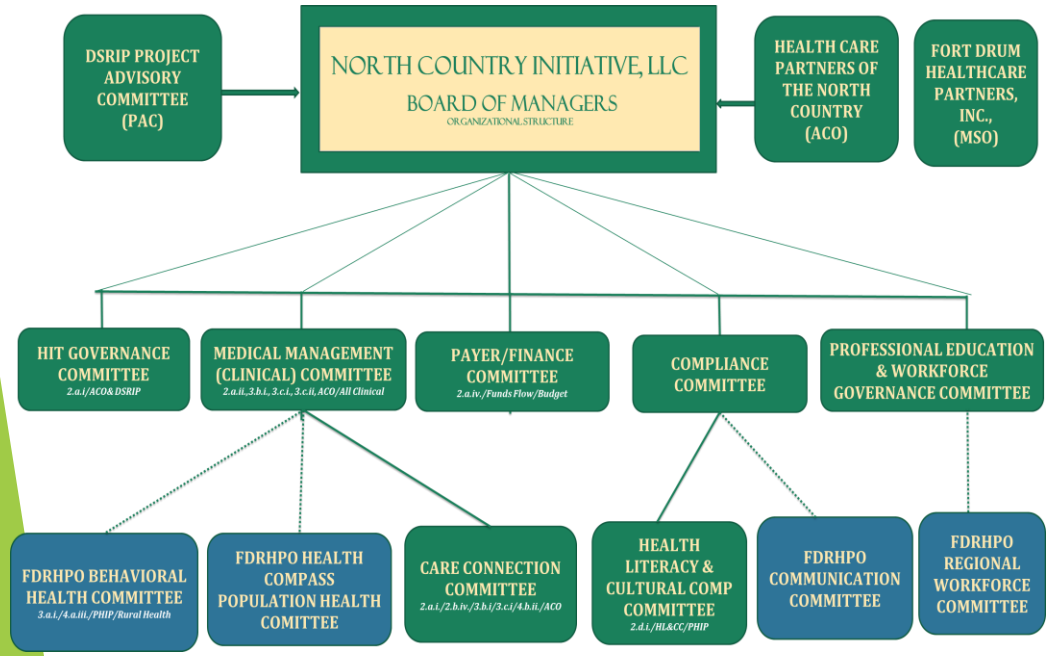
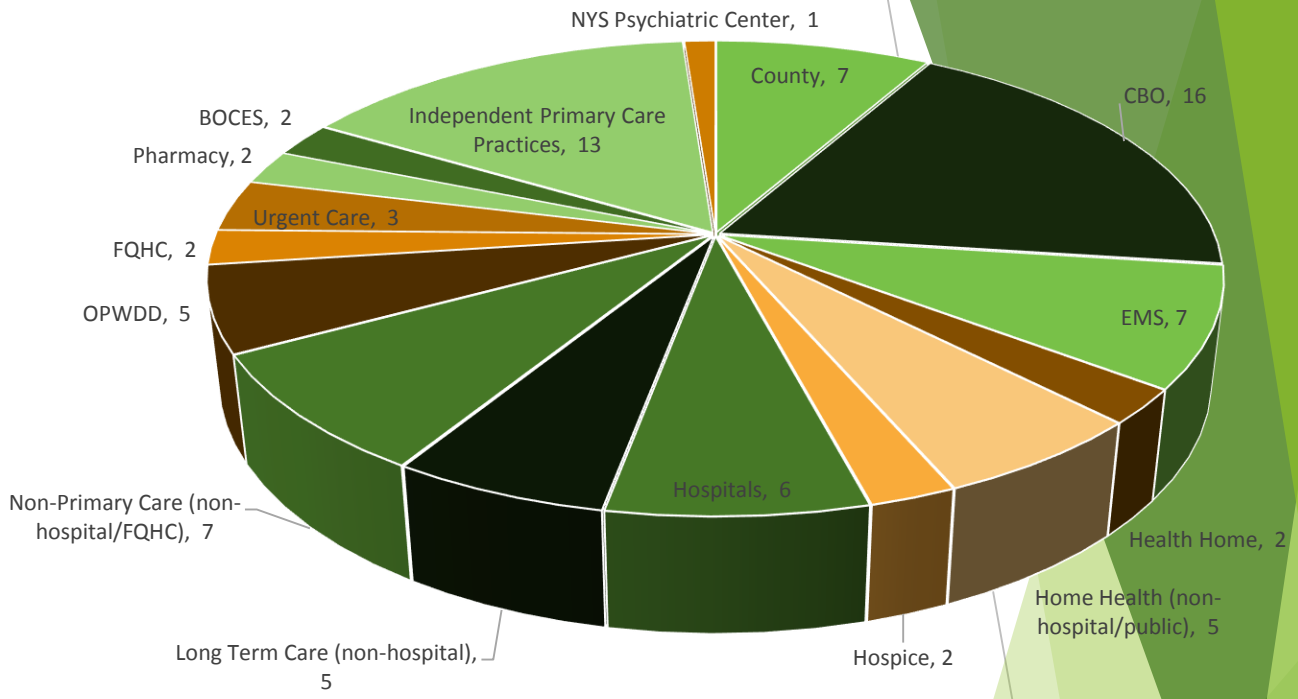
NORTHCOUNTRY
INITIATIVE

Governance/Partner Engagement

A physician led governance structure, with 18 of 24 board members being clinicians





A full committee structure with partner representation across the care continuum. CBO and Primary Care engagement throughout.

NORTHCOUNTRY INITIATIVE

Value Based Purchasing

2015

- VBP Committee Formation
- VBP Baseline Survey to all PPS Partners
- Release of VBP Education (i.e. Webinar and Glossary of Terms)

2016

- PPS commenced meetings with MCOs
- VBP bootcamps attended by PPS & partners
- VBP Baseline Assessment approved by Finance & Board

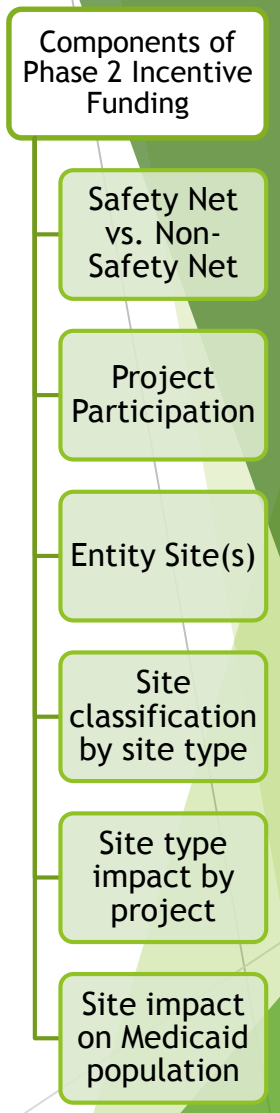
2017

- Targeted survey to primary care & behavioral health partners
- Increased membership to the VBP Committee to include a wider representation of partners
- Targeted educational opportunities to various site types
- Implementation Plan development
- Identify and contract with a facilitator experienced in value based contracting
- Population Health tool to reflect Medicaid data and associated DSRIP measures
- Creation of NCI IPA
- Sign VBP arrangement with at least one MCO

NORTHCOUNTRY INITIATIVE

Finance – Funds Flow

- Partners engaged in the development of the multifaceted approach to phase 2 incentive funding
- All partners received projections for phase 2 funding through 2020
- Incentive funds paid to all active partners within a project for:
  - Reaching performance measures (paid 2x/year)
  - Achieving patient engagement targets (paid 2x/year)
  - Recognition for PCMH Level 3 (5 sites, $175,000 to date)
- Additional opportunities to receive direct funding:
  - Workforce recruitment ($2.5 million to date)
  - Revenue loss- hospitals only ($1.1 million to date)



NORTHCOUNTRY INITIATIVE

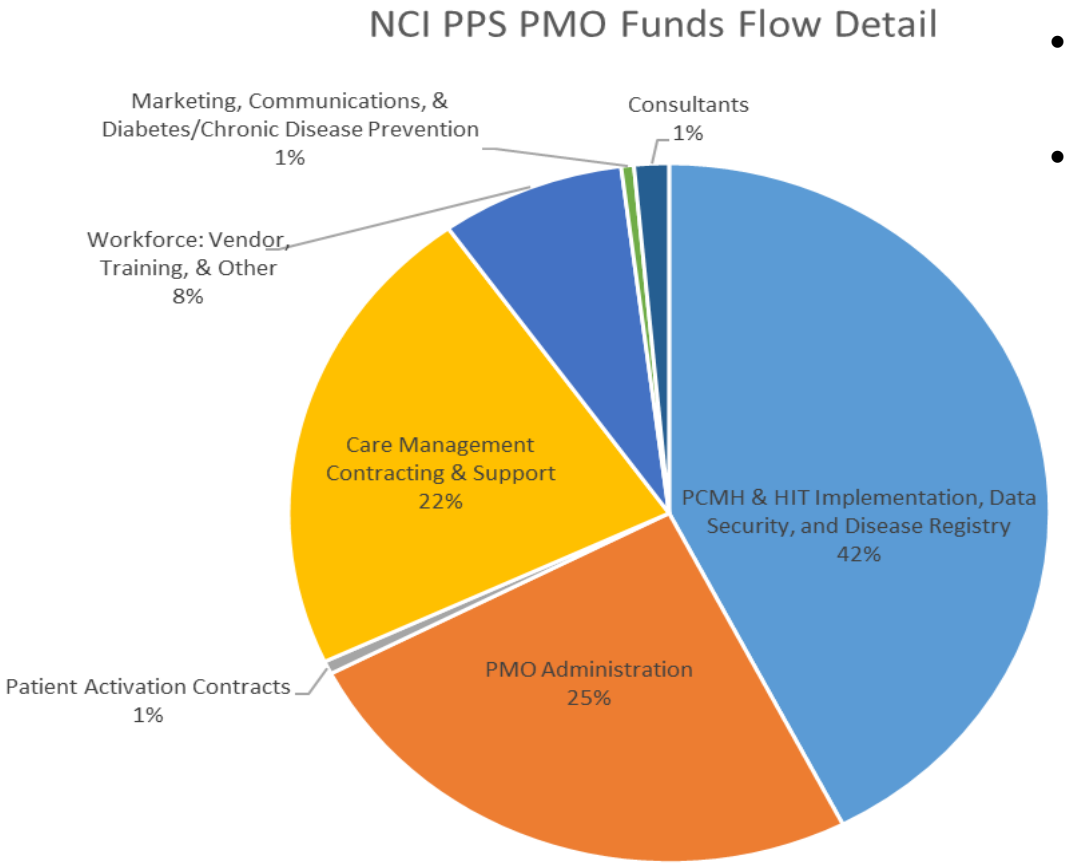
Funds Flow by Provider Type

Provider Type	Total # Entities for Funds Flow	Total Dollars through DY2Q2	# of Community Organizations	$ to Community Providers
All Other	14	$ 108,121.09	2	$ 40,904.53
Case Management	6	$ 115,580.21	6	$ 115,580.11
Clinic	12	$ 2,742,251.48	5	$ 739,411.14
Community Based	17	$ 108,374.20	17	$ 108,374.20
Hospice	3	$ 10,899.35	0	$ -
Hospital	6	$ 911,871.81	0	$ -
Mental Health	9	$ 718,875.21	6	$ 346,212.38
Nursing Home	6	$ 76,763.86	0	$ -
Pharmacy	2	$ 8,944.66	0	$ -
Non-PCP	4	$ 74,086.88	0	$ -
PCP	11	$ 276,501.21	0	$ -
Substance Abuse	4	$ 129,162.55	3	$ 117,598.67
Uncategorized	16	$ 49,967.20	11	$ 39,351.12
Total to Providers	**110**	**$ 5,331,399.71**	**50**	**$ 1,507,432.15**
Total to PMO PPS		**$ 2,463,589.29**		
Total Funds Flow		**$ 7,794,989.00**		

- All Other → St. Lawrence NYSARC, DPAO
- Case Management → Public Health, ACR, JRC
- Clinic, Community Based → FQHCs, NNYCP, Planned Parenthood
- Mental Health → TLS, House of the Good Shepherd, St. Lawrence Psych Center, Children's Home
- Substance Abuse → Credo, Rosehill
- Uncategorized → Catholic Charities, Community Services, Hospitality House, EMS

NORTHCOUNTRY INITIATIVE

PPS PMO Funds Flow Detail



- Funds Flow to the PPS PMO represents only 32% of all Funds Flow
- Within the PPS PMO expenses, 42% are for PCMH & HIT Implementation, Data Security, and Disease Registry

Table 1: NCI Funds Flow Table with PMO PPS detail

Provider Type	Total Dollars through DY2Q2
Total to Providers	**$ 5,331,399.71**
Total to PMO PPS	**$ 2,463,589.29**
PCMH & HIT Implementation, Data Security, and Disease Registry	$ 1,045,968.38
PMO Administration	$ 614,787.15
Care Management Contracting & Support	$ 545,129.78
Workforce: Vendor, Training, & Other	$ 192,991.57
Consultants	$ 36,359.95
Patient Activation Contracts	$ 14,971.81
Marketing, Communications, & Diabetes/Chronic Disease Prevention	$ 13,380.65
Total Funds Flow	**$ 7,794,989.00**

NORTHCOUNTRY INITIATIVE

Cultural Competency & Health Literacy

How the PPS is addressing disparities by race, ethnicity, geography, and access to primary care and/or other preventative services:

- As identified by the **DSRIP Community Needs Assessment**, the health disparities affecting residents within the PPS are overwhelmingly driven by low socio-economic status
- To a far lesser degree, other health disparities observed within the region are driven by ethnic and/or cultural variation in small populations including the Akwesasne (Native Americans) in Northern St. Lawrence County (near Massena Memorial Hospital) and the Amish populations throughout the three counties (Jefferson, Lewis and St. Lawrence)
- The PPS has therefore given specific attention to the health needs of the most vulnerable community members – Medicaid beneficiaries and the uninsured. All efforts to improve access to care address the barriers (e.g. transportation, cost, hours of service, location of service).
  - Transportation – partnered with and supporting the work of Volunteer Transportation Center in collaboration with the Medicaid Transportation System
  - Cost – offering preventive screenings at little or no cost in clinical and community settings
  - Hour of service – promoting a review of clinical hours (via PCMH) to accommodate the needs of the vulnerable
  - Location of services – Medical village, integrating BH and PC, mobilizing services to “hot spot” communities

Cooperative Agreements

Community Health Workers/Insurance Navigators:

- Agreement with a PPS CBO, the North Country Prenatal-Perinatal Council, to resource all primary care practices in the PPS with CHW.
- Will also be a vehicle for targeted efforts to reach folks not fully engaged in healthcare through potential placement at EDs, and targeted outreached based on PAM results or community hot spots.
- Approximately $1,100,000 is expected to be invested in this effort throughout DSRIP.

Behavioral Health Peer Supports:

- Agreement with a PPS CBO, the Northern Center for Independent Living, to resource all primary care practices in the PPS with a BH Peer Support.
- Will also be a vehicle for targeted efforts to reach folks not fully engaged in healthcare through potential placement at EDs, and targeted outreached based on PAM results or community hot spots.
- Approximately $1,100,000 is expected to be invested in this effort throughout DSRIP.

Certified Diabetes Educators:

- Agreement with 3 regional leads to resource all primary care practices with CDEs
- Approximately $450,000 is expected to be invested in this effort throughout the remainder of DSRIP.

Tobacco Cessation:

- Agreement with a regional lead to resource tobacco cessation at hospitals, primary care teams, and community partners to assist patients in targeted high need (hot spot) areas to quit tobacco use.
- Approximately $300,000 is expected to be invested in this effort throughout the remainder of DSRIP.

NORTHCOUNTRY INITIATIVE

Workforce

- **Leveraging Long-term Pipeline**
  - *Career exploration programs*
- **Collaborating with Institutions of Higher Education**
  - *Bachelors & Masters Programs at community college (i.e. Nurse Practitioner & Social Worker)*
  - *Development of North Country Care Coordination Certificate Program with SUNY Jefferson & SUNY Canton*
- **Customized Training Videos** *(DSRIP 101, Blood Pressure Measurement, Health Literacy & MEB, Medicaid Health Home, Care Transitions)*
- **Provider Incentive Programs**
  - *Approximately $3 million for recruitment of 8 Primary Care Physicians, 6 Family Nurse Practitioners, 2 Psychiatric Nurse Practitioners, 5 Physician Assistants, 2 Psychologists, 2 Psychiatrists, 2 Dentists, 4 Certified Diabetes Educators (growth), 1 Licensed Clinical Social Worker (growth) & 6 Licensed Clinical Social Worker-R (5 growth, 1 recruit)*
- **Regional Expansion of Graduate Medical Education**
  - *Partner hospital – recipient of Rural Residency GME Grant. PPS providing support of residency spots at local GME Program with rotations at regional sites. Minimum 3 year service commitment to region*

3ai: Impact Model

- Consulting Psychiatrist hired to support the 5 IMPACT Model practices & provide education to PPS providers (i.e. psychotropic medications)
- Standardized policies, procedures & evidence-based guidelines adopted by all 5 practices for medication management, care engagement & consultations with the psychiatrist
- Customized patient education materials being provided by the PPS for all practices
- All 5 practices utilizing the AIMS Center CMTS (Care Management Tracking Software) to enroll and monitor patients in the program
- Movement from weekly to monthly 1-hour coaching calls with the AIMS Center ("Learning Collaborative" model with all 5 practices)
- 3 of the 5 eligible practices approved for OMH Collaborative Care Program (Medicaid Case Rate). Medicare Reimbursement also underway for eligible practices.
- AIMS Center IMPACT Trial Results indicate: 50% or greater improvement in depression at 12 months
- "How the IMPACT Model is Making an IMPACT"

NORTHCOUNTRY INITIATIVE

3cii: Chronic Disease Self Management Program and National Diabetes Prevention Program

North Country Initiative (only PPS in the State participating in this project)

- All milestones as well as speed and scale were completed
- All Primary Care Practices in the PPS are screening and referring
- CDSMP/NDPP Programs across the PPS (including CBO's) are connected directly to PCP's through secure messaging through the RHIO
- 12% increase in participation in these programs in 2016, and we expect a sharp increase in 2017
- Funds distributed to program providers to offset costs and/or incentivize patient participation
- Specific to the NDPP Program: NCI providers have observed an average of 7% weight loss for participants who complete the program.

NORTHCOUNTRY INITIATIVE

North Country Initiative (NCI): Sustainability

NCI was created prior to DSRIP

- A Clinically Integrated Network since 2013
- Formed Healthcare Partners of the North Country a regional ACO in 2014 (providing experience with VBP contracts)

Strategic effort to leverage partner resources

- Leverages partner organizations i.e. Fort Drum Regional Health Planning Organization to assist with implementation of contracts and initiatives
- Targeted investments in HIT infrastructure will allow NCI to be successful in contracting

VBP Participation

- In process of creating an IPA, on-track for executing value-based arrangements by end of 2017
- Staffing will be adjusted to reflect only what is necessary in meeting current goals (ie. VBP goal - data analyst, compliance officer & finance director)
- Focusing our resources (staff and dollars) on plans that will assist the overall goals of our provider partners, our MCO partners, and the State.

Leadership

- NCI is physician led and partners have the committee representation to help create direction (better engagement and support of regional project)

Continued: Engagement-Analysis-Planning-Collaboration-Responsiveness

NORTHCOUNTRY INITIATIVE

Thank You for the Privilege to be Part of such a monumental effort; As said by Martin Luther King Jr.

"True compassion is not flinging a coin at a beggar, it comes to see that an edifice which produces beggars needs restructuring."

NorthCountry Initiative

Appendix 1: Financial Sustainability further detail

NorthCountry Initiative

Financial Sustainability

- Assessment of Network Partners
  - PPS Essential Partners are monitored to ensure sustainability
  - An Essential Partner is a safety-net partner with total project involvement over 220 project valuation points
    - County agencies and private entities were omitted from monitoring
  - The NCI DSRIP Finance Committee has been entrusted with the responsibility to assess the financial health of network partners
  - The PPS subcontracts with Fust Charles-Chambers to provide the financial assessment consisting of the criteria in Table 1
    - Essential Partner Financial Summary
    - Detail Assessment Example: SMC
  - Essential Partners who have an overall rating <40 points are considered Financially Fragile

Table 1:

Ratios	Ratio Weight	Measure		
		Red	Yellow	Green
Financial Metric		0%	50%	100%
Days Cash on Hand	30%	< 25 days	25-50 days	> 50 days
Current Ratio	25%	< 1.0	1.0 to 1.5	> 1.5
Debt Service Coverage Ratio	15%	< 0	0 to 1.2	> 1.2
Debt to Capitalization Ratio	10%	> 50%	40% to 50%	< 40%
Operating Cash Flow Margin	20%	< 2.5 %	2.5% - 5.0%	> 5.0%
OVERALL RATING	100%	< 40 pts	40-60 pts	> 60 pts

NORTHCOUNTRY INITIATIVE

Financial Sustainability

- Monitoring of Financially Fragile
  - Essential Partners identified as Financially Fragile are required to submit their income statements and balance sheets to the subcontractor each quarter
    - Note: Hospitals will be required to submit these financials every quarter regardless of their status
  - Ongoing analysis and trends will be analyzed by the subcontractor and PPS to determine if the NCI DSRIP Finance Committee will need to intervene on sustainability efforts
  - The following steps will be taken should a partner need assistance:
    1. Financially Fragile partner review status, trends, & solutions with the subcontractor
    2. Partner reviews impact assessment and internal sustainability plan
    3. Partner reaches out to the PPS if they conclude that their financial status will have an impact on completing the DSRIP project deliverables
    4. NCI DSRIP Finance Committee determines method to assist partner & receives NCI Board approval
    5. Funding may be made available through the following budget categories:

       Revenue Loss, Other: Contingency, or Workforce Recruitment

Appendix 2: Cultural Competency & Health Literacy further detail

NorthCountry Initiative

Cultural Competency & Health Literacy

Efforts for Implementing Training Plan Across the PPS

- What materials have you developed to train people on CC/HL?
  - The PPS has developed the following materials:
    - North Country Initiative – Health Literacy & Cultural Competency Introductory Video [3 minutes] (Pat Fontana, Jr, *MA*) https://www.youtube.com/watch?v=ZsX0ha_rIBg
    - MEB promotion, prevention and treatment: regional testimony video and public service announcements (PSAs) in collaboration with 4th Coast Productions [15-20 minute video and 30 second PSAs]
    - NCI Customized video: An Introduction to the Medicaid Health Home
      - https://www.surveymonkey.com/r/NCIHealthHome
    - NCI Customized video: Care Transition Protocols
      - https://www.surveymonkey.com/r/CareTransitionProtocols

Cultural Competency & Health Literacy

Efforts for Implementing Training Plan Across the PPS

- Materials NCI has developed to train people on CC/HL
  - North Country Initiative – Health Literacy & Cultural Competency Introductory Video [3 minutes] (Pat Fontana, Jr, *MA*) https://www.youtube.com/watch?v=ZsX0ha_rIBg
  - MEB promotion, prevention and treatment: regional testimony video and public service announcements (PSAs) in collaboration with 4th Coast Productions [15-20 minute video and 30 second PSAs]
  - NCI Customized video: An Introduction to the Medicaid Health Home https://www.surveymonkey.com/r/NCIHealthHome
  - NCI Customized video: Care Transition Protocols https://www.surveymonkey.com/r/CareTransitionProtocols
- Engagement of Collaborators
  - The PPS has established a Cultural Competency and Health Literacy Committee comprised of representatives from hospitals, local health departments, advocacy organizations, mental health services, and substance abuse prevention
  - The group met monthly until policies and the training plan were developed, then quarterly to monitor progress
  - The PPS engages its diverse set of collaborators via:
    - Trainings
    - *e*Newsletters
    - In-person meetings

Cultural Competency & Health Literacy

- Available Tools
  - Awareness Building Resources
    - Introduction to Health Literacy and Cultural Competency; Patient Safety; Healthcare Communication; Mental, Emotional, Behavioral Health testimonials; Introduction to Health Homes, Care Transition Protocols
  - Skill Building Resources – Healthcare Stakeholders
    - Choosing Wisely; Bridges to Health and Healthcare; Plain Language; Health Literacy for Public Health Professionals; Cultural Competency for Physicians; Cultural Competency for Nurses; Cultural Competency for Oral Health Professionals; Cultural Competency in Mental Health Programs; LGBT Training Curricula for Practitioners; Chronic Care Professional Certification, Collaborative Care (IMPACT) training, Bridges Out of Poverty
  - Skill Building Resources – Community Members
    - Ask Me 3; Literacy of Northern NY

Cultural Competency & Health Literacy

The measures the PPS is using to demonstrate the extent that it is reaching, identifying and engaging attributed patients, particularly those that are underserved or heard to reach

- Patient Activation Measure (PAM) engagement and scoring metrics for the Medicaid and uninsured populations
  - Derived from critical interfaces with underserved populations (i.e. emergency rooms, patient navigators, insurance navigators, care managers)
- Medicaid Managed Care Organization (MCO) and Health Home patient rosters
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) completed by the Medicaid and uninsured populations
- Quality metrics
- Community forums
- Patient portals

Cultural Competency & Health Literacy

The most effective strategies by the PPS

- Cultural Competency and Health Literacy focus groups
- Patient Activation Measure (PAM) and Coaching for Activation
- Targeted surveys
- Inclusion of patient advocates in governance model

Appendix 3: Project 3cii National Outcomes

NORTHCOUNTRY INITIATIVE

3cii: National Outcomes

- **DPP:** Evidence-based program with research indicating the program helps people lose 5% to 7% of their body weight through healthier eating and 150 minutes of physical activity a week.
- **CDSMP**: According to the evidence base, subjects who enrolled in the program, when compared to those who did not, demonstrated significant improvements in exercise, cognitive symptom management, communication with physicians, and self-reported general health. They also spent fewer days in the hospital, and there was also a trend toward fewer outpatients visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:4. Many of these results persist for as long as three years.
- **DSME/P**: According to a randomized, controlled study to test the workshop's effectiveness, six months after the workshop, participants had significant improvements in depression, symptoms of hypoglycemia, communication with physicians, healthy eating, and reading food labels. They also had significant improvements in patient activation and self-efficacy. At 12 months, DSMP participants continued to demonstrate improvements in depression, communication with physicians, healthy eating, patient activation, and self-efficacy.