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Mid-Point Assessment Recommendation #1 (Project 2ai Create Integrated Delivery System): The IA recommends the PPS develop a strategy to increase partner engagement to support the successful implementation of this project (2ai) and in meeting the DSRIP Goals.

Risk Score: 3. **Potential Risk to PPS successful Implementation:** Partner Engagement.

PPS Action Plan Narrative:

At the heart of Project 2ai is the formation of a high-performance network of hospitals and community based partners who can improve delivery of care to Medicaid members as viewed through standardized quality metrics. While performance outcomes and payment is measured at the PPS-wide level, the delivery network performance management is best accomplished at a more local level. As indicated in the 2ai project specifications, the IDS must be an evolution beyond the ACO structure inclusive of multiple health systems and community based organizations. The Regional Performance Units (RPUs) are the organizational units in CCN best positioned to manage performance and foster the development of an integrated delivery system.

The network management functionality that needs to be implemented in the RPUs includes: RPU performance governance, evaluation and management of RPU network capacity (partner engagement, PCP capacity), and population health performance management, which includes: data analytics to identify Medicaid members at risk, engaged network partners, care coordination services, and complementary IT solutions for alerts, and shared care plans. To date, the RPUs, have largely functioned as education and quality communication forums. In reflecting on the IA recommendation, it is evident that the RPUs need to focus on performance management. CCN leadership has identified several specific new and/or accelerated actions organized around 6 milestones: (1) Infuse new resources into the RPUs (2) Analysis of RPU Network Capacity and Capability with a plan to improve or expand the network (3) Shift the focus of each RPU to data driven performance assessment, network development and rapid cycle performance (4) Accelerate Partner Engagement in the RPU (5) Facilitate contracts between CBOs, Primary Care and Health Systems and (6) Refocus the IT Strategy around the RPUs.

Milestone 1: Infuse new resources into the RPUs. The RPUs have been operating with RPU leadership by contracting with a partner to provide that service as opposed to having CCN dedicated leadership. As a result, the RPUs were left with little support to transition from collaboration forums to performance management operations. CCN will staff each RPU with five (5) positions: RPU Leader, Population Health Analyst, an RPU Project Manager, an RPU Partner Relations Specialist and an IT Project Manager. Given the urgency of performance improvement needed, CCN has established interim full time RPU leadership and analysts.

Milestone 2: Complete an RPU Partner Network Capacity and Capability Analysis with a Formal Action Plan by partner category to assure rebalancing of the delivery system and network capacity

A detailed network analysis will be prepared that examines each project by partner category to identify project and partner engagement gaps. An action plan for outreach to partners who were identified with opportunities to contract with CCN will be implemented and progress with engagement reviewed in weekly RPU meetings.

Milestone 3: Shift the focus of each RPU to data driven discussion, performance assessment, network development and rapid cycle performance improvement. CCN will prepare a standardized performance dashboard that includes: contracted patient engagement performance, and quality measure set performance. Each RPU will be accountable for monitoring and reporting RPU performance to the CCN Executive Director, PAC Executive Committee and the CCN Board of Directors. Contracted performance by partner will be tracked and reviewed in weekly RPU Meetings, bi-monthly at PAC Executive Committee and monthly at the CCN Board**.** PPS Population Health Quality Measure Sets will also be reviewed weekly. Follow up analytics to gain deeper insight into below target performance will be commissioned and reviewed in each RPU with their dedicated analyst. The RPU will develop action plans for interventions through projects and/or care coordination with contracted partners. If the RPU cannot achieve the needed improvement in performance levels working directly with the partner, the issue will be promoted to the CCN Board for resolution. In addition to speed and scale, project performance, and project quality performance will also be tracked and monitored. Each project is associated with a quality measure set. In concept, the project should be contributing to positive movement of the metric. As part of the Performance Management Agenda for the RPU, each project will be evaluated based on the quality measure set. Discussion will focus on understanding the care delivery process currently in place in the RPU network and potential interventions that could be adopted by the RPU network to change performance. RPUs will maintain an active issue log to assure that identified and approved interventions have an implementation plan that is actively managed.

Milestone 4: Accelerate Network Partner Engagement through enhanced payments and incentives

In response to the Midpoint Assessment CCN conducted a listening tour to better understand partner barriers. As a result, new incentives have been enacted by the CCN Board. These incentives include a Speed and Scale Performance based on the percentage of speed and scale achieved by a contracted partner. A new incentive was also implemented for project 3gi, Integration of Palliative Care into the PCMH Model**.** For a number of reasons Partners had been reluctant to engage in this project. A significant increase in payment was implemented to account for additional efforts needed to overcome documentation and coding issues. In the next phase of contracting beginning April 1, 2017 there will be increases in payment / funds flow for specific projects which proved to be under-valued in Phase 1 contracting, resulting in lack of partner engagement. Specific actions include: a high-performance bonus for patient engagement; high performance bonus for quality metrics achieved; start-up payments that may be needed to implement a project; a pre-payment of a % of phase 2 contract value with claw back provision for failure to achieve targeted activities; increased innovation funding for RPU initiatives needed to improve quality metrics; and increases in direct funding to the RPUs **t**o implement initiatives designed to improve performance.

Milestone 5: Facilitate contracts between CBOs, Primary Care and Health Systems Development of a value based care network of providers requires formal relationships between entities who share payment and performance measures. CCN will facilitate contracting between CBOs, primary care and the health care systems that will enhance care network capability and capacity to drive performance at the lowest cost.

Milestone 6: Refocus IT Strategy around the RPUs CCN has struggled with advancing a PPS-wide IT plan. Much has been accomplished in partner IT needs assessment and vendor assessment, however, implementation of IT infrastructure using a PPS wide approach has slowed the process. The Midpoint Assessment provided the opportunity to rethink the RPU role and performance management. In doing so, the approach to IT implementation has become clearer. Specific Actions include: each RPU will officially select and align with one of the three RHIOs serving the CCN service area. The CCN PPS-wide strategic IT plan will be focused by RPU with an IT Project Management Lead to facilitate hardware and software acquisition, EMR implementation where needed, establish connectivity to RHIO for data exchange, implement supportive IT for telehealth and online e-visit capability and implement Population Health Management Systems.

Tracking Progress RPU leads will provide monthly reporting and tracking related to contracted partner performance, population quality metrics, Project Quality Metrics, and the RPU Network Action Plan to CCN. CCN will prepare and provide the RPU reports as well as PPS wide performance reports to PAC Executive Council and the CCN Board. CCN will provide feedback, direction and approval for the RPU plans. In the event that performance is off track, this system of reporting and monitoring should signal course correction in the earliest possible time frame to the CCN Board level.

How these Actions Reflect Overall PPS Strategy for meeting DSRIP Goals From the beginning, CCN has had the benefit of strong and willing collaboration as a foundation. CCN recognized the difficulty of engagement of partners in a region that has a four-hour travel time from east to west and had the foresight to develop Regional Performance Units (RPUs). CCN has floundered primarily in its pace and implementation of RPU performance functionality, relying instead on the Project Management Office (PMO) and partner relations to manage. The reporting with the CCN board focused on IA quarterly report milestones, AV achievement, budget management and compliance. There was not adequate attention given to achievement of speed and scale and the implications of not achieving on that measure of performance.

This action plan redirects the focus of operations to the service delivery network and its effectiveness for Medicaid members. It drives attention to increasing the RPU network with respect to adequacy of the RPU network composition, partner engagement, patient engagement, effectiveness of project implementation and the effectiveness of the RPU network in improving care to the Medicaid members. The ability of CCN to achieve significantly improved speed and scale and additional partner engagement by March 31st points to a strong infrastructure and the will to succeed. The rapid redirection of resources and focus into RPU operations should lift CCN performance to expected levels of success.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

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Mid-Point Assessment Recommendation #2 (2.b.iv: Care transitions intervention model to reduce 30 day readmissions for chronic health conditions): The IA recommends the PPS develop a strategy to increase partner and community engagement.

Risk Score: 3. **Potential Risk to PPS successful implementation:** Patient Engagement, Partner Engagement

PPS Action Plan Narrative: The recommendation made by the IA in the Mid-Point Assessment report regarding PPS reported challenges with provider and community engagement was a result of start-up challenges centered around introducing and communicating the Care Transition Intervention Model as well as the difficulty reporting partners encountered with the monthly project reports CCN created.

The monthly reporting for this project required partners to complete 13 data elements for each patient who received a care plan prior to their discharge from an acute care facility. Many of the reporting elements for the projects were intended to assist CCN in building a data warehouse to be used for population health initiatives and were much more detailed than the DOH minimum reporting requirements. Since December 2016, CCN implemented the following changes as part of a strategy to increase partner and community engagement.

1. **Alignment of PPS reporting requirements to DOH reporting requirements**. One of CCN's goals for the Care Transition project is to have all four pillars of the CCN Care Transition Intervention Model incorporated into the care plan distributed prior to discharge (the four pillars - Medication Self-Management; Primary Care Provider and/or specialist follow-up; Patient understanding of "red flag" indicators of worsening condition and appropriate next steps; and, Use of a Personal Health Record). The first three pillars are minimum requirements by DOH for reporting actively engaged in this project. Upon project implementation, 3 of the 4 pillars were in use across all of the acute care facilities however, partners needed more time to adopt and incorporate the Personal Health Record. The requirement of all 4 pillars was one of the primary reasons partners were not achieving their actively engaged contracting targets. CCN has since reduced the reporting for this project to only the require first 3 pillars with optional reporting of personal health record. Additionally, of the 13 original elements partners were asked to report, CCN has changed the required elements to just 7 in order to reduce the administrative burden for partners.

2. **Patient engagement funding incentive.** In discussions with partners, it is clear the reimbursement model across many of the projects including this project has not been adequate to engage providers given all the requirements that come with project participation. At the Board of Directors meeting held on February 14th, several funding incentives were approved to directly increase patient engagement. One of the approved incentives was specifically crafted to provide a bonus payment to partners to accelerate completion of patient engagement DY2Q4 targets with the potential for up to a 60% incentive bonus on top of regular reimbursement.

As a result of revised reporting requirements, the Care Transitions project is on track to meet the actively engaged targets for DY2Q4 by 3/31/17. However, the project does not meet the full project implementation which requires adoption of the Personal Health Record. CCN will implement the following additional actions to increase partner and community engagement:

1. **Incentivize collaboration between hospital systems and community based organizations.**
    a. In addition to the project implementation requirements at an acute care facility, CCN created a Health Coach program within this project that is designed to incorporate staff from community based organizations to serve as a Health Coach for Medicaid members who are not eligible for a Medicaid Health Home nor for Certified Home Care. The vision for implementation of this project is to leverage Health Coaches in the community since the healthcare systems do not have the capacity to take on this role for all Medicaid members. One of the healthcare systems (UHS) operating in the PPS, has subcontracted with multiple community based organizations to provide Health

Coaches for this project even though UHS offers these services under their home care agency. The subcontracting approach supports knowledge transfer across the community and assists the healthcare systems with contracting to do this work when short falls exist in acute care.

CCN will need to align this subcontracting approach with the reimbursement model for this project in the next phase of contracting scheduled to begin April 1st. The reimbursement model for this project is being reviewed with the aim of incorporating additional incentive dollars to acute care facilities to collaborate with community based organizations providing Health Coach services. The intent is to build more contacts for these services through the use of the subcontracting relationships. Many of the community based organizations employ staff who have established trusted relationships with the Medicaid members in the community. In using these staff members as Health Coaches for this project, follow up home visits and phone calls can be provided for Medicaid members who would not have received such care post discharge.

b. As a function of building the Integrated Delivery Network, CCN will develop a payment approach to incentivize collaboration between healthcare systems and community based organizations. The details of this methodology are in progress and will be completed for Phase 2 contracting beginning April 1, 2017.

2. **Assist providers in building readmissions reports**. The hospitals in the PPS are performing well on the potentially preventable readmissions metric as compared to the state however, CCN's goal is to minimize hospital readmissions. Within each RPU CCN will gather real time readmission data from each of the contracted hospital partners by the end of June 2017. CCN will work with the partners for two months on adoption and submission of data to track, monitor and manage readmissions.

3. **Assist partners in adopting and incorporating the Personal Health Record.** Partners express skepticism about the value of a paper based Personal Health Record. Providers anticipate that patients will fail to bring the health record to each appointment for joint review and/or patients will not understand its utility. From the providers' perspective, the value added of incorporating a Person Health Record into their interactions with patients was minimal. CCN will utilize the CCN Clinical Governance leadership in documenting and communicating the benefits of the Personal Health Record. The CCN 2biv Project Manager will work with the facility champions at each hospital to provide education on the benefits of the Personal Health Record to all departments who perform discharges at the facility.

Tracking these actions will occur at the CCN Coordinating Council meeting with monthly progress on actions communicated to the PAC Executive Council until project implementation is complete.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

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Mid-Point Assessment Recommendation #3 (2.b.iv: Care transitions intervention model to reduce 30 day readmissions for chronic health conditions): The IA recommends the PPS develop a plan to increase outreach and education materials to partners.

Risk Score: 3. **Potential Risk to PPS successful implementation:** Patient Engagement, Partner Engagement

PPS Action Plan Narrative:

The recommendation made by the IA in the Mid-Point Assessment report regarding PPS reported challenges with lack of provider awareness and readiness to train was a result of reluctance to allow the pivotal role of a transition health coach to be performed by people other than a nurse professional. The challenge was to increase understanding of the Care Transition Intervention model and delegation of specific responsibilities to a health coach within the CTI model.

Hospitals routinely manage patient discharges but lack capacity to assign a health coach to every Medicaid member discharged and transitioning back into the community. CBO are positioned to assume responsibility for a recently discharged patient. Hospital partners and CBOs need support to develop a mutually beneficial partnership to render transitional care services. However, partners are struggling to understand the health coach role and integrate the responsibilities of this job title into their current staffing model.

The strategies to resolve the lack of understanding around the use of a health coach within the CTI model include:

1. **Develop a program to educate partners on the CCN Care Transitions Program and the Health Coach role.** Education about the Care Transition Program and the Health Coach role is critical to the success of the project. CBO and health care systems need to understand how to work together to ensure a seamless 30-day care transition period for the Medicaid member. Training focused on explaining the project workflow from inpatient to the end of the 30- day period across partner organizations is needed. The training needs to include explanations of the CTI model; role of each staff person especially the new title health coach in the transition process; communication opportunities between staff of partner organizations; and, reporting expectations. The specifics of an educational program can be designed to best meet the needs of partners. L Lunch and learn, written materials, on-line tutorials or other methods of delivering the educational program are options.

2. **Increase communication with the Care Transition facility champions**. Partners difficulties implementing this project suggest the need to increase communications with partner's facility champions and front line staff. This allows CCN staff to quickly identify implementation and reporting issues; assess adequacy of training, processes and tools needed to change the way care is delivered; and, share best practices. Regular touchpoints with facility champions with partners in the inpatient settings by CCN staff are opportunities to identify facility specific implementation challenges, resolve problems and provide technical assistance when necessary.

3. **Provide training opportunities for persons interested in becoming Health Coaches.** To support long term sustainability of Health Coach services in the community, CCN wants to ensure there is an adequate flow of people providing these services for community based organizations. CCN developed an evidenced based health coach

training program that is available to partner organizations. Identification of person appropriate to fill the health coach role, facilitating health coach training completion, and tracking the training that is done will generate a pool of persons trained as health coaches who can be utilized for this project

4. **Work with the Human Resources Department of partners contracted for this project** to integrate the health coach into the staffing mix of the organization. Adoption of the use of a health coach will be facilitated by providing HR professionals information about training and credentialing requirements, job descriptions outlining specific job responsibilities, suggested wage levels, recruitment or redeployment strategies and a broad understanding of the role of a health coach within care transitions.

5. **Monitor statewide efforts to standardize the role of health coach, community health worker or other new and emerging job titles.** The health coach is a new, emerging title that may ultimately be subject to credentialing or specific educational requirements. CCN must ensure promotion of the health coach role within this project is consistent with New York state restrictions and guidance. Participation of the CCN Workforce Manager in state and regional PPS workforce meetings, monitoring guidance from the State Education Department, dialog through on-line DSRIP workforce forums is essential to stay informed about evolving guidance on this and other newly emerging titles.

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Mid-Point Assessment Recommendation #4 (2.d.i: Implementation of Patient Activation Activities): The IA recommends the PPS develop a strategy to assist partners in better identifying the targeted population for this project.

Risk Score: 3. **Project Risk to PPS Successful Implementation:** Patient Engagement of targeted population

PPS Action Plan Narrative:

Central to the success of Project 2di is the identification of the target population of Uninsured (UI), Low-Utilizers (LU) and Non-Utilizers (NU) to whom the PAM survey is to be administered and subsequent activation activities implemented. Feedback from partners indicate confusion around services qualifying Medicaid members as Low-Utilizers (LU) and Non-Utilizers (NU) and difficulty locating "hotspots" where Uninsured (UI), Low-Utilizers (LU) and Non-Utilizers (NU) frequent.

The strategy to assist partners in better identifying the target population includes:

1. **Educate and clarify for partners the NYS DOH definition** of a UI, LU and NU so partners can broaden their outreach efforts to all uninsured and Medicaid members who meet the DOH definitions. Given the importance of a clear and correct understanding of the target population, CCN Project Manager, Emily Balmer has informed partners of the correct interpretation of the DOH definitions. Other steps to ensure partners understand the DOH definition of the target populations include:

    a. Hold a focused educational session with 2di contracted partners to educate and clarify the DOH definition and explore other issues related to project implementation. A reference handout defining the UI, LU and NU and clarifying populations that have raised questions for persons administering the PAM survey will be distributed to all partners contracted for 2di and all persons doing the PAM screening.
    b. Modify CCN's pre-screening tool to align with the NYS DOH definition of a UI, LU and NU. CCN used a paper pre-screening questionnaire of four questions to help partners identify the target population of UI, LU and NU prior to the PAM survey being administered. The brevity of the pre-screening tool inadvertently misleads PAM surveyors to exclude persons eligible to be screened. The pre-screening questionnaire will expand to align with the NYS DOH definition of a UI, LU and NU and clarify the application of the definitions to specific groups (e.g. Medicaid members receiving prenatal services). Additionally, restructuring the questions will facilitate patients understanding of what is being asked. For example; instead of "Doctors Office" as a choice, re-phrasing to "Primary Care Provider" is intended to better capture the variety of settings in which a patient sees a provider. The addition of services such as "perinatal visits", "walk-in" and "health-screening" will help target not only the population the organizations serve, but also capture those who would qualify for the PAM survey who were previously excluded.

2. **Assist partners in identifying locations** where the UI, LU and NU frequent (e.g. County Social Service offices) and facilitate connections between agencies to reach the target populations. Outside of their own organizations partners need assistance to identify and develop relationships with other organizations that interact with the target population and either are not participating in Project 2di or can benefit from assistance from another partner to reach their whole eligible target population. The Regional Performance Units (RPUs), with their knowledge of local organizations, are positioned to identify locations frequented by the UI, LU and NU populations and optimize partner collaboration and

outreach activities beyond the population they serve to locations with high concentrations of the targeted population.

3. **Utilize claims data to determine the UI, LU and NU for our partners**. Using claims data allows CCN to directly align with NYS DOH definition of a LU and NU and remove the barrier of our partners in identifying the target population. CCN data analytics staff will be able to give a list of patients who are attributed to the partner, qualify for the PAM survey, and would allow the partner to have a set cohort of patients to survey and work with on coaching for activation. The sharing of such information will comply with HIPPA safeguards to protect patient confidentiality. In February, CCN hired an analyst. CCN is recruiting for additional analysts. Additionally, a process to share PHI information with partners is under development.

4. **Track the status of Project 2di implementation at weekly RPU meetings.** Given the difficulty in getting this project moving forward, tracking the status of implementation for 2di will be a priority at weekly RPU meetings. This will allow the RPU to highlight the progress, identify the issues and most importantly seek immediate resolution pf obstacles to on-boarding this population and engaging them in their health care.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

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Mid-Point Assessment Recommendation #5 (2.d.i: Implementation of Patient Activation Activities): The IA recommends the PPS develop a plan to increase outreach and education materials to partners with respect to patient activation measures.

Risk Score: 3. **Project Risk to PPS Successful Implementation:** Partner Engagement

PPS Action Plan Narrative:

The success of CCN in meeting the goals of DSRIP requires patients to be actively engaged in their own health plan and decisions. The focus of CCN has been on administering the PAM survey. The PAM survey measures the level of patient activation but is only the first step in engaging patients fully. Partners need to aggressively screen the Uninsured (UI), Low-Utilizers (LU) and Non-Utilizers (NU) population while expanding the use of activation measures to increase patient engagement.

CCN identified the development and initiation of training for organizations' staff likely to be tasked with administering PAM surveys and implementing activation measures (e.g. scheduling and in-take staff) as a barrier to execution of both PAM surveys and activation measures. Education of partners with respect to patient activation measures is a critical step for activation measures to be used effectively.

Activities to broaden partners understanding and use of both PAM screening and activation measures as tools for engaging Medicaid members in their health care include:

1. **Create opportunities to share best practices**. Connect organizations both within the PPS and from other PPSs that have successfully screened Medicaid members and utilized activation measures to engage the Medicaid members with organizations that have cited difficulties in integrating 2di activities into their work flow. These connections and cross sharing will serve to inspire CCN partners to find creative solutions for identifying the target population and readjust workflows to incorporate survey and activation measures into other position responsibilities. The knowledge gained from organizations with successful 2di activities needs to be leveraged to optimize patient engagement.

2. **Expand pool of Master Trainers** Expand both the use of the twelve Master Trainers within the PPS and the number of available Master Trainers across the PPS for in-person trainings using the materials from Insignia Health. A sufficient number of Master Trainers and full utilization of the Master Trainers available is necessary to reach the threshold number of staff within partner organizations needed for full project implementation.

3. **Create training modules for various types of workers**. Different types of health care workers such as clerical, nursing, case management support and physicians have unique opportunities for initiating patient activation measures. Thus, training modules targeting different types of workers can be tailored to aid an understanding of how patient activation measures can be used and incorporated into the workers' job responsibilities and workflow.

4. **Analyze opportunities to integrate** the PAM survey and activation measures into other projects such as Disease Management and Behavioral Health. The use of PAM screening and activation ideally does not occur in isolation of other patient contact events. Opportunities to involve Medicaid members in PAM screening and perform activation measures exist within other projects. Attention is needed to demonstrate the integration of 2di activities within the other projects.

5. **Increase funding** to adequately cover the true cost of performing PAM surveys and implementing activation measures. Funding provided to the partners must account for expenses incurred in the course of engaging in 2di activities. The types of expenses that were underfunding include travel, time to manually input survey data, consultations with providers, and mentoring of staff in other organizations. Partners have been vocal about the underfunding which has been addressed for recent activities and will be incorporated in funding plans for Phase 2 contracting.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

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Mid-Point Assessment Recommendation # 6 (2.d.i: Implementation of Patient Activation Activities): 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.

Risk Score: 3. **Project Risk to PPS Successful Implementation:** Partner Engagement

PPS Action Plan Narrative:

Physician engagement is a key component of the establishment of a relationship between physicians and uninsured persons or non-utilizing/low-utilizing Medicaid patients as they are screened and activation measures are initiated to increase involvement of the target population in their own health care.

The recommendation to address the shortage of primary care physicians for this project is, in part an artifact of CCN reporting in PIT engagement only at the entity level vs. both at the entity level and the provider level. CCN provided an updated PIT file with engagement included at the entity and provider levels as part of the report submitted January 30, 2017. Nevertheless, CCN acknowledges that more needs to be done for CCN to meet speed and scale targets (PAM Surveys) but, more importantly, to cultivate physician willingness to incorporate 2di project activities into the workflow of their practices.

The five health care systems within the PPS have legal ties to the majority of primary care physicians within the PPS. Thus, access to the primary care physicians, for the most part, must be mediated through the health care systems. Each Chief Executive Officer of each of the health care systems is on the CCN Board of Directors. Leveraging this relationship will result in greater engagement of primary care physicians within their systems. Funding to promote practice transformation and support physician involvement in PAM and activation measures is another critical element to enhancing primary physicians' engagement. Further, work by CCN directly with primary care physicians to educate the physicians about and reinforce the 2di activities that need to occur in their practices complete the steps necessary to generate the requisite physician engagement for this project.

The specific actions for addressing the shortage of primary care physicians for this project includes:

1. **Utilize relationships with healthcare systems** leaders to reach physicians within their organizations and facilitate primary care physician involvement. Leveraging the relationships involves several interrelated activities among them:
    a. Create a mechanism for reporting involvement of primary care physicians to each health care system leader.
    b. Identification of barriers and resistance to project implementation from the primary care physicians.
    c. Identification of health care system attributes that impede primary care physician involvement in 2di
    d. Develop strategies to overcome barriers and mitigate causes of resistance to project participation
    e. Align the work of community based organizations in acquiring the PAM score and initiating activation measures with primary care physician practice to whom the patient is going to seek care

2. **Adjust the funding methodology** to promote practice transformation and to support primary care physician engagement. Funding thus far was developed to compensate for

the completion of a PAM survey without taking into account the practice transformation that needs to occur as a result of capturing a PAM score. Physicians are not administering PAM surveys and therefore had no incentive to incorporate PAM scores and the follow-up activity needed to engage patients in their own self-management goal development. A broader view of what activities need to be funded to support success of 2di is a major step toward practice transformation.

3. **Develop a process for connecting the PAM score with a specific physician.** Acquisition of the PAM score is the first step in engaging the Uninsured (UI), Low-Utilizers (LU) and Non-Utilizers (NU) population. Follow-up activation measures need to be used to move the Medicaid member toward full engagement in their health care. Community Based Organizations can obtain a PAM Score and initiate activation measures but ultimately the Medicaid member needs to be connected to a primary care physician for follow-up activation measures and health care. CBOs do not necessarily work directly with physicians or a Medicaid member might not have a primary care physician to whom the CBO can share PAM scores. This renders collection of the PAM score a meaningless exercise. Developing the link between the person who obtains the PAM score and the physicians who will utilize the score is critical to engaging this population.

4. **Provide training to primary care providers** on use of the PAM score, coaching for activation and, specifically, their role of establishing self-management goals for patient centered care. Master trainers working with the Workforce Manager and Project Manager will develop targeted training for physicians to inform physicians how they can support PAM survey and activation measures within their practice and to educate the physician about their specific role in 2di project implementation. This should mitigate lack of clarity about the intent of the project, concerns about the lack of time to integrate patient engagement activities into their practice and confusion about the physicians' role in 2di.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

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For each of the recommendations we have provided a narrative outlining how the PPS has addressed or plans to address each particular Mid-Point Assessment Recommendation. This narrative will clearly articulate:

- Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation,
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Mid-Point Assessment Recommendation #7 (3.a.i: Integration of primary care and behavioral health services): 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.

Risk Score: 3. **Potential Risk to PPS successful implementation:** Patient Engagement, Partner Engagement

PPS Action Plan Narrative:

When CCN began this project, the assessment indicated that implementation of Model 1, the integration of behavioral health into primary care would be the preferred model for most partners in CCN with a more limited number of primary care providers being integrated into existing behavioral health practices under Model 2. CCN took advantage of the opportunity to gain more insight into the implementation of Model 1 by engaging one of the Our Lady of Lourdes Memorial Hospital primary care sites to work with the MAX Behavioral Health Integration into Primary Care pilot.

The concerns expressed about low partner engagement in the Midpoint Assessment prompted CCN to conduct a listening tour with partners across the PPS, the PAC and project leads to determine the factors that led to poor performance and weak partner engagement. The input from the partners identified two primary issues:

1. A significant performance gap between contracted commitments and actual qualified events. Contracted performance is 22,223 while actual performance is 2,574, and
2. Partner engagement, as viewed through current partners contracted for this project, is not balanced across the four RPU's

CCN has identified the following strategies to reduce the risk of project failure:

1. **Identification and removal of barriers and resistance to implementation:** The IA midpoint assessment identified the need for a specific plan to address the shortfall of primary care physicians engaged in the project in order to meet project speed and scale commitments. The initial barrier that partners identified involved project data reporting requirements. CCN has taken action to suspend the submission of data beyond the minimal data set. This led to a significant jump in reported speed and scale commitments from partners currently contracted. Focused meetings with contracted partners who were underperforming in contract commitments continue on a weekly basis to identify the work flow issues with this projects.

   Insight into resistance to project implementation was evident in the MAX pilot which highlighted a need for ongoing education to assist providers in understanding the importance of care integration for these Medicaid members and the positive impact on patient outcomes that is realized with improved patient management. CCN will implement learning collaboratives organized at the RPU level based on the lessons learned in the MAX pilot to facilitate the physician engagement and adoption of tested work flow strategies for partners.

2. **Create a funds flow methodology for practice transformation to increasing screening in PCMH sites:** During project design, most PCP practices in CCN indicated they were performing some type of behavioral health screening during the annual wellness visit. The project team did not realize that in many instances non-standardized assessment tools were being used and documentation of the screening was not in place. This lack of consistency in screening practice and documentation meant that many

practices would need to introduce a new tool, changes in work flow and a protocol for documentation of the screening and any resulting referral. This introduced potential new expenses for the practice which was not included in the funds flow methodology for this project. In response to these concerns, the Funds Flow methodology will be adjusted to provide upfront funding for a portion of contracted commitment of project speed and scale to accommodate the costs of new materials and workflow changes. These changes will be shared at the RPU meetings by participants in the MAX pilot and individually with primary care partners through the contracting process.

3. **Identify guidelines for Clinical Depression Screening and follow up:** The CCN listening tour also revealed significant confusion surrounding the requirements of behavioral health screening. The relatively narrow guidance of acceptable screens and needed documentation limited partner engagement and project performance.

   This situation was presented to the CCN Clinical Governance Committee (CGC) for their attention and action. As a result, the CGC adopted and communicated guidelines for the use of age appropriate screening tools. In addition to the PHQ9, the CGC adopted the PHQ2, as well as any other evidence based age appropriate screening tools. The CGC also provided detailed guidance for the required documentation elements.

   CCN project leadership, partner relations and RPU Network leadership will assist in the communication of the significant changes related to the project to encourage broader partner engagement.

4. **Increase partner participation to better support the project:** The additional staffing resources through the RPUs will be used to continually work with partners who are not engaged in the project as well as tracking patient engagement the performance and the project quality measure set. The RPUs will monitor contracted status and pursue ongoing action plans to assure the accomplishment of project requirements.

5. **Foster a greater understanding of rationale for integration of primary care and behavioral health:** In meeting with partners it became apparent that there was some combination of cultural resistance and a general lack of understanding of how to implement the overall integration. CCN will assure that learning collaboratives are held to share the insights from MAX pilot which has resulted in an adaptable model for project adoption and expansion.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

For each of the recommendations we have provided a narrative outlining how the PPS has addressed or plans to address each particular Mid-Point Assessment Recommendation. This narrative will clearly articulate:

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Midpoint Assessment Recommendation #8 (3ai: Integration of primary care and behavioral health services): The IA recommends the PPS develop a plan to address the workforce challenges with licensed behavioral health specialists and care coordinators.

Risk Score: 3. **Potential Risk to PPS successful implementation:** Patient Engagement, Partner Engagement

PPS Action Plan Narrative: At the core of workforce challenges with licensed behavioral health specialists and care coordinators are several interrelated circumstances. Not unlike other areas of New York, the nine- county region of this PPS faces a severe shortage of licensed behavioral health specialists. The PPS also has a moderate shortage of care coordinators which is expected to accelerate as care coordination activities increase across several projects. Compounding the shortages are a variety of factors that include:

- the primarily rural nature of the PPS
- compensation and benefits packages that lag behind other areas of the state
- the perceived undesirability of living in the central and southern tier
- educational programs that are not graduating sufficient numbers of licensed behavioral health specialists
- lack of standard requirements, licensing requirements and/or job descriptions for persons hired to work as "care coordinators"
- absence of transdisciplinary curriculum to prepare persons to work in an environment of changing or new expectations of work responsibilities

This list is not necessarily all inclusive; nor is CCN unique in experiencing the workforce challenges created by these and other factors. However, it is incumbent on CCN to find solutions to workforce challenges with licensed behavioral health specialists and care coordinators tailored to the specific resources of this region and the needs of the population being served.

The workforce challenges are both short-term and long-term. The short-term workforce challenge is explained as a shortfall in key job titles, especially licensed behavioral health specialists. Initial thoughts that the redeployment of workers from the acute care setting to the community setting might help alleviate this problem. Within the larger organizations there is some potential to shift personnel from acute care to their outpatient services but this is limited. The Compensation and Benefit Analysis confirmed the PPS is experiencing personnel shortages in key job titles needed for 3a.i. (integration of primary care and behavioral health) success. Standard measures to reduce or eliminate the shortfall in personnel include measures such as increasing compensation packages, recruitment bonuses, bonuses for staying with an employer for a specified period, loan forgiveness, referral bonuses and specialized work schedules (e.g. three-day weekend work obligation for full pay and benefits). These measures meet with mixed success. Nevertheless, CCN can assist partner organization with recruitment efforts and information to help partner employers design attractive benefits packages to help partners be competitive in recruiting the needed workforce.

The longer- term effort to address workforce challenges revolves around education and training persons in sufficient numbers to meet the demand for staff. The path for education of licensed behavioral health specialists is established. Enticing these graduates to remain in the CCN region with competitive benefits packages, adequate supports (e.g. internships) requires building an educational pathway that leads itself to the expectations for these titles under DSRIP. For unlicensed titles, such as care coordinators, efforts need to be targeted to regional higher education curriculum development that supports the appropriate training and skill development that employers need to augment their current workflow and staffing to accomplish project goals.

Neither the short-term or long term activities are quick fixes to the workforce challenges. CCN can take additional steps to maximize the work that can be accomplished with the available number of licensed behavioral health specialists and care coordinators. Specifically, CCN can work with partner organizations to examine job descriptions/workflow processes and provide information about scope of

practice/licensing requirements to assist partners to realign work activities so licensed professionals are working at top-of-license and activities that can be delegated to a position that can more easily recruit staff and still provide quality, affordable health care. This systematic examination both within an organization and across CCN partnering organizations has the potential for optimizing service delivery even in the face of significant shortages in licensed behavioral health specialists and care coordinators.

Identification of factors that generate workforce challenges with licensed behavioral health specialists and care coordinators across CCN serve to inform a plan to address the workforce challenges with licensed behavioral health specialists and care coordinators. The plan includes both short-term and long term strategies and includes:

1. **Develop a recruitment strategy to address the shortage of licensed behavioral health specialists across the PPS.** Developing a thoughtful, coordinated, effective recruitment plan to assist partners can attract licensed behavioral health specialists and care coordinators to the CCN region. Inherent in this approach is the need to examine creative approaches (e.g. internships or mentoring programs, alternative schedules, etc.) that are sought after as novice or experienced workers make employment decisions. Examining opportunities such as HPSA offerings is also a part of this strategy.

2. **Provide partner organizations who employ licensed behavioral health specialists with compensation and benefit information, job descriptions and other information.** Assisting partners to appropriately utilize and compensate health care professionals, particularly those in short supply, will help partners to recruit, retain and optimize the productivity of staff.

3. **Advise partner organizations about scope of practice and licensing requirements of various licensed behavioral health specialists to assist partners to realign workflow activities with available staff in an effort to optimize service delivery.**
   Health care organizations have informally and of necessity shifted work responsibilities when personnel shortages drive a realignment. The magnitude of the shortage in licensed behavioral health specialists and care coordinators as CCN seeks to implement three behavioral health projects and ties integration of the health delivery network to care coordination demands a systematic review and realignment of job responsibilities and adoption of new titles such as health coach. The identification of options to substitute persons with different educational preparation for specific mental health services (e.g. BS in Psychology) or care coordination (e.g. BS in Social Work) while respecting scope of practice mandates may open a pool of candidates to help alleviate the shortages of licensed behavioral health specialists and care coordinators.

4. **Collaborate with regional and statewide efforts to accelerate the education of licensed behavioral health specialists and track solidified requirements for care coordinators.** CCN will engage with other PPS, SUNY, AHECS and other organizations working on educational offerings, licensing requirements and other aspects of the healthcare workforce shortages in New York. DSRIP is not the only initiative that is driving changes in the healthcare workforce so it is necessary for CCN to stay informed about the broader efforts to addresses evolving curriculums, new job titles and other components that impact the training and supply of health care workers.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

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Mid-Point Assessment Recommendation #9 (3.b.i: Evidence-based strategies for disease management in high risk/affected populations (adult only)): The IA requires the PPS develop a comprehensive action plan to address the implementation of this project in consultation with the Project Advisory Committee (PAC) that must be reviewed and approved by the Board of Directors. This Action Plan must detail how the PPS will monitor and intervene when project milestones, partner engagement, or patient engagement for this project fall behind schedule.

Mid-Point Assessment Recommendation #10 (3.b.i: Evidence-based strategies for disease management in high risk/affected populations (adult only)): The PPS should develop a strategy to educate their partners on the value of DSRIP in order to increase their engagement.

Mid-Point Assessment Recommendation #11 (3.b.i: Evidence-based strategies for disease management in high risk/affected populations (adult only)): To address the issue of partner reluctance to participate in this project due to perceived lack of reimbursement, the PPS should develop creative strategies, either in the form of services, consultation, or work with a vendor to assist the PPS in this outreach.

Mid-Point Assessment Recommendation #12 (3.b.i: Evidence-based strategies for disease management in high risk/affected populations (adult only)): In order to address the issue of identifying targeted panels of patients eligible to be included in this project, the IA recommends that the PPS convene a group of stakeholders to develop a strategy to develop common solutions.

Risk Score: 4. **Potential Risk to PPS successful implementation:** Patient Engagement, Partner Engagement

PPS Action Plan Narrative: The IA in the Mid-Point Assessment report indicated the PPS did not meet patient engagement targets (no actively engaged was submitted through DY2Q2) and the resulting lag in Partner engagement triggered a higher level of risk related to successful implementation of this project. The partner engagement reflected at the time of the Midpoint in the PIT tool was understated due to reporting engagement only at the entity level versus the provider level. CCN provided an updated PIT file with engagement included at the entity and provider levels on January 30, 2017, but the fact remains there is a significant gap in committed partner engagement.

After receiving the Midpoint Assessment report, CCN conducted a listening tour regarding issues and barriers for partners on the projects. For this project, the two key barriers were a lack of reimbursement and an inability to retrieve documentation from the EMR coupled with insufficient funds to invest in the efforts to be able to retrieve the data.

The comprehensive action plan to monitor and intervene when project milestones, partner engagement or patient engagement fall behind schedule is as follows:

Monitoring: The PPS will report monthly and receive input from the PAC Executive Council on the progress of project milestones, partner engagement and patient engagement for this project.

The PPS will report monthly and receive input from Coordinating Council (group consisting of Project Leads and Subject Matter Experts).

The PPS will develop short term action plans when project milestones, partner engagement or patient engagement fall behind. The action plans will be developed with an identified responsible person, timeline, and PPS funding (where applicable) to support resolution and performance.

CCN Leadership will also report monthly to the CCN Board of Directors on the progress of project milestones, partner engagement and patient engagement along with the short-term action plans to address gaps.

The monthly reporting cycle will assure early intervention and course correction.
Corrective action will be taken when performance lags.

Corrective actions include the development of short term action plans, removal of financial barriers to project implementation, facilitating additional contracting. Education with partners on best practices in project implementation, remediation work with partners, adjudication and action on poor performers. The following strategies support and supplement the actions plan.

1. **Educate partners on the value of DSRIP to increase engagement.** CCN staff will work with leadership of organized physician groups to convene discussion forums directly with physicians. The cornerstone of the value message will be to clearly articulate the goals of DSRIP and how their engagement with the DSRIP program could

facilitate their ongoing efforts with health care transformation. CCN staff will provide training to facilitate documentation and the funds flow for the project. The target date for completing these discussions is April 30, 2017. In order to effectively communicate value-add to partners during these discussions, the Marketing Manager will create electronic materials to be distributed to clinical staff clearly outlining what DSRIP does for them along with the value-add to the provider and support staff. The marketing material will be made available by March 31, 2017. This strategy addresses recommendation #10 for the 3bi project.

2. **Develop a new reimbursement model for this project aimed at increasing engagement of providers.** In order to create a funding model that provides adequate reimbursement for effort, CCN staff need to understand how patient driven self-management goals are handled today by clinical staff. CCN staff will meet with cardiology partners, to understand better what is done with self-management and how providers document this in the EMR. CCN also needs to better understand the level of staffing resource being used in coaching for patient self-management to better match reimbursement with resources. With this information, CCN will develop a revised reimbursement model with adequate funding to stimulate increased provider engagement and patient engagement. This new payment structure would be implemented by September 2017. This strategy addresses recommendation #11 for the 3bi project.

3. **Foster creative partnerships with community based resources for self-management with a customized reimbursement model for these arrangements.**

    a. CCN will identify appropriate self-management services available in the community and facilitate connections between those organizations and the physicians. This strategy addresses recommendation #11 for the 3bi project.

    b. As part of the next round of contracting beginning April 1st, CCN will assist providers in the identification of Medicaid members who are eligible for referral to the Chronic Disease Self-Management Program (CDSMP) workshops. By September 30, 2017, CCN will convene a workgroup and establish a collateral plan to incentivize providers and Medicaid members to refer to the Chronic Disease Self-Management Program workshops when appropriate. CDSMP workshops are offered in the community setting and are intended for people with different chronic health problems and assist with self-management such as learning the appropriate use of medications, techniques to deal with pain and fatigue, appropriate exercise and communicating effectively with people you interact with. This strategy will address all four recommendations (#9, #10, #11, #12) for the 3bi project.

4. **Identify Primary Care Practices in the PPS that manage large panels of CVD patients.** In order to increase patient engagement in the short term, and position CCN for future success in meeting the patient engagement targets in DSRIP Year 3 and beyond, CCN will identify and meet with Primary Care Practices who already serve large

populations of Medicaid members with a cardiovascular disease diagnosis. In three of the CCN RPUs, practitioners are organized into large medical groups exclusively affiliated with a health system partner. CCN staff will leverage leadership of organized physician groups to convene a group of stakeholders consisting of physicians and staff from primary care practices with large patient panels to discuss and communicate the opportunity to earn money for something they already do but are not adequately reimbursed for. CCN has used this approach with other challenges and has had success with this methodology. This strategy addresses recommendation #12 for the 3bi project.

5. **Establish documentation and reporting processes.** With the DY2Q3 report submitted January 30th, CCN submitted actively engaged numbers for this project though the numbers have not met the target for this project yet. CCN has partners who have incorporated the project details into their workflow but have struggled with reporting or retrieving the information from of their systems. Since early January, the CCN IT Project Manager has been meeting with partners challenged with reporting and data extraction in order to understand the issues and assist with IT solutions. With the IT Project Manager, the partners are asked to identify IT barriers as well as IT needs to implement the projects. The partners obtain the quotes for the IT needs and submit the details to CCN for review. CCN will disburse funds to support the IT needs of the partners in project implementation. CCN recognizes that many providers are currently performing the work required as part of this project so the focus is on documentation and reporting processes to retrieve the documented self-management goal information. This strategy will address all four recommendations (#9, #10, #11, #12) for the 3bi project.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

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Mid-Point Assessment Recommendation #13 (3.g.i: Integration of palliative care into the PCMH Model): The IA requires the PPS develop a comprehensive action plan to address the implementation of this project in consultation with the Project Advisory Committee (PAC) that must be reviewed and approved by the Board of Directors. This Action Plan must detail how the PPS will monitor and intervene when project milestones, partner engagement, or patient engagement for this project fall behind schedule.

Risk Score: 4. **Potential Risk to PPS successful implementation:** Patient Engagement, Partner Engagement

PPS Action Plan Narrative: The IA in the Mid-Point Assessment report indicated the PPS did not meet patient engagement targets (no actively engaged was submitted through DY2Q2) and the resulting lag in Partner engagement triggered higher level of risk level related successful implementation of this project. The partner engagement reflected at the time of the Midpoint in the PIT tool was understated due to reporting engagement only at the entity level versus the provider level. CCN provided an updated PIT file with engagement included at the entity and provider levels on January 30, 2017, but the fact remains there is a significant gap in committed partner engagement.

After receiving the Midpoint Assessment report, CCN conducted a listening tour regarding issues and barriers for partners on the projects. For this project, several barriers were identified:

- Lack of clarity about the specific services that are state qualified as palliative care services
- How the project was measured – the change in one of the project measurements in early 2016 caused hesitation by providers to contract for work DOH was in process of changing.
- Lack of an automated way to track palliative care services performed – since Palliative Care is not a reimbursable service for Medicaid, providers do note code the services. Therefore, tracking through a CPT or ICD code is not possible
- Lack of reimbursement – Given the lack of definition of services and the manual process for documenting, the reimbursement model did not sufficiently compensate for the added efforts needed to document services.
- Cultural resistance and misunderstandings around the definitions of palliative care and hospice care – In the course of discussion at the CCN Clinical Governance Committee meeting in late 2015, it was clear there are many clinical staff that are not comfortable initiating discussions with patients regarding palliative care
- Some Palliative Care activities are already organized and performed in settings other than a PCMH practice where PCPs refer to that program. This presents an organizational and cultural barrier in shifting the service to the PCMH setting.

The comprehensive action plan will need to remediate these barriers and include actions to monitor and intervene when project milestones, partner engagement or patient engagement fall behind schedule:

Monitoring: The PPS will report monthly and receive input from the PAC Executive Council on the progress of project milestones, partner engagement and patient engagement for this project. The PPS will report monthly and receive input from Coordinating Council (group consisting of Project Leads and Subject Matter Experts). The PPS will develop short term action plans when project milestones, partner engagement or patient engagement fall behind. The action plans will be developed with an identified responsible person, timeline, and PPS funding (where applicable) to support resolution and performance.

CCN Leadership will also report monthly to the CCN Board of Directors on the progress of project milestones, partner engagement and patient engagement along with the short-term action plans to address gaps. The monthly reporting cycle will assure early intervention and course correction. Corrective action will be taken when performance lags. Corrective actions include the development of short term action plans, removal of financial barriers to project implementation, facilitating additional contracting. Education with partners on best practices in project implementation, remediation work with partners, adjudication and action on poor performers. The following strategies support and supplement the action plan.

In February 2017 CCN alleviated the confusion surrounding qualifying palliative care services by developing a service listing to help participating practices understand what could be considered as a palliative care service. This listing references a clinical guideline documenting ten clinical triggers for PCMH consideration of palliative care

endorsed by the PPS Clinical Governance Committee in late 2015. It also lists some common applications of palliative care services that are being offered and opportunities to increase access to palliative care for members across the PPS. The activities are now clearly defined for partners to engage in this project.

The additional actions CCN will take to continue the progress towards project implementation are:

1. **Establish a clear documentation and reporting processes.** As of February 2017, CCN has started working with sites to create tracking CPT codes within their systems. These are already in place in all the medical systems financial systems and their billing coders are already trained on the appropriate use of a tracking CPT code. Tying together what they already do in their system for other initiatives and financial tracking helped to alleviate the perceived burden of tracking a currently non-reimbursable service.

2. **Establish a clear articulation of Palliative Care and Train clinical staff on that definition and the use of eMOLST**. Palliative care construes hospice care in the minds of many PCPs which presents a barrier to participation in this project. Many PCPs are uncomfortable having such discussions. The PPS has entered into a contract with The Center to Advance Palliative Care (CAPC) for access to the CAPC interactive website. The project team has identified specific modules within the CAPC Learning Module Library that are required elements to complete while actively participating within the 3.g.i project. These learning modules will give PCPs and other clinical staff in the PCMH setting a starting point in the integration of palliative care. CCN will work with PCP and Hospice partners to complete the CAPC training by September 30, 2017.

3. **Standardize project implementation with overlapping PPSs.** CCN is also working with the Leatherstocking PPS to identify opportunities in the overlap with the East RPU (Chenango and Delaware counties). Through this standardized baseline the PCP sites will be educated on how to better determine the need to refer a member into a community based palliative care service provider and what the member and PCP could expect in care and support from the community based palliative care service provider. CCN expects to have this standardized baseline available by June 30, 2017.

4. **Reduce Cultural resistance through knowledge sharing** There are additional pilot projects being worked on across the PPS. The North RPU, through the MAX program with Cortland Regional Medical Center (CRMC) is participating in the reduction of Inpatient Hospital Admissions for super utilizers. During the first MAX workshop held in Albany on February 9th, 2017, the action team from CRMC identified the need to have a better working relationship and integration of palliative care as many of their high utilizers for inpatient admissions should be receiving more robust palliative care services. MAX will focus on the hospital portion and the action team's plan is to build up a relationship with the community based palliative care support, Hospicare and Palliative Care Services of Tompkins and Cortland County. However, the CCN Project Manager working with the action team is pro-actively working on engaging Regional Medical Associates, the medical group governed by CRMC, as the tie back to the PCP to continue palliative care as this will be essential in CRMC meeting their reduction of high utilizer admissions. Separate from this, another pilot has evolved in the West RPU resulting from a PPS innovation fund award awarded in 2016 involving Guthrie Health System and CareFirst, the community based palliative care support for Steuben, Schuyler and Chemung counties to help integrate palliative care in that region. Guthrie held an internal action meeting with their physicians and administration in January 2017 and are in process of formalizing the start of a pilot to aid in education of PCPs within the PCMH settings, tying back to inpatient palliative care assessments, hospital discharges, better education and support through the PCP and utilization of the community based palliative care support services.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

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Mid-Point Assessment Recommendation #14 (3.g.i: Integration of palliative care into the PCMH Model): The IA recommends that the PPS finalize its contracting arrangements with their partners and begin flowing funds.

Mid-Point Assessment Recommendation #15 (3.g.i: Integration of palliative care into the PCMH Model): To address the issue of partner reluctance to participate in this project due to perceived lack of reimbursement, the PPS should develop creative strategies, either in the form of services, consultation, or work with a vendor to assist the PPS in outreach.

Risk Score: 4**. Potential Risk to PPS successful implementation:** Patient Engagement, Partner Engagement

PPS Action Plan Narrative:

To incentivize provider engagement in this project, the Care Compass Network Board of Directors approved a funding incentive for the Palliative Care project on February 14, 2017. Initially the reimbursement model allowed for payment of $25 per palliative care service provided by a Primary Care Physician (PCP) within a PCMH setting (or a site with a roadmap of achieving PCMH 2014 level 1 by March 31, 2018). The Board of Directors approved increasing the reimbursement at an enhanced rate of $500 per unique Medicaid member receiving palliative care services at the PCP within a PCMH to stimulate an accelerated and rapid implementation.

With the one-time funding incentive, service listing and a newly created tracking CPT code, many practice sites have quickly activated the contracting process for this project. On February 20, 2017, United Health Services Hospitals, Inc., one of the largest medical associations within the PPS having 30 practice sites currently undergoing PCMH 2014 Level 3 certification, agreed to payment terms for the Palliative Care project and are reviewing their data to better create a system for tracking the project elements. They have committed to at least 250 actively engaged members for this project by March 31, 2017. Guthrie Health System, Our Lady of Lourdes Memorial Hospital, Inc and Family Health Network have also finalized contracts for this project. As of early March 2017, the three largest medical groups in the PPS are implementing this project. Together, a total of 64 sites are engaged and the patient engagement targets for this project are achievable by the end of DSRIP Year 2. In addition to these sites, Cayuga Medical Associates and several independent practices across the North RPU (Cortland, Tompkins and Schuyler Counties) are in active discussion with the PPS to contract for this project as well. As a result of all of this activity CCN expects to distribute approximately $225,000 in DY2Q4 just in patient engagement activity, in addition to funds distributed to hospice organizations also participating in the project. In addition to the new structure in the reimbursement model, CCN will need to incent and support the enhancement of palliative services beyond an initial screening and conversation with the patient.

The actions CCN has implemented above address both recommendations #14 and #15 for the 3gi project. The additional actions CCN will take to continue progress towards project implementation are:

1. **Develop a New Reimbursement Model.** With the aggressive response to the incentive, the start-up hurdles with this project have been overcome. In Phase 2 contracting beginning April 1, 2017, CCN will need to articulate a funds flow for start-up and a funds flow for ongoing project engagement.

2. **Offer Provider Learning Collaboratives** To overcome the cultural barriers in this project, CCN will convene a learning collaborative among its engaged providers and community based organizations with expert consulting support to help providers develop the skills and competencies to engage in deeper educative and supportive conversations with patients and help patients recognize and value palliative services.

3. **Develop a Network of Palliative Care Services** CCN will facilitate the development of a complimentary care network of palliative services for providers to use with their patients when engaging them in palliative care.

4. **Implement a Communications Strategy with Patients** CCN will engage its communication and marketing team to develop a strategy to open Medicaid members up to using palliative services as an extra layer of support in dealing with serious illnesses.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

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Mid-Point Assessment Recommendation #16 (Community Based Organization Contracting): The IA recommends that the PPS accelerate finalizing contracts with its partnering Community Based Organizations in order to fully implement projects.

PPS Action Plan Narrative:

The observation made by the IA in the Mid-Point Assessment report indicated the PPS had contracted with several but not all Community Based Organizations (CBOs) and the PPS would be contracting with and compensating the CBOs with its contracts however, funds flow has been limited. To date contracting has proceeded at a slower than expected rate and funds flow to CBO's has lagged. Full project implementation as well as integration of a health care delivery system is contingent on active participation of organizations that fit the DOH CBO Tier 1 classification of non-profit, non-Medicaid billing community based social and human service organizations.

CBOs cite two factors that account for their reluctance to contract with CCN. A listening tour conducted by the Director of Operations in February and feedback obtained in other forums clarified some of the concerns CBOs had in contracting with CCN. The first concern is a perceived issue with receiving payments from CCN for activities that are already funded from a different entity through another mechanism (usually a grant). In discussions with CBOs who voiced this concern about "double dipping", CCN was success in contract modifications that tailored reimbursement to activities that were not being compensated yet still advanced CBO participation in CCN and project goals. The one-on-one discussions between CBOs and CCN that delineates each CBOs uniquely based reluctance to contract and seeks to find innovative ways to address those concerns needs to be and will be accelerated.

The second concern is a disconnect between the adequacy of funds flow to the CBOs with their actual costs of participation in CCN activities. CCN has already taken steps to rectify this by 1. retroactively increasing funds flow to CBOs by removing some barriers to reporting project activities which effectively allow CBOs to report increased reimbursable activities (completed February 17), 2. prepayment of contracted amounts to give CBOs more flexibility in covering their costs and 3. allocating up to $1.4 million for speed and scale bonus payments whereby CBOs could receive up to an additional 60% above the contracted rate. These additional payments were approved by the CCN Board of Directors on February 14, 2017**.** Feedback from CBOs is being used to inform the development of a modified fund flow methodology for the Phase 2 contracting scheduled to be in place April 1, 2017

CCN identified two contracting objectives. First is a short term objective for CCN to accelerate finalizing contracts with its partnering Community Based Organizations. Second is a longer-term objective of ensuring optimal contractual relationships between CCN and CBOs and also between CBOs and other partner organizations. To these ends, CCN will:

1. **Create solutions** to address contracting barriers. There are two aspects to this step. First is to tackle head on delays in meeting with CBOs to seek resolution of contracting barriers. A contracting team dedicated to an aggressive schedule to meet with each CBO to identify contracting barriers and explore innovative solutions to resolving the barriers is needed. The second aspect is generating contract language modifications tailored to the unique needs of each of the CBOs. Responsible Person: Bruce Leroy. Target Date: April 1, 2017.

2. **Adjust financial payments** to reflect the full range of CBOs participation in CCN. Funds flow was premised on payments to CBO's for specific activities in furtherance of project implementation. This failed to account for all the types of ways a CBO may participate in CCN or for the expenses actually incurred because of the CBO participation. Committee participation, attendance at PAC, infrastructure changes needed at an organization, lost productivity are some examples of costs the CBOs experience as a result of participation in CCN and for which reimbursement is needed. Responsible Person: Bob Carangelo. Target Date: April 1, 2017.

3. **Facilitate collaboration between CBOs.** CBOs are struggling to understand and integrate new funding methodologies into the financial sustainability plan for their organization. The CBOs are mission-driven, focused in their activities and often times financed piecemeal from a number of sources. CCN has, through meetings and on a case-by case basis, answered questions, provided speakers and offered guidance on a range of issues around the implications of DSRIP involvement for the CBOs. This effort will be expanded to include support as CBOs examine their mission, financial status, skills/competencies and the implications of contracting with CCN.

   Beyond this support, CBOs need resources to help them define their relationships with other CBOs and the major health care systems so they can function effectively as part of an integrated delivery network and secure the contractual and financial arrangements that ensure their future viability in a transformed health care delivery system. CCN has a major role in facilitating collaboration between partners and can achieve this objective through fully functioning Regional Performance Units. One of the major functions of the RPU is to assess regional capacity for project implementation and identify gaps in functionality (e.g. care coordination) and partners that might fill those gaps. CCN staff responsible for operationalizing the RPUs have relationships with representatives from CBOs, possess knowledge of the operations of each of the individual CBOs and understand the skills/competencies a CBO can bring to project implementation. Thus, the RPU is positioned to link CBOs who possess needed skills/competencies with health care systems that need assistance with additional capacity to meet targeted goals. Responsible Person(s): RPU leads Greg Rittenhouse (South and East); Joe Sexton (North); Robin Stawasz and Josie Anderson (West). Target Date: June 30, 2017.

4. **Explore the real or perceived legal and/or financial impediments to contracting and seek innovative solutions to addressing those issues.** The basis for CBO reluctance to contract must be adequately articulated in order to move forward to craft contract language that is acceptable to CBOs, respects funding restrictions imposed on CBOs from other funding sources and allows for CBO participation in CCN activities and projects. This reluctance must be actively identified and mitigated to enhance CBO engagement. Responsible Person(s): Provider Relations in conjunction with legal counsel. Target Date: on-going especially with the implementation of Phase 2 contracting scheduled to begin April 1, 2017.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

For each of the recommendations we have provided a narrative outlining how the PPS has addressed or plans to address each particular Mid-Point Assessment Recommendation. This narrative will clearly articulate:

- Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation,
- Timeline for actions,
- How the PPS will track progress in executing the actions, and
- How these actions reflect the PPS overall strategy for meeting its DSRIP goals.

Mid-Point Assessment Recommendation #17 (Cultural Competency and Health Literacy):
The IA recommends that the PPS develop an action plan to roll out its trainings to its workforce and partners.

PPS Action Plan Narrative: The observation made by the IA in the Mid-Point Assessment report indicated the PPS has developed a training strategy, but the PPS appears to have taken limited steps toward implementation of the strategy.

There are two factors that drive the adequacy of CCHL within a PPS for the intent of this requirement to be met and for CCHL to serve as a foundation for minimizing or, ideally, eliminating health care discrepancies. The first factor is whether CCHL training is being done. The second factor is the adequacy of the training - specifically is the content appropriate for the population being served.

Many of the organizations within the PPS, particularly the health care systems, FQHC and some of the larger community based organizations, require employees to complete CCHL training often on an annual basis. For partners that do not currently require employees to complete and CCHL, CCN needs to offer the CCHL training that is in current use at other partner organizations or is available from another source.

The focus of the CCHL training is to develop health care workers understanding and sensitivity to the characteristics of the population being served that could adversely impact the provision of health care absent such awareness. The Community Needs Assessment completed for the initial DSRIP application identified three characteristics of the population across the nine- county region that need to be incorporated into Cultural Competency and Health Literacy training in CCN. The three characteristics that define much of the population are an aging population, a largely rural population, and a population of low socio-economic status.

In 2015, The CCN Cultural Competency and Health Literacy (CCHL) committee devised a checklist of required elements that an adequate CCN CCHL training must include for overall cultural competency and health literacy in each organization. The CCHL committee reviewed training from several of partner organizations and found the training failed to address the three characteristics prevalent in the geographic area of CCN. CCHL training was and is being conducted at many of the partner organizations. However, the training was deficient in some key elements. CCHL attempted to identify CCHL training that addressed an aging population, a largely rural population, and a population of low socio-economic status. Unable to identify suitable training a different approach was adopted to obtain CCHL training modules specifically addressing the characteristics of the population identified in Community Needs Assessment.

In late August 2016, CCN released an RFP for Cultural Competency and Health Literacy Training modules that would supplement the type of CCHL training in use in partner organization. In October 2016 received two proposals for each of the four modules. The proposals were reviewed during December 2016 and January 2017.

To fully implement the CCHL training strategy, CCN must ensure training in CCHL is being conducted in all partner organization and finalize supplemental modules that address the characteristics of the PPS population. The following steps will ensure training is being accomplished and the training addresses the characteristics of the population within the PPS:

1. **Identify partners that do not provide or require training in CCHL for their employees.** Health care disparities are a systemic problem. A partial approach that requires some, but not all health care workers to complete CCHL signals a lack of commitment to establishing culturally sensitive expectations in the delivery of health care that serves to perpetuate disparities.

2. **Make CCHL training available to all CCN partners**. Lack of resources to develop or purchase, lack of making CCHL a priority in their organization or other reasons that account for a partner's failure to provide and require CCHL does not absolve CCN from the requirement to ensure CCHL is available and training is taking place for all health care workers participating in CCN.

3. **Complete the development of supplemental training modules.** As identified in the Community Needs Assessment, the CCN CCHL training needed differs from some of the more widely recognized factors that contribute to health disparities. Across the PPS there are pockets of people who differ and may experience discrimination because of race, ethnicity, religion, sexual orientation, language or other factors. These cannot be overlooked in CCHL training. But, additionally, advancing age, rural living and low socio-economic status are defining attributes that impact the delivery of health care in this region. The addition of these supplemental modules will improve the quality and appropriateness of the training that is offered to partners.

4. **Make CCHL supplemental training modules available to all CCN partners.** The availability of the supplemental modules is an essential aid to increasing the CCHL sensitivity of health care providers working with a population across the PPS that is aging, largely rural and generally of lower socio-economic means.

This strategy aligns with the achievement of DSRIP goals in that changes in attitudes about cultural competency and health literacy constitute a cultural shift. Due to the nature of these changes and the need for messaging to continue consistently to generate buy-in, the PPS must aim to roll out its trainings as quickly as possible but also ensure that these are not the only CCHL efforts underway as training only begins to change individuals' understanding.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

For each of the recommendations we have provided a narrative outlining how the PPS has addressed or plans to address each particular Mid-Point Assessment Recommendation. This narrative will clearly articulate:

- Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation,
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Mid-Point Assessment Recommendation #18 (Cultural Competency and Health Literacy):
The IA recommends that the PPS develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured.

PPS Action Plan Narrative: The observation made by the IA in the Mid-Point Assessment report indicated it was not clear the extent to which the PPS will be measuring how it is engaging Medicaid members as part of the Cultural Competency and Health Literacy (CCHL) strategy.

CCHL training alone does not guarantee a cultural shift that leads to greater CCHL sensitivity on the part of health care providers and a reduction of health disparities. Thus, simply reporting the number of CCHL completed is an inadequate metric for measuring the success of efforts to infuse understanding and sensitivity to factors that have historically adversely influenced health care delivery.

CCN originally listed the Nathan Kline Institute's Cultural Competency Assessment Survey (CCAS) as a way to measure CCHL efforts. This measure assesses cultural competency by examining the organization and their self -reported assessment of CCHL sensitivity. This approach measures CCHL from the perspective of the provider but not the recipient of care and thus offers some insights but not a complete assessment.

NYS DOH has defined some Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) survey measures as CCHL measures however, in general, the tool was not developed to provide feedback on whether a Medicaid member received care in a culturally sensitive manner. Thus, additional metrics related to effective strategies to engage Medicaid members and the uninsured are warranted.

CCN used information gained through a survey conducted on CCN behalf by RMS to learn more about CCHL issues in this region. Survey results help the CCN CCHL Committee to develop the training strategy. This resource is available to help develop metrics and test the relevance of any tools used to measure strategies to engage Medicaid members.

The process CCN is establishing to develop metrics to assess the most effective strategies to engage Medicaid members and the uninsured are:

1. **Convene a CCHL work group tasked with the responsibility for developing metrics**. A dedicated workgroup with a defined outcome expectation will be most effective in identifying and developing metrics to assess the most effective strategies to engage Medicaid members and the uninsured. The composition of the workgroup will be drawn from CCHL committee members as these persons have the knowledge and exposure to measuring CCHL efforts to quickly identify appropriate metrics and representatives from partner organizations to promote buy-in of efforts to assess CCHL efforts.

2. **Develop a process for using the metrics**. The metrics alone are not sufficient if partners stumble on a process for using the metrics in their organization. Data collection, review of the metrics, remediation measures needed and other logistical factors to move from information only to actionable plans to improve CCHL will need to be addressed through the CCHL Committee with feedback from partner organizations.

3. **Accelerate use of the Nathan Kline Cultural Competency Assessment Survey (CCAS).** The intent of this effort is to baseline partner organization cultural competency and health literacy at the organizational and programmatic level to measure change over time during the DSRIP waiver period and inform additional CCHL initiatives as needed. The CCAS, in conjunction with metrics aimed at assessing effective strategies for engaging Medicaid members is a more complete picture of CCN activities to ensure CCHL issues are not adversely impacting health care delivery.

This strategy aligns with the achievement of DSRIP goals of reducing health disparities. CCHL training alone does not ensure the adoption of CCHL concepts. Methods to verify the effects of training intended to drive a cultural shift and Medicaid members' perception of attention to CCHL issues as they receive care must be monitored. This information then must inform modifications needed to the CCN approach to addressing CCHL concerns.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

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Mid-Point Assessment Recommendation #19 (Financial Sustainability and VBP): The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements.

PPS Action Plan Narrative: The observation made by the IA in the Mid-Point Assessment report indicated a plan towards meeting VBP goals was being developed by the PPS. The PPS had been reporting VBP progress as per the milestones but had paused progress on completion of these when DOH announced August 29, 2016 the Financial Stability milestones 4-8 were placed on hold by the DOH while updates were processed for all PPSs.

The PPS has introduced the concept of VBP to partners by providing education and support of partners' movement towards VBP. In 2015, education was provided at each of the RPUs as well as at the PAC/Stakeholders meeting to share general information about VBP. In August of 2016, a payer forum was held with United Health Care which was attended by approximately 40 individuals representing around 35 partner organizations across the PPS. VBP assessments were completed in November 2015 as well as February 2017 to understand the movement across the PPS with regards to Value-Based Payment arrangements, but also to better inform the PPS as it develops the VBP Support Implementation Plan as required by Financial Stability Milestone 5. These early initiatives lay the groundwork and basis for creating the plan to further the statewide goal of getting VBP in place with at least 90% of Medicaid funds in Level 1 VBP and 70% (minimum 35%) of Medicaid funds in Level 2 VBP.

At the All-PPS meeting held December 9, 2016, the NYS Department of Health announced the modified VBP milestones along with the new completion date of June 30, 2017 for the VBP Implementation Plan. As part of these updated milestones, the PPS will survey providers, identify gaps, and implement initiatives to address those needs.

CCN will take the following actions to **further** educate and support partners move toward VBP:

1. **Develop VBP support implementation plan.** Since partners have been educated on the VBP concept the focus of VBP education and support will be on assisting partners in applying VBP methodologies to their specific organization. As part of VBP Milestone 5 (Develop VBP support implementation plan), CCN will detail how CCN will support the adoption of VBP as part of the plan for ongoing sustainability. Also, as part of the support plan, CCN will provide consultation services for how VBP complements the organization's financial sustainability plan, and provide VBP support as a follow-on to results from the CCN annual network financial sustainability survey. CCN will also utilize the RPU networks to identify the provisions needed in the network to support payor arrangements. The PPS will collect feedback on emerging trends, challenges, and issues with the transition to VBP from among the CCN network of partners with special attention to community based organizations, and use that information to address needs through additional education. As part of the next phase of project contracting beginning April 1st, CCN is introducing a form of risk-based payment tied to performance on metrics for each of the projects (Upside Only).

2. **Engage partners for VBP education and training.** As part of VBP Milestone 6 (Engage partners for VBP education and training), CCN will submit a VBP training/education schedule listing sessions to be held to assist partners in understanding the aspects of VBP as part of the VBP Implementation Plan in Milestone 5 (also due June 30, 2017). As part

of this training/education schedule there will be additional targeted sessions for Primary care providers/practices, Mental Health and Substance Use Disorder partners and Community Based Organizations. CCN will offer at least two sessions for each provider category group (above) per DSRIP year beginning in DSRIP Year 3. As part of the VBP education and training strategy, CCN will organize regional learning collaboratives providing specific case examples for partners to learn from in applying the VBP methodology to their individual organizations. CCN will set up VBP pilots within the RPUs targeting opportunities for community-based organizations to envision how to migrate to VBP payment arrangements.

Additionally, a VBP Pilot Program with Cayuga Area Preferred Medicare ACO has been initiated as a result of a PPS Innovation Fund award made in December 2016. Care Compass Network partnered with Cayuga Area Preferred, Inc. (CAP) in January 2017 to expand its model of clinical integration to the Medicaid population. Through this program, CAP will work with their regional MCO (Total Care) to create a Level 1 Value-Based Payment arrangement for Medicaid members in Tompkins County in alignment with the VBP roadmap provided by the NYS Department of Health which will grow to Level 2 by the end of DSRIP. Key Elements to the VBP Program:

- **Goal:** Expansion of CAP's Medicare ACO / Clinical Integration Program to the Medicaid population, including health initiatives and care coordination.
- **Duration:** Three-year Value Based Payment agreement with an MCO, commencing with Level 1 and migrating to Level 2 by end of year three.
- **Measurement:** VBP Plan to be monitored for clinical improvements and cost savings, including 15 metrics.
- **Engagement:** 206 physicians at 58 locations.
- **Incentive:** Care Compass Network will provide CAP with over $550k to support participation and performance with these agreements over the next 18 months.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

For each of the recommendations we have provided a narrative outlining how the PPS has addressed or plans to address each particular Mid-Point Assessment Recommendation. This narrative will clearly articulate:

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Mid-Point Assessment Recommendation #20 (Partner Engagement): The IA recommends that the PPS develop a strategy to increase partner engagement throughout the PPS, particularly with Primary Care Providers and Non-Primary Care Providers.

PPS Action Plan Narrative: The observation made by the IA in the Mid-Point Assessment report indicated limited partner engagement across the six projects identified (2ai, 2biv, 2di, 3ai, 3bi, and 3gi) and further emphasized limited engagement of Primary Care and non-Primary Care across the six projects. The partner engagement reflected in the PIT tool at the time of the Midpoint was understated due to reporting engagement at the entity level versus the provider level. CCN provided an updated PIT file with engagement at both entity and provider levels on January 30, 2017. The chart below provides an updated summary of Primary Care and Non-Primary Care Provider engagement (using a traffic light assessment) based on the data submitted with the most recent PIT file.

	Targeted Practitioner - PCP (from DSRIP application)	Engaged Practitioner - PCP as of Mid Point	Actual Engaged Practitioner - PCP (as of 1/31/17)	Targeted Total Practitioner - Non PCP (from DSRIP application)	Engaged Practitioner - non PCP as of Mid Point	Actual Engaged Practitioner - Non PCP (as of 1/31/17)
Project 2ai Integrated Delivery System	285	2	201	479	0	310
Project 2biv Care Transitions	58	0	198	66	0	310
Project 2bvii Implementing INTERACT	0	0	0	0	0	0
Project 2ci Community Navigation	0	0	89	0	0	120
Project 2di Patient Activation	0	0	98	0	0	142
Project 3ai Integration of PC and BH	163	0	21	0	0	2
Project 3aii Crisis Stabilization	0	0	0	0	0	0
Project 3bi CVD Disease Management	228	1	65	22	0	0
Project 3gi Integration of Palliative Care into PCMH Model	81	1	47	0	0	0

Confusion between CCN required data reporting vs. DOH required data elements compounded by difficult retrieval of certain data elements discouraged partner engagement. CCN's broader request for more data was intended to assist CCN in building a data warehouse to be used for population health initiatives but inadvertently generated a backlog of partner engagement documentation. Corrective action was taken to align CCN required data elements to DOH required elements thereby simplifying the monthly reporting requirements for partners. The net result was a re-engagement by contract partners and a rapid reporting of the backlog of data from their systems. While this corrective action improved partner engagement by removing artificially created barriers, the fact remains there is a gap in committed partner engagement.

After receiving the Midpoint Assessment report, CCN conducted a listening tour regarding issues and barriers for partners on the projects. The two primary barriers identified were:

- Lack of funds for project participation and organizational infrastructure
- RPU meetings served primarily as forums for education and information updates; they had not advanced into performance management

As a result of the listening tour, the CCN Board took immediate action to offer new incentives. These incentives included a Speed and Scale Performance bonus based on the percentage of speed and scale achieved by a contracted partner. A new incentive was also implemented for project 3gi, Integration of Palliative Care into the PCMH Model**.** For a number of reasons, Partners had been reluctant to engage in this project. A significant increase in payment was implemented to account for additional efforts needed to overcome documentation and coding issues.

CCN will take the following actions to continue to increase provider engagement:

1. **Develop new reimbursement models for the projects**. Included in the phase 2 contracting beginning April 1, 2017 are increased payments for specific projects which proved to be under-valued in Phase 1

contracting resulting in lack of partner engagement. Other new payments include a high-performance bonus for patient engagement, high performance bonus for quality metrics achieved, ability to pre-pay a percentage of phase 2 contract value with a claw back provision for failure to achieve targeted activities, increased innovation funding for RPU initiatives needed to move quality metrics, and increases in direct funding to the RPUs **t**o implement initiatives designed to improve performance. In addition to the above, payments will be distributed to partners to accommodate for upfront investment, workflow and organizational infrastructure build needed to implement a project.

2. **Complete RPU Network Capacity and Capability Analysis** with a formal action plan by partner category to assure rebalancing of the delivery system and network capacity. The listening tour told CCN there is little attention on developing and managing the networks. CCN will shift the focus of each RPU to data driven discussion, performance assessment, network development and rapid cycle performance improvement.
    a. With the PIT updated, CCN has the true gap to goal data for provider engagement across the projects. For each RPU, CCN will provide a network analysis that includes a list of partners by DSRIP partner categories, current CCN contracts for each category and level of engagement for each of the contracted partners. In three of the CCN RPUs, Practitioners (both primary care and non-primary care) are organized into large medical groups exclusively affiliated with a health system partner. Practitioners are one of the largest gaps for engagement in the projects. Therefore, the network analysis will detail specific provider sites and providers in each site to assess adequacy of supply and availability (geographic location and hours of operation).
    b. CCN will review the network analysis and the current contracted partner network at the individual RPU meetings to identify gaps or missing/needed partner services in the RPU. Each RPU will develop a plan to engage partners across the RPU and will utilize the relationships that already exist to engage those partners.

3. **Remove data reporting barriers.** Data submission requirements of a Client Identification Number (CIN) from partners qualified reporting to NYS DOH was presenting a significant barrier to partner reporting. This resulted in an extensive backlog of reportable activities that partners were not reporting because they could not easily provide a CIN. This inflated the gap in performance. It was important to correct this situation first so the performance gaps due to partner engagement, workflow issues and patient engagement could be analyzed and managed. Guidance from the IA indicated when the Medicaid CIN is not available, an acceptable alternative is the Medicaid Managed Care Policy Number. CCN has simplified the list of data elements to permit easier reporting whereby CCN matches the CIN for the partners and assists the partners with internal solutions to retrieve the CIN working with MCO supplied policy numbers.

4. **Educate partners on the value of DSRIP to increase engagement.** CCN staff will work with leadership of organized physician groups to convene discussion forums directly with physicians. The cornerstone of the value message will be to clearly articulate the goals of DSRIP and how their engagement with the DSRIP program will facilitate improvements to their practice and provide better care for all their patients. The target date for completing these discussions is April 30, 2017. In order to effectively communicate value-add to partners during these discussions, the Marketing Manager will create electronic materials to be distributed to clinical staff clearly outlining what DSRIP does for them along with the value-add to the provider and support staff. The marketing material will be made available by March 31, 2017.

Progress on provider engagement will be monitored at the RPU Level, with monthly status reports to PAC Executive Council and to the Board of Directors. The PPS will develop short term action plans when partner engagement lags. The action plans will be developed with an identified responsible person, timeline, and PPS funding (where applicable) to support resolution and performance. Implementing these actions ultimately assists the PPS in achieving the goal of improving overall population health and success in meeting DSRIP overarching goals.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

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Mid-Point Assessment Recommendation #21 (Patient Engagement): The IA requires the PPS to develop a plan to increase patient engagement across all projects.

PPS Action Plan Narrative:

Patient engagement and provider engagement work in concert to achieve success in Project speed and scale and overall implementation that ultimately improves clinical metrics and determines the ability of CCN to actualize DSRIP goals.

There are three aspects to patient engagement critical to ensuring Medicaid members are embracing and benefiting from the modification made in the delivery of health care as envisioned in the projects. These three aspects are:

1. Accurate and complete reporting of patient engagement for speed and scale
2. Bi-directional linking of Medicaid members to services and providers
3. Educating Medicaid members about the transformation in the health care delivery system – what they can expect, what services are available, how the changes affect them and the care they receive, and how they access care and services

The very limited reporting of patient engagement in Quarterly Reports raised concerns for both CCN and the IA. The numbers can, as the IA understandably concluded, be interpreted as an indicator of limited or no patient engagement across the PPS. The IA's clear message that "continued limited Patient Engagement efforts raises a concern for the PPS ability to meet the DSRIP goals going forward" served to mobilize the PPS to identify the true gap to goal in achieving Patient Engagement targets. CCN knew project implementation activities were occurring. CCN, therefore, needed to aggressively pursue answers to two questions to fully understand the low level of patient engagement evidenced in Quarterly Reports. The two questions are:

1. what accounts for the low reporting of patient engagement?
2. how can the reporting issues be addressed to ensure CCN is reporting accurate and complete patient engagement?

CCN's initial focus with project implementation was on long term change for healthcare transformation instead of short term achievement of patient engagement. One component is an aggressive, long term project to create a comprehensive data warehouse to be used for population health initiatives. Many of the reporting elements requested from partners were intended to assist CCN in building the data warehouse. These reporting requirements were much more detailed than the DOH minimum reporting requirements. This approach hampered CCN's ability to accurately reflect speed and scale patient engagement the partners were undertaking.

In response to the Mid-Point Assessment, CCN recognized the need to redirect efforts to short term achievement. Partners reported the stringent reporting requirements established by CCN compromised their ability to accurately report to CCN their activities for patient engagement. In December 2016, CCN aligned the reporting requirements from partners to CCN to align with the DOH minimum reporting requirements. This move allows partners to create efficient workflows around reporting and simplifies the monthly reporting being asked for and used to report speed and scale numbers to DOH.

Information about the modified CCN reporting requirements was shared with partner organizations in a number of settings including PAC, PAC Executive Council, Coordinating Committee and Regional Performance Units. As a result of the reduction of information to be reported to CCN, partners revealed a backlog of patient engagement activities that could now be reported and not rejected as a result of missing data fields. CCN anticipates patient engagement figures across all projects will be significantly higher in the next Quarterly Report.

Clarifying reporting requirements enables CCN to more accurately calculate the gap to goal for each project and move to address real rather than artificially created barriers to meeting speed and scale targets. CCN recognizes patient engagement goes beyond meeting speed and scale targets but is essential to overall implementation of the projects. Thus, patient engagement strategies transcend activities to improve number reporting.
The plan to increase patient engagement across all projects includes:

1. **Operationalizing the Regional Performing Units (RPUs).** CCN has completed a number of steps to operationalize the RPUs. In mid-February, Interim RPU leads were assigned in the North and South RPUS, while a search for a paid CCN staff person to fill this role is recruited. These two RPUs account for 76% of the PPS attribution. The RPUs committed to meeting weekly. A partner scorecard listing patient engagement commitments and actuals by project and by partner was distributed to RPUs and at the PAC. Each partner was asked to speak to the ability to hit their contracted targets and if not, what do they need in order to reach them. This discussion helped to identify many barriers, create solutions to problems, as well as to assign resources to assist where needed.

These initial steps in operationalizing the RPU have already shifted the RPUs from an educational and informational meeting to a forum for monitoring performance, identifying barriers, resolving obstacles and facilitating collaboration. Building on these initial steps the RPU will:

- track speed and scale – ensure complete and accurate reporting of all activity
- evaluate the adequacy of the number of contracts to complete project goals,
- monitor partner performance and where appropriate report poor performing partners
- facilitate remediation efforts of low performers
- identify and resolve implementation problems
- make recommendations for modifications in contracting or funding
- facilitate coordination between partners

Fully functioning RPUs are the foundation for monitoring and facilitating optimal performance and an integral component of transformation as CCN proceeds toward an integrated delivery network.

2. **Adequately incentivize partners to engage with patients.** Patient engagement is directly linked to partners onboarding efforts. Inadequate reimbursement to partners results in non-participatory partners who fail to engage patients. In January 2017, CCN Operations leadership engaged in a listening tour to identify methods for increasing patient engagement. The information collected as well as partner concerns expressed at PAC, Coordinating Council and other meetings was used to create enhanced financial incentives to meet short term engagement targets. The financial incentives include 1. retroactively increasing funds flow to CBOs by removing some barriers to reporting project activities which effectively allow CBOs to report increased reimbursable activities (completed February 17), 2. prepayment of contracted amounts to give CBOs more flexibility in covering their costs and 3. allocating up to $1.4 million for speed and scale bonus payments whereby CBOs could receive up to an additional 60% above the contracted rate. These additional payments were approved by the CCN Board of Directors on February 14, 2017.

   These incentives are a short-term effort to spur partner engagement and thereby patient engagement. More work needs to be done to ensure funds flow adequately covers the costs and incentivizes partners to fully perform and engage patients. Feedback from CBOs is being used to inform the development of a modified fund flow methodology for the Phase 2 contracting scheduled to be in place April 1, 2017. Risk sharing, increased upfront payments, overall increased reimbursement are factors that are anticipated to be integrated into the reimbursement methodology to improve partner engagement and performance.

3. **Create bi-directional opportunities for interaction between Medicaid members and services and providers.** Health care delivery is not uni-directional. CCN partners provide care and engage in activities (e.g. follow-up appointments) to maintain relationships with Medicaid members. Conversely, Medicaid members seek health care services and care from providers absent any prodding by health care providers. Restricting focus to partner initiation of interactions with Medicaid members diminishes the opportunities to engage when Medicaid member initiate contact. Patient engagement can be increased by attention to the factors that drive Medicaid members to seek care. Project 2di activation measures are used to engage the uninsured and non-or low-utilizing Medicaid members. Across the Medicaid population overall, each project offers opportunities to engage patients and ensure they receive the care they need in the most appropriate setting, provided by the most appropriate health care worker, in the most cost efficient manner. These opportunities to engage patients need to be identified by
   a. examining project activities to identify touchpoints for optimizing patient engagement
   b. use the Medicaid patient panel developed by RMS to explore patient engagement strategies
   c. create forums for partners to share successes in engaging patients

4. **Develop an educational and marketing campaign to explain to Medicaid members the health care delivery transformation that is in progress and how it benefits them.** As the transformation in the health care delivery system progresses it may cause disruptions in the ways in which Medicaid members previously interacted with health care providers and the overall health care system. Perceptions that these changes are driven by an interest in reducing costs and are likely to cause a decrease in the types, quantity and quality of health care services available will stymy CCN efforts and defeat the transformational goals of DSRIP. Education is the key to helping the recipients of services to understand how the changes benefit them.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

For each of the recommendations we have provided a narrative outlining how the PPS has addressed or plans to address each particular Mid-Point Assessment Recommendation. This narrative will clearly articulate:

- Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation,
- Timeline for actions,
- How the PPS will track progress in executing the actions, and
- How these actions reflect the PPS overall strategy for meeting its DSRIP goals.

Mid-Point Assessment Recommendation #22: The IA recommends that the PPS develop an action plan to address the deficiencies identified in the Primary Care Plan, notably the lack of specificity on the primary care strategy of the PPS, the limited detail on progress towards implementation of the primary care strategies, and the role of the PPS in monitoring and overseeing the implementation of the primary care strategies.

The well-coordinated integrated care system that is envisioned through DSRIP must successfully shift a Medicaid member's trust and orientation from institutional settings, like an emergency room, to a primary care setting enhanced by care coordination. To effectively accomplish this, primary care needs to enhance three key elements in their operations: (1) **Access** in terms of adequate supply of primary care, hours of operation, capacity to accept Medicaid members, positive patient experience and cultural sensitivity (2) **New Capability** such as care coordination, e-visits, IT capability and other innovations, and (3) **Collaboration with community based care** providers that supports a shared plan of care among the multiple providers and agencies caring for the Medicaid member.

CCN recognizes that this primary care plan for Medicaid members does not exist in a vacuum. Each healthcare delivery system in the CCN service area has made significant investments and placed strategic importance on Primary Care development. The CCN primary care plan must have strategies designed to synergize with these investments and focus DSRIP resources on the challenges that primary care is experiencing in realizing its central role in the delivery of care to Medicaid members.

In the overall assessment of the CCN Primary Care Plan, the IA noted that" (1) The CCN Primary Care Plan lacked specificity and focus, (2) Discussion did not focus sufficiently or clearly on primary care (3) Strategies were left to the RPUs and health system partners, (4) the plan did not indicate the specific progress of projects to indicate implementation is underway except for the MAX action site". These deficiencies were not tied to a particular element of the plan, but reflect an overall lack of robustness in its focus and articulation. In light of this feedback, CCN will reframe the plan so that it provides insight into how CCN will work with PCPs to achieve DSRIP Goals and establish accountability for achievement. The Action Plan to address the deficiencies identified in the review of the CCN Primary Care Plan is framed around the six fundamentals of the primary care profile.

FUNDAMENTAL 1**: Assessment of current primary care capacity, performance, and need; and, a plan for addressing those needs**. An explicit deficiency was not articulated for this fundamental. However, CCN believes some of the lack of specificity and focus is related to insufficient assessment and common understanding of gaps at the site/provider level within each RPU. CCN needs to complete a more targeted assessment beyond partner recruitment needs and consider total practice capacity contrasted with Medicaid practice capacity and determine the willingness and ability to expand Medicaid access. CCN should also assess practice depth with care coordination and identify opportunities where CBOs could partner with practices to provide care coordination services. Facilitating this collaboration at the primary care – CBO level is fundamental to the network development to be performed within the CCN RPU. In addition, for each practice the current hours of operation, PCMH status, EMR status and current performance with Medicaid members will be directly collected from each organization. Based on the results of the assessment, CCN, in conjunction with the established RPU quality committees, will identify gaps in capacity, care coordination, status of PCMH progress, and performance with Medicaid members. For each gap identified, a specific CCN strategy will be developed and implemented. The strategies and resources available will include recruitment assistance, facilitation in the use of advanced practice providers to expand capacity, expansion of walk-in services, telehealth / e-visit solutions for access issues related to transportation or hours of operation, and additional consulting assistance with implementation of PCMH.

FUNDAMENTAL 2: How will primary care expansion and practice workforce transformation be supported with training and technical assistance? The IA noted CCN plans to provide technical assistance for PCPs to reach PCMH 2014 Level 3 certification and with IT infrastructure needs with funding to support these efforts. For this fundamental the deficiency refers to the lack of workforce budget and synergy with state programs to recruit primary care.

The expansion of primary care capacity is reliant on two interrelated factors - the absolute number of providers and the successful development of a health care team in the PCP. To address the number of providers, CCN will convene a focused task force charged with 1. Determining the target number of PCP and geographic need 2. Identify successful recruitment and retention strategies 3. Develop a recruiting campaign and 4. Leverage existing state or federal programs (e.g. HPSA) to attract PCP. These efforts will be funded by the CCN workforce budget on behalf of partners. The expansion of provider capacity will be supplemented by enhanced use of advanced practice providers. The task force will work with Binghamton University Decker School of Nursing to build APP capacity through strategic clinical placements during training, development of a recruitment and retention strategy and leveraging existing programs for tuition forgiveness. CCN offered training for APP adoption into PCP office practice models will accelerate an increase in provider capacity and facilitate practice transformation. Further, CCN will work with primary care practices to review

practice staffing models and staff job descriptions. This information will inform recommendations for changes to develop a fully functioning health care team that utilizes all personnel at the top of their licensure and training.

FUNDAMENTAL 3: What is the PPS strategy for how primary care will play a central role in an integrated delivery system? For this fundamental the deficiency points to a lack of specifics in operationalizing the central role primary care will play in the RPU integrated delivery network. To achieve DSRIP goals, the primary care office must be repositioned for Medicaid members as the central and consistent resource for meeting their health care needs. Clinically from a Governance perspective, primary care has been well integrated into clinical integration efforts through the Clinical Governance Committee (CGC). Operationally, the CCN Primary Care Plan will articulate how PCP practices serving Medicaid members will be supported as they build out practice capability in care coordination, capital and operating resource assistance with IT and telehealth capability, assistance in RHIO connectivity and interoperable data exchange to support care coordination, and assistance with CBO collaboration to expand care coordination capability. As the RPUs move into the role of performance management, RPUs will be evaluating patient engagement and quality measure sets at the RPU level, partner level and the practice level. As the RPU identifies performance risks, CCN will need to deepen engagement with PCPs by providing individual performance data through web based score cards and other tools to facilitate real time performance monitoring and performance improvement. The CCN Primary Care Plan will incorporate strategies for engaging primary care in performance management and identification of best practices to support PCPs in their enhanced role and accountability in the integrated delivery system.

FUNDAMENTAL 4: What is the PPS strategy to enable primary care to participate effectively in value based payments? There was not a specific deficiency noted for this element in the IA report. The IA report noted several CCN strategies related to building relationships between CBOs and practices, educational forums around Value Based Payments(VBP), and provision of data to PCPs to better understand their current performance with Medicaid members. In addition, CCN will enhance the Primary Care Plan with strategies and best practices in network participation and shared accountability for performance.

FUNDAMENTAL 5 How does your PPS's funds flow support your Primary Care Strategies? The IA report indicated that the CCN Primary Care Plan was not specific in its articulation of funds flow to primary care. To address this deficiency CCN will present funds flow from an organization development perspective. Initial funds flow to primary care was organized around engagement and achievement of PCMH certification and patient engagement directly through projects: 2ai Integrated Delivery System, 3ai Integration of Primary and Behavioral Health, 3bi Evidence-Based Strategies for Disease Management (CVD) in High Risk/Affected Populations, 3gi Integration of Palliative Care into PCMH, and indirectly through projects: 2biv Care Transitions, 2ci Community Navigation, 2di Patient Activation, 3aii Crisis Stabilization, 4aiii Strengthen Mental Health and Substance Abuse Infrastructure across Systems and 4bii Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings. CCN is in the process of redesigning contracting and fund flow strategies to incentivize primary care beyond patient engagement performance on projects and migrate to a performance based payment methodology that rewards PCPs on their individual performance and the network performance on the project quality measure sets. CCN will also develop a funds flow methodology to incentivize PCP collaboration with CBOs and other community services organizations.

FUNDAMENTAL #6 How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3ai)? The IA noted in the Midpoint Report a lack of a specific plan for partner implementation beyond the Max site. To address this deficiency, CCN will develop a project implementation template based on best practice learning from the Max site. The template should provide step by step direction for accelerated implementation of the project. A site in each RPU will be identified for project implementation. In addition to broader implementation of this project, a series of "mini" pilots designed to advance increased integration of primary care and behavioral health will be developed and implemented.

During 2016, the Clinical Governance Committee (CGC) recommended to the CCN Board the adoption of guidelines for Project ECHO which specifically targets the geriatric population. Project ECHO is a free telehealth resource available to all providers. ECHO is a case-based presentation in a team-based environment to share best practices and learn about evidence-based interventions. Additionally, CGC endorsed Project TEACH as a PPS-wide resource available to all Primary Care Providers or those caring for children up to age 21 for consultations for mild to moderate mental health disorders. A strategy will be developed with funds flow to incentivize the implementation of at least one site in each RPU.

Partners in CCN have expressed interest in implementing a tele-psychiatry solution for behavioral health consults. CCN will enhance its integration efforts with a funds flow methodology to encourage and support implementation of tele-psychiatry services.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

For each of the recommendations we have provided a narrative outlining how the PPS has addressed or plans to address each particular Mid-Point Assessment Recommendation. This narrative will clearly articulate:

- Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation,
- Timeline for actions,
- How the PPS will track progress in executing the actions, and
- How these actions reflect the PPS overall strategy for meeting its DSRIP goals.

Mid-Point Assessment Recommendation #23 (PAOP White Paper): (A) 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.

(B) The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP.

(C) 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: (A)The PPS must develop a detailed plan for engaging partners across all PPS projects with specific focus on Primary Care Mental Health, Substance Use Disorder providers as well as Community Based Organizations (CBOs). The plan must outline a timeline for meaningful engagement.

In developing a plan for stronger partner engagement, CCN identified three types of partners: those who have a contract with CCN for the implementation of one or more projects, those who have contracted on a project(s) but has opportunity to contract for more, and those who have not contracted. Of those partners who have a contract, there have been four primary reasons that partners have not engaged and performed to the level of contract commitments: (1) a burdensome reporting process that caused a backlog of project actively and patient engagement that was not reported, (2) a lack of sufficient funding to accommodate start-up needs, (3) a lack of meaningful funding to provide the project services, and (4) lack of knowledge or insight into workflow issues.

The CCN Plan to realize a broad base of meaningful partner engagement is organized into five dimensions of engagement: (1) The Partner needs to see the value and benefit of participating in CCN, (2) The Partner must have a working knowledge of the opportunities available to participate, (3) The Partner must see an opportunity they believe they are able to pursue, (4) The Partner needs a funds flow methodology and other resources that facilitate start-up and ongoing participation, and (5) The Partner must receive meaningful data based feedback on performance.

(1) **The Partner needs to see the value and benefit of participating in CCN.** These strategies will be used with Partners who are not contracted and missing from the network.

Strategy	Details	Time Line
Complete a Partner Network Assessment.	In CCN, local care delivery networks are organized into Regional Performance Units (RPUs). A profile of contracted partners by project will be presented to the RPU. Active partners in that RPU in conjunction with CCN RPU staff will examine the profile and identify projects where additional partners need to be engaged, and specific partners in the RPUs service area who could be engaged.	April 30, 2017
Initiate outreach to the needed/potential partners identified in the Assessment	The RPU staff and members will develop and implement a plan to outreach to the targeted partners. Where RPU staff or members have a relationship with the target partner the outreach will be initiated by that person. Initial outreach will probe current level of awareness and interest in DSRIP. Follow-up outreach will outline for the partner the goals of DSRIP and how those goals support the work of the Partner organization.	May 30, 2017

(2) **The Partner needs to have a working knowledge of the opportunities available to participate.** These strategies will be used with Partners who are not contracted but have an increased level of interest in DSRIP/CCN and with Contracted Partners who are not engaged in all the project opportunities available to them

Strategy	Details	Time Line
Conduct a series of project collaboratives	The purpose of these collaboratives is to provide in-depth information about projects, implementation requirements, current partner experience with implementation, and funds flow; and discuss opportunities for engagement, and identify perceived barriers. When possible, address/ remove barriers or develop mitigation strategies	September 30, 2017

(3) **The Partner has identified an opportunity they want and believe they are able to pursue**.

Strategy	Details	Time Line
When a Partner indicates a fit with a project, begin contracting	CCN partner relations will work with the Partner using CCN contracting tools to complete a contract with the Partner. CCN will supply specific data to inform patient engagement commitments.	July 31, 2017
Support contracting with a detailed implementation plan	During contract discussions, areas of concern may be identified related to Project implementation. CCN will develop an implementation plan with specific identified resources to assist the partner with implementation. This includes but is not limited to work flow changes, staffing realignment, marketing/communications, IT and reporting requirements.	July 31, 2017
Facilitate collaboration among partners to implement projects	CCN and RPU leadership will identify and present opportunities for partners to collaborate in the implementation of a project.	July 31, 2017

(4) **CCN must have a funds flow methodology and project expert resources that facilitate the Partner's start-up and ongoing participation**

Strategy	Details	Time Line
Revise Funds flow for each project based on feedback from contracted partners to assure adequate funding for startup and ongoing operations	In the phase 2 contracting to begin April 1,2017, CCN has revised the project funds flow which partners have identified as undervalued from the first phase of contracting. Key revisions include: A high-performance bonus for patient engagement and for achievement of project quality measure set targets; Start-up funding and pre-payment of estimated contract value to jump start a project, and increased innovation pool funding for RPU initiatives designed to improve quality measure performance. Incentives for partner collaborations will also be offered.	March 31, 2017
Implement a project resource center and best practice project collaboratives.	CCN partners who are contracted and implementing projects have accrued significant depth and knowledge that would accelerate implementation and performance achievement. CCN will develop a virtual resource center to facilitate transfer of knowledge. CCN will organize and convene ongoing project collaboratives to facilitate deeper knowledge transfer.	July 31, 2017 and on-going
CCN will provide tools and support for project implementation through enhanced workforce and IT	For projects where IT solutions are needed, CCN will provide direct financial and technical expertise. Each RPU will have a dedicated RPU IT Project Manager supported by consulting expertise as needed, to facilitate IT solutions. For projects where workforce solutions are needed, CCN will work to increase the candidate pipeline through a competitive recruitment strategy and provide coaching guidance in job redesign. For example, CCN has developed and can facilitate the introduction of the Health Coach Role projects involved in care coordination. Additional resources will be provided as identified by partners.	September 30, 2017 and on-going

(5) The Partner must receive meaningful feedback with data measured performance. These strategies are applicable to all engaged partners to sustain efforts and improve performance.

Strategy	Details	Time Line
Transition the RPUs from an information sharing forum to a partner / network performance management function	The RPUs have been operating with RPU leadership by contracting with a partner to provide that service as opposed to having CCN dedicated leadership. As a result, the RPUs were left with little support to transition from collaboration forums to performance management operations. CCN has infused new resources, specifically 5 staff positions, into the RPUs in order to implement performance management. CCN will provide partner level performance reporting for patient engagement performance and project quality measure sets and support for performance improvement.	June 30, 2017 and on-going
Implement a performance payment model that includes network performance	To incorporate the concept of shared payment for shared performance. CCN will develop a partner payment approach that will include RPU and PPS wide performance in addition to an individual partner's performance in the payment methodology.	March 31, 2017

Focused Strategies for Primary Care, Mental Health, Substance Use Disorder providers and CBOs. These strategies are in addition to the strategies outlined above.

Strategy	Details	Time Line
Primary Care: Issues of supply, capacity and care coordination resources hinder engagement		
Reassess Primary Care for the Medicaid Population	For each RPU, CCN will perform an in-depth assessment of primary care capacity and capability. This assessment will focus on overall capability and the ability of the practice to be available for and serve Medicaid members. CCN and the RPUs will identify specific needs for primary care support and expansion.	June 30, 2017
Foster Primary Care Expansion	In fostering Primary Care expansion, CCN is interested in expanding both capacity and capability CCN will actively facilitate and assist with funding, the development of Primary care and CBO partnerships to grow the needed care coordination capability. CCN will support though funds flow and innovation funds the expansion of primary care services such as e-visits, telehealth and expansion of walk-in services.	September 30, 2017 and on-going
Mental Health: The supply of qualified staff at all levels is a threshold factor limiting engagement		

Strategy	Details	Time Line
Prioritize implementation of Tele-psychiatry	Limited psychiatrist resource impacts expansion of services. CCN has the interest of engaged psychiatrists in the development of Tele-psychiatry consults for emergency care and for integration with Primary Care.	September 30, 2017 and on-going
Provide resource support for the new psychiatry residency program	The Upstate Clinical Campus in conjunction with UHS are implementing a residency program as a regional solution to the long-standing problem of undersupply in psychiatry. To accelerate growth, CCN will dedicate workforce funds for this effort.	September 30, 2017 and on-going
Collaborate with Universities	CCN will collaborate with established Psychiatric Advance Practice Provider (APP) Programs to increase program capacity and place APPs in key roles	September 30, 2017 and on-going
Substance Use Disorder: There are a limited number of providers and they are disconnected from the care network		
Work with SUD programs on care coordination	CCN has heard from SUD providers that they struggle to know in real time when one of their clients has been hospitalized or is receiving services from other providers. Through the RPU, CCN will assist SUD programs with care coordination needs and provide opportunities to expand capability for these organizations into care coordination integrated at the primary care office	September 30, 2017 and on-going
CBOs: CBOs have difficulty envisioning their role in an IDS and their ability to function in an IDS		
Increase Funds Flow	CBOs have indicated that their engagement has been hindered by lack of start-up funding to support expansion. CCN has developed a start-up funding methodology to be introduced April 1, 2017.	March 31, 2017
Facilitate Partnerships	CBOs offer unique expertise in outreach and engagement of patients in a population health approach. CCN will facilitate partnership between CBOs, the healthcare systems and primary care to increase outreach and care coordination services	September 30, 2017 and on-going
Education and Mentorship for CBO leadership and boards	CBOs are dealing with significant change which impacts mission and scope of services. Several CBOs are looking for support with strategic planning and Community Boards to navigate these issues. CCN will identify CBO transformation resources and facilitate mentoring with CBO leaders who have successfully led change in their organizations	September 30, 2017 and on-going

(B) The Plan must also include a description of how the PPS will flow funds to partners to ensure success in DSRIP. Flowing funds to partners relies on CCN successfully remediating partner engagement and fostering partner willingness and ability to engage. Assuming that success, CCN funding has been enhanced and is organized to support initiatives that will support the achievement of DSRIP goals. Any or all of these funding streams available to partners.

Fund Flow Category	Future $ Allocated	Description
Project Implementation	$52.6M	These funds, enhanced as a result of the Midpoint Assessment are paid to partners contracted to implement all or part of a project
Start-up Funds	$3.0M	Funding in this category is paid to partners to overcome start-up barriers in implementing a project.
Innovation	$6.9M	These funds are paid to partners for proposals that reach beyond the projects to contribute to achievement of desired performance
RPU Performance Management	$3.2M	This category was recently enhanced. The funds are for the RPUs to enable RPUs take action when needed to support improved performance
IT Support	$46.4M	Comprised of both capital and operating funds, this category of funding is available to partners to support adoption of EMR, RHIO connectivity, population health analytics and interoperable data exchange
Workforce Funds	$5.4M	These funds support partners with workforce development, training/retraining, recruitment, and job re-design
High Performance	$17.4M	This fund rewards partner performance that exceeds targets
Partner Expertise	$2.5M	CCN recognizes the value of partner subject matter experts who guide the design and implementation of DSRIP Projects. These funds are paid to partner project leads for their ongoing efforts.

Fund Flow Category	Future $ Allocated	Description
Revenue loss	$29.0M	This funding is available to partially offset negative financial impacts on hospitals as the delivery system redirects resources to community based programs.

(C) The PPS must also submit a detailed report on how the PPS will ensure successful project implementation efforts with a special focus on projects identified as being at risk by the IA

Most of the CCN projects were assessed with a level of risk due to low patient engagement (speed and scale) at the time of the Midpoint and/or low partner engagement as reflected in the PIT tool. While partner engagement reported in the PIT tool was understated due to entity level reporting rather than provider level, updating the PIT did not erase a gap in partner engagement. Input from partners regarding low patient and partner engagement pointed to two key barriers: (1) a lack of sufficient reimbursement to address startup and ongoing project operations, and (2) an inability to retrieve requested data elements for reporting to CCN. The reporting impediment led to a substantial backlog of unreported activity. Changes to facilitate reporting has brought three projects to achievement of speed and scale. However, there is a critical need for CCN to recalibrate its operations to better support strong performance. To assure successful project implementation going forward, CCN will implement performance management operations in the RPUs. Specifically:

Initiative	Details
Infuse new resources into the RPUs	The RPUs have been operating with RPU leadership by contracting with a partner to provide that service as opposed to having CCN dedicated leadership. As a result, the RPUs were left with little support to transition from collaboration forums to performance management operations. CCN will staff each RPU with five (5) positions: RPU Leader, Population Health Analyst, an RPU Project Manager, and It Project Manager and an RPU Partner Relations Specialist. Given the urgency of performance improvement needed, CCN has established interim full time RPU leadership and analysts
Complete an RPU Partner Network Capacity and Capability Analysis with Action Plan	A detailed network analysis will be prepared that examines each project by partner category to identify project and partner engagement gaps. An action plan for outreach to partners who were identified with opportunities to contract with CCN will be implemented and progress with engagement reviewed in weekly RPU meetings.
Focus RPUs on data driven, performance assessment, network development and rapid cycle performance improvement	CCN will develop standardized performance dashboards that include: Contracted performance by partner for patient engagement and project quality measure sets. Each RPU will be accountable for contracted performance by partner which will be tracked and reviewed in weekly RPU Meetings. RPUs will maintain an active issue log to assure that identified performance issues and approved interventions have an implementation plan that is actively managed
Strengthen Performance Governance	Performance based reporting will be reviewed by CCN Executive Director and PAC Executive Council bi-monthly. The CCN Board of Directors will review performance monthly. The Board will act on partner performance issues if the RPU cannot achieve the needed performance levels working directly with the partner.
Accelerate Network Partner Engagement through new incentives and funds flow approaches	New incentives were enacted by the CCN Board to reward accelerated Speed and Scale and Scale. A significant new incentive was also implemented for project 3gi, Integration of Palliative Care into the PCMH Model to account for additional effort needed to overcome documentation and coding issues. Beginning April 1, 2017 there will be increases in payment / funds flow for specific projects which proved to be under-valued in Phase 1 contracting including: high-performance bonus for patient engagement and quality metrics, new start-up funding, provisions for a pre-payment of a % of contract value, increased innovation funding and increases in direct funding to the RPUs **t**o implement initiatives designed to improve performance.
Facilitate partnerships between CBOs and Health Systems	Development of a value based care network of providers requires formal relationships between entities who share performance targets and payment risk. CCN will facilitate contracting between CBOs, primary care and the health care systems that will enhance care network capability and capacity to drive performance at the lowest cost.
Refocus IT Strategy around the RPUs	The change in the RPU role to performance management has improved actionability of the IT strategy. RHIO alignment will be established for each RPU. Implementation plans for hardware and software acquisition, EMR implementation where needed, establish connectivity to RHIO for data exchange, implement supportive IT for telehealth and online e-visit capability and implement Population Health Management Systems.

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 #1 (2ai): The IA recommends the PPS develop a strategy to increase partner engagement to support the successful implementation of this project and in meeting the PPS' DSRIP goals.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Infuse new resources into the RPUs with five dedicated positions: RPU Leader, Population Health Analyst, RPU Project Manager, RPU Partner Relations and IT Project Manager.	**June 30, 2017**
Step 1a. Assign interim RPU Lead, interim RPU Project Managers and dedicated Partner Relations staffing in place for each RPU. Responsible Persons: M. Ropiecki and B. LeRoy	*Completed February 2017*
Step 1b. Reassign CCN analytics team to support the RPUs. Responsible Person(s): M. Ropiecki and E. Pape	*March 31, 2017*
Step 1c. Hire full time RPU Leaders, RPU Analysts and North RPU Project Manager to support the RPUs. Responsible Person(s): M. Ropiecki, B. LeRoy, D. Sculley	*June 30, 2017*
2. Complete an RPU Network Capacity and Capability Analysis with a Formal Action Plan by partner category to assure rebalancing of the delivery system and network capacity.	**June 30, 2017**
Step 2a. Prepare for each RPU, a network analysis by each partner category. For each category include a list of partners by DSRIP category and indicate the current CCN contracts for that partner category. Responsible Person(s): RPU Leads with Partner Relations	*April 30, 2017*
Step 2b. Evaluate the network/analysis and the current contracted partner network at the RPU meeting to identify gaps or missing/needed partner services in the RPU. Responsible Person(s): RPU Leads	*April 30, 2017*
Step 2c. Construct and implement an action plan for outreach to partners for needed services based on the network analysis. Responsible Person(s): RPU Leads	*May 31, 2017*
Step 2d. Conduct weekly Network Action Plan monitoring in each RPU until network has adequate capacity and capabilities. Responsible Person(s): RPU Leads	*June 30, 2017*
3. Shift the focus of each RPU to data driven discussion, performance assessment, network development and rapid cycle performance improvement.	**April 2017 and on-going**

Step 3a. Establish a Structure for Performance Governance. Each RPU will work with a standardized performance dashboard that includes: contracted performance by partner and project and quality measure sets organized by each project. Each RPU will be accountable for monitoring and reporting RPU performance to CCN Executive Director, PAC Executive Council and the CCN Board of Directors. Responsible Person(s): RPU Leads	*April 2017 and on-going*
Step 3b. Track and evaluate contracted performance by partners in weekly RPU meetings, bi-monthly at PAC Executive Council and monthly at the CCN Board. Performance schedules for each RPU and CCN consolidated showing performance by project and contracted partner will be prepared by the CCN Director of Finance. Responsible person(s): RPU Leads	*February 2017 and on-going*
Step 3c. Review and evaluate Population Health Quality Measure Sets. RPUs will develop action plans for interventions through projects and/or care coordination. RPUs will maintain an active issue log to assure that identified and approved interventions have an implementation plan that is actively managed. Responsible person(s): E. Pape and RPU Leads	*February 2017 and on-going*
4. Accelerate Network Partner Engagement.	**July 31, 2017**
Step 4a. Meet with partners to better understand partner barriers. Responsible person(s): B. Leroy	*Completed February 2017*
Step 4b. Incentivize partner engagement. Responsible Person(s): B. Carangelo	*Completed February 2017*
Step 4c. Increase payment/funds flow for specific projects which proved to be under-valued in Phase 1 contracting. Responsible Person(s): B. Carangelo	*March 31, 2017*
Step 4d. Devise a board approved funding model to increase direct funding to the RPUs. Responsible Person(s): B. Carangelo	*July 31, 2017*
5. Facilitate contracts between CBOs, Primary Care and Health Systems	**September 30, 2017**
Step 5a. Facilitate relationships and complete contracts between CBOs, Primary Care and Health Systems to complete the network. Responsible Person(s): RPU Leads	*September 30, 2017*
6. Refocus IT Strategy around the RPUs.	**September 30, 2017**
Step 6a. Select and align with one of the three RHIOs serving the CCN service area. Responsible Person(s): RPU Leads	*May 31, 2017*
Step 6b. Hire an IT Project Manager to support each RPU. Responsible Person(s): R. Kennis	*July 31, 2017*

Step 6c. Support deployment of IT resources. Responsible Person(s): R. Kennis.	*September 30, 2017 and on-going*
7. Monitor progress of project milestones, partner engagement, and patient engagement monthly.	**March 2017 and on-going**
Step 7a. Report monthly to PAC Executive Council and the CCN Board of Directors on the progress of project milestones, partner engagement and patient engagement.	*March 2017 and on-going*
Step 7b. Utilize input from PAC Executive Council, Coordinating Council and the CCN Board to develop short term action plans when project milestones, partner engagement or patient engagement fall behind schedule.	*March 2017 and on-going*

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Mid-Point Assessment Recommendation #2: The IA recommends the PPS develop a strategy to increase partner and community engagement.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Alignment of PPS reporting requirements to DOH reporting requirements.	**Completed January 2017**
Step 1a. Provide contract amendment to inpatient facilities to require only the following 3 elements for reporting: 1) Medication Management 2) Patient education; red flags 3) Follow up appointment scheduled. Responsible Person(s): N. Frank and Partner Relations	*Completed January 2017*
Step 1b. Align PPS reporting requirements to DOH reporting requirements. Communicate to partners. Responsible Person(s): N. Frank, E. Pape and Partner Relations	*Completed January 2017*
2. Patient engagement funding incentive.	**Completed March 2017**
Step 2a. Develop funding incentive model to directly increase patient engagement. Responsible Person(s): B. Carangelo	*Completed February 2017*
Step 2b. Obtain Board of Directors approval of patient engagement funding incentive. Responsible Person(s): B. Carangelo	*Completed February 2017*
Step 2c. Communicate patient engagement funding incentive to partners. Responsible Person(s): RPU Leads and Partner Relations	*Completed March 2017*
3. Incentivize collaboration between hospital systems and community based organizations.	**July 31, 2017**
Step 3a. Modify the reimbursement model for this project to incentivize acute care facilities to collaborate with community based organizations providing Health Coach services and align with the subcontracting approach used for this project. Responsible Person(s): N. Frank and B. Carangelo	*March 31, 2017*
Step 3b. Develop payment methodology to incentivize collaboration between healthcare systems and community based organizations. Responsible Person(s): B. Carangelo	*May 31, 2017*

Step 3c. Present collaboration payment methodology to Finance Committee and Board of Directors for review and approval. Responsible Person(s): B. Carangelo	*June 30, 2017*
Step 3d. Communicate collaboration payment methodology to Stakeholders and implement . Responsible Person(s): B. Carangelo with support from RPU teams	*July 31, 2017*
4. Assist providers in building readmissions reports	**September 30, 2017**
Step 4a. Gather real time readmission data by RPU from each of the contracted hospital partners. Responsible Person(s): RPU Leads and E. Pape	*June 30, 2017*
Step 4b. Work with partners on adoption and utilization of data to track, monitor and manage readmissions. Responsible Person(s): RPU Leads and E. Pape	*September 30, 2017*
5. Assist partners in adopting and incorporating the Personal Health Record.	**September 30, 2017**
Step 5a. Utilize the CCN Clinical Governance Committee to document and communicate the benefits of the Personal Health Record. Responsible Person(s): N. Frank	*June 30, 2017*
Step 5b. Work with the facility champions at each hospital to provide education on the benefits of the Personal Health Record to all departments who perform discharges at the facility. Responsible Person(s): N. Frank	*September 30, 2017*
6. Track the status of the Project 2biv actions until project implementation is complete.	**Start 04/01/2017 and on-going**
Step 6a. Develop simplified report for communicating status of these actions. Responsible Person(s): N. Frank and D. Sculley	*April 1, 2017*
Step 6b. Report status monthly at CCN Coordinating Council meetings as well RPU meetings. Responsible Person(s): N. Frank	*Start 04/01/2017 and on-going*
Step 6c. Report status monthly at PAC Executive Council. Responsible Person(s): D. Sculley	*Start 04/01/2017 and on-going*

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Mid-Point Assessment Recommendation #3: (2.b.iv:Care transitions intervention model to reduce 30 day readmissions for chronic health conditions): The IA recommends the PPS develop a plan to increase outreach and education materials to partners.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Develop a program to educate partners on the CCN Care Transitions Program and the Health Coach role	**September 30 , 2017 and on-going**
Step 1a. Outline topics that need to be addressed and determine formats for delivery of educational program. Responsible Person(s): N. Frank	*May 31, 2017*
Step 1b. Establish a specific timeline for educating each contracted partner Responsible Person(s): N. Frank	*May 31, 2017*
Step 1c. Develop partnerships with regional higher education institutions to support the development of a transdisciplinary curriculum for care coordination Responsible Person(s): N. Frank and M. Absi	*September 30, 2017 and on-going*
Step 1d. Partner with regional higher education institutions and AHECs to offer training and continuing education on topics relevant to project implementation Responsible Person(s): N. Frank and M. Absi	*September 30 , 2017 and on-going*
2. Increase communication with the Care Transition facility champions	**May 31, 2017**
Step 2a. Meet with facility champions no less than once/month Responsible Person(s): N. Frank	*May 31, 2017*
Step 2b. Identify facility specific implementation problems Responsible Person(s): N. Frank	*On-going*
Step 2c. Develop action plans to resolve problems, implement plan and track the problem until resolution is mitigated. Responsible Person(s): N. Frank	*On-going*
Step 2d. Deploy resources e.g. IT support, workforce, mentoring, as appropriate to assist Responsible Person(s): N. Frank in conjunction with input from D.Sculley	*On-going*
3. Work with the Human Resources Department of contracted partners	**June 30, 2017**
Step 3a. Provide information such as sample job responsibilities, suggested wage scale, etc. to contracted project partners who may hire Health Coaches. Responsible Person(s): B. LeRoy	*June 30, 2017*

Step 3b. Coordinate with HR target recruitment strategy to attract Health Coaches Responsible Person(s): B. LeRoy	*June 30, 2017*
4. Monitor statewide efforts to standardize the role of health coach, community health worker or other new and emerging job titles.	**May 31, 2017 and on-going**
Step 4a. Participate in statewide and regional PPS Workforce Meetings. Responsible Person(s): M. Absi	*On-going*
Step 4b. Monitor NYS Education Department website for guidance on licensed titles and emerging titles. Responsible Person(s): M. Absi	*On-going*
Step 4c. Join on-line health care workforce forums. Responsible Person(s): M. Absi	*On-going*

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Mid-Point Assessment Recommendation #4: The IA recommends the PPS develop a strategy to assist partners in better identifying the targeted population for this project.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Educate and clarify for partners the NYS DOH definition	**May 31, 2017**
Step 1a. Hold focused education sessions for contracted partners to educate them about DOH definitions and clarify understanding of how definition can be used to target specific populations. Responsible Person(s): E. Balmer	*May 31, 2017*
Step 1b. Modify screening tool questions to align with NYS DOH definition of LU and NU and to specifically align with organizations target population such as perinatal visits, health screenings and walk-in visits. Responsible Person(s): E. Balmer	*March 31, 2017*
2. Assist partners in identifying locations	**June 30, 2017**
Step 2a. Develop a list of organizations and location hotspots frequented by the UI, NU and LU populations. Responsible Person(s): E. Balmer	*May 31, 2017*
Step 2b. Share with contracted partners list of locations. Responsible Person(s): E. Balmer with the RPU Leads	*June 30, 2017*
Step 2c. Determine which contracted organizations will focus survey efforts at specific, identified locations. Responsible Person(s): E. Balmer with the RPU Leads	*June 30, 2017*
3. Utilize claims data to determine the UI, LU and NU for our partners.	**September 30, 2017**
Step 3a. Identify criteria for extracting information from claims data that is most helpful for partners to engage the UI, NU and LU. Responsible Person(s): E. Balmer and E. Pape	*August 31, 2017*

Step 3b. Develop a HIPPA compliant process for sharing the information about UI, NU and LU with partners. Responsible Person(s): E. Balmer and A. Rotella	*September 30, 2017*
4. Track the status of Project 2di implementation at weekly RPU meetings.	**Start 04/01/2017 and on-going**
Step 4a. Develop a short concise reporting template addressing engagement of UI, NU and LU population. Responsible Person(s): E. Balmer and D. Sculley	*April 1, 2017*
Step 4b. Identify barriers to reaching the target population. Responsible Person(s): E. Balmer with the RPU Leads	*on-going*
Step 4c. Develop specific approaches to remediate barriers that are impeding speed and scale and full project implementation. Responsible Person(s): E. Balmer and 2di project team	*on-going*

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Mid-Point Assessment Recommendation #5: The IA recommends the PPS develop a plan to increase outreach and education materials to partners with respect to patient activation measures.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Create opportunities to share best practices	**September 30, 2017**
Step 1a. Identify and prioritize implementation barriers that can be mitigated through knowledge transfer and best practices. Responsible Person(s): E. Balmer	*June 30, 2017*
Step 1b. Identify successfully performing partners or organizations in other PPSs that can be called on to share experiences. Responsible Person(s): E. Balmer	*June 30, 2017*
Step 1c. Establish at least two methods for cross-sharing best practices. Responsible Person(s): E. Balmer	*June 30, 2017*
Step 1d. Implement the approaches to cross-sharing. Responsible Person(s): E. Balmer	*September 30, 2017*
2. Expand pool of Master Trainers	**May 31, 2017**
Step 2a. Assess engagement of current master trainers. Responsible Person(s): E. Balmer	*April 30, 2017*
Step 2b. Explore obstacles to full utilization of master trainers. Responsible Person(s): E. Balmer and 2di project team	*May 31, 2017*
Step 2c. Resolve factors that block master trainer involvement in furthering screening and implementation of activation measures. Responsible Person(s): E. Balmer and 2di project team	*May 31, 2017*
Step 2d. Hold a minimum of 2 additional master trainer classes. Responsible Person(s): E. Balmer and J. Commane	*May 31, 2017*
Step 2e. Develop opportunities for master trainers to mentor partners who are experiencing difficulty in meeting targets. Responsible Person(s): E. Balmer and 2di project team	*May 31, 2017*
3. Create training modules for various types of workers.	**June 30, 2017**

Step 3a. Identify the types of workers that are involved in 2di and need training. Responsible Person(s): E. Balmer and M. Absi	*April 30, 2017*
Step 3b. Outline topics that need to be included in training. Responsible Person(s): E. Balmer and M. Absi	*April 30, 2017*
Step 3c. Develop a training module. Responsible Person(s): M. Absi, J. Commane with E. Balmer	*June 30, 2017*
Step 3d. Make training modules available to partners. Responsible Person(s): J. Commane	*June 30, 2017*
4. Analyze opportunities to integrate the PAM survey and activation measures into other projects such as Disease Management and Behavioral Health.	**June 30, 2017**
Step 4a. Convene a workgroup of project managers and selective partners to identify opportunities to integrate survey and activation measures into other projects. Responsible Person(s): E. Balmer	*June 30, 2017*
Step 4b. Summarize guidance for incorporating PAM survey and activation measures into other projects. Responsible Person(s): E. Balmer	*June 30, 2017*
Step 4c. Establish at least two methods for sharing information about integrating 2di in other projects. Responsible Person(s): E. Balmer	*June 30, 2017*
5. Increase funding to adequately cover the true cost of performing PAM surveys and implementing activation measures	**April 01, 2017**
Step 5a. Modify Phase 2 contracting funds flow for 2di as a mechanism for increasing implementation speed. Responsible Person(s): B. Carangelo and E. Balmer	*April 01, 2017*

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Mid-Point Assessment Recommendation #6: 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.Utilize relationships with healthcare systems leaders reach physicians within their organizations.	**June 30, 2017**
Step 1a. Identify barriers and resistance to project implementation from the primary care physicians. Responsible Person(s): E.Balmer with support from RPU teams	*April 30, 2017*
Step 1b. Identify health care system attributes that impede primary care physician involvement in 2di. Responsible Person(s): E.Balmer with support from RPU teams	*April 30, 2017*
Step 1c. Create a mechanism for reporting involvement of primary care physicians to each health care system leader. Responsible Person(s): E.Balmer with RPU Leads	*April 30, 2017*
Step 1d. Develop strategies to overcome barriers and mitigate causes of resistance to project participation. Responsible Person(s): E.Balmer and 2di project team	*May 31, 2017*
Step 1e. Align the work of community based organizations to use the PAM score to activate patients with primary care physician practices. Responsible Person(s): E.Balmer with support from RPU teams	*June 30, 2017*
2. Adjust the funding methodology.	**April 01, 2017**
Step 2a. Adjust funding methodology to promote integration of PAM score and activation measures into practice. Responsible Person(s): B. Carangelo	*April 01, 2017*
3. Develop a process for connecting the PAM score with a specific physician.	**June 30, 2017**
Step 3a. Identify a mechanism for the PAM score to be shared with the Medicaid member's PCP. Responsible Person(s): E.Balmer and 2di project team	*May 31, 2017*
Step 3b. For the uninsured, develop a process for linking with a PCP. Responsible Person(s): E.Balmer and 2di project team	*May 31, 2017*

Step 3c. Develop a communication pathway for persons administering PAM survey to communicate with the PCP. Responsible Person(s): E.Balmer and 2di project team	*June 30, 2017*
4. Provide training to primary care providers.	**June 30, 2017**
Step 4a. Develop training for PCPs and staff on use of the PAM score, coaching for activation and the role of self-management goals for patient centered care. Responsible Person(s): E.Balmer, M. Absi and J. Commane	*May 31, 2017*
Step 4b. Determine best delivery method for offering training to PCP. Responsible Person(s): E.Balmer, M. Absi and J. Commane	*May 31, 2017*
Step 4c. Devise a plan and timetable for training all contracted PCP partners. Responsible Person(s): E.Balmer, M. Absi and J. Commane	*May 31, 2017*

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Mid-Point Assessment Recommendation #7: 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. Identification and removal of barriers and resistance to implementation	**April 30, 2017**
Step 1a. Outreach to contracted partners to identify barriers and resistance to project implementation. Responsible Person(s): B. Rosetti, N. Frank and Partner Relations	*March 31, 2017*
Step 1b. Align PPS reporting requirements to DOH reporting requirements. Communicate to partners. Responsible Person(s): B. Rosetti, N. Frank, E. Pape and Partner Relations	*Completed February 2017*
Step 1c. Implement learning collaboratives organized at the RPU level based on the lessons learned in the MAX pilot to facilitate the project engagement and adoption of tested work flow strategies for partners. Responsible Person(s): B. Rosetti, N. Frank and Partner Relations	*April 30, 2017*
2. Create a funds flow methodology for practice transformation to increase screening in PCMH sites	**March 31, 2017**
Step 2a. Develop and implement a funds flow methodology for this project to adequately reimburse infrastructure build and changes in workflow for consistently documenting the screening and any resulting referral. Responsible Person(s): B. Rosetti, N. Frank, and B. Carangelo	*March 31, 2017*
Step 2b. Communicate funds flow changes at RPU meetings and individually with primary care partners through the phase two contracting process. Responsible Person(s): B. Carangelo, RPU Leads and Partner Relations	*March 31, 2017*
3. Identify guidelines for Clinical Depression Screening and follow up	**March 31, 2017**
Step 3a. Develop a clinical guideline for Clinical Depression Screening and follow up. Responsible Person: B. Rosetti	*Completed February 2017*

Step 3b. Present Clinical Depression Screening and follow up guideline to the CCN Clinical Governance Committee for review and endorsement. Responsible Person: B. Rosetti	*Completed February 2017*
Step 3c. Communicate the guideline along with changes related to the project to encourage broader partner engagement. Responsible Person: B. Rosetti along with the RPU teams	*March 31, 2017*
4. Increase partner participation to better support the project	**September 30, 2017**
Step 4a. Identify partners not yet contracted in the project that are needed for implementation. Responsible Person: B. Rosetti along with the RPU teams	*March 31, 2017*
Step 4b. Develop a plan and implement outreach to "uncontracted but needed partners" to contract for needed services. Communicate the revised funds flow, identify their barriers in engaging, identify their needs to implement the project. Responsible Persons: RPU Leads with B. Rosetti	*May 31, 2017*
5. Foster a greater understanding of rationale for integration of primary care and behavioral health	**September 30, 2017**
Step 5a. Implement additional learning collaboratives to share best practices as additional sites implement integration throughout the PPS to encourage collaboration. Responsible Person(s): B. Rosetti, N. Frank and Partner Relations	*September 30, 2017*
Step 5b. Create and maintain a list of available community Partners offering primary care or behavioral health services who are willing to partner with another entity. Post the list on the CCN SharePoint site and share the list at all four Regional Performing Unit Operating meetings as well as at the PAC/Stakeholders meeting. Responsible Person(s): B. Rosetti and N. Frank	*June 30, 2017*
6. Track the status of the Project 3ai actions until project implementation is complete.	**Start 04/01/2017 and on-going**
Step 6a. Develop simplified report for communicating status of these actions. Responsible Person(s): B. Rosetti, N. Frank and D. Sculley	*April 1, 2017*
Step 6b. Report status monthly at CCN Coordinating Council meetings as well RPU meetings. Responsible Person(s): B. Rosetti and N. Frank	*Start 04/01/2017 and on-going*
Step 6c. Report status monthly at PAC Executive Council. Responsible Person(s): D. Sculley	*Start 04/01/2017 and on-going*

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Mid-Point Assessment Recommendation #8: The IA recommends the PPS develop a plan to address the workforce challenges with licensed behavioral health specialists and care coordinators.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Develop a recruitment strategy to address the shortage of licensed behavioral health specialists across the PPS.	**September 30, 2017**
Step 1a. Develop a recruitment plan for licensed behavioral health specialists and care coordinators to attract people with these needed skillsets to the nine-county region. Responsible Person(s): M. Absi	*May 31, 2017*
Step 1b. Review opportunities such as Health Professional Shortage Areas (HPSA) offerings as part of the development of the recruitment plan. Responsible Person(s): M. Absi	*May 31, 2017*
Step 1c. Communicate and share the recruitment plan with partners. Responsible Person(s): M. Absi and Partner Relations	*June 30, 2017*
Step 1d. Provide funding support to develop partnerships between independent providers, independent counseling Agencies, Article 31 OMH clinics, OASAS Article 32 clinics and Article 28 Primary care clinics in order to provide integrated services at their sites. Responsible Person(s): B. Rosetti and N. Frank	*September 30, 2017*
Step 1e. Develop a healthcare recruiter campaign to assist in actively recruiting for the workforce shortages. Responsible Person(s): M. Absi and M. Gusman	*September 30, 2017*
2. Provide partner organizations who employ licensed behavioral health specialists with compensation and benefit information, job descriptions and other information.	**June 30, 2017 and on-going**
Step 2a. Generate job descriptions for behavioral health specialists and other new job titles created as part of DSRIP. Responsible Person: M. Absi	*May 31, 2017*
Step 2b. Share the PPS compensation and benefits analysis, job descriptions and other supporting human resource material with partners for workforce positions created as part of DSRIP. Responsible Person(s): M. Absi	*June 30, 2017*

Step 2c. Encourage partner participation in the regional workforce workshops sponsored by AHEC. Responsible Person(s): M. Absi and RPU teams	*June 30, 2017 and on-going*
3. Advise partner organizations about scope of practice and licensing requirements of various licensed behavioral health specialists to assist partners to realign workflow activities with available staff in an effort to optimize service delivery.	**September 30, 2017 and on-going**
Step 3a. Provide opportunities for contracted partners to participate in evidenced based Peer Recovery training through the Workforce Training Strategy. Responsible Person(s): M. Absi and J. Commane	*September 30, 2017*
Step 3b. Offer learning collaboratives to discuss and support aligning job responsibilities and adoption of new titles in the delivery of healthcare. Responsible Person(s): M. Absi	*September 30, 2017 and on-going*
Step 3c. Activate innovation proposal for development of workforce for psychiatry. Responsible Person(s): M. Ropiecki	*September 30, 2017*
4. Collaborate with regional and statewide efforts to accelerate the education of licensed behavioral health specialists and track solidified requirements for care coordinators.	**September 30, 2017 and on-going**
Step 4a. Partner with local universities to begin development of transdisciplinary curriculum for care coordination. Responsible Person(s): M. Absi	*September 30, 2017*
Step 4b. Develop internships and preceptorships for students in the Advanced Practice Nursing and behavioral health students from local universities. Responsible Person(s): M. Absi	*September 30, 2017*
Step 4c. Support on-going discussions with Binghamton University with plans to develop care coordination placements for social work students. Responsible Person(s): M. Absi and N. Frank	*September 30, 2017 and on-going*
Step 4d. Collaborate with educational institutions to bring needed resources such as NPs to rural areas. Responsible Person(s): M. Absi	*May 31, 2017*
Step 4e. Engage with other PPSs, SUNY, AHECS and other organizations working on healthcare shortages in New York to stay up to date on aspects impacting the training and supply of healthcare workers. Responsible Person(s): M. Absi	*September 30, 2017*

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Mid-Point Assessment Recommendation #9: The IA requires the PPS develop a comprehensive action plan to address the implementation of this project in consultation with the Project Advisory Committee (PAC) that must be reviewed and approved by the Board of Directors. This Action Plan must detail how the PPS will monitor and intervene when project milestones, partner engagement, or patient engagement for this project fall behind schedule.

Mid-Point Assessment Recommendation #10: The PPS should develop a strategy to educate their partners on the value of DSRIP in order to increase their engagement.

Mid-Point Assessment Recommendation #11: To address the issue of partner reluctance to participate in this project due to perceived lack of reimbursement, the PPS should develop creative strategies, either in the form of services, consultation, or work with a vendor to assist the PPS in this outreach.

Mid-Point Assessment Recommendation #12: In order to address the issue of identifying targeted panels of patients eligible to be included in this project, the IA recommends that the PPS convene a group of stakeholders to develop a strategy to develop common solutions.

PPS Defined Milestones/Tasks	*Target Completion Date*
1. Educate partners on the value of DSRIP to increase engagement.	**April 30, 2017**
Step 1a. Create electronic materials to be distributed to clinical staff clearly outlining the benefit of DSRIP to their patients and clients as well as to their organization. Responsible Person(s): M. Gusman	*March 31, 2017*
Step 1b. Identify partner organizations not yet engaged in the project and have focused discussions to cultivate opportunity to contract. Responsible Person(s): R. Haller and CCN Partner Relations.	*April 30, 2017*
2. Develop a new reimbursement model for this project aimed at increasing engagement of providers.	**September 30, 2017**
Step 2a. Meet with cardiology partners to understand better what is done with self-management and how providers document this in the EMR. CCN staff will be provide training to facilitate documentation and the funds flow for the project. Responsible Person(s): R. Haller and CCN Partner Relations.	*May 31, 2017*
Step 2b. Adjust funding methodology to promote increased provider engagement and patient engagement as well as standardizing measures into practice. Responsible Person(s): R. Haller and B. Carangelo	*September 30, 2017*

3. Foster creative partnerships with community based resources for self-management with a customized reimbursement model for these arrangements.	**September 30, 2017**
Step 3a. Identify appropriate self-management services available in the community. Responsible Person(s): R. Haller with support from the RPUs	*May 31, 2017*
Step 3b. Facilitate connections between community organizations offering self-management services and the physicians in the PPS. Responsible Person(s): Partner Relations and R. Haller with support from the RPUs	*September 30, 2017*
Step 3c. Convene workgroup and establish a collateral plan to incentivize providers and Medicaid Members to refer to the Chronic Disease Self-Management Program (CDSMP) workshops. Responsible Person(s): R. Haller	*August 31, 2017*
Step 3d. Roll-out plan identified. Responsible Person(s): R. Haller	*September 30, 2017*
4. Identify Primary Care Practices in the PPS that manage large panels of CVD	**September 30, 2017**
Step 4a. Identify Primary Care Practices in the PPS who serve large populations of Medicaid members with a cardiovascular disease diagnosis. Responsible Person(s): R. Haller	*March 31, 2017*
Step 4b. Leverage leadership of organized physician groups to convene a group of stakeholders consisting of physicians and staff from the identified PCP sites to discuss and communicate the opportunity and benefit of participation in this project. Responsible Person(s): CCN Partner Relations and R. Haller	*April 30, 2017*
Step 4c. Report attribution to partner organizations to inform their internal strategies for panel development and areas of focus. Responsible Person(s): R. Haller	*July 31, 2017*
Step 4d. For partner organizations that have the capacity to develop panels of these patients on their own, reimburse them for this effort. Responsible Person(s): R. Haller and B. Carangelo	*August 31, 2017*
5. Establish documentation and reporting processes	**September 30, 2017**
Step 5a. Meet with partners engaged in this project to understand the IT issues and assist with IT solutions. This includes documenting the requirements of the project as well as reporting the data. Responsible Person(s): R. Kennis	*March 31, 2017*
Step 5b. Identify gaps in intended implementation related to current capabilities. Responsible Person(s): R. Kennis and R. Haller	*March 31, 2017*
Step 5c. Disburse funds to support the IT needs of the partners in project implementation. Responsible Person(s): R. Kennis and B. Carangelo	*September 30, 2017*

Step 5d. Provide support for partner organizations that do not have the capacity to develop panels of the patients on their own or who need assistance with documentation and reporting processes. Provide consulting, IT support, or otherwise in order to assist them in this effort. Responsible Person(s): R. Haller with support from RPU team	*September 30, 2017*
6. Monitor progress of project milestones, partner engagement, and patient engagement monthly.	**March 2017 and ongoing**
Step 6a. Report monthly and receive input from the PAC Executive Council and the CCN Board of Directors on the progress of project milestones, partner engagement and patient engagement. Responsible Person(s): D. Sculley and B. LeRoy	*March 2017 and ongoing*
Step 6b. Utilize input from PAC Executive Council, Coordinating Council and the CCN Board to develop short term action plans when project milestones, partner engagement or patient engagement fall behind schedule. The action plans will be developed with an identified responsible person, timeline, and PPS funding (where applicable) to support resolution and performance. Responsible Person(s): D. Sculley and B. LeRoy	*March 2017 and ongoing*

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Mid-Point Assessment Recommendation #13: The IA requires the PPS develop a comprehensive action plan to address the implementation of this project in consultation with the Project Advisory Committee (PAC) that must be reviewed and approved by the Board of Directors. This Action Plan must detail how the PPS will monitor and intervene when project milestones, partner engagement, or patient engagement for this project fall behind schedule.

PPS Defined Milestones/Tasks	*Target Completion Date*
1. Incentivize provider engagement in the project	**June 30, 2017**
Step 1a. Develop a list of services that would qualify as a 'palliative care service" and distribute to contracted partners. Responsible Person(s): S. Woolever	*March 31, 2017*
Step 1b. Compensate Partner for creating internal processes and procedures (internal to contracted Partner) at each site which could also incorporate the elements of the project such as IPOS and eMOLST.	*June 30, 2017*
Step 1c. Meet with Primary Care Providers in the PPS to discuss contracting for the project, provide the list of services qualifying as 'palliative care services' and discuss the funds flow model.	*March 31, 2017*
2. Establish a clear documentation and reporting processes.	**September 30, 2017**
Step 2a. Identify methods contracted partner organizations can use to record a palliative encounter while still not a billable service. Responsible Person(s): S. Woolever	*April 30, 2017*
Step 2b. Identify gaps in intended implementation related to current capabilities. Responsible Person(s): S. Woolever	*May 31, 2017*
Step 2c. Provide support services in the form of consultants, technical support, or otherwise to address issues identified. Responsible Person(s): S. Woolever and R. Kennis	*September 30, 2017*
Step 2d. Create CPT code for PCP to use to allow them to document the palliative care service for Medicaid members. Responsible Person(s): R. Kennis	*September 30, 2017*
3. Establish a clear articulation of Palliative Care and Train clinical staff on that definition and the use of eMOLST	**September 30, 2017**
Step 3a. Work with contracted PCP and Hospice partners to complete the required CAPC module training . Responsible Person(s): S. Woolever, J. Commane with support from RPU Leads	*September 30, 2017*

Step 3b. Organize trainings for each RPU regarding clear articulation of palliative care as well as the use of eMOLST. Responsible Person(s): S. Woolever, J. Commane with support from RPU Leads	*September 30, 2017*
4. Standardize project implementation with overlapping PPSs	**September 30, 2017 and on-going**
Step 4a. Identify opportunities to standardize project implementation with overlapping PPSs. Responsible Person:(s) S. Woolever	*June 30, 2017*
Step 4b. Collaborate with overlapping PPSs to implement the identified opportunities. Responsible Person(s): S. Woolever	*September 30, 2017 and on-going*
5. Reduce Cultural resistance through knowledge sharing	**September 30, 2017**
Step 5a. Pilot palliative care as an integrated service within at least two RPUs at a PCMH site to assist in setting standards that can be applied across the PPS. Responsible Person: S. Woolever and RPU Leads	*September 30, 2017*
Step 5b. Organize learning collaboratives within each RPU to encourage knowledge sharing and to showcase benefits and best practices. Responsible Person: S. Woolever and RPU Leads	*September 30, 2017*
6. Monitor progress of project milestones, partner engagement, and patient engagement monthly.	**March 2017 and on-going**
Step 6a. Report monthly and receive input from the PAC Executive Council and the CCN Board of Directors on the progress of project milestones, partner engagement and patient engagement. Responsible Person(s): D. Sculley and B. LeRoy	*March 2017 and ongoing*
Step 6b. Utilize input from PAC Executive Council, Coordinating Council and the CCN Board to develop short term action plans when project milestones, partner engagement or patient engagement fall behind schedule. The action plans will be developed with an identified responsible person, timeline, and PPS funding (where applicable) to support resolution and performance. Responsible Person(s): D. Sculley and B. LeRoy	*March 2017 and ongoing*

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Mid-Point Assessment Recommendation #15: To address the issue of partner reluctance to participate in this project due to perceived lack of reimbursement, the PPS should develop creative strategies, either in the form of services, consultation, or work with a vendor to assist the PPS in outreach.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Incentivize provider engagement in the project	**June 30, 2017**
Step 1a. Develop a list of services that would qualify as a 'palliative care service" and distribute to contracted partners. Responsible Person(s): S. Woolever	*March 31, 2017*
Step 1b. Compensate Partner for creating internal processes and procedures (internal to contracted Partner) at each site which could also incorporate the elements of the project such as IPOS and eMOLST. Responsible Person(s): S. Woolever and B. Carangelo	*June 30, 2017*
Step 1c. Develop and obtain CCN Board approval of a funding incentive to stimulate rapid implementation. Communicate funding incentive to stakeholders. Responsible Person(s): B. Carangelo	*Completed February 28, 2017*
Step 1d. Meet with Primary Care Providers in the PPS to discuss contracting for the project, provide the list of services qualifying as 'palliative care services' and discuss the funds flow model. Responsible Person(s): S. Woolever and CCN Partner Relations	*March 31, 2017*
2. Develop a new reimbursement model	**March 31, 2017**
Step 2a. CCN staff will meet with primary care partners to understand better the effort for providing palliative care services, including completion of the IPOS, and how providers document the information in the EMR. Responsible Person(s): S. Woolever and CCN Partner Relations	*March 31, 2017*
Step 2b. Adjust funding methodology to promote increased provider engagement and patient engagement as well as standardizing measures into practice. Responsible Person(s): S. Woolever and B. Carangelo	*March 31, 2017*
3. Offer Provider Learning Collaboratives	**June 30, 2017**

Step 3a. Convene learning collaboratives with engaged providers and community based organizations to assist providers in developing the skills to engage in deeper educative and supportive conversations with patients and help patients recognize the value of palliative care services. Responsible Person(s): S. Woolever and CCN Partner Relations	*June 30, 2017*
Step 3b. Develop a marketing strategy to better explain the services incorporated within Palliative Care both on site at the PCMH PCP as well as within community organizations. Responsible Person(s): S. Woolever and M. Gusman	*May 31, 2017*
4. Develop a Network of Palliative Care Service	**September 30, 2017**
Step 4a. Facilitate the development of a complimentary care network of palliative services for providers to use with their patients when engaging them in palliative care. Responsible Person(s): S. Woolever and RPU Leads	*September 30, 2017*
5. Implement a Communications Strategy with Patients	**July 31, 2017**
Step 5a. Develop a marketing strategy to encourage Medicaid members to use palliative care services for support in dealing with serious illnesses. Responsible Person(s): M. Gusman and S. Woolever	*June 30, 2017*
Step 5b. Roll out the marketing strategy. Responsible Person(s): M. Gusman	*July 31, 2017*
6. Track the status of the Project 2biv actions until project implementation is complete.	**Start 04/01/2017 and on-going**
Step 6a. Develop a simplified report for communicating status of these actions. Responsible Person(s): S. Woolever and D. Sculley	*April 1, 2017*
Step 6b. Report status monthly at CCN Coordinating Council meetings as well RPU meetings. Responsible Person(s): S. Woolever	*Start 04/01/2017 and on-going*
Step 6c. Report status monthly at PAC Executive Council. Responsible Person(s): D. Sculley	*Start 04/01/2017 and on-going*

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Mid-Point Assessment Recommendation #17: The IA recommends that the PPS develop an action plan to roll out its trainings to its workforce and partners.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Identify partners that do not provide or require training in CCHL for their employees.	**May 31, 2017**
Step 1a. Develop list of partner organization that do not require CCHL training for employees. Responsible Person(s): CCHL Committee	*April 30, 2017*
Step 1b. Identify a general CCHL training program that can be made available for partners. Responsible Person(s): CCHL Committee	*May 31, 2017*
2. Make CCHL training available to all CCN partners.	**September 30, 2017**
Step 2a. Communicate plan to partner organization. Responsible Person(s): M. Absi	*June 30, 2017*
i. Contact Workforce Leads at contracted organizations to notify them of CCHL trainings. Responsible Person(s): M. Absi	*June 30, 2017*
ii. Announce training availability at meetings and announce via SharePoint. Responsible Person(s): M. Absi	*June 30, 2017*
iii. Announce training at Workforce Workshop. Responsible Person(s): M. Absi	*June 30, 2017*
Step 2b. Execute training roll-out. Responsible Person(s): M. Absi	*August 31, 2017*
i. Hold at least one in-person training session per RPU on each designated topic. Responsible Person(s): M. Absi and J. Commane	*August 31, 2017*
ii. Upload programs/modules to HWapps. Responsible Person(s): M. Absi and J. Commane	*August 31, 2017*
iii. Track training utilization through HWapps to monitor prevalence of use. Responsible Person(s): M. Absi and J. Commane	*September 30, 2017*

3. Complete the development of supplemental training modules	**June 30, 2017**
Step 3a. Complete vendor selection process. Responsible Person(s): M. Absi	*Completed February 2017*
i. Confirm with selected vendors willingness to create modules/programs. Responsible Person(s): M. Absi	*Completed February 2017*
ii. Pursue completion with vendor or follow-up with other process participants. Responsible Person(s): M. Absi	*Completed February 2017*
Step 3b. Finalize programs/modules. Responsible Person(s): M. Absi	*May 31, 2017*
i. Obtain draft programs/modules from vendor selected. Responsible Person(s): M. Absi	*May 31, 2017*
ii. Bring to CCHL Committee for feedback before finalization. Responsible Person(s): M. Absi	*June 30, 2017*
ii. Approve with CCHL Committee to finalize. Responsible Person(s): M. Absi	*June 30, 2017*
4. Make CCHL supplemental training modules available to all CCN partners.	**September 30, 2017**
Step 4a. Communicate plan to partner organization. Responsible Person(s): M. Absi	*June 30, 2017*
i. Contact Workforce Leads at contracted organizations to notify them of CCHL trainings. Responsible Person(s): M. Absi	*June 30, 2017*
ii. Announce training availability at meetings and announce via SharePoint. Responsible Person(s): M. Absi	*June 30, 2017*
iii. Announce training at Workforce Workshop. Responsible Person(s): M. Absi	*June 30, 2017*
Step 4b. Execute training roll-out. Responsible Person(s): M. Absi	*June 30, 2017*
i. Hold at least one in-person training session per RPU on each designated topic. Responsible Person(s): M. Absi and J. Commane	*July 31, 2017*
ii. Upload programs/modules to HWapps. Responsible Person(s): M. Absi and J. Commane	*August 31, 2017*
iii. Track training utilization through HWapps to monitor prevalence of use. Responsible Person(s): M. Absi and J. Commane	*September 30, 2017*

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Mid-Point Assessment Recommendation #18: The IA recommends that the PPS develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Convene a CCHL work group tasked with the responsibility for developing metrics.	**September 30, 2017**
Step 1a. Identify individuals interested in participating from CCHL Committee. Responsible Person(s): S. Ley and M. Absi	*Completed March 2017*
Step 1b. Identify individuals interested in participating from partner organizations. Responsible Person(s): M. Absi	*March 31, 2017*
Step 1c. Identify standing best practices with the help of the CCHL Committee. Responsible Person(s): M. Absi	*June 30, 2017*
Step 1d. Survey workgroup participants about how they measure this at their respective organizations. Responsible Person(s): M. Absi	*June 30, 2017*
Step 1e. Convene workgroup for half a day to talk through metrics identified in best practice review and survey. Responsible Person(s): M. Absi	*August 31, 2017*
Step 1f. Narrow down proposed metrics. Responsible Person(s): M. Absi	*August 31, 2017*
Step 1g. Identify appropriate selection process including voting committee. Responsible Person(s): M. Absi with CCHL Committee	*September 30, 2017*
Step 1h. Vote on identified metrics for implementation. Responsible Person(s): M. Absi with CCHL Committee	*September 30, 2017*
2. Develop a process for using the metrics	**September 30, 2017 and on-going**
Step 2a. Identify the who, when, how metric tool will be used as well as who will tabulate metric information. Responsible Person(s): M. Absi	*August 31, 2017*
Step 2b. Develop method of providing feedback to projects, partners, and other interested groups. Responsible Person(s): M. Absi	*September 30, 2017 and on-going*
3. Accelerate use of the Nathan Kline Cultural Competency Assessment Survey (CCAS).	**June 30, 2017**
Step 3a. Distribute CCHL survey to contracted organizations. Responsible Person(s): M. Absi	*March 31, 2017*

Step 3b. Develop method of providing feedback to projects, partners, and other interested groups. *Responsible Person(s): M. Absi*	*June 30, 2017*

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Mid-Point Assessment Recommendation #19: The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Develop VBP support implementation plan	**June 30, 2017**
Step 1a. Develop the VBP support implementation plan. Responsible Person(s): B. Carangelo	*May 31, 2017*
Step 1b. Review the VBP support implementation plan with the VBP sub committee. Responsible Person(s): B. Carangelo	*June 30, 2017*
2. Engage partners for VBP education and training	**September 30, 2017 and on-going**
Step 2a. Develop VBP training/education schedule. Responsible Person(s): B. Carangelo	*May 31, 2017*
Step 2b. Review the VBP support implementation plan with the VBP sub committee. Responsible Person(s): B. Carangelo	*June 30, 2017*
Step 2c. Offer at least two sessions for each provider category per DSRIP year. Responsible Person(s): J. Commane and B. Carangelo	*September 30, 2017 and on-going*
Step 2d. Organize regional VBP learning collaboratives to assist partners in applying VBP methodology to their individual organizations . Responsible Person(s): B. Carangelo and RPU teams	*September 30, 2017 and on-going*
Step 2e. Set up VBP pilots within the RPUs to provide community based organizations opportunities to envision how to migrate to VBP payment arrangements. Responsible Person(s): B. Carangelo and RPU teams	*September 30, 2017 and on-going*

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Mid-Point Assessment Recommendation #20: The IA recommends that the PPS develop a strategy to increase partner engagement throughout the PPS, particularly with Primary Care Providers and Non-Primary Care Providers.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Develop new reimbursement models for the projects.	**April 30, 2017**
Step 1a. Increase payment/funds flow for specific projects which proved to be under-valued in Phase 1 contracting. Responsible Person: B. Carangelo	*March 31, 2017*
Step 1b. Design and distribute payments to partners to accommodate for upfront investment, workflow and organizational infrastructure build. Responsible Person(s): B. Carangelo	*April 30, 2017*
2. Complete RPU Network Capacity and Capability	**June 30, 2017**
Step 2a. Prepare for each RPU, a network analysis by each partner category. For each category include a list of partners by DSRIP category and indicate the current CCN contracts for that partner category. Responsible Person(s): RPU Leads with Partner Relations	*April 30, 2017*
Step 2b. Evaluate the network/analysis and the current contracted partner network at the RPU meeting to identify gaps or missing/needed partner services in the RPU. Responsible Person(s): RPU Leads	*April 30, 2017*
Step 2c. Construct and implement an action plan for outreach to partners for needed services based on the network analysis. Responsible Person(s): RPU Leads	*May 30, 2017*
Step 2d. Conduct weekly Network Action Plan monitoring in each RPU until network has adequate capacity and capabilities. Responsible Person(s): RPU Leads	*June 30, 2017*
3. Remove data reporting barriers	**March 31, 2017 and on-going**

Step 3a. Align PPS reporting requirements to DOH reporting requirements. Communicate to partners. Responsible Person(s): E. Pape and Partner Relations	*Completed February 2017*
Step 3b. Work with partners to assist them in matching patient engagement data to CIN and/or patient identifying MCO Policy Number. Responsible Person(s): E. Pape and Partner Relations	*March 2017 and on-going*
4. Educate partners on the value of DSRIP to increase engagement.	**April 30, 2017**
Step 4a. Create electronic materials to be distributed to clinical staff clearly outlining what DSRIP does for them along with the value-add to the provider and support staff. Responsible Person: M. Gusman	*March 31, 2017*
Step 4b. Convene discussion forums directly with physicians to articulate the goals of DSRIP and how their engagement with the DSRIP program will facilitate improvements to their practice. Responsible Person(s): RPU Leads and Partner Relations	*April 30, 2017*
5. Monitor progress of project milestones, partner engagement, and patient engagement monthly.	**March 2017 and ongoing**
Step 5a. Report monthly and receive input from the PAC Executive Council and the CCN Board of Directors on the progress of project milestones, partner engagement and patient engagement. Responsible Person(s): D. Sculley and B. LeRoy	*March 2017 and ongoing*
Step 5b. Utilize input from PAC Executive Council, Coordinating Council and the CCN Board to develop short term action plans when project milestones, partner engagement or patient engagement fall behind schedule. The action plans will be developed with an identified responsible person, timeline, and PPS funding (where applicable) to support resolution and performance. Responsible Person(s): D. Sculley and B. LeRoy	*March 2017 and ongoing*

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Mid-Point Assessment Recommendation #21: The IA requires the PPS to develop a plan to increase patient engagement across all projects.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Operationalizing the Regional Performing Units (RPUs).	**April 2017 and on-going**
Step 1a. Assign interim full time RPU Leads for the North and South RPUs. Responsible Person(s): M. Ropiecki and B. LeRoy	*Completed February 2017*
Step 3a. Establish a Structure for Performance Governance. Each RPU will work with a standardized performance dashboard that includes (at a minimum): contracted performance by partner and project and quality measure sets organized by each project. Each RPU will be accountable for monitoring and reporting RPU performance to CCN Executive Director, PAC Executive Council and the CCN Board of Directors. Responsible Person(s): RPU Leads	*April 2017 and ongoing*
Step 3b. Track and evaluate contracted performance by partners in weekly RPU meetings, bi-monthly at PAC Executive Council and monthly at the CCN Board. Performance schedules showing performance by project and contracted partner for each RPU and the PPS as a whole will be prepared by the CCN Director of Finance. Responsible person(s): RPU Leads	*February 2017 and ongoing*
Step 3c. Review and evaluate Population Health Quality Measure Sets. RPUs will develop action plans for interventions through projects and/or care coordination. RPUs will maintain an active issue log to assure that identified and approved interventions have an implementation plan that is actively managed. Responsible person(s): E. Pape and RPU Leads	*February 2017 and ongoing*
2. Adequately incentivize partners to engage with patients	**June 30, 2017**
Step 2a. Develop enhanced financial incentives to meet short term patient engagement targets. Responsible Person(s): B. Carangelo	*Completed February 2017*

Step 2b. Increase payment/funds flow for specific projects which proved to be under-valued in Phase 1 contracting. Responsible Person(s): B. Carangelo	*March 31, 2017*
3. Create bi-directional opportunities for interaction between Medicaid members and services and providers	**September 30, 2017 and on-going**
Step 3a. Examine project activities to identify touchpoints for optimizing patient engagement. Responsible Person(s): RPU Leads in conjunction with Project Managers	*September 30, 2017 and on-going*
Step 3b. Use the Medicaid patient panel developed by RMS to explore patient engagement strategies. Responsible Person(s): M. Gusman	*July 31, 2017*
Step 3c. Create forums for partners to share successes in engaging patients. Responsible Person(s): RPU Leads	*July 31, 2017*
4. Develop an educational and marketing campaign to explain to Medicaid members the health care delivery transformation that is in progress and how it benefits them.	**July 31, 2017**
Step 4a. Convene workgroup of stakeholders across the care continuum and determine the marketing strategy to educate Medicaid members. Responsible Person: M. Gusman	*April 30, 2017*
Step 4b. Share marketing campaign details with RPUs, PAC Executive Council and the PAC/Stakeholders. Responsible Person(s): M. Gusman	*June 30, 2017*
Step 4c. Execute marketing campaign. Responsible Person(s): M. Gusman	*July 31, 2017*
5. Monitor progress of project milestones, partner engagement, and patient engagement monthly.	**March 2017 and ongoing**
Step 5a. CCN Leadership will report, and received input from monthly, to PAC Executive Council and the CCN Board of Directors on the progress of project milestones, partner engagement and patient engagement.	*March 2017 and ongoing*
Step 5b. Utilize input from PAC Executive Council and Coordinating Council to develop short term action plans when project milestones, partner engagement or patient engagement fall behind schedule. The action plans will be developed with an identified responsible person, timeline, and PPS funding (where applicable) to support resolution and performance.	*March 2017 and ongoing*

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Mid-Point Assessment Recommendation #22: The IA recommends that the PPS develop an action plan to address the deficiencies identified in the Primary Care Plan, notably the lack of specificity on the primary care strategy of the PPS, the limited detail on progress towards implementation of the primary care strategies, and the role of the PPS in monitoring and overseeing the implementation of the primary care strategies.	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Add specificity to the Primary Care Plan and obtain CCN Board approval	**June 30, 2017**
Step 1a. Create a Primary Care Practice multidisciplinary workgroup in the PPS to assist and support implementation of the PPS Primary Care Strategy. Responsible Person(s): D. Sculley	*May 31, 2017*
Step 1b. Prepare and present targeted assessment of primary care practice capacity inclusive of Medicaid patient capacity, depth with care coordination and access. Responsible Person(s): RPU teams	*May 31, 2017*
Step 1c. Identify gaps in capacity, care coordination, status of PCMH progress and performance with Medicaid members and develop an action plan for each gap identified. Responsible Person(s): D. Sculley and PCP multidisciplinary workgroup	*June 30, 2017*
Step 1d. Work with the Workforce Development and Transition Team to identify and incorporate strategies to address the gaps in Primary Care capacity. Responsible Person(s): D. Sculley and PCP multidisciplinary workgroup	*June 30, 2017*
Step 1e. Identify and incorporate strategies to support PCP in expanding their practice to serve Medicaid members. Responsible Person(s): D. Sculley and PCP multidisciplinary workgroup	*June 30, 2017*
Step 1f. Identify and incorporate strategies for engaging primary care in performance management. Responsible Person(s): D. Sculley and PCP multidisciplinary workgroup	*June 30, 2017*
Step 1g. Enhance the Primary Care Plan with strategies and best practices in network participation and shared accountability for performance. Responsible Person(s): D. Sculley and PCP multidisciplinary workgroup	*June 30, 2017*

Step 1h. Develop a funds flow methodology to incentivize PCP collaboration with CBOs and other community service organizations. Responsible Person(s): B. Carangelo	*June 30, 2017*
Step 1i. Develop a 3ai project implementation template based on best practice learning from the MAX pilot site. Responsible Person(s): B. Rosetti	*June 30, 2017*
Step 1j. Develop and implement pilots designed to advance increased integration of primary care and behavioral health. Responsible Person(s): B. Rosetti and RPU Leads	*July 31, 2017*
Step 1k. Update the Primary Care Plan to include the input from the Primary Care Practice multidisciplinary workgroup as well as progress to date in implementing the strategies and provide to the workgroup for review/input. Responsible Person(s): D. Sculley	*August 31, 2017*
Step 1l. Present the updated Primary Care Plan to PAC Executive Council for review and input. Present to the CCN Board of Directors for their approval. Responsible Person(s): D. Sculley	*September 30, 2017*
2. Monitor implementation of the Primary Care Plan	**September 30, 2017 and on-going**
Step 2a. Report monthly and receive input from the PAC Executive Council and the CCN Board of Directors on the progress of implementing the Primary Care Plan	*September 2017 and ongoing*
Step 2b. Utilize input from PAC Executive Council, Coordinating Council and the CCN Board to develop short term action plans when implementation of the Primary Care Plan falls behind schedule. The action plans will be developed with an identified responsible person, timeline, and PPS funding (where applicable) to support resolution and performance.	*September 2017 and ongoing*

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Mid-Point Assessment Recommendation #23 (PAOP WhitePaper): 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. Complete a Partner Network Assessment.	**June 30, 2017**
Step 1a. Prepare for each RPU, a network analysis by each partner category. For each category include a list of partners by project, by DSRIP category and indicate the current CCN contracts for that partner category. Responsible Person(s): RPU Leads with Partner Relations	*April 30, 2017*
Step 1b. Evaluate the network/analysis and the current contracted partner network at the RPU meeting to identify gaps or missing/needed partner services in the RPU. Responsible Person(s): RPU Leads	*April 30, 2017*
Step 1c. Construct and implement an action plan for outreach to partners for needed services based on the network analysis. Responsible Person(s): RPU Leads	*May 31, 2017*
Step 1d. Conduct weekly Network Action Plan monitoring in each RPU until network has adequate capacity and capabilities. Responsible Person(s): RPU Leads	*June 30, 2017*
2. Conduct a series of project collaboratives	**September 30, 2017**
Step 2a. Organize project learning collaboratives within each RPU to encourage knowledge sharing and to showcase benefits and best practices. Responsible Person(s): D. Sculley with the RPU teams	*September 30, 2017*
Step 2b. Generate solutions to identified barriers and/or develop mitigation strategies. Responsible Person(s): Project Managers with support from RPU teams	*September 30, 2017*
3. Accelerate Network Partner Engagement.	**July 31, 2017**
Step 3a. Facilitate completion of contracts with partners. Responsible Person(s): Partner Relations	*July 31, 2017*

Step 3b. Support contracting with a detailed implementation plan. Responsible Person(s): Project Managers with support from RPU team	*July 31, 2017*
Step 3c. Facilitate collaboration among partners to implement projects Responsible Person(s): RPU Leads with support from RPU team	*July 31, 2017*
4. Support Project Implementation	**September 30, 2017 and on-going**
Step 4a. Revise Funds flow for each project based on feedback from contracted partners to assure adequate funding for startup and ongoing operations. Responsible Person(s): B. Carangelo	*March 31, 2017*
Step 4b. Implement a project resource center and best practice project collaboratives. Responsible Person(s): Project Managers with support from RPU team	*July 31, 2017 and on-going*
Step 4c. CCN will provide tools and support for project implementation through enhanced workforce and IT. Responsible Person(s): R. Kennis and M. Absi	*September 30, 2017 and on-going*
5. Transition the RPUs from an information sharing forum to a partner / network performance management function	**September 30, 2017 and on-going**
Step 5a. Infuse new resources into the RPUs with five dedicated positions: RPU Leader, Population Health Analyst, RPU Project Manager, RPU Partner Relations and IT Project Manager. Responsible Person(s): M. Ropiecki, B. LeRoy, D. Sculley and R. Kennis	*June 30, 2017*
Step 5b. Provide partner level performance reporting for patient engagement performance and project quality measure sets and support for performance improvement. Responsible Person(s): Project Managers with support from RPU team	*July 31, 2017 and on-going*
Step 5c. Implement a performance payment model that includes network performance . Responsible Person(s): B. Carangelo	*March 31, 2017*
6. Support and facilitate primary care expansion	**September 30, 2017 and on-going**
Step 6a. Reassess Primary Care for the Medicaid Population. Identify specific needs for primary care support and expansion. Responsible Person(s): RPU Leads with support from RPU team	*June 30, 2017*
Step 6b. Foster Primary Care Expansion. Responsible Person(s): RPU Leads and B. Carangelo with support from RPU team	*September 30, 2017 and on-going*
7. Support and facilitate resources for Mental Health expansion	**September 30, 2017 and on-going**

Step 7a. Prioritize implementation of Tele-psychiatry. Responsible Person(s): R. Kennis	*September 30, 2017 and on-going*
Step 7b. Provide resource support for the new psychiatry residency program. Responsible Person(s): M. Absi and B. Carangelo	*September 30, 2017 and on-going*
Step 7c. Collaborate with established Psychiatric Advance Practice Provider (APP) programs to increase program capacity and place APPs in key roles. Responsible Person(s): M. Absi and B. Carangelo	*September 30, 2017 and on-going*
8. Support Substance Use Disorder providers on opportunities for expansion	**September 30, 2017 and on-going**
Step 8a. Work with SUD programs on care coordination. Responsible Person(s): RPU Leads	*September 30, 2017 and on-going*
Step 8b. Provide opportunities to expand capability for these organizations into care coordination integrated with the primary care office. Responsible Person(s): RPU Leads	*September 30, 2017 and on-going*
9. Support CBOs in their future viability in a transformed health care delivery system	**September 30, 2017 and on-going**
Step 9a. Revise Funds flow for each project based on feedback from contracted partners to assure adequate funding for startup and ongoing operations. Responsible Person(s): B. Carangelo	*March 31, 2017*
Step 9b. Facilitate relationships and complete contracts between CBOs, Primary Care and Health Systems to complete the network. Responsible Person(s): RPU Leads	*September 30, 2017*
Step 9c. Identify CBO transformation resources and facilitate mentoring with CBO leaders who have successfully led change in their organizations. Responsible Person(s): RPU Leads	*September 30, 2017 and on-going*