specific timeline details for individual project recommendations, outlining high-level strategies and defined tactics the PPS will take over the next six months for targeted projects:

- **Project 2.b.viii - Hospital-Home Care Solutions**
  - Leverage Rapid Response Teams (hospital/home care) to address patient education.
  - Incorporate LEAN process improvement methodologies to facilitate rapid cycle improvement.
  - Collaborate with Home Care Association of New York State on increasing public awareness regarding the benefit of home care services.
- **Project 2.d.i - Implementation of Patient Activation Activities**
  - Increase targeted communication and direct outreach efforts to CBO partners to ensure understanding of their role in achieving both project-specific and PPS-wide goals.
  - Revise and enhance PAM® trainings to include more detailed information regarding the roles of organizations in different sectors, including CBOs in Project 2.d.i, the PPS and DSRIP overall.

- **Project 2.d.i – Implementation of Patient Activation Activities**
  - Create and implement a plan for educating PHN leaders about 2.d.i/PAM®.
  - Develop and distribute education materials to address partners’ hesitance to conduct PAM® surveys by citing success stories.
- **Project 3.a.i – Integration of Primary Care and Behavioral Health Services**
  - Execute a communications and tracking plan for participating partner engagement.
  - Develop collaborative evidence-based standards of care, including medication management and care engagement processes.
  - Address staffing shortages and knowledge gaps, utilizing workforce programs and funding.
  - Ensure that at least 90 percent of patients aged 12 and up receive screenings (PHQ2/9 and/or SBIRT) at the practice site.
  - Co-locate primary care services at behavioral health sites.
- **Project 3.g.i – Integration of Palliative Care into the PCMH Model**
  - Identify training opportunities for PPS Partners to increase role-appropriate competence in palliative care skills.
  - Implement “Respecting Choices” in the PPS region to educate and train facilitator on advance care planning.
  - Obtain Center to Advance Palliative Care (CAPC) membership for PPS partners.
  - Identify Hospice and Palliative Care agencies to assess and educate providers about hospice care.
  - Develop PPS Palliative Care/ Hospice training plan.
  - Conduct current state assessment of board-certified palliative care professionals.
  - Conduct gap analysis to identify staffing shortages and training needs to bridge gaps.
  - Leverage the Adirondack Rural Health Network (ARHN) to assess utilization of telehealth.
- **Cultural Competency and Health Literacy**
  - Update AHI PPS CCHL strategy to include revised tactics for measurement and evaluation.
  - Implement revised tactics as described in updated AHI PPS CCHL strategy.
  - Update the AHI PPS CCHL training strategy and implement revised practices for ensuring its effectiveness.
  - Designate CCHL Champions within partner organizations and utilize them as a resource for training and evaluation initiatives at the partner site level.
  - Utilize diverse stakeholder input to arrive at metrics to measure engagement of Medicaid beneficiaries and the uninsured.
  - Develop health literate and culturally-sensitive health promotion and patient education materials that reflect the newly established metrics and track utilization to measure beneficiary engagement.
- **Financial Stability and Value-Based Payment (VBP)**
  - Conduct a Value-Based Payment Needs Assessment (“VNA”).
  - Develop an implementation plan to address needs identified in the VNA.
  - Schedule and conduct VBP education and training for PPS partners.
- **Governance**
  - Form a Steering Committee for oversight and reporting of PHN Triad teams.
  - Develop a scorecard to monitor each PHN’s progress; include P4P results, partner engagement, patient engagement, and LEAN work teams progress.
  - Report progress to governance.
  - Focus LEAN work team within each PHN on initiatives to decrease hospital use by 25 percent.
  - All Master Participation Agreements (MPAs) and project addenda fully executed.

### **How the PPS will track progress in executing the actions:**

AHI provides project-specific management support to maintain engagement with providers in each PHN to assist them in understanding and achieving DSRIP goals and deliverables. Partner participation will be tracked via a scorecard designed to assess work group participation and monitor performance results. It is the Triad Leaders’ responsibility to monitor regional and overall network performance. They are also responsible for the collective quality and financial outcomes for the PPS.

### **How these actions reflect the PPS overall strategy for meeting its DSRIP goals:**

The PPS operating model based on LEAN continuous rapid cycle improvement principles, combined with the Population Health Network structure, will serve to assure the PPS’s overall strategy aligns with and supports DSRIP goal achievement.

## **Implementation Success**

Please see the white paper executive summary and individual recommendation narratives for our plan for assuring implementation success.

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 Mid-Point Assessment Action Plan - Implementation Plan

<b>Mid Point Assessment Recommendation # 4:</b>	3.a.i: Integration of primary care and behavioral health services	The IA requires the PPS develop a comprehensive action plan to address the implementation of this project in consultation with the Project Advisory Committee (PAC) that must be reviewed and approved by the Board of Directors.
<b>PPS Defined Milestones/Tasks</b>		<b>Target Completion Date</b>
<b>MILESTONE 1. Execute a Communication and Tracking Plan for participating partner engagement</b>		<b>6/30/2017</b>
Task 1 Schedule individual partner meetings to review milestones/tasks and gather documentation needed in preparation of 3/20 all-partner meeting and 3/31/17 and 6/30/17 milestones		3/17/2017
Task 2 Host all-partner (Model 1 & 2) meeting		3/20/2017
Task 3 Review project timelines and deliverable due dates with each participating partner		3/20/2017
Task 4 Ascertain frequency for all-partner meetings and schedule meetings		3/31/2017
Task 5 Work with remaining partner which has expressed interest in project but not executed addendum to obtain execution		3/31/2017
Task 6 Participate in all regional behavioral health-primary care integration meetings		4/30/2017
<b>MILESTONE 2. Develop collaborative evidence-based standards of care including medication management and care engagement process.</b>		<b>3/31/2017</b>
Task 1 Gather current evidence-based guidelines from each partner/practice site and create crosswalk for gap analysis		3/19/2017
Task 2 Review crosswalk document at March 20 3.a.i all-partner meeting		3/20/2017
Task 3 Propose/adopt collaborative evidence-based standards of care protocols (previously prepared for review/implementation at primary care practices) including medication management and care engagement		3/20/2017
Task 4 Send finalized collaborative evidence-based standards of care protocols to all participating partners		3/24/2017
Task 5 Verify staff will be trained on adopted protocols as well as any additional internal protocols and warm transfer process.		3/31/2017
Task 6 Coordinate with Project Manager 2.a.ii regarding practice locations NCQA status and plan for achievement		3/31/2017
<b>MILESTONE 3. Address staffing shortages and knowledge gaps</b>		<b>6/30/2017</b>
Task 1 Schedule individual partner meetings to review current preventative care screening implementation, which screening tool(s) have been implemented, EHR documentation, staff training (previously provided Behavioral Health Screening Toolkit)		3/17/2017
Task 2 Agenda item / discussion of ongoing screenings and "warm transfer" at March 20 3.a.i all-partner meeting		3/20/2017
Task 3 Offer Motivational Interviewing and Health Coaching trainings in March-May		5/31/2017
Task 4 Coordinate with Project Manager for Telemedicine for 3.a.i implementation opportunities		5/31/2017
Task 5 Coordinate with Workforce Manager regarding modules in Learning Management System for behavioral health-primary care integration		5/31/2017
Task 6 Coordinate with Workforce Manager regarding recruitment/retention funding opportunities for providers necessary to the implementation of this project		5/31/2017
<b>MILESTONE 4. Ensure that at least 90% of patients ages 12 and up receive screenings (PHQ2/9 and/or SBIRT) at the practice site</b>		<b>6/30/2017</b>
Task 1 Schedule meetings with all PPS partners participating in this project to verify appropriate screenings are taking place and to discuss obstacles and potential strategies		5/31/2017
Task 2 Share information across providers regarding effective strategies to meet PHQ2/9/ SBIRT screening targets		5/31/2017
Task 3 Share information across providers regarding effective PHQ2/9/SBIRT follow ups and referrals		5/31/2017
<b>MILESTONE 5. Co-locate primary care services at behavioral health sites.</b>		<b>3/31/2018</b>
Task 1 Schedule individual partner meetings to review milestones/tasks and gather documentation needed in preparation of 3/20 all-partner meeting and 3/31/17 and 6/30/17 milestones		3/17/2017
Task 2 Facilitate all-partner (Model 1 & 2) meeting		3/20/2017
Task 3 Discuss availability of primary care providers to ensure adequate coverage at BH sites at all-partner meeting		3/20/2017
<b>Mid Point Assessment Recommendation # 10:</b>	Financial Sustainability and VBP	The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements
<b>PPS Defined Milestones/Tasks</b>		<b>Target Completion Date</b>
<b>MILESTONE 1: Conduct a Value Based Payments Needs Assessment ("VNA")</b>		<b>6/30/2017</b>
Task 1: Re-issue survey conducted in Aug '16 to partners who did not previously respond		3/31/2017
Task 2: Present updated results to PPS Finance Committee & AHJ management team		4/30/2017
<b>MILESTONE 2: Develop an implementation plan to address needs identified in the VNA</b>		<b>6/30/2017</b>

Task 1: Establish meeting schedule for the VBP Workgroup of the PPS Finance Committee	3/31/2017
Task 2: Conduct gap analysis	5/31/2017
Task 3: Finalize support services relationship with Adirondacks ACO for VBP related functions	6/30/2017
Task 4: Finalize and submit VBP support Implementation Plan (per Financial Stability Milestone # 5 updated requirement)	6/30/2017
<b>MILESTONE 3: Schedule &amp; conduct VBP education and training for PPS Partners</b>	<b>9/30/2017</b>
Task 1: Select education topics identified in gap analysis	6/30/2017
Task 2: Identify vendors & sources of education material for VBP training	6/30/2017
Task 3: Leverage Learning Management System (LMS) for education and training opportunities	6/30/2017
Task 4: Work with ADK ACO to implement education strategies for ACO members	9/30/2017
Task 5: Hold VBP break-out session at annual AHI Summit	9/30/2017

Mid Point Assessment Recommendation # 12:	Governance	The IA recommends that the PPS develop a plan to ensure that all partners engaged in project implementation efforts have an executed contract by the end of DY2, Q4 to ensure the PPS is able to successfully meet project milestones, Patient Engagement targets, and the performance goals of the DSRIP Program.
<b>PPS Defined Milestones/Tasks</b>		<b>Target Completion Date</b>
<b>MILESTONE 1: All Master Participation Agreements (MPA) and project addenda fully executed</b>		<b>3/31/2017</b>
Task 1: Finalize and release project addendum for 2.a.i		Completed 2/6/2017
Task 2: Finalize and release project addendum for 4.b.ii		Completed 2/17/2017
Task 3: Outstanding contracts reviewed with PHN leads and plan executed to contact partners for completion		5/15/2017
Task 4: Identify needed new partners to fill project gaps through PHN leads		5/15/2017
Task 5: Complete contracting steps (MPA & addenda) for new partners needed to fill project gaps		5/15/2017
Mid Point Assessment Recommendation # 13 a:	Organizational	The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement. The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP.
<b>PPS Defined Milestones/Tasks</b>		<b>Target Completion Date</b>
<b>MILESTONE 1: Engage partners across all projects, with specific focus on non-acute providers and CBO's.</b>		<b>3/31/2017</b>
Task 1. Utilize contracting process to confirm and secure partner participation and engagement in PPS.		3/31/2017
Task 2. Structure PPS in geographic-based Population Health Networks (PHN's) to better address unique needs of each population.		Completed
Task 3. Establish & optimize PPS Operating Model based on Lean principles of continuous rapid cycle improvement.		Completed
Task 4. Provide project-specific PMO support to providers in each PHN to assist in understanding and achieving DSRIP goals and deliverables.		Completed
Task 5. Partner engagement and success will be tracked via attendance/active participation in Lean workgroups and scorecard monitoring of performance results.		7/30/17 & 9/30/2017
<b>MILESTONE 2: Detailed timeline for meaningful partner engagement and funds flow to partners.</b>		<b>9/30/2017</b>
Task 1. <b>April 2017:</b> Triad leaders will meet with Executive Director twice monthly to oversee the development, implementation performance of quality and cost initiatives throughout the PHN. PHN's will each establish Lean work teams that will result in reduction of preventable hospital utilization by closing care gaps. Innovation Grants will be awarded and funded. Steering Committee will meet monthly to provide strategic leadership and general oversight of the 5 PHN's for the purpose of achieving DSRIP program goals and developing a sustainable Integrated Delivery System.		4/30/2017
Task 2. <b>May 2017:</b> P4R Cycle 4 Funds Flow will distribute funds earned to partners. PHN Lean Rapid Cycle Workgroups meet and report every 2 weeks. PPS will issue a 2nd Innovation Grant RFP designed to align and accelerate IDS formation and DSRIP goal achievement. Implement PPS Workforce Training Plan for DY3.		5/30/2017
Task 3. <b>June 2017:</b> MAX Series Train-the-Trainers will launch 3 new Improvement Projects. PPS will initiative a Care Management Feasibility Study. Triad Leaders will review and score grant applications. PHN Lean workgroups continue rapid improvement cycles.		6/30/2017
Task 4. <b>July 2017:</b> Triad Leaders will monitor DSRIP milestones and metrics. Max Series workshops and PHN Lean Workshops continue rapid improvement cycles.		7/31/2017
Task 5. <b>August 2017:</b> P4RCycle 5 Funds Flow will distribute funds earned to partners. Steering Committee and Independent Auditor will approve and award 2nd round of Innovation Grants. Innovation Grants will be funded and work initiated.		8/31/2017
Task 6. <b>September 2017:</b> Initial MAX Series Projects wrap-up at Adirondack Heath and Nathan Littauer Hospitals, results are reported and celebrated. AHI hosts 9th Annual Summit focused on Rural Population Health. PHN Lean rapid cycle workshops continue. The three MAX Series projects launched in June continue and begin making traction. PHN Scorecards document progress of rapid improvement cycle workgroups. Steering Committee will report PHN progress to the AHI Board of Directors. AHI workgroups will be presenting P4P funds mechanisms to the PPS Finance Committee and to AHI Board of Directors. Corrective Action Period closes and projects are now on-track to meet program goals.		9/30/2017

<b>Mid Point Assessment Recommendation # 13 b:</b>		Organizational	The PPS must also submit a detailed report on how the PPS will ensure successful project implementation efforts with special focus on projects identified by the IA as being at risk.
<b>PPS Defined Milestones/Tasks</b>			<b>Target Completion Date</b>
<b>MILESTONE 1: Utilize contracting and funds flow process to engage and secure partners' active participation in PPS initiatives.</b>			<b>9/30/2017</b>
<i>Task 1. Funding Incentives, as outlined in MPA and Addendums and agreed to by partners, provide substantial motivation to partners and provide support for innovations and efforts required to achieve sustainable improvements.</i>			Completed
<i>Task 2. Aspiring to earn High Performance incentives, along with improvements in cost and care delivery for at-risk patients, are key drivers for partners committed to improving quality of life in their communities.</i>			9/30/2017
<b>MILESTONE 2: Utilize Triad Leadership to facilitate cooperation among partners in each PHN.</b>			<b>9/30/2017</b>
<i>Task 1. Triad Leader role, as specified in triad Leader Support Agreement, is designed to oversee the development, implementation and performance initiatives.</i>			Completed
<i>Task 2. Triad Leaders role will include monitoring network performance.</i>			7/30/2017 & 9/30/2017
<i>Task 3. Ongoing Lean Improvement initiatives, will actively engage partners across the continuum to drive results/improvements; progress will be tracked on PHN scorecard.</i>			9/30/2017
<i>Task 4. Quarterly DSRP Reporting requirement on milestones, metrics and deliverables compels partners o stay engaged and implement plans that will deliver results.</i>			6/30/2017 & 9/30/2017
<b>Mid Point Assessment Recommendation # 13 c:</b>		Organizational	These reports will be reviewed and approved by the IA with feedback from the PAOP prior to April 1, 2017.
<b>PPS Defined Milestones/Tasks</b>			
<b>1. INSERT MILESTONE 1</b>			
<i>Task 1</i>			
<i>Task 2</i>			
<i>[Please add additional tasks based on your plan and timeline]</i>			
<b>2. INSERT MILESTONE 2</b>			
<i>Task 1</i>			
<i>Task 2</i>			
<i>[Please add additional tasks based on your plan and timeline]</i>			



State of New York  
 Department of Health  
 Delivery System Reform Incentive Payment (DSRIP) Program  
 Mid-Point Assessment Action Plan - Funds Flow

Partner Category	Funds Flow (all funds)			
	Funds Flow through DY2, Q3	Projected Funds Flow through DY2	% of Earned Dollars Planned for Distribution DY3	% of Earned Dollars Planned for Distribution DY4 DY5
Practitioner - Primary Care	\$ 437,444	\$ 497,884	2.50%	2.00%
Practitioner - Non-Primary Care	\$ -	\$ -		
Hospital - Inpatient/ED	\$ 4,123,100	\$ 6,692,375	25.00%	22.50%
Hospital - Ambulatory	\$ -	\$ -	6.33%	5.00%
Clinic	\$ 1,324,403	\$ 1,833,376	10.00%	11.00%
Mental Health	\$ 758,166	\$ 933,661	4.00%	4.50%
Substance Abuse	\$ 659,979	\$ 810,121	3.75%	4.00%
Case Management	\$ 185,552	\$ 236,739	1.00%	1.00%
Health Home	\$ 294,860	\$ 418,315	2.00%	2.00%
Community Based Organization (Tier 1)	\$ 688,736	\$ 949,098	4.00%	4.00%
Nursing Home	\$ 260,480	\$ 528,408	2.25%	2.25%
Pharmacy	\$ -	\$ -		
Hospice	\$ 314,650	\$ 365,650	2.00%	2.00%
Home Care	\$ 609,087	\$ 961,035	5.00%	5.00%
Other (PPS PMO)	\$ 6,078,236	\$ 7,578,804	20.17%	25.92%
Other (Uncategorized)	\$ 128,980	\$ 230,980	1.00%	1.02%
Other (Uncategorized - County Agency)	\$ 173,130	\$ 176,091	1.00%	1.00%
<b>Total</b>	<b>\$ 16,036,804</b>	<b>\$ 22,212,536</b>	<b>90.00%</b>	<b>93.19%</b>