NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Final Report

North Country Initiative PPS

December 2016

www.health.ny.gov

Prepared by the DSRIP Independent Assessor

North Country Initiative

Contents

North Country Initiative

I. Introduction

North Country Initiative PPS (NCI), led by Samaritan Medical Center, serves three counties in the Tug Hill Seaway of New York: Jefferson, Lewis, and St. Lawrence. The Medicaid population attributed to this PPS for performance totals 39,755. The Medicaid population attributed to this PPS for valuation was 61,994. NCI was awarded a total valuation of $78,062,821 in available DSRIP Performance Funds over the five year DSRIP project.

North Country Initiative selected the following 11 projects from the DSRIP Toolkit:

Figure 1: North Country Initiative 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.ii.	Increase certification of primary care practitioners with patient centered medical home certification and/or advanced primary care models (as developed under the NYS Health Innovation Plan (SHIP))
2.a.iv.	Created a medical village using existing hospital infrastructure
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
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.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 (adults only) (diabetes care)
3.c.ii.	Implementation of evidence-based strategies for disease management in high risk/affected populations (adults only) (diabetes care)
4.a.iii.	Strengthen mental health and substance abuse infrastructure across systems
4.b.ii.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings

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
All Other	*2.84*		2.92	2.83	2.63	2.69

[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.

North Country Initiative

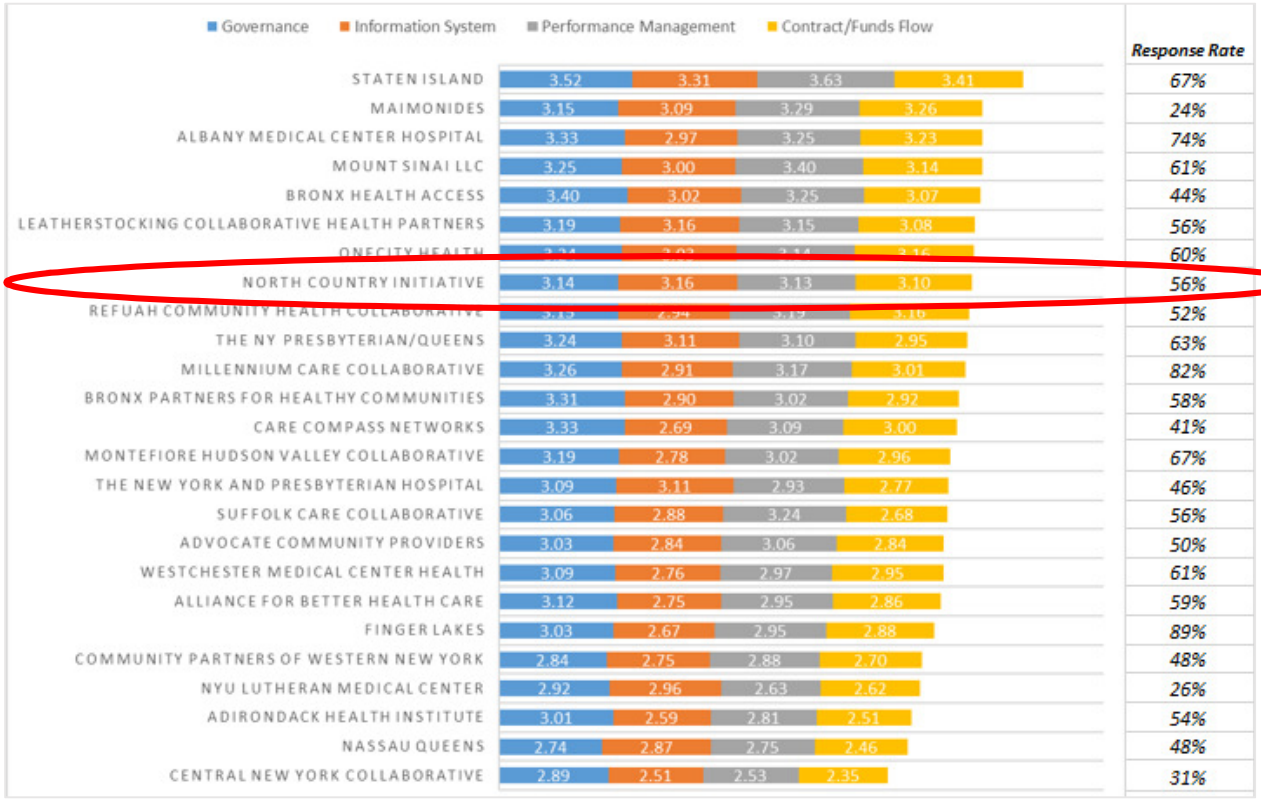
Mental Health	*2.81*		2.94	2.85	2.56	2.75
Hospice	*2.74*		2.93	2.75	2.41	2.41
Practitioner - PCP	*2.66*		2.68	2.66	2.61	2.31
Average by Organizational Area	***2.90***		**3.00**	**2.89**	**2.70**	**2.67**

Data Source: 360 Survey Results

North Country Initiative 360 Survey Results[2]

The NCI 360 survey sample included 43 participating network partner organizations identified in the PIT; 24 of those sampled (56%) returned a completed survey. This response rate was fairly consistent with the average across all PPS (52% completed). The NCI aggregate 360 survey score ranked 8th 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".

North Country Initiative

NCI PPS 360 Survey Results by Partner Type

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 Case Management/Health Home survey result was the highest of all partner categories, which was consistent with all PPS' (4th out 12). Mental Health and Practitioner – Primary Care Provider categories were also low, which was consistent with peer PPS responses. Most negative answers were for the Contracting / Funds Flow and the Performance Management questions.

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

PPS	Partner Type		Respondents over Total Surveyed
North Country Initiative	Case Management / Health Home	3.58	1/2
	Nursing Home	3.50	1/1
	Hospice	3.38	2/2
	Hospital	3.29	2/2
	All Other	3.14	9/12
	Community Based Organization	3.00	1/3
	Practitioner - Non-Primary Care Provider (PCP)	2.82	1/8
	Substance Abuse	2.75	2/2
	Practitioner - Primary Care Provider (PCP)	2.45	3/5
	Mental Health	2.36	2/2
	Clinic	0.00	0/2
	Pharmacy	0.00	0/2
Grand Total			24/43

Data Source: NCI 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 low 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, NCI **earned all available Organizational AVs and earned three of a possible three Patient Engagement Speed AVs.**
- In DY1, Q4, NCI **earned all available Organizational AVs and earned seven of a possible seven Patient Engagement Speed AVs.**

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 submit 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 areas, the PPS are expected to provide quarterly updates on any changes to the milestones

[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.

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 PPS is led by a Board of Managers which is informed by the Project Advisory Committee (PAC), the Health Care Partners of the North County Accountable Care Organization (ACO), and Fort Drum Healthcare Partners, Inc. The Board of Managers is physician led, with 17 of 24 Board members being clinicians. Reporting to the Board are the following committees: Health Information Technology (HIT), Medical Management (Clinical), Payer / Finance, Compliance, and Professional Education & Workforce. Subcommittees reporting to the Clinical Committee include Behavioral Health, Population Health, and Care Connection. A Health Literacy & Cultural Competency subcommittee reports to the Compliance committee. All county agencies are represented on committees. There are also patient advocates involved in every committee. Furthermore, there is a Medical Director for each county which assists the PPS in partner outreach.

The Project Management Office (PMO) works closely with the Fort Drum Regional Planning Organization. The PMO has extensive experience in population health, Community Based Organizations, finance, Information Technology and project management. Of note, the PPS has developed individualized implementation plans for each partner in the PPS and meets each partner in person to discuss their role in DSRIP.

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 NCI had reported spending of $614,787.00 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 NCI spends $15.46 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.

Looking further at the PPS fund distributions to the PPS PMO, NCI distributed $2,463,588.80 to the PPS PMO out of a total of $7,794,988.51 in funds distributed across the PPS network, accounting for 31.60% 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, Q4 PPS Quarterly Report, NCI included a list of all Community Based Organizations (CBOs) in its network, 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.

In reviewing the funds distributions to CBOs, the IA found that NCI has distributed $108,374.20 to its CBO partners. This figure represents 1.39% of all funds distributed to NCI partners 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 NCI approach to Cultural Competency and Health Literacy (CCHL) was informed by their Community Needs Assessment (CNA). The PPS also leveraged focus group feedback, health data, literacy rates, and provider information to develop a robust strategy to train providers and build patient capacity. In conjunction with the PPS wide strategy, a provider-facing training video was developed for regional distribution. Additionally, the PPS created patient education materials to ensure that at-risk community members have the tools they need to sufficiently partner with their provider during the care experience. The PPS has also supported training for three partners to become master trainers for the Bridges out of Poverty program. The PPS has filmed Public Service Announcements to promote mental, emotional, and behavioral health (MEB) cultural competence in clinicians who assist individuals with mental illness and substance abuse disorders. The PPS has also filmed Public Service Announcements which are running at local movie theaters to destigmatize mental illness.

The PPS is using multiple metrics to assess the cultural linguistic competency of its partners. This includes the Consumer Assessment of Healthcare Providers and Systems (CAHPS), PCMH 2014 standards and elements related to CCHL, related clinical quality metrics, and tools such as the vital sign health literacy assessment. Effective strategies employed by the PPS include CCHL focus groups, Patient Activation Measure (PAM) and Coaching for Activation, targeted surveys, and the inclusion of patient advocates in its governance model.

Financial Sustainability and Value Based Purchasing (VBP)

The NCI Finance Committee is responsible for assessing the financial health of its network partners on an annual basis. The PPS contracts with a vendor to conduct this assessment. The vendor conducts analysis and trends to determine if a partner is financially fragile. Partners identified as financially fragile are required to submit their income statements and balance sheets to the subcontractor each quarter. The Finance Committee is responsible for determining the method of assisting financially fragile partners; this assistance is subject to Board approval.

A VBP committee that reports to the Finance Committee conducted a baseline assessment of partner activity and readiness for VBP. This committee developed a webinar and glossary of terms for its partners. The PPS is near completion of a VBP strategy which will be sent to partners. In addition, the PPS is meeting with MCOs to discuss VBP.

Funds Flow

Through the DY2, Q2 PPS Quarterly Report, NCI funds flow reporting indicates they have distributed 66.69% ($7,794,988.51) of the DSRIP funding it has earned ($11,688,960.97) to date. In comparison to other PPS, the distribution of 66.69% of the funds earned ranks 9th among the 25 PPS and falls above the statewide average of 56.20%.

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

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

Total Funds Available (DY1)	$11,688,961.00		
Total Funds Earned (through DY1)	$11,688,961.00 (100.00% of Available Funds)		
Total Funds Distributed (through DY2, Q2)	$7,794,988.51 (66.69% of Earned Funds)		
Partner Type	**Funds Distributed**	**NCI (% of Funds Distributed)**	**Statewide (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$276,501.21	3.55%	3.89%
Practitioner - Non-Primary Care Physician (PCP)	$74,086.88	0.95%	0.73%
Hospital	$911,871.81	11.70%	30.41%
Clinic	$2,742,251.48	35.18%	7.54%
Case Management/Health Home	$115,580.21	1.48%	1.31%
Mental Health	$718,875.21	9.22%	2.43%
Substance Abuse	$129,162.55	1.66%	1.04%
Nursing Home	$76,763.86	0.98%	1.23%
Pharmacy	$8,944.66	0.11%	0.04%
Hospice	$10,899.35	0.14%	0.16%
Community Based Organizations[7]	$108,374.20	1.39%	2.30%
All Other	$108,121.09	1.39%	5.82%
Uncategorized	$49,967.20	0.64%	0.53%
Non-PIT Partners	$0.00	0.00%	0.58%
PMO	$2,463,588.80	31.60%	41.99%

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

In further reviewing the NCI funds flow distributions, it is notable that the distributions it has made are primarily directed toward its Clinic partners and the PPS PMO, which represent 66.78% of the funds being directed to these partner categories. While the PPS has distributed funds across all partner types, it will be important for the PPS to continue distributing funds to its key partners to ensure their continued engagement in the implementation of 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

[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.

demonstrated by the PPS in the Primary Care Plan. The IA agrees with the assessment that NCI produced a "Well-organized, detailed and thorough PC Plan". The IA also agrees that many initiatives are already established and in progress and that NCI had detailed funds flow information available.

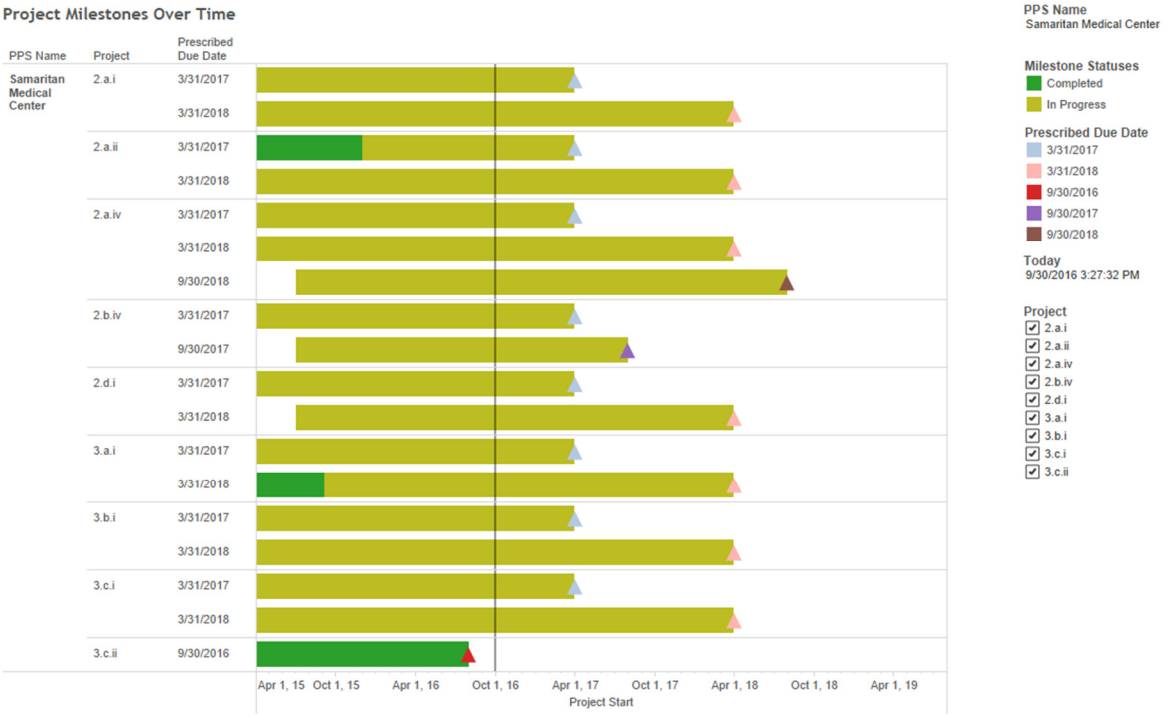
B. Project Assessment

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



Data Source: NCI DY2, Q2 PPS Quarterly Report

Based on the data in Figure 6 above, the IA identified no project risks due to the current status of project implementation efforts.

Patient Engagement AVs

In addition to the analysis of the current project implementation status, the IA reviewed NCI's performance in meeting the Patient Engagement targets through the PPS Quarterly Reports. The PPS earned all available Patient Engagement Speed AVs for DY1. The Patient Engagement numbers reported by the PPS in DY2, Q2 appear to meet their targets but are still subject to IA review and validation. As such, the IA has not identified any projects as at risk due to failed Patient Engagement efforts.

[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.

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.

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.

As documented in the previous sections related to Project Milestone Status, Patient Engagement and, Partner Engagement the IA has not identified any project as being at risk for successful implementation. The IA therefore, has not presented any project narratives for this section.

IV. Overall Project Assessment

Figure 7 below summarizes the IA's overall assessment of the project implementation efforts of NCI 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 7: 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 home certification and/or advanced primary care models (as developed under the NYS Health Innovation Plan (SHIP))			
2.a.iv.	Created a medical village using existing hospital infrastructure			
2.b.iv.	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions			
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.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 (adults only) (diabetes care)			
3.c.ii.	Implementation of evidence-based strategies for disease management in high risk/affected populations (adults only) (diabetes care)			

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 8: 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.ii.	Increase certification of primary care practitioners with patient centered medical home 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.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.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.
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.	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	1	This the lowest risk score indicating the project is more than likely to meet intended goals.

	populations (adult only) (cardiovascular health)		
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (diabetes care)	1	This the lowest risk score indicating the project is more than likely to meet intended goals.
3.c.ii.	Implementation of evidence-based strategies for disease management in high risk/affected populations (adults only) (diabetes care)	1	This the lowest risk score indicating the project is more than likely to meet intended goals.

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

VI. IA Recommendations

The IA's review of the North Country Initiative 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. NCI PPS has achieved many of the organizational and project milestones to date in DSRIP. The PPS has successfully leveraged existing resources of the Fort Drum Regional Health Planning Organization that existed prior to DSRIP to support the infrastructure of the PPS. The PPS also places a strong emphasis on community outreach and working with CBOs to promote DSRIP goals.

The IA recognizes there is an ongoing shortage of health care workforce in this region; however, the PPS Workforce Committee has developed a number of programs to address the creation of a long term pipeline of workers. The PPS has a provider incentive program to recruit PCPs who commit to stay in the region. They are collaborating with community colleges and SUNY to develop programs geared toward nurse practitioners, social workers, and care coordinators. The IA recommends the PPS continue to pursue creative solutions to address its ongoing workforce needs.

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 and VBP

Recommendation 1: The IA recommends the PPS develop a strategy to enhance partner engagement with MCOs to achieve VBP goals.

B. Project Recommendations:

Following a review of the Patient Engagement, Milestone Status, and Partner Engagement metrics for this PPS, the IA has determined that no projects are currently at risk. Therefore, the IA does not have any specific project recommendations at this time. The IA encourages the PPS to continue to pursue creative solutions to IT, workforce, telemedicine, and transportation challenges across all projects.