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DSRIP Independent Assessor

Mid-Point Assessment Report

Alliance for Better Health Care PPS

Appendix PPS Narratives

November 2016

www.health.ny.gov

Prepared by the DSRIP Independent Assessor

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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: Alliance for Better Health Care, LLC

Project: 2.a.i

Challenges the PPS has encountered in project implementation:

Risks identified as part of the project implementation plans for all projects are continually being addressed, mitigated and re-evaluated as part of Alliance momentum in transformation and project achievement.

Challenges that Alliance has encountered in creating an Integrated Delivery System focused on Evidence based Medicine and Population Health include:

1. Successful NCQA recognition under PCMH level 3 2014 standards for primary care practices by DY3, Q4 (3/31/2018).
2. Aggressive targets for provider and patient engagement have been set which are a challenge to meet within the designated timelines.
3. Limited collaboration between hospital systems and community based organizations.
4. Lack of knowledge and widespread participation of physician providers in the DSRIP initiative.

Efforts to mitigate challenges identified above:

To mitigate the risks and challenges noted above, Alliance has taken the following actions:

1. Alliance has a hired a Quality Transformation Coach to focus on PCMH certification and keep Alliance providers on target to meet the timeline. Our first Coach is a nurse with years of experience in meaningful use and PCMH certification requirements working under the direction of our Clinical Transformation Director. Alliance will hire additional coaches as needed. Current state of the practices has been assessed and technical assistance needs identified. Technical and business process support is being provided to practices as needed.
2. Alliance has conducted a comprehensive gap analysis for IT capability of partner organizations and has carefully considered the results while searching for an IT platform that will provide interoperability between organizations in our communities.
3. To encourage collaboration between hospital systems and community based organizations, Alliance has incorporated collaboration as a funds flow criteria.
4. Physician participation and engagement are the foundations of successful system transition. To mitigate this risk, Alliance has taken active steps toward provider participation.
   - Physician leaders have been added to Alliance governing board.
   - Alliance and IHANY (the regional Medicare Shared Savings Program ACO) have initiated collaboration between their respective Clinical Integration and Quality Committees to promote alignment, avoid duplication and streamline provider time requirements for participation in administrative activities associated with both organizations.

- Alliance is planning a comprehensive educational effort using a variety of methods and leveraging physician champions. A recent example includes the Palliative Care Symposium with Dr. Patricia Bomba as the key note speaker.
- Alliance will establish financial incentives to reward achievement of quality targets.

Implementation approaches that the PPS considers a best practice:

Best practices include but are not limited to:

- Alliance has identified a Clinical Framework for our core data aggregation and analytics platform. The company that we have selected is focused on NYS DSRIP and has already completed two implementations with NYS PPSs and is in the selection phase with five others. This comprehensive platform will provide the framework necessary to advance our clinically integrated network strategy.
- Alliance has also selected a Care Coordination product which will be integrated with the clinical framework noted above. Implementation of both products will begin upon approval by the Alliance Board at the July meeting.
- Both of the systems will work closely with HIXNY to create a community-wide framework that will support the health homes, CBOs, primary care providers and hospitals - creating a clinically integrated network.
- Alliance has engaged a firm called Teton Health to help define and enhance the Alliance's communication strategy to ensure that we are communicating and engaging with all of our audiences in the most effective way.
- Alliance has released project e-workbooks to make project requirements, population attributes and performance and utilization metrics transparent to our partner organizations.

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

We have adopted universal principles of successfully integrated healthcare systems to assist with integration efforts that include:

1. Physician Driven Model - Creating a physician-driven model in which physicians fill the primary lead roles is illustrated through the Patient Centered Medical Home (PCMH). Alliance is working actively with the PPS primary care providers to cultivate effective physician leadership who may serve as a bridge between the various physician constituencies and the hospitals. The goal to achieve NCQA 2014 Level 3 Medical Home standards by the end of DSRIP Year 3 drives Alliances' strategic plan.
2. Organization Structure - The organizational structure of the PPS provides opportunities for broad participation among medical staff members, with a mix of specialties and a variety of relationships with the hospital, including employed, contracted (e.g. medical directors, hospital-based physicians), and independent practitioners. Alliance is a collaborative network of more than 1,400 providers led by three health systems (Ellis Medicine, St. Peter's Health Partners and St. Mary's Healthcare, Amsterdam); two federally qualified health centers (Hometown Health Centers and Whitney M. Young, Jr. Health Center); and a large and highly diverse group of community based organizations.
3. Team Collaboration - Maximizing the use of teams including physicians, nurse practitioners, physician assistants, nurses, health educators, and other ancillary personnel to effectively coordinate and manage care for a patient population is completed through the development of Project Workgroups and break-out groups. Workgroups specific to each project were created, bringing different cultures together, to further analyze and foster collaboration on project development at the PPS level with key roles (provider mapping) for primary care physicians, community-based organizations, providers of medical services and long-term care services, and other service providers. These team members, including the physicians' in-office staff, work to expand the reach of the physician, manage disease registries, coach and teach patients, perform case management duties, and coordinate care among multiple providers. The workgroup dynamics allow local implementation by partner organizations and

providers that respect unique local needs, and networks operational attributes and processes. Identification of service planning and information management system capability and the level of desire and involvement to engage and redesign internal processes to improve patient satisfaction and outcomes are discussed.

4. Geographic Coverage – Alliance provides geographic coverage to 6 counties, maximizing patient access to the services and to minimize duplication, and takes responsibility for that identified population, with clients having the right to exit if they wish to seek services from other providers.
5. Organizational Culture and Leadership – The Cultural Competency/Health Literacy Training Strategy is a thoughtful plan to Alliance's commitment to significantly enhancing cultural competency and health literacy across its service area.
6. Governance Structure – By bringing together organizations and services into an integrated health system through contractual relationships or networks required diversified governance, which is represented by a variety of stakeholders including physicians and the community.

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

There have been no changes to the proposed population.

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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: Alliance for Better Health Care, LLC

Project: 2.b.iii

Challenges the PPS has encountered in project implementation:
Challenges identified as part of the implementation for the ED Triage project include: 1. The number of new patients referred to Primary Care Physicians (PCP) from the ED is expected to exceed the current primary care capacity. As the project progresses, this risk still remains a challenge as the navigator programs are established at the participating hospitals and PCPs become involved in the process. 2. Patients may not want to be redirected to PCPs and the potential of knowledge deficits regarding the importance of care consistency and preventive care. 3. IT Risks previously identified are consistent across the projects. EHR systems are diverse and have variable components that make tracking engagement, alerts to providers and maintaining a continuum of care challenging. This requirement has a completion date of DY2Q4 so successful mitigation is imperative. 4. Successful implementation of this project will have negative impacts on the hospitals' finances. Since ED visits & inpatient admissions via the ED are sources of revenue for the hospitals, as patients become more engaged in appropriate outpatient venues, volume for the EDs & revenues for the hospitals may decline.
Efforts to mitigate challenges identified above:
To mitigate the risks above the Alliance has taken the following actions: 1. Alliance has identified PCPs that are accepting new patients and ensure that processes are in place for ED navigators to refer patients to these targeted PCPs. a. Ellis Medicine Group has limited access for PCP new appointments, but has identified partnering with Hometown Health and exploring ways to open new appointments. b. St. Mary's Hospital Amsterdam is increasing PCPs in area, expanding urgent care and partnering with Hometown Health to increase access. c. St Peter's Health Partners PCP practices have capacity to accept new patients; will be able to accept to new patients as ED Navigator project expands to other campuses. Additionally, a new Urgent Care Center is opening near Albany hospitals for non-emergent visits d. Clinical Integration and Quality Committee has discussed need to not only open more PCP slots, but to consider change in practice, such as: i. Mid-level use for well check, medication renewal visits in PCP practices ii. Easing roadblocks for patient navigators to contact PCP by establishing direct contact person in PCP office

iii. Direct access into scheduling system
iv. Awareness of direct line to PCP office, instead of being placed in queue
v. Extended hours, keeping slots available
vi. Mitigating "no shows" by including patient call back as appointment reminder either by patient navigator or PCP staff prior to appointment
vii. Exploring transportation needs during encounter
viii. Throughput studies in ED and PCP offices

e. Open access scheduling capabilities are being explored with PCP practices, RHIO, and recommendations for future state are part of Alliance IT strategy.
f. Workforce Committee has had discussions on retraining & redeployment of current employed staff and the possibility to pursue advanced practice credentials to support primary care practices.

2. Alliance is developing and expanding on a patient education campaign that includes preventive health importance and continuity of care importance, including
   a. Ellis Hospital pamphlet distributed to ED patients
   b. Urgent Care Centers being established and Ad campaigns
3. To mitigate IT challenges, each project team is identifying solutions where available. Both manually tracking and electronic tracking with various levels of data mining are occurring. This project works in conjunction with the other projects and the organizational components of the IT roadmap and strategy, the clinical integration strategy and population health technologies to fulfill the requirements of the EHR expectations. Alliance is working closely with the RHIO to fulfil the IT components as PHIT roll-out depended on sufficient capital funding from NYS; delay in the capital award delayed the rollout. The PPS will accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs & PHIT tool functionality aren't yet available.
   a. Capital expenditure IT funding denied by State
   b. Financial model developed and deployed for IT costs
   c. IT strategy and roadmap developed without state funding allocations
   d. Finance committee and Board approval for strategy obtained, will be moving forward with IT components of projects
   e. Completion of requirement remains on track.
4. The Alliance strategy is to monitor hospital admissions/readmissions, revenues/sources of revenue; document the amount, timing & duration of the impact; & allocate funding in the budget & funds flow to offset revenue losses due to reduced hospital utilization.

Implementation approaches that the PPS considers a best practice:

The following approaches and literature are considered best practices for this project:

- Patient Navigator Tool Kit Boston Medical Center toolkit distributed (volume 3)
- Kaiser Health News: Hospital's Eye Community Health Workers To Cultivate Patient's Success
- Workflow charts in ED for navigator
- Data driven staffing model recommendations for navigator positions developed
- http://www.avonfoundation.org/assets/bmc-patient-navigation-toolkit-vol-1.pdf
- https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf

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

A project mission statement has been developed:

Project Mission:
To improve the health and quality of life in the communities we serve by actively assisting and supporting the non-emergent patient by connecting them through evidence-based approaches to primary and preventive care

Current State – ED Care Triage
Ellis Medicine Hospital

- 1.5 FTE patient navigator embedded in the ED from Care Central cost center
- Manually tracking patient engagement and submitting totals to Alliance
- Patient Navigator refers to internal and external PCP practices
- Analysis of data on tracking ED utilization done internally and externally

St. Peters Health Partners

- One of four hospital programs rolled out at Samaritan Hospital
- I FTE patient navigator hired February 2016, started interfacing with patients April 2016
- Oriented to position with collaboration from Ellis Hospital and St Mary Amsterdam programs
- Long term plan to hire and deploy patient navigators in all ED sites, including Albany Memorial, St Peter's Hospital, St Mary's Troy locations

St Mary's Hospital Amsterdam

- 1 FTE patient navigator embedded in the ED
- Patient in ED for nine months (9) of DY 1, and all DY2 to date
- Electronically tracking patient engagement
- Scope of position includes follow up phone calls for appointment compliance
- Refers to internal and external PCP practices, health homes
- Addresses other social determinant needs: i.e. transportation

Hometown Health and Whitney Young FQHC

- Working on initiatives to enhance/expand capacity for patient population
- Collaborative meetings with Ellis Hospital, St. Mary's Hospital, Amsterdam, St. Peter's Health Partners, CBOs including Planned Parenthood, and RHIOs.
- Plans to incorporate ambassadors in waiting areas

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

- Population remains the ED utilizers, with focus on those utilizers that do not have PCP identified.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Alliance for Better Health Care, LLC

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:
Challenges that Alliance has encountered in implementing the Care Transitions to reduce readmissions project include: 1. There is an inconsistent approach to transitions of care across the PPS & providers' lack of resources, knowledge and time is a risk. The existing culture with regard to care transitions is a challenge. Historically there has been a medically focused care transitions model, however, there are a variety of models which can be embraced to incorporate and address behavioral health as well as psychosocial issues. 2. Lack of knowledge of the full extent of causes of readmission. Hospitals currently rely on internal methods to monitor 30-day readmissions. 3. IT Risks are consistent across the projects. EHR systems are diverse and have variable components that make tracking engagement, alerts to providers and maintaining a continuum of care challenging. This requirement has a completion date of DY2Q4 so successful mitigation is imperative. 4. Care Transitions Services are not reimbursable. Care Transition services are not currently reimbursed by Medicaid and Medicaid consumers are generally reluctant or unable to pay for this type of service. Some MCOs provide reimbursement for care transitions but not all. 5. This project will have negative impacts on the hospitals' bottom line. In the fee for service reimbursement environment, hospital admissions are associated with revenue. As avoidable admissions decline, hospital revenues will also decline. To mitigate this risk, the PPS will monitor hospital admissions/readmissions, revenues/revenue sources, document the amount, timing & duration of the impact & allocate monies in the budget & funds flow to offset revenue losses.
Efforts to mitigate challenges identified above:
To mitigate the risks above the Alliance has taken the following actions: 1. To mitigate this risk of inconsistent approaches to care transitions, a significant amount of time was spent encouraging workgroup participants to think more broadly about new best practice models in addition to the Coleman Model. To foster innovative thinking Alliance staff made themselves available to conduct on site visits to assess and recommend ideas on how to reengineer workflows as well as have best practices highlighted within our workgroup to foster collaboration. Most importantly, the group now sees care transition as not only a “medical approach” and are now focused on the a more integrated approach. Utilizing the bridge model within the substance abuse, mental health and homeless community settings is an example of the new approach. The new CARE

act requirement has also been a positive influence to encourage hospitals to implement new processes that will be in line with the requirements of this project.

2. Alliance has made a recommendation to the Alliance Board to implement an IT solutions that will provide transparency to the reasons for 30-day readmissions so that the hospital systems and providers have the information necessary to intervene with their patients.
3. To mitigate IT challenges, each project team is identifying solutions where available. Both manually tracking and electronic tracking with various levels of data mining are occurring. This project works in conjunction with the other projects and the organizational components of the IT roadmap and strategy, the clinical integration strategy and population health technologies to fulfill the requirements of the EHR expectations. Alliance is working closely with the RHIO to fulfil the IT components as PHIT roll-out depended on sufficient capital funding from NYS; delay in the capital award delayed the rollout. The PPS will accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs & PHIT tool functionality aren't yet available.
    a. Capital expenditure IT funding denied by State
    b. Financial model developed and deployed for IT costs
    c. IT strategy and roadmap developed without state funding allocations
    d. Finance committee and Board approval for strategy obtained, will be moving forward with IT components of projects
    e. Completion of requirement remains on track.
    f. Additional focus has been on ways to improve real time communication and the use of secure texting among physicians and care managers within the hospital, home care and primary care setting are being
    explored and possibly piloted within the next few months

4. To mitigate this risk, considerable education has been done on Population Health and Value based payment. We are still in a fee for service world and shifting the culture is slow. However, by providing ongoing education and feedback to the group as well as identifying with other programs such as managed care entities requiring the same commitment to quality, a change in mindset is occurring. Health systems are now realizing that they need to collaborate with the community to ensure support is provided to the consumer and caregiver in order to be successful in decreasing readmissions. The PPS is also working with the MCOs to advocate for reimbursement of interventions key to the project success.
5. The Alliance strategy is to monitor hospital admissions/readmissions, revenues/sources of revenue; document the amount, timing & duration of the impact; & allocate funding in the budget & funds flow to offset revenue losses due to reduced hospital utilization.

Implementation approaches that the PPS considers a best practice:

Best Practices Identified include:

- 30 Day supported transitional period post discharge from an acute care setting
- Readmission Risk Assessment Tool
- Comprehensive care plan to patient and designated family members prior to discharge
- Scheduled follow up appointment prior to discharge
- Bi-directional communication between acute care and post-acute care providers, including social services
- Culturally competent and health literacy appropriate instructions for patient and family
- Medication Reconciliation
- Care Transitions Standard protocol
- Early notification of discharge

- https://www.jointcommission.org/search/?Keywords=care+transitons&sitename=Joint+Commission&guid=1a24d8fa127145c59d8d9f045116b376&f=sitename%252cbrand&brand=Home+Care
- http://www.ntocc.org/
- http://www.chcf.org/projects/2009/coleman-care-transitions-intervention

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

Additional Project Accomplishments to Date include:

- Expanded workgroup perspective on Care Transitions
- Increased collaboration across the continuum of care
- Workgroup consensus on best practices and the definition of a 30 day care transition
- Movement towards adoption of Zone Sheets across entire continuum
- Adoption of a project mission statement

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 to the population has been identified.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Alliance for Better Health Care, LLC

Project: 2.b.viii

Challenges the PPS has encountered in project implementation:

Challenges identified as part of the implementation for the Hospital to Homecare collaboration project include:

1. IT Risks are consistent across the projects. EHR systems are diverse and have variable components that make tracking engagement, alerts to providers and maintaining a continuum of care challenging. Additionally, for this project, there are IT requirements that are necessary to implement the interact-like principles and utilize zone sheets consistently.
2. Lack of knowledge of the full extent of causes of readmission. Hospitals currently rely on internal methods to monitor 30-day readmissions.
3. Due to varying documentation methods among the participating home health agencies, care processes are at risk due to miscommunication and missing information.
4. Despite recruitment efforts, it is difficult to fill home care/home health aide positions as some professionals/home care aides do not have access to a car or do not desire making home visits.
5. This project will have negative impacts on the hospitals' bottom line. In the fee for service reimbursement environment, hospital admissions are associated with revenue. As avoidable admissions decline, hospital revenues will also decline. To mitigate this risk, Alliance will monitor hospital admissions/readmissions, revenues/revenue sources, document the amount, timing & duration of the impact & allocate monies in the budget & funds flow to offset revenue losses.
6. Community Resources such as transportation and obtaining medication and food post-discharge are not easily accessible.

Efforts to mitigate challenges identified above:

To mitigate the risks above the Alliance has taken the following actions:

1. To mitigate IT challenges, each project team is identifying solutions where available. Both manually tracking and electronic tracking with various levels of data mining are occurring. This project works in conjunction with the other projects and the organizational components of the IT roadmap and strategy, the clinical integration strategy and population health technologies to fulfill the requirements of the EHR expectations. Alliance is working closely with the RHIO to fulfil the IT components as PHIT roll-out depended on sufficient capital funding from NYS; delay in the capital award delayed the rollout. Alliance will accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs and PHIT tool functionality are not yet available.
    a. Capital expenditure IT funding denied by State
    b. Financial model developed and deployed for IT costs

   c. IT strategy and roadmap developed without state funding allocations
   d. Finance committee and Board approval for strategy obtained, will be moving forward with IT components of projects
   e. Completion of requirement remains on track.
   f. Additional focus has been on ways to improve real time communication and the use of secure texting among physicians and care managers within the hospital, home care and primary care setting are being explored and possibly piloted within the next few months.
2. Alliance has made a recommendation to the Alliance Board to implement an IT solutions that will provide transparency to the reasons for 30-day readmissions so that the hospital systems and providers have the information necessary to intervene with their patients.
3. To mitigate the risk, this project will work with the IT committee to use consistent electronic tools across agencies. Alliance will assess the current use of the INTERACT-like program and implement INTERACT-like tools.
4. Alliance will coordinate with the Workforce Committee to address vacancy issues and retrain and redeploy workers within the PPS if necessary.
5. The Alliance strategy is to monitor hospital admissions/readmissions, revenues/sources of revenue; document the amount, timing and duration of the impact; and allocate funding in the budget & funds flow to offset revenue losses due to reduced hospital utilization.
6. Health systems are realizing that they need to collaborate with the community to ensure support is provided to the consumer and caregiver in order to be successful in decreasing readmissions. Alliance has included community collaboration as a component of the funds flow structure and this has encourages the hospital systems to look outside of their organizations for community support. Alliance and its providers have focused a significant amount of time building partnerships to address transportation, access to medications and ensuring basic needs are met across all projects. For example, ensuring risk assessment tools incorporate social determinants of health, literacy tools are utilized to proactively identify issues. Partnering with pharmacy and grocery store chains to provide delivery and maximizing the 211 information directory.

Implementation approaches that the PPS considers a best practice:

- Interact-like principles
  - Interventions to Reduce Hospitalizations
- Home Health Quality Initiative's Fundamentals of Reducing Acute Care Hospitalizations BPIP
- Key Components include:
  - Early detection of signs and symptoms
  - Early management of clinical conditions
  - Enhanced communication between home health and hospitals, as well as between home health and physicians
  - Discussions with families about hospitalizations
  - SBAR progress communication notes
  - Hospital risk assessment
  - Medication reconciliation
  - Acute care transfer log
  - Quality Improvement tool for review of acute care transfers
- http://interact2.net/
  - https://www.jointcommission.org/assets/1/18/Coord_of_Care_JQPS0714.pdf

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

Current State – Hospital to Home:

- Certified Home Health Agency (CHHA) Home Care sub-committee organized, including
  - Community Health Center
  - VNS of Schenectady
  - EDDY Home Care
- Identified need to reduce potentially avoidable readmissions by using standardized care protocols
- CHHA to pilot Congestive Heart Failure (CHF) rescue plans
- Identified and plan put in place to adopt consistent patient/caregiver education symptom identification and classification (zone) sheets for CHF, diabetes, COPD, anemia, heart attack, atrial fibrillation, sepsis, mental health conditions and other conditions
  - Zone sheets approved by Clinical Integration and Quality Board and were rolled out for use in CHHA, hospital, primary care, health homes, outpatient clinics and skilled nursing facilities in May 2016
- Interact-like principles incorporated into EHRs
  - Allows for patient and care giver education regarding recognizing early warning signs
- Readmission review of home care patients occurring
  - Eddy /SPHP; monthly
  - Ellis /Care Central/ VNS; monthly
  - Ellis care management and physicians within Hospital, VNS, Care Central are going to be utilizing secure texting as a means of improving real time communication to
  - CHC/ St Mary's piloting project that will increase communication between acute care staff and home care staff
  - Benefit
    - Sharing real time information

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 in previously identified population

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Alliance for Better Health Care, LLC

Project: 2.d.i

Challenges the PPS has encountered in project implementation:

Challenges that Alliance has encountered in implementing the Patient Activation project include:

- Identifying uninsured, low- and non-utilizing Medicaid recipients
  - screening for insurance status in certain community-based settings (e.g., food pantry) challenging
  - some CBOs concerned that clients might worry about current services they receive being taken away if they don't "qualify"
- Setting both CBO and community expectations; health care is a new focus for many CBOs, significant education required to set foundational understanding of initiative
- Communication with Insignia Health representatives is poor, Insignia
  - not responding timely to inquiries and questions from PPS
  - not notified about webinars in a timely manner to allow for planning
  - not forthcoming with reporting capabilities
- Ensuring timely primary care access for preventive services
- Navigating implementation in counties that overlap with other PPSs

Efforts to mitigate challenges identified above:

To mitigate the risks and challenges noted above, Alliance has taken the following actions:

- Provided screening questions to CBOs engaged in the project to help them identify the target population
- Workgroup meetings have facilitated dialogue and collaboration between CBOs and clinical partners; looking to develop regional CBO and clinical partnerships for this project
- Have developed scripts for introducing the PAM tool, as well as for basic coaching and navigation
- Developing a community resource guide for CBOs engaged in navigation; includes resources for communicating with providers, recommended screenings, contact information for primary care practices and dental services, ordering Medicaid transportation, and tobacco cessation
- Working with PCMH staff to assess capacity of primary care practices in the PPS; will share this information with CBOs engaged in navigation to ensure timely access for clients
- Established affiliation with Insignia Health representatives, working to improve bi-directional communication
- Focused implementation efforts on counties that don't overlap with other PPSs, keep open lines of communication with project leads at other PPSs, and continue to engage leadership of other PPSs in developing strategies to reduce duplication of efforts

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Implementation approaches that the PPS considers a best practice:

Best practices include but are not limited to:

- Introducing PAM tool: Opportunity for client/patient to have a "voice" in his/her own care
  - Identified PAM scores to be a more reliable indicator of patient awareness when staff have a pre-existing relationship with clients
  - PAM considered a tool for assessing engagement in healthcare, not a "survey"
  - More successful engagement in PAM tool when conducted in person
  - When tool is administered by staff they can assist with literacy/interpretation of questions
- Utilize individuals who live in the community they are serving
- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361049/
- http://www.insigniahealth.com/

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

- Trained 200 individuals in the PAM tool
- Engaged numerous CBOs
- Outreach to community based organizations in the six counties
  - Included outreach to shelters during winter months
- Engaged conversationalist for education sessions and outreach
- PAM Service Agreements executed
- Exceeded patient engagement targets for DY1 and DY2Q1
- Aggregated and reviewed PAM data from DY1
  - identified retraining opportunities to ensure quality of data collected
- Focused on engaging the uninsured in PAM
  - working with CBOs to determine best way to identify uninsured
  - shared uninsured data by zip code across 6 county service area with workgroup to assist with targeting outreach efforts
- Developing navigator program/toolkit; identifying training needs
- Formed subcommittee of workgroup to focus on navigator role and responsibilities
- Assessing capacity of engaged organizations to conduct navigation/coaching

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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No changes to the population at this time.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Alliance for Better Health Care, LLC

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

Challenges that make it difficult to deliver primary care in the behavioral health setting, or behavioral health in the primary care setting in the current environment include:

- A lack of supply of, and access to behavioral health services. Gaps in access vary across the service area and are especially problematic in areas such as Schenectady.
- While partners routinely screen patients for behavioral health conditions, providers were not comfortable with follow-up strategies that address problems found on screening.
- The State recently released clarification to the requirements for 3.a.i. Model 2 where PPSs must screen for preventive care screenings in the behavioral health setting. As all PPSs, Alliance is delayed in incorporating this requirement.
- High ED utilization among patients with behavioral health diagnoses with fragmented follow-up and inadequate access to care for chronic co-morbid conditions.
- A reluctance among behavioral health patients to seek primary or chronic care services, despite the higher-than-average prevalence of chronic conditions among individuals with Serious Mental Illness (SMI).
- The lack of capital to address inadequacies in updates to physical space required to see patients for primary care services in the behavioral health setting, and to also see patients for behavioral health services in the primary care services. Additional challenges stem from a range of regulatory, physical space and operational considerations. Regulatory barriers have been addressed for some settings; however, potentially costly modifications may be needed to update existing space (if such space exists) to support visits in both settings in the absence of funding for capital expenditures.
- Information Technology (IT) resources, which do not currently support sharing of information between PCPs and behavioral health providers within or across settings.

Efforts to mitigate challenges identified above:

To mitigate challenges above, Alliance has taken the following steps:

- Alliance is working with PPS partners to incorporate strategies that augment both primary care and behavioral health appointments. For example, in primary care, some Alliance partners are hiring new staff to accommodate patients on evening and weekend hours. In addition, PPS partners are utilizing "no-show" slots for patients who were not scheduled in advance and require care following a primary care screening visit or an Emergency Department visit.
- Alliance developed a work flow with all partners to address follow-up from a positive screening in either the primary care or behavioral health setting. Alliance is augmenting such workflows with partners to reflect the incorporation of screening for medical needs in the primary care setting.
- To address high ED utilization and fragmented follow-up care, Alliance partners are in the process of developing care management services for high-risk patients whose ED utilization could be avoided. Alliance partners are further educating patients regarding self-care within multiple projects. In particular, patients with behavioral health needs are encouraged to seek out medical care and are triaged to medical providers at the point of service.
- Partners are seeking to determine low-cost strategies to develop appropriate space to see patients in integrated settings.

Implementation approaches that the PPS considers a best practice:

Best practice identified for integration of primary care and behavioral health includes

- Literature and discussions with providers indicates that best practices include, but are not limited to:
  - Team-oriented treatment with consistent communication at the system, team and individual levels across primary and BH care that appears seamless to patients
  - Team-selected evidence-based protocols that are implemented across disciplines
  - Population-based medical and behavioral health screening as a standard practice with referrals to accessible clinicians as needed
  - Use of a single treatment plan that incorporates plans to address medical, behavioral and psychosocial supports
  - Formal and informal meetings to collaborate on patient needs across the continuum of care
  - Ongoing measurement and improvement of integrated care delivery over time
  - Interdisciplinary Care Management to address the needs of individuals with SMI with medical, behavioral and psychosocial professionals capable of addressing the holistic needs of patients in a culturally and linguistically sensitive manner. There is a strong emphasis on self-care, which is pervasive throughout the Alliance's approach to DSRIP.

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

Today, a majority of partners have processes to screen patients for behavioral health needs in the primary care setting; however, fewer partners have screening tools and processes in place to screen patients for primary care needs in the behavioral health setting. Given the change in the definition of "active engagement" for 3.a.i., this will be a major focus of activity in the next DSRIP quarters.

Partners believe that screening individuals for medical needs in the BH setting is an important step to improve the health of individuals with Serious Mental Illness (SMI); therefore, partners are pursuing such screening and referral mechanisms going forward. In the next several months, partners will focus their efforts on ensuring that protocols are in place to conduct medical screenings and to provide referrals for services where appropriate for patients who screen positive for physical health care needs in the behavioral health setting.

In the primary care setting, a majority of partners are screening patients using the PHQ-2. A PHQ-9 screening is conducted if behavioral health needs are identified as a result of the PHQ-2 screening process. Whitney Young

developed a tool that is unique to their facility and that tool was shared with the Integrated Primary Care and Behavioral Health Workgroup. This validated tool represents an evidence-based best practice model and the tool offers a score, similar to the PHQ-9.

With regard to Model 2, co-location of integrated care, some sites are currently co-located and others are developing plans to co- locate. This is a major focus of activity now through March 31, 2017. Partners are using strategies ranging from using existing space that is in the same building with primary care to building urgent care space that will include both primary care and behavioral health services. FQHC partners are waiting to obtain further guidance from the State regarding licensure requirements in their facilities.

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 population

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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: Alliance for Better Health Care, LLC

Project: 3.a.iv

Challenges the PPS has encountered in project implementation:
At the outset of DSRIP, there was no system to provide ambulatory withdrawal management services in the Alliance service area. Key barriers include: - Given the insufficient number of community-based treatment sites, there are an inadequate number of providers to serve patients with Substance Use Disorders (SUDs); patients utilize ED services given the absence of an organized system of outpatient care and inadequate access to services. - As a result of the lack of organized ambulatory detoxification services, whatever services that are available are highly fragmented. When a patient presents at an ED, they receive episodic treatment, counseling and/or detox services may or may not be available in the community following the ED visit. - Many providers are not willing to become x-licensed and offer Suboxone or Naltrexone treatment, which is an ongoing barrier to obtaining access to services. - There are challenges related to regulatory guidance regarding licensing issues that require significant time and resources. - Some, but not all, MCOs cover medically supervised symptom relief for individuals in need of withdrawal management services; Only individuals with high acuity are able to gain access to such services, specifically offered at Conifer Park.
Efforts to mitigate challenges identified above:
Strategies to mitigate challenges include: - Efforts within Alliance and among Alliance partners, to create ambulatory withdrawal management sites. The PPS is also in the process of identifying Primary Care Providers (PCPs) who wish to become x-licensed to deliver suboxone. Furthermore, Alliance is in the process of creating a “no wrong door” entry point where patients can contact a centralized triage system for an initial assessment – as well as a comprehensive assessment if needed – to obtain the appropriate type and level of care. - Alliance partners are in the process of applying workflows that incorporate best practices to individual delivery systems within the PPS. While the workflows were developed by the Alliance Workgroup, individual sites must customize the approach while maintaining the best practices employed in the workflow. - Alliance has provided support to providers, as requested, to determine the most practical approach to licensing issues for their sites whether they wish to provide co-located primary care, behavioral health care and/or SUD services. - Alliance is in the process of developing stronger relationships with MCOs in order to request coverage for medically supervised symptom relief for individuals in need of withdrawal management services. - Alliance has developed an approach that relies more on implementation at the local level with a focus on local teams and partnerships in order to ensure strong implementation of centrally developed guiding principles and work products.

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Implementation approaches that the PPS considers a best practice:

Given the general lack of "best practices" in Ambulatory Withdrawal Management for SUD, Alliance has adapted best practices from different areas for SUD treatment. Alliance further contracted with an SUD expert at a safety net organization in the Boston area to obtain best practices used at their site specifically to develop a robust approach to Ambulatory Withdrawal Management. Best practices identified by Alliance include, but are not limited to:

- A "No wrong door policy" to identify people at any point that they seek help within the system with the ability to triage the patient to care quickly at the time they are seeking help
- A population-based approach to SUD, medical and behavioral health screening as a standard practice with referrals to accessible clinicians as needed using a seamless, team-based approach
- Use of best practice treatment protocols for all drug agents (alcohol, opiates, other) including the use of a single integrated treatment plan
- The ability to function as a single integrated system across behavioral health and primary care and SUD
- Use of consistent communication at the system, team and individual levels with appropriate sharing of patient information that supports the delivery of integrated care
- The convening of formal and informal meetings to collaborate on patient needs across the continuum of care including medical, mental health, SUD and psychosocial support needs
- Ongoing measurement and improvement of integrated care delivery over time

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

To date, the Alliance Workgroup, including partners from across the PPS, has focused on:

- Reviewing best practices in ambulatory withdrawal management
- A review of network adequacy and strategies to augment existing access;
- Developing a best practice clinical protocol for outpatient withdrawal services which partners are now adjusting to meet the needs at their individual facilities;
- Reviewing regulatory and licensure requirements to deliver integrated care; and,

Within the current system, inpatient treatment is available and outpatient treatment is available on a limited basis. There are significant capacity issues for general patient population when transitioning to outpatient treatment and services are variable across the PPS. In particular, there are limited providers able to deliver suboxone and partners are seeking to identify additional PCPs who are interested in becoming x-licensed. The PPS is also hopeful that legislation that allows Nurse Practitioners to deliver suboxone under the direction of a physician will also be passed. In addition, coordination across the PPS service areas needs to be enhanced.

Through the end of DY2, PPS partners will focus on completing the tasks described just above in order to implement all DSRIP requirements. Specifically, Alliance and its' partners will focus on: relationship development across the SUD continuum and integration of services; final implementation of best practice protocols and workflows including services provided by CBOs; final implementation of the 24- hour "no wrong door" system; addressing all training needs. The PPS will further identify any policy changes needed from DOH. Finally, the PPS will implement the full IT system including data and information sharing, tracking and other key functions.

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 population.

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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: Alliance for Better Health Care, LLC

Project: 3.d.ii

Challenges the PPS has encountered in project implementation:

Challenges that the Alliance has encountered while implementing the Asthma project include:

1. Identifying and extracting patient engagement from various EHR systems has been challenging as specific data elements have been lacking. Additionally, the three Healthy Neighborhood Programs that provide home assessment and home-based, self-management services, do not collect the Client identification number (CIN) or patient identifiers as they funded by NYS and do not bill for their service.
2. Alliance service area lacks sufficient numbers of Certified Asthma Educators (AE-Cs) to support the objectives of the project.
3. Alliance service area lacks a standardized curriculum with which to train CHWs (et al) in asthma home-based, self-management.
4. Reimbursement practices are a key risk to provider engagement in this project. For example, MCO policies do not cover multiple prescriptions for the same inhaler so that inhalers can be simultaneously available at home, school, and other family member locations.
5. IT Risks, such as data interoperability using multiple vendors that may not support existing standards - the risk mitigation strategy is to engage vendors early & determine supplemental solutions if available. The RHIO (the expected interoperable clinical platform) has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing DSRIP needs with existing commitments. Population Health IT (PHIT) systems & tools are required & delay to PHIT implementation delays the projects & risks not meeting speed/scale requirements. PHIT depends on sufficient capital funding from NYS & delay in capital release will delay the rollout.
6. Traditional providers need to be linked with home-based programs and community health workers to minimize missed opportunities for home visits and access to patient homes; if not the project has an increased risk of resistance to change and stagnation in current state management.
7. Engaging patients in their care will also be important to the success of this project and the challenges associated with the SDOH in engaging this patient population are formidable.

Efforts to mitigate challenges identified above:

1. Practice Managers continue to work with their IT systems to build the necessary data elements to secure accurate extraction of legitimate episodes of patient engagement. We continue to explore how we could legally attain the CIN for those patients served by Healthy Neighborhoods Programs. A request to NYSDOH to consider waiving the CIN requirement for this population is envisioned.
2. Alliance is sponsoring an Asthma Educator Exam Preparation course and has contracted with Kettering National Seminars to provide this 2-day training for our partners and affiliated CBOs as well as the AMCH PPS. The course is scheduled for August 18-19 and will accommodate approximately 24 professionals.
3. Alliance has adopted the Association of Asthma Educators – Asthma Education for the Community Health Worker training program and plan to promote its use by all of the Partners and CBO's that have identified training needs for CHWs or equivalent positions.
4. Building on PPS partnership agreements with the regional MCOs, Alliance will mitigate this risk by advocating for enhanced coverage of home-based self- management that has been shown to reduce overall burden of asthma costs. Success of the mitigation strategy will be seen when MCO/PPS agreements have been made.
5. Alliance will work with the RHIO, accelerate implementation of PHIT interoperability, use alternate methods where EHRs & PHIT tool functionality aren't ready & work with NY to ensure capital is given in sufficient time.
6. Alliance has formed an asthma task force to develop and coordinate in-services to educate providers and care managers about community-based resources and referrals. Alliance has leveraged its active partnership with the Asthma Coalition and School-Based Asthma Management program.
7. Alliance will develop strategies to provide culturally and linguistically appropriate care by promoting the training and development of a CHW workforce and leveraging them to serve as community asthma champions/educators.

Implementation approaches that the PPS considers a best practice:

The following programs have been identified as best practice:

- The Asthma Care Program at Ellis Medicine
- The Healthy Neighborhoods Programs (Schenectady, Albany and Rensselaer)
- The Cornell Cooperative Extension
- http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines
- https://www.epa.gov/indoor-air-quality-iaq

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

1. All five of the DSRIP requirements that are due at the end of DY2 are on track
2. Formally adopted the following Mission and Vision Statements:
   - *Our mission is to actively coordinate a six-county, community-wide effort to reduce preventable ED visits and hospitalizations for asthma through promotion of evidenced-based, self-management strategies*
   - *Our vision is to improve both the quality of life and self-efficacy of individuals with asthma while increasing their satisfaction with care*
3. Established a total of six subcommittees to address various project requirements as follows:
   - Home Visitation Referrals
   - Workforce Training (AE-Cs, CHWs, Navigators, Case Managers, ED Nurses and School Nurses)
   - ED/Hospitalization, Patient Education, RCA and follow up
   - PCP Support (education, registry and clinical decision support tools)
   - Community Education
   - Tobacco Use Cessation

The goal of the subcommittees is to come up with specific recommendation(s) as to how we as a PPS, could best reach the project requirements to reach desired future state. The recommendations and rationale will be forwarded

to the Clinical Integration and Quality Committee for review and approval, and then shared with the partners and CBO's for implementation.

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

The community needs assessments accurately identified the appropriate populations to be served by the project – there are no changes.

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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: Alliance for Better Health Care, LLC

Project: 3.g.i

Challenges the PPS has encountered in project implementation:

1. Palliative Care in the primary care setting and lack of qualified/credentialed professionals with palliative care knowledge and expertise. Many providers in the primary care setting do not recognize when palliative care is appropriate or are not comfortable addressing patients and family members about the same since very few have been adequately and appropriately trained on palliative care. Lack of knowledge around palliative care in general could also slow down referrals and delay the timeline.
2. Palliative Care is not presently a covered benefit across all providers which places this project at risk for succeeding if providers refuse to engage in unreimbursed services.
3. As care shifts to the Primary Care Provider, there are risks to overwhelm providers with expectations associated with the DSRIP projects.
4. Smaller practices lack patient volume and resources to hire dedicated staff to support palliative care. Under-resourced providers will be reluctant to provide palliative care as it will put additional strain on the practice, thus reducing the number of patients able to benefit from this service.
5. Receptivity to receiving palliative care services may vary by many factors, including ethnicity, religion and cultural characteristics of the population, which will uniquely impact patients' interactions with providers.
6. Patient comprehension of palliative care. There is an existing misunderstanding of patients, families and providers that palliative care is applicable only for patients at the end of life.
7. Another risk to the successful completion of this project is that all providers do not achieve NCQA recognition by DY3, Q4.

Efforts to mitigate challenges identified above:

1. To mitigate the risk of Palliative Care in the primary care setting and lack of qualified/credentialed professionals with palliative care knowledge and expertise, increasing provider, patient, and community knowledge base around palliative care services is paramount. Providers and other care team members are educated on the concepts of generalist palliative care as well as teaching when and how to make referrals to a specialty provider, a home-based palliative care team and when appropriate, the local Hospice partner. Supporting efforts providing evidence include but are not limited to the June 7th Regional Palliative Care Symposium hosted by Alliance with an expert key note address speaker and a panel of champions. Alliance has also partnered with the Center to Advance Palliative Care (CAPC) and allowed registration for 100 PPS providers for membership, promoting access to CAPC tools and resources, including 37 CME/CEU courses on a variety of clinical and operational topics related to palliative care. In addition, PMCH and PPS staff will be engaged in trainings to increase role-appropriate competence and deploy formal palliative care education for clinicians and members of the multi-disciplinary team. Educating key clinical integration team members embedded in Projects 2.b.iv (Care Transitions) and 2.b.viii (Hospital to Homecare) to increase awareness of palliative care services for hospitalized patients and their

families to reduce preventable readmissions is critical, and Alliance is reviewing training opportunities with the Area Health Education Center (AHEC) through a proposed curriculum relative to the DSRIP projects.

2. To mitigate the risk of cost effectiveness, Alliance is working to develop a statistical model for demonstrating outcomes of palliative care projects and prove cost effectiveness of care. Alliance is also building upon effective partnerships with MCOs in DSRIP project design to advocate for reimbursement for services required by the project.
3. The mitigation strategy to prevent or minimize provider fatigue is to bundle interventions as much as possible. The project leads demonstrate the common links between DSRIP requirements, and identify technical support, tools and training to practices. Alliance also extends the reach of its current palliative care services to accommodate patient referrals and decrease the burden to the PCP practice.
4. Potentially having central palliative care staff that can support multiple small practices would reduce the cost and burden of those practices who are unable to support the services with the current resources.
5. Cultural competency training for staff will play a large role in patient engagement. To ensure that the workforce is culturally competent, Alliance has a Cultural Competency/Health Literacy Training Strategy plan with specific timeline of training activities. Community based organizations are engaged and currently working with Alliance on the social determinants of health and with religious organizations to help understand and appropriately address cultural factors that influence how patients receive this care.
6. Alliance has initiated discussions with PPS providers on how best to provide emotional support, education, and training to patients and their family caregivers. Collaboration with certified ACP facilitators has allowed these conversations to begin in the community, in provider offices, at regional forums, and partnering with Hospice organizations to offer innovative methods of education within the community. These efforts, along with Alliance plans to integrate palliative care into the primary care setting will further normalize activities around palliative care.
7. To mitigate the risk of providers failing to achieving PCMH 2014 Level 3 standards, Alliance works with its PPS primary care providers through a dedicated team to achieve recognition, and has developed a thoughtful strategic plan, recognizing that no two practice sites look alike and that they also reflect local circumstances and preferences which drive the program. Success of the mitigation strategy will be seen in number of providers achieving NCQA recognition within the targeted timeframe.

Implementation approaches that the PPS considers a best practice:

1. The Advisory Quality Palliative Care Sub-Committee is reviewing best practice modalities to integrate Palliative Care Services and Primary Care with consideration to:
    a. pain and symptom management
    b. addressing psychosocial and spiritual concerns
    c. establishing goals of care
    d. coordination of care
2. Securing membership with the Center to Advance Palliative Care (CAPC) will allow and strengthen critical components of best practice - comparative data and reporting on palliative care program dimensions such as staffing, costs and patient access, provide essential palliative care interactive curriculum, and provide comparative data and reporting on palliative care program dimensions such as staffing, costs and patient access.

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

1. Established a diverse Advisory Quality Palliative Care Sub-Committee
2. Sub-Committee adopted mission statement – "To integrate a palliative model of care and clinical guidelines within the primary care setting and beyond; defining and applying best practice that will afford populations to attain a level of support and care, and a higher quality of life."
3. Inventory complete for partnering PCP practices, hospice providers, palliative care providers.
4. Established relationships with community and provider resources including community Hospice and HPCANYS to bring the palliative care supports and services into the PCP practice. This provided momentum for the creation of a coalition.
5. Successfully meeting patient engagement targets
6. While the Sub-Committee will serve as the platform for the project, break-out groups have been created and will be effective because:
    a. Each group can focus on a different topic
    b. Topic will be explored in some depth
    c. Greater exploration, depth, and understanding of ideas.
    d. Large group discussion becomes more efficient
    e. <u>Topics for Break Out Groups:</u>
        - Referral process for sites to engage Palliative Care consultation services (workflows)
        - Tele-medicine opportunities for palliative care consultations
        - Best practice modalities and Clinical guidelines (and MOLST)
        - Trainings to increase role-appropriate competence in palliative care skills and protocols

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

The intended population has not changed.

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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: Alliance for Better Health Care, LLC

Project: **4.a.iii**

Challenges the PPS has encountered in project implementation:
Challenges identified during implementation of the Strengthen Mental Health and Substance Use Disorder Infrastructure Across Systems (Mental, Emotional, Behavioral - MEB) project include: • The initial challenge for the MEB project was to identify appropriate and willing participants and leadership for the workgroup. • Challenges related to community and provider understanding of MEB philosophy, training, evidence-based approaches, evaluation and communication were discussed and highlighted among workgroup leadership.
Efforts to mitigate challenges identified above:
To mitigate the risks and challenges noted above, Alliance has taken the following actions: • The MEB workgroup has been established and is led by Kathy Coons, Commissioner of Rensselaer County Department of Mental Health. Ms. Coons' clinical reputation and leadership have provided access to the development of cross functional workgroup of the region's most forward thinking leaders/clinicians in areas of multi-cultural, multi-linguistic, multi-therapeutic trauma informed care. • The MEB workgroup has begun to evaluate, discuss and seek training in various integrated care solutions that incorporate all touch points that serve the Medicaid consumer related to trauma informed care. Touch points include but are not limited to: Primary Care, Specialty Care, Social Services, Shelters, Food Pantries/Soup Kitchens, Schools, and Faith based organizations, Managed Care Organizations, Local Housing Authorities, Law Enforcement, First Responders and Legal Aid. • The MEB workgroup is seeking education and training on trauma informed care among the following best practices programs. At present we have identified best practices with the following organizations: SNUY Albany, SUNY Buffalo, ACES and the Center for Youth Wellness. • The MEB workgroup will begin to define additional training curricula to meet specific community need related to Workforce and Cultural Competency requirements.
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:
None at this time.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
There have been no changes to the proposed population.

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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: Alliance for Better Health Care, LLC

Project: 4.b.i

Challenges the PPS has encountered in project implementation:
Risks for the tobacco cessation project include: 1. Some partner facilities and CBO sites utilize leased properties where the landlord is either personally opposed or reluctant to impose smoke-free grounds restrictions upon the other tenants of the building. 2. Issues related to the interfacing of the Opt-to-Quit module to the numerous and various EHR systems such as cost, time, resource constraints and competing EHR needs.
Efforts to mitigate challenges identified above:
1. We continue to pursue all opportunities to promote adoption of smoke-free grounds status amongst our partners, affiliated CBOs and others. 2. We continue to work with our partners to assist with implementation and to promote the positive benefits of a system-wide solution for ensuring compliance with the US Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence.
Implementation approaches that the PPS considers a best practice:
1. Improving Referrals to the NYS Smokers' Quitline: • Samaritan and Albany Memorial Hospitals have implemented a performance improvement project to increase referrals to the NYS Smokers' Quitline. The program uses Respiratory Therapists assigned the ED to facilitate referrals amongst patients presenting with pulmonary related issues. During the first 6-months of the program, they generated over 1,000 referrals to the NYS Smokers Quitline! 2. Tobacco-Free Workplace Grounds: • Whitney Young Health Center • Unity House • Capital Care Medical Group • Hometown Health Center • http://bphc.hrsa.gov/buckets/treatingtobacco.pdf • https://www.nysmokefree.com/download/OptToQuitPrintable.pdf

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
June 8, 2016, Albany County Executive signs law raising the minimum legal sales age for tobacco products (including e-cigarettes) to 21 years of age! Albany County joins Suffolk and Chautauqua as the only others in NYS to do so. July 5, 2016, Schenectady County conducts a hearing to discuss raising the age to buy tobacco products. The PPS partnering organizations and project workgroup members have actively participated and supported these efforts via petitions, resolutions, letters of support and attendance at public hearings.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
The community needs assessments accurately identified the appropriate populations to be served by the project – there are no changes.