NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Final Report

Adirondack Health Institute

December 2016

www.health.ny.gov

Prepared by the DSRIP Independent Assessor

the PPS indicated that the AHI PPS management team will assess the partner's need for technical assistance and financial resources required to attain financial sustainability.
The PPS has conducted a baseline assessment survey to determine the readiness of AHI's partners for VBP. During the onsite visit, the PPS stated that the assessment is ongoing and that initial results indicate very little VBP activity.

Funds Flow

Through the DY2, Q2 PPS Quarterly Report, AHI's funds flow reporting indicates they have distributed 44.48% ($12,501,682.22) of the DSRIP funding it has earned ($28,104,145.23) to date. In comparison to other PPS, the distribution of 44.48% of the funds earned ranks 16th among the 25 PPS and falls below the statewide average of 56.20%.

Figure 5 below indicates the distribution of funds by Adirondack Health Institute PPS across the various Partner Categories in its network.

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

Total Funds Available (DY1)	$28,195,877.01		
Total Funds Earned (through DY1)	$28,104,145.23 (99.67% of Available Funds)		
Total Funds Distributed (through DY2, Q2)	$12,501,682.22 (44.48% of Earned Funds)		
Partner Type	**Funds Distributed**	**AHI (% of Funds Distributed)**	**Statewide (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$74,000.00	0.59%	3.89%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%	0.73%
Hospital	$3,207,185.77	25.65%	30.41%
Clinic	$1,014,793.88	8.12%	7.54%
Case Management/Health Home	$442,859.92	3.54%	1.31%
Mental Health	$770,704.35	6.16%	2.43%
Substance Abuse	$527,265.54	4.22%	1.04%
Nursing Home	$223,986.66	1.79%	1.23%
Pharmacy	$0.00	0.00%	0.04%
Hospice	$139,250.00	1.11%	0.16%
Community Based Organizations[7]	$253,271.04	2.03%	2.30%
All Other	$1,059,761.50	8.48%	5.82%
Uncategorized	$54,150.00	0.43%	0.53%
Non-PIT Partners	$243,050.00	1.94%	0.58%
PMO	$ 4,491,403.56	35.93%	41.99%

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

In further reviewing the AHI funds flow distributions, it is notable that the distributions it has made are primarily directed toward the PPS PMO and Hospital partner categories, which represent 61.6% of the funds being directed to these partner categories. The PMO category is the largest expenditure at 35.93% which is lower than the statewide average of 42% for this category. While the PPS has distributed funds across almost all of the partner categories, the amount of funds distributed to the PCPs has been limited through DY2, Q2, while its distribution to Mental Health and Substance Abuse has been above the PPS state-wide average. The PPS should identify opportunities to increase its funding distributions to this key partner

[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.

category to ensure their continued engagement in the implementation of the PPS' DSRIP projects.

Primary Care Plans

The IA reviewed the executive summaries of the Primary Care Plan submitted by DOH during the public comment period. The IA review focused on the completeness and the progress demonstrated by the PPS in the Primary Care Plan. The IA agrees with the assessment that AHI had a "Detailed and thorough PC plan, with many activities already in motion."

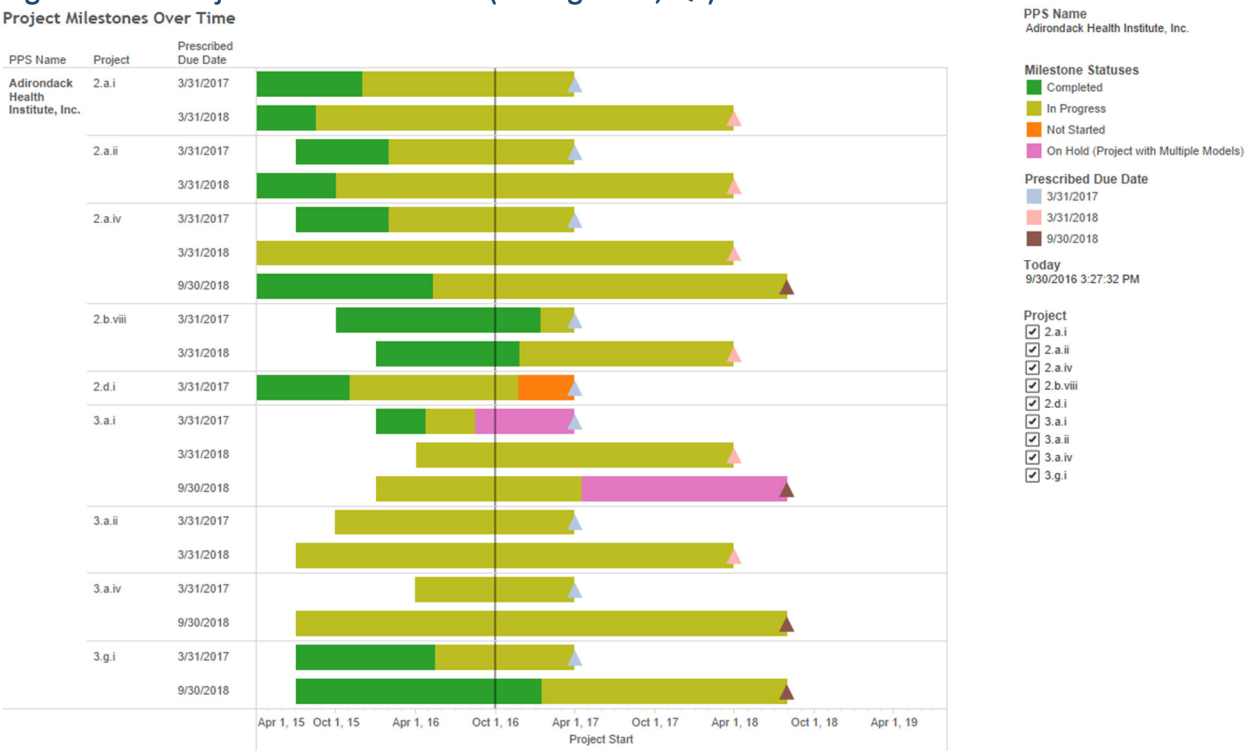
B. Project Assessment

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 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.

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 AHI'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: AHI Project Milestone Status (through DY2, Q2)[8]



Data Source: AHI DY2, Q2 PPS Quarterly Report

Based on the data in figure 6 above, the IA identified one project that is at risk due to the current status of project implementation efforts; project 3.a.i 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.

[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.

Further assessment of the PPS project implementation status for project 3.a.i. indicates that many of the project milestones with a status of 'On Hold' are related to the PPS not pursuing Model 3 for this project. Therefore, for the models the PPS is pursing, there is no risk of project implementation not meeting the required completion dates at this time.

Patient Engagement AVs

In addition to the analysis of the current project implementation status, the IA reviewed AHI's performance in meeting the Patient Engagement targets through the PPS Quarterly Reports. The IA identified seven projects where the PPS has missed the Patient Engagement targets in at least one PPS Quarterly Report. Figures 7 through 13 below highlight those projects where AHI has missed the patient Engagement target for at least one quarter.

Figure 7: 2.a.ii (Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0
DY1, Q4	45,000	5,194	11.54%
DY2, Q2	49,500	6,177	12.48%

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

Figure 8: 2.b.viii (Hospital-Home Care Collaboration Solutions) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0
DY1, Q4	0	0	0
DY2, Q2	1,042	220	21.11%

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

Figure 9: 2.d.i (Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0
DY1, Q4	8,000	436	5.45%
DY2, Q2	28,000	2,583	9.23%

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

Figure 10: 3.a.i (Integration of primary care and behavioral health services) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0
DY1, Q4	0	0	0
DY2, Q2	6,619	1,027	15.52%

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

Figure 11: 3.a.ii (Behavioral health community crisis stabilization services) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0
DY1, Q4	0	0	0
DY2, Q2	2,100	352	16.76%

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

Figure 12: 3.a.iv (Development of Withdrawal Management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0
DY1, Q4	0	0	0
DY2, Q2	133	23	17.29%

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

Figure 13: 3.g.i (Integration of palliative care into the PCMH Model) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0
DY1, Q4	0	0	0
DY2, Q2	972	2	.21%

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

For projects 2.a.ii, 2.b.viii, 2.d.i, 3.a.i, 3.a.ii, 3.a.iv, and 3.g.i, 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 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.

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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. The IA does however, note that while the PPS indicates it has engaged its partners across all partner categories and projects, there are concerns about the level of engagement with these partners as evidenced by the limited Patient Engagement reporting by the PPS and by the PPS' admission that it has not yet fully executed contracts with all partners due to organizational challenges.

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.a.ii (Increase certification of primary care practitioners with Patient centered medical homes certification and/or advanced primary care models)

The PPS identified a number of challenges. The PPS is still finalizing contracts with their partners, especially large primary care practices. In addition, many of the PCPs are participating in multiple projects and are challenged by the reporting requirements of each.

2.b.viii (Hospital home-care collaboration solutions)

The PPS noted that their region has been designated as a Health Providers Shortage Area (HPSA), which negatively impacts access to primary care, specialty providers, and long-term care that are needed to strengthen the transition from hospital to home. Additionally, the lack of a comprehensive regional IT platform leads to increased lag time for updated and accurate information, and omissions of relevant data. Furthermore, the PPS states that patients lack a general understanding of the role of the various providers of care and the relationship between hospitals and home care.

2.d.i (Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care)

The PPS states that they are still finalizing contracts with their partners. Additionally, the PPS states that many of the CBOs in their region lack understanding of their role in DSRIP.

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

The narrative submitted by the PPS is very limited and indicates an overall lack of strategy for this project. The PPS states that they are still finalizing contracts with their partners. Additionally, the PPS identified a lack of access to resources for both behavioral health and primary care.

3.a.ii (Behavioral health community crisis stabilization services)

The PPS states it has challenges with recruitment and staff for behavioral health providers.

3.a.iv (Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs)
The PPS has identified a lack of workforce resources in one region of their PPS which they state is affecting their overall implementation of this project. The PPS also states that they are finalizing contracts with their partners.

3.g.i (Integration of palliative care into the patient centered medical home model)
The PPS identified a number of challenges. Primarily, patients lack a general understanding of the role of palliative care services and its distinction from hospice care. Additionally, there are a limited amount of practitioners that are board certified in palliative medicine that could assist in engaging PCPs.

IV. Overall Project Assessment

Figure 14 below summarizes the IA's overall assessment of the project implementation efforts of AHI 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 14: 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.ii.	Increase certification of primary care practitioners with Patient centered medical homes certification and/or advanced primary care models	X		
2.a.iv.	Created a medical village using existing hospital infrastructure			
2.b.viii.	Hospital home-care collaboration solutions	X		
2.d.i.	Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care.	X		
3.a.i.	Integration of primary care and behavioral health services	X		
3.a.ii.	Behavioral health community crisis stabilization services	X		
3.a.iv.	Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs.	X		

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 15: 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	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.
2.a.ii	Increase certification of primary care practitioners with Patient centered medical homes certification and/or advanced primary care models	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.
2.a.iv	Created a medical village using existing hospital infrastructure	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
2.b.viii	Hospital home-care collaboration solutions	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges
2.d.i	Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care.	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges.
3.a.i	Integration of primary care and behavioral health services	4	This is a high risk score indicating the project may fail to meet intended goals without significant modifications or performance improvements.
3.a.ii	Behavioral health community crisis stabilization services	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.a.iv	Development of withdrawal management capabilities	2	This is a low risk score indicating the project is more than likely to meet

	and appropriate enhanced abstinence services within community-based addiction treatment programs.		intended goals but has minor challenges to be overcome.
3.g.i	Integration of palliative care into the patient centered medical home model	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges

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

In assigning the project risk scores for AHI, the IA notes that while the review of the Project Milestone Status and Partner Engagement data did not indicate any risks for the successful implementation of the PPS' DSRIP projects, there was information presented in the PPS Project Narratives submitted with the DY2, Q1 PPS Quarterly Reports that raised concerns about the PPS' ability to successfully implement a number of the DSRIP projects. As such, the IA has assigned an elevated risk score to projects 2.b.viii., 2.d.i., 3.a.i., and 3.g.i.

Of these projects, the IA has the greatest concern for project 3.a.i. where the PPS Project Narrative provided little detail on the PPS' progress towards implementing this project, its plan for successfully meeting project implementation commitments, and for overcoming project implementation challenges. The IA's review did not indicate that the PPS has a clearly defined path for the successful implementation of project 3.a.i.

While the IA did not identify any specific risks associated with project 2.a.i., the IA notes that the organizational challenges identified, most notably the delayed partner contract execution efforts, raises the risk associated with the PPS' ability to successfully implement this project. As such, the IA has assigned an elevated risk score for this project.

VI. IA Recommendations

The IA's review of the Adirondack Health Institute 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. AHI has achieved many of the organizational and project milestones to date in DSRIP. The PPS organized into 5 Population Health Networks (PHNs) to address the needs of a large geographic area covering 6.1 million acres in Northern New York. However, the IA is concerned about the ability of the PPS Governing Body to effect change at the PHN level as it is not clear what role the PPS will play in the oversight and monitoring of the execution of project implementation efforts across the PHNs. The IA also notes that the administrative staffing of the PMO is relatively new to DSRIP, and as such efforts such as contracting with network partners have been delayed.

The IA also has some concerns regarding AHI's project implementation. During the onsite visit, the PPS indicated that it had little to no Partner Engagement contracts through DY2, Q1, despite indicating in the PPS Quarterly Reports that they have engaged partners to support the implementation of the DSRIP projects. The PPS had recently hired its Finance Director and additional staff to address this issue. The IA notes that the contracting issue appears to be impacting the limited Patient Engagement across multiple projects. The increase in Partner Engagement contracting should positively impact the Patient Engagement in future quarters. The IA will continue to closely monitor the PPS performance in this particular area.

The IA also highlights that while the review of the PPS' Project Milestone Status and Partner Engagement data did not indicate there were potential issues with the implementation of the DSRIP projects, the information presented in the PPS Project Narratives provided additional insights that raised concerns for the IA and as such resulted in the assignment of elevated risk scores for certain projects. The biggest concern for the IA is on project 3.a.i., where the PPS Project Narrative provided little detail on the PPS' progress towards implementing this project, its plan for successfully meeting project implementation commitments, and for overcoming project implementation challenges. The IA has therefore assigned an elevated risk score to this project as the IA's review does not indicate that the PPS has a clearly defined path for the successful implementation of project 3.a.i.

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.

Adirondack Health Institute

A. Organizational Recommendations

Governance

Recommendation 1: The IA recommends that the PPS develop and provide a strategy to increase oversight and accountability of the PHNs to ensure that projects are being implemented in a timely manner.

Recommendation 2: The IA recommends that the PPS develop a plan to ensure that all partners engaged in project implementation efforts have an executed contract by the end of DY2 to ensure the PPS is able to successfully meet project milestones, Patient Engagement targets, and the performance goals of the DSRIP program.

Cultural Competency and Health Literacy

Recommendation 1: The IA recommends that the PPS develop a strategy to address how it will measure the effectiveness of their CCHL outreach efforts across the PPS network.

Recommendation 2: The IA recommends that the PPS develop a strategy to better address the effectiveness of the CCHL training of its partners.

Recommendation 3: The IA recommends that the PPS establish metrics that it will use to demonstrate the extent to which it is reaching and engaging Medicaid beneficiaries and the uninsured.

Financial Sustainability and VBP

Recommendation 1: The IA recommends that the PPS establish a plan to further educate and support their partners move toward VBP arrangements.

B. Project Recommendations

2.b.viii (Hospital home-care collaboration solutions

Recommendation 1: The IA recommends the PPS develop an education strategy to address the patient lack of knowledge regarding the role of various caregivers in this project and to more effectively engage patients regarding the benefits for their care

2.d.i (Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care)

Recommendation 1: The IA recommends the PPS develop a strategy to educate the CBOs about their role in DSRIP, the PPS and their role in this project for improved partner engagement in project implementation.

Recommendation 2: The IA recommends the PPS provide further orientation and develop education materials for partners that are hesitant to conduct PAM surveys.

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

The IA considers this project to be at risk and believes the project may fail to meet intended goals without significant modifications or performance improvements. The PPS committed to begin reporting Patient Engagement in DY2, Q2, and did not meet their target. Furthermore, the PPS reports they are still in the contracting phase with regard to Partner Engagement in this project. Finally, the PPS narrative submitted as part of the Mid-Point Assessment identified a series of overarching challenges without a clearly defined plan for overcoming these challenges which lead the IA to question the ability of the PPS to implement this project.

Recommendation 1: The IA requires the PPS develop a comprehensive action plan to address the implementation of this project in consultation with the Project Advisory Committee (PAC) that must be reviewed and approved by the Board of Directors.

3.g.i (Integration of palliative care into the patient centered medical home model)

Recommendation 1: The IA recommends the PPS develop a training strategy to inform the targeted population of the role of palliative care services and the distinction between hospice care.

Recommendation 2: The IA recommends the PPS develop a workforce strategy to increase the number of board certified palliative care professionals to assist with training PCPs or to consider other options such as telehealth for consultation.