Recommendation #1 – ED Triage

The IA recommends the PPS create a systematic process of triaging patients who are not linked to a Health Home, to a PCP in order to (1) Increase engagement of a broad patient population; (2) Meet patient engagement targets; and (3) Ensure access to services before getting linked to a Health Home.

Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation

Community Partners of Western New York (CPWNY) recently formalized processes that will triage patients who are not linked to a Health Home and connect them to primary care services. The PPS has taken a multi-faceted approach to increase engagement of a broad patient population and to meet patient engagement targets.

CPWNY created a new position inside the hospital emergency department (ED) called Patient Navigators. These individuals meet face-to-face with patients in CPWNY hospitals with identified high Medicaid emergency department volume. During their patient interaction, the Navigators use tools and resources to identify barriers in the patients' medical care and provide resources to the patient moving forward. The Navigators collect data through an internal electronic care management module tracking tool, which will provide CPWNY feedback for project monitoring.

In an effort to reduce as many preventable ED visits as possible, CPWNY developed an outreach program which utilizes the services of the Catholic Health System's established call center, Health Connections. The staff of Health Connections provides support for patients that present to the ED during the hours the Patient Navigators are not on site. These outreach staff will perform the same functions and provide the same resources to the patients as the Patient Navigators.

Through the employment of both the Patient Navigators and the Health Connections staff, CPWNY has enhanced its process for linking existing Health Home patients back to their appropriate care coordinators, creating greater continuity of care for the patients. Additionally, the Patient Navigators and Health Connections share a formal Health Home referral process that supports the established Health Home recruitment workflows which have existed at high Medicaid volume hospitals since 2015. The existing process includes the correct identification and enrollment of candidates in the Health Home. Patient Navigators and Health Connections staff are another way that patients can obtain information and knowledge about the Health Home model.

Timeline

High Medicaid volume EDs have been identified and Patient Navigators have been hired and will complete orientation and training during March 2017. It is expected that the Patient Navigators will be fully deployed to their respective ED's by March 30, 2017. The Call Center team (Health Connections)

has appointed several staff to the project and will continue to do so through DY2Q4 based on service volume. For the DY2Q4 reporting timeframe we expect to see growth in engagement numbers and a further increase by the end of DY3Q2.

Monitoring

Patient Navigators and the Health Connections team will provide weekly status reports and patient engagement statistics to the Project Administrator. There is an ED Triage operational oversight team which meets weekly to monitor progress and look for opportunities for improvement using Rapid Cycle Improvement methodology.

Linkage to overall PPS strategy to meet DSRIP goals

CPWNY's strategy for this project has shifted over the course of the first two years of the DSRIP program from a focus on enhancing the Health Home referral process, to increasing the number of hospital Care Management staff who provide guidance and dialogue with patients who come to the ED with low-acuity concerns that may be better addressed in a primary care setting.

The support of the Health Connections staff and Patient Navigator team is integral to the long term outcomes of DSRIP and targets the Potentially Preventable Emergency Department Utilization performance metric so critical to PPS success. Health Home referrals, while also integral to CPWNY's success, serve only a portion of the ED patient population. Some patients are not interested in applying or enrolling in a Health Home. The use of Patient Navigators and the Health Connection team provides additional resources to encourage and support access to primary care.

Recommendation #2 – ED Triage

The Independent Assessor recommends the PPS create a plan to address the shortage of primary care physicians engaged in this project.

Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation

Similar to PPS's across NYS, CPWNY has recognized a shortage of primary care physicians who serve the Medicaid population within its network. CPWNY has found that this shortage of physicians is further exacerbated by a lack of access to available, timely appointments with existing providers. For example, patients and ED staff report a barrier to scheduling timely follow-up appointments due to the inability to reach the office scheduler by telephone and the lack of available appointments within the prescribed window of time.

To address access barriers, the PPS has developed a strategy to designate specific ED follow-up appointment times (and in some cases providers) for the Medicaid/Managed Medicaid population. Staff additions and enhancements such as Patient Navigators and the Health Connections team will be able to schedule appointments directly into the electronic scheduling system of affiliated primary care centers. This will enable greater patient access to medical services, provide patients with resources, and reduce unnecessary ED utilization.

Timeline

The PPS has completed initial meetings with the primary care centers and successfully developed a direct scheduling process. As of the end of February 2017, three out of the four identified primary care centers have a direct scheduling system operational. The fourth primary care center will be fully operational by mid–March 2017.

Monitoring

The ED Triage Operational Oversight Team will review scheduling reports weekly. Qualitative data from the Patient Navigators and Health Connections team will also be used to monitor progress and identify areas for improvement.

Linkage to overall PPS strategy to meet DSRIP goals

Direct scheduling of primary care visits by non-clinical staff help the PPS achieve ED Triage project specific patient engagement goals. It eliminates barriers to appointment scheduling and provides timely primary care appointments at partnering health care centers. Additionally, direct scheduling is integral to the long term outcomes of DSRIP and directly improves performance on the Potentially Preventable Emergency Department Utilization performance metric so critical to PPS success.

Recommendation #3 – Telemedicine

The Independent Assessor recommends the PPS develop an action plan to shorten the credentialing process of providers in order to improve the patient and partner engagement shortcomings.

Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation

One of the main challenges of the Telemedicine project for CPWNY is the credentialing process for providers in New York State. In an effort to eliminate this barrier, CPWNY is planning to insource the Telemedicine project to the partners within the PPS. The PPS strategy shift to insourcing solutions shortens the timeframe for implementing additional telemedicine projects by tapping providers who are already credentialed in NYS.

CPWNY has identified a crucial need in Chautauqua County, an area that represents about 30% of the PPS's patient attribution. Building off its existing relationship with WCA Hospital, the PPS is implementing a Maternal Fetal Medicine (MFM) ultrasound review program. This program focuses on health concerns of both the mother and baby during and shortly after the pregnancy period. One procedure used in this program is the nuco-translucency test, which is performed through an ultrasound and used to detect early signs of disease in the fetus, such as Down's syndrome or heart conditions. This initiative also focuses on women presenting that are diagnosed as high risk pregnancies, due to preexisting health conditions of the mother, as well as pregnancy related complications such as pre-term labor, preeclampsia, and or twins/multiples.

These services are not widely available in most rural counties, and are not offered in the county of Chautauqua. WCA Hospital currently refers patients outside the county to receive this service and reports very low compliance rates. The Maternal Fetal Medicine telemedicine initiative, by connecting WCA providers to OB/GYN specialists within the PPS network via telemedicine, will improve low compliance rates, and positively affect the health outcomes for the patients in Chautauqua County.

Another initiative of the telemedicine project involves engaging with an agency that specializes in working with persons with Intellectual and Developmental Disabilities (ID/DD) with the goal of providing medical triage for these individuals at their place of residence. With this focus, the ID/DD serving agency assigned the project contract will use a telemedicine vendor to link with the medical professional at the ID/DD residence to perform a virtual consultation. During this virtual consultation, a determination will be made on treatment type, or whether the patient needs to go to the ED. An exciting opportunity, this initiative not only bolsters the telemedicine patient engagement numbers but also helps achieve one of the overall goals of the DSRIP grant: reduction of avoidable ED visits.

CPWNY, in addition to insourcing the telemedicine project, has extended a community wide request for proposals (RFP) for additional telemedicine pilot projects. The goal is to evaluate the community's level of interest as it pertains to telemedicine, and work with the providers who have an interest in developing or expanding their practices' current telemedicine services. The PPS welcomes any clinical area specialty and is ideally looking to develop programs that will serve the community's greatest areas of need.

Timeline

The PPS is moving forward with a dual approach in an effort mitigate or remove the credentialing barrier for telemedicine initiatives. The first approach, adding projects which focus on in-sourced, in-network solutions, is underway and will be operational by end of DY3Q2. For the second phase, the community outreach approach, the PPS plans to begin implementation of the projects funded under the RFP process by the end of DY3Q2.

Monitoring

With both phases of the approach, regularly scheduled meetings with the PPS, organizational leadership, team leads, IT, vendor(s) and all other participants will be held to provide feedback on operational issues as they relate to the successful implementation of pilot project(s). Milestones such as contract execution and vendor selection, as well as go-live date for first telemedicine encounter, will be monitored.

Linkage to overall PPS strategy to meet DSRIP goals

By striving to explore and expand the telemedicine project within the PPS, the telemedicine project will eliminate barriers to patient care, and provide increased access to medical care throughout the community in which the patient resides. In providing additional opportunities for medical care, the PPS is also intends to reduce the overall cost associated with the patient's medical treatment plan and improve the quality of health care and outcomes for the patient.

Recommendation #4 – Maternal & Child Health

The Independent Assessor recommends that the PPS explore opportunities to expand the services for this project into Erie County which is a part of the PPS service area and impacts a significant portion of the patient population.

Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation

CPWNY has been actively exploring opportunities and is now implementing services to expand maternal child health services in Erie County. The Community Health Worker model was chosen as the primary strategy after careful consultation with key stakeholders, including hospital-based clinic providers, community organizations, and other subject matter experts. This model employs a Community Health Worker on a clinical care team who provides patient support beyond the clinic walls to affect key project outcomes. With a focus on improving care and HEDIS measure outcomes, this program places Community Health Workers (CHW) in high-risk, low-income communities, to assist OB/GYN health centers in getting women into prenatal care early (in the first trimester), and keeping them in ongoing prenatal care, with the goal of decreasing the number of low birth weight babies. The CHW also provides follow-up postpartum.

CPWNY engaged local agencies to assist in the design and implementation of the CHW program. Community Health Worker Network of Buffalo has been instrumental in program design, and the Buffalo Urban League has provided oversight to ensure the success of the CHW. Buffalo Urban League hired a senior Prenatal CHW to pilot the program, and that individual began touching lives in November 2016. The prenatal CHW works as part of the care team in a hospital-based OB/GYN clinic, but has the unique ability to work outside of the clinic walls and reach out to and support patients in their homes and neighborhoods. We have seen great success with the pilot program. The CHW has created relationships and built trust within the community and has assisted women navigating to prenatal appointments and connected them to community resources.

In addition to the successful Prenatal CHW program and its expansion, CPWNY is engaging Community Based Organizations (CBOs) to support and enhance the work of DSRIP maternal child health projects and/or to identify additional needs or gaps in the community. CPWNY continues to meet with other established Erie County programs to explore expansion opportunities. CPWNY attends quarterly Erie County maternal child health coalition meetings, hosted and facilitated by the United Way of Buffalo and Erie County, in order to learn about new programing and identify opportunities to collaborate. Through participation in the coalition, CPWNY was asked to join a sub-committee along with March of Dimes, Catholic Charities, Erie County Department of Health, the local health plans, and United Way. The recent work of the sub-committee has focused on supporting the IMPLICIT program, a March of Dimes initiative that aims to improve birth outcomes, with a concentration on inter-conception care in the health care setting. March of Dimes sent out an RFP in January 2017, and the sub-committee will review and make a determination of award in early March 2017. If awarded to a practice in our PPS, CPWNY will aid in supporting program implementation. Centering Pregnancy expansion and collaboration with Buffalo Prenatal-Perinatal Network programs have been other avenues for exploration.

Timeline

Given the positive response from the pilot program, CPWNY is in the process of expanding and adding additional CHWs to other OB/GYN health centers with a large percentage of Medicaid patients. Buffalo Urban League has started the recruitment and interview process and anticipates on-boarding two new CHWs at the start of DY3. Further expansion to at least two additional health centers will take place by the end of DY3Q4.

Monitoring

Regular meetings are in place to monitor the quality of the maternal child health projects. CPWNY has monthly meetings with the OB/GYN clinic staff, monthly meetings with the CHW program design team (which includes the Buffalo Urban League and Community Health Worker Networker of Buffalo), and weekly meetings with the large DSRIP team. Feedback is solicited and discussed from frontline staff, progress and outcome reports reviewed, and data from surveys are analyzed, when available. Process improvement plans are implemented on an ongoing basis to positively impact outcomes.

CPWNY is establishing a patient-centered approach to identify potential gaps in maternal child health services and care within the PPS, and preparing to implement process improvement plans, when necessary. In early DY3, a local agency will be selected to conduct focus groups with Medicaid constituents. Feedback will be solicited on the Prenatal Community Health Worker program and its perceived value to patients, and to determine if there are unmet needs that could be addressed within our purview. In addition to focus groups, surveys are being used to collect data from patients. A survey was developed and distributed in November 2016 to collect baseline data at the clinic where the Prenatal CHW is based. These surveys will be distributed and data collected once a quarter to compare from baseline and track progress.

Linkage to overall PPS strategy to meet DSRIP goals

While exploring, planning, and implementing programing to support maternal child health in our PPS, CPWNY strives to keep Medicaid constituents' voice involved while aligning those needs with the overall PPS strategy. The main goal of the Prenatal CHW program is to improve HEDIS scores, but in the work of the CHW, many other goals are met as well. Pregnant moms who link with the CHW are attending more prenatal appointments, and should see improved care and outcomes, and decreased usage of emergency departments. The CHW coordinates care more fluidly by linking pregnant moms to others services and agencies, again leading to improved overall care and health. CPWNY staff spend a significant amount of time networking in the community in order to collaborate on projects and provide services, but to also expand the referral network, which improves linkages to care and care coordination.

Recommendation #5 – Palliative Care

The Independent Assessor recommends that the PPS create an action plan to increase the presence of palliative team members in primary care practices in order to increase referrals, which will further improve patient engagement shortcomings.

Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation

The PPS will increase the presence of palliative care team members in primary care practices to increase referrals and patient engagement by meeting with key practice leadership to determine any gaps in awareness of palliative care. The PPS is also working with practices who have received initial palliative care trainings to solicit feedback to learn what is working well and where improvement is needed in palliative care awareness trainings. Both of these initiatives are in progress and the PPS continues to make changes to increase palliative care within primary care practices. The PPS is working with primary care offices to continue to imbed palliative care staff in high Medicaid-volume practices. There are currently two palliative care nurses from CPWNY's lead partner organization embedded into four of the high Medicaid-volume practices on a regular basis.

In addition to increasing the presence of palliative care team members in practices, the PPS has developed a screening tool for practice nursing staff to identify and "flag" potential palliative care-eligible patients. The PPS is providing training to the primary care nursing staff to ensure increased education around identifying palliative-care eligible patients and the benefits of palliative care to patients. Through training on the use of the nurse screening tool, practice staff will become more familiar and comfortable identifying palliative care-eligible patients.

The PPS created a palliative care template in the EHRs for physicians to use to document palliative care consults. Physicians who chose to use the EHR template will review the "flagged" patients and complete the palliative care consult based on the physician's perspective of need. Both tools are assisting in the improved tracking and sharing of patient information. The physician template is currently being piloted at one CMP primary practice, and will be offered to all of CMP primary care physicians by the summer of 2017. The physician template will enable tracking and documentation within a primary care EHR which was previously unavailable. This new way of tracking primary care consults will increase the capture of patient engagement.

The PPS is also currently working with Chautauqua County primary care practices and Hospice Chautauqua to expand these tools into Chautauqua County.

Timeline

The above efforts of the PPS are in progress. The primary care palliative care screening tool and physician template continue to be implemented in CPWNY (CMP) and CCHN primary care practices. Expanded use of the tool will be monitored through DY3, and Rapid Cycle Improvement processes will be applied at the practice level to enhance primary care efforts in palliative care interventions and referrals.

Monitoring

The PPS will track progress on the above actions through project meetings and status updates with the partner organizations (hospice teams). The team will monitor ongoing palliative care training within the primary care offices.

The PPS project administrator periodically receives in-service training lists from the partner organizations as well as the schedules of the nurses who are imbedded in the high Medicaid volume practices. Monitoring attendee and training efforts will continue through the duration of the project.

The PPS is also tracking the ongoing progress of the implementation of the nurse screening tool though the Clinical Integration team at CPWNY (CMP). The physician template is also able to be monitored through a report run from the EHR.

Ongoing meetings are scheduled with the first site to use the physician template. Regular feedback from the practice will help determine when the template is deemed ready for implementation by all interested primary care physicians in the network. Additionally, the PPS Care Management team will execute and monitor all the activities of this project.

Linkage to overall PPS strategy to meet DSRIP goals

This project success is dependent on its continued efforts working with high volume Medicaid practices and offering palliative care services to patients with chronic illnesses. The target outcome is that patient's symptoms are managed more successfully at home, and thereby provide a positive, acceptable alternative to presenting to the emergency department. Primary care screening and consultation tools provide enhanced tracking and integration of data within the primary care EHRs and between primary care physicians and specialists, enabling improved quality of care and care coordination.

Recommendation #6 – Palliative Care

The PPS should also create a plan to continue partner engagement beyond the original training.

Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation

The PPS is adopting a strategy for continued engagement of primary care practices. The PPS's Clinical Integration team is working with key provider networks (Catholic Medical Partners and Chautauqua County Health Network) to incorporate palliative care tools into primary care practices.

Primary care staff are trained to identify palliative care-eligible patients. The physicians also have the option to adopt a palliative care template that is built directly into the EHR where the physician can complete palliative care consultations with patients who they believe may benefit from palliative care services. If the physician feels that enhanced palliative care services would be beneficial to the patient, and the patient agrees, a referral will be sent to our palliative care partner agencies (hospice teams).

A workflow to support the template is developed, and implementation into the primary care practices is in progress. The workflow's goal is to increase the use of the palliative care identification and consult tools and increase referrals to palliative care partner agencies.

Hospice staff continually provide training to primary care staff and physicians to better identify palliative-care eligible patients and help to increase the comfort level of having that initial palliative care conversation with the patient and their family.

Timeline

The above actions are in progress. Training for the nurse screening tools is in progress and a large CMP primary care practice is currently piloting the physician template. The key provider network in Chautauqua County is engaged in the project to adopt similar practices at high volume Medicaid practices.

Monitoring

The PPS is monitoring the ongoing progress of the implementation of the nurse screening tool though the Clinical Integration team at CPWNY (CMP).

The physician template is monitored through a report run through the primary care practice's EHR. Ongoing meetings are scheduled with the initial implementation site. Once the template is deemed ready for use by all interested primary care physicians in the networks, our Care Management team will execute the template in additional practices and monitor its utilization.

Linkage to overall PPS strategy to meet DSRIP goals

The actions to address the PPS's recommendations are consistent with the overall strategy of the PPS to meet DSRIP goals. The actions enable better communication between primary care and specialists and create an improved method for systematically tracking patients between providers. Ultimately, through offering increased palliative care services to chronically ill patients in their home, the number of unnecessary hospital visits should decrease and the quality outcomes measures will reflect improvements network-wide.

Recommendation #7 – Financial Sustainability and VBP

The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements.

Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation

In September 2016, CPWNY formed a Value Based Payment (VBP) Work Group as a sub-committee of the CPWNY Finance committee. A VBP Work Group charter was established to clarify the roles and responsibilities of the Work Group and the charter was further endorsed and approved by both the Finance Committee and Executive Governing Board of CPWNY. The role of the VBP Work Group is to provide guidance and support for PPS members as payment models continue the transition from fee-for-service to value-based. This includes support such as education on alternative levels of VBP along with the risk associated with each arrangement, the development of educational materials as part of a broader communication strategy for the PPS network that includes information to be shared with providers, alignment between DSRIP goals and value based payment reform and guidance on VBP contracting with managed care organizations.

The VBP Work Group began and will continue to provide VBP guidance and education to organizational members of the PPS. DSRIP funds were utilized to further educate CPWNY partners through NYS sponsored VBP workshops. These workshops allow our partners the opportunity to stay informed on payment reform and engage with members of other PPS' to share experiences and ideas. An initial survey conducted in September 2016 by CPWNY to contracted partners provided an assessment of the PPS network's readiness and willingness to transition to VBP. The survey requested information on the each organization type, the level of familiarity with VBP and how it relates to DSRIP initiatives. It further assessed the current state of partner's participation in pay for performance contracts, and what percentage of partner's current revenue falls into Medicaid Managed Care. Additionally, information regarding future contacting preference was assessed. The level of risk that the partners would be willing to assume was also addressed. The results of the initial survey were reviewed by the Finance Committee and VBP Work Group to determine the current state of VBP in the network and the preferred compensation modalities. The VBP Work Group will utilize the information collected through the survey to facilitate the PPS's understanding of the overall healthcare payment transformation through the New York State VBP Roadmap. It will further provide a forum for discussion of VBP implementation and the risks and opportunities associated with it.

VBP information and updates are being communicated with partners as well as the community through the Project Advisory Committee (PAC) as a standing agenda item at every meeting. This meeting provides an opportunity to reach an audience that extends beyond members of the PPS so the overall community will also be informed of healthcare payment transformation. CPWNY has VBP information posted on the website to assist partners in exploration of alternative levels of VBP and the risk associated with each type of arrangement. Educational materials include information that can assist partners in evaluating financial incentives that support each level of VBP, to ensure alignment between DSRIP goals and VBP reform and provide guidance on VBP contracting, and to evaluate principles for shared savings distribution and shared losses allocation.

CPWNY is uniquely positioned to facilitate the transition to VBP as PPS members include two major Independent Practice Associations (IPA), Catholic Medical Partners (CMP) and Chautauqua County Health Network. Both IPAs currently participate in VBP arrangements and are well positioned to assist other PPS partners' transition towards VBP. The IPA's have established partnerships with hospital systems, behavioral health organizations,

and community based organizations (CBO), independent primary care physicians, pediatricians, and specialists allowing for increased collaboration amongst all partners.

Both IPAs participate in VBP arrangements. Currently, CMP is the only member of the PPS participating in VBP arrangements targeted to the Medicaid managed care population. CMP has approximately 50,000 Medicaid patients enrolled in its provider network, who are part of existing health plan contracts and are attributed to CPWNY through the DSRIP initiative. Some of these contracts currently participate in VBP arrangements while the remaining contracts are being converted into VBP arrangements with a planned complete date of DY2 Q4. Catholic Medical Partner's executive team meets regularly with MCOs in the local community, including Fidelis Care, Independent Health Association (IHA), YourCare, HealthNow NY, and WellCare. CMP, as part of the VBP Work Group, will use its experience with VBP to educate and guide the PPS partners, including primary care providers, through the transition to VBP. Additionally, the PPS has been in collaboration with other PPS's for a collective educational program for partners in both PPS's. The experience CMP has in value based payment will also allow CPWNY to enhance its education to partners on building the information technology infrastructure required to be successful in a VBP arrangement. CMP through its experience can provide guidance on establishing a care management program that creates patient registries and utilizes clinical business intelligence to appropriately manage the population.

CPWNY will conduct a second survey in March 2017 to provide additional assessment of all CPWNY partners and will include a review of the partners' current resources for care coordination, evaluate integration of behavioral health services and Health Homes and assess collaboration with CBOs to determine what non-clinical needs are being addressed as related to housing support, transportation, and other social determinants of health. Additional inquiries in the March 2017 survey will include an assessment of technology and analytic resources. This will include an assessment of current technology: including usage of Electronic Medical Record; participation in a Regional Health Information Organization (RHIO), utilization of telemedicine and Clinical Decision Support. The partners' ability to analyze data will also be assessed, to include whether they are currently evaluating their provider services on quality, performance for patient utilization, costs/claims data from insurers, disease registry data, data from quality organizations, patient satisfaction and predictive analysis. Specific tasks have been developed which are included in the detailed implementation plan.

Timeline

The implementation plan will be completed by June 30, 2017. Measures for quality will be assessed from the survey by April 30, 2017, resulting in steps to be included in the implementation plan.

Monitoring

Success of the VBP will be measured by successful completion of the NYS Milestones for VBP. Ongoing surveys will be conducted to measure change in percent of participation in the initiatives being assessed related to state of contracting, resources for care coordination, areas for additional education, and assessment of technology and analytic resources.

Linkage to overall PPS strategy to meet DSRIP goals

The VBP Work Group implementation and educational plans will continue to develop relationships with PPS partners and CBOs for potential collaboration which will result in the sustainability of DSRIP initiatives. Creating a more clinically integrated network will help the patient throughout the continuum of care and lead to increased quality and patient satisfaction along with overall lower costs.

Recommendation #8 – Partner Engagement

The IA recommends that the PPS develop a strategy to increase partner engagement throughout the PPS network. The limited partner engagement across multiple projects is a significant risk to the ability of the PPS to implement its DSRIP projects and meet the DSRIP goals.

Specific actions the PPS has taken or will take to remedy the deficiency noted in the recommendation

As noted in the PPS's presentation to the PAOP on Feb 2, 2017, Community Partners of Western New York leverages existing physician and hospital network structures to engage its partners. The result of this structure is the achievement of operational efficiency and positive funds flows to partners, but it presents CPWNY with the challenge of maintaining a unified identity as a PPS community presence. For example, partners may not always know the projects and efforts they engage in are DSRIP initiatives or funded through the DSRIP program. To address this, and to help create a common voice in the community, CPWNY will have a two-fold strategy detailed below.

Strategy 1: The PPS will improve partner communication to address identity issues for the DSRIP program. Among the actions included in this strategy are:

- The creation of a "DSRIP 101" video which gives high-level overview of CPWNY DSRIP program. The video is posted at http://wnycommunitypartners.org/resources/
- The distribution of relevant and useful network quarterly newsletter to partner contact list, hospital intranet systems, and IPA contact lists and other established communication vehicles. As of 12/15/16, the PPS made the newsletter document and its contents more applicable to the network and included key features such as a project focus, project and work-stream updates, VBP communication updates and case studies as they apply to project shared learning. The newsletter will be printed as needed for community engagement meetings and all past and future versions of the newsletter will be posted on the PPS website at: http://wnycommunitypartners.org/resources/
- A network wide project request for proposals (RFP) was sent to all engaged providers and community based groups on 2/23/17. By sending a network-wide RFP, the PPS seeks to gain engagement from new partners who can infuse new energy to projects such as our 2cii Telemedicine project. The RFP was sent via email, U.S. mail and email lists via established physician networks.
- The PPS recognizes that many providers are in need of continued education programming to further partner engagement in project improvement. The PPS is committed to providing educational engagement opportunities to partners and providers, including participation in training (e.g. interactive rapid cycle improvement training, value based payment education, DSRIP project updates and clinical integration efforts as part of partner board & committee meetings).
- To provide transparency in all funding made available by the PPS, the PMO team will publicly present and make available its consolidated operating budget for DY3. The creation of the budget is a combined effort of project leadership, the CPWNY Finance Committee and Executive Leadership Governing Body of the PPS.
- CPWNY will establish routine communication and provider engagement activities in Chautauqua County, which accounts for approximately 30% of the patient attribution of the system. Activities will include, but will not be limited to, regular update & planning meetings, regional education activities and community based organization planning utilizing services of the Chautauqua County Health Network and the Chautauqua County Department of Health.

Strategy 2: The PPS will identify and fill partner engagement gaps for projects and community based organization engagement. Among the actions included in this strategy are:

- The PPS will perform gap analysis of partner engagement including but not limited to review of care coordination and care management referral programs, project level engagement, workforce analysis and/or workstream level engagement, plus review of primary care engagement activities. CPWNY will revise its

reporting to the state based on the gap analysis to include all partners participating in the projects and the integrated delivery system. The PPS will fill partner engagement gaps with deliverable based contracts, direct funds flow, referral agreements and/or participation in project teams or the Governing Committee.

- The PPS will establish formal contract and reporting arrangements with community hospitals; including but not limited to Bertrand Chaffee, Orleans Community Health, and Westfield Hospital.
- The PPS will fill known gaps in Community Based Organization (CBO) engagement by contracting with the P2WNY Collaborative to develop and implement additional CBO engagement activities. Additionally, Chautauqua County Health Network will facilitate Community Based Organization outreach grant efforts in collaboration with the regionally appointed grant recipient. CBO engagement activities include, but are not limited to, sponsoring CBO business planning education, leveraging existing hospital-based community benefit strategies to support CBO engagement, and/or identifying and contracting with CBOs for engagements activities that align with the goals and objectives of the NYS wellness agenda and the NYS PHIP (population health improvement program).

Timeline

The PPS was made aware of the recommendations from the NYS independent assessors in November 2016. Since then, the PPS has begun its improved partner engagement strategy and several are already in progress. All strategies and activities will be completed and reported by DY3Q2.

Monitoring

- The PPS will monitor its partner engagement goals monthly and subsequently update MAPP tool with all engaged partners in order to successfully communicate partner engagement to state stakeholders for DY2Q3, DY2Q4, DY3Q1 and DY3Q2.
- The PPS will monitor all CBO and Community Engagement Activities monthly and report all CBO and Community Engagement Activities in its quarterly updates to New York State within the governance workstream milestone updates in the MAPP tool.
- The PPS will monitor its website hits monthly for key education and outreach sections of its website.
- The PPS will monitor its training log monthly maintained by its workforce partner, Rural AHEC.
- The PPS will monitor regular attendance at its regional meetings and conduct evaluations of its regional meetings by attendees.
- The PPS will report new engagement contracts and funds flow to Community Based Organizations resulting from the network wide RFP process, as part of its quarterly Reporting to New York State in the MAPP tool.

Linkage to overall PPS strategy to meet DSRIP goals

During the mid-point assessment process, the NYS independent assessor noted that the PPS has lower than average administrative costs. Both the lead organization, Sisters of Charity Hospital, and well as the Project Management Office (PMO) at Catholic Medical Partners have significant experience with existing integrated delivery systems that allow for efficiency in operations and reduced administrative costs for the DSRIP program.

Categorized as a “small” PPS by New York State, CPWNY’s partner engagement approach maintains low administrative overhead and facilitates substantial funds flow directly to project contracts, and project or work stream related deliverables. This engagement approach leverages the reputations and trust of existing community networks to perform. The Executive Governing Body of the PPS maintains a balanced community focused philosophy and directs the PMO to keep its managing costs low so that the majority of funds can be placed with providers and organizations providing direct care and support to Medicaid beneficiaries.

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 #2: 2biii ED Traige project	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Create dedicated PPS clinic time slots for scheduling of ED follow up appointments in a timely manner.	DY3Q1
1.1.1 - Obtain list of all Catholic Health System primary care clinics	DY3Q1
1.1.2 - Schedule group meeting with leadership from all the clinics to discuss details of the pilot project	DY3Q1
1.1.3 - Identify/evaluate clinics with to ability to participate in the pilot project	DY3Q1
1.1.4 - Meet with leadership at each facility to identify specific requirements for implementation of the pilot project at their facility	DY3Q1
1.1.5 - Meet with internal IT team to build the infrastructure using the information obtained from meetings with clinics	DY3Q1
1.1.6 - Train all appropriate staff who will be using this system	DY3Q1
1.1.7 - Implement the system with the Patient Navigators and Health Connection teams.	DY3Q1
1.1.8 – Monitor progress through regularly scheduled meetings	DY3Q1

Mid Point Assessment Recommendation #3: 2.c.ii Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Develop telemedicine projects with network providers, in an effort to eliminate the credentialing barrier.	DY3Q2
1.1.1 - Discuss with internal PPS partners and request proposals for pilot projects.	DY3Q1
1.1.2 - Review and evaluate proposals	DY3Q1
1.1.3 - Meet with leadership from proposals to identify gaps and requirements to implement project proposals	DY3Q1
1.1.4 - Meet with project lead/teams to identify system requirements, IT connectivity issues, equipment specifications, etc.	DY3Q1
1.1.5 - Identify vendor(s) to assist with the Telemedicine component	DY3Q1
1.1.6 - Train selected staff to implement selected pilot programs	DY3Q1
1.1.7 - Schedule meetings with teams from each selected pilot program to monitor project progress	DY3Q1
2. PPS to send out community wide RFP for Telemedicine pilot projects.	DY3Q2
2.1.1 - PPS draft RFP for Telemedicine pilot projects	DY3Q1
2.1.2 - PPS distribute RFP to service area of the PPS	DY3Q1
2.1.3 - Review/evaluate returned RFP(s)	DY3Q1
2.1.4 - Meet with leadership of proposal to identify gaps and requirements of the proposal	DY3Q1
2.1.5 - Identify vendor(s) to assist with the Telemedicine project	DY3Q2
2.1.6 - Train selected staff to implement pilot project	DY3Q2
2.1.7 - Schedule meetings with teams from each selected pilot program to monitor project progress	DY3Q2

Mid Point Assessment Recommendation #5: 3.g.i Intergration of palliative care into the PCMH Model	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Continue offering the presence of palliative care team members and increase awareness of palliative care and available treatment options at participating CPWNY primary care practices.	DY3 Q2
1.1.1 - Meet with key practice leadership to survey and determine gaps in palliative care awareness.	DY2 Q4
1.1.2 - For practices identified who have already received an initial training by PPS Hospice partners, solicit feedback on what's working well and what areas have opportunity for improvement then develop a second wave of outreach or education to the identified practices establish follow up training plan based on practice interest.	DY3 Q1
1.1.3 - Establish a schedule for embedded palliative care staff in practices with high Medicaid volume who are interested in expanding palliative care services.	DY3 Q2

2. Develop tools for primary care EMRs to screen palliative care needs and systematically track palliative care engagements.	DY3 Q2
2.1.1 - Develop a screening tool for practice nursing staff to identify potential palliative care-eligible patients.	DY2 Q4
2.1.2 - Establish a training plan for practices to implement the screening tool into practice workflow.	DY2 Q4
2.1.3 - Develop a workflow to recommend the patient to the practitioner for palliative care and for follow up palliative care services for identified patients.	DY3 Q1
2.1.4 - Train all participating practices on screening tool and have established a workflow for patient follow up.	DY3 Q2
2.1.5 - Develop an EMR template for physician use to systematically track patients receiving palliative care services.	DY2 Q4
2.1.6 - Pilot the tool at key primary care practices and make adjustments as needed.	DY2 Q4
2.1.7 - Develop a training plan for practices to implement the palliative care engagement tracker into practice.	DY3 Q1
2.1.8 - Train all participating practices on the palliative care engagement tracker.	DY3 Q2
2.1.9 - Expand the screening tool Chautauqua County practices under direction of the Chautauqua County Health Network	DY3 Q2

Mid Point Assessment Recommendation #6: 3.g.i Intergration of palliative care into the PCMH Model	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. Develop and adopt a strategy for continued engagement of primary care practices in palliative care initiatives.	DY3 Q2
1.1.1 - Incorporate palliative care into clinical integration strategy for key providers networks (e.g. Catholic Medical Partners and Chautauqua County Health Network)	DY2 Q4
1.1.2 - Establish metrics for tracking palliative care engagements and performance for the clinical integration program.	DY2 Q4
1.1.3 - Incorporate tools for identifying patients and tracking palliative care engagements into standard practice workflow for CMP primary care practices	DY3 Q1
1.1.4 - Continue to offer practices training and education on palliative care best practices from Hospice partners, as requested.	DY3 Q2
1.1.5 - Establish an embedded schedule for palliative care staff at interested high volume Medicaid practices to maintain practice engagement with palliative	DY3 Q1
1.1.6 - Continue to work with community partners and promote trainings on palliative care.	DY3 Q2
1.1.7 - Roll out tools for identifying patients and tracking palliative care to Chautauqua County region practices under the direction of Chautauqua County Health Network	DY3 Q2

Mid Point Assessment Recommendation #7: Financial Sustanability and VBP	
PPS Defined Milestones/Tasks	***Target Completion Date***
1. PPS will establish a plan to further educate and support partners moving toward Value Based Purchasing arrangements	DY3Q1
1.1.1 - The VBP Work Group will continue to educate and provide guidance on VBP to all members within the PPS and throughout the community through our PAC meeting. The work group will develop a work plan to strategize collaboration amongst the managed care organizations and partner organizations. Updates to our education materials will occur as new information regarding VBP is disseminated by NYS.	DY3Q1
1.1.2 - The VBP Work Group will work towards developing a plan to achieve the VBP goals across the PPS by year five of the DSRIP waiver and communicating results to the PPS network. The plan will outline the transition to the various levels of VBP.	DY3Q1
1.1.3 - Utilizing information gathered from the March 2017 survey, the VBP Work Group will include in the implementation plan measures that will focus on best practices and evidence based guidelines, including monitoring the impact of quality outcomes such as Healthcare Effectiveness Data and Information Set (HEDIS), Quality Assurance Reporting Requirements (QARR), Five Star Quality rating metrics for Medicare. Other models such as ACOs, Integrated Primary Care models, Bundled Payments for Care Improvement (BPCI), Comprehensive Care for Joint Replacement Model (CCJR) will also be explored as potential VBP options.	DY3Q1
1.1.4 - The VBP Work Group plan will follow guidance provided by the New York State Department of Health included in the CMS-approved VBP Roadmap, and will include identification of accelerators and challenges with a detailed timeline to guide the implementation of VBP.	DY3Q1
1.1.5 - CPWNY will expand efforts in line with the updated guidance from the DOH with focused attention on WCA Hospital, Bertrand Chafee Hospital, and Medina Hospital.	DY3Q1
1.1.6 - CPWNY will also expand efforts to include discussions with other CBO partners including but not limited to our behavioral health partners that are currently not engaged in VBP arrangements. Discussions to possibly engage these providers as sub-contractors in a VBP arrangement with limited risk exposure.	DY3Q1
1.1.7 - CPWNY will also continue to support the CCHN team in pursuing VBP arrangements, including risk based value added contracts, for its IPA, the Chautauqua Integrated Delivery System. CPWNY will continue to build partnerships with the CMP IPA and its existing VBP agreements.	DY3Q1

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

		Partner Engagement	
Partner Category		***Project 2cii***	***Project 3gi***
Practitioner - Primary Care			249
Practitioner - Non-Primary Care		6	107
Hospital - Inpatient/ED		1	
Hospital - Ambulatory			
Clinic		1	
Mental Health		1	
Substance Abuse		1	
Case Management			
Health Home			
Community Based Organization (Tier 1)		2	5
Nursing Home			
Pharmacy			
Hospice			3
Home Care			
Other (CBO/Provider RFP Respondents)*		2	331
Other (OPWDD)		1	
Other (Define)			

*respondents to the Telemedicine RFP could be from any partner category