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DSRIP Independent Assessor

Mid-Point Assessment Report

Advocate Community Partners LLC PPS

Appendix PPS Narratives

November 2016

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Prepared by the DSRIP Independent Assessor

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DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Advocate Community Providers, Inc.

Highlights and successes of the efforts:

ACP OVERALL – The period of April 1, 2016 through June 30, 2016 was a period of rapid maturation of ACP as an organization and re-focusing of our projects and processes. The April 2016 site visit by SDOH included a comprehensive review of ACP projects and policies/procedures. The written findings of that review served as the basis for a plan of action that resulted in significant change.

Mary Ellen Connington, RN joined ACP as its Chief Operating Officer on May 2, 2016. ACP engaged the services of Dr. Richard Bernstein to revise ACP's evidence based guidelines to be more reflective of national standards and align with CPG's of local health plans and hospitals.

Mr. Jason Helgerson and Ms. Peggy Chan attended ACP's anniversary celebration wherein they addressed ACP physicians and staff on the future of DSRIP and addressing ACP's vision of achieving project outcomes.

ACP's Chief Medical Officer Diego Ponieman, MD, MPH and Director of Workforce Moises Perez hosted a physician forum designed to explore and address barriers to physician engagement in the ACP network. Topics explored were the realities of community physicians as small business owners who are responsible for many administrative functions beyond clinical functions. Examples of this include: physician as Human Resources Director, IT Director, etc. The forum also addressed identifying and supporting champion providers within practices, strategizing and improving access to care and other topics.

ACP negotiated major changes in the Centene contract that significantly reduced payments.

ACP planned for a new vision in the provision of Technology, Data and Analytics. The ACP Board appropriated resources to take the Data/Analytics function in a new and innovative direction to achieve best-in-class status. A Chief Technology Officer was recruited to architect a cloud-based platform, and ACP leaders met with Joe Conte of the Staten Island PPS to view their platform for calculating measures.

ACP worked with Healthix to develop a program to support ACP providers in the implementation of RHIO services. ACP executed a formal contract with Healthix and implementation meetings are intensively underway.

ACP conducted a formal Physician Workforce Survey and is currently analyzing results for insight.

ACP prepared for Value Based Payment reform by engaging in preparatory session with KPMG regarding the pilot and innovator programs. ACP declared its intent for both of these programs.

ACP hosted Dr. Kerner and PCG representatives to review and comment on ACP's interpretation of the IMPACT model. ACP is incorporating changes to the model based upon this feedback.

ACP filed an appeal with CMS regarding the findings of the IA with regard to Board approval of the CC/HL Plan. ACP filed a letter of reconsideration with SDOH subsequent to SDOH's delaying by one quarter any item that requires Board approval.

FINANCE – FINANCIAL SUSTAINABILITY

The providers in ACP's PPS network primarily are independent physicians and community-based organizations. In DY1, ACP had no indication that any of its network physicians or partners were at risk for immediate financial failure.

ACP has identified approximately 700 physician practices in its network that lack the financial resources needed to implement PCMH certification. ACP is actively providing financial and information technology resources to help these PCPs ensure their practices are PCMH certified within the state's mandated timeframe.

ACP successfully developed a Financial Sustainability Plan to monitor the financial health of its network providers. The network providers were surveyed in Q1 2016 using four baseline indicators to measure their financial health:

(1) Operating margin
(2) Current ratio
(3) Debt ratio
(4) Days cash on hand

A provider would be put on the Financial At-Risk Monitor List if its financial ratios fell below the critical value as follows: (1) Operating Margin less than zero or negative, (2) Current Ratio less than 1, (3) Debt Ratio exceeds 1, and (4) Days cash on hand less than 15 days. Network providers on the At-Risk Monitor List will be surveyed twice a year; providers in good financial health will be surveyed annually.

ACP has established Revenue Loss reserve funds in the budget to be ready to support hospital and other partners should they experience decreased revenues in DY2 through DY5.

FINANCE – FUNDS FLOW

Throughout DY1, ACP successfully established funds flow distribution models to distribute incentive and project implementation funds. As of DY2 Q1, $8.1M had been distributed to network providers and hospital partners.

Approximately 300 practices and specialists and 5 hospitals have benefited to date. For those providers not yet paid, the funds flow model has been established, calculations completed and ACP is prepared to distribute incentive payments in DY2 Q1 to the Clinic, Case Management, Mental Health, Pharmacy, Hospice, CBO and all Other providers.

Physicians, Hospitals and Other partners will continue to be able to earn Incentive payments if performance on metrics is achieved. All providers in ACP will be trained to succeed in a managed Medicaid environment where appropriate utilization is encouraged, and performance, quality and outcomes are tracked and rewarded.

GOVERNANCE

Advocate Community Providers finalized the Board of Director structure, which is comprised of 25% AW Medical, 25% NYCPP, and 50% Northwell Health.

ACP created a committee structure that is responsible for reporting to the Board of Directors: Steering Committee, Clinical Quality Committee, Finance Committee, HIT Committee, Audit Committee and Compliance Committee. Each member of the corporation has assigned a representative to each committee to participate in conjunction with key stakeholders of the organization. All of the committees meet at minimum on a quarterly basis. The Committees have put in place protocols and guidelines for the organization and projects that are being implemented.

ACP's partners have signed a Provider Participation Agreement (PPA) committing them to the ACP DSRIP goals.

During DY1, ACP developed and obtained governing body approval for ACP's:

- Community Engagement Plan
- Workforce Communication and Engagement Plan, and
- Public Agency Coordination Plan

<u>Community Engagement</u>

ACP completed a thorough "Hotspot" analysis of its patient/geographic base that is being utilized to target the deployment of ACP people and resources.

To date, a total of 6 CBOs have been contracted with for a total of $250,000 in support of ACPs projects and workstreams deliverables.

A total of 21 Community Health Workers and 2 CHW Supervisors were recruited, trained and deployed across ACP's network area. CHWs play a major role in implementation of the community engagement plan and patient outreach. CHWs were recruited directly from the communities in which they work and as frontline workers are chiefly responsible for maintaining two-way communication with stakeholders. CHWs have engaged 115 medical practices and 56 pharmacies, interacting with more than 4,000 ACP patients.

ACP has signed partnership agreements with 9 schools and organized 12 health, fitness and reading events at 11 schools, engaging 1,385 children and their families.

A total of 11 community health forums have been held, impacting 497 individuals. Two ACP health fairs have been held.

Health Week, a major event that mobilizes a wide range of community resources to highlight the importance of fitness, nutrition and connections to primary care will be launched in Morrisania in the Bronx, the state's "sickest" community district.

Workforce Communication and Engagement Plan

A web-based workforce training/communication portal has been designed in contract with the 1199TEF and is operational. A DSRIP 1.01 workforce training module has been designed and will be fully operational by DY2Q2.

Public Agency Coordination Plan

A comprehensive collaborative agreement has been signed with the NYC DOHMH.
Initially, the agreement will facilitate implementation of a major disease self-management initiative. Direct linkages with local DOH stations in support of ACP projects is also underway.

Negotiations are underway for collaborative agreements with key public agencies that include: NYC HRA, NYCHA, DOE, DIFTA, local school boards, and individual schools.

ACP signed contractual agreements with three CBOs to implement its Public Agency Coordination Plan strategy: Northern Manhattan Improvement Corp, RAIN Inc., Chinese American Planning Council.

PHYSICIAN ENGAGEMENT

Physician Engagement processes to date have consisted of developing physician and staff-friendly materials. Protocol summaries, quick reference guides, "how to's" that include step-by-step instructions with screen shots have been prepared and distributed to the physicians' offices during in-practice visits.

Physicians and their staffs have received one-on-one trainings on project requirements as well as on efficient ways to capture all procedures performed for accurate and reportable documentation. With a firm understanding that our providers' practices are already burdened with many processes and documentation requirements, ACP has put a great deal of time and effort into creating processes that improve patient care, produce better outcomes, and create efficiencies at the practice level. These materials have been presented via general physician engagement meetings as well as in-person practice trainings.

In assisting with DSRIP project requirement compliance, ACP has developed materials for patient education in four languages that can easily be presented to and understood by the patient. We have shared with our physicians the necessary metrics and made arrangements with our majority EMR vendors to expedite documentation in a more condensed manner.

CULTURAL COMPETENCY AND HEALTH LITERACY

- Hired Workstream Manager;
- Convened a CCHL Committee that meets quarterly;
- Finalized CCHL strategic plan;
- Finalized training strategy and specific training plan to address health disparities;
- Identified priority groups experiencing health disparities, identified "hotspots" in target area.

WORKFORCE

ACP contracted with the Center for Health Workforce Studies (CHWS) who administered the workforce survey and collect point-in-time data from ACP network providers on their workforce configuration, compensation and benefits, current training efforts, future training needs, and staff functions.

Initiated work with CHWS on all Workforce deliverables.

Organized a Symposium on May 31 to assess the organizational impact of DSRIP on neighborhood medical practices.

Conducted wide range of training across the PPS that includes PCMH; CHW Core Training; Compliance Training (Including HIPPA); Physician Training:

- 170 physicians and medical practice staff attended in-person introductory physician engagement meetings, where an overview of ACP PPS, DSRIP and the projects was provided.

- 197 office managers and office administrators were trained on an individual basis at their practice by one of ACP's physician engagement representatives on ACP PPS, DSRIP and projects.

- 133 staff of medical practices attended Project 3.a.1 medical assistant/in-practice behavioral health care manager training as part of the IMPACT model. This training focuses on how to appropriately integrate Mental Health and Substance Abuse with Primary Care Services to ensure coordination of care for both services. This integration will take place through three Patient-Centered Models:
  - Model I: Providing Behavioral Health in Primary Care Settings
  - Model II: Providing Primary Care in Behavioral Health Sites/Center
  - Model III: Implementing IMPACT Model

- 17 ACP Community Health Workers received intensive training by Sobeira Guillen, LCSW, BCD on: the helping relationship, professionalism, professional boundaries, communication, safety in the field, adult mental health, outreach engagement and referrals, telephone etiquette and professionalism, patient self-management.

Contracted with 1199TEF as Primary Workforce/Training consultant.

- They will provide ACP with three staff:
  - One full-time DSRIP Workforce Consultant
  - One part-time Field Coordinator
  - One part-time Recruiter

- 1199SEIU TEF developed the workforce portal through HWApps, which will offer:
  - Training to ACP network providers' staff
  - A job center where vacancies will be posted and resumes will be collected.

Developed and launched DSRIP 101 web-based training module.

POPULATION HEALTH

Population health – preventing people from getting sick and preventing the sick from getting sicker – is fundamental to Triple Aim. ACP is facilitating transformation among our independent physicians by encouraging a collaborative, technologically enabled, value-based, culturally competent and patient-centered model of care.

Physician Engagement

- Ensuring that our network of partner physicians understand and are comfortable with how to manage population health.
- Emphasis on preventive care and proactively managing chronic diseases.
- Implementing an organized, planned approach to care both during and between office visits, working with physicians and their workflow.
- Extending our network to fill gaps.
- Implementing PCMH to ensure patient-centered interventions.

Value-Based Payments

- Focusing on transition to Value-Based Payments: through Triple Aim (increasing quality, at a low cost and with great patient experience).

Care Management

- ACP Care Managers provide extra assistance, checking in regularly with high-risk, chronically ill and high utilizer patients to see how they're doing and working with their challenges, adding care coordination.
- Mining data to identify patients with care gaps, whether or not they seek care.
- Access to providers is increased, patients are educated about their conditions and the importance of following their care plans.

Patient Engagement

- Facilitating patient engagement, starting at the level of the waiting area, to encourage healthy behaviors and ability of patients to take care of themselves.
- Personalized treatment plans (reflecting our own population socio demographic challenges)

Collaboration

- Collaborating with NYC DOH to implement Q-tac with National Diabetes Prevention Program (NDPP) and Diabetes/Chronic Disease self-management, training more coaches to improve access to our physicians and their patients.
- Collaborating with established community based entities.
- Facilitating cooperation among primary care providers and specialists, PCPs and Hospitals
- Information exchange
- Cooperation with specialists who are cost effective and perform to high quality standards

IT

- Completion and approval of ACP's current state of IT systems. Target Operating Model (facilitated by KPMG in mid-2015) is still the approach taken by ACP.

- Completion and approval of ACP's Integrated Delivery System Roadmap, which includes the future state approach of creating Data Stores, Enterprise Data Warehouse/Repositories and the relevant connectivity efforts required for virtual integration.
- Rollout and deployment of centralization of two key EHRs in ACP's community-based physician network (MDLand and ECW).
- Execution of contracts with vendors that will start the PCMH process with physicians.
- Execution of contract with Healthix, the partner RHIO that ACP will use for the DSRIP program.

PERFORMANCE REPORTING

- Reporting structure established, including data sources and reporting work flow approaches. Currently developing cloud-based environment (Amazon Web Services) and corresponding security requirements to accept state Medicaid data.
- Training programs and training schedule established to date. ACP recently re-strategized approach for engaging and training next tier physicians.

CLINICAL INTEGRATION

- Completion and approval of ACP's Integrated Delivery System Roadmap, which includes clinical integration needs assessment of network (assessment requested for existing infrastructure, capabilities, data sharing, PCMH level (if required) and potential existing RHIO connectivity).
- Establishment of culturally competent Care Coordination program that engages patients with their care requirements and addresses barriers to receiving this care.
- Execution of contracts with vendors that will start the PCMH process with physicians.

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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: Advocate Community Providers, Inc.

Project: 2.a.i

Challenges the PPS has encountered in project implementation:
ACP has encountered several integration challenges regarding project 2ai, including: • Development of an adequate security plan as part of the security workbooks. ACP is retaining Amazon Web Services, who are familiar with the guidelines and requirements, in order to address current gaps within DY2 Q2. • High volume of providers requiring PCMH. ACP's community-based network has many primary care physicians who will be submitting an application for PCMH. While many of these Primary Care Physicians have previously achieved 2008 and 2011 PCMH level 3 certification, some will submit an application for the first time. ACP is assessing the Advance Primary Care option for those who may not have the systems or processes to achieve PCMH status. • High volume of community-based providers, which will impact RHIO connectivity speed. ACP is working closely with Healthix to formulate an appropriate roll out schedule. • ACP's community-based network, comprised of independent physicians, utilize a wide array of EHRs; however, most physicians use a concentrated set of EHRs.
Efforts to mitigate challenges identified above:
• ACP originally had an in-house lock-box server with limited functionality. Moving forward with Amazon Web Services allows for more flexibility in addressing workbook needs. • ACP has partnered with four vendors with experience helping the community-based providers achieve 2008 and 2011 PCMH status. These vendors have the relationships and an existing understanding of office workflows that can assist with expediting the certification process. • Continuing weekly dialogue with Healthix keeps the schedule clear with appropriate accountability for responsible parties. Additionally, ACP works closely with EHRs to ensure technical issues are immediately addressed. • ACP has prioritized ECW and MDLand, which represent a high percent of its primary care physicians. Next priority is to address EHRs outside of these two dominant systems.

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Implementation approaches that the PPS considers a best practice:

- Physician leadership at the IPAs that comprise ACP has relationships with their community-based physicians, which allows ACP to move forward with its grass-roots initiatives.
- The IPAs have long-term and very successful experience with level 2 value-based payment contracts. ACP will leverage this experience when the transition to value-based care occurs.
- IPA physicians are part of ACOs that already are familiar with data sharing, adherence to evidence-based care/protocols and care coordination processes.
- A high percent of physicians belongs to two dominant EHRs; ACP has worked on centralization of systems where data from physicians with these EHRs can be captured centrally.
- Primary care has high patient volume that is satisfying ACP speed and scale commitments with patient engagement. Those who are currently PCMH level 3 certified have the workflows and processes in place to successfully capture appropriate flags that indicate positive patient engagement.

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

ACP is working closely with vendors to establish a centralized solution to meet DSRIP goals. Participation in the IT Target Operating Model, facilitated by KPMG in 2015, helped identify the need for an effective care delivery system that suggested central repositories and aggregated sources of data (this model, with some modification, is still the basis for many system design approaches for ACP). These vendors, including EHRs (ECW and MDLand) and Optimus Health Analytics, are assisting with efforts to combine data from our independent community-based physician practices to achieve objectives. The ability to have a centralized system for clinical EHR data from community physicians will allow ACP to get to the source where care gaps are closed, preventive medicine can be emphasized, and early detection of chronic conditions can be made.

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

As with other projects, similar findings have been seen with ACP's population (ACP hotspots have been increasing with time). The need for an effective, monitored integrated delivery system will facilitate proper care, provide support to practices that are beyond capacity, and allow for analytics that can further target populations within hotspots.

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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: Advocate Community Providers, Inc.

Project: 2.a.iii

Challenges the PPS has encountered in project implementation:

ACP's Health Home at Risk project implementation has encountered the following challenges.

1. Cultural Barriers: Our population has traditional dietary and eating patterns that are not conducive to lifestyle modification and disease self-management behavior.

2. Changing the mechanics of primary care offices: Practices need to become PCMH 2014 level 3 certified and align with evidence-based guidelines for ACP's DSRIP projects (e.g., Million Hearts Campaign, IMPACT Behavioral Health depression care model). These offices will need to incorporate more patient education and spend additional time with no additional reimbursement.

3. Many of our patients do not know how to navigate healthcare services appropriately, making it difficult to manage their condition and prevent deterioration of their health. Social determinants of health faced by our patients include poor housing conditions and limited access to transportation.

4. Low levels of health literacy make it difficult for patients to understand or self-manage their condition, comply with care plans, or modify their lifestyle.

5. Identifying which patients are enrolled in a health home has been challenging due to the limited interoperability of our existing IT infrastructure.

6. Our partner health home in Manhattan and the Bronx was decertified.

7. The lack of familiarity with the Health Home eligibility criteria by our Primary Care Providers hindered the referral process to ensure appropriateness of care.

Efforts to mitigate challenges identified above:

1. Challenges related to cultural barriers are being addressed by working from within the population itself through a collaborative effort with our participating CBOs and neighborhood programs to reach the patient in their own language and tone, including families and caregivers, who are often responsible for the patient. ACP has developed handouts and population-wide education materials for these community organizations, where we have also held health fairs and informational presentations on topics such as nutrition and asthma, giving the patient a one-on-one feeling of caring in their community setting.

2. ACP is providing support and training to front- and back-office staff. ACP has trained and deployed Physician Engagement staff who have provided easy-to-use materials that are being incorporated into EMRs, making patient education more effective and efficient. ACP has created simplified workflows and formed a back office with care management/care coordination team to assist in providing and supporting patient with disease care management and health education skills.

3. ACP has a large network of diverse health care providers who can address and provide the needed care and services. ACP has established agreements and working relationships with these entities in order to improve our patient's access to care and have further access to culturally sensitive care. ACP with its Care Coordination/Care Management team will close the gap of access services by providing coordination for timely appointments and other services that the patient might require in order to improve patient experience and enhance health outcomes.

4. ACP has developed relationships with housing organizations, MCOs, and transportation providers, and continues to use other community resources to assist and intervene as appropriate. ACP has also leveraged its social support systems and partners to assist as needed. ACP's Care Coordination and support teams help patients in obtaining necessary services.

5. ACP is creating educational materials and patient incentives and is negotiating with MCOs to cover additional care enhancing services (e.g., smoking cessation).

6. ACP is building a robust IT function and EHR vendor connectivity. We are building a centralized platform utilizing the RHIOs and the EMRs such that we will be able to send and receive real-time data from all network resources including health homes that can then be filtered and analyzed to put in place strategic action plans.

7. ACP has established a relationship with Health Home Community Care Management Partners (CCMP), a community-based health home comprised of eight partners serving Manhattan and the Bronx, in order to serve our eligible patients.

8. ACP has developed a protocol for the Health Home at Risk project that explains and clarifies the Health Home enrollment criteria to help our PCPs provide the patient with the best and most appropriate level of care.

ACP is strongly positioned to respond to these challenges. ACP is engaging physicians, nurses and other providers through its network. Self-management is taught through patient education and care coordination models. Evidence-based guidelines have been created to standardize optimal care and identify and manage health Home at Risk interventions and their risk factors.

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Implementation approaches that the PPS considers a best practice:

The goal of ACP's Health Home At-Risk Intervention Program is to proactively manage higher risk patients who are not currently eligible for Health Home by providing access to high quality primary care and support services and through comprehensive care management. By modeling Health Home-quality practices and care management for patients who would benefit but are not eligible, we ensure quality, adequacy and frequency of care to avoid the progression into a Health Home. Health Home elements incorporated in standard practice include comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings, including appropriate follow-up, individual and family support, referral to community and social support services as appropriate, and use of HIT to link services.

ACP addresses health care disparities in our communities by incorporating culturally sensitive care and improving health literacy and implementing evidence-based best practices. ACP is embedding itself through its culturally relevant providers and community resources into the very fabric of the community that it serves. To achieve better disease self-management, it is imperative that health education is administered in ways the patient understand and can engage with on a daily basis.

HEDIS training has been provided to ACP project managers in order to get the most updated information on quality state measures, provide the best evidence-based evaluations, to support providers in becoming more effective and to ensure successful outcomes during performance DSRIP years.

Additional initiatives include the creation of physician-friendly materials distributed by the Physician Engagement team. Physician forums have been conducted where project updates are presented, physicians' question/concerns are clarified, performance measures are distributed.

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

In order to implement the Health Home At- Risk project, additional initiatives have been undertaken, such as the creation of physician-friendly materials distributed by the Physician Engagement team. Physician forums have been conducted at which project updates are presented, questions/concerns are clarified, in addition to the distribution of performance measures.

HEDIS training has been provided to ACP project managers and in-network providers in order to get the most updated information on quality state measures, provide the best evidence-based evaluations and to become more effective and to have successful outcome during performance DSRIP years.

A summary of the Health Home At-Risk protocol has been created that is more efficient for physicians and helps ensure best outcomes in implementing the projects at the practice level.

There is great synergy between the Patient Centered Medical Home and the Health Home At-Risk projects. We have created a crosswalk that displays the advantageous PCMH processes and procedures that can be incorporated into the Health Home At-Risk.

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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:
ACP has found that hotspots for conditions like asthma and obesity have increased in our service areas, including the South Bronx and Harlem. ACP has worked with community providers to increase access to Primary Care as well as specialty services. Additionally, we have refocused population health campaigns to these areas to promote awareness, disease prevention and management. We have aligned our efforts with our community-based organizations and Community Health Workers to increase patient access to care, increase engagement, and redirect our patients into care, as needed. We have provided culturally sensitive and culturally appropriate health education seminars on how these conditions affect quality of life and how to avoid triggers and other contributing disease progressing factors.

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Advocate Community Providers, Inc.

Project: 2.b.iii

Challenges the PPS has encountered in project implementation:
Challenges that ACP has encountered include: 1. Culture: We serve a population that believes the ED is a one-stop shop where they can receive all the care they need without having to wait for an appointment. They see it as convenient and immediately responsive. These populations have lacked sufficient community outreach and education regarding ED use and alternative sites of care. 2. Capacity of PCPs/Alternative Sites of Care: Encouraging patients to see their PCP more often rather than use the ED is challenging in the underserved communities we serve. PCP offices are usually booked to capacity with very little availability for new appointments or walk-ins. 3. Technology: Given the unique structure of our PPS, which spans more than 2,000 physicians and 900 community-based partners, communication and information sharing have posed significant challenges, therefore making it difficult to connect hospitals and PCPs to guarantee timely scheduling of PCP appointments by a patient navigator at the ED.
Efforts to mitigate challenges identified above:
1. Our PPS has developed materials to provide population-wide education and awareness campaigns that better inform patients on proper care and the importance of remaining connected to a Primary Care Provider. ACP is working closely with our physicians to build trusted relationships within the populations so that these patients will want to use their PCPs for care. ACP is working with the PCPs to enhance services, including open appointment scheduling, accepting walk-ins and offering additional services geared toward making the PCP's office a true medical home where the patient comes with confidence. Additionally, we will work alongside our community-based organization partners to expand outreach and education into the many ethnic groups represented in the patient population in a culturally appropriate manner. 2. Success requires PCPs to create greater capacity and possibly extend office hours. ACP is providing support and training to the PCPs and staff to help make their practices more efficient and patient care more satisfying. ACP is also making available Care Managers and Care Coordinators who may be able to lighten the load for the PCP through participation in patient care and ensuring that the patients get all services that they need before they worsen.

3. ACP is addressing technology challenges through a robust, integrated platform that will be accessible across all of our providers. We are currently building capabilities alongside our IT vendors, ECW and MDLand, who are providing interfacing capabilities to 80% of our PCPs and also leveraging Healthix and its platform to interconnect with all providers inside and out of our PPS.

Implementation approaches that the PPS considers a best practice:

Community Health Workers have been hired from within the communities they serve, with the same background and language as the patients they interact with. This has made a significant improvement in patient communication and understanding.

ACP has developed educational materials to assist the patient in understanding proper use of resources such as the ED.

ACP has leveraged the IPAs within our network to enhance relationships with physicians and obtain up-to-date information and access to their schedules in order to provide timely appointments.

ACP is investigating technology options to provide immediate appointments to ACP patients who incur an ED Visit.

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

ACP is working with MCOs to assist in PCP assignments to those patients that either do not have a PCP that they can connect with or are disconnected from the assigned PCP. The first step in assigning a PCP is understanding the patient's needs and concerns regarding PCP services and removing those barriers.

ACP intends to use CBOs and CHWs in the distribution of and implementation of educational materials on proper use of resources.

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

Based on the original CNA results with respect to ED use and current reviews, the area pattern remains the same area of focus.

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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: Advocate Community Providers, Inc.

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:
ACP has several challenges: 1. Patients who are hospitalized may be fearful to let their provider know that they don't understand the discharge instructions. This is further exacerbated by linguistic and health literacy challenges. As a result, the patient does not always reliably follow through on discharge instructions, which can lead to a re-admission or subsequent ED Visit. 2. The patient's PCP may not know his/her patient was hospitalized and cared for by a hospital. This is complicated when the patient fails to inform the hospital that they have a PCP in the community and follow up appointments are given with other providers. As a result, needed follow up care with the patient's community-based provider is delayed or does not occur. 3. Failure to follow up with the community-based provider and conduct a medication reconciliation that addresses any new medications started in the hospital represent a threat to a safe discharge.
Efforts to mitigate challenges identified above:
1. ACP recognizes that it is critical to have timely follow up with the community-based PCP after discharge from the ED or inpatient setting. ACP is working intensively with Healthix to establish connectivity and enable the flow of clinical event notifications (CEN) that will alert ACP when one of its patients is admitted to the ED or inpatient setting; or discharged. ACP has signed a contract with Healthix and is presently conducting implementation meetings. 2. When Healthix CENs are established, ACP will establish a care management function to follow up on discharged patients to ensure appropriate follow up. Specifically, ACP will utilize the information to inform the PCP of the patient's admission; and activate community partners (such as CHWs, CBOs or Health Homes) to ensure support for maintaining critical PCP visits.
Implementation approaches that the PPS considers a best practice:

Best practices include:

Immediate notification of physicians that their patient has been admitted or discharged so that they are no longer unaware of a critical event and can arrange for appropriate follow-up services. Healthix Clinical Event Notifications will provide the immediate notifications, which ACP will also provide to the physician.

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

Partnering with and utilization of a house calls practice available to do interventions when needed even if the patient cannot get to their PCP at the time, the patient will still receive care. ACP has established agreements with a house calls practice that services ACP patients who are homebound and cannot follow up with their PCP so that they can receive efficient continuity of care. During the 30-day care transitions period, they are available to perform interventions when needed that can prevent the patient from deteriorating and needing to go to the hospital.

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

Recent analytics from SDOH demonstrate an increase in Potentially Preventable Re-Admissions and ED Visits in the ACP population. ACP anticipates that Healthix connectivity should provide a more efficient and timely communication channel between providers in the various settings of care to avert PPV's.

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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: Advocate Community Providers, Inc.

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

The integration of Primary Care and Behavioral Health Services (Project 3ai) faces several challenges.

1. Changing the culture within the primary care setting to increase the level of assessments and services provided for mental/behavioral health. Medical providers are trained to assess and manage physical health, leaving behavioral health issues to others. The challenge has been to educate and motivate Primary Care Providers on the use of standardized assessment tools such as Patient Health Questionnaires as part of their regular workflow.

2. Integrating behavioral health measures and treatments into the primary care practice. In New York City, and more specifically in the areas served by Advocate Community Providers, there is a shortage of both Primary Care Providers as well as Mental/Behavioral Health Providers. This makes it increasingly challenging to place full scope primary care services into behavioral health settings and vice versa.

3. The culture of the patients we serve. There is a deep-rooted stigma with regard to behavioral health issues, which are seen as weakness, vices or character flaws rather than real medical issues. This makes it challenging to present the patient with a treatment plan that he/she will accept and be compliant with.

Efforts to mitigate challenges identified above:

ACP's efforts to mitigate project implementation risk factors began with an effective analysis of the culture of our healthcare providers.

1. ACP has employed, trained and deployed Physician Engagement teams to PCP practices to distribute protocols and easy-to-follow training materials on performing evidence-based assessments such as PHQ, DAST, GAD, and Audit C by integrating these into the EHRs. The PE teams engage PCPs and their staff and help them navigate the processes. ACP has contracted consulting psychiatrists and conducted trainings on incorporating behavioral health into the everyday practice and reducing the associated stigma.

2. ACP has aligned with behavioral health partners to assist in bringing primary care and behavioral health professionals to work together in facilities where collocation is possible. ACP has also brought together hospitals and collocated partners to enhance patient care. ACP's network is primarily

community-based physicians and we have leveraged the trusted relationship that exists between the providers and their patients to implement the IMPACT Model of collaborative care. After consultation with SDOH and OMH, it was determined that ACP must revise its protocol to demonstrate greater fidelity to the IMPACT model. ACP is exploring the ways in which it can insert licensed behavioral health clinicians into the ACP design. ACP has added Dr. Les Halpert (Psychologist) to serve on this expert team; and he is providing guidance on transitioning the ACP program to greater conformance with the impact model.

3. Mitigating the challenge of the stigma regarding behavioral health has come from leveraging the close relationship that exists between Primary Care Providers and their longstanding patients. The IMPACT Model increases the opportunity to identify and provide appropriate access to patients in need of behavioral health care. ACP understands that patients often also have a trusted relationship and comfort level with the staff of their Primary Care Provider.

Implementation approaches that the PPS considers a best practice:

Best Practices that ACP is using for project 3ai are:

- Integration of evidence-based assessment tools such PHQ 2/9, GAD7, AUDITC, DAST10 into the EHRs and incorporating these into the everyday workflow. ACP has worked with MD-Land (EMR Vendor) to successfully prototype the ability for a patient to complete the PHQ Instrument on a tablet and have the results go directly into the physician's EMR. The PHQ is available in multiple languages and will be tested in the upcoming quarter.

- Developing physician friendly, easy-to follow materials, and providing support through a well-trained Physician Engagement team has bolstered the physicians' confidence and motivation to incorporate behavioral health in a way that seems realistic and attainable.

- Ongoing Collaborative Care training provided to physician practice staff by ACP's Supervising Behavioral Health Team.

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

ACP has collaborated with the New York City OMH and Regional Planning Consortium to share lessons learned amongst the statewide PPSs to incorporate best practices and achieve desired outcomes.

ACP is collaborating with the state and city OMH in developing a comprehensive evidenced-based SBIRT training for our team. Trainings are to begin in about a month.

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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Based on the results of our Community Needs Assessments, we had a pretty good idea of the populations that we needed to target. After a year of DSRIP implementation, we have been able to confirm through interactions with our providers that the need still remains as presented in the original community needs assessment.

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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: Advocate Community Providers, Inc.

Project: 3.b.i

Challenges the PPS has encountered in project implementation:

Implementation of ACP's Cardiovascular project has encountered a number of challenges:

1. Lack of connectivity between patients and ambulatory/community-based care to engage patients to keep cardiovascular conditions under control.

2. The Million Heart Campaign requires resource-constrained Primary Care offices to incorporate a dedicated blood pressure station and have trained staff available for blood pressure checks with no additional reimbursement and no appointment.

3. Patient compliance to a preventive care plan can be heavily compromised by the low health literacy rate of the population that ACP serves. The majority of patients served by ACP providers are immigrants who speak little or no English, making it difficult for them to understand educational materials. Lack of education and low levels of health literacy make patient self-management and positive outcomes much more difficult to achieve resulting in poor patient compliance rates.

4. The community ACP serves has traditional eating patterns and diets with high sodium, fat and carbohydrates.

5. Strong immigrant cultures make lifestyle modification difficult when the behavior requiring modification is rooted in that culture.

6. IT platform and connectivity in such a wide network of independent physicians has been a challenge.

Efforts to mitigate challenges identified above:

1. ACP has built a strong infrastructure of culturally aligned and linguistically competent providers who understand and address the needs of their patients in a cultural sensitive way. To achieve the goals of the Cardiovascular project, ACP is engaging physicians, nurses and other provider types through its network especially in the identified hotspot service areas. Our PCPs and CBOs reach out to, and follow up with, the patients and promote health literacy and regimen compliance.

2. We have instructed employees, providers and patients in Disease Self-management through patient education and implementation of care models, such as Million Hearts Campaign. We have created training materials and provided training for office staff members on performing Blood Pressure measurements and conveyed the need to have a designated BP station. We have developed BP measurement training materials for the offices to provide training to the patient for self-management. Our Physician engagement team has been trained and deployed to assist the practices and provide necessary support to the office staff and provider.

3. Patients receive care and education in a language and culture that they are comfortable with, increasing receptivity to this intervention. ACP has in its network social support partners and Community-based organizations that work collaboratively with ACP's central teams such as care coordinators to facilitate services for patients.

4. To standardize optimal care, evidence-based guidelines have been created to identify and manage cardiovascular diseases along with their risk factors. All of these are created and presented to the patient in a culturally sensitive manner showing not only that we speak the language but with the utmost respect to the culture.

5. Population-wide campaigns are being conducted with the help of our partner CBOs that emphasize lifestyle modification and encourage culture change. Patient incentive programs are in place to motivate compliance.

6. Greater than 90% of ACP's providers currently have *EHRs and registries implemented* and we will further expand on health information exchange/RHIO connections. Ultimately, ACP will create an *IDS platform* in the development of project 2.a.i that will be leveraged for the purpose of communication, data sharing, patient tracking and interoperability within this project.

Implementation approaches that the PPS considers a best practice:

Development of simplified training materials that are culturally sensitive.

Training the internal staff and Physician Engagement team on every step of the process so they can conduct one-on-one training with the PCP staff.

Physician support through the ACP Physician Engagement team has led to greater cooperation and readiness of the PCP practice to implement all aspects of the project.

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

After creating a complete Cardiovascular protocol, the ACP created an easy-to-use Protocol summary for our physicians.

Training in HEDIS measures has been provided to ACP project managers and in-network providers in order to get the must updated information on these quality state measures.

ACP employees have been trained on accessing and retrieving data from the Salient data platform to have access to a quality patient data source.

ACP project managers were offered training on types of EMR software used by our providers. After conversations with different EMR vendors, DSRIP-pertinent pop ups were created, making the physician's job more expedient and documentation complete at the time he/she discussed patient care.

Working with ACP's IT department, How to's have been created to provide our in-network physicians with easy visual steps on how to use the EMR to be in compliance with the PPS guidelines.

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

ACP's Cardiovascular project identified the hotspots of patients with cardiovascular diseases in the population we serve. Knowing where these hotspots are, ACP has been providing lifestyle modification trainings, health fairs, and conversations with the heads of families in order to educate ACP patients on how to take care of their health, improve patient self-management and avoid unnecessary hospitalizations.

There have been no significant changes in the hot spot areas identified in the original CAN.

During ACP community activities, in addition to education on lifestyle modification, patients are able to get their blood pressure readings and blood glucose levels. Blood pressure and Diabetes log books are provided to keep track of daily measurements, and this data helps the physicians have a better understanding of the patient's condition.

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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: Advocate Community Providers, Inc.

Project: 3.c.i

Challenges the PPS has encountered in project implementation:
ACP's Diabetes Project implementation encountered challenges in the following areas: 1. ACP providers serve ethnic populations that are accustomed to high carbohydrate diets that are a high risk factor in developing diabetes and are detrimental to good diabetes control. Changing eating patterns that are passed down from generation to generation represents a great challenge. 2. Lack of education and low levels of health literacy make patient self-management and positive outcomes much more difficult to achieve resulting in poor patient compliance rates. 3. Primary Care Providers, who are already overworked and stretched, are now being asked to put in more time to incorporate project requirements and increased documentation. 4. Centralizing of information for data analytics has been a great challenge due to ACP's broad network of independent providers.
Efforts to mitigate challenges identified above:
To meet these challenges, ACP has: 1. Leveraged its cultural diversity and the integration of its neighborhood providers to reach both the patient and the families/caregivers who are usually responsible for providing for the needs of the patients in a language and tone that they can understand and accept. ACP has also leveraged its relationships with community-based organizations to provide another source to reach patients in a culturally sensitive manner and encourage the peer-to-peer support. **2.** ACP has developed patient educational materials that are culturally and linguistically sensitive to the population we serve. Our network of social support partners and community-based organizations work collaboratively with ACP on population health campaigns that are being conducted within the communities; campaigns focus on nutrition, lifestyle modification, and disease-specific self-management techniques that help motivate toward adopting healthy lifestyle behaviors. ACP understands that health literacy directly correlates to better compliance and better outcomes. 3. ACP has provided patient education at the primary care level on disease prevention and disease management. Patient education has been provided one-on-one and through educational materials, such as handouts. In addition, ACP provides up-to-date patient information and disease-related

information through population wide campaigns.

4. ACP assists PCPs by providing support and training to certain physician office staff. It is anticipated that by providing appropriate, standardized, and evidence-based staff training, better performance outcomes and improved patient quality of care will be achieved. ACP has created user friendly materials for the physicians to efficiently implement evidence-based DM protocols. ACP also has a care coordination/care management back office support team to assist the physicians with patient disease/health education, access to care, prompt healthy lifestyle modification, disease management.

5. ACP is developing a centralized IT platform to have the interoperability between our EHR and the state RHIOs. This connectively is vital to facilitate effective and efficient data gathering, exchange and monitoring. Through this inter-operative system, ACP will be able to access real-time data to effectively follow-up, monitor compliance and improve patient health care outcomes.

Implementation approaches that the PPS considers a best practice:

Lab reports of A1C, cholesterol and renal functions are key metrics to effectively manage diabetes. ACP has collected thousands of diabetic patients' data through relationships with EHR vendors (MdLand and eCW) and laboratories (Bio-reference Inc., Empire City). These entities send batch lab reports with metrics that we can put together and analyze.

To foster patient self-management, ACP has provided its provider practices with blood sugar/blood pressure log books, to be given out to ACP-engaged Diabetic patients for disease self-management and compliance, as well as for the PCP to be able to better gauge what goes on when the patient is at home.

ACP has hosted community events and community-wide health fairs in our target hotspots. During these events, ACP presents DM basic education seminars, measured and taught blood sugar and blood pressure self-monitoring techniques and appropriate recording of logbooks.

ACP educated community health workers (CHWs) on evidence-based diabetes self-management skills to be an additional layer of support and to assist patients in the community.

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

HEDIS training was provided to ACP project managers to get the most updated information on quality state measures, provide the best evidence-based evaluations, to support providers in becoming more effective, and to ensure successful outcomes during performance DSRIP years.

ACP developed an easy-to-use comprehensive CPT/HCPCS code fact sheet to be used at our provider practice sites. The code fact sheet is a listing of quality indicator codes related to each project (e.g., diabetic retinal screening and comprehensive diabetic screening codes). The goal of the fact sheet is to promote accurate provider coding and documentation in the EHR system. In addition, the code fact sheet will help to more accurately capture, track, and analyze our data in order to proactively identify gaps in care at the patient and population level.

ACP created home-grown CPT-style codes for reporting in order to gauge physician performance (e.g., LSM01 for lifestyle modification) codes.

ACP has generated “a quick reference guide” and a checklist for PCPs as an easy hands-on reference to facilitate better documentation. These tools were reviewed and approved by the DM Clinical Quality Committee and disseminated to engaged PCPs in-person, via email, and at physician engagement events and forums.

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

Our Community Need Assessment identified the Bronx as a hotspot for diabetes prevalence, hospitalizations and short-term complications. The Bronx is a focus for our diabetes project, and ACP has incorporated more PCPs and specialists in the Bronx to address the community health related needs.

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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: Advocate Community Providers, Inc.

Project: 3.d.iii

Challenges the PPS has encountered in project implementation:
ACP's Asthma Management project implementation has encountered a number of challenges: Patient compliance to a preventive care plan can be heavily compromised by the low health literacy rate of the population that ACP serves. The majority of the patients served by ACP providers are immigrants who speak little or no English, making it difficult for them to understand educational materials. Lack of education and low levels of health literacy make patient self-management and positive outcomes much more difficult to achieve due to poor patient compliance rates. Primary Care Providers, who are already overworked and stretched, are now being asked to put in more time to incorporate project requirements and increased documentation and coding. Additionally, primary care offices must incorporate patient-centered education and evidence-based quality asthma care, such as the proper use of inhalers and nebulizers as well as the utilization of a comprehensive asthma action plan, in order to improve patient experience and achieve effective self-management. ACP failed to meet its patient engagement target for the last quarter.
Efforts to mitigate challenges identified above:
To meet these challenges, the PPS has leveraged its culturally diverse physicians to serve our patients in a manner that is culturally and linguistically sensitive, thereby facilitating greater patient and family engagement. Additionally, ACP promotes asthma self-management education in various ways, such as one-on-one, educational handouts, and population-wide education at the primary care and community level. Through our physician engagement team, on-going trainings have been conducted with our network providers. ACP has developed personalized action plans that can be uploaded into an EMR and tagged to print with the patient's treatment plan, including coaching and information to improve medication compliance. ACP 3.d.iii Implementation of Evidence-Based Medicine Guideline for Asthma Management has culturally aligned primary care provider offices located within the same geographical areas as the targeted population. These providers are of ethnic and racial minority groups reflecting the populations served and have established strong patient/provider relationships. Included in ACP's network are a number of

specialists (e.g., pulmonologists, allergists) who can provide specialized, effective care to our asthmatic population.

ACP has active partnerships with governmental and community-based initiatives that can assist with containment/modification/improvement of environmental factors such as infestations that are known triggers for asthma exacerbation. We also work closely with schools to coordinate and improve pediatric asthma management. Furthermore, this project is implementing specific community outreach and education best practices, designed for each community in a language and format that can reach the targeted population.

The PPS is exploring the use of certified asthma educators to support the primary care offices by providing direct education and training of the offices' clinical staff, in such areas as basic asthma education, trigger identification/avoidance, and self-management skills.

ACP conducted a root cause analysis to understand why its patient engagement targets were not met. ACP learned that there was an opportunity for improvement with the data integrity of the patient engagement file submitted to SDOH. For example, Medicaid CIN numbers and DOB information were missing on a large number of records; in addition, duplicate and blank records were noted by the IA. ACP asked its Technology/Data Analytics team to investigate the integrity of the data submission and develop quality control routines to prevent this from happening in the future. At present the Tech/Data Analytics team is in process of revising its protocols for the submission of patient engagement statistics for all projects and not just the Asthma project.

Implementation approaches that the PPS considers a best practice:

ACP has implemented evidence-based asthma management guidelines between Primary Care Practitioners, specialists and community-based asthma programs to ensure population health-wide initiatives.

In conjunction with physician leads, the project's Clinical Quality Committee and according to national guidelines for asthma management, an evidence-based protocol has been created, including EMR connectivity. Additionally, asthma education materials, such as the proper use of inhalers and nebulizers, have been created that can be uploaded into the EMR and printed with personalized patient information at the push of a button.

Training in HEDIS measures has been provided to ACP project managers and in-network providers in order to get the must updated information on these quality state measures. Specifically, ACP project managers attended measure training by Empire/BC/BS on and overview of HEDIS and QARR; and ACP arranged for on-line training with NCQA for their program entitled: "What is HEDIS?".

ACP is providing support to practices to achieve PCMH level 3, 2014; to better enable them to document compliance with evidenced based protocols.

It is crucial for all stakeholders to work collaboratively. Aligning our collective resources and knowledge to support this ongoing endeavor is vital for the sustainability and success of this initiative.

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

ACP 3.d.iii PMO has attended DOH conferences in Albany to receive updates, share different strategies/lessons learned, process and procedures used by other PPSs around the state.

Working with community-based organizations, ACP has conducted asthma seminars and health fairs to reach the high risk population that were identified by the hotspots analysis. These health fairs and health educational seminars' main goals are to promote evidence-based asthma care and awareness.

Furthermore, primary care practices have established collaborations with specialists and community-based asthma programs to support a regional population-based approach to asthma management.

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

ACP has found that the asthma hotspots in our service areas have increased. ACP has worked with community providers to increase both primary care and specialty services, such as pulmonology and allergy. Additionally, we have refocused our population health campaigns to effectively and efficiently address the increasing prevalence of asthma within our identified hotspots.

We have aligned our efforts with our community-based organization partners and Community Health Workers to effectively reach a greater number of patients in our CNA targeted populations to help redirect them into care.

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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: Advocate Community Providers, Inc.

Project: 4.b.i

Challenges the PPS has encountered in project implementation:
1. Significant challenges to project 4.b.i are related to the culture of the population, especially with regard to males who believe that smoking is a part of their manhood. Within the culture of ACP's target population, smoking is perceived as "cool" and considered socially acceptable. As a result, this population is resistant to quitting for fear of alienation from peers and is shielded from the stigma that smokers experience in other communities. Patients acceptance, adherence to a treatment plan, and follow through have proven to be a challenge. 2. Educational materials are heavily compromised by the low health literacy rate of this population. The majority of the patients served by the ACP providers are immigrants who speak little or no English. Many of these patients are not well educated and have low levels of literacy, making our youth particularly susceptible to cigarette advertisements. 3. Additional challenges related to smoking cessation, treatment adherence and compliance are: A) Cost and availability of tobacco cessation counseling programs; B) Implementation of smoking cessation programs is costly and difficult to monitor. Our target population mainly consists of low socio-economic status (SES) patients who often will not follow through with treatment due to lack of money to cover out-of-pocket costs after Medicaid/MCO's partial coverage of smoking cessation treatment.
Efforts to mitigate challenges identified above:
1. ACP has worked diligently with over 2,000 physicians, many of whom are of the same cultural background and speak the same language as their patients. Through culturally and linguistically appropriate educational materials and health campaigns, ACP aims to explain to patients the serious consequences of smoking and second-hand smoking in a way that is relevant and understandable. 2. ACP understands that these challenges should continuously be addressed with culturally sensitive educational efforts, ongoing monitoring, and consistent implementation of the tobacco use cessation evidence-based protocol across providers. With our tobacco use cessation evidence-based protocol in place and the active engagement of the providers, we anticipate a decrease in the smoking habit in our target population. Providing health seminars with culturally and linguistically competent educational material will raise awareness of the risks that come with smoking and second-hand smoke, contributing to decreased cigarette use in targeted neighborhoods. In addition, this protocol will address prevention of chronic diseases associated with cigarette smoking.

However, ACP's seminars are largely attended by parents and not the target youth population we seek to inform. ACP will endeavor to develop ways to directly message adolescents about smoking prevention and cessation. ACP will work with community leaders to raise awareness about what appears to be a disproportionate amount of cigarette advertising in certain lower socio-economic communities.

3. ACP has care coordination and other resources in place to provide effective and efficient "warm patient hand-off" referrals to our partners, such as smoking cessation CBO partners and employed counselors. ACP has had ongoing meetings with relevant MCOs to negotiate coverage for services and supplies needed in the treatment of tobacco addiction, as well as providing some patient incentives for quitting.

Implementation approaches that the PPS considers a best practice:

In conjunction with physician leads, the project's Clinical Quality Committee and in accordance with NCBI and CDC guidelines, ACP has developed evidence-based tobacco cessation protocols. These protocols include tobacco use assessments, treatment plans addressing pharmaceutical and cessation counseling goals, and interventions that are embedded in our EMR systems.

Our Physician (Provider) Engagement Team provides ongoing on-site trainings and education at individual practices on the implementation of protocols and procedures for assessing and treating tobacco use. To achieve best performance outcomes, this project will continue to implement evidence-based best practices, patient-centered collaborative care approaches and continuous quality improvement methods.

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

ACP has created culturally and linguistically sensitive educational material on such topics as smoking health risks and second-hand smoking. Health fairs and health educational seminars have been conducted for adults and the youth in our target communities. In conjunction with Community-Based Organizations, ACP has established support groups within our target population that will provide counseling and tobacco cessation initiatives. Additionally, No-Smoking signs have been created and distributed to be posted at our network provider's facilities to prompt smoking cessation awareness, education, and create a smoke-free zone in our practices.

ACP's PMO has incorporated quality improvement methodology, such as Six Sigma, Focus and PDSA, to strengthen our department and achieve best performance outcomes, in anticipation of upcoming performance-based DSRIP years.

ACP staff have been trained on HEDIS measures in order to assist our providers on achieving optimized best practices when it comes to coding, proper documentation, and implementing evidence-based quality improvement best practices.

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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ACP Tobacco Use Hotspots have increased in the last two years, based on comparisons of the CNA analysis conducted in 2011 with the analysis done in 2013. The 2013 CNA analysis indicated that the South Bronx (20%), Astoria (21%), East Harlem (19%) and Williamsburg (20%) neighborhoods have the greatest concentration of smokers.

ACP will continue its anti-tobacco campaigns but will place additional efforts in these hot spot areas.

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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: Advocate Community Providers, Inc.

Project: 4.b.ii

Challenges the PPS has encountered in project implementation:

Significant challenges for ACP's Chronic Disease revolve around patient compliance.

1. Patient compliance to a preventive care plan can be heavily compromised by the low health literacy rate of the population that ACP serves. The majority of the patients served by ACP providers are immigrants who speak little or no English, making it difficult for them to understand educational materials. These patients are also of low socioeconomic status (SES), which makes it difficult for them to pay for medical care. Many of these patients have a low level of education and an overall low literacy rate and are not accustomed to preventive care but rather seek only curative care.
2. Educating patients and family members in the benefits of preventive care such as vaccination, and teaching children about safe sex in cultures where these topics are taboo, has been challenging. This population relies more on word of mouth than on written, evidence-based preventive treatment protocols and care plans. This has made it difficult to evaluate the effectiveness of implementing patient and population preventive health strategies and tools. This leads to gaps in care, since patients may not incorporate preventive lifestyle changes, which will place them at higher risk of developing a preventable chronic disease.
3. Another challenge is changing the provider's office mechanics and culture since new workflows require more work and more documentation processes within current time and staffing constraints.
4. ACP has faced challenges in patient compliance due to cost. The PPS serves a low-income population that cannot absorb the cost of preventive services and/or costly healthy lifestyle practices (e.g., fresh fruit and vegetables, lean protein, gym memberships).

Efforts to mitigate challenges identified above:

1. ACP avails itself of culturally and linguistically appropriate educational materials that are provided and reviewed by practice providers and staff. ACP patients receive care and education by providers and staff in their own language and culture to better enhance patient comprehension and acceptance.

2. ACP's broad educational plan is to hold population-wide campaigns on disease prevention and benefits of early detection through linguistically and culturally sensitive campaigns. These population health-wide targeted campaigns have been conducted through media, print, as well as community based organizations holding community-centered health education seminars.

3. ACP providers follow written evidence-based protocols on "how," "when" and "on whom" to perform screening exams as well as who to provide with preventive care and education. Additionally, ACP has provided on-going training and guidance to our providers through our Physician Engagement team. The PPS has also contracted care coordinators and care managers to provide an integrated care coordination approach of services and to facilitate a seamless stream of effective and efficient communication.

4. ACP has been having ongoing meetings with relevant MCOs to negotiate coverage for all preventive services at no cost to the patient, as well as with its partners to provide more timely lower cost services.

Implementation approaches that the PPS considers a best practice:

In conjunction with physician leads, the chronic disease prevention project's Clinical Quality Committee and in accordance with national standards, ACP has developed evidence-based protocol for screening, educating and providing preventive care to its target population. The project addresses clinical and community preventive care for chronic diseases (e.g., cancer, hepatitis B and C, HIV), obesity and vaccinations. Protocols also stipulate criteria on how, when and on whom to perform screening exams in accordance with national standards and recommendations as well as whom to appropriately provide with preventive care and education.

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

ACP has created culturally and linguistically sensitive educational material. Health fairs and health educational seminars have been conducted for adults and youth within our target communities.

Within this year the PMO has incorporated quality improvement methodology, such as Six Sigma, FOCUS and PDSA, to strengthen our department and achieve best performance outcomes in anticipation of performance-based DSRIP years. ACP staff have been trained on HEDIS measures in order to assist our providers on achieving optimized best practices when it comes to coding, proper documentation, and implementing evidence-based quality measures to enhance performance outcomes.

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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:
ACP Chronic Disease Hotspots have increased in the last two years, compared with the CNA analysis conducted in 2011 with the analysis done in 2013. ACP plans to continue to focus on implementing preventive strategies within all the communities that we serve and place emphasis on disease prevention targeting specific diseases prevalent within our communities, such as our identified disease hotspots. Population health campaigns include specific campaigns to target high-prevalence areas.