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DSRIP Independent Assessor

Mid-Point Assessment Report

Final Report

Suffolk Care Collaborative

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Prepared by the DSRIP Independent Assessor

Suffolk Care Collaborative

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I. Introduction

Suffolk Care Collaborative PPS (SCC), led by Stony Brook University Hospital, serves Suffolk County. The Medicaid population attributed to this PPS for performance totals 212,287. The Medicaid population attributed to this PPS for valuation was 437,896. SCC was awarded a total valuation of $298,562,084 in available DSRIP Performance Funds over the five year DSRIP project.

Suffolk Care Collaborative selected the following 11 projects from the DSRIP Toolkit:

Figure 1: Suffolk Care Collaborative 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.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.ix.	Implementation of observational programs in hospitals
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.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular Health)
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes Care)
3.d.i.	Development of evidence-based medication adherence programs (MAP) in community settings– asthma medication
4.a.ii.	Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
4.b.ii.	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer

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).

[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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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
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

Suffolk Care Collaborative 360 Survey Results[2]

The Suffolk Care Collaborative 360 survey sample included 54 participating network partner organizations identified in the PIT; 30 of those sampled (56%) returned a completed survey. This response rate was fairly consistent with the average across all PPS (52% completed). The Suffolk Care Collaborative aggregate 360 survey score ranked 20th out of 25 PPS (Figure 3).

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

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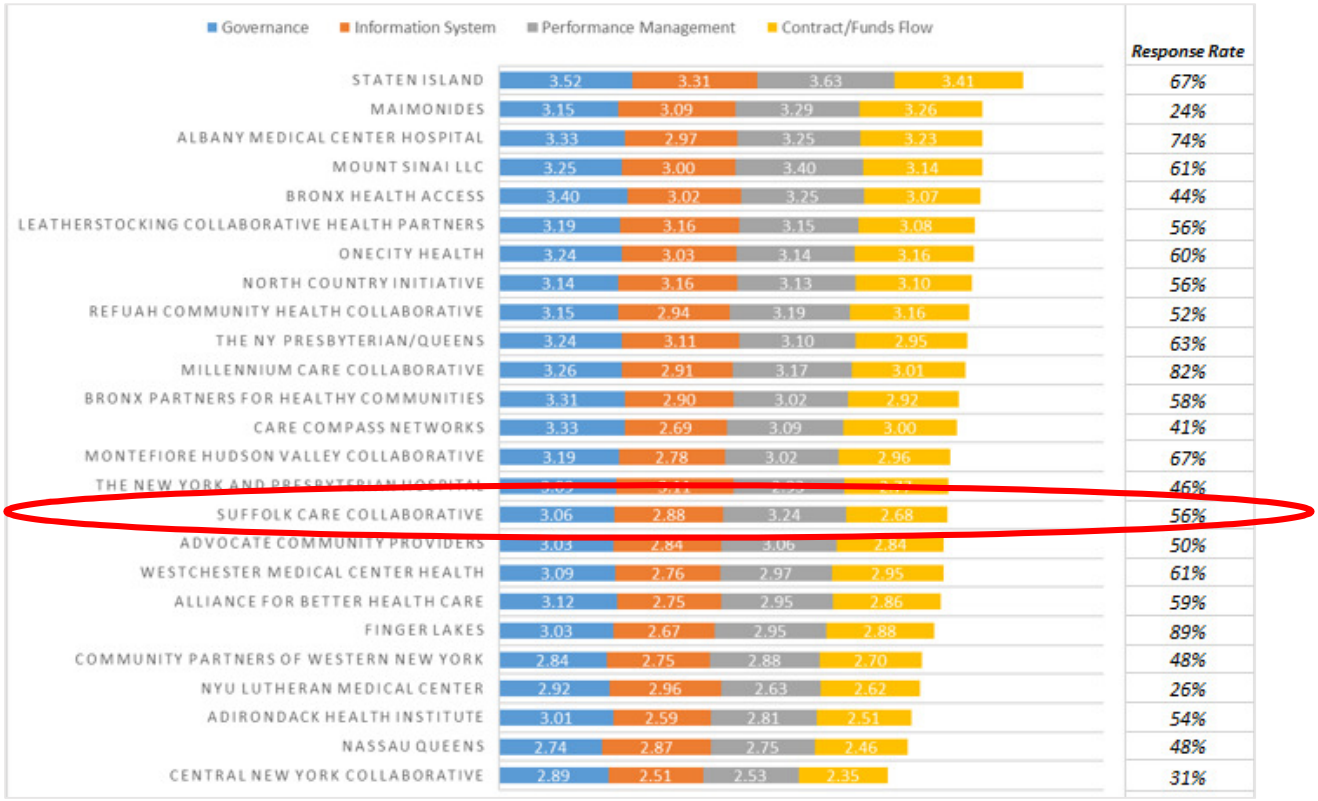
Figure 3: PPS 360 Survey Results by Organizational Area



Data Source: 360 Survey Data for all 25 PPS

<u>Suffolk Care Collaborative 360 Survey Results by Partner Type</u>

The IA analyzed the survey response by partner category to identify any trends by partner type. Figure 4 below identifies and ranks the average survey responses. The Practitioner – Primary Care Provider (PCP) survey result was high (5th out of 12), which was unusual compared to all PPS' (12th out of 12). Pharmacy and Substance Abuse categories were low, which was consistent with peer PPS responses. Most negative answers were for the Contract / Funds Flow and the Performance Management questions.

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Figure 4: Suffolk Care Collaborative 360 Survey Results by Partner Type[3]

PPS	Partner Type		Respondents over Total Surveyed
Suffolk Care Collaborative	Hospital	3.33	2/2
	Clinic	3.19	3/5
	Practitioner - Non-Primary Care Provider (PCP)	2.97	4/10
	Case Management / Health Home	2.96	4/6
	Practitioner - Primary Care Provider (PCP)	2.78	9/14
	Nursing Home	2.68	2/2
	All Other	2.65	3/7
	Pharmacy	2.20	1/2
	Substance Abuse	1.79	2/3
	Community Based Organization	0.00	3/7
	Hospice	0.00	0/0
	Mental Health	0.00	0/1
Grand Total			33/59

Data Source: Suffolk Care Collaborative 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, Suffolk Care Collaborative **earned all available Organizational AVs and all Patient Engagement Speed AVs.**
- In DY1, Q4, Suffolk Care Collaborative **earned all available Organizational AVs and all Patient Engagement Speed AVs.**

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

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

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

A. Organizational Assessment

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

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

efforts in establishing the organizational infrastructure to support the successful implementation of the PPS DSRIP plan.

PPS Governance

The PPS Governance structure includes a Board of Directors with 21 representatives from various stakeholders from the Suffolk Care Collaborative partnerships. Seven sub-committees support the Board in the following areas: 1) Clinical; 2) Finance; 3) Community Needs Assessment, Cultural Competency & Health Literacy and Outreach; 4) Health Information Technology and Biomedical Informatics; 5) Workforce; 6) Compliance; and 7) Audit. The Governance includes 11 individual Project Committees to represent each DSRIP project chosen by the PPS.

Suffolk Care Collaborative PPS is designed into 3 HUBs, the Stony Brook University Hospital HUB (SBUH HUB), Northwell Health System HUB, and Catholic Health Services of Long Island HUB. The HUBs operate collaboratively within all 3 levels of governance and project stakeholder engagements through workgroups and committees. Collectively, the processes, structures and approaches developed with HUBs input has positioned all participating network providers, regardless of "HUB" to participate in a DSRIP program that is organized, consistent and positioned to meet the challenges of the future payment system.

During the IA's on-site visit with Suffolk Care Collaborative, representatives from each Hub were present to demonstrate collaboration and continuity amongst hubs.

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 SCC had reported spending of $6,406,179.00 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 SCC spends $30.18 per attributed life on administrative costs compared to a statewide average spend of $23.93 per attributed life on administrative costs.

[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.

Looking further at the PPS fund distributions to the PPS PMO, SCC distributed $3,066,208.00 to the PPS PMO out of a total of $12,115,372.78 in funds distributed across the PPS network, accounting for 25.31% of all funds distributed through DY2, Q2. Comparatively, the statewide average for PPS PMO distributions equaled $5,966,502.64 or 42.85% of all funds distributed.

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

Community Based Organization Contracting

As part of the DY1, Q4 PPS Quarterly Report, Suffolk Care Collaborative included a list of seven Community Based Organizations in its organization with whom it had a contract or were in contract negotiations with and had an intention to compensate. The PPS also included an extensive list of CBOs with whom it has established a relationship with.

While on-site, the PPS discussed its CBO engagement strategy. With the intent to foster meaningful CBO engagements, the PPS aligned CBO contracting with project needs. SCC has four DSRIP projects with CBO contracts: Projects 2.d.i, 3.a.i, 4.a.ii, and 3.d.ii. There are four CBOs contracted to lead program operation of CAHPS surveys for Project 2.d.i. The goal is for CBOs to engage the uninsured, non-utilizing and low-utilizing Medicaid Beneficiaries in person and complete a PAM survey while providing Community Navigation and Wellness Coaching. A CBO partnered with the PPS to develop collaborative care models between PCPs and behavioral health organizations for Project 3.a.i. SCC partnered with a CBO to implement an Underage Drinking Prevention Program under Project 4.a.ii. Finally, the PPS has partnered with a CBO to promote Asthma Self-Management under Project 3.d.ii.

In further assessing the engagement of CBOs by SCC, the IA found that the PPS had distributed $410,668.60 or 3.39% of the funds distributed to its CBO partners through DY2, Q2. It will be important for the PPS to expand its fund distributions across all of its CBO partners to maintain engagement of these key partners.

Cultural Competency and Health Literacy

The Suffolk Care Collaborative approach to Cultural Competency and Health Literacy (CCHL) was informed by their Community Needs Assessment (CNA). Within the governance structure of the PPS a Cultural Competency Advisory Workgroup has been formed, inclusive of key PPS stakeholders and partners. The Workgroup reports to the Community Needs Assessment, Outreach, and Cultural Competency and Health Literacy Committee. Additionally, Suffolk Care Collaborative participates in a cross collaboration of PPS CCHL Workgroups with Staten Island PPS, and One City Health PPS.

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The PPS submitted its CCHL Strategy with its DY1, Q3 Quarterly Report and submitted its CCHL Training Strategy with its DY2, Q1 Quarterly Report. The purpose of CCHL Strategy is to provide a framework for: (1) cultural competence which enables systems, agencies, and groups of professionals to function effectively understanding the needs of groups accessing health information and healthcare; and, (2) health literacy which enables individuals to understand information and services and use them to make informed decisions about their health. The Strategy Plan informs the Training Plan. The PPS is approaching CCHL training as a mechanism utilized to orient partners on the PPS CCHL strategy, introduce partners to the meaning of culturally and linguistically appropriate services, and educate partners on evidence based research addressing health disparities.

The PPS deployed a survey of its partners to assess the current state of its CCHL competency and efforts and used the results of the survey to identify potential training needs and to guide the ongoing development of training programs. Of the total respondents to the survey, 46% had no cultural competence training and 42% had no health literacy training. The PPS intends to measure the effectiveness of the PPS Cultural Competency and Health Literacy training programs, which will be assessed based on participation rates, evaluation results and performance outcomes.

During the IA on-site visit Suffolk Care Collaborative was asked what measures the PPS is using to demonstrate the extent to which it is reaching / engaging ALL attributed Medicaid beneficiaries and uninsured patients, particularly those who are historically underserved and hard to reach. The PPS articulated that it identified areas of high hospital utilization by Medicaid Members in Suffolk county by using SPARCS census data. American Community Survey data was used to identify regional characteristics in those communities. An analysis of community characteristics included race, ethnicity, language, and socioeconomic factors. Healthcare asset mapping of the identified regions with high utilizers will then be conducted to determine available resources for these communities as well as assess any gaps between available resources and community needs.

Financial Sustainability and Value Based Purchasing (VBP)

The Finance Committee, a subcommittee of the Suffolk Care Collaborative Governing Body, has charged the Financial Sustainability Work Group with the responsibility to assess the financial health of network partners. One of the efforts undertaken to date by the committee was the creation of a plan to identify and assist financially fragile partners. Suffolk Care Collaborative performed a baseline assessment of its key partners' financial health in DY1, from which it found four partners to be in financial hardship. When a partner is deemed fragile they are placed on a 'Watch' list and closely monitored. In the case of the four partners who were identified as having financial hardship, they were monitored and improvement was noted.

Although the PPS developed a strategy to identify the criteria to determine if a provider is deemed financially fragile, it has not demonstrated plans for assisting fragile partners beyond increased monitoring. It will be important for Suffolk Care Collaborative to enhance a plan to assist partners who are deemed financially fragile. This will be of particular importance as DSRIP

funding shifts from pay for reporting (P4R) to pay for performance (P4P) and as partner reimbursement shifts towards Value Based Purchasing (VBP).

SCC submitted an update in its Organizational Narrative regarding its efforts around Value Based Purchasing (VBP). The PPS has established a VBP Workgroup, inclusive of members from all three hubs. The VBP Workgroup created a VBP Survey which it sent to network partners in April 2016. Its purpose is to gauge the VBP landscape of its partner organizations to develop a detailed baseline assessment of revenue linked to VBP, preferred compensation modalities for different provider types, and MCO strategy.

Further, since April 2015, the PPS has held monthly calls with the five MCOs with which it is paired to discuss the transition from FFS to VBP. These calls allow the MCOs and the PPS to discuss and strategize for project-specific milestones involving VBP. The intent is that once the PPS VBP Plan is approved by the Board of Directors then each of the HUBs will work with the MCOs in operationalizing the VBP Plan.

Funds Flow

Through the DY2, Q2 PPS Quarterly Report, SCC's funds flow reporting indicates it has distributed 42.24% ($12,115,372.78) of the DSRIP funding it has earned ($28,679,013.87) to date. In comparison to other PPS, the distribution of 42.24% of the funds earned ranks 17th and places the PPS below the statewide average of 56.20%.

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

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

Total Funds Available (DY1)	$28,679,013.86		
Total Funds Earned (through DY1)	$28,679,013.87 (100% of Available Funds)		
Total Funds Distributed (through DY2, Q2)	$12,115,372.78 (42.24% of Earned Funds)		
Partner Type	**Funds Distributed**	**SCC (% of Funds Distributed)**	**Statewide (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$214,479.01	1.77%	3.89%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%	0.73%
Hospital	$3,686,168.94	30.43%	30.41%
Clinic	$554,578.85	4.58%	7.54%
Case Management/Health Home	$731,640.60	6.04%	1.31%
Mental Health	$0.00	0.00%	2.43%
Substance Abuse	$0.00	0.00%	1.04%
Nursing Home	$8,000.00	0.07%	1.23%
Pharmacy	$0.00	0.00%	0.04%
Hospice	$0.00	0.00%	0.16%
Community Based Organizations[7]	$410,668.60	3.39%	2.30%
All Other	$3,438,135.00	28.38%	5.82%
Uncategorized	$5,493.78	0.05%	0.53%
Non-PIT Partners	$0.00	0.00%	0.58%
PMO	$3,066,208.00	25.31%	41.99%

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

In further reviewing SCC's funds flow distributions, it is notable that the distributions are heavily directed towards the Hospital, PMO, and All Other partner categories, with 84.12% of the funds being directed to those three partner categories. While the PPS has distributed funds across many of the partner types, the PPS has distributed limited funding to PCP and Behavioral Health (Mental Health and Substance Abuse) partners. It will be important for the PPS to address the funds distributions to these key partners going forward to ensure their continued engagement in the implementation of DSRIP projects.

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

Primary Care Plan

The IA reviewed the executive summaries of the Primary Care Plans submitted by DOH during the public comment period. The IA review focused on the completeness and the progress demonstrated by the PPS in the Primary Care Plan. The IA agrees with the assessment that Suffolk Care Collaborative has strong training initiatives and is making progress toward PCMH certification. The PPS could have provided greater detail through the Primary Care Plan on how much funds flowed to primary care providers (PCPs).

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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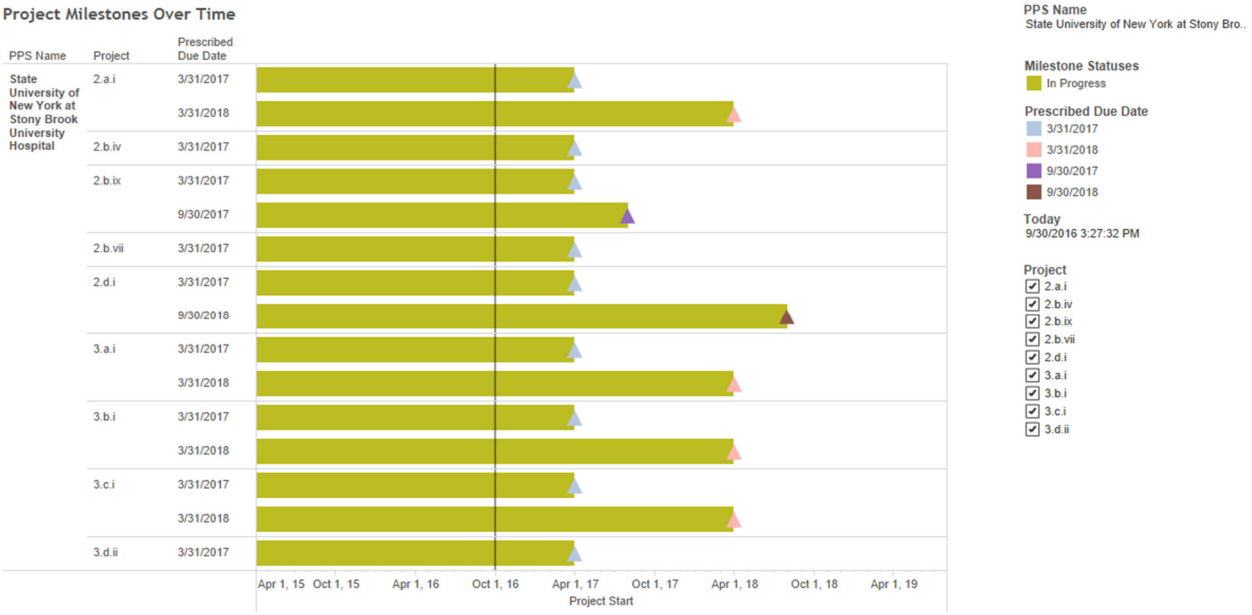
PPS Project Milestone Status

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

Figure 6: Suffolk Care Collaborative Project Milestone Status (through DY2, Q2)[8]



Data Source: Suffolk Care Collaborative DY2, Q2 PPS Quarterly Report

Based on the data in Figure 6 above, the IA identified no projects as at risk as they are all in progress towards timely completion of its milestones.

Patient Engagement AVs

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

Figure 7: 2.b.ix (Implementation of observational programs in hospitals) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	886	910	102.71%

[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.

DY1, Q4	3,546	3,488	98.36%
DY2, Q2	3,103	1,445	46.57%

Data Source: Suffolk Care Collaborative PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

For Project 2.b.ix. the PPS reported that it failed to meet Patient Engagement targets in the current quarter, DY2, Q2, and though it presents a concern this data point alone does not indicate significant risks to the successful implementation of the projects.

At the time of the on-site it was revealed that the audit sample for Project 3.a.i required further review and follow up for eight of the sampled items. Upon further review the PPS identified a discrepancy with the CPT codes used to report patients engaged in the project in DY1, Q4. The PPS identified the reporting partner and conducted an internal audit of its patient engagement reporting process. The PPS identified the root cause and created a Corrective Action Plan which was submitted to and accepted by the IA.

As a result of the discrepancy, the patient engagement data for Project 3.a.i will be adjusted, reducing its patient engagement amount by 2,616. By removing these patients, the PPS actively engaged numbers will be reduced from 15,575 to 12,959. SCC's recalculated 3.a.i. patient engagement achievement rate will be reduced to 191% (Committed: 6,785, Engaged: 12,959) and the PPS has still met it patient engagement commitments for DY1. The IA's acceptance of the PPS' Corrective Action Plan will be closely monitored for compliance.

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.

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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 8 through 14 below illustrate the level of partner engagement against the Speed & Scale commitments for all projects based on the PPS reported partner engagement efforts in the DY2, Q2 PPS Quarterly Report. The data included in the tables is specifically focused on those partner categorizations where PPS engagement is significantly behind relative the commitments made by the PPS.

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

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

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Figure 8: 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	1,079	11
	Safety Net	176	3
Case Management / Health Home	Total	10	0
	Safety Net	7	0
Clinic	Total	15	5
	Safety Net	12	4
Community Based Organizations	Total	38	12
	Safety Net	0	0
Hospice	Total	1	0
	Safety Net	0	0
Hospital	Total	8	7
	Safety Net	6	5
Mental Health	Total	126	41
	Safety Net	47	21
Nursing Home	Total	38	34
	Safety Net	33	33
Pharmacy	Total	95	0
	Safety Net	1	0
Practitioner - Non-Primary Care Provider (PCP)	Total	1,615	229
	Safety Net	128	31
Practitioner - Primary Care Provider (PCP)	Total	511	112
	Safety Net	64	39
Substance Abuse	Total	19	2
	Safety Net	19	2
Uncategorized	Total	0	25
	Safety Net	0	0

Data Source: Suffolk Care Collaborative DY2, Q2 PPS Quarterly Report

Suffolk Care Collaborative

Figure 9: 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	1,079	11
	Safety Net	176	3
Case Management / Health Home	Total	10	0
	Safety Net	7	0
Clinic	Total	0	5
	Safety Net	0	4
Community Based Organizations	Total	38	12
	Safety Net	0	0
Hospital	Total	6	7
	Safety Net	5	5
Mental Health	Total	0	41
	Safety Net	0	21
Nursing Home	Total	0	34
	Safety Net	0	33
Practitioner - Non-Primary Care Provider (PCP)	Total	1,615	229
	Safety Net	128	31
Practitioner - Primary Care Provider (PCP)	Total	408	112
	Safety Net	64	39
Substance Abuse	Total	0	2
	Safety Net	0	2
Uncategorized	Total	0	25
	Safety Net	0	0

Data Source: Suffolk Care Collaborative DY2, Q2 PPS Quarterly Report

Suffolk Care Collaborative

Figure 10: Project 2.b.ix (Implementation of observational programs in hospitals) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	1,079	11
	Safety Net	176	3
Case Management / Health Home	Total	10	0
	Safety Net	7	0
Clinic	Total	15	5
	Safety Net	12	4
Community Based Organizations	Total	0	12
	Safety Net	0	0
Hospital	Total	6	7
	Safety Net	5	5
Mental Health	Total	126	41
	Safety Net	47	21
Nursing Home	Total	38	34
	Safety Net	33	33
Practitioner - Non-Primary Care Provider (PCP)	Total	0	229
	Safety Net	0	31
Practitioner - Primary Care Provider (PCP)	Total	408	112
	Safety Net	64	39
Substance Abuse	Total	19	2
	Safety Net	19	2
Uncategorized	Total	0	25
	Safety Net	0	0

Data Source: Suffolk Care Collaborative DY2, Q2 PPS Quarterly Report

Suffolk Care Collaborative

Figure 11: Project 3.a.i (Integration of primary care and behavioral health services) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	1,079	11
	Safety Net	176	3
Clinic	Total	15	5
	Safety Net	12	4
Community Based Organizations	Total	38	12
	Safety Net	0	0
Hospital	Total	0	7
	Safety Net	0	5
Mental Health	Total	126	41
	Safety Net	47	21
Nursing Home	Total	0	34
	Safety Net	0	33
Practitioner - Non-Primary Care Provider (PCP)	Total	1,615	229
	Safety Net	128	31
Practitioner - Primary Care Provider (PCP)	Total	408	112
	Safety Net	64	39
Substance Abuse	Total	19	2
	Safety Net	19	2
Uncategorized	Total	0	25
	Safety Net	0	0

Data Source: Suffolk Care Collaborative DY2, Q2 PPS Quarterly Report

Suffolk Care Collaborative

Figure 12: Project 3.b.i (Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular Health)) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	1,079	11
	Safety Net	176	3
Case Management / Health Home	Total	10	0
	Safety Net	7	0
Clinic	Total	15	5
	Safety Net	12	4
Community Based Organizations	Total	38	12
	Safety Net	0	0
Hospital	Total	0	7
	Safety Net	0	5
Mental Health	Total	126	41
	Safety Net	47	21
Nursing Home	Total	0	34
	Safety Net	0	33
Pharmacy	Total	95	0
	Safety Net	1	0
Practitioner - Non-Primary Care Provider (PCP)	Total	1,615	229
	Safety Net	128	31
Practitioner - Primary Care Provider (PCP)	Total	408	112
	Safety Net	64	39
Substance Abuse	Total	19	2
	Safety Net	19	2
Uncategorized	Total	0	25
	Safety Net	0	0

Data Source: Suffolk Care Collaborative DY2, Q2 PPS Quarterly Report

Figure 13: Project 3.c.i (Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes Care)) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	1,079	11
	Safety Net	176	3
Case Management / Health Home	Total	10	0
	Safety Net	7	0
Clinic	Total	15	5
	Safety Net	12	4
Community Based Organizations	Total	38	12
	Safety Net	0	0
Hospice	Total	0	7
	Safety Net	0	5
Mental Health	Total	126	41
	Safety Net	47	21
Nursing Home	Total	0	34
	Safety Net	0	33
Pharmacy	Total	95	0
	Safety Net	1	0
Practitioner - Non-Primary Care Provider (PCP)	Total	1,615	229
	Safety Net	128	31
Practitioner - Primary Care Provider (PCP)	Total	408	112
	Safety Net	64	39
Substance Abuse	Total	19	2
	Safety Net	19	2
Uncategorized	Total	0	25
	Safety Net	0	0

Data Source: Suffolk Care Collaborative DY2, Q2 PPS Quarterly Report

Figure 14: Project 3.d.ii (Development of evidence-based medication adherence programs (MAP) in community settings– asthma medication) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	1,079	11
	Safety Net	176	3
Case Management / Health Home	Total	10	0
	Safety Net	7	0
Clinic	Total	15	5
	Safety Net	12	4
Community Based Organizations	Total	38	12
	Safety Net	0	0
Hospital	Total	0	7
	Safety Net	0	5
Mental Health	Total	0	41
	Safety Net	0	21
Nursing Home	Total	0	34
	Safety Net	0	33
Pharmacy	Total	95	0
	Safety Net	1	0
Practitioner - Non-Primary Care Provider (PCP)	Total	1,615	229
	Safety Net	128	31
Practitioner - Primary Care Provider (PCP)	Total	408	112
	Safety Net	64	39
Substance Abuse	Total	0	2
	Safety Net	0	2
Uncategorized	Total	0	25
	Safety Net	0	0

Data Source: Suffolk Care Collaborative DY2, Q2 PPS Quarterly Report

As the data in Figure 8 through 14 above indicates, the PPS has engaged network partners on a limited basis of different provider types such as Case Management / Health Homes and Non-Primary Care Providers across projects. Of particular note is project 3.a.i, where SCC has committed to engaging 126 Mental Health partners and 408 PCP partners but has only engaged 41 Mental Health partners and 112 PCP partners through DY2, Q2.

The IA notes that the numbers reported in the Partner Engagement tables are identical on all projects. The IA finds the identical reporting of partner engagement across the range of projects selected by this PPS to be a point for ongoing monitoring, given the variation across projects and the need for different partner engagement types.

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 that would indicate efforts by the PPS to address challenges related to project implementation efforts.

2.b.ix. (Implementation of observational programs in hospitals): The PPS acknowledges in its Project Narrative that it has had challenges in meeting patient engagement commitments. The PPS noted that they have begun to see a trend in utilization that could lead to unattainable patient engagement targets. The PPS admittedly over-forecasted its patient engagement commitments when the DSRIP application was submitted.

IV. Overall Project Assessment

Figure 15 below summarizes the IA's overall assessment of the project implementation efforts of Suffolk Care Collaborative based on the analyses described in the previous sections.

Figure 14: 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.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions			X
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)			
2.b.ix.	Implementation of observational programs in hospitals	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			
3.a.i.	Integration of primary care and behavioral health services			X
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular Health)			X
3.c.i.	Evidence-based strategies for disease management in high risk/affected			X

	populations (adults only) (Diabetes Care)			
3.d.i.	Development of evidence-based medication adherence programs (MAP) in community settings– asthma medication			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 16: 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.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	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.ix.	Implementation of observational programs in hospitals	3	This is a moderate risk score. The PPS has had patient and partner engagement 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.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular Health)	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.c.i.	Evidence-based strategies for disease management in	2	This is a low risk score indicating the project is more than likely to meet

	high risk/affected populations (adults only) (Diabetes Care)		intended goals but has minor challenges to be overcome.
3.d.i.	Development of evidence-based medication adherence programs (MAP) in community settings– asthma medication	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 Suffolk Care Collaborative 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. SCC 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.

While the IA did not identify any organizational concerns related to the ability of the PPS infrastructure to support the implementation of DSRIP projects, there are concerns related to the limited Partner Engagement efforts of the PPS through DY2, Q2. It will be important for the PPS to address the Partner Engagement concerns raised in this report to ensure the successful implementation of the DSRIP projects, the meeting of performance metrics, and the achievement of the DSRIP goals.

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 recommends that the PPS review its Partner Engagement reporting and develop a plan for engaging network partners across all projects to ensure the successful implementation of DSRIP projects.

B. Project Recommendations

2.b.ix. (Implementation of observational programs in hospitals): The PPS acknowledges in its Project Narrative that it has had challenges in meeting patient engagement commitments. The PPS noted that they have begun to see a trend in utilization that could lead to unattainable patient engagement targets. The PPS admittedly over-forecasted its patient engagement commitments when the DSRIP application was submitted.