Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Advocate Community Providers

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Prepared by the DSRIP Independent Assessor

Advocate Community Providers

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I. Introduction

Advocate Community Providers, Inc. (ACP) PPS serves four counties in the New York City region: Bronx, Kings (Brooklyn), New York (Manhattan) and Queens. The Medicaid population attributed to this PPS for performance totals 644,916. The Medicaid population attributed to this PPS for valuation was 312,623. ACP was awarded a total valuation of $700,038,844 in available DSRIP Performance Funds over the 5 year DSRIP project.

ACP selected the following nine projects from the DSRIP Toolkit:

Figure 1: ACP DSRIP Project Selection

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health Homes At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.b.iii.	ED Care Triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
3.a.i.	Integration of primary care and behavioral health services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular Health)
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only) (Diabetes)
3.d.iii.	Implementation of evidence-based medicine guidelines for asthma management
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health

II. 360 Survey Results: Partners' Experiences with the PPS

Survey Methodology and Overall PPS Average Results

The Independent Assessor (IA) developed a 360 survey to solicit feedback from the partners of each PPS regarding engagement, communication, and effectiveness. The survey consisted of 12 questions across four PPS organizational areas; Governance, Performance Management, Information Systems, and Contracting/Funds Flow. The Independent Assessor selected a sample of PPS network partners to participate via a sample generator from the PPS Provider Import/Export Tool (PIT)[1] report. A stratified sampling methodology was used to ensure that each category of network partner was included in the surveyed population. This was done to ensure a cross-section of the partner types in the PPS network. The IA used 95% confidence interval and 5% error rate to pull each sample. For the 25 PPS the IA sent out a total of 1,010 surveys, for an average of 40 surveys per PPS partner. The response rate overall was 52%, or 523 total respondents, for an average of approximately 21 responses per PPS.

360 Survey by Partner Category for All PPS

An analysis of the average survey scores by partner category for all PPS identifies some key trends. The two most favorable survey results were from Hospitals and Nursing Homes. The least favorable survey results came from the Mental Health, Hospice, and Primary Care Providers. These results reflect (generally) a high approval rating of PPS' engagement, communication, and effectiveness by institutional providers and a low approval rating of PPS' engagement, communication, and effectiveness by non-institutional/community based providers. A more thorough review of the four PPS organizational areas demonstrated that all partners perceived that Contracting/Funds Flow and Information Systems as the least favorable rankings (compared to Governance and Performance Management).

Figure 2: All PPS 360 Survey Results by Partner Type and Organizational Area

Partner Type	*Average Score*	Governance	Performance Management	IT Solutions	Funds Flow
Hospital	*3.32*	3.42	3.39	3.04	3.28
Nursing Home	*3.06*	3.15	2.93	2.93	2.79
Community Based Organization	*3.00*	3.17	3.04	2.73	2.97
Case Management / Health Home	*2.93*	2.98	2.87	2.81	2.75
Practitioner - Non-PCP	*2.93*	3.03	2.80	2.64	2.40
Clinic	*2.92*	2.96	3.03	2.75	2.66
Substance Abuse	*2.91*	3.08	2.96	2.78	2.82
Pharmacy	*2.87*	3.00	2.84	2.31	2.25

[1] The Provider Import/Export Tool (PIT) is used to capture the PPS reporting of partner engagement, as well as funds flow for the PPS Quarterly Reports. All PPS network partners are included in the PIT and are categorized based on the same logic used in assigning the partner categorization for the Speed & Scale commitments made during the DSRIP Project Plan Application process.

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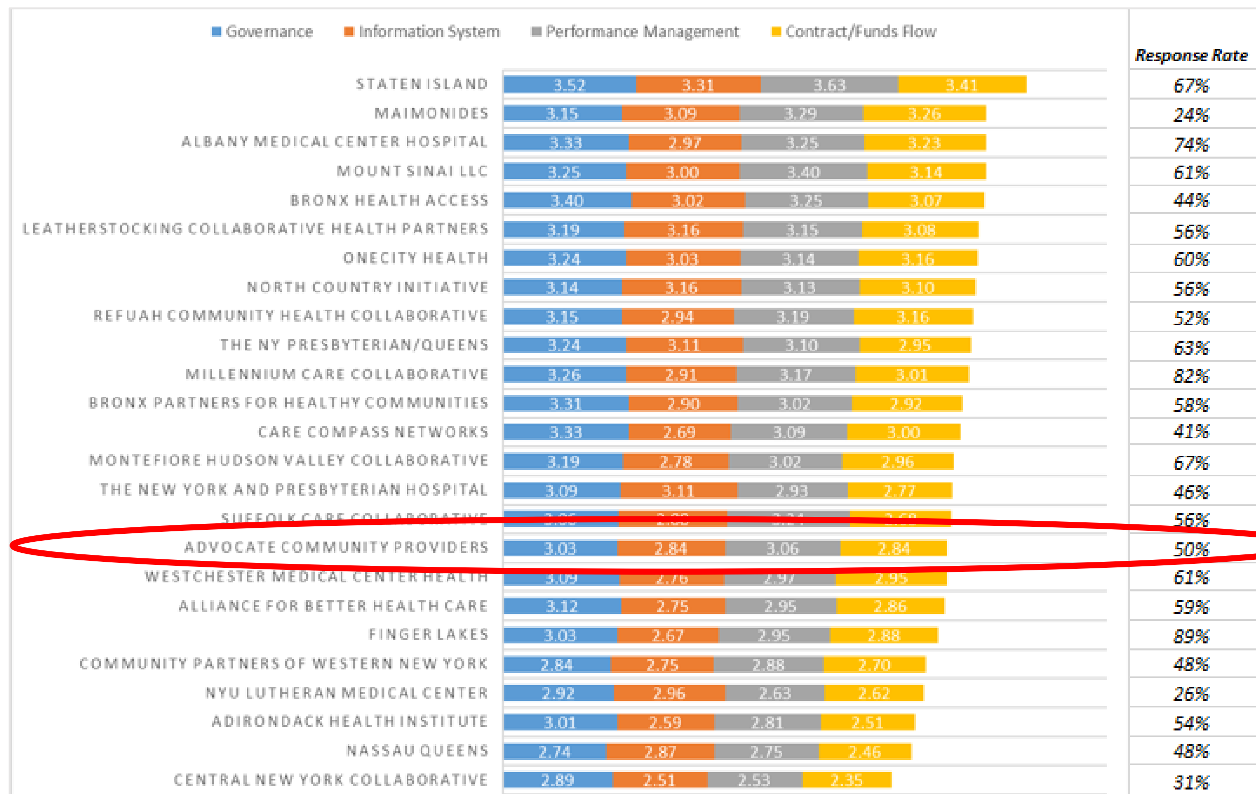
All Other	*2.84*		2.92	2.83	2.63	2.69
Mental Health	*2.81*		2.94	2.85	2.56	2.75
Hospice	*2.74*		2.93	2.75	2.41	2.41
Practitioner - PCP	*2.66*		2.68	2.66	2.61	2.31
Average by Organizational Area	***2.90***		**3.00**	**2.89**	**2.70**	**2.67**

Data Source: 360 Survey Results

<u>Advocate Community Providers, Inc. 360 Survey Results</u>[2]

The ACP 360 survey sample included 48 participating network partner organizations identified in the PIT; 24 of those sampled (50%) returned a completed survey. This response rate was fairly consistent with the average across all PPS (52% completed). The ACP aggregate 360 survey score ranked 17th out of 25 PPSs (Figure 3).

Figure 3: PPS 360 Survey Results by Organizational Area



Data Source: 360 Survey Data for all 25 PPS

<u>ACP Survey Results by Partner Type</u>

The IA analyzed the survey response by partner category to identify any trends by partner type. Figure 4 below identifies and ranks the average survey responses. The Nursing Home survey result for ACP was high (2nd out of 12), which was similar compared to all PPS' (2nd out 12). Mental

[2] PPS 360 Survey data and comments can be found in the "Appendix 360 Survey".

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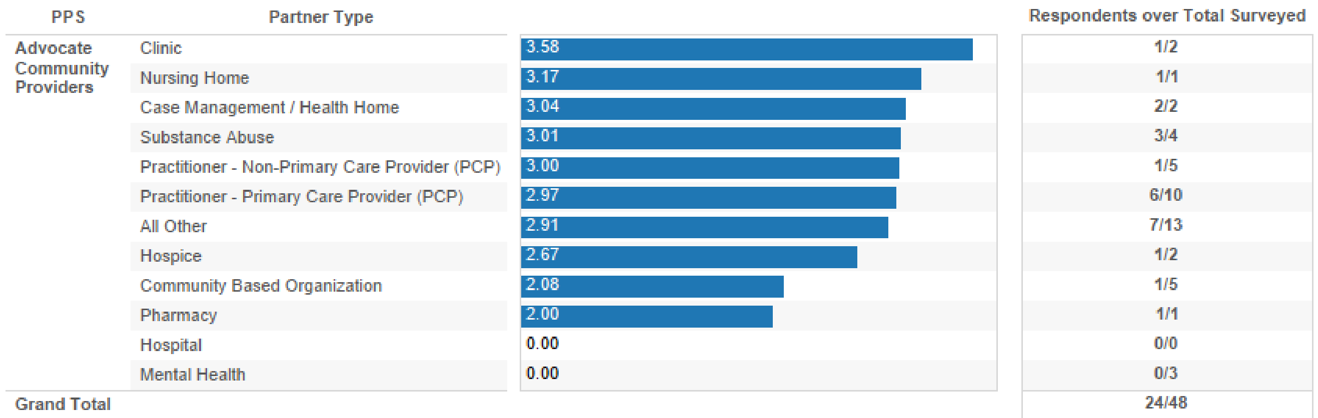
Health was low, which was also consistent with peer PPS responses. Most negative answers were for the Contracting / Funds Flow and the IT Solutions questions.

Figure 4: ACP 360 Survey Results by Partner Type[3]



Data Source: ACP 360 Survey Results

While the data from the 360 Survey alone does not substantiate any specific recommendations at this time, it serves as an important data element in the overall assessment of the PPS through the first five quarters of the DSRIP program and may guide the PPS in its efforts to engage its partners.

[3] For the survey results, while the CBO category appears to have returned zero results, the IA found that CBO entities may have also been identified as part of the All Other partner category.

III. Independent Assessor Analysis

The Independent Assessor (IA) has reviewed every Quarterly Report submitted by the PPS covering DY1, Q1 through DY2, Q2[4] and awarded the Achievement Values (AVs) for the successful completion of milestones, as appropriate.

- In DY1, Q2, ACP **earned all available Organizational AVs and six out of seven possible Patient Engagement Speed AVs.**
- In DY1, Q4, ACP **earned four out of five possible Organizational AVs and six of a possible seven Patient Engagement Speed AVs.** ACP failed to earn the Cultural Competency and Health Literacy Organizational AV in DY1, Q3 due to its failure to demonstrate PPS Board Approval of the required Cultural Competency and Health Literacy strategy.

In addition to the PPS Quarterly Reports, the PPS is required to submit narratives for each of the projects the PPS was implementing and a narrative to highlight the PPS' organizational status. These narratives were required specifically to support the Mid-Point Assessment and were intended to provide a more in depth update on the project implementation efforts of the PPS.

Lastly, the IA conducted site visits to each of the 25 PPS during October 2016. The site visits were intended to serve a dual purpose; as an audit of activities completed during DY1, including specific reviews of Funds Flow and Patient Engagement reporting, and as an opportunity to obtain additional information to support the IA's efforts related to the Mid-Point Assessment. The IA focused on common topics across all 25 PPS including Governance, Cultural Competency and Health Literacy, Performance Reporting, Financial Sustainability, and Expanding Access to Primary Care.

The IAs leveraged the data sources available to them, inclusive of all PPS Quarterly Reports, AV Scorecards, the PPS' Narratives, and the On-Site Visits to conduct an in depth assessment of PPS' organizational functions, PPS' progress towards implementing their DSRIP projects and the likelihood of the PPS meeting the DSRIP goals. The following sections describe the analyses completed by the IA and the observations of the IA on the specific projects that have been identified as having varying levels of risk.

A. Organizational Assessment

The first component of the IA assessment focused on the overall PPS organizational capacity to support the successful implementation of DSRIP and in meeting the DSRIP goals. As part of the quarterly reports, the PPS are required to support documentation to substantiate the successful completion of milestones across key organizational areas such as Governance, Cultural Competency and Health Literacy, Workforce, Financial Sustainability, and Funds Flow to PPS partners. Following the completion of the defined milestones in each of the key organizational

[4] At the time of this report, the IA was reviewing the PPS Quarterly Report submissions for DY2, Q2 and had not issued final determinations on PPS progress. However, items not subject to remediation such as engagement numbers and funds flow data were necessary to provide for the most recent and comprehensive IA analysis.

areas, the PPS are expected to provide quarterly updates on any changes to the milestones already completed by the PPS. The following sections highlight the IA's assessment on the PPS efforts in establishing the organizational infrastructure to support the successful implementation of the PPS DSRIP plan.

PPS Governance

Advocate Community Partners, Inc. (ACP) is a membership not-for-profit organization comprised of three members: AW Medical Office, P.C. (AW), New York Community Preferred Providers, LLC (NYCPP), and Northwell (previously NSLIJ). ACP is a physician-led PPS with over 2,000 providers across 600 practices. It operates under a delegated partnership model where the Board membership is divided amongst its voting members. The Board representation of the entities has evolved from DSRIP Year 1 where 25% of the members were from AW Medical, 25% were from Northwell and 50% were from NYCPP to the current model where AW Medical has 25%, NYCPP was reduced to 25% and Nothwell has 50% as of March 31, 2016. Currently, Northwell is serving as the PPS' fiduciary under an Administrative Services Agreement.

The PPS governance structure includes an Executive Committee which is supported by a Steering Committee, an Audit Committee, a Compliance Committee, a Finance Committee, a Clinical Quality Committee and a Health Information Technology Committee. The Executive Committee is comprised solely of the representatives of the three members: AW Medical, NYCPP and Northwell. Each member of the corporation has assigned a representative to each committee to participate in conjunction with key stakeholders of the organization. All of the committees meet at minimum on a quarterly basis.

During the IA's on-site visit with the ACP, the PPS discussed the evolution of its governance structure and the impact of Northwell as it shifted to 50% ownership. A Northwell representative was present throughout the day to demonstrate the close involvement Northwell has with the PPS Project Management Office (PMO) staff.

PPS Administration and Project Management Office (PMO)

The IA also reviewed the PPS spending through the DY2, Q2 PPS Quarterly Reports related to administrative costs and funds distributed to the PPS PMO. It should be noted that PPS administrative spending will vary due to speed of staffing up the PMO, size of the PMO, the type of centralized services provided, and the degree of infrastructure investment, such as IT, that it may find necessary to support the PPS' partners to achieve project goals.

In reviewing the PPS spending on administrative costs, the IA found that ACP had reported spending $5,074,437.00 on administrative costs compared to an average spend of $3,758,965.56 on administrative costs for all 25 PPS. As each PPS is operating under different budgets due to varying funding resources associated with the DSRIP valuations, the IA also looked at spending

on administrative costs per attributed life[5], relying on the PPS Attribution for Performance figures[6]. The IA found that ACP spends $7.87 per attributed life on administrative costs compared to a statewide average of $24.23 per attributed life on administrative costs.

Looking further at the PPS fund distributions to the PPS PMO, ACP distributed $4,689,016.75 to the PPS PMO out of a total of $18,812,376.61 in funds distributed across the PPS network, accounting for 24.93% of all funds distributed through DY2, Q2. Comparatively, the statewide average for PPS PMO distributions equaled $5,966,502.64 or 42.85% of all funds distributed.

The data on the administrative costs and PMO funds flow distributions present a point of comparison across PPS, however do not alone provide enough information from which the IA can assess the organizational capacity of the PPS to support the implementation of DSRIP. It is important for the PPS to invest in the establishment and maintenance of an organizational infrastructure to support the PPS through the implementation of the DSRIP projects to ensure the PPS success in meeting its DSRIP goals.

Community Based Organization Contracting

As part of the DY1, Q3 PPS Quarterly Report, ACP included a list of all Community Based Organizations (CBOs) in its organization, whether they had completed contracts, and whether they would be compensated. Of the CBOs included on that list, the IA found that the PPS had indicated that they contracted with 1/5th of the CBOs but upon further analysis the IA found that the PPS submitted Memorandums of Understandings (MOU) with the majority listed. Pursuant to the language in the MOU, it sought to define and formalize collaborative agreements with each CBO. ACP has continued to update the list of CBOs with each PPS Quarterly Report as contracting efforts evolve.

Of the CBOs listed, ACP indicated that a large number of the CBOs will be compensated for services rendered. As indicated in the analysis of the funds flow distributions through DY2, Q2 (see Figure 5), it appears that the PPS has not flowed any funds to CBOs through DY2, Q2. The PPS should identify opportunities to distribute DSRIP funds to these partners to ensure their continued engagement in the implementation efforts of the PPS.

Cultural Competency and Health Literacy

The ACP approach to Cultural Competency and Health Literacy (CCHL) was informed by their Community Needs Assessment (CNA). Pursuant to its CCHL Committee Charter and Strategic Plan, ACP formed the Cultural Competency and Health Literacy (CCHL) Advisory Committee, comprised of key PPS stakeholders and partners. The CCHL committee meets twice a year to discuss issues brought forth by the ACP Cultural Competency and Health Literacy Staff. Committee members are tasked with both implementing programs and initiatives to ensure that

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[5] Attribution for Performance was used as a measure of the relative size of each PPS to normalize the administrative spending across all 25 PPS.

[6] The Attribution for Performance figures were based on the data included on the individual PPS pages on the NY DSRIP website.

the ACP network is culturally competent and raising the health literacy level of ACP Medicaid recipients.

Between August and December 2015, ACP conducted a survey to assess baseline health literacy of its providers. In December, 2015, the PPS hosted a focus group on Patient Education and Health Literacy which was open to providers in its network.

During the IA's on-site visit the PPS demonstrated the efforts surrounding CCHL. ACP has developed a training strategy for both the provider and the patient. Patient training is on the topic of Health Literacy and the PPS has committed to educating Latino and Asian cultures on health issues specific to those communities. For the Latino culture, the PPS has developed a Zika Virus video in both Spanish and English to educate the population who travels abroad to countries affected by the virus. The PPS has also hired a former Telemundo personality as its Director of Communication in order appeal to the Spanish speaking community as a familiar face while executing a cultural competency communication campaign to promote healthy eating via the Dash Diet. Within Asian communities, the PPS has collaborated with the Chinese Christian Herald Crusades to invite students to participate in pop-up health events to use exercise as currency to buy books. This targeted campaign aimed to educate on the benefits of exercising and health. The PPS has also collaborated with Chinese Promise Baptist Church to conduct free screenings of the community.

Provider training focuses on improving communication and education between providers and patients which in turn will improve patient experience. Though many providers are from the community the PPS recognized a need for improvement and has contracted with a vendor who is providing training platforms to educate providers on Ask Me 3 and Teach Back strategies.

The PPS has also implemented an approach to target non-utilizers. The PPS conducted a root cause analysis and identified all the social determinants that has created barriers to care. The PPS used this information to inform its approach and concentrate its efforts in order to collaborate with community based providers and target its outreach in the community.

As part of the IA on-site reviews, the PPS was asked to specifically address questions the following questions:

1) What measures are the PPS using to assess the cultural and linguistic competency of the clinical providers in the network of the PPS? How is the PPS measuring and working to address disparities - by race, ethnicity, language, geography- in access to primary, specialty, preventive screening & other services?
2) What measures are the PPS using to demonstrate the extent to which it is reaching / engaging ALL attributed Medicaid beneficiaries and uninsured patients, particularly those who are historically underserved and hard to reach? What are the most effective strategies being employed by the PPS and what is the evidence that they are working?

3) How is the PPS working with CBOs outside the medical sphere? Please share the contracts / financial agreements between the PPS & CBOs. What systems have the PPS set up to facilitate CBO's data and reporting capacity?

In responding to these questions the PPS indicated:

1) ACP conducted a root-cause analysis to identify barriers to access to care based on race, ethnicity, language and culture. The PPS used the metrics from this analysis to model its CCHL approach and to educate patients. The PPS developed protocols to reach this population of patients and connected with them via phone and home visits. As a result, 1/3 of the targeted group kept a PCP appointment.
2) The PPS created measures based on the population of patients, physicians and staff. An example would be whether or not the physicians reflected the needs of the community. This data is used to concentrate efforts leading to results as articulated in the response to Question 1 above.
3) The PPS is working with CBOs outside of the medical sphere. Particularly CBOs that focus on various social determinants and that can assist in increasing access to care once the social determinants are addressed. CBO contracts were requested as an audit sample and reviewed by the Independent Assessor.

Financial Sustainability and Value Based Purchasing (VBP)
ACP created a Financial Committee that is tasked with oversight of several areas related to finance. One of the major efforts undertaken to date by ACP was the creation of a Financial Sustainability Strategy to identify and assist financially fragile partners. Submitted with its DY1, Q4 Quarterly Report, the goal of the strategy is to define/layout its approach to identify, assist, and monitor financially distressed physicians and providers to further assess whether their state of financial health is short term or long term and to make a determination on how their financial status impacts their ability to deliver services to underserved communities. ACP has established Revenue Loss reserve funds in the budget to be ready to support hospital and other partners should they experience decreased revenues in DY2 through DY5.

ACP performed a baseline assessment of its partners' financial health in DY1, from which ACP reported that it did not find any partners in financial hardship. However, while on-site the IA discovered that few ACP partners requested financial assistance, indicating potential hardship. Upon further review, the PPS concluded that these partners were not truly fragile. These partners were responding to the survey questions that asked partners whether they needed assistance, what kind of financial assistance was needed, and what was their timeframe for assistance. These open ended questions are subject to interpretation and solicited requests for financial assistance.

ACP submitted its Value Based Purchasing (VBP) Transition Roadmap with its DY1, Q4 Quarterly Report. The PPS leadership has made a substantial commitment to pursue innovative, value-based care and/or full risk arrangements. The PPS is exploring and discussing how to actively participate in the VBP program among its providers as an approach and mechanism to serve as a

sustainable integrated delivery care system. ACP has been invited to participate in the VBP Pilot Program as well as invited to jointly participate in an Innovator Program with a major hospital institution. The PPS will work closely with a vendor as it develops and defines the strategic plan for ACP's VBP strategy toward achieving 80% value- based payments across the PPS network by DSRIP year 5.

Funds Flow

Through DY2, Q2 PPS Quarterly Report, ACP's funds flow reporting indicates they have distributed 35.63% ($18,812,376.61) of the DSRIP funding it has earned ($52,795,126.07) to date. In comparison to other PPS, the distribution of 35.63% of the funds earned ranks 22nd and places ACP below the statewide average of 56.20%.

Figure 5 below indicates the distribution of funds by ACP across the various Partner Categories in its network.

Figure 5: PPS Funds Flow (through DY2, Q2)

Total Funds Available (DY1)	$53,821,024.96		
Total Funds Earned (through DY1)	$52,795,126.07 (98.09% of Available Funds)		
Total Funds Distributed (through DY2, Q2)	$18,812,376.61 (35.63% of Earned Funds)		
Partner Type	Funds Distributed	ACP (% of Funds Distributed)	Statewide (% of Funds Distributed)
Practitioner - Primary Care Physician (PCP)	$7,673,869.10	40.8%	3.9%
Practitioner - Non-Primary Care Physician (PCP)	$1,149,999.18	6.1%	0.7%
Hospital	$3,431,579.00	18.2%	30.4%
Clinic	$437,043.21	2.3%	7.5%
Case Management/Health Home	$0.00	0.0%	1.3%
Mental Health	$36,666.58	0.2%	2.4%
Substance Abuse	$0.00	0.0%	1.0%
Nursing Home	$0.00	0.0%	1.2%
Pharmacy	$0.00	0.0%	0.0%
Hospice	$0.00	0.0%	0.2%
Community Based Organizations[7]	$0.00	0.0%	2.3%
All Other	$1,106,253.09	5.9%	5.8%

[7] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

Uncategorized	$287,949.69	1.5%	0.5%
Non-PIT Partners	$0.00	0.0%	0.6%
PMO	$4,689,016.75	24.9%	42.0%

Data Source: PPS Quarterly Reports DY1, Q2 – DY2, Q2

In further reviewing the ACP funds flow distributions, it is notable that the distributions are heavily directed towards the Practitioner – Primary Care Physician (PCP), PPS PMO, and Hospital partner categories, with 83.9% of the funds being directed to those three partner categories. The data indicates limited to no fund distributions to other key partner types such as Mental Health, Substance Abuse, and CBO partners. It will be important for the PPS to distribute funds to the key partners to ensure their continued engagement in the implementation of ACP's DSRIP projects.

B. Project Assessment

In addition to the assessment of the overall organizational capacity of the PPS, the IA assessed the PPS' progress towards implementing the DSRIP projects the PPS selected through the DSRIP Project Plan Application process. In assessing the PPS' progress towards project implementation, the IA relied upon common data elements across various projects, including the PPS' progress towards completing the project milestones associated with each project as reported in the PPS' Quarterly Reports, PPS efforts in meeting patient engagement targets, and PPS efforts in engaging network partners in the completion of project milestones. Based on these elements, the IA identified potential risks in the successful implementation of DSRIP projects. For each project identified as being at risk by the IA, this section will indicate the various data elements that support the determination of the IA and that will ultimately result in the development of the recommendations of the IA for each project.

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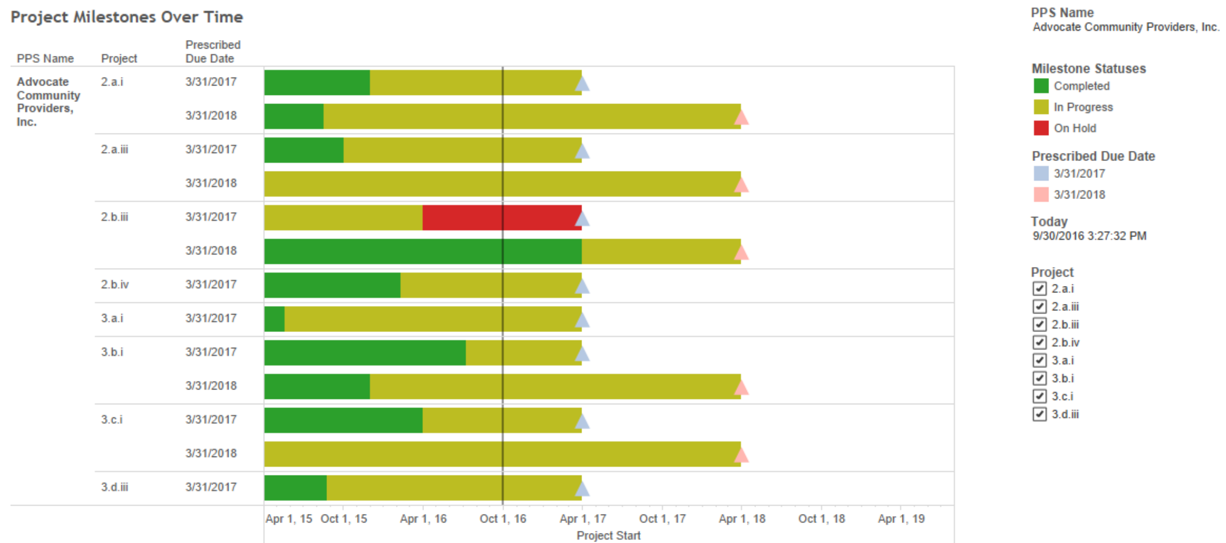
PPS Project Milestone Status

The first element that the IA evaluated was the current status of the PPS project implementation efforts as indicated through the DY2, Q2 PPS Quarterly Reports. For each of the prescribed milestones associated with each Domain 2 and Domain 3 project, the PPS must indicate a status of its efforts in completing the milestone. The status indicators range from 'Completed' to 'In Progress' to 'On Hold'. Figure 6 below illustrates ACP's current status in completing the project milestones within each project. Figure 6 also indicates where the required completion dates are for the milestones.

Figure 6: ACP Project Milestone Status (through DY2, Q2)[8]



Data Source: ACP DY2, Q2 PPS Quarterly Report

Based on the data in Figure 6 above, the IA identified Project 2.b.iii as being at risk due to the current status of project implementation efforts. Project 2.b.iii has milestones with required completion dates of DY2, Q4 that are currently in a status of 'On Hold'. This status indicates that the PPS has not begun efforts to complete these milestones by the required completion date and as such are at risk of losing a portion of the Project Implementation Speed AV for each project.

Patient Engagement AVs

In addition to the analysis of the current project implementation status, the IA reviewed ACP's performance in meeting the Patient Engagement targets through the PPS Quarterly Reports. The IA identified three projects where the PPS has missed the Patient Engagement targets in at least one PPS Quarterly Report. Figures 7 through 9 below highlight those projects where ACP has missed the patient Engagement target for at least one quarter.

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[8] Note that this graphic does not include Domain 4 projects as these projects do not have prescribed milestones and the PPS did not make Speed & Scale commitments related to the completion of these projects.

Figure 7: 2.b.iii. (ED Care Triage for at-risk populations) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	6,500	8,175	125.77%
DY1, Q4	11,375	16,553	145.52%
DY2, Q2[9]	16,250	8,179	50.33%

Data Source: ACP PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

Figure 8: 3.b.i (Evidence-based strategies for disease management in high risk/affected populations (adult only) (Cardiovascular Health) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	67,025	111,709	166.67%
DY1, Q4	95,751	0	0.00%
DY2, Q2[10]	124,477	124,477	100.00%

Data Source: ACP PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

Figure 9: 3.d.iii. (Implementation of evidence-based medicine guidelines for asthma management) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	33,839	32,513	96.08%
DY1, Q4	84,599	66,766	78.92%
DY2, Q2[11]	84,599	48,503	57.33%

Data Source: ACP PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

For project 2.b.iii, the combination of lagging project implementation efforts as indicated in the Project Milestone Status analysis and the failure to meet Patient Engagement targets would indicate that this project is at an elevated risk to the successful implementation of projects

For projects 3.b.i and 3.d.iii, the failure to meet Patient Engagement targets presents a concern. However, this data point alone does not indicate significant risks to the successful implementation of the projects.

Partner Engagement

The widespread engagement of network partners throughout the PPS service area is important to the overall success of DSRIP across New York State. Engagement of partners in isolated portions of the PPS service area will not support the statewide system transformation, improvement in the quality of care, and reduction in costs that are expected as a result of this

[9] The DY2, Q2 Patient Engagement figures reflect 'As Submitted' data by the PPS and have not been validated by the IA at the time of this report.

[10] The DY2, Q2 Patient Engagement figures reflect 'As Submitted' data by the PPS and have not been validated by the IA at the time of this report.

[11] The DY2, Q2 Patient Engagement figures reflect 'As Submitted' data by the PPS and have not been validated by the IA at the time of this report.

effort. It is therefore important to the success of the PPS and to the overall DSRIP program that the PPS engage network partners throughout their identified service area.

In continuing to further assess the project implementation efforts of the PPS and to identify the potential risks associated with project implementation the IA also assessed the efforts of the PPS in engaging their network partners for project implementation relative to the Speed & Scale commitments made for partner engagement as part of the DSRIP Project Plan Application.

The IA paid particular attention to the PPS engagement of Practitioner – Primary Care Provider (PCP) and of behavioral health (Mental Health and Substance Abuse) partners given the important role these partners will play in helping the PPS to meet the quality improvement goals tied to the Pay for Performance (P4P) funding. The engagement of PCPs and behavioral health partners is especially important across Domain 3a projects where six out of ten High Performance Funding eligible measures fall.

As part of this effort, the IA reviewed all projects with a specific focus on those projects that were identified as potential risks due to Project Milestone Status and/or Patient Engagement performance. The PPS reporting of partner engagement, as well as funds flow, is done through the Provider Import Tool (PIT) of the PPS Quarterly Reports. All PPS network partners are included in the PIT and are categorized based on the same logic used in assigning the partner categorization for the Speed & Scale commitments made during the DSRIP Project Plan Application process.

Through this review, the IA did not identify any limited partner engagement efforts relative to the commitments made by the PPS during the DSRIP Project Plan Application. The IA will continue to monitor the engagement of network partners as the PPS completes its project implementation efforts.

PPS Narratives for Projects at Risk

For those projects that have been identified through the analysis of Project Milestone Status, Patient Engagement AVs and Partner Engagement, the IA also reviewed the PPS' narratives to determine if the PPS provided any additional details provided by the PPS that would indicate efforts by the PPS to address challenges related to project implementation efforts.

2.b.iii. (ED care triage for at-risk populations): The PPS indicated in the Project Narrative there are challenges surrounding Patient Engagement in that it serves a population that requires significant community outreach and education regarding ED use and alternative sites of care in order to successfully engage these patients. In addition, there are challenges and concerns around the capacity of PCPs/Alternative Sites of Care that are inhibiting the PPS' Partner Engagement commitments. Specifically, PCP offices are usually booked to capacity with very little availability for new appointments or walk-ins. Lastly, the PPS acknowledges the technological difficulty it has incurred in connecting hospitals and PCPs to guarantee timely scheduling of PCP appointments by a patient navigator at the ED.

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3.b.i. (Evidence-based strategies for disease management in high risk/affected populations (adult only)):
The PPS Project Narrative states that patient compliance to a preventive care plan can be heavily compromised by the low health literacy rate of the population that ACP serves. The majority of patients served by ACP providers are immigrants who speak little or no English, making it difficult for them to understand educational materials. Lack of education and low levels of health literacy make patient self-management and positive outcomes much more difficult to achieve resulting in poor patient compliance rates.

3.d.iii. (Implementation of evidence-based medicine guidelines for asthma management):
ACP has acknowledged their failure to meet the Patient Engagement speed targets for this project. Although the PPS identifies challenges to project implementation, ACP conducted a root cause analysis to identify why it missed its Patient Engagement commitments. The PPS learned that there was an opportunity for improvement with the data integrity of the patient engagement file submitted to the IA. Presently, ACP's Tech/Data Analytics team is in process of revising its protocols for the submission of patient engagement statistics for all projects.

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IV. Overall Project Assessment

Figure 10 below summarizes the IA's overall assessment of the project implementation efforts of ACP based on the analyses described in the previous sections. The 'X' in a column indicates an area where the IA identified a potential risk to the PPS' successful implementation of a project.

Figure 10: Overall Project Assessment

Project	Project Description	Patient Engagement	Project Milestone Status	Partner Engagement
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management			
2.a.iii.	Health Homes At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes			
2.b.iii.	ED Care Triage for at-risk populations	X	X	
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions			
3.a.i.	Integration of primary care and behavioral health services			
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)	X		
3.c.i.	Evidence-based strategies for disease management in high risk populations			
3.d.iii.	Implementation of evidence-based medicine guidelines for asthma management	X		

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V. Project Risk Scores

Based on the analyses presented in the previous pages the IA has assigned risk scores to each of the projects chosen for implementation by the PPS. The risk scores range from a score of 1, indicating the Project is on Track to a score of 5, indicating the Project is Off Track.

Figure 11: Project Risk Scores

Project	Project Description	Risk Score	Reasoning
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
2.a.iii.	Health Homes At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
2.b.iii.	ED Care Triage for at-risk populations	3	There are multiple milestones on hold for this project, inclusive of those due at the end of DSRIP Year 2. The PPS has had patient engagement challenges.
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
3.a.i.	Integration of primary care and behavioral health services	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
3.c.i.	Evidence-based strategies for disease management in high risk populations	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
3.d.iii.	Implementation of evidence-based medicine guidelines for asthma management	2	The PPS has had patient engagement challenges.

****Projects with a risk score of 3 or above will receive a recommendation.***

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VI. IA Recommendations

The IA's review of the Advocate Community Providers PPS covered the PPS' organizational capacity to support the successful implementation of DSRIP and the ability of the PPS to successfully implement the projects the PPS selected through the DSRIP Project Plan Application process. While ACP has achieved many of the organizational and project milestone in DSRIP to date, the IA believes it will be important for the PPS to continue to focus on establishing the necessary infrastructure to support the implementation of its DSRIP projects. ACP should continue to leverage its partnership with Northwell to assist the PPS in establishing this infrastructure. The further attention to establishing the infrastructure of the PPS will help to ensure the successful completion of organizational and project milestones, the engagement of Medicaid members, and the achievement of the PPS' DSRIP goals.

The following recommendations have been developed based on the IA's assessment of the PPS' progress and performance towards meeting the DSRIP goals. For each recommendation, it is expected that the PPS will develop a Mid-Point Assessment Action Plan (Action Plan) by no later than March 2, 2017. The Action Plan will be subject to IA review and approval and will be part of the ongoing PPS Quarterly Reports until the Action Plan has been successfully completed.

A. Organizational Recommendations

Financial Sustainability

Recommendation: The IA recommends that the PPS tailor the Financial Sustainability survey of its partners. The survey should aim to gather hard data to assess the financial state of its partnering organizations in order to determine fragility. The IA further recommends that the PPS educate its partners on the role of the PPS in terms of assisting them financially.

B. Project Recommendations

Project 2.b.iii.: ED care triage for at-risk populations

Recommendation 1: The IA recommends that the PPS create a plan to continue to educate patients regarding ED use and alternative sites of care in order to successfully continue to engage patients.

Recommendation 2: The IA recommends the PPS develop a plan to address the current delays resulting in DY2, Q4 project milestones having a status of 'On Hold.

Recommendation 3: As the PPS acknowledges the technological difficulty it has incurred in connecting hospitals and PCPs to guarantee timely scheduling of PCP appointments by a patient navigator at the ED, the IA recommends the PPS address this through workflow agreed upon as part of partner agreements.