NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Leatherstocking Collaborative Health Partners PPS

Appendix PPS Narratives

November 2016 **www.health.ny.gov** **Prepared by the DSRIP Independent Assessor**

Delivery System Reform Incentive Payment Program (DSRIP) Mid-Point Assessment Executive Summary

I. Background

The Bassett Medical Center Performing Provider System (PPS) d/b/a Leatherstocking Collaborative Health Partners (hereinafter referred to as LCHP) is comprised of 78 partners in a five-county region in the Mohawk Valley region of New York State. The composition of the PPS includes hospitals, primary care providers, behavioral health agencies, county agencies, and community-based organizations.

After review of a comprehensive community needs assessment, the PPS submitted its application to pursue eleven projects, including 2.d.i, Patient Activation Measure (PAM).

II. PPS Governance

As noted in the original application, "an effective governance model is [a] key [factor] in building a well-integrated, high-functioning PPS network". To that end, the Bassett Medical Center PPS has developed and has maintained a governance structure ~ named the Executive Governance Body (hereinafter referred to as EGB) ~ that has ensured balanced representation from all "swim lanes", including partners from government and community-based organizations and all PPS counties. Though familiar to Bassett Medical Center, the lead agency in the PPS, not all partners represented on the Executive Governance Body have been avid supporters of the Bassett Healthcare Network. In fact, some have been staunch competitors. This is among the reasons that Bassett Medical Center was chosen to lead agency in this new endeavor.

The original composition of the EGB was determined by Project Advisory Council (PAC), the original governing body of the PPS. Ms. Patricia Kennedy, CEO of Springbrook, inc. and Dr. Carlton Rule, President/CEO of O'Connor and Tri-Town Regional Hospitals were selected as co-chairs. Ms. Kennedy represents the developmentally disabled population and community-based organizations, while Dr. Rule, a primary care physician, represents our Delaware County partners, as well as primary care, emergency departments and hospital partners within the PPS. The eleven-member body is further comprised of Sean Fadale, CEO of Community Memorial Hospital (hospital; Madison County); Marion Mossman, Regional Director, Mental Health Association of Ulster County (behavioral health, government agency); Christa Serafin, CEO, Sitrin (long-term care, Herkimer County; co-chair, Finance Committee); Mike Kettle, Regional Director, Conifer Park (substance abuse); Lisa Betrus, CEO (long-term care; EGB representative on Compliance Committee); Gerald Groff, MD, Bassett Medical Center (physician; Medicaid Health Home; health plan/population health expertise); Scott Bonderoff, VP, Patient Services, Bassett Medical Center (emergency department); Sue Andrews, CFO, Bassett Medical Center (finance); and Scott Groom, VP & CIO, Bassett Medical Center (information technology).

Governed by firmly established Articles of Governance, the EGB has been a key factor in the early successes of the PPS by ensuring and encouraging transparency, equity, and accountability among the EGB constituents and the PPS leadership. Early results included policy development including Underperforming Partners, Conflict of Interest, and Dispute Resolution; approval of

the funds flow model; committee membership approvals; PPS project tracking and oversight, among other tasks. EGB members are not compensated for their time or travel.

EGB meetings are open and have been attended by partners and members of the LCHP staff. Other key stakeholders throughout the PPS will be invited in the future.

EGB took on some challenging tasks early in their formation including ranking the capital funding requests from partners throughout the PPS, developing policies relating to underperforming partners and conflict resolution, the review and approval of the funds flow model, among others.

Governing the PPS since February of 2015, the EGB will soon enter its third year of existence. The Article of Governance denotes three-year terms, though members may serve consecutive terms.

III. Partners and Partnerships

The Delivery System Reform Incentive Payment Program has provided the unique opportunity for healthcare institutions, community based organizations and Medicaid consumers to collaborate on improving the provision of services to build a more streamlined, efficacious and efficient delivery system.

As the Community Needs Assessment indicates, the composition of the LCHP PPS region is 98% white with little ethnic diversity. Through collaboration with our partners our PPS project teams are focusing initial efforts on the region's LGBTQ population, mental/behavioral health issues and end of life conversations to increase awareness and remove barriers to care.

Whereas the mental/behavioral health and end-of-life conversations correspond well with our project choices (3.a.i. Integration of Behavioral Health and Primary Care (models one and two); 3.a.iv. – Ambulatory Withdrawal; and 4.a.iii - Mental Health Substance Abuse), the focus on the LGBTQ population was determined based on our partnership with the Gender Wellness Center and the physician-leader's passion for this work.

The Gender Wellness Center, located in Oneonta, New York, offers multidisciplinary trans-affirming health care as part of the primary inpatient/outpatient services provided at Susquehanna Family Practice. It is one of the few centers in New York State providing expertise and services for this patient population. The Center has served over 300 transgender patients and receives approximately four to eight new referrals each week.

According to Carolyn Wolf-Gould, MD, the physician-leader at the Gender Wellness Center, transgender and gender non-conforming people face discrimination in education, employment, family life, housing, and public accommodation, but some of the worst discrimination happens when they reach out for help -- in health care settings. It is the goal of our PPS to educate the region's general population and health care workers to ensure such discrimination ends. Educational sessions have already occurred for clinical staff and other health care staff as

outlined in the PPS Cultural Competency training guide remitted as part of the DY2Q1 submission.

The PPS administration works closely with the lead agency and participates actively in its Disparities in Care work group, which has been charged with developing a strategic plan focused on addressing disparities. The PPS will continue to drive this agenda to ensure all consumers have equitable access to the highest quality of care, regardless of their socio-economic, gender and health status.

IV. Addressing Emerging Workforce Issues

In close coordination with the Workforce Steering Committee, the PPS administrative team continues to focus its efforts on ensuring the workforce is adequately trained and prepared for the shift from emergent and inpatient care to care that is focused on prevention and maintaining a satisfying quality of life.

Care managers (outpatient case management) are being actively recruited and deployed to partner sites for pilot projects including, but not limited to, addressing the outpatient needs of COPD patients to mitigate avoidable readmissions. In addition to receiving the requisite training required to perform this work, the care managers and community navigators will partake in motivational interviewing training to ensure they are reaching the population in a culturally competent, effective manner.

V. Sustaining the Transformation

It is essential that the investment in DSRIP – both financial and organizational – is sustained beyond the demonstration years and well into the future.

The lead agency was recently awarded a HRSA grant for chronic disease management. The chronic disease self-management group sessions that will be held for high-risk patients with chronic conditions is designed to improve clinical outcomes. The grant complements the work being accomplished through DSRIP initiatives, including the patient-centered medical home. Health coaches and diabetic educators will lead this work, corresponding well with the PPS' commitment to addressing emerging workforce needs in the outpatient setting.

Additionally, the lead agency applied for the CMS Accountable Care Communities grant, which is designed to further connect community-based organizations with traditional healthcare providers to more effectively manage our populations. Though the grant will not be awarded until the end of 2016, the application itself further demonstrates the PPS' commitment to sustaining this work well beyond the demonstration years.

DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Bassett Medical Center

Highlights and successes of the efforts:

Governance

Governed by firmly established Articles of Governance, the Executive Governance Body (EGB) has been a key factor in the early successes of the PPS by ensuring and encouraging transparency, equity, and accountability among the EGB constituents and the PPS leadership.

The original composition of the EGB was determined by Project Advisory Committee (PAC), the original governing body of the PPS. Ms. Patricia Kennedy, CEO of Springbrook, Inc. and Dr. Carlton Rule, President/CEO of O'Connor and Tri-Town Regional Hospitals were selected as co-chairs. Ms. Kennedy represents the developmentally disabled population and community-based organizations, while Dr. Rule, a primary care physician, represents our Delaware County partners, as well as primary care, emergency departments and hospital partners within the PPS.

Successes to Date

- Executive Governance Body (EGB) formed in early 2015 with input from PAC, the former governing body of the PPS.
- Representation from all "swim lanes", all PPS counties.
- Articles of Governance approved Feb 3, 2015.
- CRFP Ranking.
- Review/approval of committee charters (ongoing).
- Review/approval of committee membership (ongoing).
- Conflict of Interest Policy.
- PPS administration funding model (June 2015).
- Implementation funds flow model review/approval.
- Metric based Funds flow model review/approval.
- Dispute Resolution Policy.
- Underperforming Partner Policy.
- Review/approval of PPS administration budget (annual) and staffing plan.
- Review of Compliance Policy - Code of Conduct.
- Review of Compliance Policy & Procedure.
- Review of Compliance attestation form.
- PPS Compliance Plan.
- Routine updates from committees/project teams.
- Routine review of key performance indicators.

Risks

- In the application submission (Section 2.2, Process 8), the intention was stated that in order to engage stakeholders on key and critical topics pertaining to the PPS over the life of DSRIP, a Consumer Subcommittee would be created. This, in fact, has not come to fruition. Inherent in its mission and administration, however, the PPS leadership understands the importance of engagement of key stakeholders – consumers, partners and others – as the fundamental basis for success in the transformation efforts. The PAC structure is currently being re-evaluated with key members of the PAC (including a Medicaid consumer). When re-evaluation is complete, we are confident we'll have a stronger, more effective group to assist with PPS efforts in the future.
- A Learning Collaborative Committee was considered to be a necessary resource for assessment of training needs throughout the PPS. In fact, this is being addressed PPS-wide by both the Cultural Competency/Health Literacy and Workforce Committees. Project level training requirements are being managed and tracked at the project level. A Learning Collaborative Committee would therefore be redundant and unnecessary to achieve the goals of the transformation.
- A Consumer's Subcommittee of the Learning Collaborative Committee was not created due to redundancy. The LCHP administrative team actively participates in Inpatient and Outpatient focus groups that include patients from all payer types in the LCHP region. In these meetings, patients have an opportunity to openly share concerns with the system relating to access, insurance, care, etc. Sessions are recorded for review.
- The PPS is in the process of "regionalizing" its work, following the model of larger PPS's that have "Regional Provider Units". The goal is to allocate resources to regions based on their area(s) of need and ensure projects are implemented that will address those needs.

Future Considerations

- EGB members serve three-year terms with opportunity for serving additional consecutive terms. The group will have to determine whether the current leaders offer adequate representation for the future of the PPS. Conversely, a question remains as to whether a change in leadership will stall progress. This will be a discussion in DY2Q4, as the third year for all EGB representatives will begin February 2017.

Financial Sustainability

The Finance Committee is among the longest-standing committees in the PPS, having been formed in November of 2014. The committee is co-chaired by Christa Serafin, CEO of Sitrin (long-term care facility) and Jim Vielkind, CFO, Little Falls Hospital. The committee is further comprised of financial experts in the healthcare field from a variety of partner organizations.

The Finance Committee has developed an understanding and undergone in-depth education to gain an effective understanding of the DSRIP financial funds flow principles and adapt guidance from the state in an effort to reward partners whose efforts bring about the desired transformation.

Successes to Date

- A financial analysis was completed to assess each partner organization's financial stability. The first assessment was completed in January 2016 with a 75% return rate. Each partner was determined to be financially stable.

- Development of implementation funds flow model with substantial input from partners and key stakeholders throughout the PPS.
- Development of complex funds flow model designed to reward partners who participate meaningfully in transformation efforts.
- Administration of lead agency financial stability test.
- Presentations to PPS partnership and EGB to instill a working knowledge of the funds flow modeling and process for adopting the model.
- Development of Funds Flow Summary for each check received and remitted to partners.
- Only PPS in the state to flow over 50% of funds received in the early stages of DSRIP.
- External auditor provides audit of financial statements (as part of the Bassett Medical Center accounting processes) annually.
- Monthly variance reports outline financial performance; presentation to the EGB on a quarterly basis.
- Creation of a seven-member sub group of the Finance Committee to assess the results of each partners Financial Sustainability test.

Risks

- Despite developing an equitable, inclusive, transparent model designed to reward participation and transformation, partners will not always be satisfied with the end result, funds received, etc. The PPS risks alienating partners due to this reasoning. Every effort will continue to be made to mitigate such risks.
- The MAX series (focused on super-utilizers) has offered the PPS a unique opportunity to evaluate the impact that rapid transition in volume may have on partner organizations. A consultant, as originally planned, will therefore not be required for this work.

Future Considerations

- As the work within the PPS shifts from pay-for-reporting and foundational development of the PPS to pay-for-performance, the Finance committee will be required to revisit the funds flow model, as well as develop a plan for sustaining financially fragile providers affected by the transformational change.

Compliance

The Compliance Committee, once a stand-alone group, has joined the Finance Committee as a sub-committee. The sub-committee includes compliance experts from throughout the PPS, including Ronette Wiley, PPS Compliance Officer, and Aaron Howland, Compliance Officer, Catholic Charities, who co-chair the committee, and Lisa Betrus, CEO, Valley Health Services (EGB liaison), among others. A compliance training program has been developed in coordination with AHEC (workforce consultants) for partners that do not have a formal compliance program. All partners have been required to agree to the PPS Code of Conduct and sign and notarize a Compliance Attestation form.

Successes to Date

- Compliance survey of all partner organizations to determine whether they have a written Compliance plan that meets all of the requirements of New York's Social Services Law Section 363-d and Part 521 of the New York Codes, Rules and Regulations.

- Developed a Compliance policy, Code of Conduct, and Compliance Attestation form.
- Developed a Compliance training program through AHEC (workforce consultant) for partner organizations that do NOT have a written compliance plan that meets all of the requirements of New York's Social Services Law Section 363-d and Part 521 of the New York Codes, Rules and Regulations.
- Compliance Attestation Form AND notarized Code of Conduct required of all partners as part of the Funds Flow process.
- Established a PPS-wide compliance reporting phone number included in the Compliance policy and posted on the website.
- Developed a Compliance page on the PPS website that includes all applicable policies and the compliance reporting number - http://leatherstockingpartners.org/compliance/.

Risks

- There has been some uncertainty as to the level of lead organization involvement in partner compliance (beyond having a compliance officer). There is concern of having a required level of oversight that may not be feasible in the PPS and/or responsibility for compliance issues beyond our scope. The PPS lead agency will continue to stay abreast of situations pertaining to this important work.

Workforce

The Workforce Steering Committee is co-led by AHEC (workforce consultants) and PPS leadership staff, and is co-chaired by Sara Albright, VP, Human Resources, Bassett Medical Center and Jennie Gliha, VP, Human Resources, AO Fox Memorial Hospital. The committee is comprised of workforce experts representing multiple partner types throughout the PPS.

Successes to Date

- Development of a Workforce Committee charter.
- Development of work groups to better define the steering committee's direction:
  - -Training Strategy Work Group,
  - -Compensation and Benefits Work Group,
  - -Gap Analysis Work Group
- Re-definition of the Cultural Competency Health Literacy work group. This eventually became its own standing committee.
- Completion of initial projections for Workforce strategy budget as committed to in the original application.
- Working in conjunction with AHEC, developed HWAPPs, a central repository of workforce-related documents, best practices, training, partner reporting against baseline staffing impact and DSRIP strategy spending.
- PPS hosted Workforce Lead and Vendor Meeting.
- Completion of compensation and benefits survey (multi-PPS effort).
- Creation of Core Teams to create a sustainable communication structure to inform and report workforce-related activities, allowing partners to engage and own their portion of the work.
- Completion of Workforce impact analysis.

Risks

The Bassett Medical Center PPS is located of a rural region in Upstate New York. A risk that has long existed is recruitment and retention. Despite best efforts by Bassett and other partners to recruit and retain key staff, it remains an issue. It is for this reason that staff reduction efforts are anticipated to be quite low. Workforce AV is currently pass/fail; missing a single element penalizes the PPS, despite successful completion of other elements. The pass/fail nature dis-incentivizes partial completion when one element is in doubt.

Future Considerations

- Consider utilizing DSRIP funds for recruitment/retention improvement including, but not limited to, incentive bonus payments.

Clinical Integration

Accomplishing Clinical Integration is the responsibility of the Clinical Governance Committee. This committee is led by Dr. Gerald Groff, the Chief Medical Innovation and Insurance Officer for the Bassett Healthcare Network. Multiple partner types are represented at this meeting in order to fully represent our integration opportunities and challenges.

Successes to Date

- Identification of providers already clinically integrated and those who will be integrated in the future.
- Patient focus groups have been held in order to identify areas of opportunity for clinical integration.
- Achieving clinical integration as it relates to electronic interoperability
- Hospital and non-hospital partners held breakout sessions to identify areas of opportunity
- Survey of PPS providers with regard to access, care coordination, community resources, etc.
- Development of Clinical Integration Needs Assessment Plan

Risks

- Achieving clinical integration as it relates to electronic interoperability will be limited due to the absence of capital dollars for the LCHP PPS. However, we will continue to forge ahead by leveraging our RHIO strategy to use HIXNY to attain a basic level of information sharing.
- Services for Mental Health and Substance Abuse are highly desired by our Primary Care providers, as seen in our survey. As the Withdrawal Management and Behavioral Health projects progress, resources will be aligned to alleviate some of this need.

Future Considerations

- The “Clinical Integration Strategy” is currently being created in order to detail the final steps to share information in the PPS and coordinate care transitions. This will be submitted and approved by the EGB.

IT Systems/Processes

The DSRIP program is designed to be an agent of transformation for the health care system. In order to bring about meaningful and sustained changes, information technology initiatives must be robust and directed at interoperability and information sharing. To that end, the IT and Data Analytics Committee (ITDAC) was formed and staffed with IT leaders throughout the PPS. The team is currently led by the PPS Director of Performance Metrics, co-chaired by Scott Cohen, MD, Chief Medical Information Officer, Bassett Medical Center; and Jack Sienkiewicz, CIO, Springbrook.

Successes to Date

- Development of current state assessment of PPS-wide IT capabilities.
- Review of all projects with committee input to better understand present and future IT needs.
- PPS has identified RHIOs/SHIN-NY as a primary vehicle for data sharing; have engaged with HIXNY to provide partner education on RHIO functionality.
- Completed security requirements for receipt of member roster and claims data; working with Business Analytics experts to better understand possible utilization of this data.
- Active Participation in Performance Measurement Workgroup.
- Initiated SIM user group participation in CIO Steering Committee meetings.

Risks

As with colleagues throughout the state, the lack of capital funding remains a risk for future project success – that is, to achieve a fully integrated IT system with a data warehouse for tracking and measuring.

Performance Reporting

Successes to Date

- Active educational efforts in place with project chairs and PPS leaders to assign responsibility for achievement of performance measures.
- Implemented Performance Logic for PPS wide project management tracking.
- Created PPS database for ongoing measure tracking, categorization and prioritization of work.
- Created secure server for partner transmission of actively engaged patient data.
- Utilizing MAPP dashboards as data source for aggregate (de-identified) performance reporting to partners via website and newsletter.
- Hired Business Analytics resource to build performance dashboards using real time data for rapid cycle improvement.
- Contract secured with Press Ganey to determine satisfaction of the uninsured patient population.

Risks

- Lack of capital dollars limits the degree to which real-time data may be aggregated at the PPS level; therefore, many real time performance data reports will be at the partner level.
- The data use restrictions with Medicaid claims data are too stringent to utilize for contacting Medicaid patients directly through telephone calls, letters and home visits.

Cultural Competency/Health Literacy

At its inception, the Cultural Competency/Health Literacy Committee was a subgroup of Workforce Steering. It soon became apparent, however, that there was much work to be done in this regard that did not overlap with or fully complement the Workforce committee's agenda. Thus, the Cultural Competency Health Literacy (CCHL) Committee was formed and tasked with determining which populations our PPS could most positively affect and how the PPS might develop tactics to combat health illiteracy.

Successes to Date

- After an extensive review of the community needs assessment and engagement of community-based providers, the CCHL Committee determined its populations of focus as LGBTQ, mental health/substance abuse, and mental/behavioral health.
- Development of a training strategy based on results of a training needs assessment and identified resources of expertise to provide requisite training.

Risks

No risks have been identified.

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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: Bassett Medical Center

Project: 2.a.ii

Challenges the PPS has encountered in project implementation:

Challenge 1: Participating providers in PPS must meet NCQA 2014 Level 3 recognition. 1 partner is converting their EMR during PCMH implementation period. This places high demands on staff resources and creates barriers for data reporting.

Challenge 2: Clinical Interoperability is a challenge with varying EMRs across PPS

Challenge 3: Identifying Physician champions to attend training and attain CCE (certified content expert) status is a challenge due to limited PCP practitioners who can be spared, limited frequency of training & high demand for NCQA training/exams as well as the cost to travel to and attend NCQA trainings.

Challenge 4: There is a lack of RNs in the workforce with ambulatory experience

Challenge 5: There were concerns with Partner Engagement for PCMH.

Challenge 6: Negotiating contracts with MCOs for services not reimbursed/under-reimbursed

Challenge 7: Practitioner Engagement-Under the current model, the majority of practitioners are not incentivized by engaging in the NCQA work. The model will need to change in order to motivate practitioners to want to engage in the NCQA work.

Efforts to mitigate challenges identified above:

Mitigation 1: Consultant support for partners, PPS ops team support and detailed plans for implementation of the NCQA standards in place. Each partner must work with their IT department to export reports for NCQA standards to pull data from their EMR. Data from both the existing and new EMRs will be accepted by NCQA.

Mitigation 2: EHR connectivity is not present across the PPS. PPS Ops Team has worked with partners as DSRIP projects rely on EHR systems & other technical platforms to track patient engagement.

Mitigation 3: PPS practices will use advanced practice clinicians (APCs) and administrative staff in addition to physicians as champions to create the depth in knowledge and the sustainability for the NCQA recognition in the future. The PPS has paid for the initial training for several workforces to attend NCQA training.

Mitigation 4: A workforce impact consultant is engaged with the PPS to employ creative workforce strategies. The PPS will leverage Bassett's relationship with local colleges to create programs necessary to serve population. Utilizing expertise of the consultant, AHEC, and the Collaborative Learning Committee, online and in-person training will be offered to retrain existing employees. Economies of scale will be implemented when training staff across the PPS. RNs will be hired without care coordination and other necessary experience. The PPS will work with AHEC on strategies to identify, attract and successfully recruit experienced RNs. All RN Care Managers will be hired with the intent to provide care coordination.

Mitigation 5: A non-safety net PPS Partner had not been engaged in planning projects due to lack of designated resources to engage in planning and execution. PPS Ops Team contacted partners who were deemed essential, and completed a funds flow model to better inform their involvement. Regular updates to partners through email, project and all partner meetings, and utilization of tools such as website, Constant Contact, survey tools and Health Workforce NY are some strategies used currently. The non-safety net provider sent representation to the PCMH kick off meeting in late July; however, has since ceased participation due to restrictions of available funds to flow. All active providers engaged in this project are working with the PCMH consultants on individualized plans to achieve NCQA recognition.

Mitigation 6: To negotiate contracts with MCOs, there will be a need to combine efforts across the PPS and with other PPSs to strengthen and consolidate the message and make patient care in DSRIP projects sustainable. NCQA recognition will be used to leverage MCOs when negotiating reimbursement.

Mitigation 7: The PPS has identified an overall risk of individual practitioners not being committed to the DSRIP activities. A comprehensive practitioner communication and engagement plan will be created by the Clinical Governance Committee to engage practitioners. This committee will have representation of different types of practitioners. The PPS will leverage existing gatherings of practitioners within partners such as the Primary Care Council, the Regional Medical Director Group and the Clinical Leadership Group (CLG) as models for clinical integration and practitioner engagement in creating PPS-wide professional

groups. The PPS operations team is available to partner organizations to conduct presentations.

Implementation approaches that the PPS considers a best practice:

Identification of CCE's and practice champions early on in the project planning has proven effective for leaders within each practice to lead the work towards NCQA recognition. As practices are at various level of readiness with their applications, the use of PCDC consultants and resources from the PPS project management office has allowed for easier partner cross collaboration.

Collaboration with other PPSs: The PCMH project has little overlap with other PPS's. One partner who is newly engaged in the PCMH project will have 2 of their 10 practices that reside within the Bassett PPS. This lends an opportunity to streamline processes and deliverables that are consistent across the PPS's which they participate in.

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

- In order to achieve the milestones, partners engaged in the PCMH project must become very familiar with the NCQA recognition standards, elements and factors. It is a rigorous program, which requires the care team within the primary care practice to all understand and embed the standards into their practice.
- Year 1 was used to learn about the 2014 Patient Centered Medical Home NCQA recognition standards. PCDC was engaged as a consultant for the Bassett Medical Center PPS partners who are going through the PCMH transformation. Eight learning collaboratives were conducted and are available on the PPS website for later reference and viewing by new partners.
- Partners are at various stages of the application process. While some are renewing their 2011 status with the 2014 PCMH standards, others are beginning this work for the first time. Support is provided to the partners based on their level of readiness.
- Actively Engaged Patient commitments continue to be met and are anticipated to only increase as additional partners transform their practice settings in line with NCQA recognition standards.
- Project level milestones have not come due yet; however, many tasks have been completed:
    - An all partner kick off meeting was conducted to launch the official consulting relationship with PCDC.
    - Partners have completed a readiness assessment to identify their gaps.
    - Initial partner teams have been trained in the PCMH transformative work. Additional partners can access training materials as they engage in the PCMH project.
    - Physician champions have been identified.
    - Certified Content Experts have been identified, attended training and obtained their CCE. As additional CCE's are identified on an ongoing basis, they will be added to the PPS list.
- **Funds Flow:** Partners involved in this project received incentive funds according to the approved funds flow methodology

- **Stakeholder engagement:**

    - **Partners involved:**
        - A.O. Hospital
        - Bassett Medical Center (primary care & pediatric practices and School Based Health Centers)
        - Community Memorial Hospital
        - Herkimer Nurse Practitioners
        - Little Falls Hospital
        - Planned Parenthood Mohawk-Hudson

    - **SMEs engaged/contracted:** Primary Care Development Corporation

- **Performance Measures:**

Our PPS has taken the approach of assigning performance measures to the project that can impact to the highest extent. It is understood that several projects may impact a performance measure. The project taking

responsibility of the measure will lead the effort to make a positive impact on the measure by engaging all the other project teams impacting that particular measure. The performance measures which the PCMH project team will be leading across the PPS are:

- **Adult Access to Preventive or Ambulatory Care**
  Adult Access to Preventive or Ambulatory Care – 45 to 64 years (NYS DOH)
  Adult Access to Preventive or Ambulatory Care – 65 and older (NYS DOH)
  Adult Access to Preventive or Ambulatory Care – 20 to 44 years (NYS DOH)

- **Children's Access to Primary Care**
  Children's Access to Primary Care – 25 months to 6 years (NYS DOH)
  Children's Access to Primary Care – 7 to 11 years (NYS DOH)
  Children's Access to Primary Care – 12 to 24 months (NYS DOH)

- **Appointment Satisfaction - CG CAHPS**
  Getting Timely Appointments, Care and information (Q6, 8, and 10) (NYS DOH)

- **Primary Care – CG CAHPS**
  Primary Care – Length of Relationship – Q3 (NYS DOH)
  Primary Care - Usual Source of Care - Q2 (NYS DOH)

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

There are no changes to the proposed populations to be served at this time.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Bassett Medical Center

Project: 2.b.vii

Challenges the PPS has encountered in project implementation:

Challenge 1: Availability of current data on nursing home-to-hospital transfers to measure the effectiveness of the project. Although the Skilled Nursing Facilities (SNFs) are collecting this information from DY1, we have not been capturing this data before. Therefore we are unable to provide a baseline for DY0.

Challenge 2: SNFs face high turn-over in their staff, which is a barrier to maintain an adequate level of competent staff to use the INTERACT tools and requires constant training.

Challenge 3: Clinical Interoperability - Varying EHRs among partners present a challenge in interconnectivity. Although SNF EHRs are connected to HIEs, they are unable to send any information to it. The SNFs can only view information.

Challenge 4: We maybe at a risk of not meeting our patient engagement target.

Efforts to mitigate challenges identified above:

Mitigation 1: LCHP PPS will gather the data available from the beginning of DY1 and set up baseline for a time period in DY1 until we receive any communication otherwise.

Mitigation 2: For new staff, the INTERACT Champion will train staff on a continuous basis. For turn-over with INETRACT Champion itself, the SNFs are able to reach out to the contracted trainers to catch up on training to use INTERACT tools. Written implementation plans and logs are in the process of being created and maintained for such circumstances.

Mitigation 3: In our collaboration with other PPSs, we got in touch with Jeff Paul, the Project Manager for NY-RAH project, which has similar goals as this project as far as connectivity is concerned. Since they are further ahead in their project and have overcome challenges we are currently facing. We will consider their

experience and approaches from their recent presentation.

Mitigation 4: Although we are currently meeting our patient engagement target, there is a possibility of us not meeting it in the future quarters due to the sudden rise in our commitment. We are in the process of leveraging some mergers of SNF entities in our PPS to include them as well in this project.

Implementation approaches that the PPS considers a best practice:

A couple of skilled nursing facilities (SNFs) are ahead of others in implementing INTERACT tools. One of the advanced partners is leading the INTERACT Champion team and facilitating exchange of ideas and best practices along with the trainers involved.

Each Skilled Nursing Facility (SNF) identified INTERACT Champion (s), who is in the process of being trained. Implementation of INTERACT Toolkit is led by the champion. Some of the SNFs are in the process of incorporating an EMR.

Collaboration: Our PPS is a part of the Greater New York Hospital Association (GNYHA) lead post-acute care transitions workgroup. We also formed a smaller work-group to discuss any ideas/issues specific to this project.

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

Stakeholder engagement:

- **Partners involved**: The following partners are involved in this project:

  - A O Fox Nursing Home
  - A O Fox Memorial Hospital (Hospital)
  - Alpine Rehab & Nursing Center
  - Chestnut Park Rehab and Nursing Center
  - Crouse Community Center
  - Focus at Otsego
  - Little Falls Hospital (Hospital)
  - Lutheran Care
  - Mary Imogene Bassett Hospital (Hospital)
  - Masonic Care Community
  - Norwich Rehab
  - Sitrin Medical Rehabilitation Center
  - St. Johnsville Rehabilitation & Nursing Center, Inc
  - Valley Health Services

  This project has 2 committees – the Implementation team and the INTERACT Champion team. The implementation team oversees the implementation of project requirements and removes any barriers. The INETRACT Champion team consists of champions from each SNF.

- **SMEs engaged/contracted:** Foundation for Quality Care is contracted to train the INTERACT Champions in the participating skilled nursing facilities (SNFs) in our PPS. One of the SNFs is further ahead of others in implementing INTERACT tools and their INTERACT Champion is leading the Champion team.

Performance Measures:

Our PPS has taken the approach of assigning a project team responsibility of overseeing the measures that are most directly impacted by that team. However, the responsible team will need to engage other projects which may also have an impact on those measures. Although this project team is not the primary influencer for any performance measures, project work will impact the following measures.

- Advanced Directives – Talked about appointing for Health Decisions
- Depressive Feelings – percent of members who experienced some depression feeling
- Potentially Avoidable Emergency Room Visits
- Potentially Avoidable Readmissions
- PQI 90 – Composite of all measures

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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:

Chase Health was indicated as being involved in this project in the initial application. Unfortunately, it is not involved with our PPS in this project anymore since they chose to be involved in another PPS.

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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: Bassett Medical Center

Project: 2.b.viii

Challenges the PPS has encountered in project implementation:

Challenge 1: Patient engagement
Challenge 2: Physical Space
Challenge 3: Practitioner Engagement
Challenge 4: Primary Care Practitioner Shortage
Challenge 5: Partner Engagement
Challenge 6: IT Technology including EHR interoperability/sharing of PHI/IT infrastructure
Challenge 7: Transition planning with medical professionals
Challenge 8: Funding for staff/training
Challenge 9: Identifying/recruiting expertise in rural area
Challenge 10: Re-branding funding
Challenge 11: Standardized Protocols
Challenge 12: Capital Funding
Challenge 13: Lack of mobile application
Challenge 14: Contract negotiations

Efforts to mitigate challenges identified above:

Mitigation 1: Education for patients to engage in their healthcare to identify & address social determinants will be needed. Referral tracking and patient follow-up in CBOs will be strategies used.

Mitigation 2: Identify other projects that may have available space, consider overlapping needs to consolidate needs, and identify highest demand areas to be located.

Mitigation 3: A detailed plan will be created by the Practitioner Engagement Subcommittee, a subcommittee of the Clinical Governance Committee, to engage practitioners in DSRIP activities. The committee will have representation of various practitioners. PPS will leverage existing practitioner groups such as Primary Care Council, Regional Medical Director Group and Clinical Leadership Group as models for

clinical integration and practitioner engagement. The traditional approach to managing after-hours calls has been to direct patients to the Emergency Department. Training of staff involved in rapid response decisions on INTERACT-like tools and pathways will be the approach to transforming to an "in the moment" response and intervention to avoid unnecessary ED visits. Innovation funding is being sought for a guest speaker to present to the primary care and specialty practitioners on modalities that can be safely provided at home.

Mitigation 4: The PPS is working with Health Workforce New York to evaluate primary care practitioner shortages. The work of the HHCC project on transitions of care across various environments is anticipated to take some of the burden off the primary care practitioner by allowing care coordinators, navigators, RN care managers and others to collaboratively work together. Working through the transitions of care to get patients to schedule and attend their preventive appointments leads to more engaged and healthier patients and more efficient primary care practices.

Mitigation 5: Some PPS partners are not engaged in project planning due to uncertainty of projects/lack of designated resources to engage in planning/execution. The PPS Ops Team confirmed partner involvement in projects and completed funds flow models to inform their involvement. Updates to partners via email, project/all partner meetings, and utilization of tools such as website, Constant Contact/survey tools/Health Workforce NY are some strategies to continue to engage/inform.

Mitigation 6: Patient tracking and provider communications is challenged by variability of technology across PPS project partners. Resources to acquire new technology to achieve interoperability are substantial. The PPS's Information Technology and Data Analytics Committee (ITDAC) will focus on standardization, assistance in joining partners to RHIOs, and developing electronic interfaces for HIE. Patients who are non-ambulatory need to be connected to specialty providers via interactive video.

Mitigation 7: Build relationships among health providers in service area. The PPS Ops Team with the Practitioner Engagement Subcommittee, Collaborative Learning Committee(CLC), and ITDAC will engage home care agencies to develop/enhance relationships with hospitals in and around PPS, with goal of creating standardized clinical protocols and rapid guidance in the moment.

Mitigation 8: Request/align resources between partners and collaborate with the Finance Committee to request special funding (e.g., innovation). Shared staffing and "train the trainer" method is being used to increase efficiency and avoid duplication. Will look to have a home care agency in the respective regions take the lead for training staff at primary care practitioners and staff in their region.

Mitigation 9: The PPS will use creative regional recruitment/retention strategies to attract practitioners/nursing staff while emphasizing use of telemedicine to benefit patient care. PPS has engaged AHEC, workforce consultant. A global approach to staffing needs across PPS and a creative approach for recruitment in a rural setting will be key to successful recruitment/retention of necessary staff.

Mitigation 10: Project team will work with the PPS to request/resource re-branding plan.

Mitigation 11: Care providers have various ways of addressing patient needs. Standardizing protocols across PPS may be a challenge due to large number of care providers/locations. The project team will collaborate with other teams on efforts, approaches and implementation.

Mitigation 12: Involve sources like Robert Wood Johnson Foundation, PHIP (Population Health Improvement Program) team to assist in finding other funding. Funding for interactive video and telehealth options will be essential for home bound patients.

Mitigation 13: Selection of tools to include off-line usage capabilities and increase mobility of home care.

Mitigation 14: In order to negotiate contracts with MCOs, efforts across project teams within the PPS and other PPSs will be combined to strengthen and consolidate the message and make patient care in DSRIP projects sustainable, especially for services not reimbursed/under-reimbursed.

Implementation approaches that the PPS considers a best practice:

The HHCC project team is comprised of representatives from the following groups: primary care practitioners, home care agencies, hospice agencies, care management leadership and regional primary care leadership. This representative group continues to further develop rapid response teams and their respective workflows. Much planning has been done and the next year will be execution of each of the transitional phases.

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

The project team has developed a phased approach for their work, which has included a pre-pilot phase for the COPD population and planned phases for ED to Home, Hospital to Home, Office to Home, and Hospital to Hospice.

- **Accomplishments:**
  - Actively Engaged Patient commitments continue to be met.
  - **Milestone 5**: Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care is complete.
    - A team comprised of Advanced Care Planning experts from partner organizations convened to inventory policies, procedures and tools used across the project partners. They developed, adopted and disseminated tools across the project partners.
    - Additionally the following work has been accomplished at the task level:
      The INTERACT-like interventions have been decided upon and home care, hospice, DD

and DME partners have been trained on the pathways and principles.
Roles of the rapid response team have been identified for the various phases.

- **Funds Flow:** Partners involved in this project received incentive funds according to the approved funds flow methodology

- The HHCC team has taken the lead on development of an asthma pilot project. This work will assist with actively engaged patients for the asthma project and the hospital home care project with testing their various phases in a controlled manner. Their approach was to develop the rapid response team in Delaware County as a comprehensive Clinical Integration Team to manage the care transitions of the asthma population which includes primary care practitioners, care managers, transition coach, navigator, respiratory therapy, DME, and pharmacy. This initial work will be applied to other regions and chronic medical conditions in the future.

- **Data sets used to support program design/implementation**
  - The hospitals used Business intelligence Solutions in the compilation of patient lists to introduce patients to HHCC pathways.

- Partners involved**:**
  - A.O. Hospital
  - Bassett Medical Center (primary care & pediatric practices and School Based Health Centers)
  - Community Memorial Hospital
  - Little Falls Hospital
  - At Home Care
  - Community Health Center
  - HCR Home Care
  - Elderchoice
  - Springbrook
  - The ARC Otsego
  - Herkimer ARC
  - Hospice of Chenango County
  - Catskill Area Hospice
  - Hospice of Herkimer-Oneida

- **Performance Measures:**
  Our PPS has taken the approach of assigning performance measures to the project that can impact to the highest extent. It is understood that several projects may impact a performance measure. The project taking responsibility of the measure will lead the effort to make a positive impact on the measure by engaging all the other project teams impacting that particular measure. The Hospital Home Care Collaborative Team has selected to own the following performance measures across the PPS.

- PDI 90 - Composite of all measures
- Potentially Avoidable Emergency Room Visits
- Potentially Avoidable Readmissions
- PQI 90 - Composite of all measures

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

It was originally anticipated that the target population of the Hospital Home Care Collaboration project would be Medicaid beneficiaries who were adults (18 years and older). Through contracting with partner organizations, particularly those that serve the developmentally disabled population; it was identified that this project may serve Medicaid beneficiaries who are younger than 18 years old.

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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: Bassett Medical Center

Project: 2.c.i

Challenges the PPS has encountered in project implementation:
Challenge 1: Availability of and access to Non-Clinical Resources **Challenge 2:** Space **Challenge 3:** Rural geographic area **Challenge 4:** Funding **Challenge 5:** Staff recruitment/retention **Challenge 6:** Clinical Resources **Challenge 7:** Low level of computer literacy **Challenge 8:** Negotiate MCO contracts **Challenge 9:** Practitioner Engagement **Challenge 10:** Clinical Interoperability **Challenge 11:** Patient engagement **Challenge 12:** Partner Engagement **Challenge 13:** Availability of Funds
Efforts to mitigate challenges identified above:
Mitigation 1: Transportation, housing, food, etc. will be relied upon for success. Social needs identified with participants will need to be linked appropriately. Where demand for services is greater than what exists, PPS to assist CBOs to leverage non-clinical resources (e.g.-transportation contracts across PPS to increase/expand services as identified). **Mitigation 2:** New/repurposing space presents challenges in terms of cost. For efficiency, PPS to combine projects 2.c.i. & 2.d.i. for navigators/support staff & deliver related services in shared space. **Mitigation 3:** PPS has started to embed navigators (who will work with participants to get and stay connected) in CBOs in high traffic areas/hotspots w/consideration that they may not always be available/accessible to patient.

Mitigation 4: Involve sources like Robert Wood Johnson Foundation, PHIP (Population Health Improvement Program) team to assist in finding other funding sources for needed resources to be successful

Mitigation 5: Staffing poses challenge in rural area. Project committee will identify community leaders for assistance in recruiting former Medicaid consumers, who could be trained to fill positions for CBOs in their counties. Recruitment strategy would enhance the representativeness/diversity of PPS workforce. PPS will also avail of career fairs, external websites, CBOs and schools to advertise position openings. A workforce impact consultant, Health Workforce New York, will work closely with PPSs Collaborative Learning Committee (CLC) & partners to employ creative workforce strategies. Utilizing expertise of workforce impact consultant, HWNY & CLC, online & in-person training will be offered to train/retrain employees. PPS to leverage AHECs cross-PPS job opportunities.

Mitigation 6: Navigation is dependent on availability of clinical resources such as PCPs, Behavioral Health, etc. providers to accept/see patients in timeframe needed. Collaboration across projects especially with care coordination is required. Workflows have been developed from the various entry points to ensure open communication among CBOs and clinicians in the moment.

Mitigation 7: Low level of computer literacy among target population will be mitigated via simplified user interfaces/systems.

Mitigation 8: Combine efforts across project teams in/across PPSs to negotiate MCO contracts especially for non-reimbursed/under-reimbursed services to strengthen/consolidate message and make patient care in DSRIP projects sustainable.

Mitigation 9: Practitioners are not always committed to the DSRIP activities. To address Comprehensive practitioner communication/engagement plan to be created by the Clinical Performance Committee (CPC) to engage practitioners in DSRIP activities.

Mitigation 10: To track actively engaged patients, an evaluation of IT reporting capability was needed. PPS operations team assisted with informing of the required fields to document and extract for actively engaged patient reporting. Universal EHR connectivity is not present across service area providers, so the approach is to build out the care manager platform to centrally document and report Navigation activities in the same system used to track Medicaid Health Home and Patient Engagement activities.

Mitigation 11: Care coordinators, patient navigators, case managers, care managers and health educators will be critical team members at CBO sites. Referral tracking and patient follow-up will be part of the ongoing strategies used to engage patients.

Mitigation 12: Some PPS partners have not been consistently engaged in planning projects due to ambiguity

in funds flow, uncertainty of contribution to project requirements, lack of designated resources to engage in planning and execution, etc. PPS Operations Team confirmed partner involvement, reached out to partners who are deemed essential, & completed a funds flow model to inform involvement. Regular updates to partners through email, project and all partner meetings, and utilization of tools such as website, Constant Contact, survey tools, Health Workforce NY, etc. are some strategies used currently.

Mitigation 13: A challenge of the Navigation and Patient Engagement partners was the lack of approved funds flowing to each agency. Due to organizations needing to offset expense with a funding source, the project lagged behind until an approved funds flow model was developed and actual checks were received by partners. A funds flow model for both the 2ci and 2di projects was developed based on a commitment from the Phase I organizations to develop the infrastructure, processes, and workflows as well as to assist with fulfilling actively engaged patient commitments.

Implementation approaches that the PPS considers a best practice:

The Navigation and Patient Engagement Steering Committee were able to utilize existing relationships with Medicaid Health Home contracted partners and convene over numerous hours to inventory partner organizations to develop work plans for Navigation. The team has completed a resource guide, community navigator listing outlining placement and service type, developed workflows, and has begun testing all of their work. Over the course of DY2, the guides and resources will be finalized and partners will be trained on materials.

Collaboration with other PPSs

- The Navigation project occurs in all 5 of the PPS counties; however, the PAM project only occurs in Otsego, Herkimer and Schoharie counties. This lends itself to evaluate workflows in Madison and Delaware counties where we have Navigation, but not Patient Engagement.
- Discussions with bordering PPSs on approach to strategic planning, marketing and resource guide development has begun.

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

- The Navigation and Patient Engagement (PAM) program was built off the infrastructure of the Medicaid Health Home program. There were established relationships with several CBO's, so this was a natural opportunity to expand the work, avoid redundancy and streamline workflows to be most efficient and effective. The Navigation and Patient Engagement Steering Committee was founded and the committee leads and oversees the project work.
- The project team has developed a screening tool and workflows that align with the overall Navigation and Patient Engagement program to direct individuals towards the Medicaid Health Home, engage Navigation services, enlist community outreach services and/or assist with referrals/appointments to clinical services.
- Workflows have been developed for each service type such as from a primary care setting, community based organization setting, etc.

- **Stakeholder engagement:**
  - **Partners involved:**

    Phase I (DY1-currently contracted)
    - Southern Tier Care Coordination
    - Rehabilitation Support Services
    - Catholic Charities Care Coordination (Community Maternity Services/Catholic Charities of Otsego, Delaware and Schoharie Counties)
    - Catholic Charities of Herkimer County
    - Schoharie County Office of Community Services
    - Bassett Community Health Navigation

    Phase II (DY2-next phase of contracts)
    - Chenango County Health Network
    - Bassett Medical Center (Patient Access and Emergency Department)
    - Family Planning of South Central New York, Inc.
    - Herkimer County Health Net
    - Little Falls Hospital
    - Planned Parenthood Mohawk Hudson
    - Mohawk Valley Perinatal Network
    - O'Connor Hospital
    - Community Memorial Hospital
    - Cobleskill Regional Hospital
    - Otsego County Department of Social Services-Meadows Complex

    Phase III (DY3-TBD determined contracts)
    - Schoharie County Department of Social Services
    - AO Fox Hospital

- Catholic Charities of Madison County (2ci only)
- MCAT (Schoharie, Otsego, Delaware County)
- Neighborhood Center
- Herkimer County Mental Health
- Schoharie County Community Action Program
- Catskill Center for Independence

- **SMEs engaged:** The knowledge base from representatives of community based organizations across the PPS has been invaluable.

- **CBO currently engaged/contracted:**
  - Southern Tier Care Coordination
  - Rehabilitation Support Services
  - Catholic Charities Care Coordination
  - Catholic Charities of Herkimer County
  - Schoharie County Office of Community Services

  Additional CBO's will be contracted during DY2 and beyond as noted above.

- **Accomplishments:**
  - Actively Engagement Patient commitments have been consistently met.
  - **Milestones 1-** Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently was completed in DY1Q4.
    - The Navigation and Patient Engagement Steering Committee have developed various work groups to address, plan and manage the various aspects of the 2.c.i. and 2.d.i. plans.
    - A screening tool has been developed and is being trialed in various environments.
    - Workflows continue to be developed specific to the environment navigators are working in.
    - Bassett Community Navigation program has developed roles and job duties based on existing job descriptions to be shared with partners as appropriate and needed. Roles and Job Duties/Descriptions will continue to be refined as needed to evolve with the project.
    - Contracts have been executed with Phase I trial agencies and Navigation offices have been established in Herkimer, Otsego, Schoharie and Delaware county.

- **Performance Measures:**

  Our PPS has taken the approach of assigning performance measures to the project that can impact to the highest extent. It is understood that several projects may impact a performance measure. The project taking responsibility of the measure will lead the effort to make a positive impact on the measure by engaging all the other project teams impacting that particular measure. The Navigation and Patient Engagement Steering Committee and team have agreed to be responsible for the following performance measures:

  - ED use by uninsured

- Use of primary & preventive care svc - % of attributed Medicaid
- PAM Level

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

It was originally anticipated that the Navigation project would target individuals who have a PAM score of 1 or 2; however, through development of a screening tool, it was determined that participants eligible for Navigation services would have at least 1 risk factor and 1 social determinant.

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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: Bassett Medical Center

Project: 2.d.i

Challenges the PPS has encountered in project implementation:

Challenge 1: Patient Engagement
Challenge 2: Funding
Challenge 3: Training
Challenge 4: Practitioner Engagement
Challenge 5: Transportation
Challenge 6: Varying to no IT systems
Challenge 7: Staff Recruitment
Challenge 8: Contracts with insurance companies
Challenge 9: Contract negotiation with MCOs
Challenge 10: Partner Engagement
Challenge 11: Meeting actively engaged patient commitments

Efforts to mitigate challenges identified above:

Mitigation 1: A key challenge will be to engage a culturally diverse population that does not usually seek care at the right time/place/location. Locating these individuals is a challenge. PPS engagement with AHEC will assist w/language needs/training materials appropriate to target populations. Additionally, use of the Coaching for Activation (CFA) tools will likely assist with engaging patients. Agencies may also use incentives to motivate individuals to participate in PAM assessments.

Mitigation 2: Funding for staffing is limited. Consolidation of staff resources across projects like 2ci/2di will exist. Contracts among partners to share staff will lower costs

Mitigation 3: Insignia has provided training to LCHP to conduct the PAM assessment. A train the trainer model is being used to train additional agency staff across our PPS network.

Mitigation 4: Practitioners are not yet committed to DSRIP goals. Comprehensive practitioner communication/engagement plan to be created by Clinical Performance Committee to engage practitioners in the DSRIP initiatives. LCHP will also leverage existing gatherings of practitioners within partners to create PPS-wide professional groups

Mitigation 5: Integrating diverse/segmented programs for critically important services such as transportation will be a challenge. Navigators will have timely access to these resources, will collect information on new resources and report this information back to LCHP. Leveraging PHIP with expanding 211 resources will be ideal. Transportation services are not as available as the demand for them. CBOs will work with each other and w/transportation agencies to increase/expand services to serve patient populations

Mitigation 6: Lack of a common IT platform can limit effectiveness of program. Integration of PAM assessment within the Care Management system will aid in consistency of system and increase efficiencies by only having to use one system. Limited access to PCs and internet within population can pose a challenge. Leveraging libraries and other public access sites in the field may assist. Paper copies of screening/assessments can be loaded into a computerized system when available

Mitigation 7: It is important to engage representatives from service areas CBOs, LCHP Committees and beneficiaries from hot spot locations to strategize on ways to recruit target population. LCHP will explore use of community champions to distribute information regarding available services to area food pantries, religious organizations and other agencies that offer services to those facing financial hardships and to network with community residents to raise awareness of available service

Mitigation 8: Sharing of patient registries to connect with UI/LU/NU will be essential to success DSRIP.CBOs are committed to working with recipients and insurance companies to connect patients to clinical service providers. LCHP is currently restricted from sharing the PPS member roster until the IT security plan is revised. In the meantime, leveraging existing data sources from contracted partner agencies will be used as the starting point.

Mitigation 9: In order to negotiate contracts with MCOs, there is a need to combine efforts across project teams within LCHP PPS and across PPSs to strengthen and consolidate message and make patient care in DSRIP projects

Mitigation 10: Some LCHP Partners, who are deemed essential, have not been engaged in planning projects due to ambiguity in funds flow, uncertainty of contribution to project requirements, lack of designated resources to engage in planning and execution, etc. LCHP Operations Team confirmed current partner involvement in projects, reached out to partners who are deemed essential, and completed a funds flow model to better inform their involvement. Regular updates to partners through email, project and all partner meetings, and utilization of tools such as website, Constant Contact, survey tools, Health Workforce

NY, etc. are some strategies

Mitigation 11: The teams approach to ensure the PAM assessments are completed on the intended population of UI/NU/LU was to develop a screening tool to guide which patients to conduct PAM assessments on. Although this has slowed the team down, the screening tool will ensure that PAM's are completed according to DOH guidelines.

Implementation approaches that the PPS considers a best practice:

The Navigation and Patient Engagement Steering Committee were able to utilize existing relationships with Medicaid Health Home contracted partners and convene over numerous hours to inventory partner organizations to develop work plans for Navigation. PAM training was conducted by Insignia and train the trainer for Phase I agencies curriculum was developed and trained to in accordance with PPS workflows. The train the trainer model will continue for later phased agencies.

Collaboration with other PPSs: The Navigation project occurs in all 5 of the PPS counties; however, the PAM project occurs in Otsego, Herkimer and Schoharie counties. This lends itself to evaluate workflows in Madison and Delaware counties where we have Navigation, but not Patient Engagement.

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

- The Navigation and Patient Engagement (PAM) program was built off the infrastructure of the Medicaid Health Home program. There were established relationships with several CBO's, so this was a natural opportunity to expand the work, avoid redundancy and streamline workflows to be most efficient and effective. The Navigation and Patient Engagement Steering Committee was founded and the committee leads and oversees the project work.
- The project team has developed a screening tool and workflows that align with the overall Navigation and Patient Engagement program to direct individuals towards the Medicaid Health Home, engage Navigation services, enlist community outreach services and/or assist with referrals/appointments to clinical services.
- Workflows have been developed for each service type such as from a primary care setting, community based organization setting, etc.

- **Partners involved:**

  Phase I (DY1-currently contracted)
  - Southern Tier Care Coordination
  - Rehabilitation Support Services
  - Catholic Charities Care Coordination (Community Maternity Services/Catholic Charities of Otsego, Delaware and Schoharie Counties)

- Catholic Charities of Herkimer County
- Schoharie County Office of Community Services
- Bassett Community Health Navigation

Phase II (DY2-next phase of contracts)

- Chenango County Health Network
- Bassett Medical Center (Patient Access and Emergency Department)
- Family Planning of South Central New York, Inc.
- Herkimer County Health Net
- Little Falls Hospital
- Planned Parenthood Mohawk Hudson
- Mohawk Valley Perinatal Network
- O'Connor Hospital
- Community Memorial Hospital
- Cobleskill Regional Hospital
- Otsego County Department of Social Services-Meadows Complex

Phase III (DY3-TBD determined contracts)

- Schoharie County Department of Social Services
- AO Fox Hospital
- Catholic Charities of Madison County (2ci only)
- MCAT (Schoharie, Otsego, Delaware County)
- Neighborhood Center
- Herkimer County Mental Health
- Schoharie County Community Action Program
- Catskill Center for Independence
- Delaware Opportunities
- Opportunities for Otsego
- Resource Center for Independent Living
- Workforce Solutions of Schoharie County
- CDO Workforce

- **SMEs engaged:** The knowledge base from representatives of community based organizations across the PPS has been invaluable.

- **CBO engaged/contracted:**
  - Southern Tier Care Coordination
  - Rehabilitation Support Services
  - Catholic Charities Care Coordination
  - Catholic Charities of Herkimer County

- Schoharie County Office of Community Services

  Additional CBO's will be contracted during DY2 and beyond as noted above.

- **Performance Measures:**

  Our PPS has taken the approach of assigning performance measures to the project that can impact to the highest extent. It is understood that several projects may impact a performance measure. The project taking responsibility of the measure will lead the effort to make a positive impact on the measure by engaging all the other project teams impacting that particular measure. The Navigation and Patient Engagement Steering Committee and team have agreed to be responsible for the following performance measures:

  - ED use by uninsured
  - Use of primary & preventive care svc - % of attributed Medicaid
  - PAM Level

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 at this time.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Bassett Medical Center

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

Challenge 1: Bi-directionally shared records.

Challenge 2: Historical separation (i.e. “siloing”) between intra-organization departments.

Efforts to mitigate challenges identified above:

Mitigation 1: Education about HIPAA laws and distinction between psychotherapy and progress notes.

Mitigation 2: Continued shared meetings and dialogue, hiring Medical and Administrative Directors to help shift the culture towards one more accepting of integration of behavioral and physical healthcare.

Implementation approaches that the PPS considers a best practice:

- Collaboration between primary care providers and behavioral health providers in creating protocols, and continuing communication between intra-organization departments.
- Collaboration between Behavioral Health DSRIP Committee and Clinical Project Teams(Care Managers and PCMH) to successfully achieve Performance Measures, Actively Engaged Patients and Milestones.
- LCHP PPS has started collaboration with FLPPS to offer ECHO to our primary care clinics within our five county PPS.

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

- **Project Approach:** Initial emphasis on Model 1, partner with PCMH to work towards early quick wins (e.g. PHQ2/9), Start with co-location with a plan to gradually move towards full-scale integration. We are currently collaborating with our care management and primary care providers team to create a system to help our patients who are prescribed anti-depressant medication adhere to treatment recommendations in order to obtain the best possible outcomes from treatment.

- **Explain any work completed outside the milestones:** Infrastructure for bi-directionally shared records between primary care providers and behavioral health providers. Achieving this is vital not only for meeting early milestones but also long term success of behavioral health integration. Working with Excellus and the University of Rochester Medical Center (URMC) to offer general psychiatry Extension for Community Healthcare Outcomes (ECHO) to interested community primary care clinics within our five county PPS.

- **Partners involved**: Aurelia Osborn Fox Memorial Hospital, Catholic Charities, Community Memorial Hospital, Conifer Park, Leatherstocking Education on Alcoholism/ Addictions Foundation, Little Falls Hospital, Mary Imogene Bassett Hospital, Otsego County Community Services, Rehabilitation Support Services Inc, Schoharie County Office of Community Services, and Springbrook.

- **SMEs engaged/contracted:** Conifer Park

- **Performance Measures:**
  Our PPS has taken the approach of assigning performance measures to the project that can impact to the highest extent. It is understood that several projects may impact a performance measure. The project taking responsibility of the measure will lead the effort to make a positive impact on the measure by engaging all the other project teams impacting that particular measure. This committee will oversee work towards the below performance measures, the team intends to engage other project that will further impact meeting these measures.
  - Adherence to antipsychotic medications for people with schizophrenia
  - Antidepressant medication management – effective acute phase treatment
  - Antidepressant medication management – effective continuation phase treatment
  - Cardiovascular monitoring for people with cardiovascular disease and schizophrenia
  - Diabetes monitoring for people with diabetes and schizophrenia
  - Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication
  - Follow-up after hospitalization for mental illness – within 30 days
  - Follow up after hospitalization for mental illness – within 7 days
  - Screening for clinical depression and follow-up
  - Follow-up care for Children Prescribed ADHD Medications – Continuation Phase (NYS DOH)

- Follow-up care for Children Prescribed ADHD Medications – Initiation Phase (NYS DOH)

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

There are no changes at this time.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Bassett Medical Center

Project: 3.a.iv

Challenges the PPS has encountered in project implementation:

Challenge 1: Engaging providers to provider Medication-Assisted Treatment, or MAT.

Efforts to mitigate challenges identified above:

Mitigation: providing expert trainings and on-going support (e.g., Extension for Community Healthcare Outcomes, or ECHO) to providers who may interested in providing these services. The PPS lead has hired an addictionologist to support providers with more extreme cases and to initiate care for these patients with plans to transfer them back to primary care when treatment has stabilized.

Implementation approaches that the PPS considers a best practice:

We have identified office-based MAT as an approach that has a solid evidence base, and appears well-suited for our region, which has people spread out over a large geographic area. We are also working to make naloxone more readily available to those who may benefit, recognizing that it is an effective tool in saving lives. We are working to educate both providers and patients about the possible benefits of naloxone, how to use it, and where to get it, as well as to increase the supply in order to get it in to the hands of patients who may benefit from its use.

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

- **Project Approach:**
  - We have taken an ambitious approach to expand the capacity of our PPS to provide services for patients struggling with addiction. Much of our effort has been to begin creating the infrastructure for office-based medication-assisted treatment (MAT) for addiction. We have partnered with the University of Massachusetts to submit a national grant to the Agency for Healthcare Research & Quality (AHRQ) to support the creation and maintenance of such a system. While we wait for word as to whether or not that grant is funded (we expect to know by the end of the year), we are developing a contract for on-site training and ongoing support in the model of the University of New Mexico's Extension for Community Healthcare Outcomes (ECHO), and have a speaker who has agreed to provider education to prepare us to offer MAT to patients struggling with alcohol dependence. This model will help our primary care clinics add treatment of addiction as part of the comprehensive care already offered to patients, and prepare support staff to aid in this process.
  - We are also collaborating with other hospital-based committees and staff to improve prevention of addiction, by creating protocols for decisions about when to prescribe opioids, guidelines for chronic opioid prescription, and medication disposal.

- **Stakeholder engagement:**
  - **Partners involved**: Buffalo Beacon Corp, Catholic Charities, Conifer Park, Delaware County Office of Community Services, Excellus BlueCross BlueShield, Friends of Recovery of Delaware & Otsego, Leatherstocking Education on Alcoholism/ Addictions Foundation, Mary Imogene Bassett Hospital, Otsego County Community Services, and Schoharie County Office of Community Services
  - **SMEs engaged/contracted:** United Health System, Delaware Valley Health System, Neal Felber

- **Performance Measures:**

  Our PPS has taken the approach of assigning performance measures to the project that can impact to the highest extent. It is understood that several projects may impact a performance measure. The project taking responsibility of the measure will lead the effort to make a positive impact on the measure by engaging all the other project teams impacting that particular measure. This committee will oversee work towards the below performance measures, the team intends to engage other project that will further impact meeting these measures.

  - Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days) (NYS DOH)
  - Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days) (NYS DOH)
  - Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) (NYS DOH)

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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:
There are no changes to the population at this time.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Bassett Medical Center

Project: 3.d.iii

Challenges the PPS has encountered in project implementation:
Challenge 1: No regional asthma coalition identified **Challenge 2:** Practitioner Engagement **Challenge 3:** Partner Engagement **Challenge 4:** Clinical Interoperability - varying EHRs among partners present a challenge in interconnectivity. Additionally, involving new partners with varied EHRs later on in the process will add risk for clinically interoperability in the required timeline.
Efforts to mitigate challenges identified above:
Mitigation 1: For our five-county area, no regional asthma coalition was identified. Therefore meeting the milestone specifically to join an asthma coalition is not possible. **Mitigation 2:** A comprehensive practitioner communication and engagement plan will be created by the Clinical Governance Committee to engage practitioners in the initiatives under DSRIP Program. This committee will have representation of different types of practitioners. LCHP will also leverage existing gatherings of practitioners within partners such as Grand Rounds, Primary Care Council, Regional Medical Director Group and Clinical Leadership Group as models for clinical integration and practitioner engagement in creating PPS-wide professional groups. **Mitigation 3:** Some essential LCHP Partners are not engaged in planning projects due to lack of understanding funds flow, contribution to project requirements, lack of designated resources to engage in planning and execution, etc. LCHP Operations Team will confirm current partner involvement in projects, reach out to partners who are deemed essential, and complete a funds flow model to better inform their involvement. LCHP will regularly update partners through by using various tools. **Mitigation 4:** Patient registries will be required to track target patients and their care in the service area. Universal EHR connectivity is not present across service area providers. LCHP Operations Team will

collaborate with partners since several proposed DSRIP projects will also rely on EHR systems and other technical platforms to track patient engagement. To address addition of new partners later on, LCHP Operations Team will confirm current partner involvement in this project, reach out to partners who are deemed essential, and complete a funds flow model to comfort partners on their participation.

Implementation approaches that the PPS considers a best practice:

- Cross Collaboration among the project teams of 2aii Patient Centered Medical Home, 2bviii Hospital Home Care Collaboration, and 3diii Asthma projects gave birth to a pilot project tasked with improving clinical pathways and procedures for persistent asthma patients within Delaware County. A task force was created to execute this pilot, and future diagnosis-based pilots, called the Delaware County Clinical Integration Team. This team consists of Navigators, Transition Coaches, Respiratory Therapy, Pharmacy, Care Management, ED Nurse Management, DME and Primary Care. If successful, this iterative, regional, diagnosis-based team model will be spread throughout the PPS, and will build upon the pathways, policies and procedures that are developed in the Delaware County pilots.
- **Collaboration:** Since our PPS area does not have some asthma specialists (Pediatric Pulmonologist for example), we are in the process of forming referral mechanisms with University of Rochester Medical Center from Finger Lakes PPS in providing these services to our patients. Further work is under process for engaging telemedicine technology for these services.

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

- **Project Approach:**
  - **Actively Engaged Patients:** Development of Asthma Action plan in the EHR coinciding with practitioner trainings have allowed for patients to receive mineable asthma action plans. ICD 10 codes for asthma have made identifying and tracking patients easier.
  - **Project Implementation:** Hot spots for this project are identified to be frequent flyers to ED for asthma. Recently, work began in gathering data on these specific frequent flyers.
- **Accomplishments:** The team successfully developed education materials for the entire PPS to be educated in the National Heart, Lung, and Blood Institute's (NHLBI's) guidelines to manage asthma. The asthma action plan build in the respective EHRs of participating partners has made tracking this work easy. The team finally has assigned Primary Care expertise to support the project.
- **Stakeholder engagement:**
  - **Partners involved**: The following partners are involved in this project
    - A O Fox Hospital
    - Cobleskill Regional Hospital

- Community Health Center – Town of Cherry Valley (newly engaged)
- Community Memorial Hospital
- Little Falls Hospital
- Mary Imogene Bassett Hospital

The team identified partners who have certified asthma educators and is in the process of finding ways to engage them either through contracts or other means.

- **SMEs engaged/contracted:** The chairs of the project are primary care physicians who are experts in the National Heart, Lung, and Blood Institute's guidelines of asthma management. They have also taken the lead in developing education/training materials for practitioners throughout the PPS. We recently engaged an adult primary care physician to get involved in this work to expand the focus beyond our pediatric patients.

- **Performance Measures:**

  Our PPS has taken the approach of assigning performance measures to the project that can impact to the highest extent. It is understood that several projects may impact a performance measure. The project taking responsibility of the measure will lead the effort to make a positive impact on the measure by engaging all the other project teams impacting that particular measure.
  This project committee has taken responsibility to oversee asthma-related performance measures below:
  - Asthma Medication Ratio (5 – 64 Years)
  - Medication Management for People with Asthma (5 – 64 Years)
  - Pediatric Quality Indicator # 14 Pediatric Asthma
  - Prevention Quality Indicator #15 Younger Adult Asthma

  These measures will be improved with the assistance of 'Asthma Pilot' team. This pilot team consists of members from projects 2aii PCMH, 2bviii Hospital Home Collaboration, and 3diii Asthma. The intent of this team is to collaborate across projects to achieve common goals.

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

NEW YORK STATE | Department of Health

There are no changes to the populations at this time.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Bassett Medical Center

Project: 3.g.i

Challenges the PPS has encountered in project implementation:
Challenge 1: Managing the fear that primary care providers' volumes would decrease due to adding longer visit types into their scheduling structure. **Challenge 2:** The state's definition for Actively Engaged Patients limits the project to only primary care providers, and does not incentivize our Community Based Organizations to partake in the project. **Challenge 3:** Although all partners have adopted the use of the Medical Orders for Life-Sustaining Treatment (MOLST) form, there is no universal location for everyone to access the most up to date document. **Challenge 4:** Costs, provider and trainers time.
Efforts to mitigate challenges identified above:
Mitigation 1: The project has created a phased approach with three phases (pilot phase, phase 1 & 2) to ensure the shift is gradual and not all providers/partners are affected by the change of having longer visits. Each partner is slowing ramping up their trained providers who are willing and able to see patients for palliative care visits. **Mitigation 2:** CBOs and PCPs are currently having ongoing discussions and negotiations to achieve the goals of this project by providing palliative care services to patients regardless of the limitations of the state's definition. **Mitigation 3:** Each partner is looking into whether or not the MOLST can be uploaded into the RHIOs **Mitigation 4:** We have bundled goals of care, symptom management into one training that we hosted on a Saturday morning. This training provided Continuing Medical Education (CME) credits for those who attended. The lead agency recruited a palliative care provider (Nurse Practitioner) who ended up withdrawing his acceptance of employment. This result has delayed furthering the Palliative Care Program

Trainings. Alternate training resources are currently being reviewed at the partner level.

Implementation approaches that the PPS considers a best practice:

- Utilizing Hospice and Home Care Agencies in addition to Inpatient Palliative Care providers as Subject Matter Experts(SME) for project planning

- Leveraging our SMEs to train and implement the use of Conversation Ready, Serious Illness Conversation Guide, Palliative Care Trigger Tool, Comfort Care for Patients Dying in the Hospital, Quality of Life Matters, Equianalgesic Table for Adults, and Guidelines for Pain Management of Adults

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

- **Project Approach:** The lead agency has created a phased approach to implement palliative care services into the primary care setting. Seven primary care providers were chosen to pilot and implement the program into their practices. Five existing APCs and two existing Regional Medical Directors were re-allocated to the project. These practitioners were given training to provide palliative care services in their respective primary care practices. As the pilot ends in late summer, the second phase will be implemented. The second phase allows other providers within the lead agency to choose to be trained and provide palliative care services. Following this phase, there will be a "push phase" where all primary care providers will be trained.

- **Provider Engagement**- Providers perception of sacrificing Relative Value Units (RVUs), which drives their compensation model, to provide palliative care services to their patients was deterring them from providing these services. It was established that the RVUs would be comparable and not negatively affect providers RVU accrual.

- **Partners involved**: At Home Care, Aurelia Osborn Fox Memorial Hospital, Catskill Area Hospice & Palliative Care, Cobleskill Regional Hospital, Hospice & Palliative Care(of Oneonta & Herkimer County), Hospice of Chenango County, Inc., L. Woerner Inc.(dba HCR Home Care), Little Falls Hospital, Mary Imogene Bassett Hospital, Otsego County Chapter NYSARC Inc., and Otsego Manor dba FOCUS Otsego

- **Performance Measures:**
  - Advanced Directives – Talked about Appointing for Health Decisions (NYS DOH)
  - Depressive feelings - percentage of members who experienced some
  - Depression feeling (NYS DOH)
  - Project Specific - Community Project – PPS will conduct assessments for all members that are not enrolled in Managed Long Term Care (MLTC) plans or other waiver programs which are already conducting Uniform Assessment System (UAS-NY) assessments (PPS)

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

NEW YORK STATE | Department of Health

There are no changes to the populations at this time.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives
PPS must submit a narrative in each
section for every project the PPS is implementing

PPS Name: Bassett Medical Center

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:
Challenge 1: Engagement from partners to provide trainings across our five County PPS
Efforts to mitigate challenges identified above:
Mitigation: Creating a funds flow model that will incentivize partners to engaged in providing training opportunities throughout our five county PPS
Implementation approaches that the PPS considers a best practice:
We have worked to bring partners and community agencies together to address problems of mental health and substance abuse at the community level. We are developing a calendar of educational opportunities for those in the community in an attempt to reduce binge drinking, engage in suicide prevention, and increase knowledge and availability of naloxone (Narcan) to reduce preventable premature deaths. We are placing these events at various places across our five county PPS in order to make trainings as accessible as possible for interested parties. We have collaborated with the Otsego County opiate task force in order to create a comprehensive and unified vision for combating the opioid and heroin addiction epidemic. Our Cooperstown police department in Otsego County, under the leadership of Chief Mike Covert, has initiated a police-assisted program to promote recovery from addiction, inspired by the successful program in Gloucester, MA.

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

- **Project Approach:** We have chosen three major populations that will most affect our performance measures to focus on providing training to providers, and office staff throughout our five county PPS. These focus populations are: premature deaths, adult binge drinking and suicide prevention.

- Collaboration with Mobile Crisis Assessment Team to refer all patients presenting at the emergency departments. Collaboration with the Otsego County Opiate task force to provide education about dangers of opioid abuse & possible benefits of Narcan.

- **Stakeholder engagement:**

  - **Partners involved**: Aurelia Osborn Fox Memorial Hospital, Buffalo Beacon, Catholic Charities, Community Memorial Hospital, Friends of Recovery of Delaware & Otsego, Leatherstocking Education on Alcoholism/ Addictions Foundation, Little Falls Hospital, Mary Imogene Bassett Hospital, Otsego County Community Services, Otsego County Department of Health, Schoharie County Council on Alcoholism, Schoharie County Office of Community Services

  - **SMEs engaged/contracted:** Mobile Crisis Assessment Team (MCAT), SUNY Oneonta

- **Performance Measures:**
  Our PPS has taken the approach of assigning performance measures to the project that can impact to the highest extent. It is understood that several projects may impact a performance measure. The project taking responsibility of the measure will lead the effort to make a positive impact on the measure by engaging all the other project teams impacting that particular measure.
  This project committee has taken responsibility to oversee asthma-related performance measures below:
  - Age-adjusted percentage of adult binge drinking during the past month (NYS DOH)
  - Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month (NYS DOH)
  - Age-adjusted percentage of adults who have a regular health care provider -Aged 18+ years (NYS DOH)
  - Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years (NYS DOH)
  - Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years – Ratio of Black non-Hispanics to White non-Hispanics (NYS DOH)
  - Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years – Ratio of Hispanics to White non-Hispanics (NYS DOH)
  - Age-adjusted suicide death rate per 100,000 (NYS DOH)
  - Percentage of adults with health insurance - Aged 18- 64 years (NYS DOH)
  - Percentage of premature death (before age 65 years) (NYS DOH)

- Percentage of premature death (before age 65 years) – Ratio of Black non- Hispanics to White non-Hispanics (NYS DOH)
- Percentage of premature death (before age 65 years) – Ratio of Hispanics to White non-Hispanics (NYS DOH)

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

There are no changes to the population at this time.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Bassett Medical Center

Project: 4.b.i

Challenges the PPS has encountered in project implementation:
Challenge 1: Achieving smoker buy-in and monitoring compliance with policies. **Challenge 2:** Risk to revenue for performing non-covered/non-reimbursed services; negotiating contracts with Medicaid MCOs is needed since many services are not reimbursed/under-reimbursed.
Efforts to mitigate challenges identified above:
Mitigation 1: Develop a method to obtain good baseline data on number of current smokers in target population, track success in smoking cessation efforts, correlate success rates with techniques used, and flag individuals who quit and then start smoking again. **Mitigation 2:** Allow uniform, universal coverage; to negotiate contracts with MCOs, need to combine efforts across project teams within the PPS and across PPSs to strengthen/consolidate the message & sustain patient care in DSRIP projects.
Implementation approaches that the PPS considers a best practice:
• Three pilot projects are in process of being implemented to support this goal. I o In an effort to promote smoking cessation among cigarette smokers the lung cancer screening program is requesting funding to cover the cost of over the counter smoking cessation products and written publications purchased in bulk; o Bassett Medical Center is seeking to target inpatient Medicaid patients who are smokers to connect them directly with the NYS Quit line and offer smoking cessation services while in the hospital. o A O Fox Memorial Hospital is seeking to create a community-based outpatient smoking cessation program for employees and patients in the community. This effort will connect inpatients at Bassett with a community-based resource for ongoing smoking cessation services.

- The DSRIP administrative team and Tobacco Cessation Steering Committee is working closely with St. Peter's to consolidate these efforts.

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

As indicated in the previous section.

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

There are no changes at this time.