Suffolk Care Collaborative Midpoint Assessment Corrective Action Plan Response

PPS	Suffolk Care Collaborative
PPS ID	16

Attachments	Mid-Point Assessment Action Plan Response	SCC MPA Action Plan Response_v4FC

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Mid-Point Assessment Recommendation

These recommendations reflect the Project Approval and Oversight Panel modifications.

#	PPS	Section	Focus Area	Final Recommendation
1	Suffolk Care Collaborative (Stony Brook)	Organizational	Partner Engagement	The IA recommends that the PPS review its Partner Engagement reporting and develop a plan for engaging network partners across all projects to ensure the successful implementation of DSRIP projects.
2	Suffolk Care Collaborative (Stony Brook)	Organizational Modified		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. These reports will be reviewed and approved by the IA with feedback from the PAOP prior to April 1, 2017.

Suffolk Care Collaborative Action Plan

General Administration of MPA Recommendations

Upon receipt of the Midpoint Assessment Final Recommendation Report the Suffolk Care Collaborative (SCC) organized a **MPA Action Plan Workgroup** (“Workgroup”) to design the Action Plan Response. This Workgroup has been charged with creating specific actions the PPS will take to remedy the deficiency noted in the recommendations, create a detail implementation plan, evaluate current state provider engagement and create a report that will ensure that any gaps in provider engagement are closed. Further, this group will continue to meet to monitor progress towards completion of the Implementation Plan through September 30, 2017.

The following internal stakeholders participate on the Workgroup: Executive Director, Medical Director, Sr. Director Project Management Office (Facilitator), Sr. Director Network Development & Performance, Sr. Director Care Management & Care Coordination, Director, Community & Practice Transformation, Administrative Manager, Community Engagement & Cultural Competency, Business Manager DSRIP Operations, Administrative Manager, Integrated Care Programs, Provider Relations Manager, Data Analyst and additional key staff to be engaged as determined necessary by the Workgroup.

The Workgroup has agreed, the Mid-Point Assessment Action Plan will be fully implemented by no later than September 30, 2017. Should schedule constraints arise during implementation, the critical path may require adjustment.

The efforts by the Workgroup will have a specific focus on **Provider Engagement** since MPA recommendations are both specifically under this scope of work. Progress will be monitored by the workgroup through recurring meetings that have been scheduled. Specific individuals on the workgroup have been delegated tasks to manage and provide updates. The Sr.

Director, Project Management Office will facilitate workgroup meetings, document updates on the implementation plan, identify areas of risk and support risk mitigation planning as well as monitoring the project schedule.

Provider Engagement Reporting Modifications

Within the MPA Recommendation Report, the IA specifically noted, the SCC reported the same provider engagement by DSRIP Project in the PIT table. The SCC has revised its methodology on reporting provider engagement by DSRIP project in the PIT and changes will be reflected in the DY2Q4 Quarterly Report. You may also reference the Provider Engagement Template requirement within this Midpoint Assessment Action Plan submission for the expected engagement by DSRIP project through 9/30/2017.

Project Implementation & Performance Incentive Funds Flow Model

The PPS funds flow model for contracted providers includes two sources of funding for providers: *Project Implementation Costs* and *Performance Incentive Funds*. The first source of funding, project implementation costs, is defined as costs budgeted and incurred by the PPS on behalf of the provider to help in providing foundational elements and resources to achieve the DSRIP project goals. Some examples include, vendors to transform contracted PCPs practices to NCQA 2014 Level 3 PCMH, information technology resources for technical on-boarding and RHIO connectivity, and behavioral health staff to support primary and behavioral health integrated care (model 1, 2 or 3 as applicable), provide care management staff and/or resources, and support through the development of toolkits and subject-matter-experts or consultants to implement the chronic disease self-management and clinical improvement programs. The SCC has estimated that project implementation costs will represent approximately 60% of anticipated revenue over 5 years. At 100% achievement this equates to approximately $179M. The second source of funding to providers, performance incentive funds, is derived from a Performance Payment Incentive Pool, which accounts for approximately 40% of all DSRIP waiver revenue. At 100% achievement this equates to approximately $119M. The performance incentive fund pools are spread across various providers types (PCPs, Non-PCPs, Hospitals, SNF's and Behavioral Health/Substance Abuse) and are released to providers upon the achievement of performance factors designed by the SCC and directly linked to DSRIP project goals and timelines.

For DY3, our PPS has forecasted that approximately $1.3M will be flowed to CBOs as service providers, approximately $5.7M will be flowed to PCPs as performance payments, and $1.8M will be flowed to BH/SUD in performance payments. Further, the PPS projects it will see an increase of approximately 200% in performance payments to providers in DY3.

Provider Contracting Strategy Implemented

Beginning 2015, the SCC had designed and operationalized a comprehensive plan to engage all Provider Types identified by the NYS DOH by DSRIP Project. The SCC felt a performance-driven funds flow model would meaningfully engage contracted partners. Our concept was formalized through Performance Payment Distribution Plans outlined within the SCC Coalition Partner Participation Agreements, Exhibit B: Project Participation Requirements.

The SCC created a **Round 1 Partner Contracting Plan** beginning mid-2015 which initiated mid-2016 through 12/31/2016. In the first phase of provider contracting, SCC prioritized partners that had specific Domain 1 requirements, patient engagement reporting requirements within DSRIP projects, specifically, PCPs, Non-PCPs, Hospitals, Skilled Nursing Facilities, Behavioral Health sites and targeted Community Based Organizations (CBO). The SCC has created a **Round 2 Partner Contracting Plan** that will initiate in April of 2017 to engage and formally contract with Pharmacies, Home Care Agencies, Hospice, Care Management and additional CBOs through Collaboration Agreements. Although formal contracting of attested Pharmacies, Home Care Agencies, Hospice, Care Management and additional CBOs has not commenced, there **has been significant engagement** with these partners across our DSRIP portfolio which is further explored in the Plan for Engaging Partners across DSRIP Projects section.

Each HUB is responsible for their networks project implementation costs and performance incentive funds flow contracting. A PPS guiding principle approved by the Board of Directors requires each HUB model to be consistent in their

approach towards supporting providers and managing performance payments. The PPS Coalition Partner/Provider Participation Agreement is used by all HUBs and outlines the performance incentive funds, definition of responsibility of provider and payment distribution plan. The performance factors are tied to DSRIP project goals that the PPS is held accountable to by the NYS DOH. These performance factors will help to ensure that the PPS and providers will be successful in DSRIP.

In the table below we've provided copies of the Performance Payment Distribution Plan found in each Coalition Partner Participation Agreement by provider type.

Provider Type	Performance Factors
PCP	PCP - Performance Factors.pdf
Hospital	Hospital - Performance Factors
Non-PCP	Non PCP - Performance Factors
Behavioral Health	Behavioral Health - Performance Factors
SNF	SNF - Performance Factors.pdf

Another key document is the SCC Coalition Partner Participation Manual referenced in the SCC's participation agreement, which further defines Provider Project Requirements by project. Our performance-based funds flow model awards incentive dollars for achieving specific "Performance Factors" defined through the NYS DOH Domain 1 Project Requirements. For example, when Primary Care Providers achieve NCQA PCMH Level 3 2014 designation, they will receive an incentive payment.

The SCC used the *NYS DOH DSRIP Quarterly Review Process Guidance* document to create our DSRIP project schedules and approach for Provider Engagement across DSRIP projects. This document truly guided the development of each provider types' scope of work across all DSRIP projects. The guidance indicated which Domain 1 project requirements had specific "Unit Level" or "Provider Type" prescribed scope of work.

Participating Provider Contracting as of March 1, 2017

The SCC has provided a table to demonstrate actual provider engagement/contracting as a result of **Round 1 Partner Contracting efforts.**

Provider Type	*NYS DOH PIT Submission DY2Q2 Midpoint Assessment Evaluation **	*SCC Actual Contracted as of 3/1/2017*	*Progress*	*Percent Increase*
PCP	***112***	**453**	**+ 341**	**404%**
Hospitals	***7***	**11**	**+ 4**	**157%**
SNF	***34***	**39**	**+ 5**	**115%**
BH	***43***	**347**	**+ 304**	**807%**
Non-PCPs	***229***	**1676**	**+ 1447**	**732%**

**This count was evaluated to determine the Midpoint Assessment Recommendation the SCC received. The SCC was mid-way through Round 1 Partner Contracting Efforts at that time.*

Plan for Engaging Partners across DSRIP Projects & Closing Engagement Gaps

In preparing the MPA Action Plan response, the SCC evaluated the current-state-progress of provider engagement by provider type. The SCC has organized a summary narrative by provider type highlighting their engagement in the DSRIP Projects. If the SCC **has met** provider engagement speed and scale commitments, we did not categorize this as a gap and have not addressed engagement in the MPA Implementation Plan Template.

If the SCC has **not yet met** provider engagement speed and scale commitments, we classified this as a gap, have brainstormed an engagement plan and described the gap in the sections below. Further a detailed plan and timeline is outlined in the MPA Implementation Plan Template. In summary, the SCC will close contracting gaps with Non-PCP and PCP's by continuing to roll out Round 1 Partner Contracting efforts. For targeted provider types such as Pharmacies, Home Care and community-based organizations (tier 1-3), the SCC will roll-out **Collaboration Agreements** beginning early-2017 through 9/30/2017 to close out gaps in contracting for targeted organizations described herein.

Practitioner – Primary Care (Includes Clinic & FQHC partners) There **are no identified gaps** in partner engagement for primary care providers and practices. The SCC has exceeded its provider engagement scale commitment of 408 for DY2Q4. There are a total of 453 actively engaged providers with executed SCC Coalition Partner Participation Agreements. In total 656 primary care providers have been identified for contracting and the SCC has executed contracts with 69% of the providers to date for DY3Q4. The remaining targeted physicians for contracting are mostly organized into large IPAs. We expect half of the remaining providers to be contracted by September 30, 2017 and the remaining providers by the end of this calendar year through DY3Q4.

A comprehensive partner onboarding program was created to standardize the process and education materials across the PPS which is available on the SCC website https://suffolkcare.org/forpartners/onboarding . The SCC has developed a Primary Care Implementation Plan that identifies the specific tasks to be completed, the associated due dates as well as the supporting documentation to be returned to the SCC. Each Hub is responsible for the oversight of the progress with implementing the primary care plan at each of their aligned practice sites.

The Suffolk Care Collaborative has been providing PCMH transformation support to our engaged providers in our Hubs. All three Hubs have developed internal PCMH teams which are engaged in reaching out to our provider partners and providing education on transformation models that will effectively position their practices to participate in the current healthcare trend of value based purchasing models as NCQA 2014 PCMH Level 3 or Advanced Primary Care (APC) models.

Partner engagement status indicates that SCC is on track in engaging primary care providers in either PCMH or APC transformation activities and/or discussions. **545** providers have been targeted for Practice Transformation. **147** providers have completed transformation **224** are in progress and **174** are targeted for transformation.

More detail regarding the SCC primary care strategy is addressed in the SCC Primary Care Plan which is included here for your reference.

Practitioner – Non-Primary Care There **is no identified gaps** in partner engagement for non-PCP providers and practices. The SCC has exceeded **100%** of its provider engagement scale commitment of **1615**, at **1676** non-PCP providers contracted to date. Focus to date had been on ensuring identification and onboarding of PCPs within practices due to the urgency of engagement and long lead-time in PCMH and IT onboarding projects. Immediately after identification and contracting, a focused outreach to orient the non-PCPs to key projects (i.e. Transitions of Care and Tobacco Cessation strategies under the Million Hearts Campaign) will be initiated by 9/30/2017.

Hospital – Inpatient/Emergency Department There are **no identified gaps** in partner engagement for Suffolk County Hospitals. The SCC has exceeded its provider engagement scale commitment of **6** Hospitals by **183%**. There are a total of **11** active Hospital Coalition Partner Participation Agreements. The SCC organized an approach to engage and contract

with all attested Hospitals as part of the SCC's Initial Contracting Plan which rolled out in 2016. Due to strong relationships with all attested Hospitals participating in the DSRIP Project 2biv, 2bix and 4aii the hospital contracting effort was a success. Program engagement and implementation efforts for all attested Hospitals began in 2015, the first year of operations for the SCC. The SCC engaged each hospital and helped them identify Facility Champion roles for the Transition of Care (2biv), Hospital Observation (2bix) and SBIRT in Emergency Department implementations (4aii). The SCC project management office also wrote project plans for each of these 3 projects and assigned them to each hospital. Each Hospital's Facility Champion or designee was trained and permissioned to the SCC PMO project management software Performance Logic, where they update and manage their project plan with the assistance of the SCC Project Manager for Acute Care Transitions and Project Manager for Behavioral Health Services. The estimated complete date for the Transition of Care Project is 3/31/2017, Hospital Observation Program is 9/30/2017 and SBIRT Implementation in Emergency Departments is 3/31/2018. All hospitals are on target to complete implementation within these schedules. As DSRIP Project implementation closes the SCC PMO has organized roles for Hospitals in performance improvement and quality assurance activities through Regional Performance Improvement Workgroups alongside partner SNFs (see SNF section below). Further the SCC has had multiple Learning Collaboratives with SNFs and Hospitals integrating across health care continuum providers with the goal to implement practical solutions to prevent avoidable hospitalizations.

Hospital – Ambulatory (includes Primary Care/HIV, Mental Health, Substance Use Disorder, Other Specialty)

As the SCC contracts with Hospitals' ambulatory networks of Primary Care, Mental Health, Substance Use Disorder and Non PCPs they will follow the same scope of work as described in the PCP, Mental Health, Substance Abuse and Non PCP sections herein.

Mental Health & Substance Use Disorder Providers & Clinics (includes Article 28 D&TC)

There are **no identified gaps** in partner engagement for mental health and substance use disorder providers and clinics. The SCC has exceeded its behavioral health provider engagement commitment of **126** behavioral health providers. Through targeted behavioral health contracting efforts, the SCC has reached a count of **347** (Exceed commitment by **275%**) contracted behavioral health providers, to date. This number was reached through the strong relationship building efforts with attested mental health and substance use disorder facilities participating in the DSRIP Project 3ai Primary & Behavioral Health Integrated Care Program.

Program implementation and engagement efforts began in the fall of 2015, marking the first year of operations for the SCC. To aid in provider engagement, the Suffolk Care Collaborative contracted with the Foundation for Health Leadership & Innovation Center of Excellence for Integrated Care (COE). The COE is a program that provides technical assistance to clinics and health systems seeking to integrate medical and behavioral health services. COE consultants all have practice-based experience in integration efforts. The COE supports the SCC by providing on-site and distance based technical support and coaching. Starting in October 2015, COE consultants began visiting sites in Suffolk County to perform and teach the administration of a tool called the MeHAF. This self-assessment tool helps sites measure their current degree of integration based on over 18 core competencies. This tool will be completed by a team of site professionals across all areas of the clinic, as coached by the COE team, to arrive at a baseline measure. The tool will also inform areas where practices can begin improvement work. The COE is also providing support through web-based Learning Collaboratives, which provide interactive opportunities for our Model 1 and Model 2 partners. Through the use of webinars and guided question and answer sessions, subject matter experts are able to cover a range of topics including integrated care basics, workflow and screening procedures, staffing competencies, joint treatment planning, regulations and billing structures, and data and registries. The first round of these Learning Collaboratives ran through 2016, and we have recently begun the second round in March of 2017, which are open to all HUB partners of the primary care and behavioral health provider type.

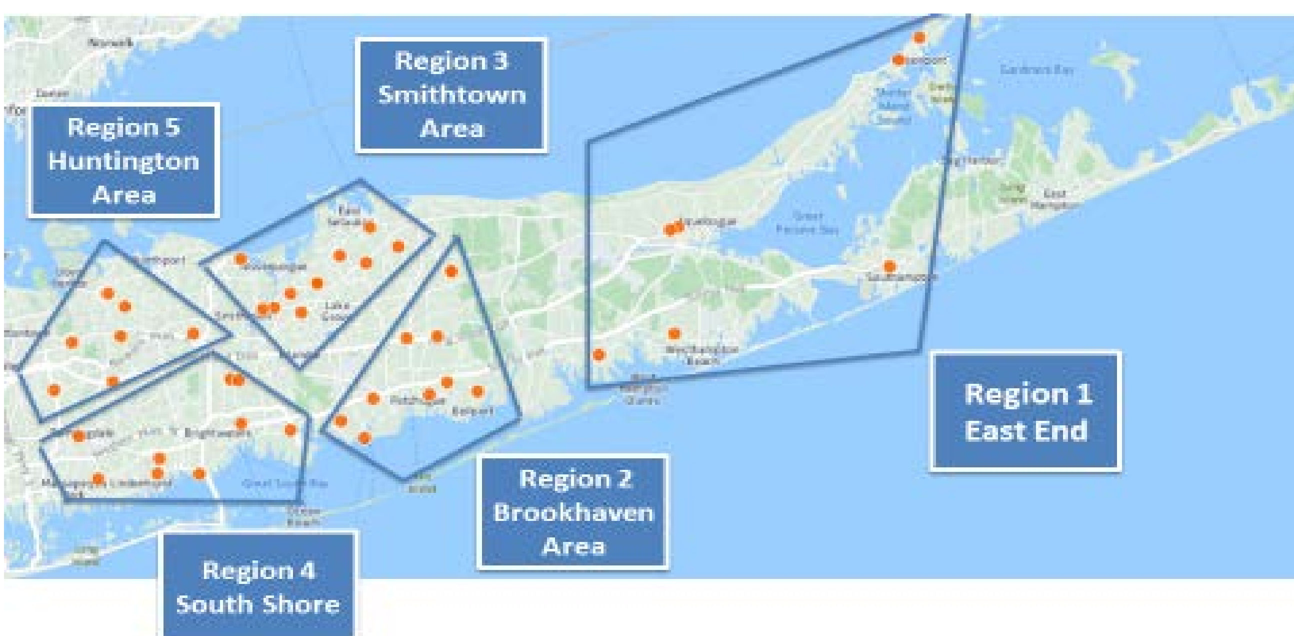
To further support our partners, the SCC has created 3 Integrated Care Implementation Toolkits (one for each model). The purpose of these toolkits is to assist our participating Primary Care and Behavioral Health partners during the implementation phase and during the life cycle of the 3.a.i project, throughout the DSRIP years. It is meant to act as a guide and information source to which our partners can refer to for all of their 3.a.i. DSRIP project needs. The general content in each toolkit includes overview of the DSRIP project requirements for implementation, overview of the Primary & Behavioral Health (PCBH) Integrated Program, project protocols, PCMH alignment, billing information, and instructions regarding how to submit documents and maintain binder. While some of the content in each toolkit is specific to the Model that will be adopted in each location, the aforementioned general format still applies. These toolkits are designed to be amendable documents, therefore we expect the toolkits to undergo several iterations as the project progresses. This design allows for the accuracy and relevancy of the content to be maintained. Future versions of the toolkits will be made available to our partners electronically through the SCC Partner Portal. These toolkits are distributed to our partners at an “Implementation Kick-off Breakfast”, which are hosted for each cohort of engaged sites following the completion of the MeHAF assessment.

Engaged and contracted partners are also supported through the Director of Behavioral Health Integration with the Suffolk Care Collaborative, Susan Jayson. Susan provides tailored, regular, technical support for each site, which is inclusive of, but not limited to, site visits, phone calls, e-mails, and regularly scheduled meetings. Susan’s experience in the behavioral health field, along with her longstanding positive rapport and professional relationships with behavioral health providers in Suffolk County has allowed the SCC to contract quickly and efficiently with these partners.

Our dedication to the meaningful inclusion of behavioral health providers in the DSRIP program is evident through our contracting efforts in exceeding our engagement commitment. We will continue to work with these contracted providers in order to move towards, and achieve, primary care and behavioral health integration by 3/31/2018.

Nursing Home There are **no identified gaps** in partner engagement for skilled nursing facilities (SNFs). The SCC has exceeded its provider engagement scale commitment of **38** SNFs. There are a total of **39** active SNF Coalition Partner Participation Agreements. The SCC organized an approach to engage and contract with all attested SNFs as part of the SCC’s Initial Contracting Plan which rolled out in 2016. Due to strong relationships with all attested SNFs participating in the DSRIP Project 2bvii INTERACT the SNF contracting effort went seamlessly.

Program engagement and implementation efforts for all attested SNFs began in 2015, the first year of operations for the SCC. The SCC rolled out its first Certified INTERACT Champion Training Program attended by 44 SNFs (88 participants) in November of 2015. Since then, the majority of engaged SNFs have already implemented INTERACT and the remaining are targeted to complete INTERACT implementation by 3/31/2017 (DY2Q4). The SCC has created an SNF Implementation Plan, INTERACT Implementation Toolkit and INTERACT Quality Improvement & Assurance Plan that are all operational. Each participating SNF has been trained and permissioned to the SCC PMO project management software Performance Logic, where they update and manage their project plan. The SCC’s Director for Care Transition Innovation has provided onsite coaching and training sessions for SNFs and their Implementation Teams. SNFs have participated in an organized collaboration with Dr. Patricia Bomba, at IPRO (*IPRO, the Medicare Quality Improvement Organization for NYS has launched a CMS Special Innovation Project focusing on adoption of a community based approach to Advance Care Planning in the Nassau and Suffolk county region*), to provide technical support to hospitals, SNFs, home health agencies (HHAs), hospices, emergency medical services (EMS), and physician practices for adoption, training and implementation of eMOLST and Advanced Care Planning education. Further the SCC has had multiple Learning Collaboratives with SNFs and Hospitals integrating across health care continuum providers with the goal to implement practical solutions to prevent avoidable hospitalizations. This integration for Hospitals and SNFs resulted in the initiation of Regional Performance Improvement Workgroups (meet quarterly) that engage SNFs and Hospitals within georgic regions throughout Suffolk County (map below). Goals for the workgroups include performance improvement action planning using data and INTERACT quality improvement tools. In addition to INTERACT implementation under DSRIP project 2bvii, SNFs participate and have key roles in DSRIP Project 2ai, 2biv and 2bix.



Pharmacies There **is an identified gap** in partner engagement for pharmacies. The SCC intends on engaging and contracting with 20 pharmacies by 9/30/2017, the SCC also understands that this target is dependent on the attested pharmacies interest and engagement and may not achieve 100% contracted by 9/30/2017. Pharmacies play an integral role in the successful transition of patients from acute to post-acute care. Medication reconciliations and timely fill of new medications is imperative in order to prevent readmissions within the first 30 days post discharge. Additionally, Pharmacies are engaged with patients who have chronic conditions on a monthly basis, ensuring that medications are refilled, interactions are caught and corrected, side effects are explained, and Providers are engaged in the medication management of their patients. To date, pharmacies are represented in the design and development of our program protocols and models via our Project Workgroups & Project Committees to ensure successful integration of pharmacies in our 2ai, 2biv, 2bix, 3ai, 3bi, 3ci, and 3dii, projects. The SCC has identified 9 clinical performance metrics driven through pharmacy data such as Asthma Medication Ratio for people age 5-64. Further, we have begun planning how to include pharmacy data into our Population Health Management Enterprise Data Warehouse to support concurrent monitoring of these metrics.

Home Care Agencies There **is an identified gap** in partner engagement for Home Care Agencies. The SCC intends on engaging and contracting with 10 Home Care Agencies by 9/30/2017, the SCC also understands that this target is dependent on the attested home care agencies interest and engagement and may not achieve 100% contracted by 9/30/2017. The SCC does not have any speed and scale commitments for Home Care Providers, rather the SCC recognizes the vital skilled services provided by Home Care Agencies necessary to patient care particularly in the areas of post-acute care and prevention of deconditioning and falls. Home Care utilizes the expertise of Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Social Work, and Personal Care Attendants/Home Health Aides and brings these services to the homes of patients in need. Home Care Agencies are engaged with patients as they discharge from inpatient medical and surgical admissions, Observation stays, Psychiatric Units, and Skilled Nursing Facilities as well as receive direct referrals from community based partners such as PCPs, Specialists, and Care Management agencies when an identified need arises. Home Care can allow patients to remain safely in their homes and decrease the necessity of hospitalization as well as the frequency of readmissions.

The SCC's Home Care Agencies have been engaged in Project Workgroups and Committees and even have a seat at the Board of Directors. Further, the SCC had recognized the need to engage our Home Care Partners and therefore initiated a

Home Care Initiative in December of 2016. This initiative is designed to ensure that agencies are connected to the work being done throughout all DSRIP projects. The SCC created and deployed a Home Care Survey which inquired about the type of care provided in each agency, the populations served, any specialty services provided, and a brief understanding of the agency's plans for Value Based Purchasing. This survey was sent to Home Care Providers in Suffolk County including Certified Home Health Agencies, Licensed Home Health Care Agencies, and Managed Long Term Care Agencies. A copy of the survey can be found here. Data was then collected and analyzed in order to determine alignment within projects. As a next step, the SCC is planning a Learning Collaborative where all agencies will be invited to review the 11 DSRIP Programs and understand how the patient output of these programs is best served through Home Care. Opportunities will be available for membership in workgroups and committees, if the agency has not done so already.

Hospice Care There are **no identified gaps** in partner engagement for Hospice Care Agencies. The SCC has reached its provider engagement scale commitment of one Hospice Care Agency and has contracts in place with **1** contracted entities for Hospice Services. Hospice can be provided in hospital settings, specialty hospice locations, or in the patients' home. Hospice is engaged by both acute care and community based providers when a patient's condition is deemed to continue to deteriorate or fail to improve and the medical decision has been made that the patient may expire within the following six months. Care received via hospice allows patients to be supported medically, psychologically, and spiritually through comfort care, pain management, and specialized professionals. Hospice is a vital service provided to patients with terminal and/or end stage disease. Hospice referrals can be part of a transition of care plan or can be engaged at the end stage of Diabetes, Cardiovascular Disease, or respiratory diseases such as COPD. The SCC's strategy to engage Hospice partners has been primarily through the larger contracted entity and through referral relationships to such services as deemed necessary by the healthcare team. Patients are identified for Hospice referrals through community based providers such as PCPs and Specialists and these referrals are facilitated by the Care Management Organizations supporting the PCP network. Additionally, patients are referred to Hospice care through the Transitions of Care Program as applicable and the Hospice provider would then take over all post-acute transition needs of this patient as identified in the SCC's Post Discharge Protocols.

Case Management There are **no identified gaps** in partner engagement for Care Management Agencies. The SCC has reached its provider engagement scale commitment of **10** Care Management Agencies. The SCC's strategy for engagement with Care Management Agencies has been through participation agreements at the contracted entity for providers that are also engaged in the Behavioral Health and Primary Care Integration Program. Care Management services offer a one on one relationship with patients and specially trained professionals who work together to help patients manage their medical, psychological, and social conditions more effectively. The goal of Care Management services it to work with patients towards achieving patient centered goals and to gain an optimal level of wellness. Care Management is provided at various levels and through many different provider types including, in Hospitals, in Sub-Acute Facilities, through Home Care, via Health Homes, in Patient Centered Medical Homes, through Accountable Care Organizations, with Managed Care Organizations, via Managed Long Term Care plans, and through system level Care Management Organizations. These provider types are engaged with the SCC to manage the high and rising risk patients living and receiving care throughout Suffolk County. Patients are referred to Care Management through Hospitals, Skilled Nursing Facilities, and through community based partners such as PCPs and Specialists. Care Management providers are essential to the DSRIP initiatives of decreasing the rate of avoidable ED utilization and hospital admissions while improving the quality of care provided to patients. These agencies participate in many of the SCC's workgroups and committees and play an integral role in the Care Management and Care Coordination Workgroup where organizations across Suffolk County meet to discuss the key elements of becoming an integrated delivery system and troubleshoot the current barriers to care navigation.

Many of the engaged Care Management agencies are acting as downstream partners for the Health Homes in Suffolk County. The SCC's Health Home partners participate in the Care Management and Care Coordination Workgroup and have been involved in Transitions of Care, Hospital Observation and the Behavioral Health Integration projects. In addition to

this work in Suffolk County, the SCC has partnered with NQP PPS and the two regional Health Homes to develop and pilot a centralized referral line for all Health Home referrals. The purpose of this program is to streamline the referrals from hospitals and providers, making it easier for staff to refer their patients and thereby increasing the number of patients connected to appropriate services.

Community Based Organizations (CBOs) SCC is developing a CBO survey to address gaps in services and further reduce silos. From a previous 2015 survey it provided a snapshot of the gaps. Our initial phase targeted CBOs to support implementation of the DSRIP projects. Currently, we have 139 CBO's, which ~7% are contracted or in service agreements with our PPS in 6 of the 11 DSRIP projects (refer to CBO Narrative). In the next phase, now with a larger pool of CBO's to survey, SCC can capture an analysis from our enhanced 2017 survey to increase our community engagement with our CBO's. The survey will inquire about the type of services provided in the CBOs, the populations served, addressing social determinants of health needs, and updating CBOs' fit in the CBO Tiered structure. In 2017, SCC's Community Engagement team will be coordinating a CBO survey to further engage all CBOs in particular Tier-1.

By the end of DY3Q3 SCC plans to aggregate the survey results and perform an evaluation of the results. The survey findings will inform this phase of CBO partner engagement and create an even more robust repository of information to support our integrated delivery system. In addition, SCC will implement the information gained from the survey to our asset mapping, particularly in underserved communities to identify available CBO resources. Furthermore, it is anticipated that our outreach will continue to expand with CBO's by contracting 25% Tier-1 CBO's through:

- Engagement with various community leaders (i.e., faith based and educational) - Through an introduction letter, phone and in person meetings, attending public events;
- Connecting with Tier 2 and Tier 3 CBO's that have pre-existing community relationships with Tier 1 CBO's;
- Strengthening sustainability – routine updates, circulate a SCC-CBO newsletter, attend school district meetings, and public events; and
- In addition to the current Community Consumer Advisory Council, will explore the development of a faith based council to address health issues within targeted underserved communities.

Based on the survey efforts the SCC will engage in contracting with tier 1 CBO and non-tier 1 CBOs through 9/30/2017. SCC has already contracted with 16% of the total commitment of CBO contracts. Anticipated engagement through 9/30/2017 is outlined in the MPA Partner Engagement Template. The commitment of contracted CBO's for the SCC is 38, the SCC is targeting contracting with 38 CBOs by 9/30/2017. The SCC suspects that we may not meet 38 contracted CBO's by 9/30/2017 if constraints to the critical path unknown today are recognized.

Monitoring Program Implementation for Project Risks

Only 1 DSRIP project had a risk score of '3' or more, DSRIP Project 2bix, Hospital Observation Program due to missed patient engagement commitments. The IA previously reported "The PPS acknowledges in its Project Narrative that it has had challenges in meeting patient engagement commitments. The PPS noted that they have begun to see a trend in utilization that could lead to unattainable patient engagement targets. The PPS admittedly over-forecasted its patient engagement commitments when the DSRIP application was submitted." The SCC will continue to work with all participating Hospitals but due to the constraints reported to the IA it is not expected the SCC will meet this patient engagement commitment.

EXHIBIT E

Performance Payment Distribution Plan

Primary Care Practitioner (PCP)

Funding: Consistent with the provisions governing the DSRIP program, funds will be received by SCC only to the extent that applicable milestones and metrics are found by DOH and the Independent Assessor to have been satisfied by the SCC, and to the extent that CMS has approved funding for the State of New York through the DSRIP waiver. Therefore, the exact amount of funding to be received in a measurement period cannot be known with certainty at this time. Funds distribution to participating providers will take place only to the extent that the SCC receives DSRIP funding from the DOH.

Performance Payment Distribution Plan: Defined as a "trigger event," upon successful completion would qualify a partner for a funds flow distribution.

Payment Schedule: Please refer to Table 2 below.

Table 1: Description of Performance Factors

#	Performance Factor	Description
1	Engagement Payment	**Initial Commitment** • Submission of Required SCC On-boarding documentation as outlined in the *SCC Contracting Plan* • Initiate performance factors # 2 - 5 **Ongoing Commitment:** 1. Good citizenship 2. Timely and complete quarterly Domain 1 patient engagement reporting 3. Data sharing 4. Participation in Population-wide-prevention programs (D4) – Strengthen Mental Health and Substance Abuse Infrastructure; Promote Tobacco Use Cessation, Especially among Low SES Populations and those with Poor Mental Health 5. Updates towards successful completion of the Domain 1 Process Measures 6. Updates towards successful completion of the Workforce reporting requirement 7. Participation in DSRIP Project 2ai (Integrated Delivery System), oriented to SCC Care Coordination program and other resources to ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. 8. EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Safety Net Only) and returns required documentation. 9. Initial and ongoing training services
2	Technical On-Boarding	• Complete Technical On-boarding, i.e. technical data integration and system interoperability between the Partner's source system and the HUB data-warehouse, which will then feed the Suffolk PPS Population Health Platform.
3	Clinical Improvement Programs (Domain 3)	• Meet requirements of *Primary & Behavioral Health Integrated Care Program* • Demonstrate completion by submission of all required documents of Model 1 or 3 of DSRIP Project 3ai.
		• Meet requirements of *Cardiovascular Health Wellness & Self-Management Program* • Demonstrate completion by submission of all required documents of DSRIP Project 3bi.
		• Meet requirements of *Diabetes Wellness & Self-Management Program* • Demonstrate completion by submission of all required documents of DSRIP Project 3ci.
		• Meet requirements of *Promoting Asthma Self-Management Program* • Promote patient engagement in asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use and medical follow up. • Demonstrate completion by submission of all required documents of DSRIP Project 3dii.

4	PCMH Certification/APC	• Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards (EHR vendor Meaningful Use certification provided).
5	Domain 2 & 3 Clinical Outcome Measures	• Adhere to the Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided.

Table 2: Distribution of Performance Factors

Performance Factor (PF) Name	Total Weight of PF	Payment Due Date *	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4	Frequency of Payment
Engagement - Initial Commitment	30%	3 months following contract effective date	3.75%	0.00%	0.00%	0.00%	One Time
Engagement - Ongoing Commitment		Semi-annual payments**	3.75%	7.50%	7.50%	7.50%	Two payments per year once contracted
Technical On-Boarding	10%	Semi-annual payments**	2.50%	2.50%	2.50%	2.50%	Two payments per year once PF complete
Clinical Improvement Programs (Domain 3)	15%	Semi-annual payments**	3.75%	3.75%	3.75%	3.75%	Two payments per year once PF complete
PCMH / APC	20%	Semi-annual payments**	5.00%	5.00%	5.00%	5.00%	Two payments per year once PF complete
Domain 2 & 3 Clinical Outcome Measures	25%	Semi-annual payments**	0.00%	8.33%	8.33%	8.33%	Two payments per year based on performance

*Semi-Annual payments distributed net 60 days

**Each contract year's PF will be paid in semi-annual payments equal to half of the total percentage weight for a given year as described above

Notes:

1) If a performance factor is not completed by the contract anniversary, you will not receive payment. Money will not rollover to the next anniversary. This will reduce the overall PF weight.

EXHIBIT E

Performance Payment Distribution Plan

Hospital

Funding: Consistent with the provisions governing the DSRIP program, funds will be received by SCC only to the extent that applicable milestones and metrics are found by DOH and the Independent Assessor to have been satisfied by the SCC, and to the extent that CMS has approved funding for the State of New York through the DSRIP waiver. Therefore, the exact amount of funding to be received in a measurement period cannot be known with certainty at this time. Funds distribution to participating providers will take place only to the extent that the SCC receives DSRIP funding from the DOH.

Performance Payment Distribution Plan: Defined as a "trigger event," upon successful completion would qualify a partner for a funds flow distribution.

Payment Schedule: Please refer to Table 2 below.

Table 1: Description of Performance Factors

#	Performance Factor	Description
1	Engagement Payment	**Initial Commitment** • Submission of Required SCC On-boarding documentation as outlined in the *SCC Contracting Plan* • Initiate performance factors # 2 - 4 **Ongoing Commitment:** 1. Good citizenship 2. Timely and complete quarterly Domain 1 patient engagement reporting 3. Data sharing 4. Participation in Population-wide-prevention programs (D4) – Strengthen Mental Health and Substance Abuse Infrastructure; Promote Tobacco Use Cessation, Especially among Low SES Populations and those with Poor Mental Health 5. Updates towards successful completion of the Domain 1 Process Measures 6. Updates towards successful completion of the Workforce reporting requirement 7. Participation in DSRIP Project 2ai (Integrated Delivery System), oriented to SCC Care Coordination program and other resources to ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. 8. EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Safety Net Only) and returns required documentation. 9. Initial and ongoing training services
2	Technical On-Boarding	• Complete Technical On-boarding, i.e. technical data integration and system interoperability between the Partner's source system and the HUB data-warehouse, which will then feed the Suffolk PPS Population Health Platform.
3	System Transformation Programs (Domain 2 & 4)	• Meet requirements of *Transition of Care Program for Inpatient and Observation Units.* • Stage 2 Meaningful Use certification from CMS • Demonstrate completion by submission of all required documents of DSRIP Project 2bix & 2biv.
		• Meet requirements of *SBIRT Implementation Program.* • Demonstrate completion by submission of all required documents of DSRIP Project 4aii.
4	Domain 2 & 3 Clinical Outcome Measures	• Adhere to the Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided.

Table 2: Distribution of Performance Factors

Performance Factor (PF) Name	Total Weight of PF	Payment Due Date *	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4	Frequency of Payment
Engagement - Initial Commitment	50%	3 months following contract effective date	6.25%	0.00%	0.00%	0.00%	One Time
Engagement - Ongoing Commitment		Semi-annual payments**	6.25%	12.50%	12.50%	12.50%	Two payments per year once contracted
Technical On-Boarding	10%	Semi-annual payments**	2.50%	2.50%	2.50%	2.50%	Two payments per year once PF complete
System Transformation Programs (Domain 2 & 4)	15%	Semi-annual payments**	3.75%	3.75%	3.75%	3.75%	Two payments per year once PF complete
Domain 2 & 3 Clinical Outcome Measures	25%	Semi-annual payments**	0.00%	8.33%	8.33%	8.33%	Two payments per year based on performance

*Semi-Annual payments distributed net 60 days

**Each contract year's PF will be paid in semi-annual payments equal to half of the total percentage weight for a given year as described above

Notes:

1) If a performance factor is not completed by the contract anniversary, you will not receive payment. Money will not rollover to the next anniversary. This will reduce the overall PF weight.

EXHIBIT E

Performance Payment Distribution Plan

Non-Primary Care Practitioner (Non-PCP)

Funding: Consistent with the provisions governing the DSRIP program, funds will be received by SCC only to the extent that applicable milestones and metrics are found by DOH and the Independent Assessor to have been satisfied by the SCC, and to the extent that CMS has approved funding for the State of New York through the DSRIP waiver. Therefore, the exact amount of funding to be received in a measurement period cannot be known with certainty at this time. Funds distribution to participating providers will take place only to the extent that the SCC receives DSRIP funding from the DOH.

Performance Payment Distribution Plan: Defined as a “trigger event,” upon successful completion would qualify a partner for a funds flow distribution.

Payment Schedule: Please refer to Table 2 below.

Table 1: Description of Performance Factors

#	Performance Factor	Description
1	Engagement Payment	**Initial Commitment** • Submission of Required SCC On-boarding documentation as outlined in the <u>*SCC Contracting Plan*</u> • Initiate performance factors # 2 - 4 **Ongoing Commitment:** 1. Good citizenship 2. Timely and complete quarterly Domain 1 patient engagement reporting 3. Data sharing 4. Participation in Population-wide-prevention programs (D4) – Strengthen Mental Health and Substance Abuse Infrastructure; Promote Tobacco Use Cessation, Especially among Low SES Populations and those with Poor Mental Health 5. Updates towards successful completion of the Domain 1 Process Measures 6. Updates towards successful completion of the Workforce reporting requirement 7. Participation in DSRIP Project 2ai (Integrated Delivery System), oriented to SCC Care Coordination program and other resources to ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. 8. EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements (Safety Net Only) and returns required documentation. 9. Initial and ongoing training services
2	Technical On-Boarding	• Complete Technical On-boarding, i.e. technical data integration and system interoperability between the Partner’s source system and the HUB data-warehouse, which will then feed the Suffolk PPS Population Health Platform.
3	Clinical Improvement Programs (Domain 3)	• Meet requirements of *Cardiovascular Health Wellness & Self-Management Program* • Demonstrate completion by submission of all required documents of DSRIP Project 3bi.
4	Domain 2 & 3 Clinical Outcome Measures	• Adhere to the Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided.

Table 2: Distribution of Performance Factors

Performance Factor (PF) Name	Total Weight of PF	Payment Due Date *	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4	Frequency of Payment
Engagement - Initial Commitment	50%	3 months following contract effective date	6.25%	0.00%	0.00%	0.00%	One Time
Engagement - Ongoing Commitment		Semi-annual payments**	6.25%	12.50%	12.50%	12.50%	Two payments per year once contracted
Technical On-Boarding	10%	Semi-annual payments**	2.50%	2.50%	2.50%	2.50%	Two payments per year once PF complete
Clinical Improvement Programs (Domain 3)	15%	Semi-annual payments**	3.75%	3.75%	3.75%	3.75%	Two payments per year once PF complete
Domain 2 & 3 Clinical Outcome Measures	25%	Semi-annual payments**	0.00%	8.33%	8.33%	8.33%	Two payments per year based on performance

*Semi-Annual payments distributed net 60 days

**Each contract year's PF will be paid in semi-annual payments equal to half of the total percentage weight for a given year as described above

Notes:

1) If a performance factor is not completed by the contract anniversary, you will not receive payment. Money will not rollover to the next anniversary. This will reduce the overall PF weight.

EXHIBIT E

Performance Payment Distribution Plan

Behavioral Health (BH)

Funding: Consistent with the provisions governing the DSRIP program, funds will be received by SCC only to the extent that applicable milestones and metrics are found by DOH and the Independent Assessor to have been satisfied by the SCC, and to the extent that CMS has approved funding for the State of New York through the DSRIP waiver. Therefore, the exact amount of funding to be received in a measurement period cannot be known with certainty at this time. Funds distribution to participating providers will take place only to the extent that the SCC receives DSRIP funding from the DOH.

Performance Payment Distribution Plan: Defined as a "trigger event," upon successful completion would qualify a partner for a funds flow distribution.

Payment Schedule: Please refer to Table 2 below.

Table 1: Description of Performance Factors

#	Performance Factor	Description
1	Engagement Payment	**Initial Commitment** • Submission of Required SCC On-boarding documentation as outlined in the *SCC Contracting Plan* • Initiate performance factors # 2 - 4 **Ongoing Commitment:** 1. Good citizenship 2. Timely and complete quarterly Domain 1 patient engagement reporting 3. Data sharing 4. Participation in Population-wide-prevention programs (D4) – Strengthen Mental Health and Substance Abuse Infrastructure; Promote Tobacco Use Cessation, Especially among Low SES Populations and those with Poor Mental Health 5. Updates towards successful completion of the Domain 1 Process Measures 6. Updates towards successful completion of the Workforce reporting requirement 7. Participation in DSRIP Project 2ai (Integrated Delivery System), oriented to SCC Care Coordination program and other resources to ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. 8. EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Safety Net Only) and returns required documentation. 9. Initial and ongoing training services
2	Technical On-Boarding	• Complete Technical On-boarding, i.e. technical data integration and system interoperability between the Partner's source system and the HUB data-warehouse, which will then feed the Suffolk PPS Population Health Platform.
3	Clinical Improvement Programs (Domain 3)	• Meet requirements of *Cardiovascular Health Wellness & Self-Management Program* • Demonstrate completion by submission of all required documents of DSRIP Project 3bi.
		• Meet requirements of *Primary & Behavioral Health Integrated Care Program by* completing Model 2 of project 3ai. • Demonstrate completion by submission of all required documents of DSRIP Project 3ai.
4	Domain 2 & 3 Clinical Outcome Measures	• Adhere to the Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting,

		performance measurement, analysis and improvement for the healthcare services provided.

Table 2: Distribution of Performance Factors

Performance Factor (PF) Name	Total Weight of PF	Payment Due Date *	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4	Frequency of Payment
Engagement - Initial Commitment	50%	3 months following contract effective date	6.25%	0.00%	0.00%	0.00%	One Time
Engagement - Ongoing Commitment		Semi-annual payments**	6.25%	12.50%	12.50%	12.50%	Two payments per year once contracted
Technical On-Boarding	10%	Semi-annual payments**	2.50%	2.50%	2.50%	2.50%	Two payments per year once PF complete
Clinical Improvement Programs (Domain 3)	15%	Semi-annual payments**	3.75%	3.75%	3.75%	3.75%	Two payments per year once PF complete
Domain 2 & 3 Clinical Outcome Measures	25%	Semi-annual payments**	0.00%	8.33%	8.33%	8.33%	Two payments per year based on performance

*Semi-Annual payments distributed net 60 days

**Each contract year's PF will be paid in semi-annual payments equal to half of the total percentage weight for a given year as described above

Notes:

1) If a performance factor is not completed by the contract anniversary, you will not receive payment. Money will not rollover to the next anniversary. This will reduce the overall PF weight.

EXHIBIT E

Performance Payment Distribution Plan

Skilled Nursing Facility (SNF)

Funding: Consistent with the provisions governing the DSRIP program, funds will be received by SCC only to the extent that applicable milestones and metrics are found by DOH and the Independent Assessor to have been satisfied by the SCC, and to the extent that CMS has approved funding for the State of New York through the DSRIP waiver. Therefore, the exact amount of funding to be received in a measurement period cannot be known with certainty at this time. Funds distribution to participating providers will take place only to the extent that the SCC receives DSRIP funding from the DOH.

Performance Payment Distribution Plan: Defined as a "trigger event," upon successful completion would qualify a partner for a funds flow distribution.

Payment Schedule: Please refer to Table 2 below.

Table 1: Description of Performance Factors

#	Performance Factor	Description
1	Engagement Payment	**Initial Commitment** • Submission of Required SCC On-boarding documentation as outlined in the *SCC Contracting Plan* • Initiate performance factors # 2 - 4 **Ongoing Commitment:** 1. Good citizenship 2. Timely and complete quarterly Domain 1 patient engagement reporting 3. Data sharing 4. Participation in Population-wide-prevention programs (D4) – Strengthen Mental Health and Substance Abuse Infrastructure; Promote Tobacco Use Cessation, Especially among Low SES Populations and those with Poor Mental Health 5. Updates towards successful completion of the Domain 1 Process Measures 6. Updates towards successful completion of the Workforce reporting requirement 7. Participation in DSRIP Project 2ai (Integrated Delivery System), oriented to SCC Care Coordination program and other resources to ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. 8. EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Safety Net Only) and returns required documentation. 9. Initial and ongoing training services
2	Technical On-Boarding	• Complete Technical On-boarding, i.e. technical data integration and system interoperability between the Partner's source system and the HUB data-warehouse, which will then feed the Suffolk PPS Population Health Platform.
3	System Transformation Programs (Domain 2)	• Meet requirements of *INTERACT Program.* • Demonstrate completion by submission of all required documents of DSRIP Project 2bvii. • Stage 2 Meaningful Use certification from CMS
4	Domain 2 & 3 Clinical Outcome Measures	• Adhere to the Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided.

Table 2: Distribution of Performance Factors

Performance Factor (PF) Name	Total Weight of PF	Payment Due Date *	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4	Frequency of Payment
Engagement - Initial Commitment	50%	3 months following contract effective date	6.25%	0.00%	0.00%	0.00%	One Time
Engagement - Ongoing Commitment		Semi-annual payments**	6.25%	12.50%	12.50%	12.50%	Two payments per year once contracted
Technical On-Boarding	10%	Semi-annual payments**	2.50%	2.50%	2.50%	2.50%	Two payments per year once PF complete
System Transformation Programs (Domain 2)	15%	Semi-annual payments**	3.75%	3.75%	3.75%	3.75%	Two payments per year once PF complete
Domain 2 & 3 Clinical Outcome Measures	25%	Semi-annual payments**	0.00%	8.33%	8.33%	8.33%	Two payments per year based on performance

*Semi-Annual payments distributed net 60 days

**Each contract year's PF will be paid in semi-annual payments equal to half of the total percentage weight for a given year as described above

Notes:

1) If a performance factor is not completed by the contract anniversary, you will not receive payment. Money will not rollover to the next anniversary. This will reduce the overall PF weight.