Mid-Point Assessment Recommendation:

The IA recommends the PPS develop a training strategy to educate their partners and the targeted population about community based health navigation services.

PPS Action Plan Narrative:

Prior to the IA recommending a stronger training strategy, LCHP, in conjunction with their lead Care Management agency, has been training their partners and target population about the community based health navigation program and services available.

- *Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation.*
    - Over the past 6 months, the lead Community Navigation Agency has been meeting with the hospitals, primary care clinics, care management agencies, home care agencies and other community partners to educate and market the navigation program *as per* 2.c.i.-Navigation Project Milestone Requirement 7- Market the availability of community-based navigation services.
    - PPS All Partner Meeting held on 12/14/2016 has been used as a venue to educate and engage PPS partners about navigation services, current approach of PPS, and inviting them for participation.
    - In addition, our partner engagement strategy explained under recommendation #7 and #10 will enhance engagement of partners

- *Timeline for actions*
    - By 3/31/17, LCHP will have educated their partners about the Navigation program and services.

- *How the PPS will track progress in executing the actions.*
    - The lead care management agency has managers assigned to track this work using project management tools. The PPS intends to submit the supporting documentation per the project requirement.

- *How these actions reflect the PPS overall strategy for meeting its DSRIP goals.*
    - LCHP utilized the existing Medicaid Health Home infrastructure to expand to and assist Medicaid and Uninsured members with navigating the health care and social system. By utilizing the existing foundation, the PPS is able to benefit from the existing workflows, having community navigators already trained in health insurance enrollment, and familiarity of community resources. Additionally, with

the expansion of the Navigation program across LCHP, the PPS anticipates additional referrals to be generated for Medicaid Health Home.

Mid-Point Assessment Recommendation:

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

PPS Action Plan Narrative:

LCHP, in conjunction with their lead Care Management agency, has created a screening tool in line with identifying target Uninsured (UI), Non Utilizers (NU) and Low Utilizers (LU) populations. There are 2 milestone requirements in the 2di-PAM project aimed at addressing this recommendation:

- Milestone 3- Identify UI, NU, and LU "hot spot" areas
- Milestone 9-Measure PAM(R) components, including: Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.

Due 3/31/17 with the DY2Q4 quarterly report, LCHP has contracted with additional community based agencies and partners such as hospitals and clinics to screen for PAM eligibility to educate and screen for UI, NU and LU members, conduct PAM assessment and/or refer for care management agency/navigator to conduct PAM. We will submit documentation supporting these two milestone requirements.

- *Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation.*
    - To meet the above mentioned milestones, the PPS developed/obtained education materials.
    - Over the past 6 months, the lead Community Navigation Agency has been meeting with the hospitals, primary care clinics, care management agencies, home care agencies and other community partners to determine various partnership arrangements and how to identify the target population.
    - In addition, the partner engagement crew as explained under partner engagement recommendations #7 and #10 will be engaged as needed.
- *Timeline for actions*

  By 3/31/17, all LCHP partners will have been provided with education for identifying the PAM eligible members.
- *How the PPS will track progress in executing the actions.*
    - All activities supporting project deliverables will be submitted with DSRIP DOH DY2Q4 report in April 2017. Assigned Project Managers will take lead on organizing information for submission.
- *How these actions reflect the PPS overall strategy for meeting its DSRIP goals.*

- LCHP utilized the existing Medicaid Health Home infrastructure to expand to and assist Medicaid and Uninsured members with navigating the health care and social system. By utilizing the existing foundation, the PPS is able to benefit from the existing workflows, having community navigators already trained in working with the NU/LU and UI populations.

Mid-Point Assessment Recommendation:

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

PPS Action Plan Narrative:

For the past 6 months, LCHP has been refreshing their core group on PAM outreach and education. Additionally, they have communicated PAM training and coaching for activation monthly training sessions hosted and facilitated by Insignia. Most recently, LCHP arranged for a PAM refresher complete with Coaching for Activation education.

The IA recommendation is in line with the following 2.d.i.-PAM project deliverables due with the DY2Q4 quarterly report:
Milestone 2-Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.
Milestone 3-Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.
Milestone 5-Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.
Milestone 13-Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.

- *Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation.*
    - Participating partners have been educated on PAM workflows and coaching for activation techniques.
    - The PPS will explore more venues for engaging partners in these activities.
    - As explained under recommendations #7 and #10, partner engagement crew will be involved in engaging identified potential partners on an ongoing basis.
- *Timeline for actions*
    - By 3/31/17, contracted partners will be educated on outreach and education with respect to patient activation members.
- *How the PPS will track progress in executing the actions.*
    - All activities supporting project deliverables will be submitted with DSRIP DOH DY2Q4 report in April 2017. The lead Care Management agency in conjunction with LCHP has provided education and tracked the meetings.
- *How these actions reflect the PPS overall strategy for meeting its DSRIP goals.*
    - LCHP utilized the existing Medicaid Health Home infrastructure to expand to and assist Medicaid and Uninsured members with navigating the health care and

social system. By utilizing the existing foundation, the PPS is able to benefit from the existing workflows, having community navigators already trained in working with the NU/LU and UI populations.

Implementation Date:
4/1/17

Mid-Point Assessment Action Plan Due Date:
4/30/17

Mid-Point Assessment Recommendation:

The IA recommends the PPS create a plan to address the shortage of primary care physicians engaged in this project in order to meet their project implementation speed commitments.

PPS Action Plan Narrative:

The lead Care Management agency is the Bassett Community Health Navigation program who is leading both 2ci Navigation and 2di PAM projects in LCHP. They have met with hospital partners and primary care practices to develop workflows to identify target population (UI, NU, and LU) and connect them to primary care, navigation, and other needed services.

Bassett is the lead agency for the PPS as well as Medicaid Health Home/lead Care Management agency. Bassett makes up the greatest percentage of primary care practitioners in our PPS. The hospitals in LCHP employ the majority of the participating primary care practitioners/practices. Given this structure, the largest approach the team has taken to partner with the hospitals including inpatient, emergency department and primary care provider offices is to embed navigators in the hot spot locations (including CBOs) and educate them on how to refer to the Navigation program.

- *Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation.*
    - Identified primary care practices and hospitals to work with on the 2.d.i. project deliverables
    - Scheduled time with the primary care practices and hospitals to educate on the Navigation program
    - Presented to the largest primary care council at Bassett Healthcare Network
    - Presented and conducted panel discussion at the December 2016 LCHP All Partner Meeting
    - In August 2016, the 2.c.i.-Navigation and 2.d.i.-PAM Steering Committee experienced some keys leadership changes. The group re-grouped and re-organized their work. Over the past 6 months, the lead Community Navigation Agency has been meeting with partners, especially hospitals and primary care providers. Multiple educational presentations have been conducted across the PPS with the ultimate goal of either embedding a navigator in the primary care practice or training the PCP practice to conduct PAM assessments and actively work with the care management agencies to increase member's engagement.

- *Timeline for actions*
    - By 3/31/17, all primary care partners will receive education on the Navigation program, PAM eligibility criteria and how to work with care management agencies.
- *How the PPS will track progress in executing the actions.*
    - All activities supporting project deliverables will be submitted with DSRIP DOH DY2Q4 report in April 2017.
- *How these actions reflect the PPS overall strategy for meeting its DSRIP goals.*
    - LCHP utilized the existing Medicaid Health Home infrastructure to expand to and assist Medicaid and Uninsured members with navigating the health care and social system. By utilizing the existing foundation, the PPS is able to benefit from the existing workflows, having community navigators already trained in working with the NU/LU and UI populations. Training to primary care partners has been provided and will continue in a manner which benefits the target population; however, the approach of the PPS has been for care management agencies to embed navigators throughout the PPS in their identified "hot spots".

2.d.i.-PAM Project Milestone Requirement 5-Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency. Due 3/31/17 with the DY2Q4 quarterly report, LCHP has engaged additional partners such as hospitals and clinics to screen for PAM eligibility to conduct a PAM assessment or refer eligible individuals for the care management agency/navigator to conduct PAM. Workflows, training materials, screening tools, referral forms, brochures and the like have been developed for this purpose.

Mid-Point Assessment Recommendation:

The IA recommends that the PPS create an action plan to increase collaboration between palliative care team members and primary care practices (either onsite or via telemedicine) in order to increase referrals, which will further improve patient engagement shortcomings.

PPS Action Plan Narrative:

The Palliative Care project team has a systematic approach for implementation of IPOS Survey utilization at partner PCMH sites to engage primary care practices and their patients. The high level steps are listed below. Best practice recommendations for subsequent sites will be generated from lessons learned during initial roll-out. Standard documentation to capture these lessons learned for each site will be developed by the Palliative Care project team.

1. **Patient Identification** – Partner primary care practices will use EHR data quarries to generate a list by PHMC site of patients who meet the determined criteria (diagnosis codes recommended by the project group and determine by partner).
2. **PCMH site education** – The PCMH site will get education on the utilization of the IPOS survey by the medical staff of the palliative care team in person or via IPOS webinar.
   -Documentation of the education that takes place: Date, Time, Location, Topic, Format (on-line, in-person), Materials used if any, Attendance sheets.
3. **Patient Validation** – Partner PCMH site clinical teams will review EHR generated list and validate patient eligibility to introduce and administer IPOS.
4. **Administering IPOS** – PCMH site teams will customize work flow processes to educate patients about the IPOS, then administer IPOS surveys appropriately.
   -Best practice recommendations for subsequent sites will be documented.

   -Standard document to capture these lessons learned for each site will be developed by the Palliative Care project team.

Additionally, in order to address the IA recommendation, the following collaborations have been initiated by partners:

- A partner palliative care agency is contracting to embed in a partner PCMH site to provide palliative care consults for referred patients. Measure of the success of this agreement to provide services will be tracked and shared to set up a model for additional partnerships like this.
- A partner DD agency has partnered with a PCMH provider in their area to refer DD patients who are eligible for palliative care services and bring completed IPOS surveys in with the patients for review during the appointment. This partnership system will be shared with all PPS partners to show mutual benefit of these types of partnerships across the PPS. The funds flow model for community partners will be reviewed post implementation to examine the appropriateness of compensation of engaged partners.

Timeline for actions,

- Implementation time line:

- 1/1/17 – 6/30/17: Initial IPOS implementation to the highest opportunity partner sites for pilot partner.
- 3/31/17: Finalize palliative care agency contracted for embedment in PCMH site.
- 6/30/17: Developed standard lessons learned document for initial sites, and collect lessons learned.
- 7/1/17 – 6/30/18: Expanded IPOS implementation to all partner PCMH sites, with developed "best practices". (Best Practices will continue to be developed and documented during expanded implementation)
- 6/30/17: Track utilization of pilot embedment system, lessons learned and best practices to report to the project team.
- 9/30/17: Create a model for additional partnerships from results of pilot programs.
- 9/30/17: Review developed implementation plan and review current funds flow for possible modification to better compensate community partners and palliative care agencies for their contributions.

How the PPS will track progress in executing the actions, and

The PPS will track the implementation success through the following methods:

- The number, by PCMH site, of IPOS surveys submitted to the PPS via secure transfer systems.
- The number of reported AEPs by partner from quarterly reporting.
- The number of staff trained for each partner in PPS.

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

This implementation plan is intended to be directly aligned with the project goals already in place but not being met:

1. Set baseline measurement for IPOS survey performance measures (Initial roll-out).
2. Improve on baseline ratio by using "best practices" (expanded roll-out) and sharing with group for improvement at all sites.
3. Educate primary care staff members on site about utilization of IPOS survey and interventions to offer patients to provide palliative care services that are available (collaboration of palliative care team members and primary care practices).
4. Engage eligible patients at partner PCMH sites though IPOS surveys and offer available palliative care services (system to continually increase Actively Engage Patient numbers).

Mid-Point Assessment Recommendation:

The IA recommends the PPS hire a Compliance Officer who reports directly to the EGB.

PPS Action Plan Narrative:

Early in its formation, the PPS named a compliance officer who is, as required, an employee of the lead agency. Since that time, the "lead agency" has been replaced by an LLC, named Bassett PPS d/b/a Leatherstocking Collaborative Health Partners (LCHP). The IA finds it insufficient that the compliance officer is an employee of Bassett Medical Center, not Leatherstocking Collaborative Health Partners. It should be noted that LCHP does not employ any members, per se. All employees remain members of Bassett Medical Center and are "leased" to the LLC.

However, the PPS leadership recognizes the importance of having one of its leadership team who involved in the day-to-day workings of the PPS overseeing its compliance program. To that end, the PPS has named Michael Sweet, Director of Finance Operations, the compliance officer for the PPS.

In this role, Mr. Sweet interacts with the Finance Committee, partakes in the statewide compliance workgroup and ensures all partners complete requisite compliance training on an annual basis. Mr. Sweet reports directly to the Executive Governance Body regarding matters relating to compliance, finance, etc. and seeks input from Ms. Ronette Wiley, the compliance officer for Bassett Medical Center.

Mid-Point Assessment Recommendation #7 and #10:

Recommendation #7: The IA recommends LCHP strengthen their community and partner education and engagement, in particular with entities outside the lead entity, Bassett Healthcare.

Recommendation #10: The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement. The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP.
The PPS must also submit a detailed report on how the PPS will ensure successful project implementation efforts with special focus on projects identified by the IA as being at risk.

PPS Action Plan Narrative:
Prior to the IA recommending a stronger connection with our community and non-Bassett partners, we were in the process of planning & implementing the following strategies, which are either being enhanced or initiated in 2017:

- Refocus & redesign of Project Advisory Council (PAC)
  - The Project Advisory Council (PAC) strayed from its charter to brainstorm about community impact without sustainable structures or follow through.
  - Halfway through 2016, we invited members of PAC to a feedback session focused on the group's mission & make-up.
  - Six PAC members attended the feedback session to revisit the original charter & various iterations of the membership roster.
  - The overwhelming feedback from our partners was that they felt overshadowed by Bassett, the lead entity, and did not feel the Community-Based Organizations (CBOs) had enough presence or voice.
  - The group also agreed to return to the original purpose in the charter of project review, barrier removal, and true advisory capacity.
  - In January of 2017, we revised the charter and roster, removing duplicate contacts from the same organization but also expanding the list from 21 to 29 participants to include more CBOs.
  - A formal invitation went out in February of 2017 for what will be quarterly meetings beginning March 28, 2017.
  - On Wednesday, March 8, 2017, we will present the updated charter & membership roster to our Executive Governance Body (EGB) for their approval & ratification.

- Feature non-Bassett speaker at quarterly All-Partner Meetings
  - Engage leadership of PPS partners through specific Executive Leadership Forum
  - We typically have one or more partners present individually or as part of a panel discussion at our quarterly All-Partner Meetings.
  - The featured partner for March 2017 will be Catskill Area Hospice to share a reorganization of staff & services.
  - We will continue to focus public speaking opportunities on our partners (formal & informal) who don't have as loud a voice.

- "Spotlight on CBOs" in quarterly newsletter
  - In addition to reporting the latest DSRIP & PPS news to our partners on a quarterly basis, we will begin featuring one of our CBO partners in each newsletter, as well, again to provide education, engagement opportunities, & a communication platform.

- Recruitment of Full-time Network Operations Manager to engage with partners, educate community members, & align resources strategically to meet DSRIP performance measures
  - On January 16, 2017, Lucinda Levene joined the Leatherstocking Collaborative Health Partners team full-time as our Network Operations Manager, reporting directly to the Senior Director of Patient & Partner Engagement.
  - Cindy's primary goal will be to support the Project Managers & their committees by physically spending time in our multi-county coverage area to connect community needs with community resources to further the goals of DSRIP, particularly our performance measures.
  - Cindy will also capture the informal but equally important projects related to community impact & social determinants of health, such as transportation, housing, & food sourcing.
  - After three to six months of Onboarding, Cindy will have a formal work plan with measurable goals for the remainder of DY3 & beyond.

- Transition of Director Partner Engagement from part-time to full-time
  - With the loss of several key team members to promotions out of state, the part-time Director of Partner Engagement, Kara Travis, will divest herself of other Bassett Medical Center responsibilities to join the Leatherstocking team full-time.
  - In addition to providing leadership to the middle managers & clerical staff on the team, this full-time role will primarily be responsible for building relationships throughout the PPS coverage area & facilitating community impact conversations.

- Partner Site Visits
  - As part of the orientation & onboarding of both the newly developed Network Operations Manager role, as well as the transition to full-time of the Director of Partner Engagement, Cindy Levene & Kara Travis will embark on a tour of each county to visit key partners & CBOs in their own space.
  - In addition to learning more about what our partners have to offer, this "media tour" of sorts provides a prime opportunity to educate partners, recruit additional partners, & tabulate resources & best practices across the PPS.

- Community Impact Meetings – Geographic Performance Hub Approach
  - Following a strategic planning retreat on March 6, 2017, the Leatherstocking team is in the process of restructuring the approach to its work to focus on geographic hubs to more successfully & sustainably meet performance measures in an impactful, inclusive way.
  - Beginning in April 2017 with key leaders of partners located in each hub, we will identify key community members & CBO constituents to engage in community conversation around the performance measures & a community-specific tailored approach.
  - From there, we will continue to educate, resource, and ultimately fund as appropriate the hub work in each of our geographic outreach locations.
  - This work will be supported by the Executive Director, Director of Partner Engagement, Network Operations Manager, and various Project Managers as appropriate.

- Project Specific Engagement: While some projects are very specific allowing certain types of partners to be engaged (e.g. 2bvii INTERACT in SNFs with SNF and hospital engagement), there is opportunity for innovative ways to engage partners in other projects (e.g. Navigation). We are working to build a team that pulls together available resources to maximize effectiveness and efficiency of delivery of outcomes to our population. The project managers will work with the Partner Engagement crew closely to identify engagement issues and address them at the earliest possible time. We will create a communication tool for the team to assist in partner engagement with the existing technology. Some of the ongoing engagements are:
    - Engaging existing care management and navigation capability in the PPS partners to assist in project work to improve performance measures.
    - Making all DSRIP trainings available to all PPS partners: We will revamp our website to make al trainings available to partners, and have the ability to record trainings where there are no restrictions.
    - Innovative methods of involvement by engaging partners as a site for navigation services

  - Other innovative ideas include training PPS staff to identify people who might need withdrawal/tobacco cessation services.
  - Assist the hiring of a recovery coach/counselor at the Schoharie county community services clinic.

- Centralized Office & Meeting Space for Team & Partners
  - Currently, the Leatherstocking team is scattered among multiple buildings within Cooperstown, on and around the Bassett campus.
  - The current set-up is non-productive, as well as inconvenient for partners who travel from multiple counties and then have difficulty parking or accessing meeting space.
  - Furthermore, the current configuration contributes to the Bassett-centric stigma often perceived by non-Bassett partners & smaller CBOs.
  - In mid-April, the team will relocate to its own building closer to Oneonta and conveniently close to Routes 28, 7 and I-88. In addition to promoting a more collaborative & productive workplace, it will also afford ample parking & multiple meeting space options for our partners & other colleagues in the DSRIP industry.

Funds Flow:

In addition to flowing funds to partners who are meeting specific metrics, the Leatherstocking Collaborative Health Partners (LCHP) PPS has built a funds flow model which will incentivize partners for participation in DSRIP activities through 'citizenship funds' set aside. The Finance Committee now recognizes the shift to Pay for Performance and the need to review our current funds flow model to incentivize partners to be engaged as well as drive improved performance.

The funds flow model has encouraged PPS to take on most of the training expense for clinical and organizational projects – for e.g. 2aii. PCMH, 2bvii INTERACT training, Compliance Training, Workforce-related training, 3diii Asthma, 3ai Integration of behavioral health and primary care, 3aiv withdrawal management services, 2ci. Navigation, 2di PAM,

Our Finance Committee will be working on, in collaboration with project management, to identify changes needed to align with performance metrics. We will look to incentivize outcomes needed through our projects. We are in the process of reviewing our current fund flow model by focusing on metric achievement through the collaboration with our partner organizations and with the involvement of our CBO's to determine the best way to flow funds to them for moving the needle without making it complicated so that our partners can understand the methodology as an acceptable Funds Flow Model.

Partner Engagement:

The partner engagement template has been completed with an assumption that the number of providers we submit are to be engaged by 9/30/2017. Additionally, except practitioner PCPs and Non-PCP provider types, all other providers are counted at a partner organization level.

Implementation Plan and Dates:

See attached Implementation Plan Template

Mid-Point Assessment Recommendation:

The IA recommends that the PPS develop an action plan to address the concerns raised in the Primary Care Plan, notably the lack of an overall approach or strategic plan for primary care and the limited detail on the scale of implementation efforts.

PPS Action Plan Narrative:

The LCHP PPS is primarily comprised of hospital employed primary care practitioners. Below is a breakout of the number of primary care practices represented by LCHP partners undergoing PCMH transformation. Below is our high-level strategic plan and timeline for PCMH recognition of practices in our PPS.

Partner	***# Practice Locations***	***Target Date for Corporate Submission***	***Target Date for Practice Sites Submission***	***Recognition Achieved***
Bassett Medical Center (Primary Care and Pediatrics)	30	3/31/17	9/30/17	Recognition granted at practice level
Bassett Medical Center (SBHC)	20	3/31/17	9/30/17	Recognition granted at practice level
Community Memorial	4	10/30/2016-completed	12/31/16-completed	
CMH Hamilton FHC				*2014 NCQA Level 3*
CMH Waterville FHC				*2014 NCQA Level 3*
CMH Morrisville FHC				*2014 NCQA Level 3*
CMH Munnsville FHC				*2014 NCQA Level 3*
AO Fox Hospital	7	3/31/17	9/30/17	Recognition granted at practice level
Little Falls Hospital	2	NA	3/31/17	Recognition granted at practice level
Regional Primary Care Network (New FQHC-opened April 2016)	1	NA	9/30/17	Recognition granted at practice level
Oneida Healthcare Hospital	4	NA	9/30/17	
Verona Health Center				*2014 NCQA Level 3*
Canastota Lenox Health Center				
Chittenango Family Care				
Chittenango Internal Medicine				
Planned Parenthood Mohawk-Hudson	1	NA	12/31/17 (will only be for 2 year recognition)	Recognition granted at practice level

- *Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation.*
    - Engaged Primary Care Development Corporation as a Patient Centered Medical Home Expert to assist with 2014 NCQA Level 3 recognition for primary care practices
- *Timeline for actions*
    - All participating primary care practices will submit for PCMH 2014 NCQA Level 3 recognition according to timelines in the above table (latest 12/31/17)
- *How the PPS will track progress in executing the actions.*
    - PCDC is assisting practices with their documentation collection in order to prepare for submission. A shared documentation checklist is maintained for corporate and site submissions by the PCDC consultant.
    - All high level activities supporting project deliverables are tracked in performance logic and will be submitted with DSRIP DOH quarterly reports.
- *How these actions reflect the PPS overall strategy for meeting its DSRIP goals.*
    - LCHP engaged the PCDC consultant early on in 2015 to "kick off" the Patient Centered Medical Home transformation work. Partners are at various levels of readiness and the consultant has been instrumental in understanding this and meeting practices where they are at and guide them in the transformation. Patient Centered Medical Home is a foundation to the primary care practices and will support other DSRIP projects such as Integration of Behavioral Health.

Implementation Date:
4/1/2017

Mid-Point Assessment Action Plan Due Date:
3/31/2018

Mid-Point Assessment Recommendation:

The IA recommends that the PPS develop an action plan to document its approach to addressing the challenges identified for compensation models and incentives for providers that will impact the PPS' primary care strategy related to VBP.

PPS Action Plan Narrative:

The current funds flow model is inclusive of a multitude of partners – including CBOs, primary care, mental health providers, and substance use disorder providers. However, it is focused largely on participation (citizenship) and achievement of actively engaged patient commitments. Whereas actively engaged commitments will continue to be AV-driving, the shift in focus for the transformation is to clinical performance metric achievement. Therefore the PPS leadership intends to shift its focus to engage providers to reach these goals.

Strategies towards achieving the goal:

1. Utilize the VBP-QIP implementation plan and contracting as a resource to educate other partners throughout the PPS in the value-based reimbursement model;
2. Utilizing an existing partner's "best practice", recommend a plan to primary-care partners for utilizing DSRIP funds to incentivize quality and metric achievement;
3. The PPS intends to shift its bonus payment model – with input from community-based organizations, primary care practitioners, substance abuse providers, developmental disabilities providers, mental health providers, etc., to one based on achievement of clinical performance metrics as assigned by the state. This will include extensive community engagement and partner input so to incentivize new partnerships designed to meet the overarching goals of the DSRIP program and metric achievement.

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

Mid Point Assessment Recommendation # 3: The IA recommends the PPS develop plan to increase outreach and education materials to partners with respect to patient activation measures.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Educate Participating Partners	**4/30/2017**
Complete education to participating partners in order to increase outreach and provide education materials with respect to patient activation measures.	4/30/17
2. Submit Supporting Documentation for 2.d.i.-PAM Project Milestone Requirements	**4/30/2017**
Submit Documentation for 2.d.i.-PAM Project Milestone Requirement 2-PAM trained invididuals	4/30/17
Submit Documentation for 2.d.i.-PAM Project Milestone Requirement 3-Engage CBO's to conduct outreach	4/30/17
Submit Documentation for 2.d.i.-PAM Project Milestone Requirement 5-Train PPS providers trained in PAM	4/30/17
Submit Documentation for 2.d.i.-PAM Project Milestone Requirement 13-Train community navigators in patient activation and education in PAM	4/30/17
Mid Point Assessment Recommendation # 4: The IA recommends the PPS create a plan to address the shortage of primary care physicians engaged in this project in order to meet their project implementation speed commitments.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Introduce and Engage Primary Care Partners in the 2.d.i.-PAM Project Work	**4/30/2017**
Identify primary care practices to educate	4/30/17
Coordinate time with primary care practices to review Navigation program and determine how care management agencies can best work with PCP offices.	4/30/17
Feature Navigation Program at LCHP All Partner Meeting-completed in December 2016	4/30/17
Mid Point Assessment Recommendation #5: The IA recommends that the PPS create an action plan to increase collaboration between palliative care team members and primary care practices (either onsite or via telemedicine) in order to increase referrals, which will further improve patient engagement shortcomings.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Initial roll-out of implementation to at least the (3) highest opportunity partner sites for pilot partner,	**6/30/2017**
1. Patient Identification	3/31/2017
2. PCMH site education	6/30/2017
3. Patient Validation	6/30/2017
4. Administering IPOS	6/30/2017
2. Pilot palliative care agency contracted for embedment in PCMH site.	**9/30/2017**
1.Finalize partner contract	3/31/2017
2. Track Utilization of pilot embedment system, lessons learned and best practices to the group.	6/30/2017
3. Create model for additional partnerships and embedment from evidence based results of pilot program.	6/30/17 - 9/30/17
3. Expanded IPOS implementation to all partner PCMH sites, with developed "best practices". (Best Practices will continue to be developed and documented during expanded implementation)	**9/30/2017**
1. Developed standard lessons learned document for Initial sites, and collect data from lessons learned.	6/30/2017 - 9/30/17
2. Implementation of developed IPOS implementation plan	9/30/2017
4. Funds Flow review for Modification	**9/30/2017**
1. Review developed implementation plan and review current funds flow for possible modification to better compensate community partners and palliative care agency's for their contributions.	9/30/2017
Mid Point Assessment Recommendation # 8: The IA recommends that the PPS develop an action plan to address the concerns raised in the Primary Care Plan, notably the lack of an overall approach or strategic plan for primary care and the limited detail on the scale of implementation efforts.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Submit Corporate Applications to NCQA (NCQA dedline is 5/31/17)	**5/31/2017**
Community Memorial Hospital	10/31/16
Bassett(Primary Care and Pediatric Practices)	3/31/17

Bassett (SBHC)	3/31/17
AO Fox	3/31/17
Oneida Healthcare	3/31/17
2. Submit Site Applications to NCQA (NCQA deadline is 12/31/17)	**3/31/2018**
Community Memorial Hospital	12/31/16
Bassett(Primary Care and Pediatric Practices)	9/30/17
Bassett (SBHC)	9/30/17
AO Fox	9/30/17
Oneida Healthcare	9/30/17
Regional Primary Care Network	9/30/17
Planned Parenthood Mohawk Hudson (will only be for 2 year recognition)	12/31/17
3. Submit Supporting Documentation	**3/31/2018**
Submit Documentation for 2.a.ii.-PCMH Project Milestone Requirement -NCQA recognition documentation for 2014 NCQA Level 3 recognitionwith DY3Q4 quarterly report	3/31/18

Mid Point Assessment Recommendation #9: The IA recommends that the PPS develop an action plan to document its approach to addressing the challenges identified for compensation models and incentives for providers that will impact the PPS' primary care strategy related to VBP.

PPS Defined Milestones/Tasks	*Target Completion Date*
1. Utilize the VBP-QIP implementation plan and contracting as a resource to educate other partners	8/1/2017
Invite AO Fox Hospital and Excellus (VBP-QIP partners) to present and/or participate in a panel discussion	8/1/2017
2. Utilizing an existing partner's "best practice", recommend a plan to primary-care partners for utilizing	6/30/2017
Through engagement of PCMH implementation project team, engage primary care providers throughout	6/30/17
3. The PPS intends to shift its bonus payment model – with input from community-based organizations,	9/30/2017
Introduce concept of "performance hubs" at Executive Leadership Forum with the goal of educating	4/1/2017
Introduce concept of "performance hubs" at 1st quarter all partner meeting with the goal of educating	4/1/17
Create regional "performance hubs" designed to engage partners within communities/counties and develop	6/15/17
Amend funds flow model to award bonus payments to providers who engage in the performance hub work	9/30/17

Mid Point Assessment Recommendation #10: The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement. The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP.
The PPS must also submit a detailed report on how the PPS will ensure successful project implementation efforts with special focus on projects identified by the IA as being at risk.

PPS Defined Milestones/Tasks	*Target Completion Date*
1. Partner Engagement	9/30/2017
Refocus & redesign of Project Advisory Council (PAC)	3/28/17
Feature non-Bassett speaker at quarterly All-Partner Meetings	3/22/17
Recruitment of full-time Network Operations Manager	1/16/17
Work Plan for Network Operations Manager	7/17/17
Partner Site Visits	9/30/17
Community Impact Meetings - Geographic Hub Approach	6/30/17
Centralized Office & Meeting Space for Team & Partner	4/30/17
Update website with training materials and other information	6/30/17
"Spotlight on CBOs" in quarterly newsletter	4/3/17

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

		Partner Engagement for Recommendation #7 and #10: The partner engagement template has been completed with an assumption that the number of providers we submit are to be engaged by 9/30/2017								
Partner Category		***2.a.ii PCMH***	***2.b.vii Interact in SNFs***	***2.b.viii Hosp Home Care Collab***	***2.c.i Navigation***	***2.d.i PAM***	***3.a.i Integ of Behav Hlth & Prim Care***	***3.a.iv Withdrawal Mgmt***	***3.d.iii Asthma***	***3.g.i. Palliative Care***
Practitioner - Primary Care		222		21	177	177	124	28	88	55
Practitioner - Non-Primary Care				120			5	2		2
Hospital - Inpatient/ED		4	3	6	5	5	4	1	5	2
Hospital - Ambulatory										
Clinic		6		7	6	6	5	1	7	3
Mental Health		32		2	32	32	6	9	1	1
Substance Abuse					1	1	3	5		
Case Management		1		3	5	5	4	3	1	1
Health Home		1		3	5	5	4	3	1	1
Community Based Organization (Tier 1)				2	6	6	2	4		1
Nursing Home			11							
Pharmacy										
Hospice				1						2
Home Care										1
Other (All Other as categorized by DOH)		3		9	5	5	4	6		5
Other (Define)										
Other (Define)										

State of New York
Department of Health
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Mid-Point Assessment Action Plan - Funds Flow

		Recommendation #10: Funds Flow (all funds)			
Partner Category		***Funds Flow through DY2, Q3***	***Projected Funds Flow through DY2***	***% of Earned Dollars Planned for Distribution DY3***	***% of Earned Dollars Planned for Distribution DY4 DY5***
Practitioner - Primary Care		$ -	$ -	0.00%	0.00%
Practitioner - Non-Primary Care		$ -	$ -	0.00%	0.00%
Hospital - Inpatient/ED		$ 6,008,766.87	$ 6,008,766.87	37.94%	43.27%
Hospital - Ambulatory			$ -	0.00%	0.00%
Clinic		$ 134,653.79	$ 134,653.79	0.85%	0.97%
Mental Health		$ 3,131.63	$ 3,131.63	0.02%	0.02%
Substance Abuse		$ 184,804.52	$ 184,804.52	1.17%	1.33%
Case Management		$ 197,493.47	$ 197,493.47	1.25%	1.42%
Health Home			$ -	0.00%	0.00%
Community Based Organization (Tier 1)		$ 79,302.86	$ 79,302.86	0.50%	0.57%
Nursing Home		$ 877,207.67	$ 877,207.67	5.54%	6.32%
Pharmacy		$ -	$ -	0.00%	0.00%
Hospice		$ 63,394.95	$ 63,394.95	0.40%	0.46%
Home Care		$ -	$ -	0.00%	0.00%
Other Uncategorized		$ 276,166.81	$ 276,166.81	1.74%	1.99%
Other All Other		$ 413,673.82	$ 413,673.82	2.61%	2.98%
Other (Define- Additional Provider)		$ 494.40	$ 494.40	0.00%	0.00%
Other (Define- PPO Admin)		$ 3,066,378.00	$ 3,066,378.00	14.40%	14.38%
Other (Define- Hold for other budget categories)				33.59%	26.28%
Total		**$ 11,305,469**	**$ 11,305,468.79**	**100.00%**	**100.00%**