NORTHCOUNTRY
INITIATIVE
Collaborating for better healthcare

SAMARITAN MEDICAL CENTER – DSRIP FIDUCIARY LEAD

NCI DSRIP – Telling the story

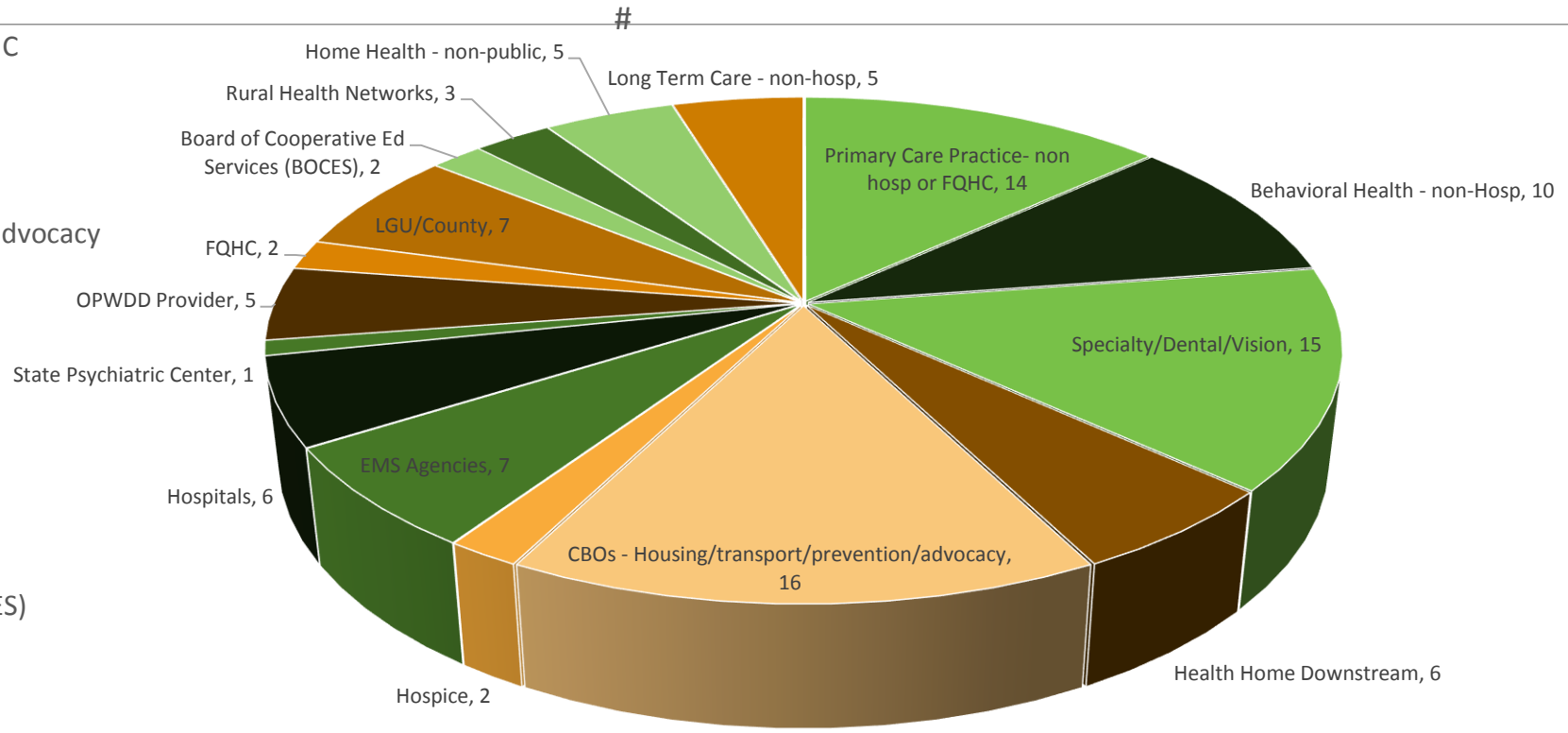
1. Who do we serve. Who are our partners.
2. Governance - What is our structure, who sits where
3. Building the Workforce – the three questions
4. Maximizing the Linkages – with other population health programs and with our CBOs and LGUs/Counties
5. Reaching the PCMH Milestones for Primary Care – Getting from here to there
6. Integration of Primary Care and Behavioral Health

Who do we serve – Tughill-Seaway Region

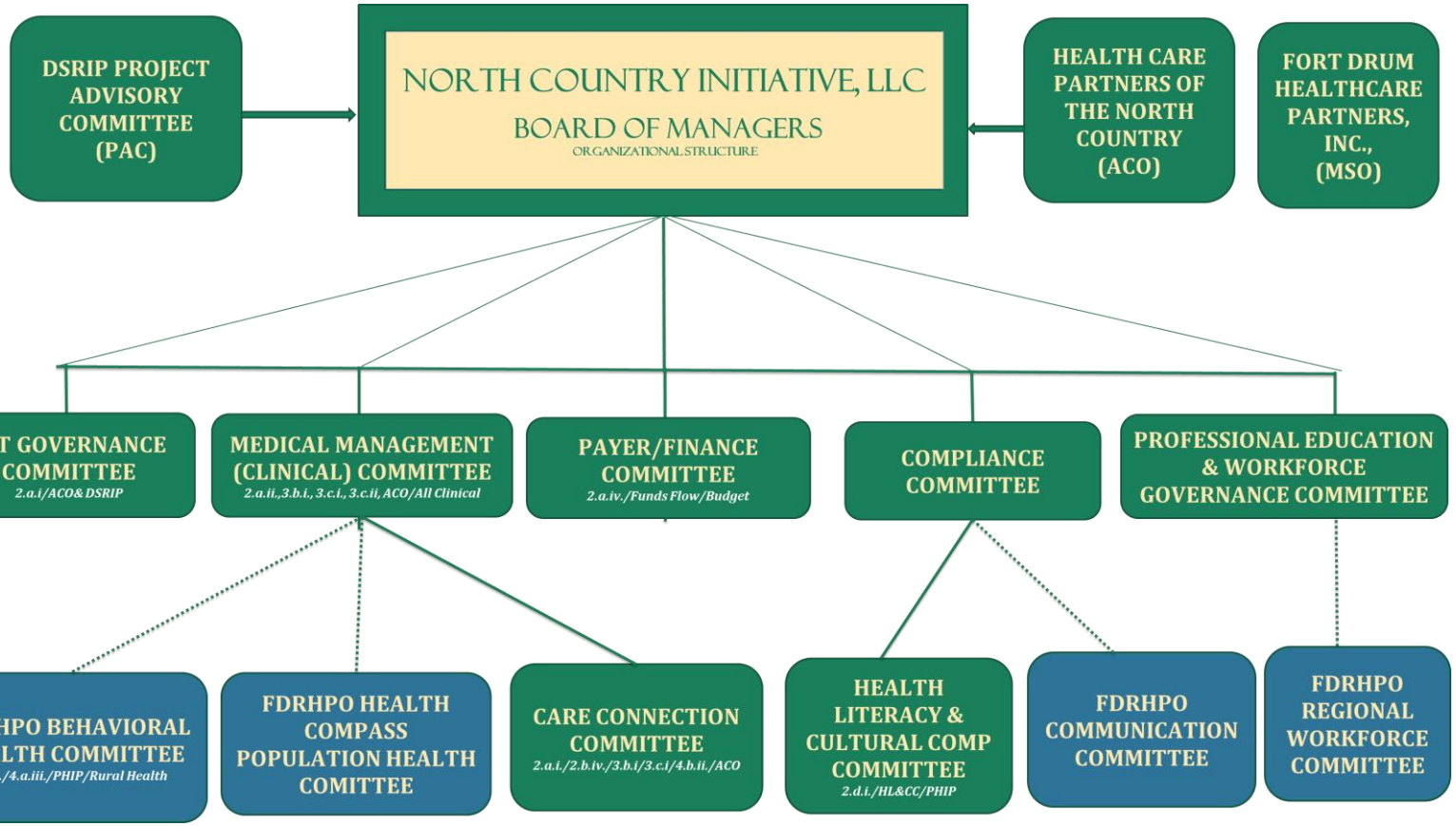
1. Location - Jefferson, Lewis, St. Lawrence Counties in Northern NY along Canadian Border
2. Population - 262,650
3. Land-Mass/ Population Density - 5,224 square miles of land mass. Population density is 50 persons per square mile
4. Demographics – 92% white, 91% English Speaking, Median Income $11,000 less than NYS, Poverty rate exceeds NYS in all three counties (1 in 4 children live in poverty), both disability and unemployment rates are significantly higher than statewide average
5. Primary Health Disparity – Socio-economic
6. Other Cultural Considerations – Generational, Amish, St. Regis Reservation, cultural variations between physician population and region's population
7. Largest employers – Healthcare, Military, Education
8. Leading causes of avoidable hospitalizations & ED use – Mental Illness, cardiovascular disease, respiratory disease, diabetes and substance abuse
9. Leading causes of death – heart disease, cancer, respiratory disease, stroke and diabetes.
10. Other Health indicators - Suicide rate is nearly double NYS rate, less than 50% of children receive the recommended number of well-child visits, and over 40% of third graders have untreated tooth decay
11. Health Professional Shortage Areas for primary care, mental health and dental.

NCI Partners

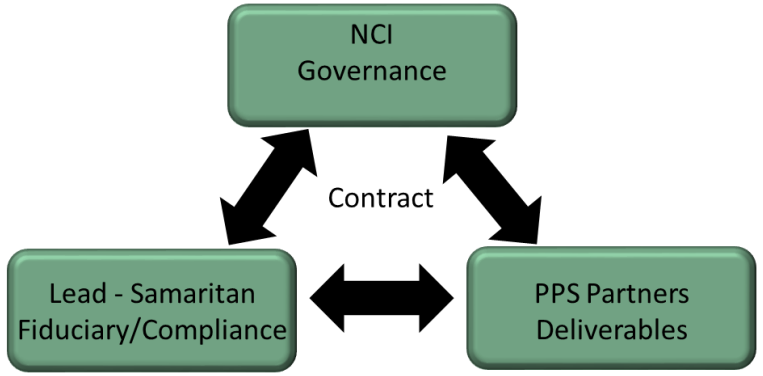
- Primary Care Practice- non hosp or FQHC
- Behavioral Health - non-Hosp
- Specialty/Dental/Vision
- Health Home Downstream
- CBOs - Housing/transport/prevention/advocacy
- Hospice
- EMS Agencies
- Hospitals
- State Psychiatric Center
- OPWDD Provider
- FQHC
- LGU/County
- Board of Cooperative Ed Services (BOCES)
- Rural Health Networks
- Home Health - non-public
- Long Term Care - non-hosp



North Country Initiative (NCI)
Governance Structure



NCI PPS Contractual Responsibilities



NorthCountry Initiative

Budget

Project Implementation Costs - 25% (includes Workforce, PCMH&PHM Vendors, Marketing and PH Media

Costs for Services Not Covered - 12% CHWs, DPP, Care Manager, PAM Navigators - Contractual

Incentive Payments – 30%

Revenue Loss - 15%

Other - 18%
Contingency (10%), Innovation (5%), High Performance (3%)

Funds Flow

NYS DOH 100%

Safety Net Fiduciary Lead Contract for PPS under NCI Governance

Safety Net Partners 95%

Non-Safety Net Partners 5%

Building the Workforce

How is your PPS working with community-based providers on workforce and training?

- Community Health Workers
- Patient Navigators
- Care Managers/Coordinators
- Patient Activation Measure
- Health Literacy & Cultural Competency - RFP
- Community Forums & Hot Spotting
- Committee Involvement

A. What types of jobs are being anticipated in the "emerging titles" category and

B. How are training and career ladders being discussed?

•EMERGING TITLES

- Community Health Workers
- Patient Navigators
- Care Managers/Coordinators
- Health Information Technology

•SHORTAGES

- Physicians (Family Practice, Internal Medicine, Psychiatry)
- Nurse Practitioners
- Physician Assistants
- Dentists
- Psychologists & Social Workers
- Certified Diabetes Educators

•TRAINING/CAREER LADDERS

- Development & sustainment of certificate program (i.e. Care Coordination, HIT)
- Online, self-directed learning & webinars (i.e. IMPACT & Chronic Care Professional)
- Bachelors & Masters level programs at Community College (i.e. NP, MSW)
- Pipeline Programs
- Regional GME Expansion
- Provider Incentive Program (recruitment, retention & education)

How is training being designed so that the workforce is able to meet the performance outcomes that the PPS must achieve?

- Project by project analysis
- Prioritize by speed, scale & impact
- Learning Management Platform for online learning
- Targeted audience & direct employer outreach
- Geographically located and/or offered via distance learning (i.e. webinars, online)
- DSRIP 101
- Interdisciplinary teams & cross committee involvement
- Frontline worker engagement & participation to inform the process
- PPS Collaboration (i.e. AHI & CNY)

Maximizing the Linkages

Rural Health Network Development Program (RHNDP)

Key Objectives:

- **Implement a regional web-based health data system (North Country Health Compass[1])**
- **Develop a regional Community Health Assessment and implement a regional Community Health Improvement Plan**
- **Engage patients to improve chronic disease outcomes**
- **Collaborate with other northern NY Rural Health Networks**

Delivery System Reform Incentive Payment (DSRIP)

Key Objectives:

- **Engage the uninsured and Medicaid customers**
- **Strengthen the mental health and substance abuse infrastructure through data sharing, cultural & linguistic training, disorder prevention, and health promotion**
- **Increase access to high-quality chronic disease preventive care and management**
- **Reduce avoidable hospitalizations and ED use by 25%**
- **Conduct "*hotspotting*" to connect high risk populations to primary and preventive care**

GOALS:

Assess and Improve Population Health
Strengthen Population Health Infrastructure
Improve Access to Primary and Prevention Care
Eliminate Health Disparities

Population Health Improvement Program (PHIP)

Key Objectives:

- **Convene key population health stakeholders[3]**
- **Serve as regional population health data resource**
- **Support public health agencies and hospitals to advance the Prevention Agenda**
- **Support regional workforce initiative, health information technology strategy and DSRIP**
- **Implement a community and patient engagement tool[4]**

State Health Innovation Plan (SHIP)

Key Objectives:

- **Improve access to care for all regional residents**
- **Promote population health**
- **Develop workforce strategy**
- **Maximize health information technology**
- **Performance measurement & evaluation**

[1] www.NCNYHealthCompass.org
[2] Utilizing the Patient Activation Measure (PAM) developed by Insignia Health
[3] Regional Population Health Coalition (North Country Health Compass Partners)
[4] North Country Vitals website (to be launched by Fall 2015)

North Country HEALTH COMPASS

Hospitals
Local Health Departments
Fort Drum MEDDAC
Human Service Agencies
Federally Qualified Health Center
Behavioral Health Providers
Rural Health Networks
Health Insurers
Prevention Councils
Patient Advocate
Schools
Faith Groups
Fitness Facility
Chamber of Commerce

Established April 2013

IMPACT

- Developed population health data portal
- Developed regional Health Assessment and Health Improvement Plan
- Engaged diverse stakeholders and community coalitions
- Implemented policies addressing community needs (oral health, tobacco control, cancer screening)
- Raised awareness of community-based prevention resources (using paid media, direct patient engagement and social media)

NCI Health Literacy and Cultural Competency

COMMITTEE

Patient Advocate
Communication Coordinators
Hospitals
Behavioral Health Providers
Prevention Councils
Local Health Department

Established January 2015

Community Health Worker

COLLABORATIVE

Patient Advocate
Local Health Department
Federally Qualified Health Center
Behavioral Health Providers
Prevention Councils
Charitable Organizations

Established April 2015

Patient Activation Measure

Work Group

Patient Advocates/ Peer Support
Federally Qualified Health Center
Hospitals
Behavioral Health Providers
Prevention Councils
Local Health Department
Charitable Organizations
Housing Providers
Transportation Provider
Developmental Disability Service Providers

Established June 2015

Reaching the PCMH milestones

HIT Road Map

Tentative Timeline for DSRIP

NORTHCOUNTRY INITIATIVE

April 1, 2015	March 31, 2016	March 31, 2017	March 31, 2018
PCMH 1 Entities, 1 Sites, 3 Providers	**PCMH** 10 Entities, 18 Sites, 75 Providers	**PCMH** 11 Entities, 23 Sites, 85 Providers
PHM 5 Entities, 5 Sites, 24 Providers	**PHM** 15 Entities, 15 Sites, 113 Providers	**PHM** 8 Entities, 12 Sites, 21 Providers
HIE 31 Entities, 33 Sites, 143 Providers	**HIE** 35 Entities, 45 Sites, 52 Providers	**HIE** 18 Entities, 42 Sites, 88 Providers
Meaningful Use 16 Entities, 16 Sites, 85 Providers	**Meaningful Use*** 13 Entities, 13 Sites, 175 Providers	**Meaningful Use*** 3 Entities, 3 Sites, 178 Providers
Telemedicine 11 Entities, 11 Sites, 104 Providers	**Telemedicine** 17 Entities, 17 Sites, 51 Providers	**Telemedicine** 5 Entities, 5 Sites, 12 Providers
Assess Privacy Security	Blood Pressure Monitors 2 Months	Assess Privacy Security	Assess Privacy Security

* Meaningful Use occurs annually therefore providers accumulate

What are your plans for reaching PCMH/APC milestones?

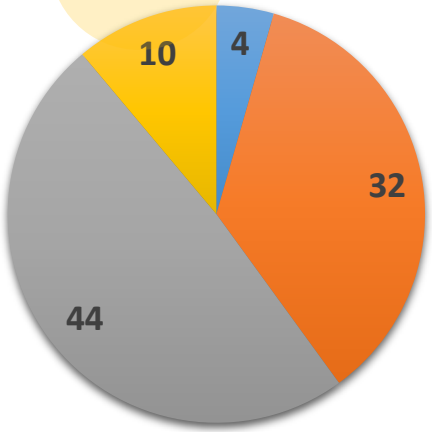
HIT Key Performance Indicators 11/9/2015

Link to Definition Slide 1

Link to Definition Slide 2

Telemedicine

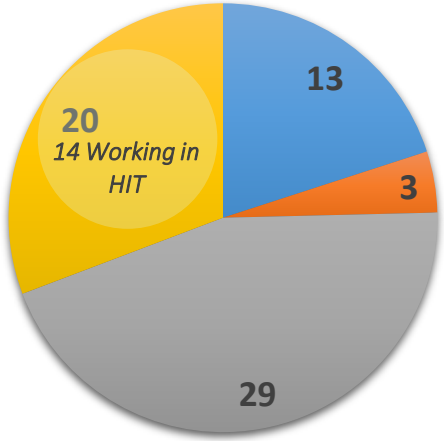
Over 200 patient visits



90 Sites

- In Queue
- Engagement
- Implementation
- Production

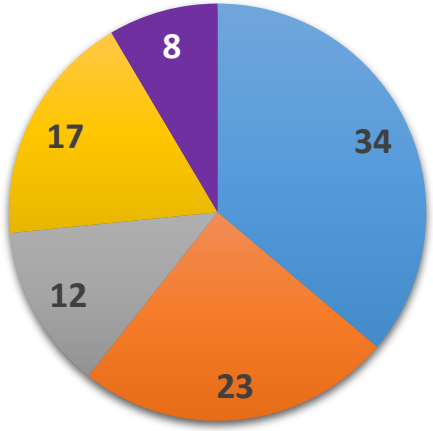
Health IT Workforce Training



45 Recruited Trainees

- In Training
- Dropped Out
- Trained
- Trained & Certified

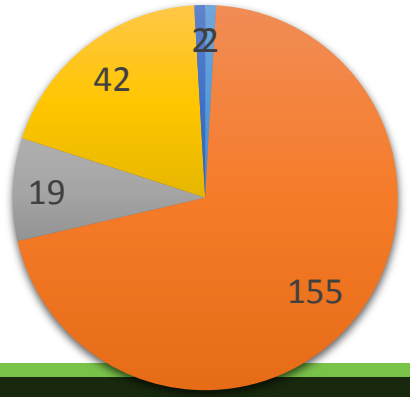
Health Information Exchange (HIE)



148 Sites

- In Queue
- Engagement
- Implementation
- Connected Direct
- Connected Send\Receive

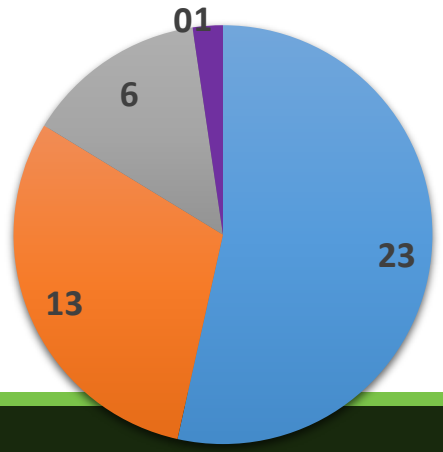
Meaningful Use (MU)



219 Eligible Providers

- In Queue
- Engagement
- Implementation
- Submitted - Stage 1
- Submitted - Stage 2

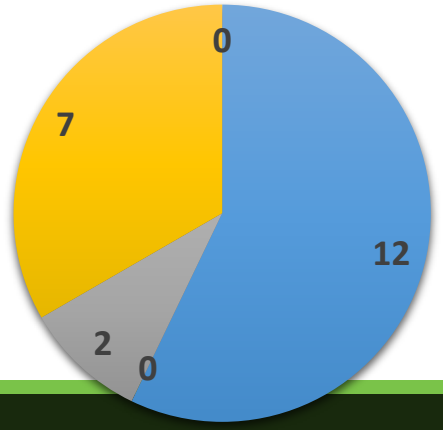
Patient-Centered Medical Home (PCMH)



42 Sites

- In Queue
- Engagement
- Implementation
- Submitted
- Recognized

Connectivity to Disease Registry



21 Practices/Clinics (Entities)

- In Queue
- Engagement
- Implementation
- Optimization
- Production

Integration of Behavioral Health & PC

1. Over 90% of NCI Primary Care Capacity implementing one of the three models
2. Independent practices already training depression care managers
3. PCMH Certified Content Experts will be trained to incorporate Impact model into PCMH workflow
4. Co-locating PC with BH at two BH sites
5. Co-locating BH with PC at multiple hospital based PC sites
6. May be the single most important thing we can do.

Closing thought…

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Questions?

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