NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Redline (following 1st Public Comment)

Adirondack Health Institute

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Prepared by the DSRIP Independent Assessor

Contents

Adirondack Health Institute

I. Introduction

Adirondack Health Institute PPS (AHI) (made up of Adirondack Health, Glens Falls Hospital, Hudson Headwaters Health Network, and UVM Health Network – CVPH) serves nine counties in Northern New York: Saratoga, Hamilton, Franklin, Clinton, St. Lawrence, Fulton, Essex, Warren, and Washington. The Medicaid population attributed to this PPS for performance totals 81,090. The Medicaid population attributed to this PPS for valuation was 143,640. AHI was awarded a total valuation of $186,715,496 in available DSRIP Performance Funds over the 5 year DSRIP project.

AHI selected the following 11 projects from the DSRIP Toolkit:

Figure 1: AHI 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 homes certification and/or advanced primary care models
2.a.iv.	Created a medical village using existing hospital infrastructure
2.b.viii.	Hospital home-care collaboration solutions
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.ii.	Behavioral health community crisis stabilization services
3.a.iv.	Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs.
3.g.i.	Integration of palliative care into the patient centered medical home model
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

[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.

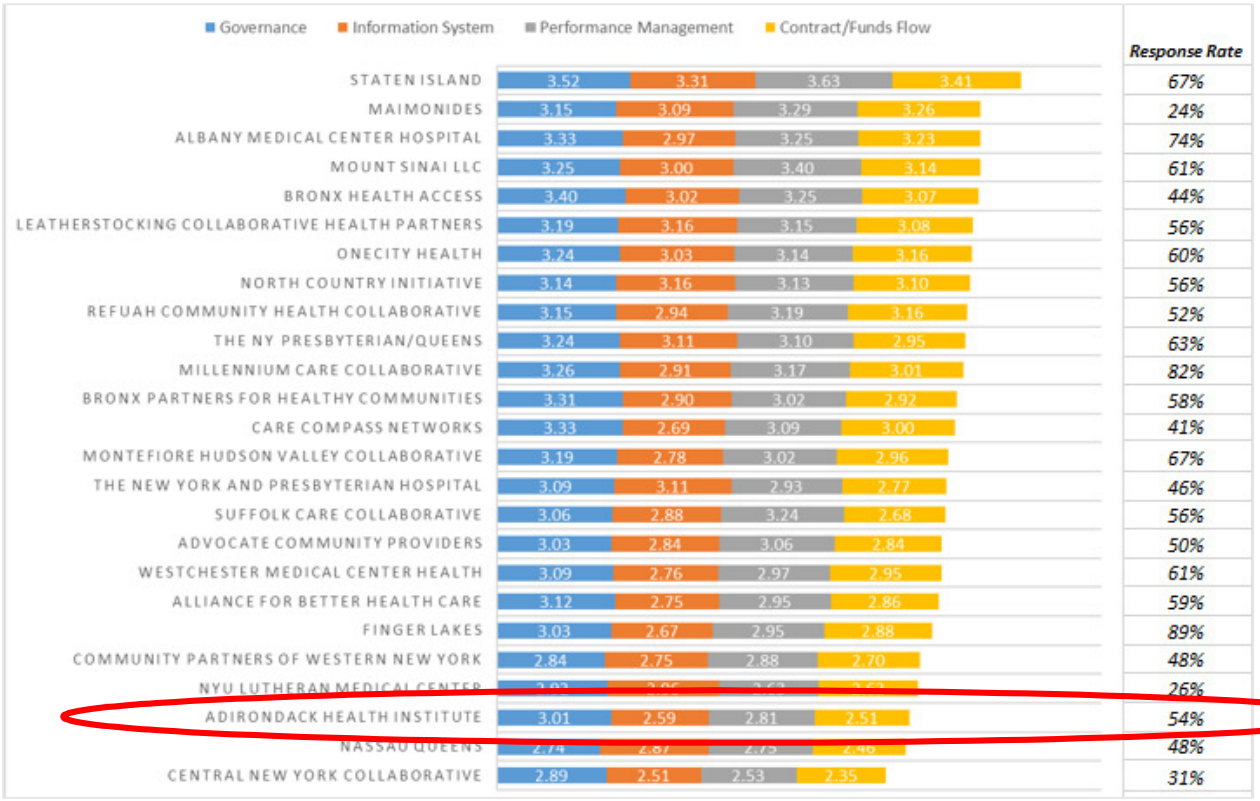
All Other	*2.84*		2.92	2.83	2.63	2.69
Mental Health	*2.81*		2.94	2.85	2.56	2.75
Hospice	*2.74*		2.93	2.75	2.41	2.41
Practitioner - PCP	*2.66*		2.68	2.66	2.61	2.31
Average by Organizational Area	***2.90***		**3.00**	**2.89**	**2.70**	**2.67**

Data Source: 360 Survey Results

Adirondack Health Institute 360 Survey Results[2]

The AHI 360 survey sample included 26 participating network partner organizations identified in the PIT; 14 of those sampled (54%) returned a completed survey. This response rate was fairly consistent with the average across all PPS (52% completed). The AHI aggregate 360 survey score ranked 20th out of 25 PPSs (Figure 3).

Figure 3: PPS 360 Survey Results by Organizational Area



Data Source: 360 Survey Data for all 25 PPS

AHI Survey Results by Partner Type

The IA then analyzed the survey response by partner category to identify any trends by partner type. Figure 4 below identifies and ranks the average survey responses. Primary Care Provider responses ranked 3rd within AHI, much higher than that across all PPS' (12th out of 12). The Case

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

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Management/Health Home survey result was low (9th out of 12), which was unusual compared to all PPS' (4th out 12). Mental Health and Hospice categories were also low, which was consistent with peer PPS responses. There were no Community Based Organization responses, whereas across PPS, CBOs ranked 3rd of 12. Most negative answers were for the Contracting / Funds Flow and the IT Solutions questions.

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

PPS	Partner Type		Respondents over Total Surveyed
Adirondack Health Institute	Nursing Home	3.00	1/1
	Practitioner - Non-Primary Care Provider (PCP)	2.83	3/7
	Practitioner - Primary Care Provider (PCP)	2.82	1/2
	Substance Abuse	2.73	1/2
	Hospital	2.42	1/1
	Clinic	2.40	1/2
	All Other	2.29	4/5
	Case Management / Health Home	2.25	1/2
	Hospice	2.25	1/2
	Community Based Organizations	0.00	0/2
	Mental Health	0.00	0/0
	Pharmacy	0.00	0/0
Grand Total			14/26

Data Source: AHI 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, AHI **earned all available Organizational AVs and had no commitments for Patient Engagement Speed.**
- In DY1, Q4, **AHI earned all available Organizational AVs and earned zero of a possible two 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 support documentation to substantiate the successful completion of milestones across key organizational areas such as Governance, Cultural Competency and Health Literacy, Workforce, Financial Sustainability, and Funds Flow to PPS partners. Following the completion of the defined milestones in each of the key organizational 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

[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.

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 Directors which is representative of a broad spectrum of partners across its region. Reporting to the Board is the AHI Steering Committee, which is responsible for strategic leadership and general oversight of the PPS. Reporting to the Steering Committee are a number of subcommittees, including: Finance, Clinical Governance and Quality, IT and Data Sharing, Community Beneficiary and Engagement, and Network and Workforce. AHI has 20 staff dedicated entirely to DSRIP, with 13 additional staff who provide expertise and experience to complete organizational work stream and project activities.

The PPS is organized into five Population Health Networks (PHNs), which are ultimately responsible for driving change. AHI stated that its role is to act as a resource to support the PHN activities, rather than provide direct oversight of partner activities.

PPS Administration and Project Management Office

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 AHI had reported spending of $3,566,983.00 on administrative costs compared to an average spend of $~~3,758,965.56~~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 AHI spends $43.99 per attributed life on administrative costs compared to a statewide average spend of $~~24.23~~23.93 per attributed life on administrative costs.

Looking further at the PPS fund distributions to the PPS PMO, AHI distributed $4,491,403.56 to the PPS PMO out of a total of $12,501,682.22 in funds distributed across the PPS network, accounting for 35.93% of all funds distributed through DY2, Q2. Comparatively, the statewide average for PPS PMO distributions equaled $5,966,502.64 or 42.85% of all funds distributed.

The data on the administrative costs and PMO funds flow distributions present a point of comparison across PPS, however do not alone provide enough information from which the IA can

[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.

assess the organizational capacity of the PPS to support the implementation of DSRIP. It is important for the PPS to invest in the establishment and maintenance of an organizational infrastructure to support the PPS through the implementation of the DSRIP projects to ensure the PPS success in meeting its DSRIP goals.

Community Based Organization Contracting

As part of the DY1, Q3 PPS Quarterly Report, AHI 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 some but not all of the CBOs they have listed as participating in their project.

AHI also indicated that a significant number of the CBOs would be compensated for services rendered on behalf of the PPS. As indicated in the analysis of the funds flow distributions through DY2, Q2, CBOs received 2.03% or $253,271.04 of funds distributed to date by the PPS.

Cultural Competency and Health Literacy

The AHI approach to Cultural Competency and Health Literacy (CCHL) was informed by their Community Needs Assessment (CNA) and a community needs assessment survey distributed to PPS partners. The PPS convened a Community and Beneficiary Engagement (CBE) Committee in October 2015. The committee meets quarterly and has 16 members primarily from CBOs and public agencies. This committee guides the CCHL strategies and Community Engagement plan for the PPS. In addition, the PPS convened community forums to gather feedback to help address health disparity priority areas. The PPS intends to educate health care consumers as part of the CCHL strategy using tools such as “Ask Me 3” and conducting community forums. The PPS plans to increase efforts to engage community members through social media, community events, and other promotional vehicles.

The CCHL training strategy was developed with input from the Workforce Committee and was approved by the Steering Committee in June 2016. This strategy focuses on general CCHL principles and application and also uses evidence-based trainings to address health disparity priority groups. This training will be conducted online through a learning management system. The PPS is collaborating with Alliance for Better Health and Albany Medical PPS to streamline training efforts and implement CCHL champions in overlapping service areas. To date, the PPS has conducted training of 200 staff members within its PPS partners.

Financial Sustainability and Value Based Purchasing (VBP)

The PPS Finance Committee established the financial structure of the PPS, developed Policies and Procedures for oversight, and completed a financial stability plan for the PPS. They conducted a financial stability analysis of 111 partners to assess the overall financial health of the network. This assessment will be performed on an annual basis. As a result of the initial survey, the PPS identified one financially fragile partner. To address this, the PPS met with the partner to develop a performance improvement plan. Additionally, this partner is subject to increased monitoring while the PPS provides additional consulting services. As part of the AHI Financial Stability Plan,

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."

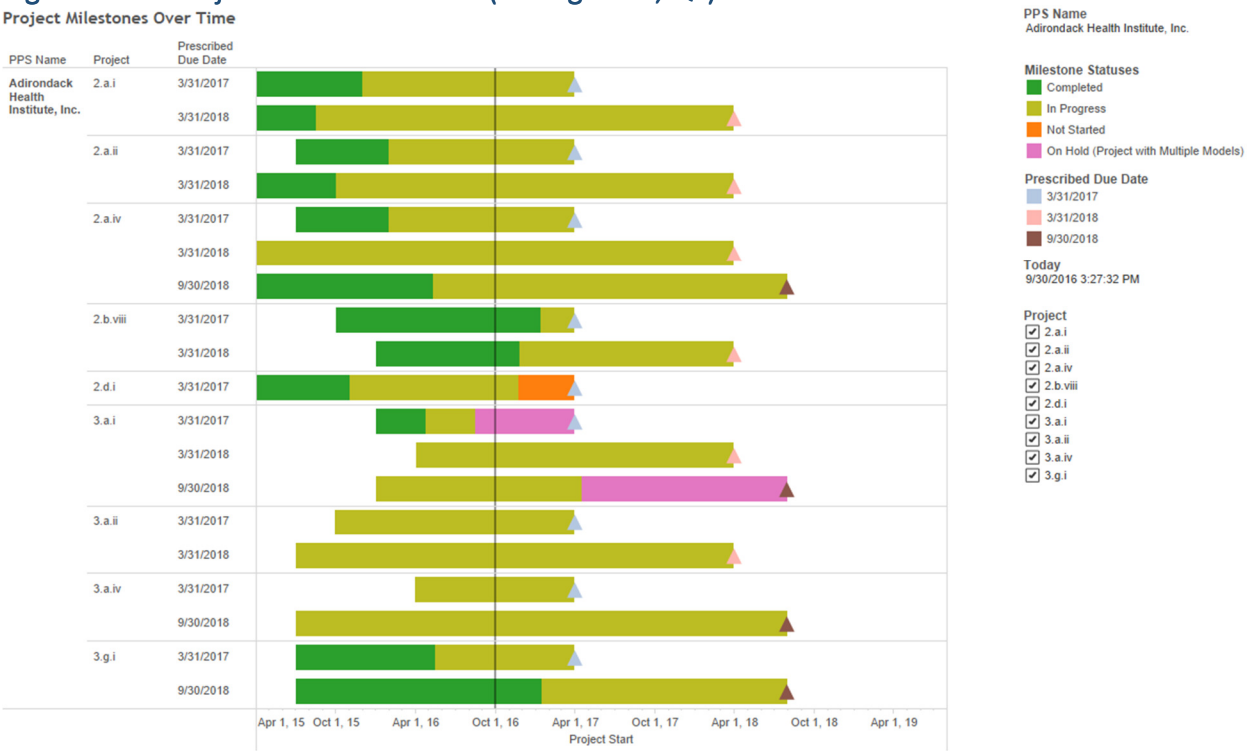
B. Project Assessment

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[9]	49,500	~~7,708~~6,177	~~15.57%~~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[10]	1,042	~~320~~220	~~30.71%~~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[11]	28,000	~~2,601~~2,583	~~9.29%~~9.23%

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

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

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

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

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[12]	6,619	~~1,588~~1,027	~~23.99%~~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[13]	2,100	~~818~~352	~~38.95%~~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[14]	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[15]	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.

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

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

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

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

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		

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