NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Redline (following 1st Public Comment)

Central New York Care Collaborative PPS

December 2016

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Prepared by the DSRIP Independent Assessor

Central New York Care Collaborative (CNYCC)

Contents

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I. Introduction

Central New York Care Collaborative PPS (CNYCC), led by SUNY Upstate Hospital, St. Joseph's Hospital, Faxton St. Luke's Healthcare, and Auburn Community Hospital, serves six counties in Central New York: Cayuga, Lewis, Madison, Oneida, Onondaga, Oswego. The Medicaid population attributed to this PPS for performance totals 186,744. The Medicaid population attributed to this PPS for valuation was 262,144. CNYCC was awarded a total valuation of $323,029,955 in available DSRIP Performance Funds over the five year DSRIP project.

CNYCC selected the following 11 projects from the DSRIP Toolkit:

Figure 1: CNYCC DSRIP Project Selection

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.b.iii.	ED care triage for at-risk patients
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
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.ii.	Behavioral Health community crisis stabilization services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.g.i.	Integration of palliative care into the PCMH model
4.a.iii.	Strengthen Mental Health and Substance Abuse infrastructure across Systems
4.d.i.	Reduce premature births

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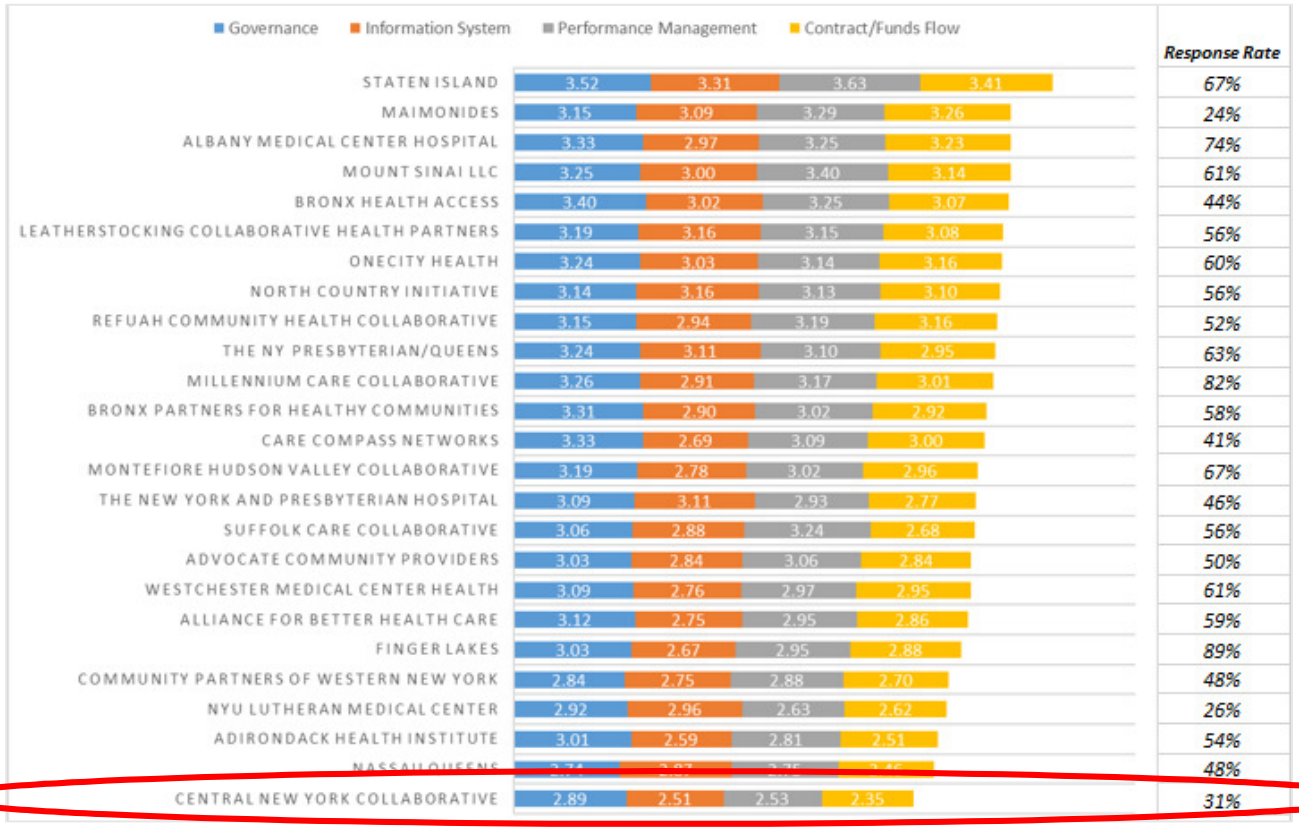
Mental Health	*2.81*		2.94	2.85	2.56	2.75
Hospice	*2.74*		2.93	2.75	2.41	2.41
Practitioner - PCP	*2.66*		2.68	2.66	2.61	2.31
Average by Organizational Area	***2.90***		**3.00**	**2.89**	**2.70**	**2.67**

Data Source: 360 Survey Results

Central New York Care Collaborative 360 Survey Results[2]

The CNYCC 360 survey sample included 45 participating network partner organizations identified in the PIT; 14 of those sampled (31%) returned a completed survey. This response rate was relatively lower than the average across all PPS (52% completed). The CNYCC aggregate 360 survey score ranked 25th 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 Survey data and comments can be found in the "Appendix 360 Survey."

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CNYCC 360 Survey Results by Partner Type

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 Substance Abuse survey result was relatively high (2nd out of 12) compared to all PPS' (7th out 12). The All Other, Hospital, and Practitioner – PCP categories significantly underperformed compared to the PPS average in terms of average score compared to the PPS Average.

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

PPS	Partner Type		Respondents over Total Surveyed
Central New York Care Collaborative	Nursing Home	3.75	1/3
	Substance Abuse	3.33	2/2
	Mental Health	3.00	1/2
	Community Based Organization	2.67	1/5
	Hospice	2.33	2/2
	Hospital	2.08	1/1
	Practitioner - Primary Care Provider (PCP)	1.75	1/4
	All Other	1.30	5/13
	Case Manager / Health Home	0.00	0/2
	Clinic	0.00	0/1
	Pharmacy	0.00	0/2
	Practitioner - Non-Primary Care Provider (PCP)	0.00	0/8
Grand Total			14/45

Data Source: CNYCC 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, CNYCC **earned all available Organizational AVs and earned two of a possible two Patient Engagement Speed AVs.**
- In DY1, Q4, CNYCC **earned four out of a possible five available Organizational AVs and earned six of a possible six Patient Engagement Speed AVs.** The PPS failed to earn the Workforce Organizational AV for failing to meet the minimum threshold for Workforce Spending in DY1.

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

[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.

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 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 (BOD) that report to four corporate members. These four corporate members are scheduled to meet on an annual basis. The BOD is comprised of at least four representatives of the corporate members, plus elected Board Members, not to exceed 22. The BOD meets on a monthly basis and is charged with the general management of the PPS. Reporting to the BOD are the following committees: Executive, Nominating, Finance, Compliance, Clinical Governance, IT and Data Governance, and Workforce. Additionally, the PPS recently filed for 501(c) (3) status with the Internal Revenue Service.

A review of the Board minutes from its Quarterly Reports reveal that the PPS has faced a number of organizational challenges, including the hiring of an Executive Director. During the on-site visit, the IA discovered that key positions, such as Director of Finance and Chief Medical Officer, remain vacant. When these factors are taken in total, the IA is concerned about the sustainability of the PPS Governing structure.

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 CNYCC had reported spending of $4,285,153.00 on administrative costs compared to an average spend of $~~3,758,965.56~~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 CNYCC spends $22.95 per attributed life on administrative costs compared to a statewide average spend of $~~24.23~~23.93 per attributed life on administrative costs.

Looking further at the PPS fund distributions to the PPS PMO, CNYCC distributed $2,996,358.00 to the PPS PMO out of a total of $10,008,030.79 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 29.94% 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

CNYCC has provided a list of Community Based Organizations (CBOs) in its organization and whether they had completed contracts. Submitted as part of the Quarterly Reports, this list indicated that the PPS had contracted with several, but not all, CBOs. In the DY2, Q2 PPS Quarterly Reports, the PPS stated it had completed contracting with CBOs, but kept the milestone status as "In Progress," meaning not yet complete. Additionally, during the IA on-site, there were a number of CBOs listed in material provided to the IA that are not listed in the CBO listing included in the Quarterly Report. Therefore, it is unclear if the PPS has contracted with all its CBO partners.

In further assessing the engagement of CBOs by CNYCC, the IA found that the PPS had distributed $6.678.87 or 0.07% 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 CNYCC approach to Cultural Competency and Health Literacy (CCHL) was informed by their Community Needs Assessment (CNA). Additionally, the PPS states it will use the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and Ten Attributes of Health Literate Health Care Organizations to further support the CCHL efforts to provide future assessment, implementation, and evaluation processes.

The CCHL Workgroup is comprised of individuals from partner organizations representing a broad spectrum of partners from across the PPS. They identified hot spots that were then used to prioritize main activities. The IA noted that the PPS has chosen to locate its physical location in in one of the poorest zip codes in its PPS region. The PPS connected with CBOs to develop a strategy for community forums and education. Their approach to training staff and partners, was to develop a baseline assessment survey using the aforementioned standards, to evaluate partner gaps. They intend to conduct this survey on an annual basis. To date, they have established goals and developed on-line training that is made available to its partners. In reviewing the Quarterly Reports, it is not clear to what extent this training has been conducted at partner sites.

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Financial Sustainability and Value Based Purchasing (VBP)

The Finance Committee created an overall assessment of its partners to identify organizations that are potentially financially fragile. The PPS submitted their "Financial Sustainability Strategy" in DY1, Q4. As part of this strategy they will be conducting an annual assessment. As part of its initial assessment, three partners self-identified themselves as "Very Financially Fragile." One of these partners contacted CNYCC and requested financial assistance. After review by the Finance Committee and Board, and after this partner was determined to be extremely vital to PPS' DSRIP efforts, the PPS agreed to accelerate future payments (earned but not disbursed) to this partner.

The PPS has hired a consultant to assist with strategic planning around the Value Based Purchasing (VBP) initiative and to provide general and Board-level education. This education was delivered via several PPS-wide webinars and through a series of white papers. The PPS additionally indicated that two of its partners participate in the VBP-QIP Program, and two partners are looking at participating in the VBP Pilot Program.

Funds Flow

Through the DY2, Q2 PPS Quarterly Report, CNYCC's funds flow reporting indicates they have distributed 40.63% ($10,008,030.79) of the DSRIP funding it has earned ($24,630,798.16) to date. In comparison to other PPS, the distribution of 40.63% of the funds earned ranks 18th among the 25 PPS and falls below the statewide average of 56.20%.

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

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

Total Funds Available (DY1)	**$25,082,462.72**		
Total Funds Earned (through DY1)	**$24,630,798.16 (98.20% of Available Funds)**		
Total Funds Distributed (through DY2, Q2)	**$10,008,030.79 (40.63% of Earned Funds)**		
Partner Type	**Funds Distributed**	**CNYCC (% of Funds Distributed)**	**Statewide (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%	3.9%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%	0.7%
Hospital	$4,927,906.27	49.24%	30.4%
Clinic	$1,160,921.82	11.60%	7.5%
Case Management/Health Home	$97,003.25	0.97%	1.3%
Mental Health	$215,758.44	2.16%	2.4%
Substance Abuse	$45,343.55	0.45%	1.0%
Nursing Home	$146,193.49	1.46%	1.2%
Pharmacy	$4,164.35	0.04%	0.0%
Hospice	$12,874.15	0.13%	0.2%
Community Based Organizations[7]	$6,678.87	0.07%	2.3%
All Other	$303,596.24	3.03%	5.8%
Uncategorized	$19,914.05	0.20%	0.5%
Non-PIT Partners	$71,318.31	0.71%	0.6%
PMO	$2,996,358.00	29.94%	42.0%

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

In further reviewing the CNYCC funds flow distributions, it is notable that the distributions it has made are heavily directed towards the Hospital, PPS PMO, and Clinic partner categories, with 90.78% of the funds being directed to these partner categories. Hospitals are the largest expenditure at 49.24%. While the PPS has distributed funds across almost all of the partner categories, the amount of funds distributed to these partners has been limited relative to the distributions to the Hospital partners and PPS PMO. The IA specifically highlights the lack of funds distributions to the PCPs. The PPS should identify opportunities to increase its funding distributions to this key partner category to ensure their continued engagement in the implementation of the PPS' 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 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. The IA agrees with the assessment that the plan included an overall approach to primary care but that most activities identified in the plan remain in the planning stages with minimal discussion of implementation efforts. CNYCC's recent hire of a Corporate Medical Officer is anticipated to accelerate the primary care activities of the PPS.

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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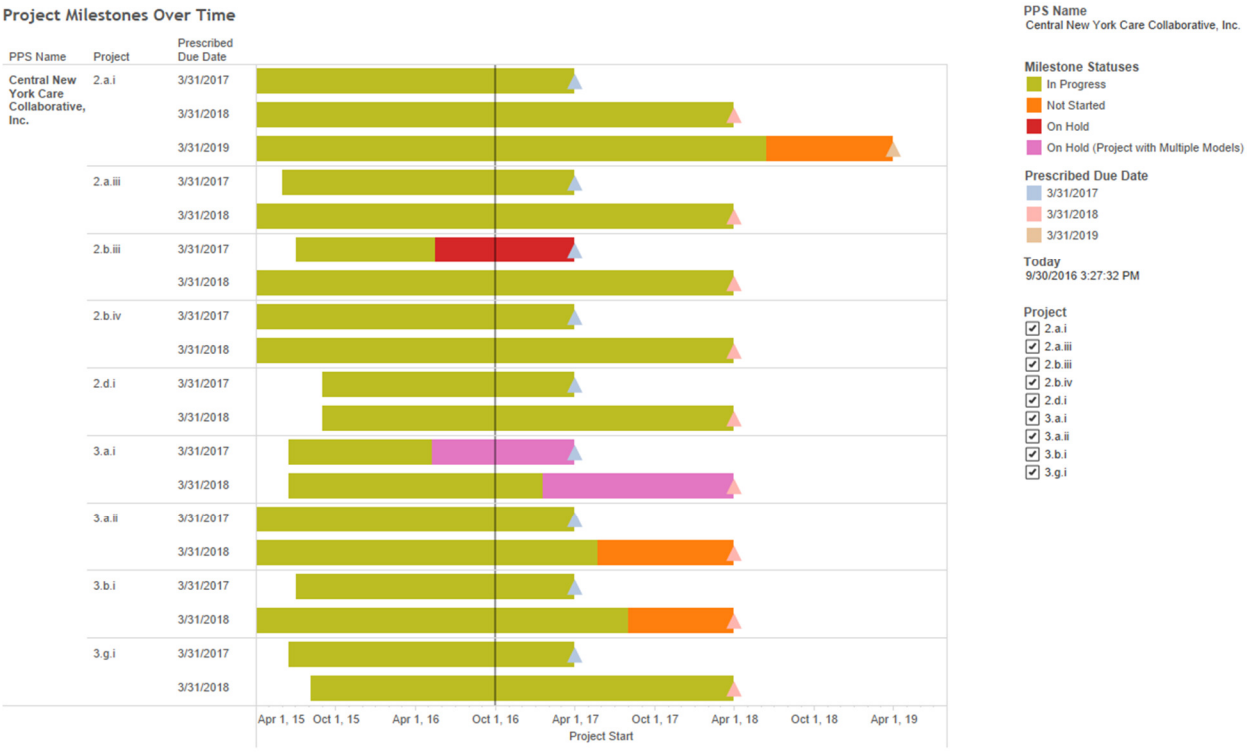
PPS Project Milestone Status

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 CNYCC'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: CNYCC Project Milestone Status (through DY2, Q2)[8]



Data Source: CNYCC 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. all 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.

[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.

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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. Similarly, for project 3.a.i., 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 pursing, there is no risk of project implementation 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 CNYCC's performance in meeting the Patient Engagement targets through the PPS Quarterly Reports. The IA identified two projects where the PPS has missed the Patient Engagement targets in at least one PPS Quarterly Report. Figures 7 through ~~8~~ 11 below highlight those projects where CNYCC has missed the patient Engagement target for at least one quarter.

Figure 7: 2.a.iii. (Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	200	193	96.50%
DY1, Q4	1,100	1,141	103.73%
DY2, Q2[9]	2,200	~~196~~43	~~8.91%~~1.95%

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

Figure 8: 2.b.iii. (ED care triage for at-risk patients) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0.00%
DY1, Q4	1,440	1,703	118.26%
DY2, Q2	2,880	1,026	35.63%

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

Figure ~~9~~8: 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) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0.00%
DY1, Q4	0	0	0.00%
DY2, Q2[10]	5,600	955	17.05%

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

~~[9] The DY2, Q2 Patient Engagement figures reflect 'As Submitted' data by the PPS and have not been validated by the IA at the time of this report.~~

~~[10] The DY2, Q2 Patient Engagement figures reflect 'As Submitted' data by the PPS and have not been validated by the IA at the time of this report.~~

Figure 10: 3.a.ii. (Behavioral Health community crisis stabilization services) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	500	642	128.40%
DY1, Q4	4,050	7,935	195.93%
DY2, Q2	5,400	1,982	36.70%

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

Figure 11: 3.b.i. (Evidence-based strategies for disease management in high risk/affected populations (adult only)) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0.00%
DY1, Q4	285	674	236.49%
DY2, Q2	3,230	1,568	48.54%

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

For projects ~~2.a.iii and 2.d.i~~the five projects identified in Figures 7 through 11 above., 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.

PPS 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. 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.

Through this review, the IA did not identify any limited partner engagement efforts relative to the commitments made by the PPS during the DSRIP Project Plan Application. The IA will continue to monitor the engagement of network partners as the PPS completes its project implementation efforts. The IA does, however, note that while the PPS indicates it has engaged its partners across all partner categories and projects, there are concerns about the level of engagement given the limited funding distributions reported by the PPS through DY2, Q2.

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.a.iii. (Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services) The PPS has indicated challenges identifying members who meet the criteria for this project. Specifically, the PPS has identified many members who have two or more chronic conditions rather than one chronic condition as required. Additionally, the PPS states that it has shifted its project activities toward primary care practices which requires knowledge of care coordination that has been difficult for the PCPs to attain.

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) The PPS is in the beginning phase of implementation for this project. The PPS notes that only partners that had completed its contracting process had received appropriate PAM trainings and were able to begin implementation of this project on schedule. Additionally, the PPS has identified the need to increase the number of partner organizations engaged in this project in order to meet its targets.

IV. Overall Project Assessment

Figure 12~~9~~ below summarizes the IA's overall assessment of the project implementation efforts of CNYCC based on the analyses described in the previous sections. The 'X' in a column indicates an area where the IA identified a potential risk to the PPS' successful implementation of a project.

Figure 12~~9~~: 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			
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes	X		
2.b.iii.	ED care triage for at-risk patients	X		
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions			
2.d.i.	Implementation of Patient Activation activities to engage, educate, and integrate	X		
3.a.i.	Integration of primary care and behavioral health services			
3.a.ii.	Behavioral Health community crisis stabilization services	X		
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)	X		
3.g.i.	Integration of palliative care into the PCMH model			

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 13~~2~~: 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	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes	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 patients	~~1~~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.~~This the lowest risk score indicating the project is more than likely to meet intended goals.~~
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
2.d.i.	Implementation of Patient Activation activities to engage, educate, and integrate	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	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
3.a.ii.	Behavioral Health community crisis stabilization services	2~~1~~	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.~~This the lowest risk score indicating the project is more than likely to meet intended goals.~~
3.b.i.	Evidence-based strategies for disease management in	2~~1~~	This is a low risk score indicating the project is more than likely to meet

	high risk/affected populations (adult only)		intended goals but has minor challenges to be overcome.~~This the lowest risk score indicating the project is more than likely to meet intended goals.~~
3.g.i.	Integration of palliative care into the PCMH model	1	This the lowest risk score indicating the project is more than likely to meet intended goals.

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

VI. IA Recommendations

The IA's review of Central New York 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. Most projects are on track for patient engagement and partner engagement has been reported to meet the committed goals of the PPS. A review of funds flow demonstrates that CNYCC is paying some downstream providers like Mental Health and Clinics. However, CBO and Practitioner payments are lagging compared to their peers. CNYCC should continue to focus on execution of project plans. Findings on projects at risk have high partner engagement but low patient volume. This raises questions regarding PPS project implementation strategy and resources for effectively working with partners to support them in achieving project 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

Community Based Organization Contracting

Recommendation 1: The IA recommends that the PPS develop a clear strategy of contracting with CBOs.

Recommendation 2: The IA recommends that the PPS finalize contracts with partnering CBOs.

Cultural Competency and Health Literacy

Recommendation 1: The IA recommends that the PPS develop an action plan to roll out its trainings to partners.

Recommendation 2: The IA recommends that 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 recommends that the PPS hire a Finance Director.

Primary Care Plans

Recommendation 1: The IA recommends that the PPS develop an action plan to detail how the PPS will move its approach to primary care from the planning stages to implementation.

B. Project Recommendations

2.a.iii (Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services)

Recommendation 1: The IA recommends that the PPS develop a training plan to educate PCPs on the care coordination requirements for this project.

Recommendation 2: The IA recommends that the PPS develop a care coordination resource to support PCPs.

Recommendation 3: The IA recommends that the PPS establish a system for identifying the targeted patients to assist the PCPs for this project as part of overall PPS population health strategy in working with its network partners.

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)

Recommendation 1: The IA recommends that the PPS finalize the contracts with partners participating in this project.

Recommendation 2: The IA recommends that the PPS increase the trainings available to assist partners in implementing this project.