Central New York Care Collaborative

Mid-Point Assessment Recommendation Action Plan Narratives

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations to address specific areas identified as deficiencies that could impact the CNYCC's 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).

Mid-Point Assessment Recommendation #1:

Project 2.a.iii: Health Home At-Risk Intervention Program: "The IA recommends that the PPS develop a training plan to educate PCPs on the care coordination requirements for this project."

PPS Action Plan Narrative:

To ensure practitioners are actively engaged in implementing the Health Home At-Risk Intervention Program, CNYCC received the IA recommendation to create a training plan in order to educate Primary Care providers on the care coordination requirements of the project.

CNYCC has delineated the following steps in order to address this recommendation:

1. Determine which training modules need to be conducted via the care coordination requirements in conjunction with the care coordination resource (Recommendation #2)
2. Refine care coordination modules with feedback from partnered Health Homes/Care Management Agencies and Primary Care Practices
3. Determine which Primary Care Practices need/would like to complete the care coordination training
4. Determine how many individuals within the Primary Care setting need to be trained in each care coordination modules
5. Determine/select most appropriate resource to lead, develop, and coordinate implementation of training plan
6. Develop training modules for each topic within curriculum
7. Coordinate trainings based on partner availability and geographic locations
8. Roll out training to partner Primary Care Providers

Through project work, CNYCC previously gathered a group of project participants (that included both Health Homes/Care Management Agencies and Primary Care Providers) to create a training outline that would be essential for any Primary Care Practice to receive in order to become familiar with care coordination. The group generated four (4) different modules that were necessary for effective care coordination/management:

1. Care Management 101
2. How to Engage an Individual
3. How to Create a Care Plan
4. How to Coordinate Care

Within each module, the group determined what the main training points and learning objectives. A complete training grid containing this information is available upon request.

As this curriculum was generated prior to the recommendation from the PAOP, CNYCC will determine which training modules need to be conducted via the care coordination requirements in conjunction with the care coordination resource which is Recommendation #2 from the PAOP. CNYCC will examine this curriculum to ensure that is coincides with training that will need to be conducted for the care coordination resource.

To ensure that these modules encompass everything Primary Care Providers will need to perform care coordination services, CNYCC will solicit feedback from partnered Health Homes/Care Management Agencies and Primary Care Practices. From this feedback, it is CNYCC's goal to identify any additional skills and/or modules needed to successfully perform care coordination services. As this curriculum has already been created, reviewing the curriculum and soliciting partner feedback can happen immediately.

Once these modules have been vetted by partner organizations, CNYCC will work with partners to determine which Primary Care Practices need and/or would like to complete this care coordination training. As not every Primary Care Practice has contracted for Project 2.a.iii, CNYCC will allow all interested partner organizations to participate in this training. Additionally, providers other than Primary Care may be interested in participating in some of this training. From this identification, CNYCC will determine how many individuals from each of those providers would need and/or like to be trained in the care coordination modules. This information will allow CNYCC to adequately budget and plan for these trainings.

From the determination of the training modules, CNYCC will be determining the most appropriate resource to lead, develop, and coordinate implementation of this training plan. Due to the fact that many partner organizations hold expertise in one or several of the modules, CNYCC will implement an evaluation process to select and implement this training resource. Once this resource has been selected, CNYCC will work to create the curriculum for each module. In the development of these modules, CNYCC will ensure the each module meets the expectations set forth in the original curriculum. The selection of the most appropriate resource and creation of the curriculum is estimated to require the most time of all milestones.

Once the appropriate resource is determined, CNYCC will coordinate trainings based on partner availability and geographic location. CNYCC will work closely with the training resource in order to facilitate these trainings and ensure they are scheduled on a regular basis so that all partner organizations have the opportunity to participate. Additionally, CNYCC will continuously facilitate trainings and make resources available for partner organizations in order to ensure that all appropriate staff are trained in the care coordination modules.

Tracking progress in executing these actions is the responsibility of the CNYCC Project Manager overseeing Project 2.a.iii. When each step within the recommendation is complete, the Project Manager will create supporting documentation to establish successful completion of that step. For instance, meeting schedules, meeting minutes and training documentation will be collected to substantiate completion.

These actions reflect the overall PPS strategy for meeting DSRIP goals as care coordination spans across multiple projects. Care coordination and care management services are the key link between all aspects within the projects. It is necessary to connect individuals to community services in order to reduce unnecessary Emergency Department visits and hospital readmissions by 25% by March 2020. Through education and promotion of care coordination skills and activities through this training, CNYCC is equipping partner organizations with the knowledge and skills needed to effectively coordinate care for patients.

Mid-Point Assessment Recommendation #2:
Project 2.a.iii: Health Home At-Risk Intervention Program, "The IA recommends that the PPS develop a care coordination resource to support PCPs."

PPS Action Plan Narrative:
Among CNYCC's primary care partner organizations, there is a range of interest in and capacity to hire and manage employed care coordinators. Additionally, among the three lead Health Homes in CNYCC's 6-county area and their many downstream Care Management Agencies, there exist differences in interest and capacity to embed staff in primary care practices and to utilize staff to provide different forms of care coordination/care management than the Health Home model. Recognizing this diversity in interest and capacity, the overall care coordination/care management strategy for the PPS is a hybrid model that accommodates both delegated care coordination/care management for those practices and agencies that wish to provide those services themselves as well as the creation of a centralized care coordination resource for those that cannot.

The following key milestones are part of CNYCC's planned implementation of a centralized care coordination resource for primary care practices:

1. Define care coordination resource model with input from Health Homes/Care Management Agencies, primary care practices, and at least one Medicaid MCO (DY2 Q4)
2. Establish care coordination resource pilot program with partnered Health Home or care management agency and primary care practice(s) (DY3 Q1)
3. Expand pilot care coordination resource to additional Health Homes/care management agencies and primary care practices (DY3 Q2)

The need to establish a central care coordination resource to support primary care practices was identified not only through the implementation challenges facing Project 2.a.iii but also through CNYCC's work to support practices seeking PCMH recognition and through collection of current state workforce data that informed our gap analysis and workforce transitions roadmap. CNYCC is also in the early stages of implementing a regional population health management system with care management and central care planning modules connected to community-wide data analytics that will drastically enhance all partners' ability to detect patient gaps in care that can be addressed through care coordination/management. These are key considerations for the care coordination model that CNYCC has begun to develop with input from Health Home/Care Management Agency and Primary Care Practice partner organizations.

In order to proactively plan for sustainability, CNYCC intends to engage at least one Medicaid Managed Care plan in the 6-county PPS area in discussions about coverage of these care coordination services. And in order to scale the intervention successfully, CNYCC has begun to identify Health Home/Care Management Agency and Primary Care Practice partner organizations interested in piloting the care coordination model that will be offered through the care coordination resource. Once the pilot program has been implemented effectively, CNYCC intends to expand the care coordination resource by contracting with Health Home/Care Management Agencies that are interested in providing these services while employing staff at CNYCC to oversee training, technical assistance, and program quality/effectiveness.

Tracking execution of this plan will be the responsibility of CNYCC's Director of Program Operations & Strategy, using an implementation plan that aligns with the above milestones and timelines (available upon request). When each step within the recommendation is complete, CNYCC staff will create supporting documentation to

establish successful completion of that step. For instance, numbers of patients provided care coordination services through the pilot or expanded care coordination resource as well as contracts/MOUs and meeting materials could be provided to substantiate milestone completion.

These actions reflect the overall PPS strategy for meeting DSRIP goals as care coordination spans across multiple projects. Care coordination and care management services are the key link between all aspects within the projects. It is necessary to connect individuals to community services in order to reduce unnecessary Emergency Department visits and hospital readmissions by 25% by March 2020. Through establishing a central care coordination resource for primary care practices that would otherwise be unable to staff this vital function, CNYCC will provide partners with the necessary resource to effectively coordinate care for patients.

Mid-Point Assessment Recommendation #3:
Project 2.a.iii: Health Home At-Risk Intervention Program, "The IA recommends that the PPS establish a system for identifying the targeted patients to assist the PCPs for this project as part of overall PPS population health strategy in working with its network partners."

PPS Action Plan Narrative:
Patient identification for Project 2.a.iii has proven tremendously difficult for partner organizations. As a result, the IA has recommended that the PPS establish a system for identifying the targeted patients to assist PCPs. With this recommendation, CNYCC has created three strategies that will assist in patient identification as well as the overall PPS population health strategy. These three strategies are:

1. Utilize claims data for patient identification
2. Utilize Managed Care Organizations information for patient identification
3. Assist Primary Care Providers in internally identifying eligible patients

Within the first strategy, CNYCC has delineated the following steps that will need to occur in order to successfully utilize Medicaid claims for patient identification. These steps include:

1. Examine data provided by DOH in the Medicaid Claims file
2. Extract data for individuals with either a single chronic condition and/or individuals with two chronic conditions that have no history of Health Home billing
3. Generate list of plan-assigned Primary Care Providers of those patients
4. Connect with assigned Primary Care Providers of those identified patients

Within the second strategy, CNYCC has delineated the following steps that will need to occur in order to successfully utilize Managed Care Organization information for patient identification. These steps include:

1. Work with Managed Care Organizations to obtain lists of individuals with a single chronic condition and/or individuals with multiple chronic conditions
2. Work with Health Homes to ensure the individuals on the MCO lists are not currently in outreach
3. Work with Health Homes to engage patients on MCO list who are not currently in outreach
4. Generate list of Primary Care Providers that are assigned to patients not eligible for Health Homes
5. Connect with assigned Primary Care Providers of those identified patients

Last but not least, CNYCC will implement a third strategy to assist Primary Care Providers in internally identifying the eligible patient population. For this strategy, CNYCC will take the following steps:

1. Educate Primary Care providers on the various care coordination options available (Health Homes, the Health Home At-Risk Intervention, internal PCMH care coordination)
2. Generate a reference sheet of eligibility requirements for various care coordination options
3. Create a workflow for Primary Care providers to utilize for referring patients to appropriate care coordination/care management services

In order to begin to educate Primary Care Providers on the various care coordination options, CNYCC asked the three lead Health Home entities: Central New York Health Home Network (CNYHHN), Circare (formerly Onondaga Care Management Services), and St. Joseph's Care Coordination Network to conduct various presentations and outreach meeting throughout the PPS. These presentations included a PPS-wide educational webinar and in-person meetings through the Cardiovascular Disease Management and Care Transitions projects.

On a more personalized level, CNYCC has directly connected Primary Care Providers and Health Homes through in-person meetings and formal introductions. As there are three lead Health Homes and a plethora of downstream Care Management Agencies, CNYCC created a directory of each Health Home and Care Management Agency that provides Health Home services and in which county throughout the PPS. CNYCC has utilized workgroup meetings to facilitate introductions as well as connected partners via email in order to schedule 'in-service' presentations for Primary Care Practices that are not well versed in Health Home services. As education is a large part of Project 2.a.iii, this step has been underway and will continue to be until all Primary Care Providers have a good working knowledge of the various care coordination services.

Secondly, CNYCC has developed a reference sheet of patient eligibility criteria for the various care coordination options within the Primary Care setting. This reference sheet incorporates the patient eligibility criteria for Health Homes, the Health Home At-Risk Intervention, and internal PCMH care coordination. This reference sheet ties directly to a draft workflow that Primary Care Providers can utilize when referring patients to the appropriate care coordination/care management service. The workflow depicts a model workflow and communication feedback loop between Primary Care and Care Management Agencies.

Tracking progress in executing these actions is the responsibility of the CNYCC Project Manager overseeing Project 2.a.iii. When each step within the recommendation is complete, the Project Manager will create supporting documentation to establish successful completion of that step. For instance, meeting schedules, meeting minutes and training documentation will be collected to substantiate completion.

These actions reflect the overall PPS strategy for meeting DSRIP goals as it expands care coordination to patients throughout the PPS, regardless of project. Additionally, this expands Primary Care Provider knowledge of care coordination services that can be utilized for their entire patient panel. It is necessary to connect individuals to community services in order to reduce unnecessary Emergency Department visits and hospital readmissions by 25% by March 2020. Through establishing a process for identifying patients that are eligible for Health Home At-Risk Intervention Program services as well as other care coordination/care management services, CNYCC is equipping partner organizations with the knowledge and skills needed to effectively coordinate care for patients.

Mid-Point Assessment Recommendation #4:
Project 2.d.i: Implementation of Patient Activation Activities, "The IA recommends that the PPS finalize the contracts with partners participating in this project."

PPS Action Plan Narrative:
CNYCC is currently contracted with 42 organizations for Project 2.d.i. Of the 42 contracted organization, only 17 organizations are currently reporting actively engaged patients. All contracts are finalized with partners who are currently participating in this project. CNYCC recognizes the need to outreach to the 25 contracted partners who are not reporting and provide additional assistance with implementation. We have also identified a need to engage more community organizations who are providing services to the target population of uninsured individuals and non- and low-utilizing Medicaid members.

CNYCC has delineated the following steps in order to address this recommendation:

1. Conduct an additional environmental scan to obtain updated information to identify the "Hot Spot" areas for the target population utilizing the Salient Interactive Miner (SIM) and seek to engage and contract with additional organizations located within "Hot Spot" areas (DY3 Q1)
2. Seek to engage non-participating organizations within "Hot Spot" areas to participate in project with a goal of adding more contracted partners (DY3 Q2)
3. Outreach organizations who are contracted but not reporting actively engaged patients, assess needs of organizations, and provide assistance to partners regarding implementation (DY3 Q2)

CNYCC will track the progress of this action plan based on ongoing analysis of the increase in newly contracted partner organization and the increase in actively engaged patients. In addition, CNYCC will utilize Insignia Health's Flourish platform to produce participation and activity reports for the registered users of each contracted and trained partner organization.

The ability to contract with new organizations who are providing services to the target population and accelerate their project implementation will increase opportunities to conduct PAM® screenings and connect patients with primary and preventive care services/resources. By increasing the number of contracted partner organizations that can outreach to the target population, CNYCC expects to increase the number of actively engaged patients that are reported towards the PPS target.

Mid-Point Assessment Recommendation #5:
Project 2.d.i: Implementation of Patient Activation Activities: "The IA recommends that the PPS increase the trainings available to assist partners in implementing this project."

PPS Action Plan Narrative:
CNYCC has offered 11 trainings to partners beginning March 2016 to the present date. Currently, we have a growing number of individuals trained in the PAM® and/or CFA®. We have trained 348 (trained by CNYCC staff and PAM® Trainers), of those 29 individuals are PAM® Trainers. PAM® Trainers are individuals who participated in our Train-the-Trainer session. The PAM® Trainers are able to train staff within their own organizations.

In order to increase the trainings available to assist partners in implementing this project, CNYCC will:

1. Provide quarterly trainings in Patient Activation techniques (DY3 Q2)

2. Provide on-site trainings to partners who are newly contracted or identified as needing additional training to support implementation (DY3 Q2)
3. Provide a Train-The-Trainer session at least twice a year for partner organizations to have the ability to train staff within their own site (DY3 Q2)

CNYCC will track the progress of this action plan based on ongoing analysis of all newly trained individuals in Patient Activation techniques and contracted organizations ability to obtain trainings to begin implementation of project. This plan once implemented will continue based on the needs of the project.

The ability to provide access to trainings will help organization to begin implementation in a timely fashion. This will increase opportunities to conduct PAM® screenings and connect patients with primary and preventive care services/resources. By increasing the number of trainings available to partner organizations that can outreach to the target population, CNYCC expects to increase the number of actively engaged patients that are reported towards the PPS target.

Mid-Point Assessment Recommendation #6:

Community-Based Organization Contracting: "The IA recommends that the PPS develop a clear strategy of contracting with CBOs."

Mid-Point Assessment Recommendation: #7:
Community-Based Organization Contracting, "The IA recommends that the PPS finalize contracts with partnering CBOs."

PPS Action Plan Narrative (combines Recommendations #6 and #7):
CNYCC recognizes the value of conducting comprehensive outreach to local Community-Based Organizations (CBOs). CBOs play a vital role in community engagement and provide a wide range of resources (social, economic, education, etc.) for a significant segment the local population. Building relationships with local CBO partners will greatly benefit CNYCC engagement efforts and allow CBO partners to explore opportunities to participate in DSRIP activities and provide much needed services for the Medicaid population.

CNYCC has developed a comprehensive outreach and engagement strategy to foster relationships with CBO partners across the region. CBO engagement efforts have included:

Development of Relationships with Regional CBO Coalitions (e.g., Human Services Leadership Council, HSLC)

The HSLC is a membership organization and a coalition of leaders of nearly 65 human service not-for-profit agencies. The agencies deliver a broad range of services to people in Onondaga County, the Greater Syracuse Area and Central New York. CNYCC has worked closely with HSLC leadership to engage member organizations and leverage partnership opportunities related to DSRIP. CNYCC staff presented to the HSLC Board of Directors; conducted lunch-n-learn workshops for HSLC members; and engaged HSLC leadership in activities to support applicants for the DOH CBO planning grant. In additions to these types of regional efforts, CNYCC is working closely with Local Governmental Units (LGUs) in each County to identify and engage CBO partners.

CBO Learning Collaborative

CNYCC conducts monthly meetings with CBO partners as part of the CNYCC Learning Collaborative model. The CBO Learning Collaborative meetings include a review of project implementation and performance measures.

CBOs also discuss best practice and project implementation challenges. The CBO Learning Collaborative has recently began meeting in conjunction with the Acute and Post-Acute Learning Collaboratives. This joint meeting provides an opportunity for CBOs, acute, and post-acute partners to develop strategies for collaboration and discuss the 30-day transition program in which CBOs will play an important role.

Development of Community Outreach/Engagement Activities

CNYCC has recently coordinated community outreach efforts to help educate the public on health-related issues. The Community Forums will take place in each of CNYCC's six counties and will focus on engagement, education, and patient interaction with the healthcare system. Local CBO organizations will be tasked with conducting public forums and working with the community to determine effective strategies to increase awareness of DSRIP related activities such Project 2.d.i in order to increase patient participation.

CBO Recruitment for Project Activities

CNYCC has and will continue to recruit various CBOs to participate in DRIP project implementation. For example, as part of Project 2.d.i, CNYCC is actively recruiting CBO partners for participation. Additionally, CNYCC is actively working with Safety-Net partners to establish sub-contracting partnerships with Non-Safety-Net partners to provide additional opportunities for those Non-Safety-Net partners to receive payment for their DSRIP activities.

In addition to these efforts, CNYCC continues to work with CBOs on an individual basis through one-on-one meetings, and through collaborations with current network partners and other agencies such as the Health Foundation of Central and Western New York.

CNYCC will leverage these relationships to provide education and information about PPS activities to the community related to DSRIP through public presentations, development of collateral materials, and the continued work of DSRIP project implementation with CBO partners.

Mid-Point Assessment Recommendation #8:
Cultural Competency and Health Literacy, "The IA recommends that the PPS develop an action plan to roll out its trainings to partners."

PPS Action Plan Narrative:
The ability of CNYCC to apply cultural competency and health literacy strategies throughout the PPS is essential to include Medicaid members from all backgrounds in improved quality of care and health outcomes. Ultimately, these strategies must be infused into all areas impacting care delivery, including staff training, community outreach and education, partnerships with community organizations, and organizational policy.

With over 170 independent partner organizations with diverse representation across the PPS, administration of the CC/HL training program was developed to address the various needs of different providers, some of whom have already instituted some level of CC/HL training in their operational structure. With that in mind, CNYCC has developed training activities to provide partners with a comprehensive resource that adheres to prescribed standards for cultural competency and health literacy (The National Standards for Culturally and Linguistically Appropriate Services [CLAS] in Health and Health Care & Ten Attributes of Health Literate Health Care Organizations). The desired outcomes of the training is increased compliance with both sets of standards which should in turn lead to better engagement of (and service to) Medicaid members and the uninsured.

CNYCC's CC/HL Training Strategy details preferred training concepts identified within each CNYCC project. The complete set of training offerings provide general CC/HL education and awareness resources, and also include topic specific resources for organizations that may only need to supplement their current offerings.

The CC/HL Training Strategy will be incorporated as part of CNYCC's overall workforce training strategy. The overall CNYCC Workforce Training Strategy includes a number of potential approaches to meet partner training needs and DSRIP requirements: a menu of trainings available online; training curriculum offered by various vendors; or training materials that could potentially be developed by CNYCC to fit the specific needs of partners.

Awareness vs. Skills-based

Awareness training refers to an overview or introductory topic focus, in this case on cultural competency and health literacy. These trainings will provide a general understanding of CC/HL, its prevalence and how it affects a provider, and/or and organization's ability to serve their communities equitably.

Skills-based trainings refer to specific skills needed to provide culturally competent and health literate care. These include creating a welcoming environment, communicating clearly, checking for understanding, using language access services appropriately, and developing health messages which resonate with the individual and community. Additionally, topic specific skill based trainings will be offered that focus on individual projects (e.g., training for Project 3.b.i regarding chronic disease self-management).

Partner organizations will have the opportunity to choose from a diverse CC/HL curriculum that can be tailored based on their level of project participation.

Online vs. In-person

As part of CNYCC's CC/HL Training Strategy, curricula will be provided for partner organizations in both on-line and in-person formats. On-Line curriculum offerings will be provided for both Awareness and Skill based trainings.

Workforce Training Strategy

As stated above, CNYCC's CC/HL Training Strategy will be a component of the overall Workforce Training Strategy for partner organizations. CNYCC's Workforce Training Strategy is based upon the five-step ADDIE instructional design model: Analyze, Design, Develop, Implement, and Evaluate.

CNYCC has identified four potential approaches to meeting the functional requirements for workforce training content delivery and tracking:

1. Acquisition of a Learning Management System (LMS) to deliver centrally licensed course content;
2. Development of a central marketplace for vetted course content that partners could then license for their employee's use;
3. Extension of an existing LMS (currently utilized by a partner organization) to the rest of the network;
4. Distribution of the training syllabus to partners who could then independently deliver or acquire needed training for their employees.

CNYCC's Workforce Committee is currently evaluating the proposed delivery models and will make a formal recommendation to CNYCC's IT/Data Governance and Finance Committee(s) prior to final approval by CNYCC's Board of Directors.

Mid-Point Assessment Recommendation #9:
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:
In an effort to support the measurement of desired outcomes pertaining to CC/HL, CNYCC has identified evaluation approaches to assess the level of effectiveness of CC/HL trainings. CC/HL training implementation will be evaluated based on CLAS and the 10 Attributes of Health Literate Organization standards to measure impact and effectiveness across the PPS. CC/HL measurement will focus on both the extent of provider training and education, and the overall impact on the patient population.

PPS Partner Organization CC/HL Measurement

CNYCC will conduct a pre-training assessment of the PPS network via a customized CC/HL Survey. The survey will provide a baseline of CC/HL utilization and impact across the PPS, provide CNYCC with the opportunity to track improvement over time, and also support the development of best practices for CC/HL education and awareness.

The survey will focus on the following elements:

1. Provide culturally competent and health literate care and service
2. Integrate and use cultural competency and health literacy interventions.
3. Work effectively with translators, interpreters and community health outreach workers
4. Engage with and partner with community-based organizations and providers

The CC/HL Survey will be administered periodically to PPS partners. Partner organizations will then have the ability to adopt and implement recommended trainings available through CNYCC's CC/HL curriculum. Integration of CC/HL trainings will lead to an increase in an organization's adherence with the desired standards, measured by subsequent performance on the CC/HL partner survey. By tracking the survey scores of as many partners as possible over time, the CNYCC can track its own progress in supporting our partners' efforts. And each partner will be able to use these scores to track their individual progress.

Consumer Engagement Measurement

As part of the CC/HL program efforts, CNYCC will gain feedback from the patient population to assess the effectiveness of CC/HL implementation by partner organizations across the PPS. CNYCC will utilize two standard methods for assessing CC/HL implementation from the individual patient/client/consumer view-point: community forums and CAHPS survey results.

The Community Forums will be conducted by CBO partners across the PPS to evaluate the overall consumer experience with healthcare organizations in the region with a specific focus on CC/HL practices. The forums can be conducted periodically to help CNYCC identify CC/HL best practices and identify areas of improvement.

CNYCC will also work with partner organizations to capture, measure, and improve the CC/HL components of their CAHPS survey information. CAHPS surveys are standard patient satisfaction surveys that are routinely conducted by healthcare organizations. Utilization of CAHPS can provide valuable patient feedback on items such as provider's attitude, cultural sensitivity, access to linguistically appropriate material/interpreter services, and use of clear communication techniques. CAHPS information can be a valuable tool in monitoring the level of CC/HL adoption by individual providers and give partner organizations the opportunity to adjust implementation efforts to maximize effectiveness.

Mid-Point Assessment Recommendation #10:
Financial Sustainability and VBP, "The IA recommends that the PPS hire a Finance Director."

PPS Action Plan Narrative:
CNYCC successfully recruited and hired a Director of Finance, Michael Riley, whose start date was February 13th.

Mid-Point Assessment Recommendation #11:
Primary Care Plan, "The IA recommends that the PPS develop an action plan to detail how the PPS will move its approach to primary care from the planning stages to implementation."

PPS Action Plan Narrative:
In November 2016, the Central New York Care Collaborative (CNYCC) submitted to the New York State Department of Health (NYSDOH, "the Department") its revised Primary Care Plan. The Department reviewed the Plan as did the DSRIP Independent Assessor (IA). In its Final Mid-Point Assessment Report, the IA agreed with the Department "that the plan included an overall approach to primary care but that most activities identified in the plan remain in the planning stages with minimal discussion of implementation efforts." The IA recommended that the PPS "develop an action plan to detail how the PPS will move its approach to primary care from the planning stages to implementation." CNYCC has prepared the following Action Plan Narrative to move those activities which the PPS is acting upon from planning to implementation.

Expansion of Primary Care Capacity

The PPS will begin a three year recruitment effort of sharing recruitment costs with primary care partners who participate in DSRIP projects through the life of these projects. The PPS will share recruitment costs for a certain number of primary care providers per year with a goal of recruiting more primary care providers to the region. Communication of the cost sharing program will begin July 2017 once the final vetting process of recruitment agencies has been completed.

Expansion of local college, community college, and high school programs focused on healthcare professions

CNYCC partners have reported the "brain drain" phenomenon in our region as students interested in healthcare professions seek medical education in communities outside our region and/or fail to return to Central New York. The literature and the experience of our partners indicates that recruitment of primary care providers is most successful when the recruited party has a vested interest in the community such as having grown up or gone to school in the region or is partnered to an individual from the region. Several high schools and colleges in the region have programs which aim to pair students interested in the health professions with a healthcare

professional in the community. These efforts foment and nurture interest in the healthcare professions and embed students in practices within our region.

CNYCC will promote the expansion of these programs in our region. By June 2017, the PPS will assess the baseline existing local healthcare shadowing /mentoring programs. Commencing July 2017, the PPS will promote the creation or expansion of healthcare professions shadowing/mentoring programs at high schools and colleges in our region.

Increase primary care residency slots and medical student clinical rotations in Central New York

Expansion of primary care capacity in the Central New York region can be further expanded by increasing exposure of healthcare professionals to our community via expanded training opportunities. To that end, the PPS will work with partners capable of providing clinical training to assess the feasibility and their interest in increasing the number of primary care residency slots as well as medical student clinical rotation opportunities. Local partners are presently exploring such opportunities. The PPS will assess the capacity for expansion with local partners who currently provide these training programs. Also, it will explore with outside medical schools' interest in establishing clinical training opportunities for their students and residents within our network of providers. The opportunities for such alliances will be quantified in the summer of 2017.

Development of next iteration of fund flows policies for primary care providers

The PPS has developed various funds flow mechanisms to support primary care's participation in DSRIP activities. At present, these strategies are being revised to advance a greater share of funding up-front to primary care practices and other partners to better incentivize their participation in DSRIP projects and other Primary Care Plan based activities. Within the funds flow policy revision process, primary care providers will be key members of the Stakeholder Workgroup tasked with making key decisions about the revised funds flow policies. Weekly meetings to carry out this process are scheduled to commence March 2017. CNYCC anticipates that the revised funds flow scheme will be ready for approval and subsequent implementation in June 2017.

Mid-Point Assessment Recommendation #12:

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

PPS Action Plan Narrative:

Partner Engagement

Currently, CNYCC employs several engagement strategies to connect with various stakeholder groups throughout its network. Some of the engagement approaches that have been used to connect with stakeholders include:

- Regional Project Advisory Committees (RPACs): Quarterly meetings in each of CNYCC's six counties that provide a forum for partner organizations to provide feedback on PPS activities

- Learning Collaboratives: Monthly meetings conducted by CNYCC for Acute; Community-Based Organizations; Outpatient; and Post-Acute organizations to monitor their outcomes, share best practices, and collectively solve implementation challenges
- CNYCC Weekly Newsletter: PPS-wide weekly communication with updates on PPS activities, DSRIP program updates, upcoming events, and general news and information
- CNY Cares Website: Provides general information about CNYCC goals and objectives, web-based platform for public/partners to access resources and information; and source of DSRIP related content and news
- Webinar Series: Web-based presentations on a wide-range of CNYCC topics

In addition to the efforts outlined above, CNYCC has and will continue to work very closely both on an individual and network level with partners to help facilitate and administer DSRIP projects.

Currently, CNYCC is on track to meet the majority of Speed & Scale targets for partner types across each DSRIP project, with enough engaged partners to meet our committed provider targets. There are only a few gap areas, as noted by the fact that CNYCC did not receive any specific IA recommendations related to partner engagement. Based on current partner participation, CNYCC has identified the following areas to continue partner recruitment:

Primary Care
Based on Speed & Scale reporting, CNYCC is on track to meet the majority of Primary Care Practitioners provider targets for its DSRIP projects. That said, CNYCC recognizes the sizeable and ongoing challenge of primary care access and capacity in our region, which will require additional efforts to recruit more primary care providers to the region. Engagement efforts for Primary Care will be led by CNYCC's Chief Medical Officer and will include the outreach approaches outlined above. A summary outline of CNYCC's Primary Care implementation plan is included in the Mid-Point Assessment Action Plan narrative for Recommendation #11.

Substance Use Treatment
CNYCC is currently contracted with several Substance Use Treatment partners for project implementation. However, Substance Use Treatment partner engagement in the following projects is insufficient to meet Speed & Scale targets: Project 2.a.i; Project 2.a.iii; and Project 3.a.i. CNYCC is actively working with providers across the network (utilizing the engagement approaches outlined above) to contract and engage in project activities.

Mental Health
CNYCC has engaged several Mental Health providers through the implementation of three CNYCC projects: Project 3.a.i., Project 3.a.ii, and Project 4.a.iiii. CNYCC has consistently reached applicable actively engaged patient targets in these projects and is on track to meet the majority of Mental Health provider targets for its DSRIP projects.

Community-Based Organizations
CNYCC has developed a comprehensive outreach and engagement strategy to foster relationships with CBO partners across the region and to meaningfully engage them in DSRIP project implementation. An outline of CNYCC's CBO engagement efforts are included in the Mid-Point Assessment Action Plan narrative for Recommendations #6 and #7.

Clinics

CNYCC is currently contracted with several Clinic partners for project implementation. However, Clinic partner engagement in the following projects is insufficient to meet Speed & Scale targets: Project 2.a.i, Project 2.a.iii, and Project 3.a.i. CNYCC is actively working with providers across the network (utilizing the engagement approaches outlined above) to contract and engage in project activities.

Nursing Homes

CNYCC is currently contracted with several Nursing Homes for project implementation. However, Nursing Home engagement in Project 2.a.i is insufficient to meet Speed & Scale targets. CNYCC is actively working to identify participation opportunities for Nursing Home and other post-acute providers across the network (utilizing the engagement approaches outlined above) to contract and engage in project activities and will continue to do so to meet Speed & Scale provider targets. CNYCC is also currently modifying existing funds flow policies to increase incentive opportunities for post-acute partner participation.

Funds Flow

Funds flow to partners is an important strategic imperative for CNYCC in terms of incentivizing partners to make the transformational changes necessary to successfully operate in a value-based payment environment.

CNYCC funds flow for DY1 and DY2 was based on funds flow policies that were reviewed and approved by the CNYCC Board of Directors. After working with these policies, CNYCC has made the decision to redesign our funds flow policies to accomplish our strategic objectives and to recognize and incentivize all provider types who are key contributors to the PPS's ongoing transformational work.

CNYCC will seek to understand the impact that each provider type can have upon our key performance and outcome measures so that payments to providers relate to their contributions. This approach allows us to incentivize the provider types that are essential to our success, including community-based organizations.

Since CNYCC is in the current process of revising our funds flow policies to achieve our strategic goals, the projections included in our Mid-Point Assessment Action Plan submission must be qualified by the fact that the new policies may yield different relative percentages than what has been projected at this time.

It is important to note that CNYCC intends to manage the future funds flow in a manner that provides a stable flow of funds to the partners over time and promotes a pay-for-performance operating environment. We also recognize that we are moving into more challenging times and we feel it is important to maintain momentum as we navigate the challenges associated with pay-for-performance. Our early funds flow policies called for the smoothing DSRIP funds into later years when PPS revenue is increasingly at-risk in order to provide a stable flow of funds to partners. It is our intent to incorporate a similar approach with our new funds flow policies.

The other important addition that our PPS is making on behalf of our partners in DY3 is the implementation of a Population Health Management System. The Population Health Management System is being funded from the PPS PMO to preserve funds available to partners. This tool will assist partners with data analytics, care management, and risk identification. Utilization of this tool will play an important role in our care coordination strategy, and we expect that this will also result in additional funds flow payments to provider types who will be able to utilize this infrastructure to achieve improved outcomes for the PPS and the Medicaid patients we serve.

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Mid-Point Assessment Action Plan - CNYCC Implementation Plan

Mid-Point Assessment Recommendation #1: Project 2.a.iii, "The IA recommends that the PPS develop a training plan to educate PCPs on the care coordination requirements for this project."	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Ensure all participating PCPs are educated in the care coordination model	DY3 Q2
Task 1. Determine which training modules need to be conducted via the care coordination requirements in conjunction with the care coordination resource	DY3 Q1
Task 2. Refine care coordination modules with feedback from partnered Health Homes/Care Management Agencies and Primary Care Practices	DY3 Q1
Task 3. Determine which Primary Care Practices need/would like to complete the care coordination training	DY3 Q1
Task 4. Determine how many individuals within the Primary Care setting need to be trained in each care coordination module	DY3 Q1
Task 5. Determine/select most appropriate resource to lead, develop, and coordinate implementation of training plan	DY3 Q1
Task 6. Develop training modules for each topic within curriculum	DY3 Q2
Task 7. Coordinate trainings based on partner availability and geographic locations	DY3 Q2
Task 8. Roll out training to partner Primary Care Providers	DY3 Q2
Mid-Point Assessment Recommendation #8: CC/HL, "The IA recommends that the PPS develop an action plan to roll out its trainings to partners."	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Select Workforce Training Content Delivery System or Approach	DY3 Q1
Task 1. Form Training Delivery Workgroup to identify and evaluate options for training delivery	DY2 Q4
Task 2. Finalize inventory of feasible training delivery options and evaluation criteria	DY2 Q4
Task 3. Gather vendor information and schedule any necessary demos	DY2 Q4
Task 4. Obtain Training Delivery Workgroup recommendation for Workforce Committee approval	DY3 Q1
2. Select CC/HL Training Content	DY3 Q1
Task 1. Form workgroup to validate CC/HL training objectives and any other stipulations/requirements	DY3 Q1
Task 2. Publicize CC/HL training objectives & requirements and gather vendor proposals	DY3 Q1
Task 3. Evaluate training content based upon training objectives and requirements, gathering additional vendor information and scheduling demos as needed	DY3 Q1
Task 4. Obtain workgroup recommendation for Workforce Committee approval	DY3 Q1
3. Deploy CC/HL Training	DY3 Q2
Task 1. Validate list of partner organization staff assigned to complete CC/HL training by role	DY3 Q1
Task 2. Contact partner HR or training leads to provide information about required training and to allow for partner organization to provide current CC/HL curriculum for equivalency evaluation	DY3 Q1
Task 3. Deploy any required/desired pre-test surveys to gather baseline data and/or identify skill or awareness needs	DY3 Q2
Task 4. Deploy CC/HL training to partner organization staff with identified skill or awareness needs	DY3 Q2
Mid-Point Assessment Recommendation #11: Primary Care Plan, "The IA recommends that the PPS develop an action plan to detail how the PPS will move its approach to primary care from the planning stages to implementation."	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Implement a program of shared recruitment cost for primary care physicians and mid-level practitioners.	DY3 Q2
Task 1. Select recruitment agency or agencies	DY3 Q1
Task 2. Communicate the availability of the program to partner organizations	DY3 Q2
Task 3. Sign participating partners on to the program	DY3 Q2
2. Expand local college, community college, and high school healthcare professions shadowing/ mentoring programs	DY3 Q2
Task 1. Assess the baseline existing healthcare shadowing/mentor program to identify new opportunities	DY3 Q1
Task 2. Promote creation of additional shadowing and mentor programs	DY3 Q2
Task 3. Increase the capacity of health professional shadowing/mentor programs	DY3 Q2
3. Assess interest and feasibilty of increasing primary care residency slots and medical student clinical rotations in Central New York	DY3 Q2

Task 1. Meet with CNY hospitals that offer primary care residencies and clinical student rotations to determine their interest in expanding residency slots and medical student rotations	DY3 Q1
Task 2. Contact NYS medical schools interested in upstate primary care medical schoool rotation and residency opportunities in Central New York	DY3 Q1
Task 3. Compile results to determine the number of additional opportunities	DY3 Q2
4. Develop next iteration of funds flow policies for primary care physicians	DY3 Q2
Task 1. Include primary care physician representation in the Stakeholder Workgroups for development of the next iteration of funds flow policies	DY2 Q4
Task 2. Hold Stakeholder Workgroups monthly to develop the policies	DY3 Q1
Task 3. Obtain Board approval of new funds flow policies, including inventivized activities for partners	DY3 Q2

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Mid-Point Assessment Action Plan - CNYCC Partner Engagement

		Partner Engagement										
Partner Category		***2ai***	***2aiii***	***2biii***	***2biv***	***2di***	***3ai***	***3aii***	***3bi***	***3gi***	***4aiii***	***4di***
Practitioner - Primary Care		291	153	0	504	0	256	0	206	171	0	0
Practitioner - Non-Primary Care		776	462	0	148	0	510	0	429	459	0	0
Hospital - Inpatient/ED		9	0	0	6	0	0	0	0	0	0	0
Hospital - Ambulatory		0	0	0	0	0	0	0	0	0	0	0
Clinic		32	14	0	0	0	21	0	13	11	0	0
Mental Health		76	45	0	0	0	58	0	25	0	0	0
Substance Abuse		17	10	0	0	0	14	0	4	0	0	0
Case Management		15	13	0	10	0	0	0	7	0	0	0
Health Home		0	0	0	0	0	0	0	0	0	0	0
Community Based Organization (Tier 1)		0	0	0	0	0	0	0	0	0	0	0
Nursing Home		27	0	0	0	0	0	0	0	0	0	0
Pharmacy		6	3	0	0	0	0	0	5	0	0	0
Hospice		3	0	0	0	0	0	0	0	3	0	0
Home Care		0	0	0	0	0	0	0	0	0	0	0
All Other		686	355	0	391	0	479	0	429	389	0	0

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Mid-Point Assessment Action Plan - CNYCC Funds Flow

		Funds Flow (all funds)			
Partner Category		***Funds Flow through DY2, Q3***	***Projected Funds Flow through DY2***	***% of Earned Dollars Planned for Distribution DY3***	***% of Earned Dollars Planned for Distribution DY4 - DY5***
Practitioner - Primary Care		$0	$0	3.00%	4.00%
Practitioner - Non-Primary Care		$0	$0	0.00%	0.00%
Hospital - Inpatient/ED		$6,883,104	$7,692,600	34.50%	30.00%
Hospital - Ambulatory		$0	$0	10.00%	10.00%
Clinic		$1,398,363	$1,496,669	10.00%	10.00%
Mental Health		$350,140	$405,777	7.00%	8.00%
Substance Abuse		$86,281	$103,230	4.00%	5.00%
Case Management		$218,083	$268,213	3.00%	4.00%
Health Home		$0	$0	1.50%	2.00%
Community Based Organization (Tier 1)		$16,370	$20,382	4.00%	4.00%
Nursing Home		$334,855	$412,965	5.00%	6.50%
Pharmacy		$6,102	$6,905	0.50%	0.50%
Hospice		$29,367	$36,196	0.50%	0.50%
Home Care		$0	$0	2.00%	3.50%
All Other		$733,448	$873,644	0.00%	0.00%
PPS PMO		$3,798,977	$5,074,977	15.00%	12.00%
Total		$13,855,090	$16,391,558	100.00%	100.00%