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DSRIP Independent Assessor

Mid-Point Assessment Report

Finger Lakes PPS

Appendix PPS Narratives

November 2016

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Prepared by the DSRIP Independent Assessor

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DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting the overall organizational efforts to date.

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Highlights and successes of the efforts:

The Finger Lakes Performing Provider System (FLPPS) is the second largest Performing Provider System (PPS) with an award of $565M in New York State's Delivery System Reform Incentive Payment (DSRIP) program. FLPPS covers a 13-county region, including almost 400,000 Medicaid members and uninsured served by approximately 6,700 providers and 19 hospitals. The PPS has approximately 600 attested providers who are participating at different levels on DSRIP initiatives within the FLPPS network. The geographically expansive region is comprised of rural and urban areas, which has presented a series of communication and collaboration challenges for project implementation and organizational work streams. In order to mitigate the risks associated with these challenges, FLPPS further divided its geographic area into five sub-regions known as Naturally Occurring Care Networks (NOCNs): Finger Lakes, Monroe, Southeastern, Southern and Western. These regions were created based on the delivery of care patterns identified during the development of the community needs assessment. The NOCN structure has been a significant mitigation strategy used to facilitate provider engagement, DSRIP education for providers and the implementation of projects across the entire region. The NOCN structure has also been a best practice across the state by many for project implementation design and strategy.

The corporate structure of FLPPS is a new corporation with 501(c)3 status that was developed for the purpose of the implementation of DSRIP activities. The PPS is a collaboration between two major health systems in the region, RU System Inc. d/b/a Rochester Regional Health (RRH) and University of Rochester (collectively known as "the members"). The competitive healthcare environment in the region has presented some challenges to this collaboration, most notably in the areas of data sharing and standardization of project requirements. FLPPS continues to bring providers together to discuss opportunities for improved collaboration and providership to ensure the success of FLPPS as an Integrated Delivery System (IDS) and overcome obstacles. The PPS will also work to develop innovative plans to facilitate DSRIP goal attainment if collaboration via current efforts is unsuccessful.

As the DSRIP program continues to evolve, FLPPS has encountered several challenges related to the changes in, lack of clarity for, or undefined state expectations in program requirements, as well as the availability of data from the state and other sources. Areas presenting the most challenge are related to project patient engagement definitions and reporting requirements in multiple work streams to meet project deliverables.

This issue is particularly problematic in development of strategies for work streams like workforce and value based payment (VBP). FLPPS has addressed these challenges by developing significant innovative strategies to meet core requirements through non-traditional approaches. The other area of significant difficulty is related to the timeliness of data and the age of the data once it is received. FLPPS has begun to work with providers to eventually receive data directly from them to bridge these issues; however, it is not an easy solution due to the need to aggregate and normalize data from many different systems and platforms.

In spite of the challenges identified, FLPPS has attained 100 percent achievement on all project and organizational requirements through Demonstration Year 1 (DY1). The remainder of this organizational narrative highlights successes and challenges for FLPPS across organizational work streams.

Governance

- FLPPS's governance structure is designed to ensure that the Board of Directors and associated Committees includes diverse representation across the PPS. This structure is important due to the PPS's large geographic size and diverse provider mix.
- NOCN membership was also developed to employ diverse representation for all provider types within each region. This structure acknowledges that healthcare is local and delivered in a unique fashion depending on the demographic make-up and accessibility of services within the region. Each NOCN includes leadership and patient/consumer representation from its respective region and is a replication of the larger PPS and the associated IDS.
- In response to the challenge of convening providers in a collaborative environment due to the geographic footprint, FLPPS has introduced the ability to host virtual meetings so that provider representation is more efficient across the PPS. This technology allows providers that are located outside the Rochester, NY area to attend meetings via video conference and/or teleconference as necessary to ensure inclusion of the entire network and facilitate meeting participation.
- A dedicated Fund Flow Workgroup was formed to dive deeply into funds flow assumptions with representation from the members and other strategic providers. This workgroup makes recommendations to the Finance Committee and provides input on funds flow and contracting decisions.
- A number of tasks under the governance structure requirements have been pushed back due to a robust Board visioning and strategic planning process currently underway. These decisions were made intentionally to ensure that all Board of Director and stakeholder perspectives are included and prevent creating strategies in silos thus allowing the new corporation to fully mature. FLPPS will complete the strategic planning process to lay the foundation for these governance structure tasks during DY2.
- Compressed timelines for Board approval on major organizational decisions have been challenging due to the pace of implementation of the FLPPS DSRIP Implementation Plan and the need for significant communication on complex issues for informed decision making. To help address this, the Board of Directors meets monthly with additional sessions added as necessary. FLPPS executive and senior staff also host meetings with Board leadership and key members as necessary to ensure

that all participants are prepared for each meeting. Information sharing and approvals are also handled via email and other technology venues when timelines prevent in-person attendance.

Budget and Funds Flow

- As part of the initial budget development process, FLPPS established a "reliable dollar" budget based on the calculation of achievement values (AVs) that the PPS believed it would be able to realize as indicated by a set of agreed-upon assumptions. This method was meant to instill the appropriate amount of conservatism for planning purposes while not limiting operational achievement. The primary goal of the budget was to insure that the majority of the PPS award was distributed to providers to incent the transformation of the service delivery model. A secondary assumption was that the administrative portion of the budget would be capped at the reliable dollar amount with any excess achievement of funds reinvested in provider incentives driving the transformation.
- FLPPS did not develop project specific budgets in order to focus award dollars on building an IDS versus creating project silos. This approach allows for shared resources across projects as FLPPS meets project requirements.
- The five percent cap on payments to non-safety net providers participating in the DSRIP program has been a challenge for funds flow and contracting as the PPS works to transform access to care for Medicaid members. FLPPS has remained within the boundaries of this requirement and continues to identify opportunities to ensure appropriate CBO services are incorporated into performance based contracts. The PPS plans to use Innovation Projects, RFPs for services and other innovative funds flow mechanisms to insure that providers delivering social services who can impact the health outcomes of Medicaid members are included in the DSRIP project. The PPS is developing a comprehensive CBO engagement strategy that will promote CBO collaboration, inter-connectivity, data-sharing, and meaningful participation in the IDS, especially as it relates to addressing social determinants of health. The PPS also supports the current proposal from the State to CMS to allow an expansion of providers that are considered safety-net to facilitate this work.
- The project reporting required by the State related to funds flow has been challenging for the PPS due to the budgeting process used by the PPS. Specifically, there have been challenges with the PIT file and reporting in MAPP at the provider level by provider type. FLPPS has worked closely with the State to identify a reporting methodology that fits the Independent Assessor (IA) requirements and aligns with the FLPPS structure. Additional challenges related to the structure of the PIT and difficulty in the ability to upload the file have further complicated this process.
- There have been significant delays in contracting and funds flow for pending vital access providers (VAP) due to a delayed approval from CMS. FLPPS has addressed this by developing a strategy for these providers that ensures the five percent non-safety net provider cap is met and ensuring adequate funds are provided to these providers as indicated by their contribution to the achievements of the PPS. The risk to the PPS is that payments to other non-safety net providers

will need to be reduced in order to comply with the required five percent cap if these critical VAP pending providers are not approved for safety net status.

- FLPPS was the first to adopt a performance-based contracting strategy for providers (all provider types) that has been adopted across other PPSs in the state. FLPPS continues to develop updated contracting strategies that will further align with VBP efforts and opportunities to flow funds to non-traditional providers, such as CBOs.
- FLPPS was the first PPS to flow funds to both safety net and non-safety net providers. Development of the funds flow model was complicated due to lack of timely data on which to base incentive payments that would transform the healthcare delivery model. The PPS is working to identify proxy measures that can be used to incent providers to change behaviors with currently available datasets.
- In an effort to engage all providers regardless of current billing status for Medicaid, the PPS is actively pursuing other methodologies to flow funds moving away from attribution based drivers toward a more efforts based approach, which is further complicated by a lack of performance data.

Financial Stability, Compliance, and VBP Strategy

- The PPS developed a process to assess provider's financial health in alignment with DSRIP requirements around Financial Sustainability. This process is important to ensure that providers are able to complete the DSRIP project regardless of significant impacts that changes in reimbursement may have on financial viability. In an effort to address this issue, FLPPS established Sustainability and Contingency funds as part of its budgeting process to ensure appropriate funds are set aside to continue supporting those providers that are deemed financially fragile and essential to the success of the network. FLPPS has developed policies and procedures to support identified providers via improvement plans and guidance from FLPPS to improve business processes in an effort to support long term financial health of the providers. FLPPS has also determined that revenue replacement for providers was not an acceptable strategy due to the need to transform behavior rather than reinforce current incentive models.
- FLPPS has required providers to attest that they have a compliance plan in place as required by the State, and if not required by the State, they must abide by the FLPPS compliance plan and attest they have disseminated and implemented this plan.
- Managed Care Organizations (MCOs) and some larger providers have been reluctant to participate in VBP conversations because of competition concerns, adverse effects and fear of the unknown. The PPS continues to work with these stakeholders to define the PPS role and to assure the MCOs and others that the PPS is working to advance common goals. FLPPS will partner with major MCOs to develop appropriate VBP strategies and will continue to reach out and educate providers on VBP.
- FLPPS has developed a VBP assessment that has been approved by the Finance Committee to be used in development of a VBP baseline for the region. FLPPS will also be offering and strongly recommending a readiness assessment for VBP, though not required to participate.

- The continuous quality improvement plan for FLPPS is anchored in the formation of clinical quality subcommittees (CQSs) for each project. These started as project teams in the fall of 2014 with large provider, CBO and community stakeholder (i.e. county) involvement and became CQSs in Dec 2015. These enabled FLPPS to gather rich input into project design and promote collaboration. Over the last year and a half, the teams have continued to meet and have supplemented the project management office (PMO) by promoting provider education and project refinement. Project design flow charts have been developed to standardize the process at a high level across the PPS and include provider responsibilities, information transitions and care management needs. These were based on the Domain 1 project requirements and best practices. The Clinical Quality Committee (CQC), which is mostly comprised of PPS clinicians, Health Homes and other clinical experts, has reviewed the flow charts and provided input and suggested modifications. From that work, protocols are being written to further promote standardization. Provider readiness tools have been developed for the projects to assess the current state and facilitate project implementation throughout the various providers. As providers adopt protocols, FLPPS intends to develop a QA process to monitor adherence to the prescribed processes by conducting or reviewing self-audits.
- Learning Collaboratives have begun for some projects and will expand to facilitate the regionalization of the projects and DSRIP work.
- DSRIP system transformational and clinical quality outcomes have been communicated extensively to the providers in the PPS through smaller and regional NOCN sessions and during the full summit in June 2016. The continuous quality improvement plan for FLPPS will use a process to monitor PPS performance against the annual improvement targets. These will be broken down at the NOCN and provider level and communicated via dashboards to identify opportunities for quality improvement (QI). Rapid cycle improvement methodologies, like Kaizen, and other quality tools and methodologies, such as Lean Six Sigma, will be utilized as appropriate for performance improvement across the PPS. Implementation plans will be developed for identified opportunities with quality results evaluated by the clinical quality subcommittees.

Cultural Competency/Health Literacy

- The PPS recognizes that a significant area that must be addressed in the transformation of the service delivery model to benefit Medicaid members is how providers engage with their patients. To address this significant issue, FLPPS has created a Cultural Competency/Health Literacy (CC/HL) Committee with diverse representation of provider types and regions to help inform the internal team and Board on strategy and training necessary to ensure that CC/HL is included in all system transformation work. FLPPS project design includes CC/HL elements as an identified work stream in all project flows, emphasizing its importance.
- The CC/HL Committee has partnered with a recognized CC/HL vendor to create a comprehensive and actionable current state assessment to inform a training strategy that will facilitate this work. In support of this work stream, the PPS has hired a project manager to be dedicated to this initiative and reports directly to the FLPPS Executive Director.

- As part of the PPS effort to utilize existing community resources, FLPPS solicited advice from external organizations like the Monroe County Medical Society and University of Rochester Center for Experiential Learning (CEL) for training strategy feedback/input and the impact to providers. The CEL provided input on how to complete the application and have the trainings accredited in the future. Additionally, FLPPS has partnered with CBOs and members of community initiatives like the Latino Health Coalition and African American Health Coalition, the Finger Lakes Health Systems Agency (FLHSA), and Rochester-Monroe Anti-Poverty Initiative (RMAPI)/United Way, leveraging their expertise to support the development of the FLPPS Community and Consumer Engagement Strategy. FLPPS is exploring RFPs to find similar organizations to help roll out the strategy and mechanisms to leverage CBO expertise in delivering services outlined in the training strategy and flow funds for their contributions. FLPPS is also partnering with the Rochester-Monroe Anti-Poverty Initiative at United Way to address community building, structural racism, and trauma through their first areas of implementation: Systems Design, Adult Mentoring/Navigating and Early Childhood Support.
- Rochester has been selected by the Reinvestment Fund and the Robert Wood Johnson Foundation to take part in the new Invest Health initiative. Invest Health is aimed at transforming how cross-sector leaders from mid-size American cities work together to help low-income communities thrive with specific attention to community features that drive health such as access to safe and affordable housing, places to play and exercise, and quality jobs. The Rochester team, with FLPPS serving as a key member, will work together to develop shared strategies and coordinated investments that address health disparities in city neighborhoods with a specific focus on housing and transportation.
- FLPPS is planning to work with other PPSs where there is overlap on training strategy implementation, leading to a more cohesive and efficient rollout of CC/HL strategies across these regions.

Clinical Integration, Population Health, and Patient Centered Medical Home

- In an effort to support the need for bi-directional communication between providers, FLPPS and the RHIO have created a direct messaging platform to ease communication between providers which is being implemented currently.
- FLPPS has established a dedicated Patient Centered Medical Home (PCMH) team that has been working with primary care organizations since early 2015 on PCMH planning. Current performance indicates all contracted providers will reach required PCMH certification within the prescribed timeline. Once the network refinement process is completed as part of the Mid-Point Assessment, other providers who are required to meet PCMH certification will be addressed.
- To assist providers in the achievement of PCMH certification, FLPPS created documentation and billing templates or leveraged other resources that were obtained by the PPS to ease the administrative burden for PCMH providers.
- FLPPS is collaborating with the FLHSA and other organizations performing related practice transformation work, including the Advanced Primary Care Initiative (APC), team care training

series and working on team care concepts and formation for quality improvement projects related to PCMH.

- The rules associated with NYS tracking of certified PCMH are vastly underestimating the actual numbers of PCPs that have credible and verifiable links to certification. FLPPS developed a supported analysis of PCPs who are approved/compliant compared to what is currently communicated by the State for tracking purposes. FLPPS is working with the Department of Health to ensure that PCMH records are updated and accurate.
- To address areas that are determined to have the greatest impact on the social determinants of health, FLPPS has established dedicated Transportation and Housing Committees as a result of input on barriers to healthcare.
- Paying mindful attention to and incorporating services that address the social determinants of health is critical to the success of transforming the healthcare delivery system. Leveraging trusted CBOs and successfully incorporating agencies into the IDS will be essential. FLPPS is actively pursuing engagement strategies to keep CBOs at the DSRIP table and measure the efficacy of social interventions on health outcomes, to fully prepare our region for the future of value based payments and demonstrate the role that CBOs have to play in keeping the population healthy.
- Providers have been educated on system transformation and clinical outcomes by utilizing the latest PPS progress data.
- A review and analysis of clinical needs and IT assessment has been completed. This analysis will inform resource allocation by the PPS in support of clinical and technological integration.
- The PPS is working toward having all primary care providers that FLPPS has contracted with and flowed funds to be using Electronic Health Records (EHRs) that are Meaningful Use (MU) certified.

Information Technology, Data, and Reporting

- In an effort to integrate FLPPS providers with the IDS, FLPPS has selected the Rochester Regional Health Information Organization (RHIO) to be its Health Information Exchange (HIE). Prior to DSRIP, the Rochester RHIO had already integrated approximately 40 percent of the FLPPS provider network. This partnership with the RHIO allows the PPS to leverage pre-existing integrations, decrease time to implementation and lower overall cost associated with onboarding of the PPS providers to the IDS.
- FLPPS created a secured hosting environment, approved by the State, that is used to retrieve the Comprehensive Provider Attribution (CPA) file, Medicaid Member Roster, full claims extract, etc. in a virtual environment. This improvement allows the PPS to complete critical current state analysis to allow for facilitation of planning for future project and network interventions. These interventions include asset mapping, hot spotting, chronic disease registries, and identifying gaps in care management.
- FLPPS has developed expertise in data analytics tool sets including Tableau and Alteryx; is proficient in utilization of the MAPP dashboard including accessing patient level information and mining of provider performance data down to the provider level; and hired a Salient data miner. By leveraging additional tools including additional data sets and resources beyond State provided

sources, FLPPS now can perform analytics on Patient Activation Measures (PAM), housing and homelessness, behavioral health, perinatal, workforce, aggregation of surveys and more.

- In an effort to facilitate communication with the PPS Providers, FLPPS is currently working on a portal to share PPS-related information, data and outcomes with providers. These resources will also be used for providers to report data to the PPS in a lean process facilitating aggregation of project level data.
- FLPPS is taking the lead in the upstate region for potential overlap and duplication of lives, developing a process to identify potential duplication and how to handle deduplication for purposes of patient engagement reporting. This methodology is being leveraged as a best practice for statewide PPSs through the Healthcare Association of New York State (HANYS).
- The PPS has completed two IT assessments with contracted providers to understand EMR and RHIO connectivity status in an effort to plan for a larger integrated network adoption.
- The PPS, in collaboration with its legal counsel and in alignment with current State guidance, is developing a Data Sharing Policy to address PHI sharing with FLPPS providers and vendors.
- The hiring of qualified analysts with claims processing experience has been challenging. FLPPS is investigating the opportunities for a co-op in partnership with local universities to develop and retain talent. Inability to address this issue could impact the timeliness of project completion due to insufficient analytical support. An alternate strategy would be to outsource portions of this responsibility at a significantly increased cost.
- Delays in Capital Restructuring Financing Program (CRFP) award communications caused FLPPS to manage a worst case scenario, which leveraged non-optimal population health platform solutions initially delaying our overall strategy by approximately six months. The PPS is now in an RFP process to identify an interim population health platform and a longer term solution.
- Postponement of the release of claims and performance outcomes data sets, coupled with data that is more than twelve months old, did not allow time for project outcome interventions to positively impact results for Measurement Year 2 (MY2) and threatens to do the same for MY3. To mitigate this risk, FLPPS has asked key providers, which make up 90 percent of patient attribution, to provide surrogate clinical encounter data that will be used to calculate proxy project outcome measures. Once this data is received, it will be requested on a quarterly basis and used to plan any necessary interventions.

Patient Engagement

- FLPPS established a group of DSRIP Early Adopters early in DY1 to begin reporting patient engagement numbers and help FLPPS develop reporting processes, prior to contracting. This group of hospitals, FQHCs and other key providers had existing resources to begin to operationalize the projects and to provide early feedback regarding project design. Involving major providers as early adopters helped to understand and implement patient engagement requirements across the entire region for the life of DSRIP. The team met monthly to discuss the project and patient engagement requirements, reporting, challenges and best practices. These best practices will be used as the provider “early adopter” model is implemented across the region.

- In order to facilitate planning, FLPPS requested DY2 forecasts from providers, broken down by site. These forecasts were used by the PPS to identify weaknesses in patient engagement and to identify where an expansion of providers may be indicated.
- FLPPS was required to develop patient engagement numbers prior to fully understanding the projects (early in the DSRIP program) but still had to act on these commitments. This issue has presented some challenges for FLPPS, but the project teams continue working collaboratively to identify solutions and innovative approaches to meet patient engagement requirements that align with improved outcomes.

Workforce

- In an effort to energize the Workforce work stream, the PPS formed the Workforce and Operations Workgroup (WOW). The WOW is a large and active committee at FLPPS comprised of leaders from urban and rural areas, hospital systems, practitioners and CBOs collaborating to share workforce needs and knowledge. The main focus for this group is to identify areas of weakness in workforce related sectors and work to devise actions steps to address identified risks.
- Due to FLPPS's leadership position in the State implementation of DSRIP, the PPS was asked to co-lead an effort for a state-wide DSRIP Workforce collaboration that began in June 2016.
- Creating a comprehensive and cohesive workforce strategy in parallel with the changing workforce requirements has been a challenge. FLPPS continues to engage with its partnership, other PPSs and the IA to proactively address changes and has hired a full time workforce project manager to focus on and track these changes.
- Ongoing changes in direction from the State regarding Workforce continues to present significant issues for the PPS. The associated cost related to unnecessary work is now over $300,000, which impacts the PPS and its implementation of DSRIP.

Practitioner Engagement and Network Refinement

- In order to facilitate provider engagement and communication, a team of Provider Relations Associates (PRA) was developed early in DY1 at FLPPS to provide support and guidance to the providers in the 13-county region. Each NOCN has a dedicated PRA that acts as the liaison to providers in that area and is the direct support for any questions related to DSRIP.
- A network refinement policy and procedure has been developed and approved by our Board of Directors to address the addition and removal of providers.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 2.a.i

Challenges the PPS has encountered in project implementation:

1. FLPPS experienced IT delays as a result of the Capital Restructuring Financing Program (CRFP) process and subsequently population health management initiatives. FLPPS wanted to ensure that the appropriate capital was available so that funds would not have to be used that might reduce the total funds available for future contingency and revenue loss purposes.
2. Integrated Delivery System (IDS) creation has been challenging due to the large geographic area that FLPPS encompasses and the mix of urban and rural populations the PPS serves. The expansive region also poses a transportation challenge for patients traveling to receive appropriate care, which in turn requires the PPS to identify more innovative approaches to address this issue.
3. Creating an IDS with two large hospital systems that traditionally compete has posed some challenges, primarily in regards to data sharing and overall agreement on approaches to population health management.
4. The requirement and need to include community based organizations (CBOs) in the FLPPS network, with limits on funding for non-safety net (which includes non-billable) providers, makes is difficult to incorporate social service agencies into projects and appropriately incent them for project participation. The importance of social determinants of health can therefore appear to be minimized, despite those social interventions having a great impact on the health of the Medicaid population.

Efforts to mitigate challenges identified above:

1. The project team and FLPPS leadership planned thoroughly and well in advance so that once the CRFP was granted, plans could be rolled out. FLPPS also planned for and identified other funding sources in case the CRFP did not materialize.
2. Emphasis of the Naturally Occurring Care Network (NOCN) structure and regionalization of project implementation mitigates the large service area issue and allows for consistent communication between and with all providers. FLPPS created a dedicated Transportation Committee as part of the governance structure which was tasked with identifying transportation challenges by county and proposing solutions for review by project team and FLPPS leadership.

3. Ongoing and frequent joint conversations between the two large provider systems and FLPPS, while continuing to include all parties and emphasize DSRIP goals through collaboration, have mitigated the competitive environment and have allowed for more open conversations and collaborations. The other 10 FLPPS projects also require collaboration between these two competing health systems, creating additional opportunities to move past boundaries.
4. FLPPS continues to work with the safety net organizations of the network to encourage relationships between safety net providers and CBOs, and explore new partnerships that will bolster the success of the IDS as well as foster true incorporation of social services into the healthcare delivery system. There is also a concerted effort on behalf of the Project Management team to include CBOs in project design, as well as the Cultural Competency/Health Literacy (CC/HL) Strategy and Training Plan, to make best use of the funds that are available to non-safety net organizations and demonstrate their efficacy and contributions. The hope is that through this demonstration, CBOs will be well prepared to provide trusted, proven data around their participation in DSRIP and make the case for inclusion in VBP arrangements, per the VBP Roadmap. Lastly, FLPPS is actively pursuing the DOH RFA for CBO preparedness, to supplement technical assistance for CBOs.

Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS established the Clinical Quality Committee in the Fall of 2014 to support the development of the 2.a.i project. This committee is a governing committee of the FLPPS governance structure, dictated per the organizational bylaws, and is comprised of clinical representation from providers across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships and utilization patterns specific to the sub regions are considered in the design and implementation phases for the 13-county FLPPS network. This approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.
- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- Internal milestone owners were identified early to emphasize accountability for specific areas, such as PCMH, EHR integration, etc. These milestone owners are experts in the area of their assigned milestones and provide the input and feedback necessary to make this project successful.

- A group of providers volunteered as "early adopters" for patient engagement and related project implementation purposes early in DY1. The establishment of these early adopters helped identify and address challenges in a timely manner and recognize best practices for specific areas of project implementation prior to full rollout to the entire FLPPS region.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include:

- Project 2.a.i was used to organize the internal FLPPS team and to guide goal setting as it is all inclusive of several other projects' goals.
- Project managers and provider relations associates traveled to the different NOCNs to educate providers on projects through flow charting proposed design and including best practices, holding summits, and engaging the regional project implementation teams.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There have been no material changes to the proposed populations included in the original project plan application.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 2.b.iii

Challenges the PPS has encountered in project implementation:

1. Primary care physicians (PCPs), particularly those in the Monroe Naturally Occurring Care Network (NOCN) area, face challenges with insufficient capacity to accept new patients.
2. Information technology is currently not robust enough to support the sharing of information across the growing FLPPS network. In its current state, it hinders the success of collaborative efforts of the PPS.
3. Obtaining real time information on Home Health enrollment is a specific challenge for the PPS because information from Home Health organizations is not readily available to providers.

Efforts to mitigate challenges identified above:

1. The project team is working to assess PCP capacity in the FLPPS service areas. FLPPS also plans to work with PCP offices and providers to develop workflows that will better suit the patient population and allow for better use of resources and time. Open access scheduling and extended hours opportunities are being further investigated in alignment with PCMH certification requirements for PCPs in the FLPPS region.
2. The PPS plans to leverage RHIO connectivity and additional IT infrastructure to further streamline an improve data sharing. This connectivity will also help improve the enrollment and information sharing process among providers and Home Health services.

Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS developed and established a project team in Fall 2014 to support the development and implementation activities of this project. This team became the 2.b.iii Clinical Quality Subcommittee, part of the FLPPS governance structure, and is comprised of providers from across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.

- The project design was guided by clinically reviewed and approved project workflows that the FLPPS team created with input from the project teams. The FLPPS Project Management team led informational meetings at all five geographic Naturally Occurring Care Networks (NOCNs) in early 2015 to describe the projects through linear process workflows. The project workflows were enhanced to swimlane flow charts that show the provider responsibilities from the Domain 1 project requirements. These swimlanes include informational flow as well as care management responsibilities and transitions of care. Best practices were also identified and included in the workflow. The goal for FLPPS was to ensure stakeholder input and agreement across the network on project design. This activity improves communication and promotes standardized work across the network for Quality Improvement purposes. Note: The project specific workflow has been attached at the end of this narrative for review.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships and utilization patterns specific to the sub regions are considered in the design and implementation phases for the 13-county FLPPS network. This approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.
- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- A group of “early adopter” providers were identified to collect data in their Emergency Departments (ED) on barriers to care within the PPS and report outcomes. Based on their findings, it was concluded that patient education is needed and that access to PCPs needs to be addressed and improved.
- The project team developed internal tools for patient navigators in order to standardize interactions. Tools included scripts, introduction cards, and talking points for appropriate ED use among others.
- PCPs and EDs were brought together to discuss workflow strategies that will aid in improving PCP access.
- Status Sheets were created for each participating hospital to track project implementation status and inform the project manager on areas of risk ahead of time.
- Provider readiness assessments were conducted to identify locations and providers in need of additional resources.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include:

- Host collaborative hospital meetings to discuss and share best practices, workflows and educate providers on requirements.
- Host collaborative hospital meetings by NOCN to share implementation status, reporting status, best practices, etc. amongst participating providers.
- FLPPS has adjusted the completion date for Milestone 5 for Project 2.b.iii to coincide and align with the other projects that include similar goals. Several of the associated tasks have been completed and the milestone is not assessed to be at risk.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

To date, there has not been a comprehensive focus on the behavioral health subset of the target population. Moving forward, a strategy will be developed to specifically address this population in a standardized way. Overall, there have been no material changes to the proposed target population.

2biii ED Care Triage for at-risk populations

Objective: To develop an evidence based care coordination and transitional care program that will assist patients to link with primary care physician/ practitioner.

Hospital

- Patient enters emergency room
- Patient checked for connection to Health Home. Real time notification to HH Care Manager made as applicable.
- Medical Screening Occurs and determined non-urgent
- Navigator Meets with patient and completes patient navigator tool that identifies barriers to engaging with PCP
- ★ Hospital establishes partnerships with community primary care providers. Navigator schedules appt. with PCP
- Navigator assists the patient with identifying and accessing needed community support resources
- Patient tracked in EHR/other technical platforms between multiple providers
- Encounter Notification Service is installed in all ED's

Health Home

- Health Home care manager contacted, if applicable

PCP

- PCP is 2014 PCMH level 3 certified
- Encounter Notification Service is installed in all PCP offices
- PCP maintains access to accommodate Patients
- PCP sees patient
- PCP tracks No-Shows

CC & HL

- Navigator trained in CC & HL
- Educational Materials for patient reviewed

Project Milestones

- A defined Process for triage of patients from patient navigators to non-emergency PCP and needed community support is in place—list of non-emergent encounters eligible for triage
- Encounter Notifcation Service is installed in all ED's and PCP offices
- Process and Procedure is developed to establish connectivity between the ED and Community Care Providers

Patient Engagement

★ = The number of participating patients presenting to the ED, who after medical screening examination were successfully re- directed to a PCP as demonstrated by a scheduled appointment

Quality Measures

- Potentially Avoidable Readmissions ±
- Potentially Avoidable Emergency Room Visits ±
- Adult and Child Access to Preventive or Ambulatory Care
- H-CAHPS – Care Transition Metrics
- PQI 90 – Composite of all measures ±
- CAHPS Adult Primary Care
- Primary Care – Length of Relationship
- Percent of PCP providers meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards
- Medicaid spending on ER, Inpatient Services, Primary Care and community based behavioral health care
- Percent of eligible providers withmeeting Meaningful Use criteria,

Key: Best Practice

Last revised: 06/27/16

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:

1. Information technology (IT) is not consistent across the PPS and creates challenges with discharge information sharing between major health systems and providers as IT infrastructure is either not compatible or non-existent in many PCP offices.
2. IT is currently not robust enough to support the sharing of information across the growing FLPPS network. In its current state, it hinders the success of collaborative efforts of the PPS.
3. Obtaining real time information on Home Health enrollment is a specific challenge for the PPS as the enrollment process is difficult. Due to varying EMR systems, information from Home Health organizations is not readily available to providers.
4. The Care Management infrastructure that exists in the FLPPS network overall, is not consistently tracked in the Regional Health Information Organization (RHIO) (e.g. Medicaid Service Coordination (MSC) in intellectual and/or developmental disabilities community), which makes it difficult for individuals responsible for care management to assist in effective transitions of care.

Efforts to mitigate challenges identified above:

1. An IT initiative is currently underway to connect providers to the RHIO. Improving RHIO connectivity should adequately mitigate the issue of incompatible data sharing so long as adoption of IT use and transition away from paperwork is widespread in the network.
2. The PPS will leverage RHIO connectivity and additional IT infrastructure to streamline the enrollment and information sharing process to include Home Health services, making records more readily available to all providers.
3. The PPS will develop relevant project curriculums to educate providers and patients of the methods for and importance of improving accessibility of primary care services – including home health case management – to the service area. With input from Naturally Occurring Care Networks (NOCNs), the project team will develop protocols, work flows, and plans for implementation of the project curriculum. Additionally, materials will be written within patients' literacy and language ranges, following review by the Cultural Competency and Health Literacy (CC/HL) committee. Patient advisory panels will be convened to advise FLPPS on protocols and engagement strategies.

4. The PPS has done a full exploration of software platforms and capabilities that all providers operate under, in order to understand the best way to implement RHIO interconnectivity and assure that alerts issued through the Health Information Exchange (HIE) system can be fully utilized by all Care Managers that serve Medicaid patients.

Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS developed and established a project team in Fall 2014 to support the development and implementation activities of this project. This team became the 2.b.iv Clinical Quality Subcommittee, part of the FLPPS governance structure, and is comprised of providers from across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.
- The project design was guided by clinically reviewed and approved project workflows that the FLPPS team created with input from the project teams. The FLPPS Project Management team led informational meetings at all five geographic NOCN's in early 2015 to describe the projects through linear process workflows. The project workflows were enhanced to swimlane flow charts that show the provider responsibilities from the Domain 1 project requirements. These swimlanes include informational flow as well as care management responsibilities and transitions of care. Best practices were also identified and included in the workflow. The goal for FLPPS was to ensure stakeholder input and agreement across the network on project design. This activity improves communication and promotes standardized work across the network for Quality Improvement purposes. Note: The project specific workflow has been attached at the end of this narrative for review.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships and utilization patterns specific to the sub regions are considered in the design and implementation phases for the 13-county FLPPS network. This approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.
- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- The project was implemented with guidance from existing Medicare best practices and tailored to the specific patient population.

- The project team conducted an assessment of current clinical information exchange among participating hospitals, home health case management and PCPs in order to better understand systems currently in place.
- Readiness assessments were conducted at participating hospitals in order to identify and alert FLPSS about providers that may be at lower readiness level and may need additional attention to ensure project success.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include:

- The project team hosted a full day working session with project stakeholders intended to encourage collaboration and information exchange among the numerous involved parties, including major hospitals and providers.
- FLPPS hosted a work session on best practices for care plans, yielding a document which was submitted to the Clinical Quality Committee with suggestions for inclusion requirements in a care plan and incorporated advice from Health Homes, hospitals, home care and PCPs.
- Status Sheets were created for each participating hospital to track project implementation status and inform the project manager on areas of risk ahead of time.
- The completion date of two milestones was changed to coincide and align with other projects that have similar milestones. Several of the associated tasks have been completed and the milestones are not assessed to be at risk.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

To date, there has been less focus on the Western NOCN target population. Moving forward, a more inclusive strategy will be developed to work more closely with regional providers in that area and strengthen implementation. There have been no material changes to the proposed populations.

FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

Objective: To Provide a 30 day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission.

Hospital

Patient admitted to hospital (medical)

PCP Notified. If no PCP- call to arrange new patient appointment

Determine Care Management. If health home engaged contact HH manager, if eligible refer for assessment and referral

Patient screened for high risk of readmission and referred to Transition Care Manager to deploy the 30 day care transition plan

Hospitals coordinates with Transition Care Manager for development of 30 day Care Plan with responsible resources identified at each stage

Referrals made to Social Services to include medically tailored food services, as appropriate

Timely notification to PCP of 30 day Transition Plan

Transition Care Manager

Transition Care Manager has input into the 30 day care plan and meets with patient prior to discharge to review it.

Schedules a visit within 72 hours

Coordinates with the PCP and Health Home Care Manager, if applicable

Transition Care Manager documents completion of 30 day Care Plan

PCP

PCP is PCMH certified

PCP notified

Patient is referred for new patient appointment (Based on preference and location)

PCP reviews Care Plan

BH and Sub Specialties

Provider Notified

Patient is referred for new patient appointment (Based on preference and location)

Provider reviews Care Plan

CC & HL

Risk Assessment will encompass CC & HL to promote patient engagement

Transition Care Manager trained in CC & HL

Educational Materials for patient reviewed

Care Plan that is reviewed with the patient

Project Milestones

Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.

Develop protocols to identify health home eligible patients and link them to services as required under ACA

Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.

Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider and included in the patient's medical record.

Policies and Procedures reflect the requirement that 30 day transition of care period is implemented and utilized

Patient Engagement

= The number of participating patients with a care transition plan developed prior to discharge

Quality Measures

- Potentially Avoidable Readmissions ±
- Potentially Avoidable Emergency Room Visits ±
- Adult and Child Access to Preventive or Ambulatory Care
- H-CAHPS – Care Transition Metrics
- PQI 90 – Composite of all measures ±
- CAHPS Adult Primary Care
- Primary Care – Length of Relationship
- Percent of PCP providers meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards
- Medicaid spending on ER, Inpatient Services, Primary Care and community based behavioral health care
- PDI 90 – Composite of all measures ±
- Percent of eligible providers with meeting Meaningful Use criteria, who have participating agreements with qualified entities (RHIO's) and are able to participate in bidirectional exchange

* Transition Care Manager=Health Home, Home care, Community Agency, Hospital Employee, or other.

Last revised: 6/27/16

Key= Best Practice

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 2.b.vi

Challenges the PPS has encountered in project implementation:

1. FLPPS is the only PPS implementing this project across the state; therefore, associated challenges include not being able to share best practices and lessons learned to enhance the guidance provided for implementation and overcome a growing reduction in transitional housing programs in favor of permanent housing solutions.
2. The type of relationships and collaborations, including Memorandums of Understanding (MOUs) and service agreements, between housing providers, hospitals, and other providers required for this project are different from traditional collaborations for many providers, creating some difficulty and delays in establishing such partnerships.
3. A lack of a robust IT infrastructure between hospitals and CBOs has made it difficult to obtain and share the data required to support the goals and requirements of this project, particularly those related to transitions of care. There has also been uncertainty and risk aversion among providers in regards to patient privacy and HIPAA that contribute to this data challenge.
4. Minor legal and data related challenges have contributed to delays in some tasks submitted as part of this project's Implementation Plan, but these have not affected the completion of any milestones to date.
5. In order to create enough capacity to meet the transitional housing demands of the PPS' patients, there is a need to align capital improvements and projects. Deficits relative to the expansion of beds needed under this project still exist due to limited funding opportunities.

Efforts to mitigate challenges identified above:

1. Frequent communication with the State for clarification and additional guidance has been a priority in order to ensure FLPPS continues to meet the goals of this project as expected.
2. A project team was formed in Fall 2014 and is comprised of providers from across the PPS, including hospitals and housing providers. This representation has ensured that all perspectives are acknowledged while bringing all parties together to build and discuss successful relationships and collaborations. FLPPS is exploring different models for direct PPS to provider contracting to

support the goals of this project among smaller providers willing to participate but in need of more guidance and support.

3. In an effort to continue discussions to gather and share data that supports this project, FLPPS promotes and encourages an open dialogue between all parties involved and communicates with the State frequently for clarity when necessary. FLPPS has also supported providers to share examples and best practices that have succeeded in expanding formalized partnerships and data sharing with other project providers and enlisted creative solutions to identify and obtain proxy data where possible.
4. The FLPPS project manager and project team continue to work diligently to ensure that tasks are completed in a timely manner when delays occur and ensure that these delays do not affect the overall timing and goals for completion of this project.
5. FLPPS is working closely with providers that were funded through CRFP to develop a thorough understanding of throughput in existing organizations. This will provide support for the network to meet the demands of the patients and deliver on quality expectations for those needing transitional housing services.

Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS developed and established a project team in Fall 2014 to support the development and implementation activities of this project. This team became the 2.b.vi Clinical Quality Subcommittee, part of the FLPPS governance structure, and is comprised of providers from across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.
- The project design was guided by clinically reviewed and approved project workflows that the FLPPS team created with input from the project teams. The FLPPS Project Management team led informational meetings at all five geographic Naturally Occurring Care Networks (NOCNs) in early 2015 to describe the projects through linear process workflows. The project workflows were enhanced to swimlane flow charts that show the provider responsibilities from the Domain 1 project requirements. These swimlanes include informational flow as well as care management responsibilities and transitions of care. Best practices were also identified and included in the workflow. The goal for FLPPS was to ensure stakeholder input and agreement across the network on project design. This activity improves communication and promotes standardized work across the network for Quality Improvement purposes. Note: The project specific workflow has been attached at the end of this narrative for review.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships and utilization patterns specific to the sub regions are considered in the design and implementation phases for the 13-county FLPPS network. This

approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.

- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- The Clinical Quality Subcommittee drafted a transition of care protocol that can be used to place patients at transitional supportive housing sites that will enable additional time for stabilization, rehabilitation and recovery. Once approved by the Clinical Quality Subcommittee, this protocol will be available for providers to adopt and implement at their respective sites or use it as a guide for development of appropriate care transition protocols.
- FLPPS formed a Housing Committee, a group separate from the Clinical Quality Subcommittee, which has allowed FLPPS to identify and explore opportunities for permanent housing support to enhance this project and meet clinical outcomes. This Committee is inclusive of housing experts from multiple sectors and across the FLPPS region that can provide the expertise and insight to support the goals and vision for this project. The Housing Committee also helps identify additional housing issues in the region for a more robust infrastructure to promote transformation across the region beyond the project requirements.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include:

- Examine available permanent housing options at the macro level, identify and pursue (or support providers to pursue) opportunities to increase availability of affordable permanent housing so as to not bottleneck transitional housing resources.
- Project manager continuously fosters dialogue and coordination with local government units, including county Departments of Social Services and Single Point of Access (SPOA), to identify opportunities to align the use of existing resources in emergency housing and transitional residential programs funded through the Office of Mental Health and Office of Alcoholism and Substance Abuse Services in support of DSRIP project goals.
- Provide strategic and planning support, data, and partnership opportunities for providers that received transitional housing CRFP dollars.
- Use provider data that has been analyzed related to hospital use patterns before and after members were placed in transitional supportive housing to identify CQI opportunities.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
Due to data constraints in the initial stages of this project, the definition of super utilizers for purposes of this project's target population was primarily focused on targeting the homeless, individuals with inadequate housing, or individuals already involved in emergency/transitional housing. As more reliable data becomes available, FLPPS continues exploring and refining the definition of super utilizers to include those individuals with behavioral health issues, chronic illnesses, and co-morbidities that have housing instability issues, in line with the target population originally identified in the project application.

FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

Objective: Participating hospitals will partner with community housing providers, and home care services to develop transitional housing for high risk patients

Hospital

Patient screened for chronic diseases that are at high risk of readmission plus housing instability

PCP Notified. If no PCP call to arrange new patient appointment

Determine Care Management: If Health home Enrolled, contact assigned Care Manager, if Eligible conduct "Warm" Referral for assessment and enrollment.

identify appropriate housing discharge disposition. Coordinate with Housing Case Manager and HH Care Manager with 1 face to face meeting prior to discharge

Discharge Plan to specify Transitional Housing Discharge Location (at minimum indicate housing type). Documented in EHR for patient tracking and communicated with PCP and HH

Housing provider

Coordinate with Hospitals and health home care manager to develop transitional housing plan

Patient resides in Transitional Housing. Continue to coordinate Discharge Planning to LT Housing

* Min. 1 outreach between 80-100 days post admission to address housing status/needs

Discharge Plan to specify disposition, including Permanent Housing. Documented for patient tracking and communicated with PCP and HH

Ongoing outreach: minimum of three contacts 90 days post admission.

Health Home

If engaged in HH- Communicate Comprehensive Risk & Environment Assessment back to hospital staff

Coordinate with Hospital & Transitional Housing. Care Manager to support transitional housing plan and develops care plan

* Min. 1 outreach between 80-100 days post admission to address housing status/ needs

Continue updating Care Plan. Once secured, Permanent Housing is documented for patient tracking and communicated with PCP

PCP/BH Providers

PCP and/or BH Reviews Care Plan and Monitors progress. Coordinates with all Care Managers

PCP tracks list of individuals transitioned to permanent housing and documents in EHR

CC & HL

Risk Assessment utilized to promote patient engagement

Care Transition Coach trained in CC & HL

Educational Materials for patient reviewed

Care Plan that is reviewed with the patient

Project Milestones

Protocols to identify and prioritize chronic super utilizers with housing instability for access to transitional supportive housing

Transition of care protocols will include early notification of planned discharges and the ability of community housing providers and home care services to visit the patient in the hospital and coordinate transition of care services.

Transition of care protocols to ensure all chronic super utilizers receive appropriate health care and community support incl medical, BH, post-acute care, LT care and public health services

Protocols include care record transitions with timely updates provided to the members' providers, particularly primary care provider and included in the patient's medical record.

Establish policies and procedures among hospitals and health homes to involve HH in transitional housing plan or do "warm" referral

Patient Engagement

★ = The number of participating patients who utilized transitional supportive housing and were appropriately monitored via face to face (and telephonic) contact throughout a 90-day period to address a housing related need

Quality Measures

- Potentially Avoidable Readmissions ±
- Potentially Avoidable Emergency Room Visits ±
- Adult Access to Preventive or Ambulatory Care
- H-CAHPS – Care Transition Metrics
- PQI 90 – Composite of all measures ±
- CAHPS Adult Primary Care
- Primary Care – Length of Relationship
- Percent of PCP providers meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards
- Medicaid spending on ER, Inpatient Services, Primary Care and community based behavioral health care
- Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement
- Percent of eligible providers with meeting Meaningful Use criteria, who have participating agreements with qualified entities (RHIO's) and are able to participate in bidirectional exchange
- PDI 90 – Composite of all measures ±

Key= Best Practice

Case Manager = Health Home, Community Agency, Hospital Employee or other
*Pending DOH approval of 80-100 time period

Last revised: 7/12/16

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 2.d.i

Challenges the PPS has encountered in project implementation:

1. Community based organizations (CBOs) are facing challenges in identifying the low-utilizing (LU) and non-utilizing (NU) population, mostly due to lack of data sharing capability from Health Homes and an insufficient number of EHR systems in place. Furthermore, many of the hot spot locations that have been identified raise logistical and privacy concerns for PHI when using EHRs. Verbal screenings are the preferred methodology at these locations, but patients find it difficult to articulate the services they receive and/or identify who their Primary and Preventative Care Providers are, which makes this approach less reliable. The number of uninsured (UI) is also at an all-time low, which has impacted the ability to find PAM activation population and meet Speed and Scale commitments.
2. The Flourish database does not allow a PAM survey to be re-administered by any organization except the original surveying organization. This restriction is negatively impacting the PPS's ability to measure the change in activation score and meet Speed and Scale commitments.
3. CBO participation in the project has been slow primarily because these providers are unsure of where their services fit into the overall scope of DSRIP since social services have not traditionally been integrated into the larger healthcare delivery system. Slow participation of CBOs may also be due to lack of sufficient financial incentive for these providers, most notably caused by the safety net versus non-safety net funds flow restrictions. Appropriate funding for community based outreach and case/care management is essential to building trust and activation in the Medicaid population; however, these are not services traditionally funded through Medicaid. The burden of the five percent cap hinders the ability to do wide-scale implementation of such services across the PPS.
4. PPSs are facing a challenge presented by a high Patient Activation Score that may hinder their ability to meet the quality measurement. The high score skews results and is causing providers administering the PAM to question its validity. This uncertainty causes conflict with how providers coach patients on activation goals and activities.

Efforts to mitigate challenges identified above:

1. FLPPS developed a simple screening tool to assist those CBOs administering PAMs.
2. Issues with the Flourish database have been communicated to NYS DOH and Insignia (owner of the Flourish database) who have been encouraged to find a solution. Until the database is enhanced, FLPPS is working with providers to re-administer PAMs internally or develop strategies on how to administer PAM surveys under the same account through collaborations or subcontracting efforts.
3. A multi-faceted approach is currently underway to increase CBO engagement, inclusive of a department at FLPPS dedicated to CBO, Consumer and Community Engagement. Multiple educational webinars will be held on topics to include general DSRIP guidance, project participation and Value Based Payments (VBP). Additional RFI/RFQ's for Coaching and Navigation will offer funds outside of the current contracting and payment strategy.
4. Insignia is hosting additional training opportunities as they believe the skewed scores may be due to lack of knowledge on the administrator's part. However, multiple PPSs believe the skewing is an adverse effect of incentives tied to meeting Patient Engagement Speed and Scale requirements. FLPPS will take this into consideration as part of the design of the RFI/RFQ for Coaching and Navigation services.

Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS developed and established a project team in Fall 2014 to support the development and implementation activities of this project. This team became the 2.d.i Clinical Quality Subcommittee, part of the FLPPS governance structure, and is comprised of providers from across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.
- The project design was guided by clinically reviewed and approved project workflows that the FLPPS team created with input from the project teams. The FLPPS Project Management team led informational meetings at all five geographic Naturally Occurring Care Networks (NOCNs) in early 2015 to describe the projects through linear process workflows. The project workflows were enhanced to swimlane flow charts that show the provider responsibilities from the Domain 1 project requirements. These swimlanes include informational flow as well as care management responsibilities and transitions of care. Best practices were also identified and included in the workflow. The goal for FLPPS was to ensure stakeholder input and agreement across the network on project design. This activity improves communication and promotes standardized work across the network for Quality Improvement purposes. Note: The project specific workflow has been attached at the end of this narrative for review.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships, and utilization patterns specific to the sub regions,

are considered in the design and implementation phases for the 13-county FLPPS network. This approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.

- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- FLPPS deployed a Health Activation "Train the Trainer" program for organizations to become self-sufficient and be able to train a small group of individuals that can disseminate information and additional trainings on a larger scale at organizations. Contracts have been established with qualified providers to conduct these "Train the Trainer" trainings on behalf of the PPS. Regional trainers are knowledgeable in community resources and are more likely to gain trust and buy-in of the project.
- Webinars and regional meetings are hosted with all provider types regularly to clarify project roles and identify and align complimentary services within the network.
- Providers certified to perform Health Activation have access to a FLPPS-developed training portal that includes training and activation tools. The online document repository ensures any updates or changes can be easily disseminated.
- Offering open participation and training in Health Activation has led to ground breaking collaborations and initiated discussions between organizations and individual providers who have not previously worked together. The conversations occurring during trainings amongst the conglomerate of providers is invaluable.
- The project team offers continuous outreach including: community relationship building, provider site visits, conference calls, virtual meetings, and live webinars accessible on the FLPPS YouTube Channel.
- In order to further educate providers of the patient population, the project team held beneficiary focus groups to solicit patient input on the project. Information gathered from patient focus groups and community stakeholder meetings also helped guide the initial project design process.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include:

- Collaboration and communication between neighboring PPS Project 2.d.i leads is regularly occurring by sharing materials and strategies. Additional collaboration will occur at a "Super" PAM training in July where FLPPS and the Southern Tier PPS and Buffalo PPS will be interacting together as they discuss the PAM Health Activation Tool.
- The completion date for several milestones has been moved to coincide and align with the other project deliverables. Several of the associated tasks have been completed and the milestone is not assessed to be at risk.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

The population will remain as described originally with a modification to be inclusive of all FLPPS region UI, LU, and NU populations throughout all 13 counties, with no age restrictions.

FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

2.d.i Patient Activation

Objective: Implementation of Patient Activation Activities to Engage, Educate and Integrate the Uninsured (UI), Low Utilizing (LU) and Non-utilizing (NU) Medicaid populations into Community Based Care.

Hot Spot = Emergency Department

Coaches are trained in PAM, and connectivity to healthcare coverage, community healthcare resources, and patient education

Screen patient for (UI & NU/LU) and collect most recent contact info

UI is linked to an Insurance Navigator and list of providers servicing the UI

Is pt. currently engaged with HH?

NO

PAM is administered and input into Flourish

Level 1 & 2

YES

NO

Counsel the individual on utilizing benefits and/or connectivity to healthcare resources

Chronic Disease, and Super ED utilizer ?

NO

YES

Direct handoff to Community Navigators

Counsel the individual on utilizing benefits and/or connectivity to healthcare resources

Re-administer PAM every 6-12 Months, by phone

PAM Score is documented in E.H.R.

Health Home

HH Service Coordination

Bridge to PCP

YES

Hot Spots = Primary Care (PCP,FQHC,OB, etc.)

Coaches are trained in PAM, and connectivity to healthcare coverage, community healthcare resources, and patient education

Screen patient for (UI & NU/LU) and collect most recent contact info

UI is linked to an Insurance Navigator and list of providers servicing the UI

Is pt. currently engaged with HH?

NO

PAM is administered and input into Flourish

Level 1 & 2

YES

NO

Counsel the individual on utilizing benefits and/or connectivity to healthcare resources

Counsel the individual on utilizing benefits and/or connectivity to healthcare resources

Re-administer PAM every 6-12 Months

PAM Score is documented in E.H.R.

Provider assist with timely access for navigator connecting members to service

Hot Spots = CBO (Community Navigators)

Community Navigators are trained in PAM, and connectivity to healthcare coverage, community healthcare resources, and patient education

Get consent to participate in PAM

Screen for (UI & NU/LU) and collect most recent contact info

PAM is administered and input into Flourish

Assists the individual with developing activation goals

Is the individual UI?

NO

YES

Educate and link the individual to healthcare coverage options and community resources

Provide education on primary and preventive care, grievance process, and bridge to PCP

Re-administer PAM every 6-12 Months to Levels 1 & 2

CC & HL

Partners administering PAM and Activation Coaching are trained in CC & HL

Patient Engagement

= **The number of individuals who completed PAM or other patient engagement techniques for the uninsured and low/non-utilizing Medicaid population**

Project Milestones

- PPS Providers, located in hot spot areas trained in patient activation techniques by PAM trainers
- Increase the volume of non-emergent care provided to (UI, NU/LU)
- Partner with CBOs to develop a group of community navigators who are trained in health care coverage and resources
- **Develop a Process for Medicaid recipients and project participants to report complaints and receive customer service**
- **Train Community Navigators in PAM and engagement/activation activities**
- **Ensure direct handoffs to Community Navigators in Hot Spots.**
- **Establish a process to ensure timely access for navigator when connecting member to primary and preventive services**

Quality Measures

- **Increase in use of preventative & primary services for LU & NU**
- **Reduction in ED use by the uninsured**
- **C&G CAHPS by PPS for uninsured**
- **Increase in Cohort's PAM score**

Key:

Best Practice

Last revised:6/27/2016

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

1. Providers have expressed concerns about financial sustainability for all three models associated with the project, both in terms of implementation and long term sustainability. Integration of behavioral health and primary care is a concept that is just recently beginning to gain traction, so providers are concerned about financial implications in the future if they adopt any of the BH/PC integration models.
2. There is a lack of mental health professionals for simultaneous deployment to support the workforce needs for project implementation.
3. The restrictions on providers who can bill in Article 28 clinics pose hiring and recruitment challenges for clinics that already have limited resources and appointment availability.
4. Identifying and introducing opportunities for providers to partner in more rural regions has been challenging, especially for co-location models. Specific co-location limitations have also posed challenges for partners implementing this project. The current definition of co-location does not allow for shared space with separate entry and waiting rooms, which poses a confidentiality issue for many providers that would like to implement this project but have limited resources.

Efforts to mitigate challenges identified above:

1. A Medicaid Billing workgroup was developed by FLPPS to address challenges related to financial sustainability and propose potential solutions.
2. There are proposals to use telemedicine with depression care managers to provide services at primary care sites and use innovative approaches to mitigate workforce challenges. This would also help address capacity issues at physical locations and co-locate behavioral health and primary care. FLPPS is also working with universities and college programs through the workforce work stream to identify opportunities to increase the number of mental health professionals in the area.
3. FLPPS asked for a waiver to allow additional provider types to bill for services in Article 28 clinics, but these are laws from the Department of Education that cannot be changed. FLPPS is reviewing Article 31 licenses or joint licenses as an option for providers to address the Article 28 billing challenge. FLPPS representatives have been working closely with the state to identify opportunities

that expand the definition of co-location for BH and PC services to address the confidentiality concerns.

4. Outreach efforts via one on one meetings, regional meetings, work by provider relations associates to engage providers, and PMCH implementation team involvement have helped troubleshoot some of the issues related to identifying and partnering providers in rural areas of the region.

Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS developed and established a project team in Fall 2014 to support the development and implementation activities of this project. This team became the 3.a.i Clinical Quality Subcommittee, part of the FLPPS governance structure, and is comprised of providers from across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.
- The project design was guided by clinically reviewed and approved project workflows that the FLPPS team created with input from the project teams. The FLPPS Project Management team led informational meetings at all five geographic Naturally Occurring Care Networks (NOCNs) in early 2015 to describe the projects through linear process workflows. The project workflows were enhanced to swimlane flow charts that show the provider responsibilities from the Domain 1 project requirements. These swimlanes include informational flow as well as care management responsibilities and transitions of care. Best practices were also identified and included in the workflow. The goal for FLPPS was to ensure stakeholder input and agreement across the network on project design. This activity improves communication and promotes standardized work across the network for Quality Improvement purposes. Note: The project specific workflow has been attached at the end of this narrative for review.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships, and utilization patterns specific to the sub regions are considered in the design and implementation phases for the 13-county FLPPS network. This approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.
- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- FLPPS has developed a statewide collaborative that meets via phone call on a monthly basis so that PPSs implementing project 3.a.i can share challenges, best practices and successes and help each other problem solve around project implementation challenges.

- The FLPPS NOCN structure allows providers to share best practices and communicate with each other at a local level. The NOCN structure also allows FLPPS to ensure providers are progressing appropriately along the goals of penetrating, reaching and establishing partnerships between behavioral health and medical providers.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include:

- FLPPS created a Medicaid Billing workgroup comprised of providers and subject matter experts to address financial sustainability challenges related to behavioral health/primary care integration models prior to full transition to value based payments.
- Project team meetings have provided a venue for providers to share internal workflows amongst each other to learn and identify best practices.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There have been no material changes to the populations proposed to be served in the original application.

3.a.i. Integration of primary care and behavioral health services (model 1)

Objective: Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services

PCP

PCP is 2014 PCMH level 3 certified

At least 90% of patients screened annually using behavioral health PHQ2/9 screening tool

Provider reviews results of screen

If PHQ2/9 screen positive, is there a need for further evaluation?

no

PCP to treat using evidenced based medicine (EBM)

PCP conducts medical Preventative Screenings and monitoring for patients--- including those with SPMI

yes

Refer to Co-located BH provider with warm transfer. Results of screen and warm transfer documented in EHR

Introduction to therapist via face-to-face or by presentation of picture and credentials with appointment made

Patient checked for eligibility for HH and if eligible refer to HH

BH provider

Initiates mental health/substance use assessment and treatment plan for behavioral health condition

Regular and formal collaborative team meetings held using EBM for medication management and care engagement process with corresponding documentation

Weekly collaborative meetings for high utilizers, monthly collaborative meetings for more stable patients

Health homes

If not enrolled and eligible, HH engages patient

Once enrolled, HH follows up with patient for appointment adherence

CC & HL

Staff trained in CC/HL

Project Milestones

- Behavioral Health Services are co-located within PCMH/APC practices and are available.
- Coordinated evidence-based protocols are in place, including medication management and care engagement processes.
- Policies and procedures are in place to facilitate and document completion of screenings. Screenings are documented in EHR. At least 90% of patients receive screenings at the established sites.
- Positive screenings result in a warm transfer to behavioral health provider as measured by documentation in the EHR.
- EHR demonstrates integration of medical and behavioral health record within individual patient records

Patient engagement

= Number of patients receiving appropriate preventative care screenings that include MH/SA

Quality Measures

- Potentially Preventable Emergency Room visits
- Antidepressant medication management-effective acute phase treatment
- Antidepressant medication management-effective continuation phase treatment
- Diabetes monitoring for people with diabetes and schizophrenia
- Diabetes screening for people with schizophrenia or bipolar disease who are on antipsychotic medication
- Cardiovascular monitoring for people with cardiovascular disease and schizophrenia
- Adherence to antipsychotic medications for people with schizophrenia
- Initiation of alcohol and other drug dependence treatment (1 visit within 14 days)
- Engagement of alcohol and other drug dependence treatment (initiation and 2 visits within 44 days)
- Follow-up care for children prescribed ADHD medications-initiation phase
- Follow-up care for children prescribed ADHD medications-continuation phase
- Follow-up after hospitalization for mental illness-within 7 days
- Follow-up after hospitalization for mental illness-within 30 days
- Screening for clinical depression and follow-up

Key: Best Practice

Team members: PCP, Licensed Behavioral Health Provider, Health Home Care Manager, PCMH Care Manager
Other: Specialists, MCO Care Manager, Housing Care Manager

Last revised: 6/27/16

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 3.a.ii

Challenges the PPS has encountered in project implementation:

1. There have been challenges in centralizing and regionalizing traditionally county-centric systems of crisis management.
2. Funding and delivery for crisis services occurs at the county level and creates challenges for Naturally Occurring Care Network (NOCN) level coordination (across county lines).
3. Providers have expressed concerns about financial sustainability for innovative programming to address crisis in a community setting, both in terms of implementation and long-term sustainability.
4. Neighboring PPSs are also implementing this project and creating their own workflows and triage processes for communities and providers shared, which can create additional silos.

Efforts to mitigate challenges identified above:

1. FLPPS communicates with other PPSs to see how they manage the same issue in large geographic regions. NOCNs capitalize on regional expertise while also centralizing efforts.
2. NOCNs meet to engage and break down silos associated with county-specific funds flow and delivery of crisis services.
3. A Medicaid Billing workgroup was developed by FLPPS to address challenges related to financial sustainability and propose potential solutions.
4. FLPPS is ensuring coordination with project managers at other PPSs to create a streamlined, universal approach for patients presenting in crisis, to ensure ease of access and “no wrong door,” as well as a coordinated process for participating providers.

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Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS developed and established a project team in Fall 2014 to support the development and implementation activities of this project. This team became the 3.a.ii Clinical Quality Subcommittee, part of the FLPPS governance structure, and is comprised of providers from across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.
- The project design was guided by clinically reviewed and approved project workflows that the FLPPS team created with input from the project teams. The FLPPS Project Management team led informational meetings at all five geographic NOCNs in early 2015 to describe the projects through linear process workflows. The project workflows were enhanced to swimlane flow charts that show the provider responsibilities from the Domain 1 project requirements. These swimlanes include informational flow as well as care management responsibilities and transitions of care. Best practices were also identified and included in the workflow. The goal for FLPPS was to ensure stakeholder input and agreement across the network on project design. This activity improves communication and promotes standardized work across the network for Quality Improvement purposes. Note: The project specific workflow has been attached at the end of this narrative for review.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships and utilization patterns specific to the sub regions are considered in the design and implementation phases for the 13-county FLPPS network. This approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.
- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- FLPPS created cross disciplinary/cross functional work teams to leverage local expertise and halt a siloed approach to crisis services.
- FLPPS has been working to establish crisis stabilization services across the region via NOCN hubs to address the large geographical size of the region. FLPPS is facilitating provider-led efforts at the NOCN level to develop crisis stabilization services that build on the current behavioral health service structure and expertise, strengthening the relationships between providers across the region.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include:

- All mobile crisis teams in the region are engaged in the project and recently initiated work on care protocols that will be adopted across the PPS once vetted and approved by the Clinical Quality Committee.
- FLPPS continues to actively meet and engage with other PPSs also working on the project through project work team meetings.
- NOCNs gather for workgroup sessions with all providers participating in the project to design crisis infrastructure for that region and help build partnerships while identifying available resources/services essential to the project. This activity helps bridge county silos to work more effectively as a region.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

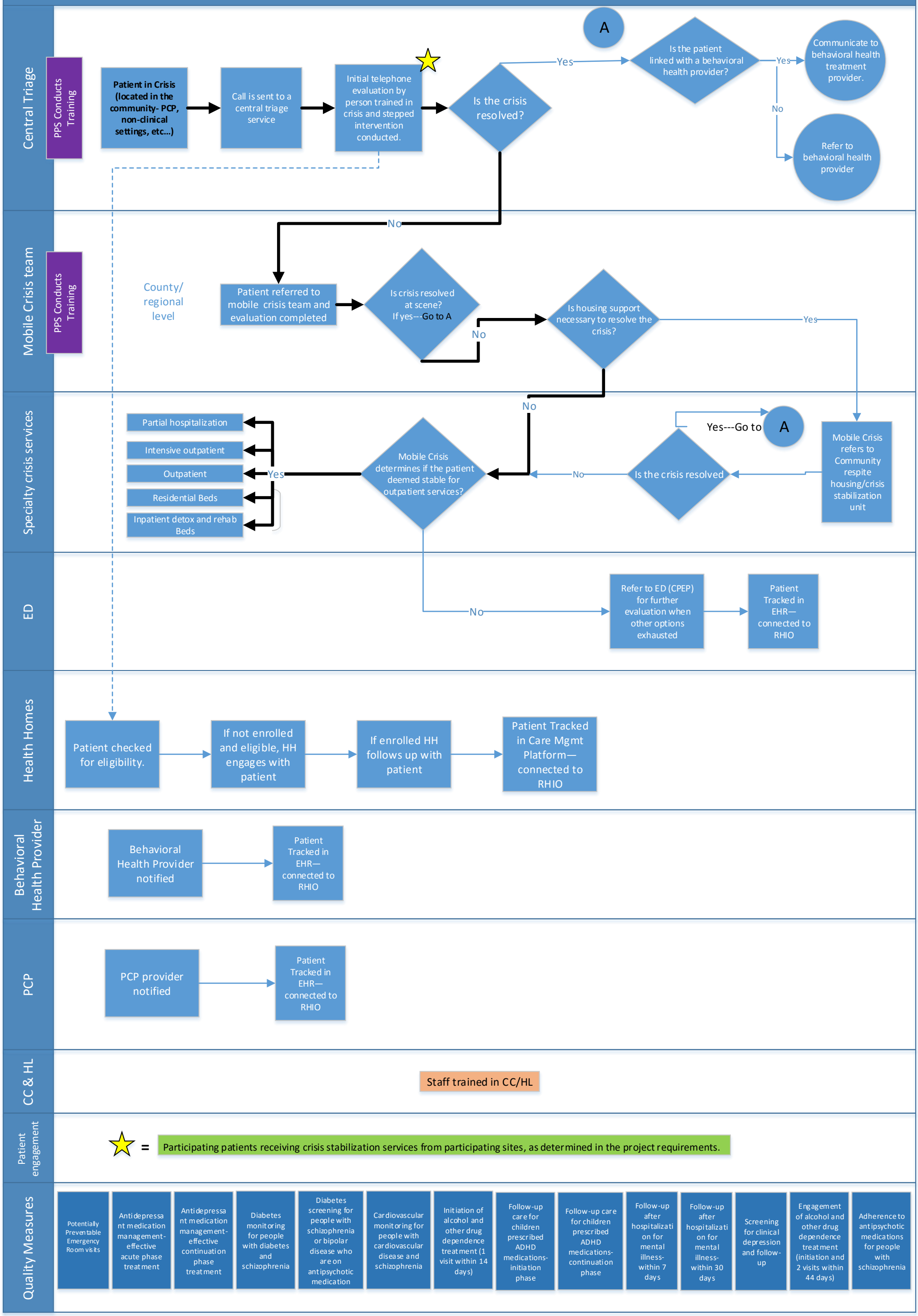
There have been no material changes to the proposed populations.

Potential additions to the proposed populations include services for children. This addition is being explored as the FLPPS region appears to be severely lacking crisis services for youth and children.

FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

3.a.ii Behavioral health community crisis stabilization services

Objective: To provide accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis.



Last revised: 6/27/16

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 3.a.v

Challenges the PPS has encountered in project implementation:

1. FLPPS is the only PPS in the state to select this project and made commitments to complete project speed and scale by 3/31/2017. The 14 project milestones have been challenging from a workforce, facility modification and IT infrastructure standpoint. Despite FLPPS support, several of the FLPPS network skilled nursing facilities (SNFs) will most likely not meet all of the project milestones.
2. Workforce shortages continue to pose challenges, specifically concerning a lack of psychiatric Nurse Practitioner providers with specialized training for purposes of this project. Recruitment and retention has been difficult for the direct and clinical SNF staff.
3. There is a lack of capital funding for required modification of SNF facilities for purposes of this project.
4. General engagement of SNFs in project activities has been challenging, due in part to the DY1 funds flow incentive structure and current contracting methodology, which has been based significantly on the number of attributed lives within each provider organization.
5. Coordinating IT interfaces with multiple electronic medical record systems (EMRs) and those currently without IT hardware and software will challenge implementation.

Efforts to mitigate challenges identified above:

1. FLPPS is responding to the workforce shortage by considering a Request for Information (RFI) to develop a clinical geropsychiatric provider team that can support facilities lacking the adequate behavioral health providers at SNFs. The project team is also considering 1) online learning collaboratives, 2) telepsychiatry, 3) facilitating behavioral health certification for social workers and non-psychiatric Nurse Practitioners/Physician Assistants, 4) facilitating a path for mid-level training for Registered Nurses, and 5) in-house trainings to improve skill-sets and competencies.
2. The project team will use FLPPS Central services to leverage economies of scale (i.e. Project ECHO-GEMH). The project team and participating SNFs have also worked to identify innovative, low cost ways to improve the environment, such as the use of comfort carts and/or meditation rooms.
3. FLPPS leadership is currently examining alternative contracting models that will further incentivize performance and level of effort at the SNF provider level.

4. FLPPS has conducted a current state analysis of the IT and EMR needs of providers, including SNFs. FLPPS has also received information from the Independent Assessor that an EMR will not be required for participating SNFs.
5. The project team plans to identify SNF champions at leadership levels within each SNF and will establish a learning collaborative amongst these champions to assure the objectives of the project are being met, while keeping clinical outcome metrics and related pay-for-performance as an active motivator for participation.

Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS developed and established a project team in Fall 2014 to support the development and implementation activities of this project. This team became the 3.a.v Clinical Quality Subcommittee, part of the FLPPS governance structure, and is comprised of providers from across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.
- The project design was guided by clinically reviewed and approved project workflows that the FLPPS team created with input from the project teams. The FLPPS Project Management team led informational meetings at all five geographic Naturally Occurring Care Networks (NOCN) in early 2015 to describe the projects through linear process workflows. The project workflows were enhanced to swimlane flow charts that show the provider responsibilities from the Domain 1 project requirements. These include informational flow as well as care management responsibilities and transitions of care. Best practices were also identified and included in the workflow. The goal for FLPPS was to ensure stakeholder input and agreement across the network on project design. This activity improves communication and promotes standardized work across the network for Quality Improvement purposes. Note: The project specific workflow has been attached at the end of this narrative for review.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships, and utilization patterns specific to the sub regions are considered in the design and implementation phases for the 13-county FLPPS network. This approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.
- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- FLPPS is participating in the Extension for Community Healthcare Outcomes in Geriatric Mental Health (ECHO-GEMH) online learning collaborative. Parallel cohort sessions are held every two weeks, consisting of a didactic training/educational presentation and a de-identified patient case presentation. Approximately 50 SNFs are currently participating in this learning collaborative to learn from experts in the field of geriatric psychiatry and share case studies for feedback and advice on approaches to care. This version of the learning collaborative is available to all Safety Net SNFs in the region and funded through the Greater Rochester Health Foundation. A recent publication[1] provides evidence that participation in ECHO could lead to a reduction in antipsychotic use in patients with dementia - one of the project's clinical outcome metrics.
- Participating SNFs in the FLPPS region have adopted key components of the INTERACT model as an early identification, ongoing observation, and Quality Improvement tool.
- Participating SNFs employ multidisciplinary behavior teams within their facilities, addressing behavioral issues as they arise.
- FLPPS, in collaboration with Millennium PPS, conducted an INTERACT training for FLPPS SNF Champions.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include:

- The project manager has personally reached out to SNFs and presented a customized presentation based on site-specific needs for project implementation purposes.
- FLPPS senior leadership held a forum specifically for SNFs in the region to discuss the objectives of DSRIP and the value proposition for SNF continued engagement as the focus shifts to clinical outcomes.
- The project team collected current-state data related to resources within SNFs to gauge ability to successfully complete the project.
- A project action plan was developed that participating sites can utilize as a tool for project planning and tracking within their organization.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There have been no material changes to the proposed populations.

[1] https://www.bostonglobe.com/metro/2016/06/04/could-video-chats-between-nursing-home-staff-and-specialists-lower-antipsychotic-use/TZpBv30bHFktTiczmW6piL/story.html


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3a.v. Behavioral Interventions Paradigm in Skilled Nursing Facilities

Project objective: *to reduce transfer of patients from a skilled nursing facility to an acute care hospital by early intervention strategies to stabilize patients with behavioral health issues before crisis levels occur.*

FLPPS FINGER LAKES PERFORMING PROVIDER SYSTEM

Skilled Nursing Facility-Intake

Clinical and non-clinical staff trained in INTERACT key components

Patient presents as a new admission or readmission to skilled nursing facility.

Intake evaluation completed, including **INTERACT medication reconciliation worksheet for post-hospital care tool.**

Individualized interdisciplinary treatment plan developed by social worker with training in behavioral health.

ECHO Learning Collaborative

Presented at biweekly ECHO team forums if appropriate.

NP with BH

NP with behavioral health training notified and assigned to coordinate care. Reassesses resident and adjusts treatment plan.

Consultation with Geriatrician.

Consultation with Psychiatrist.

Skilled Nursing Facility On-going

Holistic interventions and enhanced, person-centered recreational activities are available for residents

Resident is monitored by Certified Nursing Assistants and other direct care staff trained in **INTERACT Stop and Watch**. Staff trainings are documented.

Resident is identified by direct care and other staff as having new or worsening BH symptoms. Licensed nursing staff alerted via Stop and Watch tool.

Licensed nursing staff complete **SBAR communication tool** and review **care pathways**. including **acute mental status change and change in behaviors.**

Crisis intervention strategies applied, if needed, including sitter services.

Collaboration with behavioral health management interdisciplinary team. Regular, formal collaborative meetings are held to develop EBM standards of care and behavioral interventions protocols. Meetings are documented.

Resident activity and status, including behavior interventions and medication usage, is tracked in EMR or other technical platform.

CC & HL

Staff trained in CC & HL

Project Milestones

Implement BIP Model in Nursing Homes model using SNF skilled nurse practitioners (NP), and psychiatric social workers to provide early assessment, reassessment, intervention, and care coordination for at risk residents to reduce the risk of crisis requiring transfer to higher level of care.

Augment skills of clinical professionals in managing behavioral health issues	Enable the non-clinical staff to effectively interact with a behavioral population	Assign an NP with Behavioral Health Training as a coordinator of care	Implement a Behavior Management Interdisciplinary Team Approach to care	Implement a medication reduction and reconciliation program	Increase the availability of psychiatric and psychological services via telehealth and urgently available providers	Provide holistic psychological interventions	Provide enhanced recreation services	Develop crisis intervention strategies via development of an algorithm for staff intervention and utilization of sitter services	Improve documentation re: patient status	Modify the facility environment	Use EHRs or other technical platforms to track all patients engaged in this project

Patient Engagement

The number of participating patients impacted by program initiatives (bed census). Bed census is the number of patients under the care of skilled nurse practitioners, psychiatric social workers, and other appropriate staff who have undergone BIP model training to identify at-risk patients.

Quality Measures

% of long stay residents who have depressive symptoms

% of patients with dementia prescribed an antipsychotic medication

Key: Best practice

Behavioral Health Management Team :
-Social Worker with behavioral health training
-NP with behavioral health training
-Psychiatric consultant
-Medical Director
-Nursing staff

INTERACT Key Components:
-Stop and Watch Early Warning Tool
-SBAR Communication Tool and Change in Condition Progress Note
-Medication Reconciliation Worksheet for Post-Hospital Care
-Care Paths
-Quality Improvement Tool for Review of Acute Care Transfers

Last revised 6/27/16

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 3.f.i

Challenges the PPS has encountered in project implementation:

1. A lack of IT infrastructure in the FLPPS region between health systems and community based organizations (CBOs) has made maternal child health referrals challenging. As this project continues to expand to additional community providers, a process for referrals and data sharing will need to be expanded to capture providers outside of the usual referral patterns.
2. FLPPS's commitment for project speed and scale completion was aggressively made for September 2016. This aggressive commitment was necessary due to the high need in the FLPPS region identified by the community needs assessment to vastly improve maternal and child health outcomes. The timeline has made it challenging for project commitment completion during DY1 as the PPS concurrently focused on network development, provider engagement, DSRIP education and infrastructure development.

Efforts to mitigate challenges identified above:

1. FLPPS and its associated providers are working to build EHR connectivity and appropriate processes for referrals and documentation to meet project goals and requirements.
2. FLPPS has identified providers who are advanced in the Maternal and Infant Community Health Collaborative and the Community Health Worker (MICHC/CHW) who will support immediate project requirements; thus, FLPPS anticipates achieving project commitments by 9/30/2016. These providers will work closely with FLPPS to share best practices and guide other providers that will expand or implement MICHC/CHW programs.
3. FLPPS is currently analyzing the latest data provided by NYS to identify the appropriate counties for CHW expansion to develop a process for this deployment.

Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS developed and established a project team in Fall 2014 to support the development and implementation activities of this project. This team became the 3.f.i Clinical Quality Subcommittee, part of the FLPPS governance structure, and is comprised of providers from across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.
- The project design was guided by clinically reviewed and approved project workflows that the FLPPS team created with input from the project teams. The FLPPS Project Management team led informational meetings at all five geographic Naturally Occurring Care Networks (NOCNs) in early 2015 to describe the projects through linear process workflows. The project workflows were enhanced to swimlane flow charts that show the provider responsibilities from the Domain 1 project requirements. These swimlanes include informational flow as well as care management responsibilities and transitions of care. Best practices were also identified and included in the workflow. The goal for FLPPS was to ensure stakeholder input and agreement across the network on project design. This activity improves communication and promotes standardized work across the network for Quality Improvement purposes. Note: The project specific workflow has been attached at the end of this narrative for review.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships and utilization patterns specific to the sub regions are considered in the design and implementation phases for the 13-county FLPPS network. This approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.
- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- The project team structure has been instrumental in bringing large competitors in the region together to collaborate to reach the project's goals. There have also been significant outreach efforts amongst the major hospital systems in the region to work both together and with FLPPS.
- FLPPS has reached out to the region's county public health departments to understand what maternal child health programs are already in place and identify opportunities where the project can help fill gaps rather than re-create programs that already exist.
- The project team integrated clinicians early on in the implementation phase to guide strategy and address challenges related to this project. Additionally, the project manager for this project has a clinical background in the area of maternal-child health, which has proven to be instrumental in

meeting the goals of the project and overcoming implementation challenges.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include:

- A Request for Information (RFI)/Request for Qualifications (RFQ) has been sent to providers to assess existing resources for the maternal-child health population in the region and implement MICHC/CHW programs in identified areas of need, in order to meet patient engagement commitments.
- The two major hospital systems in the region are currently working together in a contractual relationship to effectively and efficiently utilize their MICHC/CHW program in the areas they serve.
- The project manager attended MICHC supervisor training and Center of Excellence conference through DOH to understand trends and best practices to better support the project and participating providers.
- The FLPPS data analytics team has gathered data for the population served by this project to review PPS-wide trends and ensure the project team is focusing on the identified areas of most need and improvement opportunities.
- FLPPS has met with Millennium PPS and collaborated on project implementation efforts.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

The proposed population for this project stands as indicated in the application. FLPPS will continue to focus on high risk, expectant mothers and mothers with children aged newborn to 24 months across the entire FLPPS region to ensure standardization and improved outcomes. This allows the project to have a greater impact via early interventions before and during pregnancy.

3fi. Increase Support Programs for Maternal and Child (including high risk pregnancies)

Objective: To Reduce avoidable poor pregnancy outcomes and subsequent hospitalization as well as improve maternal and child health through the first two years of the child's life.

Maternity Care Providers

- Patient presents to Maternity Care Provider
- FLPPS Prenatal Risk Assessment Performed
- Prenatal Risk Assessment referral made for patient identified at risk (form submitted)
- Determine MICHC or NFP referral (if NFP is available) -Is mom a 1st time pregnant woman less than 28 weeks Gestational Age?
- Maternity Care Provider maintains access to accommodate pregnant women
- Maternity Care Providers follow ACOG Standards of Care.

Hospital --Labor & Delivery & ER, and School Systems

- At risk pregnant woman identified. Referred to Maternity Care Provider
- YES---NFP
- No-- MICHC

CBO & HH

- At risk pregnant woman identified. Referred to Maternity Care Provider

Nurse Family Partnership

- Referral Processed and Nurse assigned
- Patient Accepts Services ★
- Nurse visits patient following NFP guidelines. Connects patients with Services to enable adherence
- Appointment adherence is tracked following ACOG,AAP, ACIP standards.
- Nurse visits patients for 2 years
- Patient tracked in EHR/other technical platforms between multiple providers

MICHC Program

- Referral Processed and CHW assigned
- Patient Accepts Services ★
- CHW visits patient per MICHC guidelines. Connects patients with Services to enable adherence.
- Appointment adherence is tracked following ACOG,AAP, ACIP standards.
- CHW visits patients for 2 years
- Patient tracked in EHR/other technical platforms between multiple providers

Pediatric Provider

- Pediatrician is PCMH 2014 certified
- Pediatrician makes referrals to MICHC or NFP program for at risk pregnant women
- Pediatric Providers maintains access to accommodate Pediatric Patients
- AAP and ACIP standards of Pediatric care followed for immunization, lead screening and Well child visits.
- Pop. Health reports are run & Patient Outreach is performed to improve adherence

CC & HL

- Staff trained in CC & HL
- Providers trained in CC & HL

Project Milestones

Develop CHW Program base on MICHC Model	Develop evidenced based home visiting program based on NFP Model	Establish protocols for deployment of CHW	Develop policies and procedures for referrals	Develop policy and procedure for reporting
M1	M1	M4	M1	M5

Patient Engagement

★ = The number of expecting mothers and mothers participating in this program

Quality Measures

Prevention Quality Indicator Low Birth Weight	Prenatal and Postpartum Care – Timeliness of Prenatal Care	Postpartum Visits	Frequency of Ongoing Prenatal Care	Well Care Visits in the first 15 months (5 or more Visits)	Childhood Immunization Status (Combination 3 4313314)	Lead Screening for Children	Early Elective Deliveries

Key: Best Practice

Last revised: 6/27/16

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:

1. The project team has identified families at risk and those affected by the criminal justice system as its priority populations. Even with this prioritization, further refinement of project scope has been challenging due to the nature of this potentially broad initiative.
2. The DY1 contracting methodology that FLPPS used relied significantly on an organization's attributed lives, so gaining needed support and participation from numerous organizations such as local schools, law enforcement and community based organizations (CBOs) has been challenging without the ability to financially incentivize their participation. This is of particular importance as there are no pay-for-performance clinical outcome measures to guide providers towards, although FLPPS does use the prevention agenda and DSRIP metrics manual as the guide.

Efforts to mitigate challenges identified above:

1. The project team undertook numerous exercises to refine its priority populations, including development of a SWOT (Strength, Weaknesses, Opportunities and Threats) analysis. County and regional level providers contributed to the exercise aimed at identifying the most vulnerable populations in our PPS.
2. The project team is working to engage non-traditional partners by building close relationships and emphasizing the importance and impact that the Domain 4 projects can have on health outcomes in communities, in particular for behavioral health and substance abuse. FLPPS is also considering opportunities to provide funding for innovation projects, as well as developing funds for prevention program opportunities related to this project.

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Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS developed and established a project team in Fall 2014 to support the development and implementation activities of this project. This team became the 4.a.iii Clinical Quality Subcommittee, part of the FLPPS governance structure, and is comprised of providers from across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships and utilization patterns specific to the sub regions are considered in the design and implementation phases for the 13-county FLPPS network. This approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.
- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- FLPPS was able to recruit passionate team leaders and has established and maintained close relationships with non-traditional partners (law enforcement, peer support organizations, etc.) in the community.
- Identifying the roles and expectations for FLPPS and providers has been crucial to the success of activities involving several stakeholders with competing project priorities.
- Developing a clearly defined structure for the partnership has led to success and prepared the project to move forward.
- Provider workgroups have been developed (MEB CC/HL and Stigma Reduction, Population Health and Evidenced Based Interventions) and have been tasked to help develop the MEB CC/HL training strategy, in coordination with the overall PPS CC/HL training strategy, and identify traditional and non-traditional sources of data that will inform the implementation of interventions in the PPS.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include:

- Success of this project hinges on participation from a wide range of different types of community providers - many not typically associated with healthcare. The Finger Lakes Organization for Wellness, Education, and Recovery (FLOWER) is the overarching partnership within the PPS community that was developed via project 4.a.iii. FLOWER membership includes representation from providers, the target population, policy makers/regulators, the business community, managed care organizations/insurance companies, criminal justice/law enforcement, the faith community, the academic community, foundations/development, schools (college, high school, elementary), members of the media, and advocacy groups. The entire partnership meets on a quarterly basis. Meetings have provided rich opportunities for collaboration, as well as presentations and informed discussion on project implementation. Expert speakers have presented at these meetings on the following topics:
  - Overview of the Courts System. Therapeutic Justice: Behavioral Health and Courts Working Together
  - Population Health Methodologies
  - Theoretical Overview of Prevention
  - Law Enforcement Assisted Diversion (LEAD) Program
  - Cultural Competency & Health Literacy from a MEB perspective
  - Population Health Data collection
  - Practical Application and Utilization of Local Data Collection

  These FLOWER partnership meetings have been well attended and very well-received. Participation in these sessions is particularly impressive as many of our partners who have not traditionally been associated with healthcare reform efforts (schools, law enforcement) continue to be invested in the project without a contracting incentive to do so. Many of our lead participants have not been incentivized by our DY1 contracting methodology, which was based significantly on attributed lives.

- The project manager is also active in a number of project related community initiatives, including:
  - Monroe County Suicide Prevention Coalition, which focuses on reducing rates of suicide, a key prevention metric for this project.
  - AWARE-C Strategic Leadership Group, a SAMHSA grant via Delphi Drug and Alcohol Council, which aims to train 1,800 adults in Youth Mental Health First Aid.
  - Monroe County Opioid Task Force. FLPPS staff are actively seeking out participation in partnerships with local recently-formed Opioid and Substance Abuse Task Forces.

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
Informed by project team brainstorming sessions and SWOT analysis, the targeted population has been refined and now focuses on individuals affected by the criminal justice system and at-risk families, supporting the original population of prevention among youth.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Finger Lakes Performing Provider Systems, Inc.

Project: 4.b.ii

Challenges the PPS has encountered in project implementation:

1. Community based organization (CBO) engagement has been one of the primary challenges for this project, especially considering: 1) the state-defined 5% funding limit for non-safety net providers; 2) an underdeveloped infrastructure across CBO entities; 3) an evolving understanding of regional CBO assets; and 4) limited existing cross-sector collaboration.
2. As the New York State Value Based Payment (VBP) Methodology continues to evolve, it is expected to include a standardized risk assessment methodology or tool. FLPPS has faced a challenge in developing a separate tool for risk assessment purposes of this project that is not duplicative of the approach that will be implemented state-wide via implementation of VBP roadmap methodologies.
3. FLPPS experienced a delay in data availability and population health platform selection, which created challenges in moving forward with project implementation.

Efforts to mitigate challenges identified above:

1. In the planning and educational phase of DSRIP, FLPPS dedicated a Provider Relations Associate; and more recently created a team to focus on CBO engagement as the focus has shifted to project implementation. This team includes Director-level support to ensure the prioritization of relationships and connectivity between social service agencies and the projects. Activities include the documentation and mapping of CBO assets by county and Naturally Occurring Care Network (NOCN) region, and deployment of team members in support of project implementation for CBOs with a lean staffing structure. The CBO engagement team will work with trusted strategic partners that are outside of the network but critical to CBO success (such as funders, the FLHSA and professional collaboratives) to fully explore participation in DSRIP and systems integration across all initiatives that are concurrently taking place in our region. The second phase of contracting strategy for FLPPS will recognize and connect CBO assets to the IDS and facilitate referral and subcontracting relationships as necessary. FLPPS will provide technical assistance as needed to ensure CBOs have access to necessary resources to successfully contract as well as report and track outcomes. Lastly, FLPPS is working to assist planning for a regional application to the CBO Planning

Grant issued by NYS DOH, to ensure that CBOs in the network can take advantage of all funding streams available in support of DSRIP.

2. FLPPS has undertaken a full analysis of chronic disease prevalence across the region to support the identification of a target population for whom the project can be focused prior to the development and adoption of a PPS-wide risk assessment. The project team will proceed as required while taking state actions into account.
3. FLPPS has prepared for a quick implementation once the data and population health management platform is available. FLPPS is currently in the RFP process to identify a population health management platform vendor.

Implementation approaches that the PPS considers a best practice:

FLPPS has adopted several best practices for project development and implementation across all projects. These activities include:

- FLPPS developed and established a project team in Fall 2014 to support the development and implementation activities of this project. This team became the 4.b.ii Clinical Quality Subcommittee, as part of the FLPPS governance structure and is comprised of providers from across the region with the appropriate expertise to aid in development of implementation plans and operationalization of the project. This team has met regularly since the inception of FLPPS.
- FLPPS developed NOCNs during the initial stages of DSRIP to address regional needs and ensure that regional healthcare referral relationships and utilization patterns specific to the sub regions are considered in the design and implementation phases for the 13-county FLPPS network. This approach has supported provider education and rapid execution of project work plans, while fostering strong network relations across a large geographic catchment area.
- The FLPPS project management office uses Performance Logic project management software to plan and aid in the project planning, implementation, and reporting process while identifying interdependencies across all projects.

In addition to the overall FLPPS best practices, activities specific to this project that have guided the successful implementation to date include:

- FLPPS examined county Community Health Improvement Plans and Community Support Programs to understand resources currently in place and identify potential gaps.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
Activities completed by FLPPS and/or that continue to evolve beyond that which has been reported in quarterly reports to date include: • FLPPS hired independent consultants to work with counties to aggregate CHIP data and identify priority areas to leverage the project and move activities forward.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
The proposed populations changed to become more focused on a chronic condition, specifically chronic back pain, based on regional data. It is also possible that the target population for the project will revert back to the originally proposed population, and the project team is formulating a strategy to approach chronic disease preventative care while waiting for more informative data.