NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Adirondack Health Institute PPS

Appendix PPS Narratives

November 2016

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Prepared by the DSRIP Independent Assessor

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting the overall organizational efforts to date.

PPS Name: Adirondack Health Institute, Inc.

Highlights and successes of the efforts:

AHI PPS

Overarching Organizational Component Workstream Summary Narrative

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Project 2.a.i - "Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management" Summary Project Description Narrative

As of June 30, 2016

Element	Description
Summary	**Project 2.a.i:** Create an integrated, collaborative and accountable service delivery structure that incorporates the full continuum of care, eliminating service fragmentation while increasing the opportunity to align provider incentives. This project will facilitate the creation of this structure by incorporating the medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system from one that is institutionally-based to one that is centered on community-based care. The integrated delivery system (IDS) will be accountable for delivering accessible evidence-based, high quality care in the right setting, at the right time, at the appropriate cost. To achieve an integrated delivery system, the PPS must collaborate as a network providing a coordinated continuum of services to ultimately achieve the goals of improving efficiency, quality and access to care. This project aims to increase the opportunity to align provider incentives through the use of population health management strategies and active collaboration. The goal of the project is to transition the health care delivery focus to value-based and evidence-based care by incorporating medical, behavioral health, post-acute and long-term needs. **Cultural Competency and Health Literacy:** The AHI PPS Cultural Competency and Health Literacy (CCHL) workstream seeks to align the capabilities and competencies of providers with the diverse and complex needs of the individuals to whom they provide care and services. Doing this will improve health outcomes and address health disparities within the nine county PPS service region. The

PPS is working with community-based organizations, trusted experts within the communities they serve, to incorporate them as a resource for developing and promoting practices for enhancing the quality and efficacy of health care services. Relevant evidence-based trainings, and other pertinent educational and informational opportunities, are being made available to the PPS workforce, and feedback will be sought from community members and DSRIP beneficiaries in order to ensure AHI PPS cultural competency and health literacy initiatives are meaningful and valuable.

Governance:

AHI PPS has taken a collaborative approach to Governance, seeking broad participation from our partners on PPS committees. The AHI PPS Steering Committee, which reports to the AHI Board of Directors, has six sub committees: Finance, Clinical Governance and Quality, Workforce, Community and Beneficiary Engagement, IT and Data Sharing and Network. Most of these sub committees also have identified several work groups. AHI PPS sought representation across our regions, partners and sectors to populate these committees and work groups. AHI PPS covers all of six upstate New York counties as well as portions of three more for a total of about 13,000 square miles. In order to effectively manage implementation of DSRIP projects across this expanse, AHI PPS has five Regional Health Innovation Teams (RHIT) which bring together the partners to implement the projects that are active in their region. The Committees and RHITs are supported by the Project Management Office (PMO), including a team of project managers that each support administrative activities for several projects.

Practitioner Engagement Strategy:

The engagement of the AHI PPS practitioners is critical to our success in restructuring the health care delivery system to achieve the primary goal of reducing avoidable hospital use by 25% over 5 years.

More than 100 organizations including hospitals, primary care providers, specialists and mental health / substance use providers have joined together to form the AHI PPS “integrated delivery system”.

Each of these providers is integral to developing a fully functioning medical neighborhood; a clinical-community partnership that includes the *medical* and *social supports* necessary to enhance health, with the PCMH serving as the patient's primary “hub” and coordinator of health care delivery.

Population Health Management:

Population health management (PHM) is an important focus for the AHI PPS as we prepare for value-based reimbursement and risk contracting.

Our more than 100 partner organizations represent a diverse sector of the Northern New York/Adirondack region across multiple settings of care:

- Hospitals
- Primary & specialty care providers
- Mental health and substance abuse treatment providers
- Skilled nursing facilities, and others.

These organizations have joined together as a clinically integrated network to provide patient-centered care across the continuum.

A number of key themes emerged as we developed the network:

- The importance of advancing primary care into comprehensive team-based care;
- The need to manage the care of high-risk patients closely;
- The need to develop medical neighborhoods and enable primary care physicians and specialists to work more closely together;

The importance of also engaging hospitals and post-acute facilities, as well as behavioral health providers.

Workforce:

Having the right workforce is vital to successful health care transformation in our region. The Workforce Workstream is tasked with developing a comprehensive set of strategies to attract, train and retain staff in targeted occupations taking in to consideration the unique needs of our PPS, including:

- Large rural regions
- Aging population (including the workforce)
- Large overall geographic region

Budget

One of the key elements in transforming the health care delivery system in New York state is transferring the waiver dollars to our network partners and providers to help fund the programs and initiatives that will lead to a 25 percent reduction in avoidable hospital use and transition to a system rooted in Value Based Payment.

The Budget Workstream is where AHI PPS:

- Accounts for waiver revenue received
- Provides a budget as to how waiver revenue will be allocated by expenditure category, project, and provider type
- Details all dollars actually spent in comparison to budget
- Tracks the flow of funds to AHI PPS partners

Ultimately, the Budget Workstream is responsible for the Funds Flow Plan which details how AHI PPS plans to flow funds to partners in order to achieve the goals of DSRIP and transform the health care delivery system.

Financial Sustainability

Ensuring the financial health of the network members is a key step in building a high functioning integrated delivery system capable of reducing avoidable hospital admissions and transitioning the system to one centered on Value Based Payment. The charge of the financial stability workstream is:

- Developing the financial structure of AHI PPS
- Perform assessment of the financial health of the network partners
- Enacting a compliance plan for AHI PPS
- Assessing the value based payment readiness of network partners
- Designing a plan to achieve 90% value based payments across the network by the end of DSRIP year 5

These actions will lead the AHI PPS network towards the goal of achieving 90% or greater total MCO-PPS payments captured in at least level 1 VBP and 70% or greater total costs captured in VBP level 2 or greater.

Clinical integration

Clinical integration refers to the coordination of care across a continuum of services, including hospitals, primary care providers, specialists, mental health & substance abuse treatment providers, and post-acute support services to improve the value of the care provided.

Integral to the success is the development of medical neighborhoods: clinical-community partnerships that include the medical and social supports necessary to enhance health, with the primary care team serving as the patient's primary "hub" and coordinator of health care delivery.

There is recognized necessity and value of practitioner engagement in the health system transformation process. In particular, strengthening and expanding primary care is central to achieving better health for patients and communities, and lowering costs for everyone.

IT Systems and Processes

The IT Systems and Process plan works to encompass appropriate data sharing arrangements that drive toward a high performing integrated delivery system while appropriately adhering to all federal and state privacy regulations.

An IT and Data Sharing Committee has been formed and charged with developing an information technology strategy for the AHI PPS. Responsibilities of this committee include:

- Taking a leadership role in the creation, implementation and oversight of the information and data management goals, standards, practices and processes of the PPS
- Provide support to all aspects of information and data governance, including data ownership, data protection, data privacy, information usage, classification and retention
- Align the PPS's information technology to the objectives of the DSRIP program
- Monitor and evaluate information technology expenditures with a view to maximizing value and return on investment
- Review and recommend processes and protocols for the adoption and use of information technology that will be used by the PPS participants

Performance Reporting

The AHI PPS's cornerstones of effective performance reporting are:

- A culture devoted to optimizing outcomes for patients;
- Clear responsibilities and accountability of staff for these outcomes;
- Optimizing and standardizing processes; and
- Continuous measurement of outcomes and the process-metrics that drive them.

To achieve performance excellence, the AHI PPS will Practice champions to assist with engaging the wide range of PPS participants with reaching consensus on the adoption of appropriate practices and standards across the PPS

	The board, quality committee and practitioner champions form a structure that requires adherence to performance reporting processes and clearly identifies accountability for specific outcomes, either on a project basis or across the entire PPS. Reporting of performance measures inform PPS leadership to the extent of improvement and areas of opportunity in patient care delivery.

Progress to Date

Project 2.a.i:

The progress to date for Project 2.a.i is noted throughout this report through the various Organizational Workstream Component summaries.

- PPS Administrative Staff Plan: Developed DY1Q4 to identify resources to build the PPS Network.
- Community Beneficiary and Engagement Committee developed the Community Engagement Plan to support CBO strategy.
- Committees have met to review population health management capabilities and evaluate the current state of an adequate network and capabilities. A Population Health Management vendor scan was completed to understand management tools/solutions needed to contribute toward meeting PPS population health management requirements.
- EHR vendor systems have been identified by participating safety net providers in the PPS.
- Workplans have been developed for each PCP participating in the PPS.

Cultural Competency and Health Literacy:

- The AHI PPS Community and Beneficiary Engagement Committee has been established, meets quarterly, and is responsible for guiding the development and implementation of the Cultural Competency and Health Literacy Strategy/ Cultural Competency and Health Literacy Training Strategy, as well as the AHI PPS Community Engagement Plan
- Cultural Competency and Health Literacy Workstream Milestone 1 was completed as of DY1 Q3, resulting in the approval of the AHI PPS Cultural Competency and Health Literacy Strategy. The Cultural Competency and Health Literacy Strategy outlines the AHI PSS' approach to implementation of initiatives which support the CCHL workstream's goals:
    - The CCHL Strategy is based on a broader understanding of diversity, as expressed in the 2013 Enhanced National CLAS (Culturally and Linguistically Appropriate Services) Standards for Health and Healthcare. CLAS Standards will function as a framework for partner organizations to use when embedding principles of cultural awareness and language access into their daily practices
    - Tools for assessing and promoting health literacy, on both an individual and organizational level, were reviewed
    - The CCHL Strategy identified several priority groups experiencing health disparities within the PPS, using the 2014 Community Needs Assessment and information gathered through the 2015 AHI PPS CCHL Provider Needs Assessment
    - Community based interventions to address identified health disparities were identified
    - The AHI PPS contracted with Wilma Alvarado Little, of Alvarado Little Consulting, LLC, a subject matter expert, for input and guidance with drafting the strategy document
    - Input was gathered from community members through community forums and through their participation on the Community and Beneficiary Engagement Committee
- The AHI PPS CCHL strategy was used as a basis for developing the AHI PPS CCHL Training Strategy and completing CCHL workstream Milestone 2:

- CCHL Training Strategy was informed and endorsed by the Community and Beneficiary Engagement Committee and the Workforce Committee's Training and Resources Workgroup; Committee members provided input on existing trainings and initiatives occurring throughout the PPS that could be incorporated into the PPS' training plan
- Wilma Alvarado Little, of Alvarado Little Consulting LLC, contributed content and subject matter expertise
- The CCHL Training Strategy takes a two-pronged approach, addressing both general principles of cultural competence and health literacy, as well as topics related to PPS specific health disparities. Both categories of trainings will be tied together through a series of customized training sessions. Evidence-based interventions to address health disparities, and expertise from CBO partners, will be integrated into trainings whenever possible
- Bridges Out of Poverty trainings were held across the PPS, with over 200 trained and 40 trained as trainers, as the start of training efforts intended to promote strategies for better serving individuals with low socio-economic status, a major driver of health disparities in our region

Governance:

AHI PPS Committee charters were approved by the AHI Board of Directors in December of 2015 however ad hoc Steering, Finance, Workforce, IT & Data Sharing committees had been meeting on a regular basis since late 2014.

- **Governing Committees:** Established in DY1 to monitor progress and outcomes. The Governing bodies perform monitoring functions, as per charter:
  - AHI Board of Directors – receives progress reports from Steering Committee; strategic decision-making (risk-management)
  - AHI PPS Steering Committee – primary governing body charged with monitoring overall progress
  - AHI PPS Finance Committee – monitors progress in Financial Sustainability (including VBP), Funds Flow & Budget, and Compliance
  - AHI PPS IT & Data Sharing Committee – monitors progress on Information Systems & Data Security
  - AHI PPS Workforce Committee – monitors Workforce Plan progress
  - AHI PPS Community & Beneficiary Engagement Committee – monitors progress in Cultural Competency / Health Literacy and Project 2di
  - AHI PPS Clinical Governance & Quality Committee – monitors progress on clinical standards and integration activities (Clinical Integration) quality measures & population health indicators (Domains 2-4)
  - AHI PPS Network Committee – monitors the network of PPS participants to ensure that it is adequate to support the DSRIP projects being implemented by the PPS and the activities of the PPS; develops and monitors progress on Primary Care Plan

- **Governance Reporting & Monitoring Plan**: Developed DY1Q3 to describe the reporting and monitoring processes of the AHI PPS governing bodies. The Plan embodies several components of reporting and monitoring processes. Processes used to establish reporting and ongoing monitoring of progress or to identify potential risks, including frequency of reporting processes are captured as well as metrics to be reported on a continuous basis by the project implementation and clinical teams. The plan describes mechanisms used to monitor project progress, clinical standards, workforce, and financial sustainability and includes copies of reports and report templates which is the means by which reporting/monitoring is done to demonstrate monitoring processes has occurred.

- As of DY1Q3, 94 organizations have signed the Terms of Participation.

Practitioner Engagement Strategy:

- **Practitioner Engagement Plan**: The Practitioner Communication & Engagement Strategy is complete. Value-based payment requires physician buy-in; the decisions of practitioners drive quality and cost. The AHI PPS strives to engage practitioners using a multi-faceted approach in a manner that will:
    - Listen to and address physician concerns, acknowledging the importance of the physicians' role in the PPS.
    - Implement effective incentives, to enable practices to implement change.
    - Develop strong physician leaders by engaging Physician Champions and Project Champions.
    - Improve transparency by providing data analytics and reporting of meaningful/actionable information.
    - Provide training, and gain enthusiasm for, quality improvement efforts.

- **Practitioner Champions**: Practitioner champions have been identified across the full continuum of care throughout the 9 county PPS region.
    - Practitioners serve on the AHI PPS Clinical Governance and Quality Committee.
    - Each primary care practice participating in DSRIP Project 2.a.ii "Primary Care" has identified a physician champion to lead the practice(s) who will serve as subject matter expert on clinical decisions (selecting evidence based guidelines, selecting criteria to identify "high risk" patients who may benefit from care management and selecting measures for quality improvement initiatives) and be a team leader, facilitating conversations between hesitant team members and supporting discussions about why change is necessary and why it needs to start now.

- **Training/Education Plan:** AHI has developed a transformation-targeted educational curriculum on topics such as integrated delivery systems, value-based payment, advanced primary care models, behavioral health, population health management, continuous quality improvement, among others.
    - Key messages will be delivered to practitioners through a number of different methods. Information will be communicated via email, the AHI web site, newsletters and social media/blog posts.
    - Practice transformation support will be provided to practices primarily through on-site coaching and practice facilitation, with ongoing remote support.
    - Additionally, group trainings will be offered bi-monthly and learning collaboratives quarterly to encourage sharing of best practices among practices.

<u>Population Health Management:</u>

- Population Health Management Roadmap: The Population Health Management Roadmap is complete. The roadmap includes goals, challenges, technology and recommended strategy for three critical areas:
    - Advancing primary care
    - Managing the care of high-risk patients
    - Developing the medical neighborhood

- Our approach to operationalizing the PHM Roadmap focuses on key core requirements:
    - Data / information exchange
    - Population identification and stratification
    - Patient engagement
    - Engaging primary care providers
    - Reporting and decision support

- While PHM requires the ability to provide patient registries and identify care gaps, risk stratification, benchmarking and clinical dashboards as well as ability to outreach to patients and automate work queues, the most important aspect for the AHI PPS is the ability to apply PHM information in meaningful ways to improve the quality of patient care provided throughout the region.

- Our goal for the AHI PPS is to provide comprehensive (including behavioral health), team-based, patient-centered care for both patients coping with illness and the healthy, to enable our providers to success with value-based reimbursement models.

- PPS-Wide Bed Reduction Plan: In conjunction with DSRIP Project 2aiv "Create a Medical Village Using Existing Hospital Infrastructure" the AHI PPS has begun developing a PPS-wide bed reduction plan.

Workforce:

- Extensive partner participation in workforce planning on the Workforce Committee, workforce workgroups and advisory council.
- Achieved Year 1 Workforce Spending requirement at 88%.
- Future State Assessment completed and approved by the Workforce Committee and Steering Committee.
- Employee Engagement Workgroup developed the Workforce Engagement Strategy for the AHI PPS which was approved by the Workforce Committee and Steering Committee.
- Convening representatives from the Workforce Committee along with project partners to assist on the gap analysis, building a transition roadmap and outlining a training strategy.
  Compensation and Benefits Analysis completed to assist in monitoring impact as DSRIP project implementation progresses.

Budget

- Completed funds flow budget and distribution plan and communicated plan to the network incorporating factors such as cost of administration, cost of implementation, revenue loss, provider bonus payments, costs of non-covered services, and contingency, sustainability, and innovation funds across AHI PPS' eleven projects and over 100 partners.
- Finished contracts between AHI PPS and the network partners. Contracts were distributed to partners in early June. As of June 30th AHI PPS has executed contracts with 58 partners, over half of the AHI PPS network.
- Paid out $7,690,636 to network partners who had signed terms of participation agreements with AHI PPS. Funds were dispersed via Workforce requests and two rounds of "engagement payments" ahead of master contracting to flow funds to the partners while contracts and funds flow plan was being finished.

Financial Sustainability

- Finalized the PPS finance structure including reporting structure and establishment of finance committee.
- Developed the financial sustainability plan, putting a plan in place to monitor the financial health of the AHI PPS partners, identify those partners in financial difficulty, and create a process to flow funds to these financially fragile partners to ensure the success of the PPS.
- Sent Financial Stability Survey to PPS partners to assess their financial health and identify any financially fragile partners.
- Finalized the AHI PPS compliance plan consistent with New York State Social Services Law 363-D.
  Developed a survey to identify the baseline of the PPS partner's familiarity with Value Based Payment.

Clinical integration

- A clinical integration "needs assessment" is well underway. The provider landscape has been evaluated, and the future state assessment for workforce completed. An HIT survey has been completed and we are in the process of analyzing the survey results to ensure data sharing and interoperability throughout the PPS.

IT Systems and Processes

- Established IT governance structure – in addition to the IT and Data Sharing Committee (described above), a number of workgroups have been identified and are being formed:
  - Data security and confidentiality

  - Population health management, performance reporting and analytics
  - Interoperability and data exchange
- An initial health information technology (HIT) readiness survey has been completed with our PPS partners, and the data gathered from the survey incorporated into the AHI PPS IT Strategic Plan
- AHI PPS IT Strategic Plan was developed and reviewed by the IT & Data Sharing Committee
- A follow up survey HIT Survey was conducted and is being used to update the IT Strategic Plan and identify priorities for HIT development.
- A plan has been developed for engaging attributed members in Qualifying Entities, including an approach to outreach into culturally and linguistically isolated communities
- A data security and confidentiality plan has been developed
- All 18 SSP Workbooks required by the state have been completed
- AHI has hired a Technology Director to oversee deployment of HIT technology within AHI to support the PPS goals and requirements.
- AHI has hired a Data Analyst to support AHI PPS reporting needs and is recruiting for two more.
- AHI has overhauled our IT infrastructure to create three environments:
  - Secure AHI employee
  - AHI Guest
  - AHI PHI environment accessible only on site using multi-factor authentication

Performance Reporting

- Implemented DSRIP Tracker project tracking and reporting tool.
- Earned 100% of available Achievement Values for DY1Q2.
- Earned 100% of available Achievement Values for DY1Q3.
- Earned 99.6% of available Achievement values for DY1Q4.
- Developing reporting structure of PPS-wide performance reporting and communication
- Establishing AHI PPS Performance Measurement structure, requiring involvement of the Regional Health Innovation Teams (RHITs)
- Developing training program focused on clinical quality and performance report for PPS partner organizations and providers/staff
- Hiring Data Analyst that has been trained on the MAPP Performance Dashboard and Salient Interactive Miner
- Presented to the Steering, IT & Data Sharing, Clinical Governance & Quality, and Network Committees on the capabilities of the MAPP Performance Dashboard
- Began developing reporting from the MAPP Performance Dashboard to support AHI PPS Committees RHITs and Project Teams and partners.
- Developed AV Modeler tool to project financial impact of different achievement value scenarios. The tool can project the dollar impact at the fractional AV level by domain, Workstream, project, metric, pay for reporting (P4R)/pay for performance (P4P), DSRIP year and quarter and payment period.
- Used AV modeler to help align and prioritize partner responsibilities in contracting process.

Challenges / Mitigation Strategy

Project 2.a.i:

Challenge: Operational challenges in implementing and executing the project's milestones and tasks within the quarter for completion. Project Milestones 1 and 2 have resulted in some changed due dates Additionally, AHI PPS has experienced changing leadership, which has impacted the project significantly. Efforts are underway to create the infrastructure to operate in an IDS fashion.
Mitigation:
AHI PPS continues to engage our partners in the development of an IDS. This includes additional training opportunities to help develop broader understanding of IDS concepts and goals. AHI PPS has successfully recruited a new CEO that is leading efforts to review the PPS Lead organizational structure and composition of the governance committees to ensure that we have sufficient resources that are effectively deployed.

Challenge: Secure contracting agreements (Master Participation Agreement and Project Schedule A2s) with PPS Partners.
Mitigation: PPS Governance has agreed upon a second round of Engagement Funds to be distributed to PPS Partners. AHI PPS has distributed a Master Participation Agreement to all partners with 57 having been returned, as of 6/30/2016. Project specific schedules for most projects have been reviewed by the PPS Finance Committee which has recommended several to the PPS Steering Committee and has several more queued up for approval.

Challenge: Performance management and engagement across the AHI PPS network.
Mitigation: Reorganize and, if necessary, increase AHI PPS resources to provide more focus on vital provider/partner engagement activities.

Cultural Competency and Health Literacy:

Challenge: The rural nature and vast geography of the PPS coverage area can be an impediment to engaging, training, and mobilizing staff members in partner organizations to undertake CCHL initiatives.
Mitigation: This challenge is mitigated by recruiting CCHL champions to organize implementation efforts within their own organizations and partner organizations. The AHI PPS is also utilizing multiple methods of training and communication with partners including using an online learning management system, offering trainings via webex, using a train-the-trainer model, and engaging stakeholders through social media, community forums, and traditional media.

Challenge: Because demographics within the AHI PPS are not as racially, ethnically, or linguistically diverse as some areas of the state, it can be challenging to impart the relevance of being culturally competent, if individuals are focusing on a more traditional definition of culture and diversity.
Mitigation: This barrier will be mitigated by education and training to raise awareness of diversity as it exists within the PPS, and the importance of providing culturally competent care tailored to meet the needs of specific populations served. The PPS will focus on how implementation of cultural competency and health literacy initiatives can impact health outcomes.

Governance:

While the AHI PPS has been successful, achieving two 100% AV score cards and missing only two achievement values on the third, we have had to push back a number of tasks and milestones. AHI PPS is proactively and aggressively taking action to correct any gaps. The items listed below identify the main issues that have contributed to this situation as well as the steps we are taking to mitigate the impact of those barriers.

Challenge: As noted previously, AHI PPS covers about 11,000 square miles, most of which is characterized by mountainous terrain, sparse population, and limited infrastructure, as well as, severe winter weather. This creates significant impediments to coordinating meetings of the participants.
Mitigation: While face-to-face meetings are preferred, when possible, practicality dictates that most meetings take place via conference calls and webinars. AHI PPS, and several of our partners, have invested in teleconferencing

capabilities to help support effective meetings while avoiding hours of relatively unproductive driving time. Most committees intersperse in-person meetings with the remote meetings to help foster relationships and team building.

Challenge: AHI PPS required an exemption in order to be granted safety net status so that it could act as PPS Lead. Safety Net status was ultimately granted in June of 2015, however, this delay retarded the formation of our governance structure which impacted a number of critical activities, especially budgeting, funds flow and contracting. The downstream effects are diminishing as we get further into DSRIP, but they are still being felt.
Mitigation: Although AHI PPS was not able to adopt a formal governance structure until December of 2015, we had convened partners in several ad hoc committees, including Steering, Finance and HIT, since late 2014. We also brought partners together in project teams and Regional Health Innovation Teams (RHIT) to begin the project planning process. Since governance was formalized, many of these committees have been meeting monthly – or even biweekly – to try and recover lost time on significant milestones and tasks. AHI PPS has also engaged consultants to augment AHI PPS resources in support of the committees.

Challenge: AHI's CEO resigned in January 2016.
Mitigation: The former CEO agreed to continue to perform her duties until June 30, 2016. While there was some lost momentum, as would be expected, the impact was diminished due to the fact that the position was never vacant. AHI's Board of Directors began a search immediately, and identified a replacement that was able to start several weeks prior to the former CEO's last day. The new CEO has implemented a review of AHI's strategic plan and organization structure to ensure that they adequately support all of AHI's programs; DSRIP, in particular.

Challenge: Some of AHI PPS' committees have not been as effective as necessary. The reasons include committee composition that does not represent the breadth of the PPS sectors and partners, over reliance on some individuals or organizations that sit on multiple committees, and inadequate education regarding DSRIP mechanics and drivers.
Mitigation: AHI's CEO, with the support of the AHI Board of Directors and Steering Committee Chair, has undertaken a review of the charter and composition for each of the PPS committees. The review seeks to ensure that committee charters are structured effectively and that committee composition represents all sectors, and geographic regions within the PPS. We are also updating educational material for the committees to reinforce their understanding of DSRIP concepts including, integrated delivery system, key DSRIP and PPS goals, funds flow, pay for performance, and reporting requirements.

Challenge: The PMO has not been resourced sufficiently due primarily to two factors: the delay in establishing governance and budgeting deferred recruiting activities; and, the original PMO staffing plan did not include sufficient subject matter expertise because it was anticipated this would be provided by the PPS partners. To date, the partner resources have not been available to adequately address the subject matter needs.
Mitigation: In the short term, AHI PPS attempted to offset the impact of staff shortages by engaging consultants to assist with completion of deliverables. Once the budget was approved, AHI PPS began actively recruiting and has retained key personnel, although some positions remain outstanding. AHI PPS has engaged recruiting firms to try and expedite placement of the remaining open positions. AHI PPS has also recruited temporary assistance to help augment subject matter expertise and reevaluate those needs going forward.

Challenge: Projects are not sufficiently integrated resulting in unnecessary redundancy and lack of coordination in achieving shared goals.
Mitigation: AHI PPS has brought in additional resources with clinical project and DSRIP expertise to help the project teams and project managers coordinate projects. We are also restructuring the RHITs to promote greater participation across sectors and refocusing them on core DSRIP deliverables to encourage a more integrated approach.

Practitioner Engagement Strategy:

Challenge: The success of any collaborative effort requires effective communication and active engagement by all participants. Practitioner communication and engagement for AHI will be challenged due to:

- The large rural geographic spread of the AHI PPS provider network.
- The degree and extent of demands on providers by numerous initiatives currently underway in the region including, MSSP ACO, Adirondack Medical Home, payer specific programs, NCQA recognition, as well as adapting to the change to value-based payment models (including the proposed MACRA legislation).
- Loss of institutional knowledge due to staff turnover during the durations of the DSRIP program.
- Clinical resistance to change and shift in organizational culture.

Mitigation: These challenges will be mitigated by:

- Adirondack Pods and the Regional Healthcare Innovation Teams (RHITs) will be a catalyst for training smaller provider organizations.
- Practitioner Champions will play a central role in the group training and education sessions for smaller provider organizations.
- Transformation coaches will provide assistance via remote and on-site consulting; data and reporting analysts will coordinate deployment of IT and data reporting infrastructure with the partners to minimize duplication and impact on the practices and partner organizations.
- Exploring innovative approaches to implementing organizational change throughout the PPS.
- Train the trainer program to include electronic and printed training materials to promote easily accessible and convenient in-service opportunities to engage practitioners during onboarding and at any point during the partner-provider relationship.
- Practitioner Champions will be the voice for evidence-based change which will be reinforced in all DSRIP communications.
- Utilization of the LinkedIn platform to identify examples of best practice that will be shared with PPS partners.

Population Health Management:

Challenge: The AHI PPS faces challenges to achieving a cohesive, integrated and comprehensive approach to health care delivery that focuses on preventative care. The barriers to success are:

- Disconnect between population health management issues identified at the system level and care delivery at the practice/provider level. For example, insufficient access to cardiology providers in a geographic location where cardiovascular disease is a priority.
- Prolonged focus on analysis of a given population's health needs at the expense of responding quickly to developing new services or interventions.
- The risk that a population health management approach will become reactive over time resulting in patient-facing care managers filling care gaps for individual patients immediately with is inefficient and leads to provider fatigue.

Mitigation: These challenges will be mitigated by:

- Clinical integration and practitioner engagement will focus on integrated care management through the development of cross-disciplinary teams for multi-morbid patient groups.
- Care managers will assume an active role in the continuous management of patient pathways and have consistent engagement with the care management team.
- Utilize value stream mapping to identify clinical priorities with the greatest opportunity for eliminating waste and where the implementation of new, efficient support systems are likely to have the greatest effect at generating momentum amongst PPS partners.
- Reinforcement of the difference between population management based care delivery and patient complaint based delivery.

- Development of information systems capable of providing timely actionable information to the appropriate care team member.
- Reorganizing the Regional Health Innovation Teams (RHIT) to provide them with the necessary support and responsibility for achieving results.

Workforce:

Challenge: Competition from the overlapping PPSs in the adjacent regions to AHI over high-demand positions**.**

- To mitigate, we will collaborate with neighboring PPSs in our region and strive for equitable access among PPSs for hiring high-demand staff. Regular meetings and discussions with key workforce staff in neighboring PPS will take place with the goal of ensuring the future state workforce needs of all PPSs are met and to identify opportunities for collaboration.

Challenge: Difficulty recruiting for providers in the AHI PPS network (particularly for relatively low-paid roles), with the challenges in a rural area compared to other PPSs in the State that will also be recruiting for the same positions.

- To mitigate this risk, the Recruitment and Retention Workgroup has been developed which is investigating strategies to building a pipeline of health care staff and a coalition of health care professionals who will speak to the need for these key positions in high schools, BOCES programs (including New Visions), and community colleges. The Recruitment and Retention Workgroup is investigating the creation a marketing campaign regionally and beyond to help identify our region as an employment destination. In addition, a Recruitment and Retention Fund has been developed to assist partners with recruitment and retention efforts for key positions which will expand services for DSRIP related projects. To further mitigate this risk, the AHI PPS is examining creative ways to address recruitment including telemedicine, remote monitoring and licensure requirements.

Challenge: Many requirements and projects, including 2.a.i, depend on the successful implementation of an electronic health records system, as well as the necessary training and change management and engagement support to ensure that impacted staff are ready, willing, and able to succeed with the new system.

- In order to execute the activities to support these endeavors in a timely and effective manner, AHI PPS continues to maintain discussions with consultants to provide technical assistance. Necessary training will be incorporated in to a training plan. Strict project management and reporting protocols will be instituted to ensure the PPS remains on track and on schedule with regard to getting our people, processes, and technology ready for success in the DSRIP future.

Challenge: The AHI PPS may have difficulty obtaining buy-in and support from frontline workers and key stakeholders, which in turn could impact DSRIP project success.

- To mitigate this risk, the PPS has approved the Workforce Communication and Engagement Strategy to provide information and updates to share with partners to then be shared with their employees. This strategy included a survey to partners to identify the mechanisms used to communicate with their employees and its effectiveness. Tools to communicate with all employees will be developed from this information and shared for use, incorporated in to a tool that they have identified works best for their organization. All workforce groups (Workforce Committee, Workforce Advisory Council and four workgroups) have membership which includes union representation as a mechanism for communication and to gain support from employees.

Challenge: Partners not completing necessary survey/assessment documentation for analysis of the PPS workforce. To mitigate this, the PPS will carefully plan important information gathering tools to ensure the best response.

- The PPS will work with professional survey organizations to ensure the questions are clear and concise. Partners will be given adequate time to fill out the surveys as accurately as possible, frequent reminders will be sent out, and extensions will be given as needed to complete assessments. When possible and appropriate, the PPS will group surveys together to reduce the numbers of surveys for Partners.

Budget

The success of any system transformation ultimately depends of the strength of the network leading the transformation. While AHI PPS is confident in the ability to lead the system transformation in the Adirondack region, there are some challenges to that success. The biggest challenge that affects the budget workstream is obtaining the complete buy-in of the AHI PPS funds flow plan from key stakeholders, especially as the stakeholders must balance the dual role of participating in AHI PPS network but also representing their own organization.

AHI PPS has largely mitigated this risk by developing the funds flow plan in conjunction with the finance committee, regional leaders, and the steering committee, groups populated with representatives from the key stakeholders. Further the funds flow plan has been communicated to all the network providers and AHI PPS will continue to provide communication and education about the plan as each part develops.

Financial Sustainability

Ensuring the financial health of the network members is a key step in building a high functioning integrated delivery system capable of reducing avoidable hospital admissions and transitioning to Value Based Payments. There are challenges addressed within the financial stability work stream that threaten the financial health of network partners or present barriers to the success of the system. These challenges include:

- Determining whether AHI PPS is properly positioned to fully support financially fragile providers who are critical to the success of the PPS.
- Transitioning to value base payment is not accepted by the PPS partners at the pace required to meet DSRIP timelines.
- Resource limitations of PPS Partners, especially smaller entities, may prevent the entities from investing required resources needed to participate in the PPS and provide timely/adequate information.
- Developing a single plan that meets the needs of a wide range of partners, covering a large geographic area, where significant differences can exist from region to region within the service area.

AHI PPS is aware of these challenges and has developed a strategy to mitigate the challenges. Mitigation strategies include:

- Leveraging the systems that will be used to measure and monitor DSRIP project performance and incorporate financial metrics in agreements with providers to monitor the financial health of the PPS providers.
- Developing tools that will be used to disseminate information, collaborate with participants, collect data, provide transparency, and timely quarterly reporting on the DSRIP projects internally to PPS and to NYSDOH.
- Developing a communications strategy to provide timely and clear information flow to PPS providers to garner support and active participation in meeting DSRIP project requirements and earning the full DSRIP payment.
- Addressing the objectives of value based payment models, as well as the possible implications of engaging in value based payment arrangements, through educational campaigns so providers can make informed decisions.
- Engaging partners to develop a flexible, multi-phased approach to contracting on a VBP basis that also allows for AHI PPS providers with longstanding relationships to contract directly with MCOs.
- Examining opportunities to facilitate and support contract negotiations between AHI PPS providers and MCOs to the greatest extent.
- Leveraging existing relationship with Adirondack ACO and the Medical Home Pilot to further support contract negotiations between AHI PPS providers and MCOs.

Clinical integration

- Challenges: Successful clinical integration requires health information technology to support adherence to new clinical pathways and the ability to operate collaboratively across settings of care. Health information technology readiness, and standardized care pathways across disparate organizations are specific areas of focus.

- Mitigation: In consideration of the current state of HIT readiness and clinical integration, the AHI PPS will develop a multi-phased approach to incorporate the technology current in place to support the integrated model; identify high priority HIT capabilities and devote resources to establishing them early in the implementation period; establish technology requirements for participation in the PPS as determined by the IT and Data Sharing Committee and Network Committee. The Clinical Governance and Quality Committee will establish standardized pathways involving providers from multiple settings. The AHI PPS will develop a strategic communications plan to encourage buy-in from key change agents, including clinicians, operations and administration.

IT Systems and Processes

- **Challenges**: IT risks and challenges include:
  - Variation in data collection, sharing and security capabilities among partner organizations
  - Inconsistent implementation of data sharing standards by eHR vendors
  - DOH restrictions on the use of Medicaid claims data critical to the success of the AHI PPS
  - Competing initiatives among AHI PPS partners that have individualized metrics and requirements
  - Limited RHIO resources available to implement connectivity
  - Recruiting IT and Analytic Staff

- **Mitigation**: The IT and Data Sharing Committee working with the PMO, Quality Committee and others as needed will be responsible for finalizing and implementing mitigation plans. The AHI PPS strategies for mitigating the risks and challenges include:
  - Assisting partners with researching and obtaining the appropriate technology – messaging capability, eHR-lite or fully functioning eHR
  - Assisting practices with Transition Coaches to incorporate technology into their workflow
  - Working with eHR vendors, provider practices and HIXNY to develop standardization in the data elements included in CCD-A and other transactions
  - Contracting with HIXNY for dedicated resources to support AHI PPS partners
  - Collaborating with other PPSs and HANYS to work with DOH to find an appropriate compromise that will protect beneficiaries while allowing all PPSs to use the data to achieve DSRIP goals
  - Utilizing the MAPP and Salient tools even with the inherent risk of silo data that will make practice transformation and achievement of AHI PPS goals more difficult
  - Align metrics and processes where possible with other initiatives and deploy PHM and performance reporting solutions that support multiple metric sets using the same practice based resources to reduce impact on PPS partners
  - Transition coaches, data analysts and human capital from larger PPS partners to assist smaller PPS organizations with implementation of appropriate technology and processes and support goals and deliverables
  - AHI PPS will provide staff support to PPS committees, work groups and project teams through PMO and other resources
  - Advocating for AHI PPS members to join a single RHIO and reliance on SHIN-NY development to provide adequate data sharing between RHIOs.
  - Retaining a recruiter to assist with finding and hiring staff with the necessary skills.

Performance Reporting

- Challenge: Many practices are engaged in other programs with their own set of goals, metrics, practices and standards across the PPS.
- Mitigation: Practice champions will work with participants to achieve appropriate alignment and consensus on the DSRIP standards. AHI PPS will also seek to focus partners on common goals that contribute to multiple sets of metrics and develop robust reporting process to collect the data to support individual metrics.

- Challenge: Performance management is at risk since the AHI PPS will rely on eHRs for initial clinical quality performance reporting.
- Mitigation: AHI PPS practice coaches and analysts will support the practices by leveraging experience and tools from practices with similar systems and characteristics.

- Challenge: Designing and implementing a standard reporting workflow that will functionally work for the entire PPS will be a significant challenge due to:
  - The geographic spread of the AHI PPS network (nine counties over 11,000 square miles)
  - Relative small median practice size diminishes confidence in metrics at an operational level
  - The diversity of the AHI PPS provider network; and
  - Long-standing professional independence with different reporting cultures and workflows
- Mitigation: Professional incentives (improving quality of care) will be coupled with financial incentives such as financial/personnel support for small practices to help them streamline their operations to support the increased reporting burden.

- Challenge: Partners are concerned about consent requirements and liability that could be incurred by sharing data with the PPS.
- Mitigation: Seek guidance form DOH and legal counsel to share with partners.

Best Practices

Project 2.a.i:

- Internal project 2.a.i team convened to meet quarterly for review of quarterly requirements.
- Internal organizational flowchart created to visually represent the collaboration required among committees, workstreams, projects and departments to achieve project 2.a.i deliverables.

Cultural Competency and Health Literacy:

- Focusing on evidence-based practices to addressing health disparities whenever possible
- Utilizing widely recognized/vetted approaches to advancing cultural competence and health literacy, such as the National CLAS standards, 10 Attributes of Health Literate Health Care Organizations, and a 'universal precautions' approach to health literacy, as described in the ARHQ's Health Literacy Toolkit
- Promoting an enhanced conceptualization of cultural competence and diversity which encompasses factors beyond race, ethnicity, and linguistics.

Governance:

- AHI PPS developed a matrix to help balance Committee participation across geography, sector, partner and competencies.
- AHI PPS developed charters for each of the Committees documenting their roles, authority, any specific DSRIP deliverables, minimum meeting frequency and quorum/voting requirements.

Practitioner Engagement Strategy:

- AHI's Practice Transformation Services Manager leads a team of Transformation Coaches (both internal and external partner resources) that work with practitioners and staff to identify opportunities for improvement, apply the improvement model and facilitate spread of best practices. The team meets monthly, and meetings with the Primary Care Project Champion, David Beguin, MD, are held bi-weekly.
- AHI is in discussion with the School of Public Health about developing a program using organization change principles to facilitate transformation in primary care practices (potentially including the integration of behavioral health and the integration of palliative care into primary care) using peer-to-peer (Vanguards) and broader learning collaboratives to help foster sharing of best practices.

Population Health Management:

- Understanding primary care is the core of PHM, AHI resources will regularly meet with the primary care teams to review/discuss PHM reports. The goals of these meetings is to identify patients who may benefit from care management, engage "at risk" patients in care management earlier in their prognosis and avoid unnecessary hospital use.

Workforce:

- Creation of four workgroups (in addition to the Workforce Committee) which consist of PPS partners and other interested parties to plan and develop key initiatives related to workforce deliverables. Each workgroup meets monthly and has a designated workgroup leader who is also a member of the Workforce Committee. The workgroup include:
    - Compensation and Benefits Workgroup
    - Employee Engagement Workgroup
    - Recruitment and Retention Workgroup
    - Training and Resources Workgroup.

  Development of the Training Fund (developed by the Training and Resources Workgroup) and Recruitment and Retention Funds (developed by the Recruitment and Retention Workgroup) to assist in the recruitment and training needs of partners to achieve successful project implementation.

Budget

AHI PPS developed the Funds Flow plan over an extended period of time weighing many factors and methods and multiple interactions with network partners, especially within the finance committee, before developing the final plan. The final Funds Flow plan was centered on an "activity payment" approach: tying partner payments to activity payments within the project work streams. By this method, payments to partners were aligned with reporting and performance milestones within the project scopes and would lead the partner towards completion of the PPS goals.

While developing the contracting and funds flow plan, AHI PPS released funds to network partners compensating the partners for engagement in the PPS. The release of funds was contingent on partners signing terms or participation agreements, returning documents to AHI PPS, such as financial stability survey and project impact assessment matrix. Tying payouts to the return of documents needed to assess the network ensured a greater response rate and timely reporting.

Financial Sustainability

- AHI PPS will be able to utilize knowledge gained and relationships made through AHI's involvement with Adirondack Medical Home Initiative (AMHI) during the transition to a network based in VBP reimbursement. AMHI is a collaborative effort between health care providers and private and public insurers that emphasizes preventative care, enhanced management of chronic conditions, and a close relationship between patients

and their primary care providers. AMHI is one of several Multi-Payer Advanced Primary Care demonstration programs designed under the CMS Innovation Center.

- AHI PPS works with the Adirondack ACO, an accountable care organization that has a large regional overlap with AHI PPS. The relationship with Adirondack ACO will provide AHI PPS the opportunity to share services to avoid duplication of efforts in the region, and leverage the resources the Adirondack ACO has developed in moving away from a fee-for-service reimbursement model to one centered on value based payment.

Clinical integration

- Providers in the PPS have engaged in a number of transformational initiatives over the past five years in an effort to address realigning capacity. The Adirondack Region Medical Home Pilot, Health Home, and Adirondacks ACO are improving access to primary and preventive care.

- Nearly 100 Regional Partners are part of the AHI PPS. Our partners are organized by Regional Health Innovation Teams (RHIT). RHITs provide a forum for collaborative planning, monitoring, and development of innovative health system programs/projects. These stakeholders throughout the nine-county service area discuss the unmet needs of the communities and the barriers to accessing care. AHI relies on these stakeholder groups to engage community partners, and play an active role in DSIRP projects.

IT Systems and Processes

- Engaging HIXNY (RHIO) in working with PPS partners on connectivity to ensure AHI PPS partners are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including DIRECT exchange (secure messaging), alerts and patient record look up.

- Completion of a Population Health Management roadmap with the basic understanding that primary care is the core of PHM. AHI resources will regularly meet with the primary care teams to review/discuss PHM reports. The goals of these meetings are to identify patients who may benefit from care management, engage "at risk" patients in care management earlier in their prognosis and avoid unnecessary hospital use.

Performance Reporting

- Our success with performance reporting can be attributed directly to our governance workstream. Effective leadership and a clearly defined organizational structure, with clear responsibilities and lines of accountability and our ability to create a common culture and to embed performance reporting structures and processes is key.
- Working closely with committees, RHITs, project teams and partners to develop reporting focused on key goals and deliverables.
- Implementation of a robust project management and reporting application, DSRIP Tracker.
- Developed AV Modeler tool to project financial impact of different achievement value scenarios. The tool can project the dollar impact at the fractional AV level by domain, Workstream, project, metric, pay for reporting (P4R)/pay for performance (P4P), DSRIP year and quarter and payment period.

Looking Ahead – DY2, Q2

Project 2.a.i:

All PPS Providers participate in the IDS:

-Secure Master Participation Agreements and Project Schedule A2 with PPS partners in the IDS including medical, behavioral health, post-acute, long-term care and community-based providers.

HHs and ACOs implement strategy towards IDS success:

-Secure contract/inventory agreements with participating HHs and ACOs.
-Establish regularly scheduled formal meetings to demonstrate a path to evolve HH and/or ACO into the IDS to incorporate a population health management strategy and to develop collaborate care practices and integrated service delivery.

PPS Network Committee to develop workplan:
-Analyze current state of network adequacy focusing on providers and expanding capacity in underserved areas.

PPS VBP Workgroup to develop payer engagement strategy:
-Develop list of target payers and define plan for engagement in PPS activities.

PPS Clinical Governance and Quality Committee to develop workplan:
-Gather existing protocols from across PPS partners and determine which to adopt by the Committee and standardize across the region.
-Develop a timeline for adoption across the region to roll out protocols and integrate measurements into quality/IT systems.
-Establish method to track dissemination of protocols and guidelines.

PPS IT & DS Committee to develop implementation plan that including setting up the sharing of health information among clinical partners in the PPS:
-Confirm EHR vendor systems being used by safety-nets.

PPS Population Health Management Workstream to develop roadmap as part of the overarching implementation plan:
-Outline the mechanism by which the PPS will utilize the data from EHRs to perform population health management

Gain commitments from each participating practice:
-Secure contracting agreements across the PPS participating practices

Contract with Medicaid MCOs:
-PPS VBP workgroup to conduct a VBP Baseline assessment while identifying and prioritizing potential opportunity and providers for VBP arrangements.
-Develop and implement an education and communication strategy for PPS network on VBP concepts, frameworks and best practices.

Establish monthly meetings with Medicaid MCOs:
-Evaluate and discuss utilization trends, performance issues and payment reform.
-Develop a process for reporting outcomes/recommendations to stakeholders and AHI PPS Leadership.

PPS VBP Workgroup to develop a VBP Growth Plan:
-Research best practices on aligned provider compensation approaches.
-Develop a "provider-facing" communications plan and evaluate existing compensation models/approaches to transition provider compensation to align with patient outcomes.

Engage patients in the IDS through outreach and navigation activities:
-PPS will contract with CBOs and health care providers to perform outreach and navigation activities.

Cultural Competency and Health Literacy:

Once it has been confirmed that the AHI PPS Cultural Competency and Health Literacy Training Strategy has been approved by the IA, we will move forward with operationalizing the training plan. The training plan supports

continued and expanded implementation of activities as outlined in the AHI PPS Cultural Competency and Health Literacy Strategy submitted in DY1 Q3.

Next steps include:

- Identify CCHL Champions within partner organizations; provide training and support as they begin to develop organization-specific strategies for implementation of CCHL initiatives
- Work with consultants/training vendors and partner organizations to develop, schedule, and promote training sessions customized to the needs of the PPS, as described in the CCHL Training Strategy
- Continue organizing and holding community forums and other events to gather feedback from community members
- Investigate developing a community calendar which can be used promote CCHL training and educational opportunities taking place across the PPS

Workforce:

Transition Roadmap and Strategy:

-Creation of transition roadmap and training strategy with guidance from workgroups, project partners and Workforce Committee members.

Innovative Programs:

-Continue the development and implementation of innovative programs to assist in attracting and retaining the workforce necessary for health care transformation in our region.

Workforce Impact:

-Track and analyze workforce impact across the PPS as project implementation continues.

Budget

- Finishing contracting process with remaining AHI PPS network partners. As of mid-July the number of partners who have executed contracts has grown from 58 to 66 and the goal is to have nearly 100% by the end of the quarter.
- Refining downstream provider relationships to ensure that funds are able to flow to community based organizations that provide much of the services in the area, while complying with the 5% cap to non-safety net providers.
- Developing partner payment system to turn partner reporting and performance requirements into payments.
- Continued reporting on the receipt of waiver revenue, cost allocations, and flow of funds to partners.
- Begin to develop the pay for performance phase of the Funds Flow plan with a completion goal before the end of DY2Q4.

Financial Sustainability

- Analyze the results of the Financial Stability Survey to identify financially fragile partners and begin the process of directing financial aid to those partners through the AHI PPS sustainability fund.
- Send Value Based Payment survey to partners and perform baseline assessment of partner's status with Value Based Payment.
- Begin formulating the plan towards achieving 90% Value Based Payments across network by year 5 of the waiver or earlier.
- Continue work towards populating and activating workgroups of the Finance Committee such as: Financial Sustainability Workgroup and Value Based Payment Workgroup.

Clinical integration

- The clinical integration needs assessment will be completed, which will inform the clinical integration strategy. It is anticipated the clinical integration strategy will be finalized by the end of DY2 Q2 for review/approval by the PPS Clinical Governance by the end of the year (DY2 Q3).

IT Systems and Processes

- The follow up HIT survey will inform the IT change strategy (including risk management) and the roadmap to achieving clinical data sharing and interoperability across the PPS network.
- Selection, contracting and implementation planning of a population health management system at AHI to support PPS and partner PHM goals and requirements.
- Recruitment of A Reporting and Analytics Manager to oversee reporting to support AHI PPS, PPS Committees, Regional Health Innovation Teams (RHIT) and AHI PPS partners.
- Recruitment of additional analytic staff to support AHI PPS, PPS Committees, Regional Health Innovation Teams (RHIT) and AHI PPS partners.
- Completion of the Security Affidavit to secure receipt of Medicaid PHI.

Performance Reporting

- Continuing development of performance measurement structure, while monitoring the level of engagement and involvement of providers in performance reporting systems and processes
- Measure the outcomes that matter most to patients and use our reporting and IT systems to monitor, evaluate and identify the contributing processes and intermediate outcomes. Providers will be surveyed and interviewed to determine the level at which they find the performance reporting system provides them with the right information, and the level at which they find the information is clear and actionable.
- Continued development of training programs targeted toward clinical quality improvement using evidence-based guidelines
- Continue working with committees, RHITs, project teams and partners to utilize data available through the MAPP Performance Dashboard and Salient Interactive Miner.
- Select and begin implementation of a PHM Data analytics platform to provide robust decision and performance measurement support to AHI PPS committees, RHITs, project teams and partners.
- Finalize implementation of a Client Relations Management (CRM) tool to help manage network relationships, communication and reporting.
- Hire Reporting and Analytics Manager to provide additional support for Performance Reporting.
- Hire additional data analysts to provide additional support for Performance Reporting.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 2.a.i

Challenges the PPS has encountered in project implementation:
Please note – the Narrative for 2ai is included in the AHI PPS organizational narrative that is uploaded to Governance module 2.
Efforts to mitigate challenges identified above:
Implementation approaches that the PPS considers a best practice:

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 2.a.ii

Challenges the PPS has encountered in project implementation:

- Challenge # 1: A number of health care providers are having increased demands on their time because of engagement in multiple ongoing primary care initiatives that are available in the region such as Medical Home, Adirondacks ACO, payer specific programs, NCQA recognition, as well as adapting to the change to value-based payment models (including the proposed MACRA legislation).

- Challenge # 2: We are still working on finalizing contracting with our participants, including some large primary care practices. These efforts were delayed for the AHI PPS in part because of the time it took to confirm Safety Net status for AHI. Until that status was confirmed, we were unable to finalize our governance which has impacted budgeting and contracting.

- Challenge # 3: The AHI PPS was very aggressive in our speed and scale targets. Several providers have indicated they feel the requirement of an annual screening for each Medicaid beneficiary, regardless of age, gender or health status is not supported by evidence and are concerned they may not have the capacity to meet the requirement.

Efforts to mitigate challenges identified above:

- Mitigation # 1: AHI Transformation resources will identify the collective challenges and collaborate with partners to leverage shared resources across the network and alleviate concurrent pressures on providers.

- Mitigation # 2: We have retained consultants and held frequent meetings of our Finance and Steering Committees in order to make up ground.

- Mitigation # 3: We are working with the providers to resolve these concerns, and are undertaking a rapid cycle quality improvement (PDSA) project around patient engagement for this project.

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Implementation approaches that the PPS considers a best practice:

- To accommodate the vast geography covered by the AHI PPS, we have implemented the Adirondack Health Institute Transformation Assistance Network comprised of AHI employed and affiliated practice transformation resources. These staff are NCQA-trained Patient Centered Medical Home Certified Content Experts. Through this network, the 88 primary care practices of the AHI PPS are provided on-site transformation assistance in achieving NCQA recognition, as well as meeting the milestones of DSRIP Project 2.a.ii "Primary Care".

- AHI has compiled a tremendous library of reference information, including tip sheets and educational resources, to assist practices in transformation. These resources can be found on the AHI PPS DSRIP Project 2.a.ii "Primary Care" web page http://www.ahihealth.org/ahipps/dsrip-projects/dsrip-project-2-a-ii/ .

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

- **Baseline Assessment**: Baseline assessments have been completed, and provider-specific project plans developed for practices to achieve NCQA recognition as Patient Centered Medical Homes at a Level 3 under the PCMH 2014 standards.

- **Physician Champions:** Physician champions have been identified for each practice.

- **Care Coordinators:** Care coordinators have been identified for each practice. The PPS Workforce Committee has arranged Care Coordinator training with the Hudson Mohawk Area Health Education Center (AHEC) for care coordinators.

- **Actively Sharing Health Information:** Confirmed that practices are connected to a RHIO/SHIN-NY (either HIXNY or HealtheConnections) and are actively sharing health information among clinical partners, including DIRECT exchange (secure messaging), alerts and patient record look up.

- **Certified EHR Systems:** Confirmed that practices are utilizing EHR systems certified by The Office of the National Coordinator for Health Information Technology, according to the Certified Health IT Product List http://oncchpl.force.com/ehrcert. Certified EHR systems meet Meaningful Use and PCMH Level 3 standards.

- **Population Management:** Confirmed practices manage population health of their patient panels, in accordance with PCMH Standard 3: Population Health Management. The PPS continues to work with practices on expanding population management on a more regional basis.

- **Training:** Primary care staff and providers received training on Patient Centered Medical Home, Meaningful Use, Preventive Visits, Care Teams and Health Literacy.

A transformation-targeted educational curriculum has been developed, and training underway on additional topics including value-based payment, building medical neighborhoods, population health management & evidence based decision support, and continuous quality improvement.

Regional learning collaboratives will be held to facilitate sharing of best practices throughout the PPS.

- **Preventive Screenings:** Confirmed that practices have policies in place and work flows developed for annual preventive visits, including behavioral health screenings; and processes are in place to assure referral to appropriate care in a timely manner. Challenges in achieving this milestone are limited resources in primary care offices (see "Challenges / Mitigation Strategy" below). The practices have begun reporting preventive visits completed on a quarterly basis.

- **Open Access Scheduling:** Confirmed that practices have open access scheduling, in accordance with PCMH Standard 1: Patient-Centered Appointment Access. The practices have begun reporting "no show" rates on a quarterly basis, and are working on identifying opportunities to reduce "no show" rates.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

- No change; the project serves Medicaid recipients and the uninsured

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 2.a.iv

Challenges the PPS has encountered in project implementation:

Challenge: Four hospitals planned MVs; 1 did not receive Capital. The remaining 3 will likely meet the DY4Q2 date for Project Implementation Speed and Scale. Due to 1 partner not receiving CRFP awards, the patient engagement speed and scale commitment may suffer to reach the total amount of targeted actively engaged patients of 4,472 in DY4Q4. First Actively Engaged Reporting is due September 2017.

Challenge: Secure contracting agreements (Master Participation Agreement and Project Schedule A2s) with Medical Village Partners.

Challenge: Recruiting, hiring, and training staff in new service at medical village.

Challenge: Internal project issue with shortage of Executive Leadership and infrastructure support (SME project champion) for this project. Three different hospitals are planning three different medical villages, with different implementation needs.

Efforts to mitigate challenges identified above:

Mitigation: The organization who did not receive capital funding has the opportunity to apply to the AHI PPS Innovation Fund RFP, or choose to sign-on with AHI and receive funds through the disbursements on the Project Schedule A2.

Mitigation: PPS Finance Committee has determined a methodology for Engagement Funds II Distribution to PPS Partners. AHI PPS has determined a Contracting timeline to prioritize Master Participation Agreements, and Project Specific Schedule A2s. The governing body of the PPS will review the Project Specific Schedule A2s prior to 6/30/16 and the Master Participation Agreements have been distributed to all PPS Partners prior to 6/30/16. During DY2Q2 the PPS plans to fully execute the Project Schedule A2s.

Mitigation: Engage workforce committees to assist with staffing needs. Medical Village Teams are to develop a strategic plan which entails documenting recruitment, retention and training needs for the medical village project.

Implementation approaches that the PPS considers a best practice:

- In-Person Kick Off Meetings held at partner organizations to discuss project plans and implementation strategy (meet and greet format)
- Project Templates developed to assist partners in reporting DOH requirements and protocols (Migration Plan template)
- Development of a summary document demonstrating Quarterly Project Progress to PPS partners
- PPS Partner Engagement activities; medical village project partners contributed to presentations at AHI Regional Team Meetings and Governing Body Meetings
- AHI PPS Project Manager direct involvement in PPS Partner Business Planning Meetings and Business Plan development activities

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The PPS will create three Medical Villages to take advantage of existing infrastructure to realign health system capacity and support the behavioral health, substance abuse and outpatient services needed in the communities.

UVM Health Network—CVPH in Plattsburgh:

1. Adult Mental Health Unit: Redesign hospital space of the Main Floor to create site to provide mental health services and meet State requirements.
2. Behavioral Health Transition Services: Renovate unneeded hospital space to create a site for post-discharge outpatient Transitional Behavioral Health Services in collaboration with community behavioral health and addiction agencies/services. Warm handoffs from the acute phase will be established.
3. Outpatient Pharmacy: Renovate hospital vacated space for outpatient pharmacy services upon discharge from the inpatient mental health unit or ER setting.
4. Patient Navigator: Patient Navigator will assist with the patient transition of inpatient to outpatient and follow-up appointments to allow for a smooth transition of care.

Moses Ludington Hospital in Ticonderoga:

3 Pillars:

1. Hospital 9M Renovation: MLH will de-certify all 15 inpatient beds and will renovate the existing MLH stand-alone ER and will also create an outpatient services center on the ILH outpatient campus under the new operation of The University of Vermont Health Network - Elizabethtown Community Hospital (ECH). The renovated space at ILH will have a new Emergency Department, 3 observation beds, and 4 treatment areas for emergency care, pharmacy services, laboratory services and radiology testing.
2. Primary Care: Expand primary care services and behavioral health integration by co-locating with HHHN. New addition and/or renovation to take place at Inter-Lakes Health.
3. LTC: Long Term Care Services will be provided by a new owner and operator (independent party) that Inter-Lakes Health is selling Heritage Commons Residential Health Care to.

Glens Falls Hospital in Glens Falls: Renovate existing hospital space into a community-based crisis care center, including 23-hour crisis stabilization beds and decertify 4 beds to establish space for outpatient resource. Create readily accessible behavioral health crisis services to adults and adolescents, supporting a rapid de-escalation of the crisis facilitated by the appropriate level of service and providers.

1. Support evaluation, triage and management for patients (adults and youth) that are experiencing acute psychotic episodes or otherwise unstable behavioral health.
2. Provide critical crisis stabilization services through clinical-community linkages.
3. Coordinate specialty care management for complex adult and pediatric patients, with clear linkages to the emergency department, hospital services, Health Home care coordination and community-based agencies.

Medical Village partners received notice of CRFP awards:

- Medical Village partners received CRFP awards March 2016. Adirondack Health was not awarded CRFP for the project, and AHI PPS held a conference call on 3/21/2016 with the organization to explore all possible avenues for mitigation. The organization has expressed interest in submitting for the AHI Innovation Fund RFP once available to potentially receive funds to execute part of the medical village project plans and will determine next steps after review of the project specific Schedule A2.

Medical Village Strategic Plans are in place:

- Partners provided documentation to support the development of a Strategic Plan. In December of 2015, the partners submitted a narrative to explain the process for how the organization will engage with community stakeholders, and also provided a description of the medical village's plan for marketing and promotion for the medical village services, including a plan for consumer education for access to the services. The Moses Ludington Hospital Medical Village in Ticonderoga began internal business planning meetings to develop a business plan to support the goals of the medical village project. The AHI PPS Project Manager began participating in the business planning meetings in May 2016 and has contributed to the organization's business plan and will continue to work collaboratively with the Ticonderoga team to complete the business plan.

Medical Village teams are established:

- AHI PPS Leadership and the AHI Project Manager met with each of the three Medical Village organizations in-person to hold kick-off meetings in April and May 2016. Each Medical Village team is comprised of key stakeholders to implement the project and report on DSRIP requirements.
- During the kick-off meetings, the following was reviewed and discussed:
    1. Partner Medical Village Project Plans
    2. Medical Village Partner Contacts & Lead
    3. 2.a.iv Project Milestones/Tasks Completed to Date
    4. Deliverables due 6/30/2016 DY2Q1 – Migration Plan
    5. Actively Engaged NYSDOH Requirements and Protocols
    6. AHI PPS Schedule A2 Contract Draft
    7. Partner Training & Recruitment Needs – Workforce
    8. May 2016 AHI Regional Health Innovation Team (RHIT) Meetings & August 2016 Steering Committee Meeting
    9. Next steps

Medical Villages are coordinated with Workforce development activities:

- During the Medical Village kick-off meetings, partners identified recruitment and training needs. AHI PPS Workforce Manager engaged with Medical Village project teams to discuss recruitment and training needs, as well as the process for how to apply for funds. Medical Village project Workforce needs are incorporated into Workforce's development activities.

Migration Plans completed for DY2Q1:

- AHI PPS developed a Migration Plan Template for each Medical Village partner to complete for DY2Q1 submission for Milestone 7 completion. The Migration Plan includes 4 sections which satisfy the NYSDOH requirements and protocols.
- Section 1: Description of Medical Village Project Plans

- Section 2: Detailed plan for migration of any services to a different setting or location due to infrastructure changes, including key milestones and dates
- Section 3: Justification description for migration plans evidenced and/or support by the Comprehensive Community Needs Assessment
- Section 4: Explanation of how frequently policies and procedures will be updated

IT & Data Sharing:

- PPS Partner EHR vendor systems and/or data available through health information exchange/RHIO/SHIN-NY will be utilized to track patients engaged in this project. The AHI PPS HIT Workgroup and IT & Data Sharing Committee developed an IT survey during March 2016 that was sent to partners and focused on patient medical record usage, connectivity with other organizations in sharing patient information, plans to manage population health, and ability to report on DSRIP and other performance measures.

Contracting and Master Participation Agreement (MPA) Development:

- PPS Finance Committee endorsed the MPA 05/11/16 for recommendation to AHI BOD to be disseminated for inspection by the partners for contracting. Discussion for approval of the MPA took place during the 5/16/16 AHI BOD Meeting. The outcome of the meeting was a consensus to recommend the MPA to PPS Steering Committee for review. The distribution of the MPA was sent electronically on 5/27/16. AHI PPS Partner Announcement was distributed on 6/6/16 with a target turnaround due date of 6/22/16.

- PPS Leadership engaged the PPS Finance Committee members to review the Project Schedule A2 drafts during the 6/13/16 meeting. PPS Steering Committee was provided an overview of the Final Funds Flow timeline during the June 14 meeting and the committee is charged with the review and endorsement of the Project Schedule A2s and Final Funds Flow Plan by 6/30/16. The PPS Steering Committee convened on 6/27/16 to engage in a decision. The Steering Committee approved for the Final Funds Flow Plan to be filed to DOH for DY2Q1. As of 6/30/2016, 58 Master Participation Agreements have been signed and returned to AHI PPS. The target timeline for Project Schedule A2s to be released to PPS Partners will be executed during DY2Q2.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to the populations served.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 2.b.viii

Challenges the PPS has encountered in project implementation:

DSRIP Project 2.b.viii. "Hospital-Home Care Collaboration Solutions"

For many patients, being discharged from the hospital is synonymous with less restriction and increased comfort – especially if they are being discharged to their own home. Knowing that there will be less restriction and increased comfort that comes with being in a familiar environment, there needs to be a process in place in which there is an effective assessment of each patient's unique condition(s) or co-morbidities, and then subsequent proactive planning, facilitating, and confirming, as appropriate, of home care services – all prior to leaving the hospital. For this process to succeed, ideally all members of the greater interdisciplinary team (primary care, hospital discharge planners, administration, home care personnel, etc.) would be actively participating in this process, with the patient and their caregiver/family being the most important member(s) of the team.

This project requires all members of the greater interdisciplinary team (primary care, hospital discharge planners, administration, home care personnel, etc., actively participate with the patient and the caregiver/family in the discharge to home process. Challenges the PPS has encountered in project implementation are:

- **Ineffective communication and breakdown of communication** - miscommunication, or lack of communication, continues to be a reoccurring issue, both inside and outside of hospitals
- **Inadequate provider accessibility and availability** – the region's status as a Health Providers Shortage Area (HPSA) negatively impacts access to primary care, specialty providers, and long-term care that are needed to strengthen the transition from hospital to home.
- **Lack of a comprehensive regional IT platform** – leads to increased lag time for updated and accurate information, and omissions of relevant data.

Efforts to mitigate challenges identified above:

- Communication and coordination issues can ultimately be resolved with a commitment to maintaining an open dialogue, accountability, and distinguishing clear roles and responsibilities, as mentioned above. The Rapid Response Teams (RRTs) that will be developed as part of this project's requirements will help address this issue – these teams will be comprised of hospital, home care/hospice, and other applicable personnel that will collaborate together to establish clear protocols and procedures for proactive discharge planning, facilitation, and confirmation of appropriate home care services. The development of a role delineation guide, to clearly explicate the roles of team members and their functions, will better position them to accurately communicate and coordinate on behalf of the patient as they are transitioning from the hospital to the home care setting. IT issues, which play a part in the breakdown of aforementioned communication and coordination, will be resolved by the PPS Regional Health Information Technology plan. This will help with identifying or acquiring a platform to support and facilitate documentation and information sharing across the region.

- In addition to the PPS being a designated HPSA, AHI is also a designated New York State Health Home, as well as, the lead for the Adirondack Medical Home Initiative (AHMI). Because of this, the region is optimally positioned to leverage not only the embedded case management, but also the existing relationships with more than 100 primary care providers, five hospitals, and seven health insurance programs that are working together to develop a model of care that strengthens the role of primary care. Telehealth/telemedicine strategies are being explored, as well, to help prepare for realigned service delivery and increased provider availability and accessibility.

- In conjunction with strengthening the accessibility and availability of primary care, the PPS region will more fully develop the concept of "medical villages" – the goal being to effectively utilize existing community resources for successful aging of the population, with home and community services being developed/expanded and promoted.

Implementation approaches that the PPS considers a best practice:

- There is an existing partnership collaborative – the Care Transitions Coalition Partnership – in the southern part of the PPS region that is led by a hospital together with Improving Healthcare for the Common Good® (IPRO) that is considered a best practice. This collaboration includes participation from hospital staff (specifically senior administration) and representatives from home care and hospice agencies, specifically from Directors of Patient Services, as well as the IPRO Care Transitions Team.

  Serving as a forum not only to discuss challenges/barriers, and strategies for mitigation, the coalition also focuses on the evaluation and implementation of best practices related to reducing preventable or avoidable admits; reducing unnecessary ECC visits; increasing effectiveness of verbal and written handoffs between hospital and home care agencies; enhancing easier access for home care agencies in scheduling outpatient testing and services; evaluation of the root causes of readmission to observations or admissions that were caused by failure of the system, as well as, the sharing of data. This partnership collaborative will hopefully be a model for other areas and can be expanded upon.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

While this particular model of collaboration does not exist in the northern part of the PPS region, many local and regional councils, coalitions, task forces, and transitions teams have developed. These groups will be mobilized and employed to help achieve project success.

- ***The Long Term Care Council*** is a group comprised of almost all health and human services providers in Franklin County. The group is tasked to complete a gap analysis, and overwhelmingly agree that lack of direct care support professions to be the largest gap in service.

- ***The Home Care Coalition*** is comprised of Franklin County Office for the Aging, Mercy Care for the Adirondacks, and State Wide Senior Action Council. They have worked through the Long Term Care Council to formulate a campaign to draw statewide attention to the lack of home health aides throughout the region. This is major concern for many counties. A PPS partner, who presented at the *Aging Concerns Unite Us conference* in June, has since collaborated with counties in neighboring PPS' since the discussion resonated with representatives from those counties, as well. She has also discussed the issue with the Directors of Offices for the Aging in Warren, Washington, Hamilton, Essex, Clinton, and St. Lawrence Counties, and all parties agree that without sufficient home health aides to provide care, individuals are not able to be managed in the community.

- ***The Blue Line Group*** is comprised of the four skilled nursing facilities in the Adirondack Park – recently expanded to include North Country Home Services and High Peaks Hospice and Palliative Care. They are the body through which Vital Access Provider (VAP) funding flows. This group has also identified the lack of support professions to be a massive barrier to ensuring individuals are safe in the community. The Blue Line Group are also members of the Home Care Coalition.

- ***The Home Care Transitions Team*** was developed by the Office for the Aging because the transition to MLTC was not going smoothly, and clients were being lost in the shuffle. Team members include local DSS, ICAN (MLTC Ombudsman), North Country Home Services, Nursing Home Transitions and Diversions, Local Medicaid Unit, and case managers from Office for the Aging.

- ***The Multidisciplinary Team*** was created by Franklin County Office for the Aging in 2016. Representation is comprised of administration at Alice Hyde Medical Center, Adirondack Medical Center, Adult Protective Services, Department of Social Services, a physician from the Federally Qualified Health Care Center, Sherriff for Franklin County, Director of Emergency Services, Director of Community Services, Director of Office for the Aging, Sergeant from New York State Police, North Star Mental Health, and the District Attorney's Office. The team has identified respite services as paramount in reducing hospital readmissions, and trips to the emergency departments. This team has identified respite services as paramount to reducing hospital readmission, and trips to the emergency department. The team is developing an educational agenda, rapid response crisis team, and a respite team.

- ***The Aging in Place Task Force*** consists of over 30 individuals representing health and human service providers in the Tri-Lakes area. This group has also identified a large demand for direct care staff.

- ***The Care giving Working Group*** is facilitated by Mercy Care for the Adirondacks and works to facilitate a large group of health and human services providers to identify issues in the community.

In addition to the work being done by these regional councils, coalitions, task forces, and transitions teams, there will also need to be an ongoing effort by Stakeholder groups on the collaborative work being done.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to the populations served; this project is designed to meet the needs of individuals with chronic conditions, who are at high-risk of re-hospitalization following discharge. There are more than 100,000 residents in the AHI PPS largely rural service area that are over age 65 and many suffer from chronic conditions and lack adequate family or other care-giver supports. The target population is specifically defined as:

- Patients discharged from an acute care hospital following an inpatient stay, observation stay, or emergency room visit with one or more of the following conditions: diagnosed hypertension, CHF, pneumonia, diabetes, COPD/asthma, heart failure, mental health, or substance abuse disorders;

- Patients readmitted within 30 days or 3 admissions within a six-month period;

- In some portions of the service area, the project will exclude dementia patients and patients with significant cognitive disabilities, unless they have a coachable care-giver or other coachable support person. In other areas, this exclusion will not apply. The availability of partner agencies and care managers with the skill set to work with this population will be the deciding factor, and developing workforce to meet this need will be part of the overall PPS workforce strategy; and,

- Patients with no primary caregiver in the home and elderly persons with health conditions of their own who are providing care for others will be included.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 2.d.i

Challenges the PPS has encountered in project implementation:

A primary barrier encountered during implementation of project 2.d.i has been the inability to fully engage partners on a large scale, resulting in lower than anticipated screening numbers, thus we have not met Actively Engaged targets. Specific challenges include:

- Without finalized contracts in place, allowing for assurance of compensation and clarification of expectations, partners from all sectors have been reluctant to commit resources to project implementation. We have several partners with staff trained in PAM and CFA (Coaching for Activation), who are eager to begin implementation activities but are not comfortable doing so until contracts are in place. Some partners who had started survey administration and/or using CFA have either stopped entirely or slowed their participation to await completion of contracting.
- Without confirmed compensation amounts, partners who are engaging in project activities are not incentivized to increase the volume of individuals activated through PAM survey administration. This concern is exacerbated in areas where the AHI PPS overlaps with a neighboring PPS that is actively compensating their partners for project activity.
- In some instances, community based organizations are finding it difficult to determine how they fit into DSRIP, and an abundance of unfamiliar terminology and concepts contributes to their uncertainty.
- Hospital partners have expressed hesitancy to embed the PAM survey into their existing work flow, citing concern over appropriateness of survey administration in an acute care setting, concern about already strained resources, and ambiguity about how the survey and other project activities will benefit their patients.
- As the PPS has adapted its approach to the project as a result of contracting delays by shifting focus to survey collection methods other than directly through partner organizations, such as by having AHI staff administering PAM surveys on site at urgent care centers and EDs, or data mining from partner organizations to gather contact information to allow AHI staff to perform outreach to project eligible individuals, additional obstacles have arisen. Some partners are not comfortable with the proposed activities, and others have suggested additional processes, such as amending current BAAs, need to occur first.

Other barriers with less adverse impact on project success include:

- PPS size and rural geography
- Community members' unfamiliarity with DSRIP and the complexity of explaining the topic and its relevance to them succinctly. This challenge present itself mostly when Community Engagement staff are administering the PAM survey at community events or in other public locations

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Efforts to mitigate challenges identified above:

- Two rounds of engagement funds have been distributed to partner organizations so far this year, to compensate partners for their participation in DSRIP projects to date. In lieu of final contracting, disbursement of engagement funds was a way to ensure partners knew their efforts were valued and to compensate them for resources expended on DSRIP activities.
- Master Participant Agreements were released to partners in June 2016, and project-specific addendums (A2s) are intended to be released in Q2.
- The AHI PPS has over 130 individuals trained to administer the PAM survey, exceeding our DY2 Q4 provider engagement target of 75, and almost 40 organizations which intend to participate in the project. As soon as contracts, including the A2s, are in place, many of these partners are prepared to begin implementation immediately.
- AHI Community engagement staff regularly administer the PAM survey at sites throughout the PPS which have been anecdotally identified as "hots spots" (DSS offices, food pantries, soup kitchens, etc), as well as at community events like fairs, job fairs, and festivals.
- Other alternate methods to increase PAM survey volume have included: distributing referral cards which can be used by partner organizations and other AHI programs with direct community interaction, to collect contact information from eligible individuals who are open to receiving an outreach call to take the survey; incentivizing survey participation; and offering to have AHI staff members collect and enter any paper surveys administered by partner organizations.
- Community engagement staff continuously perform outreach to both current and potential partner organizations across all sectors, with a heavy focus on building relationships which will benefit the PPS network. Multiple in-person meetings have been held to address project-related concerns as they arise or to help organizations better understand or feel more comfortable with the project and/or DSRIP as a whole (Please refer to the CBO Meeting Schedule Template for more detail).
- Increasing AHI's social media presence, developing promotional materials and messaging to make the purpose of the PAM survey and DSRIP easier to understand, and increasing community awareness of PPS activities builds a strong foundation for beneficiary engagement once project activities are fully underway.

Implementation approaches that the PPS considers a best practice:

- Embedding all project activities within the work flow of partner organizations which have trusted, consistent relationships with the target population. This will allow for more accurate survey results and consistent follow through to link project beneficiaries to other needed services, such as Coaching for Activation®, health insurance enrollment, referral to a PCP, and social/community services.
- Empowering community members and project beneficiaries to inform project development through input and feedback gathered via focus groups, community forums, and other methods of two-way communication
- Supporting community based organizations to understand their role in health system transformation, and to promote building of partnerships between clinical providers and community based organizations
- Utilizing data to target implementation of project activities
- Collaborating with 2.d.i leads from other PPS to share lessons learned

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

As described in the mitigations section above, project implementation has shifted focus temporarily to utilizing internal resources as the main source of PAM survey administration. However, the PPS is continuing to build on the efforts of the 2.d.i/PAM pilot group convened in late 2015, as a way to learn best practices and gain insight to guide project implementation as it expands throughout the PPS. An MOU was developed with guidance from AHI legal counsel and put in place with 5 partner organizations to pilot project activities. Two of those organizations, HHHN and CVPH, are still administering the PAM survey and have started to utilize Coaching for Activation®. Planned Parenthood Mohawk Hudson and SAIL (Southern Adirondack Independent Living Center) joined the pilot in March 2016 and are actively participating in project activities. As of May 2016, Moreau Community Center joined the pilot, and Community Connections of Franklin County and Clinton County Office for the Aging joined and started PAM administration in June. Plattsburgh Housing Authority, Glens Falls Housing Authority and Washington County Economic Opportunity Council, Citizen Advocates, BHSN, Planned Parenthood of the North Country NY, The Family Counseling Center, North Country Healthy Heart Network, Open Door Mission, Glens Falls Hospital, Alliance for Positive Health, Essex County Public Health, and Clinton County DSS are among the partner organizations which either have staff already trained in PAM and CFA or have trainings scheduled, and will begin (or restart) implementation as soon as contracts are finalized.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to the target population at this time.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 3.a.i

Challenges the PPS has encountered in project implementation:
• We are still working on finalizing contracting with our participants. These efforts were delayed for the AHI PPS in part because of the time it took to confirm Safety Net status for AHI. Until that status was confirmed, we were unable to finalize our governance which has impacted budgeting and contracting. • Access to behavioral health/primary care resources has inhibited the execution of these models.
Efforts to mitigate challenges identified above:
• We have retained consultants and held frequent meetings of our Finance and Steering Committees in order to make up ground on the contracting process. • The AHI PPS continues to work with RHIOs on developing their respective medical neighborhoods, particularly in areas where this obstacle is present. The network committee is assessing network adequacy across all specialties, and developing a strategy to address identified shortages.
Implementation approaches that the PPS considers a best practice:
• N/A
Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
• Locations for integrated delivery have been identified, and implemented in accordance with DOH integrated care guidance. • Policies and procedures are in place to facilitate completion of preventive screenings (including behavioral health screenings), and documentation of screening results in the EHR. • Targeted patients engaged in the project can be tracked, and the process for data collection translated into operational terms.

- Practice transformation resources have been engaged as necessary to successfully meet project deliverables.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

- No change; the project serves Medicaid recipients and the uninsured

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 3.a.ii

Challenges the PPS has encountered in project implementation:

- **Contracting:** AHI is working on finalizing contracts with our partners. These efforts were delayed for the AHI PPS, in part, because of the time it took to confirm Safety Net status for AHI. Until safety net status was confirmed, we were unable to finalize our governance which has had an impact on budgeting and contracting.
- **Capital Restructuring Dollars:** With a delay in Capital dollars for Glens Falls Hospital and Citizen Advocates, Inc plans have been on hold until the announcement which impacts Milestone completion and Actively Engaged participants. In March, the awards were announced and since both GFH and CAI have been working diligently on plans, renovations, certification and hiring of staff. For the two agencies, Behavioral Health Service North and Mental Health Association of Essex County who didn't receive dollars a Plan B will need to be developed.
- **Mobile Crisis Services**: Many of the Behavioral Health providers in this project are not billing Medicaid for Mobile Crisis Services until Behavioral Health Managed Care is rolled out July 1st. OMH has stated Mobile Crisis has been rolled into Crisis Intervention and will not be included in BH-HCBS services. Providers are not expanding or developing new Mobile Crisis Teams until this is figured out. This has potential to effect Milestone 7 as well as actively engaged participants.
- **Staffing and recruitment**: Licensed mental health clinicians and Psychiatric staff such as Psychiatrists, Nurses and Nurse Practitioners and Psychologists are difficult to recruit and hire prior to adding new services to organizations. This could delay the implementation of some of the milestones for the project.

Efforts to mitigate challenges identified above:

- **Contracting:** AHI has retained consultants and held frequent meetings of our Finance and Steering Committees in order to make up ground.
- **Capital Restructuring Dollars:** AHI is working with the agencies who didn't receive funding on developing their Crisis Stabilization Projects and can potentially use engagement funds distributed by AHI to help with plans.
- **Mobile Crisis Services:** Once OMH and DOH release the guidelines and regulations for billing Mobile Crisis Services all BH partners involved will move forward with the development or expansion of Mobile Crisis Services.
- **Staffing and recruitment**: Working with AHI's Workforce Manager is a mitigation strategy that will help with recruitment and retention of staff for Behavioral Health Providers

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Implementation approaches that the PPS considers a best practice:
Training of Law Enforcement Staff through a CIT model.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
Citizen Advocates Inc. (CAI) in Franklin County has received CRFP to renovate unused space at University of Vermont Health Network-Alice Hyde Medical Center to build a Multi-Functioning Crisis Center that will be open 24 hours a day, 7 days a week and will house the Mobile Crisis Team. Crisis Stabilization services will be provided through an integrated OMH/OASAS Article 31/32, Outpatient Satellite Clinic, OASAS 816 Ambulatory Detox, Respite Beds, Case Management, Peer Supports, and Community Supports. The Center will have exam rooms, counseling offices, group rooms, family support area, nurses station, 13 respite rooms, dining area, and adult and youth activity Spaces. CAI is currently discussing renovations with University of Vermont Health Network-Alice Hyde Medical Center and an architectural firm. They are also holding conference calls with OMH/OASAS/CCBHC to discuss certifications, facility, multi-programs, and crisis center guidelines, and working with OMH on determination of Mobile Crisis definitions/requirements. All CAI clinicians are registered in the HCS system and have been trained on LOCADTR. A Psychiatric Nurse Practitioner has been hired and CAI currently has a Physician Board Certified in Addiction Medicine on staff. The Center is targeted to open in the Fall of 2016. **Mental Health Association of Essex County**-MHA of Essex is in the process of developing diversion protocols with local hospital EDs and Essex County Mental Health to divert patients to their Short-term Crisis Respite. MHA of Essex is also in the process of obtaining a second respite location. **Glens Falls Hospital and Warren/Washington Counties**-Through the Medical Village Project GFH will be developing a Community Based Crisis Care Center. The Center will provide appropriate evaluation and triage and will have 23-hour crisis stabilization beds for observation. It will be staffed by a care management team with expertise and training in crisis de-escalation, linking patients to appropriate outpatient services, community agencies and Health Home Coordination. Glens Falls Hospital will triage patients and refer to Parsons Child and Family Center Mobile Crisis Teams as well as PEOPLe, Inc.'s The Rose House, which is a hospital diversion service that is a self-referral short-term stay residence. GFH is currently working with an architect on plans and the location of the Crisis Care Center. The hospital has applied to the PPS for training and recruitment funds. This regional group of behavioral health providers have met eight times with AHI's Project Management to discuss project implementation and achieving milestones. **Family Counseling Center in Fulton County will** be establishing an Assertive Community Team (ACT) consisting of LCSW Team Leaders, a Psychiatric Nurse, a Psychiatric NP, licensed mental health professionals with significant experience in SUD, and Family and Peer Advocates. The team will act as one to provide a

self-contained service delivery system to both children and adults 24 hours per day, 7 days per week to de-escalate a crisis, provide treatment post crisis to prevent avoidable hospitalization, emergency room visits or law enforcement involvement. The Family Counseling Center has drafted policies and procedures and have submitted to AHI a marketing plan detailing how they will promote their new Crisis Services as well as the expansion of their current mobile crisis services with diversion plans. Once all ACT staff are hired, AHI will work with The Family Counseling Center to bring TCI/Therapeutic Crisis Intervention training to their agency. The Family Counseling Center has contacted a trainer to deliver the training.

Behavioral Health Services North in Clinton County-BHSN has been discussing alternative locations for their Crisis Center since they didn't receive capital funding for this project. The Crisis Stabilization Center will include a 10bed community crisis stabilization program to offer short term treatment for adults with a behavioral health crisis, including those with a co-occurring substance abuse concern. The Adult Mobile Crisis Team will also be located here. Discussions are taking place with BHSN, University of Vermont Health Network-CVPH, and Clinton County regarding creating an integrated system as part of the medical village project for mental health patients in acute crisis and patients with acute detox symptoms. AHI's Project Management meets once a month with BHSN to discuss future plans.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

None

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 3.a.iv

Challenges the PPS has encountered in project implementation:

- **Recruitment**: In Plattsburgh, the challenge of finding a board certified addiction medicine physician will potentially slow down the start of detox services in Plattsburgh, as well as, finding the appropriate medical staffing for the detox services.
- **Contracting**: AHI is working on finalizing contracts with our partners. These efforts were delayed for the AHI PPS, in part, because of the time it took to confirm Safety Net status for AHI. Until safety net status was confirmed, AHI was unable to finalize the PPS governance which has had a negative impact on an ambitious budgeting and contracting schedule.
- **Capital Restructuring Dollars:** With a delay in capital restructuring dollars, withdrawal management services for CAI and CVFC were on hold until the announcement which was not until March of 2016. This has an impact on milestone completion and actively engaged participants. Since the CRFP announcement, both CVFC and CAI have been working diligently on plans, renovations, certification, and hiring staff.

Efforts to mitigate challenges identified above:

- **Recruitment:** A mitigation strategy will be to work with the Workforce Manager and OASAS to recruit a board certified addiction medicine physician and other licensed staff such as RNs and LPNs. Recovery Coaches will be used when appropriate and the training will be brought to the PPS to increase the recovery coach pool. AHI PPS will also work with CVFC and CAI and the workforce manager to develop more Credentialed Alcoholism and Substance Abuse Counselors (CASAC) in the region.
- **Contracting:** To mitigate this risk, AHI has retained finance consultants and is meeting frequently with the Finance and Steering Committees in order to make rapid progress on a delayed timeline.
- **Capital Restructuring Dollars:** Both agencies involved in the 3.a.iv project received money to implement withdrawal management services therefore no mitigation strategy is needed.

Implementation approaches that the PPS considers a best practice:

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OASAS 816 Chemical Dependence Withdrawal and Stabilization Services
OASAS 820 Residential Services

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Citizen Advocates Inc. (CAI) in Franklin County has received CRFP to renovate unused space at University of Vermont Health Network-Alice Hyde Medical Center to build a Multi-Functioning Crisis Center that will be open 24 hours a day, 7 days a week and will house the Mobile Crisis Team. Crisis Stabilization services will be provided through an integrated OMH/OASAS Article 31/32, Outpatient Satellite Clinic, OASAS 816 Ambulatory Detox, Respite Beds, Case Management, Peer Supports, and Community Supports. The Center will have exam rooms, counseling offices, group rooms, family support area, nurses station, 13 respite rooms, dining area, and adult and youth activity Spaces. .
CAI is currently discussing renovations with University of Vermont Health Network-Alice Hyde Medical Center and an architectural firm. They are also holding conference calls with OMH/OASAS/CCBHC to discuss certifications, facility, multi-programs, and crisis center guidelines, and working with OMH on determination of Mobile Crisis definitions/requirements. All CAI clinicians are registered in the HCS system and have been trained on LOCADTR. A Psychiatric Nurse Practitioner has been hired and CAI currently has a Physician Board Certified in Addiction Medicine on staff. The Center is targeted to open in the Fall of 2016.

Champlain Valley Family Center in Plattsburgh received State funding to renovate a building for an OASAS certified 820 Residential Services facility which will be open 24 hours per day, 7 days per week. The facility will provide structured treatment/recovery services in a residential setting to persons recovering from substance use disorder. A 10-bed stabilization unit will be licensed by the NYS Office of Alcoholism and Substance Abuse Services.
Progress to date-Champlain Valley Family Center has hired a Program Director for the new facility and staff members are attending in- person meetings at OASAS focused on Policy and Procedure Development for an 820 Withdrawal and Stabilization Application. Staff is also meeting with other program staff throughout the State who are developing similar programs. CVFC is also part of the Learning Community for the new 820 OASAS regulations which offers training for staff on developing a vision and implementation plan, successfully implementing this plan, and assessing and revising implementation. In July, DASNY, OASAS, and the Architectural firm will be reviewing the Feasibility Study and renovation design. It is expected that the stabilization (withdrawal services) facility will be opening during the first quarter of 2017.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

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None

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 3.g.i

Challenges the PPS has encountered in project implementation:

DSRIP Project 3.g.i "Integration of Palliative Care of PCMH"

Increasing access to palliative care programs for persons with serious illnesses and those at end of life can help ensure care and end of life planning needs are understood, addressed and met prior to decisions to seek further aggressive care or enter hospice. This can assist with ensuring pain and other comfort issues are managed and future health changes can be planned for.

Primary care provider(s) are optimally positioned to address the initial palliative care needs of many patients and families. Patients often turn first to their PCP to discuss a new diagnosis or issues related to advanced care planning, grief and bereavement. Primary care provider(s) have the opportunity to facilitate early palliative care interventions and consults and can also identify community resource referrals. However, some of the barriers below hinder the PPS' ability to facilitate these interventions

- **Varying degrees of familiarity with palliative care** – what it is, how it is simultaneously similar and different from hospice care, or the importance that it signifies. If PCPs *are* familiar with it, many PCPs experience or foresee some discomfort with having an open and honest conversation with patients regarding their beliefs, values, and goals of care.

- **Limited amount of practitioners that are board-certified in palliative medicine** that could assist in engaging primary care providers.

Efforts to mitigate challenges identified above:

Lack of education and engagement is currently being addressed by various training opportunities and educational activities that have taken place and will continue to be offered throughout the region.

- Many of the PPS partners have attended conferences and workshops in DY1 and DY2 that have been geared toward palliative care/end-of-life planning. Additionally, there is a strategic PPS-wide training plan being developed (in conjunction with Workforce) to continue to identify or conduct

palliative care training, and to ensure that PCPs and other providers understand the benefits of palliative care for the chronically ill patients in the PPS.

- The PPS Project Champion, a board-certified palliative care physician, is working closely with the PPS and is a valuable resource to primary care practices. She is very passionate about palliative care for the community and is eager to speak about the benefits of palliative care, to both medical and non-medical individuals alike. She leads an inpatient palliative care team for a hospital in the region, which includes a home care-palliative care nurse that has completed ELNEC (End of Life Nursing Education Consortium) training, in addition to a nurse practitioner that has completed the "train the trainer" model for Respecting Choices based out of La Crosse, Wisconsin.

Implementation approaches that the PPS considers a best practice:

- AHI, as the lead for the Adirondack Medical Home Initiative (AHMI) in Upstate New York, is utilizing this avenue for training, education, and provider engagement. The region is optimally positioned to leverage the existing relationships with more than 100 primary care providers, five hospitals, and seven health insurance programs that are working together to develop a model of care that strengthens the role of primary care. This is integral for project success.

- There is a partnership in place between a hospital in the southern region of the PPS that is collaborating with the area's largest Federally Qualified Health Center (FQHC) that has proven to be very successful in increasing awareness and access to palliative care services. There is a deep understanding of the need, and value, of not only palliative care as a concept, but also working towards making available outpatient palliative services, that can work together with existing inpatient palliative services. This type of partnership will be expanded upon and can be implemented in other regions of the PPS.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

There are two specific opportunities currently being examined for further integration into project implementation so that the importance of exploring and clarifying goals of care with family, close friends, and health care providers is highlighted and emphasized.

These two opportunities include the implementation of the Respecting Choices® paradigm in the PPS region, and public screenings of "Being Mortal", based on Dr. Atul Gawande's book of the same title.

- PPS partners and other interested community providers and partners convened for a leadership engagement event to discuss Respecting Choices® and determine if this initiative is a project activity that the project team would like to pursue. This would increase awareness and knowledge about palliative care and end-of-life planning/ end-of-life care. Due in part to the magnitude of implementation, which necessitates time needed for thoughtful consideration of cost, timeline, and the demands on/ realignment of workforce a decision has not been made.

- Two PPS Partners out of 200 partners nationwide were chosen by the Hospice Foundation of America to conduct public screenings of PBS's FRONTLINE "Being Mortal" – which is being utilized to sustain the conversation regarding the importance of talking about preferences for end-of-life care with family, friends, and medical professionals. These screenings will occur in DY2, Q2 and Q3. AHI will work with the host partners to make all PPS Partners aware of the viewing opportunity. Partners agree screenings such as this are critical to initiating the conversation among partners and consumers. Steps have been discussed to consider having these screenings in various parts of the PPS region.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to the populations served; the target population includes all patients enrolled in a patient-centered medical home, and those that would qualify for hospice services. This population is broken down further into these four categories:

- All adult patients should receive education regarding the importance of advance care planning (MOLST, health care proxy and advance directives);

- Adults with serious and acute health changes that are experiencing distressing symptoms (dyspnea, nausea, etc.), disease progression, and/or functional decline. These patients would benefit from more specific advance care planning and routine symptom assessment (depression, pain, non-pain physical symptoms, anxiety);

- Adults with multiple chronic illness/high symptom burden OR that have a limited life expectancy and would qualify for hospice services. These patients, in conjunction with their physician, should

complete the New York State of Health's (DOH) Medical Orders for Life Sustaining Treatment form (MOLST; DOH-5003); and,

- Children with chronic, complex or life-limiting/life-threatening conditions including, congenital/genetic, cardiovascular, neuromuscular, and malignancy, among others.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:
• Identifying resources to staff the PPS sub-region work groups has been challenging due to competing priorities.
Efforts to mitigate challenges identified above:
• The Regional Healthcare Innovation Teams (RHITs) will be a catalyst for identifying resources from each area to staff the sub-region work groups.
Implementation approaches that the PPS considers a best practice:
• N/A
Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
• The PPS sub-region groups are beginning to form and the groups' immediate priority is to review/revise the MEB Integration Plan.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
• No change; the project serves Medicaid recipients and the uninsured.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Adirondack Health Institute, Inc.

Project: 4.b.ii

Challenges the PPS has encountered in project implementation:
• **Training**: Primary care physicians will need to be trained on the GOLD standards. Physicians have tremendous time demands and are challenged to find the time to attend a training. Training of appropriate mid-level staff on spirometry and an action plan for COPD to work into the flow of patient. • **Management of COPD patients in rural areas**: Management of COPD patients in rural areas with telehealth to keep readmission rates lower. Getting patients set up with telehealth (monitoring of COPD symptoms) in rural areas can be costly and exhausting of smaller home care agencies who do not have the infrastructure. • **Contracting:** AHI is working on finalizing contracts with our partners. These efforts were delayed for the AHI PPS, in part, because of the time it took to confirm Safety Net status for AHI. Until safety net status was confirmed, AHI was unable to finalize the PPS governance which has had a negative impact on an ambitious budgeting and contracting schedule • **Engagement of providers**: Getting physicians, home care agencies and skilled nursing facilities to be engaged in the project. Along with day-to-day activities, new regulations, and other DSRIP projects, organizations are pushing back from additional requirements. Regionally, COPD rates exceed state rates and it will be important to get providers to buy in to this project with a plan for sustainability. To mitigate this risk, AHI will finalize contracts with providers to enable the physician champion to start working with primary care providers. Also, CMS will be penalizing hospitals for excessive readmissions.
Efforts to mitigate challenges identified above:
• **Training-** AHI will mitigate this challenge by gaining organizational support at the medical leadership level to deliver trainings to physicians on adopting and implementing the guidelines. Project staff are working with the workforce manager and regional teams to find a trainer to train staff on spirometry. • **Management of COPD patients in rural areas** AHI will mitigate this challenge by working with AHI's telehealth program to purchase appropriate equipment, as well as, larger home care agencies to possibly sub-contract appropriate telehealth/monitoring services.

- **Contracting:** To mitigate this risk, AHI has retained finance consultants and is meeting frequently with the Finance and Steering Committees in order to make rapid progress on a delayed timeline.

- **Engagement of providers**: To mitigate this risk, AHI will finalize contracts with providers to enable the physician champion to start working with primary care providers and incentivize through the funds flow process of A2 Schedules. Also, CMS will be penalizing hospitals for excessive readmissions.

Implementation approaches that the PPS considers a best practice:

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) standards for proper diagnosis, management and prevention of COPD.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

- **Evidence-Based Guidelines:**
  GOLD Standards - The Global Initiative for Chronic Obstructive Lung Disease (GOLD) works with health care professionals and public health officials to raise awareness of Chronic Obstructive Pulmonary Disease (COPD) and to improve prevention and treatment of this lung disease for patients around the world. This DSRIP project will be advancing efforts to focus on implementing the GOLD standards into Primary Care offices, Skilled Nursing Facilities, and Home Care Agencies. The GOLD guidelines focus on the proper diagnosis, management, and prevention of COPD.
  The COPD-PS population screener - this evidence based tool will be recommended if primary care offices decide to implement a screening tool to assess at risk patients. If a patient receives a score of 5 or higher it is recommended a spirometry test be performed.
  Tobacco treatment - Partners will have an option to work with the North Country Healthy Heart Network or Glens Falls Hospital to adopt evidence-based tobacco treatment and work to integrate tobacco treatment into daily practice.

- **Trainings**: Eight trainings were delivered to over 75 mid-level providers by Natalie Venon, Clinical Science Consultant. The trainings discussed a high level overview of COPD and a review of the Global Initiative for Chronic Obstructive Lung Disorder (GOLD) standards. Diagnosis, management, COPD prevention, and an introduction to an evidence-based screening tool and spirometry testing was discussed.

- **Project Champion**: AHI has identified a physician champion to help implement the GOLD Standards. This pulmonologist has witnessed a drop in readmission rates to single digits since joining an AHI partner hospital organization by helping COPD patients manage their health rather than the disease. AHI is working on a contract with this organization so the physician can help primary care offices implement the GOLD standards and also help to properly diagnose and manage patients with COPD

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
In the original plan, Home Care Agencies were not included. It is important that Home Care agencies be involved and following the same guidelines as primary care offices, especially for management of COPD.