NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Final Report

Leatherstocking Collaborative Health Partners PPS

December 2016

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Prepared by the DSRIP Independent Assessor

Leatherstocking Collaborative Health Partners (LCHP)

Contents

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I. Introduction

Leatherstocking Collaborative Health Partners PPS (LCHP) (led by Basset Medical Center) serves five counties in Central New York: Delaware, Herkimer, Madison, Otsego, and Schoharie. The Medicaid population attributed to this PPS for performance totals 41,716. The Medicaid population attributed to this PPS for valuation was 62,043. LCHP was awarded a total valuation of $71,839,378 in available DSRIP Performance Funds over the five year DSRIP project.

LCHP selected the following 11 projects from the DSRIP Toolkit:

Figure 1: LCHP DSRIP Project Selection

Project	Project Description
2.a.ii.	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.viii.	Hospital-Home Care Collaborative Solutions
2.c.i.	Development of community-based health navigation services
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.a.i.	Integration of primary care and behavioral health services
3.a.iv.	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
3.d.iii.	Implementation of evidence-based medicine guidelines for asthma management
3.g.i.	Integration of palliative care into the PCMH model
4.a.iii.	Strengthen Mental Health and Substance Abuse infrastructure across Systems
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health

II. 360 Survey Results: Partners' Experience 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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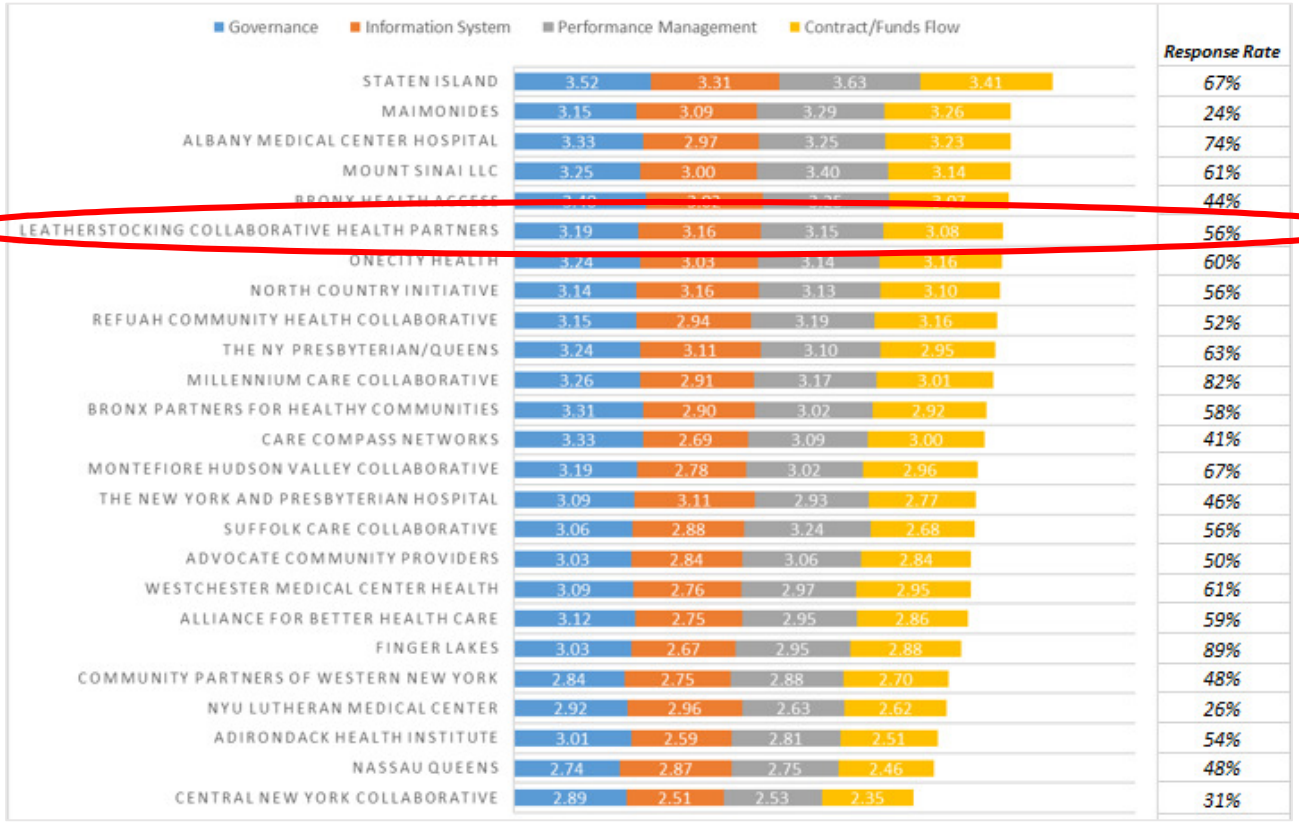
All Other	*2.84*		2.92	2.83	2.63	2.69
Mental Health	*2.81*		2.94	2.85	2.56	2.75
Hospice	*2.74*		2.93	2.75	2.41	2.41
Practitioner - PCP	*2.66*		2.68	2.66	2.61	2.31
Average by Organizational Area	***2.90***		**3.00**	**2.89**	**2.70**	**2.67**

Data Source: 360 Survey Results

Leatherstocking Collaborative Health Partners 360 Survey Results[2]

The LCHP 360 survey sample included 41 participating network partner organizations identified in the PIT; 23 of those sampled (56%) returned a completed survey. This response rate was fairly consistent with the average across all PPS (52% completed). The LCHP aggregate 360 survey score ranked 20th out of 25 PPS (Figure 3).

Figure 3: PPS 360 Survey Results by Organizational Area



Data Source: 360 Survey Data for all 25 PPS

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

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LCHP PPS 360 Survey Results by Partner Type

The then 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 All Other survey result was relatively high (3rd out of 12) compared to all PPS' (9th out 12). Mental Health and Pharmacy Provider categories were also low compared to the All PPS average.

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

PPS	Partner Type		Respondents over Total Surveyed
Leatherstocking Collaborative Health Partners	Hospital	3.67	1/1
	Nursing Home	3.67	1/3
	All Other	3.45	2/4
	Hospice	3.42	1/2
	Case Management / Health Home	3.04	2/2
	Practitioner - Primary Care Provider (PCP)	2.69	4/7
	Practitioner - Non-Primary Care Provider (PCP)	2.65	6/13
	Clinic	2.46	2/2
	Pharmacy	1.33	2/2
	Mental Health	1.00	2/2
	Community Based Organizations	0.00	0/1
	Substance Abuse	0.00	0/2
Grand Total			23/41

Data Source: LCHP 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, LCHP **earned all available Organizational AVs and earned seven of a possible nine Patient Engagement Speed AVs.**
- In DY1, Q4, LCHP **earned four of five available Organizational AVs and earned seven of a possible nine Patient Engagement Speed AVs.** The PPS failed the Financial Sustainability Organizational AV due to a failure to provide a copy of the OMIG certification indicating that the compliance program meets the requirements of the law and regulation including NY Social Service 363-d.

In addition to the PPS Quarterly Reports the PPS were required to submit narratives for each of the projects the PPS is 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 IA 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

[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.

partners. Following the completion of the defined milestones in each of the key organizational 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

The LCHP is led by an Executive Governance Body which was formed by the Project Advisory Committee (PAC). Reporting to the EGB are the following committees: Workforce, Clinical Performance, Finance, IT and Data Analytics, Compliance, and Population Health. The EGB approves all funds flow; however, they cannot remove any partners from the PPS without the approval of the Bassett Medical Center Board. The Compliance Committee, once a stand-alone group, is now a subcommittee reporting to the Finance Committee. During the onsite visit, the PPS admitted to the IA that the PPS does not employ a Compliance Officer solely dedicated to DSRIP efforts.

The PPS conducts an all partner meeting on a quarterly basis to help inform the PPS of any issues and challenges which the partners have encountered. The Clinical Governance Committee is represented by multiple partner types in order to fully represent the PPS integration opportunities and challenges. They also developed the Clinical Integration Needs assessment plan. A Cultural Competency & Health Literacy subcommittee reports to the Workforce committee. A VBP subcommittee reports to the Finance Committee.

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 LCHP had reported spending of $2,471,944.00 on administrative costs compared to an average spend of $3,684,862.24 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 LCHP spends $59.26 per attributed life on administrative costs compared to a statewide average spend of $23.93 per attributed life on administrative costs.

[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.

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Looking further at the PPS fund distributions to the PPS PMO, LCHP distributed $2,512,817.00 to the PPS PMO out of a total of $10,428,994.55 in funds distributed across the PPS network, accounting for 27.96% 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 DY2, Q1 PPS Quarterly Report, LCHP included a list of all Community Based Organizations (CBOs) in its organization, and whether they had completed contracts. The IA found that the PPS has contracted with all of the CBOs they have listed as participating in their project and that a large number of them will be compensated for services rendered.

As indicated in the analysis of the funds flow distributions through DY2, Q2, CBOs received $50,034.28, or 0.56%, of funds distributed to date by the PPS. This is less than the state average of 2.3%. 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 LCHP approach to Cultural Competency and Health Literacy (CCHL) was informed by their Community Needs Assessment (CNA) as well as key analyses including the Upstate Health and Wellness Survey, Healthy People 2020, NYS Comprehensive Cancer Control Plan, as well as updated from NYS required community service plans. They identified a key administrative leader within the PPS to oversee partner and consumer engagement work. The CCHL subcommittee determined methods to engage and educate the target population based on information derived from its CNA, community forums, PAM assessments, patient navigation, and key community stakeholders. Further, the PPS plans to identify metrics to evaluate and monitor ongoing impact of CCHL initiatives as well as develop methods to track metrics for annual reporting and publishing on the PPS website.

The IA and PPS had an in depth conversation on the topic of CCHL during the IA onsite visit. The PPS faces a unique challenge in that its region is primarily homogeneous, 98% Caucasian, yet the PPS staff, namely a majority of the medical residents at Bassett Medical Center, are foreign-born. The PPS also noted that its population faces a broad range of socio economic disparities and behavioral health issues. Its LGBTQ population receives services from the Gender Wellness Center, which offers multidisciplinary, trans-affirming health care at one of the PPS practices. The PPS is notable in its efforts to provide medical services to the transgender community in Upstate NY, where only a handful of physician offer trans-affirming care.

The CCHL committee identified the need to train clinical and nonclinical staff across the five counties of the PPS on three main populations, including: LGBTQ, persons with mental and behavioral health issues, and persons with serious illness. The CCHL committee joined the Workforce committee to develop trainings using a web-based platform. The clinical and nonclinical staff must complete these trainings annually.

Financial Sustainability and Value Based Purchasing (VBP)

The PPS Finance Committee developed specifications of the criteria to assess the financial health of network partners. This Financial Assessment Test is performed annually and the initial test established baseline financial metrics. No partners were found to be financially fragile. As part of its Financial Sustainability Plan, the PPS described how it would identify financially distressed partners and established steps to assist such partners, if necessary. In addition, the PPS has budgeted funds for sustaining fragile partners subject to EGB approval.

The PPS indicated it is contracting with partners in a state-mandated VBPQIP program. The PPS does have a VBP subcommittee which reports to the Finance Committee; however, the PPS involvement in VBP has been limited to date.

Funds Flow

Through the DY2, Q2 PPS Quarterly Report, LCHP's funds flow reporting indicates they have distributed 86.16% ($8,985,993.64) of the DSRIP funding it has earned ($10,428,994.55) to date. In comparison to other PPS, the distribution of 86.16% of the funds earned ranks 5th among the 25 PPS and is above the statewide average of 56.2%.

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

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

Total Funds Available (DY1)	**$10,670,793.28**		
Total Funds Earned (through DY1)	**$10,428,994.55 (97.73% of Available Funds)**		
Total Funds Distributed (through DY2, Q2)	**$8,985,993.64 (86.16% of Earned Funds)**		
Partner Type	**Funds Distributed**	**LCHP (% of Funds Distributed)**	**Statewide (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%	3.89%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%	0.73%
Hospital	$4,797,087.56	53.38%	30.41%
Clinic	$48,346.85	0.54%	7.54%
Case Management/Health Home	$90,731.01	1.01%	1.31%
Mental Health	$3,131,63	0.03%	2.43%
Substance Abuse	$93,541.81	1.04%	1.04%
Nursing Home	$703,306.71	7.83%	1.23%
Pharmacy	$0.00	0.00%	0.04%
Hospice	$55,303.03	0.62%	0.16%
Community Based Organizations[7]	$50,034.28	0.56%	2.30%
All Other	$356,578.37	3.97%	5.82%
Uncategorized	$274,812.39	3.06%	0.53%
Non-PIT Partners	$303.00	0.00%	0.58%
PMO	$2,512,817.00	27.96%	41.99%

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

In further reviewing the LCHP funds flow distributions, it is notable that the distributions it has made are primarily directed toward Hospital and PPS PMO partner categories, which represent 81.34% of the funds being directed to these partner categories. The Hospital category is the largest expenditure at 53.4% which is higher than the statewide average of 30.4% for this category. While the PPS has distributed funds across most of the partner categories, the limited distributions to the Mental Health and PCP partners raise a concern. It will be important for the PPS to distribute funds to these key partners to ensure they engage in the PPS' DSRIP implementation efforts.

[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.

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 the LCHP Primary Care Plan did not focus on an overall approach or strategic plan for primary care. The IA also found that the Primary Care plan was often too general and did not provide enough specifics to be able to determine the scale of implementation activities. Lastly, the IA agreed with the assessment that the challenges raised associated with the compensation model and incentives for providers presents a concern for the PPS' primary care strategy related to VBP.

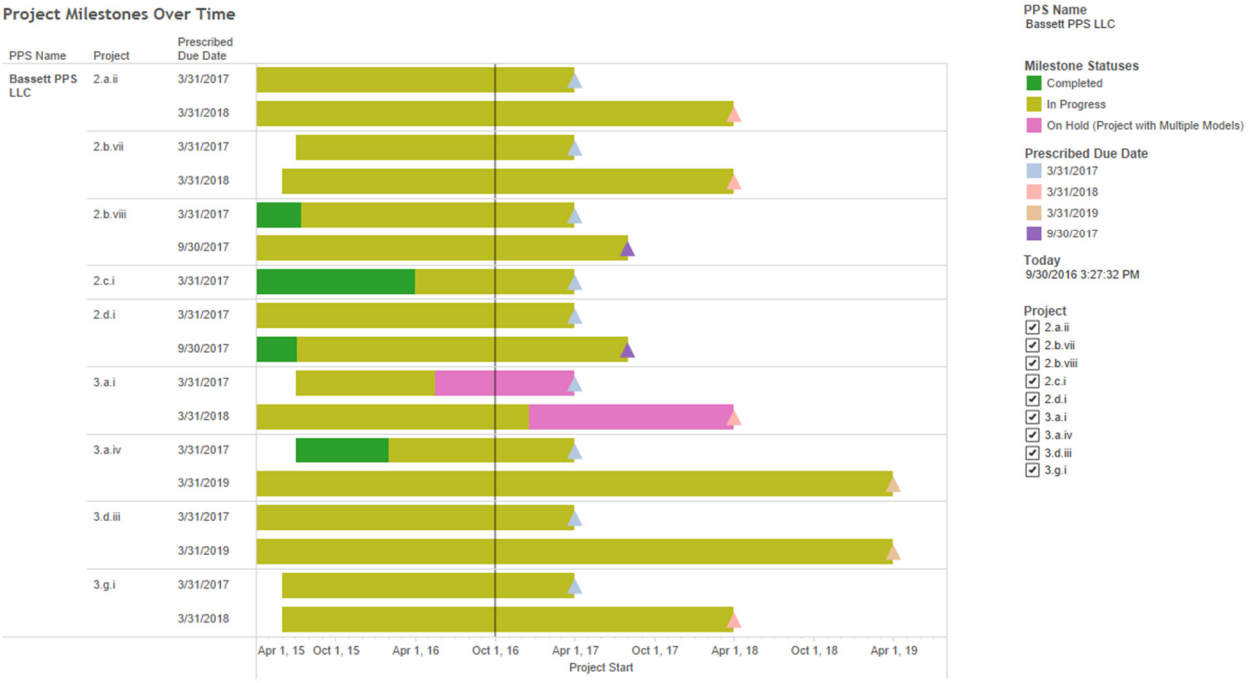
B. Project Assessment

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



Data Source: LCHP 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.

In addition to the risks associated with the current status of milestones with a DY2, Q4 required completion date for project 3.a.i, there are additional risks associated with project 3.a.i which the PPS has committed to a completion date of DY3, Q4. For this project, the PPS has multiple milestones that have a status of 'On Hold'.

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 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 LCHP's performance in meeting the Patient Engagement targets through the PPS Quarterly Reports. The

[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.

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IA identified five projects where the PPS has missed the Patient Engagement targets in at least one PPS Quarterly Report. Figures 7 through 11 below highlight those projects where LCHP has missed the patient Engagement target for at least one quarter.

Figure 7: 2.b.vii. (Implementing the INTERACT project (inpatient transfer avoidance program for SNF)) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	979	703	71.81%
DY1, Q4	1,318	1,408	106.83%
DY2, Q2	1,748	1,211	69.28%

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

Figure 8: 2.c.i (Development of community-based health navigation services) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	275	154	56.00%
DY1, Q4	899	1,055	117.35%
DY2, Q2	1,374	902	65.65%

Data Source: LCHP 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	125	57	45.60%
DY1, Q4	652	261	40.03%
DY2, Q2	978	555	56.75%

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

Figure 10: 3.d.iii. (Implementation of evidence-based medicine guidelines for asthma management) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	176	45	25.57%
DY1, Q4	439	568	129.39%
DY2, Q2	1,031	1,436	139.28%

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

Figure 11: 3.g.i. (Integration of palliative care into the PCMH model) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0.00%
DY1, Q4	276	1	0.36%
DY2, Q2	826	5	0.61%

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

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For projects 2.c.i, 2.d.i, 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.

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 data included in the tables are specifically focused on those partner categorizations where PPS engagement is significantly lagging relative to the commitments made by the PPS.

The data presented in the partner engagement tables in the following pages includes the partner engagement across all defined partner types for all projects where the PPS is lagging in partner engagement. 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.

In many cases, PPS did not have to make commitments to all partner types for specific projects, as indicated by the '0' in the commitment columns in the tables, however PPS may have chosen to include partners from those partner categories to better support project implementation efforts. It is therefore possible for the PPS to show a figure for an engaged number of partners within a partner category but have a commitment of '0' for that same category.

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Figure 12: Project 2.b.viii (Hospital-Home Care Collaborative Solutions) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	0	7
	Safety Net	19	4
Case Management / Health Home	Total	0	3
	Safety Net	0	1
Clinic	Total	0	8
	Safety Net	0	7
Community Based Organizations	Total	0	2
	Safety Net	0	0
Hospice	Total	0	2
	Safety Net	0	0
Hospital	Total	0	6
	Safety Net	5	5
Mental Health	Total	0	0
	Safety Net	1	0
Nursing Home	Total	0	1
	Safety Net	2	1
Pharmacy	Total	0	2
	Safety Net	0	1
Practitioner - Non-Primary Care Provider (PCP)	Total	0	0
	Safety Net	9	0
Practitioner - Primary Care Provider (PCP)	Total	0	0
	Safety Net	12	0

Data Source: LCHP DY2, Q2 PPS Quarterly Report

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Figure 13: 2.c.i (Development of community-based health navigation services) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	0	1
	Safety Net	25	1
Case Management / Health Home	Total	0	5
	Safety Net	1	3
Clinic	Total	0	4
	Safety Net	3	4
Community Based Organizations	Total	0	8
	Safety Net	0	0
Hospital	Total	0	2
	Safety Net	0	2
Mental Health	Total	0	2
	Safety Net	2	2
Pharmacy	Total	0	1
	Safety Net	0	1
Practitioner - Non-Primary Care Provider (PCP)	Total	0	0
	Safety Net	16	0
Practitioner - Primary Care Provider (PCP)	Total	0	0
	Safety Net	12	0
Substance Abuse	Total	0	1
	Safety Net	0	1

Data Source: LCHP DY2, Q2 PPS Quarterly Report

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Figure 14: 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) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	0	1
	Safety Net	23	1
Case Management / Health Home	Total	0	5
	Safety Net	0	3
Clinic	Total	0	4
	Safety Net	4	4
Community Based Organizations	Total	0	8
	Safety Net	0	0
Hospital	Total	0	2
	Safety Net	4	2
Mental Health	Total	0	2
	Safety Net	0	2
Pharmacy	Total	0	1
	Safety Net	0	1
Practitioner - Non-Primary Care Provider (PCP)	Total	0	0
	Safety Net	15	0
Practitioner - Primary Care Provider (PCP)	Total	0	0
	Safety Net	12	0
Substance Abuse	Total	0	1
	Safety Net	0	1

Data Source: LCHP DY2, Q2 PPS Quarterly Report

Figure 15: 3.g.i (Integration of palliative care into the PCMH model) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	152	0
	Safety Net	16	0
Case Management / Health Home	Total	0	2
	Safety Net	0	1
Clinic	Total	1	3
	Safety Net	0	3
Community Based Organizations	Total	2	1
	Safety Net	0	0
Hospice	Total	2	3
	Safety Net	0	0
Hospital	Total	0	3
	Safety Net	0	3
Nursing Home	Total	0	1
	Safety Net	0	1
Pharmacy	Total	0	1
	Safety Net	0	0
Practitioner - Non-Primary Care Provider (PCP)	Total	429	0
	Safety Net	8	0
Practitioner - Primary Care Provider (PCP)	Total	153	208
	Safety Net	12	22

Data Source: LCHP DY2, Q2 PPS Quarterly Report

As the data in Figures 12 through 15 above indicate, the PPS has engaged network partners on a limited basis for each of the four projects highlighted. Of note, no PCPs are engaged in projects 2.b.viii, 2.c.i, and 2.d.i.

Projects 2.c.i, 2.d.i and 3.g.i were also highlighted for the PPS failure to meet Patient Engagement targets in the PPS Quarterly Reports. The combination of the PPS failure to meet Patient Engagement targets and the lagging Partner Engagement across these projects indicates an elevated level of risk for the successful implementation of these projects.

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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.c.i. (Development of community-based health navigation services)

The PPS indicated a series of challenges in implementing this project including a lack of knowledge about community-based health navigation services by both partners and the targeted population. The PPS has also identified a lack of clinical resources to assist in the implementation of this project.

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 indicated challenges as their partners do not understand how to identify the targeted population for this project. The partners also need further education on how to administer the PAM surveys. They are also facing challenges with engaging MCOs in this project.

3.g.i. (Integration of palliative care into the PCMH Model)

The PPS states that some of their partners are reluctant to implement this project as they feel they do not have the capacity necessary.

IV. Overall Project Assessment

Figure 16 below summarizes the IA's overall assessment of the project implementation efforts of LCHP 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 16: Overall Project Assessment

Project	Project Description	Patient Engagement	Project Milestone Status	Partner Engagement
2.a.ii.	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))			
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	X		
2.b.viii.	Hospital-Home Care Collaborative Solutions			X
2.c.i.	Development of community-based health navigation services	X		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		X
3.a.i.	Integration of primary care and behavioral health services			
3.a.iv.	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-			

	based addiction treatment programs			
3.d.iii.	Implementation of evidence-based medicine guidelines for asthma management	X		
3.g.i.	Integration of palliative care into the PCMH model	X		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 17: Project Risk Scores

Project	Project Description	Risk Score	Reasoning
2.a.ii.	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
2.b.vii.	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	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.b.viii.	Hospital-Home Care Collaborative Solutions	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.c.i.	Development of community-based health navigation services	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	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
3.a.iv.	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services)	1	This the lowest risk score indicating the project is more than likely to meet intended goals.

	capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs		
3.d.iii.	Implementation of evidence-based medicine guidelines for asthma 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.
3.g.i.	Integration of palliative care into the PCMH 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.***

VI. IA Recommendations

The IA's review of the LCHP 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. LCHP has achieved many of the organizational and project milestones to date in DSRIP. The PPS has made positive strides to develop the infrastructure to run a successful PPS in their region. The PPS has also extended clinic hours to meet patients where and when they need it.

The IA does have some concerns regarding LCHP's project implementation. The PPS states that they face overarching challenges with how to educate partners and the population concerning the many benefits of the DSRIP program. Additionally, during the IA onsite visit, the PPS self-identified an issue with Performance Reporting. This issue did not affect any AVs and the PPS preemptively created a Corrective Action Plan. In order to address these issues, the IA encourages LCHP to strengthen their community and partner education and engagement to enhance solutions for successful project implementation. The IA also encourages the PPS to identify and pursue resources available outside of the lead entity Bassett Healthcare.

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

Partner Engagement

Recommendation 1: The IA recommends LCHP strengthen their community and partner education and engagement, in particular with entities outside the lead entity, Bassett Healthcare.

Governance

Recommendation 1: The IA recommends the PPS should hire a Compliance Officer who reports directly to the EGB.

Primary Care Plan

Recommendation 1: the IA recommends that the PPS develop an action plan to address the concerns raised in the Primary Care Plan, notably the lack of an overall approach or strategic plan for primary care and the limited detail on the scale o implementation efforts.

Recommendation 2: The IA recommends that the PPS develop an action plan to document its approach to addressing the challenges identified for compensation models and incentives for providers that will impact the PPS' primary care strategy related to VBP.

B. Project Recommendations

2.c.i.: Development of community-based health navigation services

Recommendation 1: The IA recommends the PPS develop a training strategy to educate their partners and the targeted population about community based health navigation services.

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 assist partners in better identifying the targeted population for this project.

Recommendation 2: The IA recommends the PPS develop plan to increase outreach and education materials to partners with respect to patient activation measures.

Recommendation 3: The IA recommends the PPS create a plan to address the shortage of primary care physicians engaged in this project in order to meet their project implementation speed commitments.

Project 3.g.i: Integration of palliative care into the PCMH Model

Recommendation 1: The IA recommends that the PPS create an action plan to increase collaboration between palliative care team members and primary care practices (either onsite or via telemedicine) in order to increase referrals, which will further improve patient engagement shortcomings.