NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Final Report

Alliance for Better Health Care

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Prepared by the DSRIP Independent Assessor

Contents

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I. Introduction

Alliance for Better Health Care PPS (Alliance), led by Ellis Hospital – Schenectady, and partnered with St. Peter's Health Partners, serves seven counties in the Capital District of New York: Albany, Fulton Montgomery, Rensselaer, Schenectady, and Saratoga. The Medicaid population attributed to this PPS for performance totals 123,484. The Medicaid population attributed to this PPS for valuation was 193,150. Alliance for Better Health Care was awarded a total valuation of $250,232,844 in available DSRIP Performance Funds over the five year DSRIP project.

Alliance selected the following 10 projects from the DSRIP Toolkit:

Figure 1: Alliance for Better Health Care DSRIP Project Selection

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.b.iii.	ED care triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30-day readmissions for chronic health conditions
2.b.viii.	Hospital-home care collaboration solutions
2.d.i.	Implementation of patient activation activities to engage, educate, and integrate the uninsured and low/non-utilizing Medicaid populations into community based care
3.a.i.	Integration of primary care and behavioral health services
3.a.iv.	Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
3.d.ii.	Expansion of asthma home-based self-management program
3.g.i.	Integration of palliative care into the Patient-centered medical home model
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.b.i.	Promote tobacco use cessation, especially among low socioeconomic status populations and those with poor mental health

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

Survey Methodology and Overall PPS Average Results

The Independent Assessor (IA) developed a 360 survey to solicit feedback from the partners of each PPS regarding engagement, communication, and effectiveness. The survey consisted of 12 questions across four PPS organizational areas; Governance, Performance Management, Information Systems, and Contracting/Funds Flow. The Independent Assessor selected a sample of PPS network partners to participate via a sample generator from the PPS Provider Import/Export Tool (PIT)[1] report. A stratified sampling methodology was used to ensure that each category of network partner was included in the surveyed population. This was done to ensure a cross-section of the partner types in the PPS network. The IA used 95% confidence interval and 5% error rate to pull each sample. For the 25 PPS the IA sent out a total of 1,010 surveys, for an average of 40 surveys per PPS partner. The response rate overall was 52%, or 523 total respondents, for an average of approximately 21 responses per PPS.

360 Survey by Partner Category for All PPS

An analysis of the average survey scores by partner category for all PPS identifies some key trends. The two most favorable survey results were from Hospitals and Nursing Homes. The least favorable survey results came from the Mental Health, Hospice, and Primary Care Providers. These results reflect (generally) a high approval rating of PPS' engagement, communication, and effectiveness by institutional providers and a low approval rating of PPS' engagement, communication, and effectiveness by non-institutional/community based providers. A more thorough review of the four PPS organizational areas demonstrated that all partners perceived that Contracting/Funds Flow and Information Systems as the least favorable rankings (compared to Governance and Performance Management).

Figure 2: All PPS 360 Survey Results by Partner Type and Organizational Area

Partner Type	*Average Score*		Governance	Performance Management	IT Solutions	Funds Flow
Hospital	*3.32*		3.42	3.39	3.04	3.28
Nursing Home	*3.06*		3.15	2.93	2.93	2.79
Community Based Organization	*3.00*		3.17	3.04	2.73	2.97
Case Management / Health Home	*2.93*		2.98	2.87	2.81	2.75
Practitioner - Non-PCP	*2.93*		3.03	2.80	2.64	2.40
Clinic	*2.92*		2.96	3.03	2.75	2.66
Substance Abuse	*2.91*		3.08	2.96	2.78	2.82
Pharmacy	*2.87*		3.00	2.84	2.31	2.25
All Other	*2.84*		2.92	2.83	2.63	2.69

[1] The Provider Import/Export Tool (PIT) is used to capture the PPS reporting of partner engagement, as well as funds flow for the PPS Quarterly Reports. All PPS network partners are included in the PIT and are categorized based on the same logic used in assigning the partner categorization for the Speed & Scale commitments made during the DSRIP Project Plan Application process.

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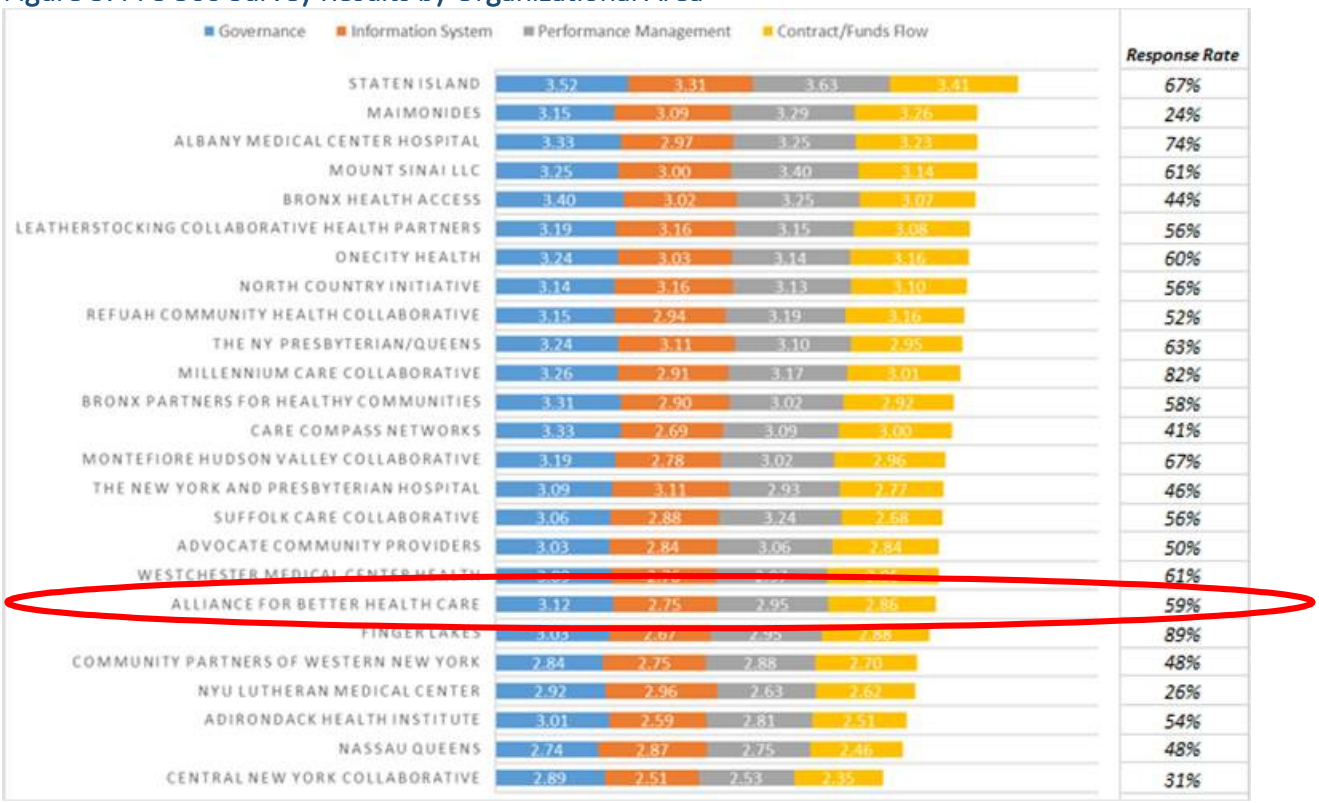
Mental Health	*2.81*		2.94	2.85	2.56	2.75
Hospice	*2.74*		2.93	2.75	2.41	2.41
Practitioner - PCP	*2.66*		2.68	2.66	2.61	2.31
Average by Organizational Area	***2.90***		**3.00**	**2.89**	**2.70**	**2.67**

Data Source: 360 Survey Results

Alliance for Better Health Care 360 Survey Results[2]

The Alliance 360 survey sample included 27 participating network partner organizations identified in the PIT; 16 of those sampled (59%) returned a completed survey. This response rate was fairly consistent with the average across all PPS (52% completed). The Alliance aggregate 360 survey score ranked 19th out of 25 PPS (figure 3).

Figure 3: PPS 360 Survey Results by Organizational Area



Data Source: 360 Survey Data for all 25 PPS

[2] PPS 360 Survey data and comments can be found in the "Appendix 360 Survey".

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Alliance PPS 360 Survey Results by Partner Type

The IA then analyzed the survey response by partner category to identify any trends by partner type. Figure 4 below identifies and ranks the average survey responses. The Case Management/Health Home survey result was low (8th out of 12), which was unusual compared to all PPS' (4th out 12). Mental Health and Practitioner – Primary Care Provider categories were also low, which was consistent with peer PPS responses. Most negative answers were for the Contracting / Funds Flow and the IT Solutions questions.

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

PPS	Partner Type		Respondents over Total Surveyed
Alliance For Better Health Care	All Other	3.27	2/4
	Community Based Organization	3.00	1/1
	Practitioner - Non-Primary Care Provider (PCP)	3.00	1/2
	Clinic	2.93	6/7
	Hospital	2.83	1/3
	Mental Health	2.83	2/2
	Substance Abuse	2.81	2/3
	Hospice	2.60	1/2
	Case Manager / Health Home	0.00	0/0
	Nursing Home	0.00	0/0
	Pharmacy	0.00	0/1
	Practitioner - Primary Care Provider	0.00	0/2
Grand Total			16/27

Data Source: Alliance 360 Survey Results

While the data from the 360 Survey alone does not substantiate any specific recommendations at this time, it serves as an important data element in the overall assessment of the PPS through the first five quarters of the DSRIP program and may guide the PPS in its efforts to engage its partners.

[3] For the survey results, while the CBO category appears to have returned zero results, the IA found that CBO entities may have also been identified as part of the All Other partner category.

III. Independent Assessor Analysis

The Independent Assessor (IA) has reviewed every Quarterly Report submitted by the PPS covering DY1, Q1 through DY2, Q2[4] and awarded the Achievement Values (AVs) for the successful completion of milestones, as appropriate.

- In DY1, Q2, Alliance **earned all available Organizational AVs and earned two of a possible eight Patient Engagement Speed AVs**.
- In DY1, Q4, **Alliance earned all available Organizational AVs and earned four of a possible eight Patient Engagement Speed AVs**.

In addition to the PPS Quarterly Reports the PPS were required to submit narratives for each of the projects the PPS is implementing and a narrative to highlight the PPS organizational status. These narratives were required specifically to support the Mid-Point Assessment and were intended to provide a more in depth update on the project implementation efforts of the PPS.

Lastly, the IA conducted site visits to each of the 25 PPS during October 2016. The site visits were intended to serve a dual purpose; as an audit of activities completed during DY1, including specific reviews of Funds Flow and Patient Engagement reporting and as an opportunity to obtain additional information to support the IA's efforts related to the Mid-Point Assessment. The IA focused on common topics across all 25 PPS including Governance, Cultural Competency and Health Literacy, Performance Reporting, Financial Sustainability, and Expanding Access to Primary Care.

The IA leveraged the data sources available to them, inclusive of all PPS Quarterly Reports, AV Scorecards, the PPS Narratives, and the On-Site Visits to conduct an in depth assessment of PPS organizational functions, PPS progress towards implementing their DSRIP projects and the likelihood of the PPS meeting the DSRIP goals. The following sections describe the analyses completed by the IA and the observations of the IA on the specific projects that have been identified as having varying levels of risk.

A. Organizational Assessment

The first component of the IA assessment focused on the overall PPS organizational capacity to support the successful implementation of DSRIP and in meeting the DSRIP goals. As part of the quarterly reports, the PPS are required to support documentation to substantiate the successful completion of milestones across key organizational areas such as Governance, Cultural Competency and Health Literacy, Workforce, Financial Sustainability, and Funds Flow to PPS partners. Following the completion of the defined milestones in each of the key organizational areas, the PPS are expected to provide quarterly updates on any changes to the milestones

[4] At the time of this report, the IA was reviewing the PPS Quarterly Report submissions for DY2, Q2 and had not issued final determinations on PPS progress. However, items not subject to remediation such as engagement numbers and funds flow data were necessary to provide for the most recent and comprehensive IA analysis.

already completed by the PPS. The following sections highlight the IA's assessment on the PPS efforts in establishing the organizational infrastructure to support the successful implementation of the PPS DSRIP plan.

PPS Governance

Alliance for Better Health is a Limited Liability Company (LLC) with five owners: Ellis Hospital, Samaritan Hospital, St. Mary's Healthcare in Amsterdam, NY, Whitney Young Health Center, and Hometown Health. Alliance is governed by a Board of Managers which includes 15 members, two managers from each of the five owners, two representatives from a primary care medical group, two independent practitioners, and one member from the Project Advisory Committee (PAC). Reporting to the Board of Managers are the following committees: Project Advisory, Finance, IT, Clinical Integration and Quality, Workforce, and Audit & Compliance. A Cultural Competency & Health Literacy taskforce is a subgroup within the Clinical Integration and Quality committee.

Notably, the PPS has partnered with the Innovative Health Alliance of NY (IHANY), an Accountable Care Organization implementing a Medicare Shared Savings Program. They have combined resources in order to more efficiently meet their respective program goals. For example, the Clinical Integration and Quality Committee is shared by both organizations and works to create clinical protocols and best practices that can be used by partner participating in both the ACO and DSRIP.

PPS Administration and Project Management Office (PMO)

The IA also reviewed the PPS spending through the DY2, Q2 PPS Quarterly Reports related to administrative costs and funds distributed to the PPS PMO. It should be noted that PPS administrative spending will vary due to speed of staffing up the PMO, size of the PMO, the type of centralized services provided and the degree of infrastructure investment such as IT that it may find necessary to support the PPS partners to achieve project goals.

In reviewing the PPS spending on administrative costs, the IA found that Alliance had reported spending of $6,616,205.00 on administrative costs compared to an average spend of $3,684,862.24 on administrative costs for all 25 PPS. As each PPS is operating under different budgets due to varying funding resources associated with the DSRIP valuations, the IA also looked at spending on administrative costs per attributed life[5], relying on the PPS Attribution for Performance figures[6]. The IA found that Alliance spends $53.58 per attributed life on administrative costs compared to a statewide average spend of $23.93 per attributed life on administrative costs.

Looking further at the PPS fund distributions to the PPS PMO, Alliance distributed $3,544,351.40 to the PPS PMO out of a total of $22,592,249.40 in funds distributed across the PPS network,

[5] Attribution for Performance was used as a measure of the relative size of each PPS to normalize the administrative spending across all 25 PPS.

[6] The Attribution for Performance figures were based on the data included on the individual PPS pages on the NY DSRIP website.

accounting for 15.69% of all funds distributed through DY2, Q2. Comparatively, the statewide average for PPS PMO distributions equaled $5,966,502.64 or 42.85% of all funds distributed.

The data on the administrative costs and PMO funds flow distributions present a point of comparison across PPS, however do not alone provide enough information from which the IA can assess the organizational capacity of the PPS to support the implementation of DSRIP. It is important for the PPS to invest in the establishment and maintenance of an organizational infrastructure to support the PPS through the implementation of the DSRIP projects to ensure the PPS success in meeting its DSRIP goals.

Community Based Organization Contracting

As part of its Quarterly Reporting, Alliance included a list of all Community Based Organizations (CBOs) in its network and identified those CBOs with which the PPS intended to execute a contract and those that would receive funding distributions from the PPS. The IA found that the PPS has contracted with some but not all of the CBOs they have listed as participating in their project.

As indicated in the analysis of the funds flow distributions through DY2, Q2, CBOs received less than 1% or $206,000 of funds distributed by the PPS compared to the state-wide average of 2.3%. It will be important for the PPS to establish a plan for distributing additional funds to its CBO partners to ensure these key partners remain engaged in the implementation efforts of the PPS.

Cultural Competency and Health Literacy

The Alliance approach to Cultural Competency and Health Literacy (CCHL) was informed by their Community Needs Assessment (CNA). Alliance formed a CCHL task force to identify priority populations as well as identify significant barriers to care and develop interventions to address them. The task force developed a strategy to identify gaps and assess needs to train partners. They intend to target education of staff by working with the Workforce committee and engage CBOs as part of their CCHL training. The PPS plans to host community listening sessions to better assess barriers to accessing care.

The PPS has begun to implement programs to address CCHL needs. For example, a refugee roundtable meets every other month at St. Peter's Hospital; the PPS has provided socks & blankets for a homeless shelter; they perform Patient Activation Measure (PAM) surveys at the Schenectady City Mission, and they have plans to convert the closing St. Mary's Hospital in Troy, NY, to a transitional homeless residence that will provide primary care.

Financial Sustainability and Value Based Purchasing (VBP)

The PPS established a Finance Committee which reports to the PPS Board of Managers. The Finance Committee meets monthly and in addition to providing financial oversight, the committee focuses on the PPS budget and funding distribution plan. The PPS conducted an initial financial assessment in 2015 that was approved by the Finance Committee and Board. The Finance Committee identified 30 key partners to participate in an annual survey. This survey will

be used to help identify any financially fragile partners. To date, no partners have been deemed financially fragile. Nevertheless, the PPS has developed a Distressed Provider Plan and Policy for partners that demonstrate financial difficulties. A partner deemed financially fragile will be subject to enhanced monitoring.

The PPS has designated a representative to address VBP contracting. However, the PPS involvement in VBP has been limited to date.

Funds Flow

Through the DY2, Q2 PPS Quarterly Report, Alliance's funds flow reporting indicates they have distributed 61.20% ($22,592,249.40) of the DSRIP funding it has earned ($36,912,871.53) to date. In comparison to other PPS, the distribution of 61.20% of the funds earned ranks 11th among the 25 PPS and places Alliance slightly above the statewide average of 56.20%.

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

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

Total Funds Available (DY1)	$37,537,450.21		
Total Funds Earned (through DY1)	$36,912,871.53 (98.34% of Available Funds)		
Total Funds Distributed (through DY2, Q2)	$22,592,249.40 (61.20% of Earned Funds)		
Partner Type	**Funds Distributed**	**AHI (% of Funds Distributed)**	**Statewide (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$2,100,000.00	9.30%	3.9%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%	0.7%
Hospital	$6,000,000.00	26.56%	30.4%
Clinic	$5,250,400.00	23.24%	7.5%
Case Management/Health Home	$750,000.00	3.32%	1.3%
Mental Health	$130,925.00	0.58%	2.4%
Substance Abuse	$150,000.00	0.66%	1.0%
Nursing Home	$0.00	0.00%	1.2%
Pharmacy	$0.00	0.00%	0.0%
Hospice	$100,000.00	0.44%	0.2%
Community Based Organizations[7]	$206,750.00	0.92%	2.3%
All Other	$4,359,823.00	19.30%	5.8%
Uncategorized	$0.00	0.00%	0.5%
Non-PIT Partners	$0.00	0.00%	0.6%
PMO	$3,544,351.40	15.69%	42.0%

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

In further reviewing the Alliance for Better Health Care PPS funds flow distributions, it is notable that the distributions it has made are primarily directed toward Hospital, Clinic, All Other, and PMO partner categories, which represent 84.8% of the funds being directed to these partner categories.

While the PPS has distributed funds across many of the partner types, the limited funding distributed to Behavioral Health (Mental Health and Substance Abuse) partners as well as to CBO partners are an area the PPS can improve upon in subsequent distributions. It will be important

[7] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

that these key partners remain engaged to ensure the successful implementation of the DSRIP projects.

Primary Care Plans

The IA reviewed the executive summaries of the Primary Care Plan submitted by DOH during the public comment period. The IA review focused on the completeness and the progress demonstrated by the PPS in the Primary Care Plan. DOH noted that the Alliance Plan addresses all fundamentals and is focused on primary care needs. Alliance can work on developing the incentive/bonus pool methodology to reward and incentivize PCPs, but this alone does not warrant a specific MPA recommendation.

B. Project Assessment

In addition to the assessment of the overall organizational capacity of the PPS, the IA assessed the PPS progress towards implementing the DSRIP projects the PPS selected through the DSRIP Project Plan Application process. In assessing the PPS progress towards project implementation, the IA relied upon common data elements across various projects, including PPS progress towards completing the project milestones associated with each project as reported in the PPS Quarterly Reports, PPS efforts in meeting patient engagement targets, and PPS efforts in engaging network partners in the completion of project milestones. Based on these elements, the IA identified potential risks in the successful implementation of DSRIP projects. For each project identified as being at risk by the IA, this section will indicate the various data elements that support the determination of the IA and that will ultimately result in the development of the recommendations of the IA for each project.

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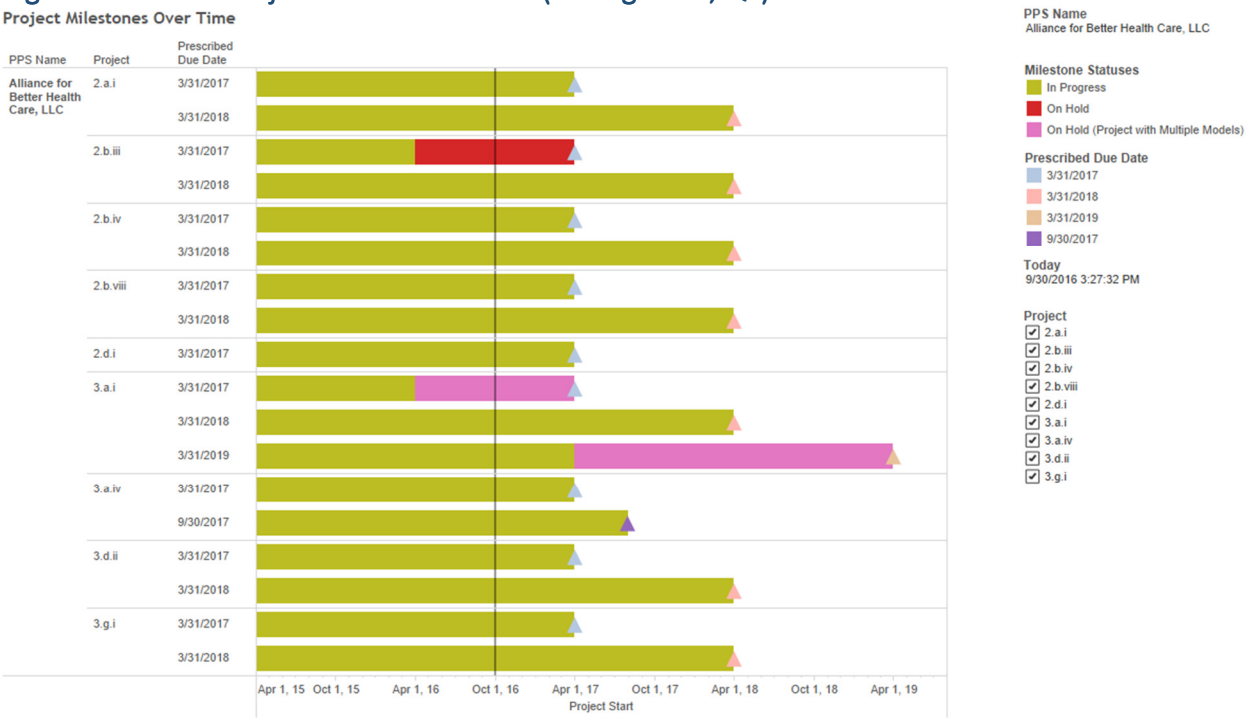
PPS Project Milestone Status

The first element that the IA evaluated was the current status of the PPS project implementation efforts as indicated through the DY2, Q2 PPS Quarterly Reports. For each of the prescribed milestones associated with each Domain 2 and Domain 3 project, the PPS must indicate a status of its efforts in completing the milestone. The status indicators range from 'Completed' to 'In Progress' to 'On Hold'. Figure 6 below illustrates Alliance's current status in completing the project milestones within each project. Figure 6 also indicates the required completion dates for the milestones.

Figure 6: Alliance Project Milestone Status (through DY2, Q2)[8]



Data Source: Alliance DY2, Q2 PPS Quarterly Report

Based on the data in figure 6 above, the IA identified two projects that are at risk due to the current status of project implementation efforts; projects 2.b.iii. and 3.a.i. both have milestones with required completion dates of DY2, Q4 that are currently in a status of 'On Hold'. This status indicates that the PPS has not begun efforts to complete these milestones by the required completion date and as such are at risk of losing a portion of the Project Implementation Speed AV for each project.

In addition to the risks associated with the current status of milestones with a DY2, Q4 required completion date for projects 2.b.iii and 3.a.i, there are additional risks associated with project

[8] Note that this graphic does not include Domain 4 projects as these projects do not have prescribed milestones and the PPS did not make Speed & Scale commitments related to the completion of these projects.

3.a.i. for milestones with completion dates in DY3 and DY4. For this project, the PPS has multiple milestones that have a status of 'On Hold'.

Further assessment of the PPS project implementation status for project 2.b.iii indicates that the one milestone which has been marked 'On Hold' is an optional requirement. Further assessment of the PPS project implementation status for project 3.a.i. indicates that many of the project milestones with a status of 'On Hold' are related to the PPS not pursuing Model 3 for this project. Therefore, for the models the PPS is pursuing, there is no risk of project implementation not meeting the required completion dates at this time.

Patient Engagement AVs

In addition to the analysis of the current project implementation status, the IA reviewed Alliance's performance in meeting the Patient Engagement targets through the PPS Quarterly Reports. The IA identified four projects where the PPS has missed the Patient Engagement targets in at least one PPS Quarterly Report. Figures 7 through 10 below highlight those projects where AHI has missed the patient Engagement target for at least one quarter.

Figure 7: 2.b.iii (ED care triage for at-risk populations) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	2,725	409	15.01%
DY1, Q4	7,358	1,726	23.46%
DY2, Q2	6,327	1,200	18.97%

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

Figure 8: 2.b.iv (Care transitions intervention model to reduce 30 day readmissions for chronic health conditions) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	3,435	308	8.97%
DY1, Q4	12,365	966	7.81%
DY2, Q2	8,169	2,752	33.69%

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

Figure 9: 2.b.viii (Hospital-Home Care Collaboration Solutions) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	3,207	0	0.00%
DY1, Q4	3,563	0	0.00%
DY2, Q2	7,195	405	5.63%

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

Figure 10: 3.d.ii (Development of evidence-based medication adherence programs (MAP) in community settings– asthma medication) Patient Engagement

DY1, Q4	2,858	659	23.06%

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

For projects 2.b.iii, 2.b.iv, 2.b.viii, and 3.d.ii the failure to meet Patient Engagement targets presents a concern; however, this data point alone does not indicate significant risks to the successful implementation of the projects.

Partner Engagement

The widespread engagement of network partners throughout the PPS service area is important to the overall success of DSRIP across New York State. Engagement of partners in isolated portions of the PPS service area will not support the statewide system transformation, improvement in the quality of care, and reduction in costs that are expected as a result of this effort. It is therefore important to the success of the PPS and to the overall DSRIP program that the PPS engage network partners throughout their identified service area.

In continuing to further assess the project implementation efforts of the PPS and to identify the potential risks associated with project implementation the IA also assessed the efforts of the PPS in engaging their network partners for project implementation relative to the Speed & Scale commitments made for partner engagement as part of the DSRIP Project Plan Application.

The IA paid particular attention to the PPS engagement of Practitioner – Primary Care Provider (PCP) and of behavioral health (Mental Health and Substance Abuse) partners given the important role these partners will play in helping the PPS to meet the quality improvement goals tied to the Pay for Performance (P4P) funding. The engagement of PCPs and behavioral health partners is especially important across Domain 3a projects where six out of ten High Performance Funding eligible measures fall.

As part of this effort, the IA reviewed all projects with a specific focus on those projects that were identified as potential risks due to Project Milestone Status and/or Patient Engagement performance. Figures 11 through 19 illustrate the level of partner engagement against the Speed & Scale commitments for all projects based on the PPS reported partner engagement efforts in

the DY2, Q2 PPS Quarterly Report. The data included in the tables is specifically focused on those partner categorizations where PPS engagement is significantly lagging relative the commitments made by the PPS.

The data presented in the partner engagement tables in the following pages includes the partner engagement across all defined partner types for all projects where the PPS is lagging in partner engagement. The PPS reporting of partner engagement, as well as funds flow, is done through the Provider Import Tool (PIT) of the PPS Quarterly Reports. All PPS network partners are included in the PIT and are categorized based on the same logic used in assigning the partner categorization for the Speed & Scale commitments made during the DSRIP Project Plan Application process.

In many cases, PPS did not have to make commitments to all partner types for specific projects, as indicated by the '0' in the commitment columns in the tables, however PPS may have chosen to include partners from those partner categories to better support project implementation efforts. It is therefore possible for the PPS to show a figure for an engaged number of partners within a partner category but have a commitment of '0' for that same category.

Figure 11: Project 2.a.i (Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	442	5
	Safety Net	76	4
Case Management / Health Home	Total	13	2
	Safety Net	9	2
Clinic	Total	23	6
	Safety Net	20	5
Community Based Organizations	Total	48	2
	Safety Net	0	0
Hospice	Total	1	1
	Safety Net	0	0
Hospital	Total	6	3
	Safety Net	7	3
Mental Health	Total	67	2
	Safety Net	24	2
Nursing Home	Total	25	0
	Safety Net	22	0
Pharmacy	Total	20	0
	Safety Net	1	0
Practitioner - Non-Primary Care Provider (PCP)	Total	299	0
	Safety Net	31	0
Practitioner - Primary Care Provider (PCP)	Total	480	1
	Safety Net	30	0
Substance Abuse	Total	17	3
	Safety Net	17	3

Data Source: Alliance DY2, Q2 PPS Quarterly Report -

Figure 12: Project 2.b.iii (ED care triage for at-risk populations) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	0	5
	Safety Net	0	4
Case Management / Health Home	Total	0	2
	Safety Net	9	2
Clinic	Total	0	6
	Safety Net	20	5
Community Based Organizations	Total	0	2
	Safety Net	0	0
Hospice	Total	0	1
	Safety Net	0	0
Hospital	Total	0	3
	Safety Net	7	3
Mental Health	Total	0	2
	Safety Net	0	2
Practitioner - Primary Care Provider (PCP)	Total	0	1
	Safety Net	30	0
Substance Abuse	Total	0	3
	Safety Net	0	3

Data Source: Alliance DY2, Q2 PPS Quarterly Report -

Figure 13: Project 2.b.iv (Care transitions intervention model to reduce 30 day readmissions for chronic health conditions) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	442	5
	Safety Net	76	4
Case Management / Health Home	Total	13	2
	Safety Net	9	2
Clinic	Total	0	6
	Safety Net	0	5
Community Based Organizations	Total	48	2
	Safety Net	0	0
Hospice	Total	0	1
	Safety Net	0	0
Hospital	Total	6	3
	Safety Net	7	3
Mental Health	Total	0	2
	Safety Net	0	2
Practitioner - Non-Primary Care Provider (PCP)	Total	299	0
	Safety Net	31	0
Practitioner - Primary Care Provider (PCP)	Total	480	1
	Safety Net	30	0
Substance Abuse	Total	0	3
	Safety Net	0	3

Data Source: Alliance DY2, Q2 PPS Quarterly Report -

Figure 14: Project 2.b.viii (Hospital-Home Care Collaboration Solutions) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	0	5
	Safety Net	76	4
Case Management / Health Home	Total	0	2
	Safety Net	0	2
Clinic	Total	0	6
	Safety Net	0	5
Community Based Organizations	Total	0	2
	Safety Net	0	0
Hospice	Total	0	1
	Safety Net	0	0
Hospital	Total	0	3
	Safety Net	7	3
Mental Health	Total	0	2
	Safety Net	24	2
Nursing Home	Total	0	0
	Safety Net	22	0
Pharmacy	Total	0	0
	Safety Net	1	0
Practitioner - Non-Primary Care Provider (PCP)	Total	0	0
	Safety Net	31	0
Practitioner - Primary Care Provider (PCP)	Total	0	1
	Safety Net	30	0
Substance Abuse	Total	0	3
	Safety Net	17	3

Data Source: Alliance DY2, Q2 PPS Quarterly Report -

Alliance for Better Health Care

Figure 15: Project 2.d.i (Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	0	5
	Safety Net	76	4
Case Management / Health Home	Total	0	2
	Safety Net	0	2
Clinic	Total	0	6
	Safety Net	20	5
Community Based Organizations	Total	0	4
	Safety Net	0	0
Hospice	Total	0	1
	Safety Net	0	0
Hospital	Total	0	3
	Safety Net	7	3
Mental Health	Total	0	2
	Safety Net	0	2
Pharmacy	Total	0	0
	Safety Net	1	0
Practitioner - Non-Primary Care Provider (PCP)	Total	0	0
	Safety Net	31	0
Practitioner - Primary Care Provider (PCP)	Total	0	1
	Safety Net	30	0
Substance Abuse	Total	0	3
	Safety Net	0	3

Data Source: Alliance DY2, Q2 PPS Quarterly Report -

Figure 16: Project 3.a.i (Integration of primary care and behavioral health services) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	114	5
	Safety Net	26	4
Case Management / Health Home	Total	0	2
	Safety Net	0	2
Clinic	Total	15	6
	Safety Net	14	5
Community Based Organizations	Total	12	2
	Safety Net	0	0
Hospice	Total	0	1
	Safety Net	0	0
Hospital	Total	0	3
	Safety Net	0	3
Mental Health	Total	24	2
	Safety Net	15	2
Practitioner - Non-Primary Care Provider (PCP)	Total	98	0
	Safety Net	11	0
Practitioner - Primary Care Provider (PCP)	Total	190	1
	Safety Net	27	0
Substance Abuse	Total	11	3
	Safety Net	8	3

Data Source: Alliance DY2, Q2 PPS Quarterly Report -

Figure 17: Project 3.a.iv (Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	377	5
	Safety Net	51	4
Case Management / Health Home	Total	13	2
	Safety Net	9	2
Clinic	Total	23	6
	Safety Net	20	5
Community Based Organizations	Total	16	2
	Safety Net	0	0
Hospice	Total	0	1
	Safety Net	0	0
Hospital	Total	6	3
	Safety Net	7	3
Mental Health	Total	67	2
	Safety Net	24	2
Pharmacy	Total	20	0
	Safety Net	1	0
Practitioner - Non-Primary Care Provider (PCP)	Total	267	0
	Safety Net	21	0
Practitioner - Primary Care Provider (PCP)	Total	455	1
	Safety Net	23	0
Substance Abuse	Total	17	3
	Safety Net	17	3

Data Source: Alliance DY2, Q2 PPS Quarterly Report -

Figure 18: Project 3.d.ii (Expansion of asthma home-based self-management program) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	114	5
	Safety Net	26	4
Case Management / Health Home	Total	13	2
	Safety Net	9	2
Clinic	Total	15	6
	Safety Net	14	5
Community Based Organizations	Total	12	2
	Safety Net	0	0
Hospice	Total	0	1
	Safety Net	0	0
Hospital	Total	0	3
	Safety Net	0	3
Mental Health	Total	0	2
	Safety Net	0	2
Nursing Home	Total	0	0
	Safety Net	0	0
Pharmacy	Total	11	0
	Safety Net	1	0
Practitioner - Non-Primary Care Provider (PCP)	Total	98	0
	Safety Net	11	0
Practitioner - Primary Care Provider (PCP)	Total	190	1
	Safety Net	27	0
Substance Abuse	Total	0	3
	Safety Net	0	3

Data Source: Alliance DY2, Q2 PPS Quarterly Report -

Figure 19: Project 3.g.i (Integration of palliative care into the PCMH Model) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	442	5
	Safety Net	76	4
Case Management / Health Home	Total	0	2
	Safety Net	0	2
Clinic	Total	23	6
	Safety Net	20	5
Community Based Organizations	Total	48	2
	Safety Net	0	0
Hospice	Total	1	1
	Safety Net	0	0
Hospital	Total	0	3
	Safety Net	0	3
Mental Health	Total	0	2
	Safety Net	0	2
Nursing Home	Total	0	0
	Safety Net	0	0
Practitioner - Non-Primary Care Provider (PCP)	Total	299	0
	Safety Net	31	0
Practitioner - Primary Care Provider (PCP)	Total	480	1
	Safety Net	30	0
Substance Abuse	Total	0	3
	Safety Net	0	3

Data Source: Alliance DY2, Q2 PPS Quarterly Report

As the data in figures 11 through 19 above indicate, the PPS has engaged network partners on a limited basis for all of its projects. The IA is particularly concerned about the limited partner engagement with PCPs, non-PCPs and mental health providers. Projects 2.b.iii, 2.b.iv, 2.b.viii and 3.d.ii were also highlighted for the PPS failure to meet Patient Engagement targets consistently through the PPS Quarterly Reports. The combination of the PPS failure to meet Patient Engagement targets and the limited Partner Engagement across the same projects indicates an elevated level of risk for the successful implementation of these projects.

PPS Narratives for Projects at Risk

For those projects that have been identified through the analysis of Project Milestone Status, Patient Engagement AVs and Partner Engagement, the IA also reviewed the PPS narratives to determine if the PPS provided any additional details provided by the PPS that would indicate efforts by the PPS to address challenges related to project implementation efforts.

2.b.iii (ED care triage for at-risk populations)

The PPS identified challenges related to patient knowledge of care transitions from the ED and the focus on primary and preventive care. The PPS also identified IT challenges. The network partners use diverse EHR systems making patient tracking and alerts to partners difficult.

2.b.iv (Care transitions intervention model to reduce 30-day readmissions for chronic health conditions)

The PPS stated that there is a decentralized approach to care transitions across the PPS partner network that do not incorporate behavioral health as well as psychosocial issues. The PPS also identified IT challenges. The PPS states that EHR systems are diverse and have variable components that make tracking engagement, alerts to providers and maintaining a continuum of care challenging.

2.b.viii (Hospital-home care collaboration solutions)

The PPS states that they have encountered challenges with various documentation methods among the participating home health agencies. This places care processes at risk due to miscommunication and missing information. The PPS also identified challenges with recruiting home health aides. Additionally, there is a lack of knowledge of the full causes of readmissions across the hospitals in the PPS. Finally, the PPS identified IT challenges with multiple EHR systems, patient tracking, and provider alerts.

3.d.ii (Expansion of asthma home-based self-management program)

The PPS has identified a shortage of certified asthma educators to support the objectives of this project. Furthermore, there is not a standard curriculum with which to train community health workers in asthma home-based self-management. Traditional providers are not well linked to home based programs and community health workers, which may lead to missed opportunities for home visits. Finally, the PPS identified a challenge to engage their patient population with this project.

IV. Overall Project Assessment

Figure 20 below summarizes the IA's overall assessment of the project implementation efforts of Alliance based on the analyses described in the previous sections. 'X' in a column indicates an area where the IA identified a potential risk to the PPS' successful implementation of a project.

Figure 20: Overall Project Assessment

Project	Project Description	Patient Engagement	Project Milestone Status	Partner Engagement
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management			X
2.b.iii.	ED care triage for at-risk populations	X		X
2.b.iv.	Care transitions intervention model to reduce 30-day readmissions for chronic health conditions	X		X
2.b.viii.	Hospital-home care collaboration solutions	X		X
2.d.i.	Implementation of patient activation activities to engage, educate, and integrate the uninsured and low/non-utilizing Medicaid populations into community based care			X
3.a.i.	Integration of primary care and behavioral health services			X
3.a.iv.	Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs			X
3.d.ii.	Expansion of asthma home-based self-management program	X		X

V. Project Risk Scores

Based on the analyses presented in the previous pages the IA has assigned risk scores to each of the projects chosen for implementation by the PPS. The risk scores range from a score of 1, indicating the Project is on Track to a score of 5, indicating the Project is off track.

Figure 21: Project Risk Scores

Project	Project Description	Risk Score	Reasoning
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
2.b.iii.	ED care triage for at-risk populations	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges.
2.b.iv.	Care transitions intervention model to reduce 30-day readmissions for chronic health conditions	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges.
2.b.viii.	Hospital-home care collaboration solutions	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges.
2.d.i.	Implementation of patient activation activities to engage, educate, and integrate the uninsured and low/non-utilizing Medicaid populations into community based care	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
3.a.i.	Integration of primary care and behavioral health services	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
3.a.iv.	Development of withdrawal management capabilities and appropriate enhanced abstinence services within	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.

	community-based addiction treatment programs		
3.d.ii.	Expansion of asthma home-based self-management program	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges.
3.g.i.	Integration of palliative care into the Patient-centered medical home model	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.

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

VI. IA Recommendations

The IA's review of the Alliance for Better Health Care PPS covered the PPS organizational capacity to support the successful implementation of DSRIP and the ability of the PPS to successfully implement the projects the PPS selected through the DSRIP Project Plan Application process. Alliance has achieved many of the organizational and project milestones to date in DSRIP. The PPS has made positive strides to develop the infrastructure to run a successful PPS in their region. The collaboration with IHANY, as previously discussed, is notable in its approach to combine resources in order to more efficiently meet their respective program goals.

The IA does have some concerns regarding Alliance's project implementation however. For example, Alliance has done very little Partner Engagement throughout their network. This is illustrated in the Partner Engagement details presented in this assessment. A low level of Partner Engagement will not achieve the scope of system transformation required to be reflected in overall improved patient care as well as the population health performance measures under DSRIP. Alliance's greatest challenge will be how to bring these disparate partners into their network as soon as possible to actively participate in project implementation. The recommendations that follow will highlight some of the key data points and IA recommendations.

The following recommendations have been developed based on the IA's assessment of the PPS progress and performance towards meeting the DSRIP goals. For each recommendation, it is expected that the PPS will develop a Mid-Point Assessment Action Plan (Action Plan) by no later than March 2, 2017. The Action Plan will be subject to IA review and approval and will be part of the ongoing PPS Quarterly Reports until the Action Plan has been successfully completed.

A. Organizational Recommendations

Partner Engagement

Recommendation 1: The IA requires the PPS to develop an action plan to increase partner engagement, in particular for PCPs and Behavioral Health partners.

Community Based Organization Contracting

Recommendation 1: The IA recommends that the PPS develop an action plan to address the contracting with CBOs.

Cultural Competency and Health Literacy

Recommendation 1: 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.

Recommendation 2: The IA recommends that the PPS develop a strategy to better address the CCHL training needs of its partners.

Recommendation 3: The IA recommends the PPS develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured.

Financial Sustainability and VBP

Recommendation 1: The IA requires the PPS to assess the status of its network partner's involvement in VBP.

Recommendation 2: The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements.

B. Project Recommendations

2.b.iii ED care triage for at-risk populations

Recommendation 1: The IA recommends the PPS develop a training strategy to address the patient lack of knowledge regarding the shift to primary and preventive care away from the ED.

2.b.iv Care transitions intervention model to reduce 30-day readmissions for chronic health conditions

Recommendation 1: The IA recommends the PPS develop a strategy to centralize the approach it is taking across the network to address care transitions and include behavioral health and psychosocial issues.

Recommendation 2: The IA recommends the PPS educate their network partners about the available models of transitions of care.

2.b.viii Hospital-home care collaboration solutions

Recommendation 1: The IA recommends the PPS develop a strategy in conjunction with home health agencies to align the documentation in order to prevent miscommunication and missing information.

Recommendation 2: The IA recommends that the PPS workforce committee develop a strategy to recruit home health aides.

3.d.ii Expansion of asthma home-based self-management program

Recommendation 1: The IA recommends the PPS workforce committee develop a strategy to recruit certified asthma educators.

Recommendation 2: The IA recommends the PPS develop a standard curriculum to train community health workers in asthma home-based self-management.

Recommendation 3: The IA recommends the PPS develop a strategy to engage their patient population in this project.