NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Central New York Care Collaborative PPS

Appendix PPS Narratives

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

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Central New York Care Collaborative, Inc.

Highlights and successes of the efforts:

Introduction

The Central New York Care Collaborative, Inc. (CNYCC) is a performing provider system (PPS) that connects more than 1,400 health, behavioral health, and community-based service providers in six central New York counties: Cayuga, Lewis, Madison, Oneida, Onondaga, and Oswego. CNYCC aims to serve our target populations, Medicaid members and the low-income uninsured, by improving healthcare service coordination, enhancing the quality of performance outcomes, and creating an overall better system of care for patients in terms of the process and outcomes of care.

CNYCC's vision is "to improve the health of our community by coordinating services and building partnerships through the healthcare system." We aim to realize this vision by integrating services to improve patient outcomes, collaborating to improve on patient care coordination, improving healthcare quality, and ultimately reducing potentially preventable hospitalizations over the remaining nearly four-year DSRIP project period.

We are pleased to provide the information below regarding our governance structure, compliance activities, and current budget; information technology and population health management activities; performance reporting, workforce development, and stakeholder engagement endeavors; cultural competency and health literacy practices and strategy; and value-based payment education and support efforts.

Governance

Overall Organizational Structure

CNYCC is a separate legal entity that formed on January 9, 2015, upon filing its certificate of incorporation with the New York State Department of State under the New York Not-for-Profit Corporation Law. CNYCC's 501(c)(3) application for federal tax exempt status is in progress.

CNYCC is a member organization with three Class A members and one Class B member. It also has a board of directors, which is described in more detail below. The members, which are four of the hospitals within the CNYCC PPS, are:

- Upstate University Hospital (Class A)
- Faxton-St. Luke's Healthcare (Class A)
- St. Joseph's Hospital Health Center (Class A)
- Auburn Community Hospital (Class B)

Pursuant to CNYCC's bylaws, the act of the member's chief executive officer, on behalf of the member, is deemed the act of the member with respect to CNYCC. The member meetings also allow CNYCC to consider other perspectives. As per the CNYCC Bylaws, the members appoint two directors who serve as non-voting attendees who are entitled to join and be heard at the member meetings (excluding member executive sessions). At least one of the non-voting attendees must be from a federally qualified health center. The members have an annual meeting and special meetings as called by a member or the CNYCC executive director. CNYCC records and maintains meeting minutes.

Board of Directors

In addition to its members, CNYCC's governing structure includes a board of directors (the "board"), which cannot exceed 22 directors. The composition of the board is representative of the partners in the CNYCC PPS. Representation considerations include organizational type and geography across the PPS. To better reflect the PPS and to enhance fair decision-making, a partner may not have more than one representative on the board.

As per CNYCC's bylaws, CNYCC's executive director is an ex-officio, non-voting director. The CNYCC senior team generally attends all board meetings. Other CNYCC staff (such as project managers) also attend as appropriate (for example, to present DSRIP project updates). CNYCC records and maintains meeting minutes. Board meetings are typically held monthly.

To establish transparency for the board's activities and participation, CNYCC adopted a board-approved conflicts resolution process and policy to which directors must adhere. Board members undergo compliance training, which includes the conflict resolution process, among other topics. CNYCC's governing structure is also designed to foster transparency for the benefit of others within the PPS. For example, members of the public may request to attend the board meetings to observe as guests, and CNYCC lists instructions on how to attend in person on our website. In addition, other individuals from CNYCC's partner organizations may, and often do, attend and observe board meetings.

The CNYCC governance webpage displays upcoming meeting dates, board and committee rosters, responsibilities and charges, the CNYCC Bylaws and an organizational chart, among other items of interest to the public and CNYCC partners alike. CNYCC's website describing governance can be found online at https://cnycares.org/our-governance/.

CNYCC recently introduced a "project spotlight" as recurring board meeting agenda item in order to highlight selected projects' achievements and challenges. These presentations, each led by an involved partner organization, aim to share best practices, engage stakeholders, and exchange ideas at the board level on improving project implementation and converting to value-based payment. Importantly, we predict that the project spotlight presentations will also help to maintain project momentum by sharing current partner accomplishments and helping to spur on similar successes within the PPS.

Committees

In addition to the corporate members and the board, CNYCC also enjoys a robust committee structure, which provides meaningful input into governance decisions, including preliminary recommendations and approvals related to a committee's specific subject matter expertise. Current CNYCC committees include:

- Compliance Committee

- Clinical Governance Committee
- Executive Committee (directors only)
- Finance Committee
- IT & Data Governance Committee
- Nominating Committee (directors only)
- Workforce Committee

The meeting schedules for the CNYCC committees are also posted on CNYCC's website calendar. The Compliance, Clinical Governance, Finance, IT & Data Governance, and Workforce Committees are composed of directors and other individuals from within the PPS with subject matter expertise related to the specific committee's mission and scope. Membership in the Nominating and Executive Committees is limited to directors. All of the above committees are chaired by directors.

The authority and scope of each of the above committees is set forth in the relevant committee charter and charge and, in most cases, in the CNYCC Bylaws. The committees report to the board on a regular basis or as necessary. CNYCC's executive director and certain senior team members, as appropriate, attend the committee meetings. CNYCC records and maintains meeting minutes, and committee meetings are held quarterly, monthly, or more frequently, depending on the task at hand. For example, the IT & Data Governance Committee met more frequently than usual while vetting and selecting CNYCC's population health management platform vendor.

Decision-Making

CNYCC believes that its member, board-level and committee governance structure is representative and inclusive while also being effective and efficient. There are challenges inherent in a corporate structure that, by design, is composed of otherwise competing entities. Nonetheless, based on CNYCC's growth and development as a new corporation, we believe that, in coalescing new infrastructure and processes to help lead transformation to value-based payment and observing outcomes, participation, and other milestones, the individuals who have agreed to take an active role in CNYCC's governance take their responsibilities seriously and are very effective.

As a best practice, the written agenda for all meetings contains a reminder of each individual's fiduciary and legal duties to CNYCC, and for the decisions made on behalf of CNYCC and the PPS. This fiduciary statement is also read aloud and discussed when CNYCC and its partners make significant decisions recommend courses of action. The approved and adopted bylaws set forth such decision-making and voting procedures, along with oversight responsibilities and accountability for the members, the board, and CNYCC's committees, consistent with the Not-for-Profit Corporation Law.

Included below is a summary of the significant actions taken by the members, the board and/or committees consistent with such body's assigned authority under the bylaws:

a. Review and approval of CNYCC's corporate documents and bylaws (including recent amendment to the bylaws via formal resolution process by the members).
b. Board review and approval of charters and charges for the committees.
c. Review, revision and/or approval of important CNYCC policies and procedures, including:
    - Payment and funds flow policies (including DSRIP and fraud and abuse compliance guidance for the funds flow plan)

- Code of Conduct/Ethics (for CNYCC, its staff, the board, and partners)
- Conflicts Resolution Policy
- Corporate compliance plan, policies, and procedures
- HIPAA privacy and security policies
- Dispute Resolution Policy
- Underperforming PPS Partner Policy
- Sanctions Policy
- Partner Payment Reconciliation Policy
- Finance Policies
- Financial Sustainability Strategy
- Actively Engaged Patient Roster Verification Policy

Financial Control Structure
CNYCC's financial control structure requires communication between the Finance Committee, the board of directors, and the members. The Finance Committee is authorized under CNYCC's Bylaws to receive and review all matters relating to CNYCC's fiscal operation. The Finance Committee recommends actions to the board and helps the board oversee CNYCC's accounting and financial reporting processes, including reviewing financial statements and outside auditor reports. CNYCC's operating and capital budgets (including budgeting for the population health management platform) have been reviewed, vetted, and discussed by the Finance Committee and board of directors, with recommendations to, and final approval by, the Class A members, per CNYCC's Bylaws.

Board and/or member approval is required before CNYCC commits, via the executive director, to any expenditures $25,000 and over. No monies are paid to vendors or partners without first executing agreements between CNYCC and the other party. Pending hiring of a director of finance, CNYCC utilizes the financial and accounting services of Iroquois Healthcare Association, whose representative regularly meets with the CNYCC's executive director, board, and Finance Committee. CNYCC engaged an auditing firm, Fust Charles Chambers, to conduct the external audit of CNYCC's financial statements.

As referenced above, CNYCC's board and members have established policies for dispute resolution, partner underperformance, and sanctions in order to address partner underperformance and/or non-compliance. The CNYCC compliance officer developed a webinar to review and explain these policies and to partners and to field their questions. Partners may access these policies within CNYCC's member section of our website.

Compliance

Overview
CNYCC's corporate compliance initiatives are designed to comply with New York State Social Services Law Section 363-d and the compliance guidelines provided by the New York State Office of Medicaid Inspector General (OMIG), including OMIG's guidance relative to DSRIP. CNYCC certified to OMIG regarding our compliance program effectiveness in December 2015, and certified as required under the Federal Deficit Reduction Act (DRA).

Chief Corporate Compliance Officer
CNYCC employs a chief corporate compliance officer (CCO), who, in cooperation with CNYCC's Compliance Committee, oversees CNYCC's compliance efforts and day-to-day compliance program operations. CNYCC

approved and adopted the CCO's job description. The CCO reports directly to the CNYCC executive director and the board of directors, and makes periodic reports at board and member meetings.

In addition to Compliance Committee meetings, the CCO routinely attends Finance Committee meetings and other CNYCC Committee meetings. The CNYCC Compliance Committee meets at least quarterly, and CNYCC records and maintains its meeting minutes. Committee members are generally compliance officers (or individuals in similar positions) from CNYCC partners and are experienced compliance professionals. The chair of the Compliance Committee is a member of the board of directors.

The CCO maintains an open-door communication policy within CNYCC and the PPS as a whole. The CCO is also a participant in an informal PPS discussion between compliance officers from numerous PPSs in New York who meet regularly via conference call to address potential compliance issues and questions relevant to DSRIP.

Corporate Compliance Program and Plan

CNYCC has implemented a board of directors-approved corporate compliance program and plan, which applies to CNYCC staff, its governance, and its partners relative to participation in the PPS and DSRIP projects. The written compliance policies and procedures address the eight elements of OMIG's mandatory compliance program to help ensure DSRIP compliance. CNYCC also created the Code of Conduct/Ethics, which covers CNYCC, its staff, the board, and its partners. Other existing CNYCC policies and procedures relevant to compliance include: payment and funds flow policies, the Conflict Resolution Policy, security and privacy policies, the Dispute Resolution Policy, the Underperforming PPS Partner and Sanctions Policies, the Partner Payment Reconciliation Policy, the Financial Sustainability Strategy, the Actively Engaged Patient Roster Verification Policy, and CNYCC's DRA Policy, which summarizes CNYCC's commitment to DRA compliance and for supporting the rights and protections of whistleblowers.

CNYCC's board and staff undergo compliance education, including annual compliance training, which includes information about OMIG's eight compliance program elements: code of conduct and policies and procedures, designated chief compliance officer, compliance training, open lines of communication, compliance disciplinary standards, identified compliance risk areas, responding to compliance issues, and non-intimidation and non-retaliation (whistleblower protections). Another important topic provided as part of compliance training is HIPAA privacy and security. Safeguarding protected health information and confidential Medicaid data is a CNYCC priority.

CNYCC has a 24/7 compliance hotline via EthicsPoint, which is available to CNYCC employees, governance, partners, Medicaid beneficiaries, and other individuals. Information about CNYCC's compliance program, including how to report an issue and the CCO's contact information, is readily available on our website. In addition, individuals may also report a compliance issue directly online at https://secure.ethicspoint.com/domain/media/en/gui/43845/index.html. Hotline reports may be made anonymously.

Finally, the compliance hotline number and CCO contact information is provided at the end of the CCO's presentations to partners. In addition, CNYCC's code of conduct, compliance plan documents, DRA Policy, and a compliance message from the former board chair are also available on CNYCC's website at https://cnycares.org/get-involved/corporate-compliance/.

Partners

CNYCC's partner organization agreements, including the business associate agreement, set forth the parties' compliance-related obligations. Recently, CNYCC published a partner compliance survey (targeting our partner organizations' compliance officers) in part to more fully assess compliance program needs across the PPS, including training on DSRIP-related compliance issues. The survey is still in progress as of this writing.

CNYCC fully appreciates the necessity of only doing business with entities and individuals who are not sanctioned or otherwise disqualified or excluded from governmental health care programs, including Medicaid and Medicare. To this end, CNYCC employs a vendor (Kchecks) to conduct monthly exclusion checks on CNYCC vendors, contractors, employees, and individuals who are involved in CNYCC's governance structure.

Budget

Initial Successes

CNYCC has made great strides to accomplish our current status of financial solvency. We initially experienced some funding challenges because we have an IGT-contributing public hospital (Upstate University Hospital) as the financial co-lead of the PPS. However, we have been able to overcome these issues and circumvent further delays in both receipt of award monies and payment to our partners. During our first year of operations, CNYCC was able to establish a funds flow plan, establish financial policies and procedures, develop regular monthly financial reports for Finance Committee review (including balance sheet, income statement, budget reports and cash flow reports), build a decision support system, create an operating infrastructure, create a budget, and most notably, receive a pristine financial audit from an outside auditing firm.

Hiring Consultants

CNYCC enlisted the help of Iroquois Healthcare Association (IHA) to set up our general ledger and to act in the capacity of our finance office, handling our invoicing, day-to-day accounting, helping establish accounting procedures and monetary supports and controls, and bolstering our existing company policies and procedures. IHA also helps process invoices and partner payments, monitors our bank accounts, and generally oversees our ledger. IHA has proved to be an integral part of CNYCC's success in establishing an operations infrastructure that is capable of processing the vast majority of our partner payments electronically. IHA continues to champion this effort in hopes that all partner payments for activities will eventually be paid via electronic funds transfers. However, CNYCC plan to hire a finance director in the near future to bring all financial processes in-house.

DSRIP Year 2

In preparation for creating a budget for CNYCC, we asked for IHA's assistance in the budget development process for DSRIP Year 2, which runs on a calendar year basis. The budget process proved challenging because of the nuances of accounting for the many unknown needs of the PPS in the coming year, as well as the large but then unspecified investment necessary to implement a population health management system for our partners. After extensive vetting by the Finance Committee and board of directors, the Members of the Corporation approved the capital and operating budget for 2016.

After extensively reviewing and discussing them at multiple levels in our organization and gaining the CNYCC Board of Directors' approval, CNYCC implemented payment policies for all projects. These payment policies included input from CNYCC governance committees, staff, and partner organization representatives who participated in our project implementation collaboratives (PICs). Because CNYCC had never made payments like this before, our main focus was to put the monetary supports in place to better help our partners successfully change the delivery system while still working within DSRIP funds flow constraints such as the 5% rule for non-safety net providers.

To help process payments, CNYCC's internal IT department developed a decision support system that calculates partner payments and produces a report to be sent to our accounting firm for processing. Creating an in-house, custom decision support system in-house allows to track partner and project payments and ensure our compliance to the funds flow rules we have established.

As CNYCC closed the first financial year, we hired a firm via a request for proposal process to complete an outside audit of our accounts, policies, and procedures. CNYCC is proud to report that the audit came back "clean," with no findings.

Information Technology and Population Health Management

Overview

To achieve the overarching DSRIP goals of creating an integrated delivery network and reducing inappropriate emergency department and inpatient care, CNYCC must focus on population health management (PHM). This new care delivery model will aid in delivering appropriate preventive, routine services to the population at large and help provide evidence-based consensus care to patients with complex medical and social concerns. PHM requires an integrated infrastructure of people, processes, and technology. CNYCC is currently developing project infrastructure that will establish the people and process components of this triad, but they must be complemented with the necessary technological infrastructure.

Population Health Vendor Selection Process

In order to identify a solution that could help CNYCC perform data management, population stratification, care coordination, and reporting, CNYCC launched a PHM vendor selection process in June 2015. To maximize DSRIP resources and align regional activities, CNYCC partnered with the Fort Drum Regional Health Planning Organization (FDRHPO), which serves as the project management office for the Samaritan Medical Center PPS/North County Initiative, and HealtheConnections, the regional Qualified Entity/RHIO. CNYCC contracted with Aspen Advisors/The Chartis Group to support a collaborative vendor selection and evaluation process. The goals of the selection process were to:

- Identify the best possible PHM vendor for CNYCC's collaborative needs, with additional consideration for potential collaboration with FDRHPO, other PPS organizations, or other applicable regional initiatives
- Facilitate a structured and objective vendor selection process
- Define application scope and core requirements for evaluation
- Define the underlying implementation and operational cost models for the top two PHM solutions

In order to facilitate direct CNYCC partner participation in the selection process, CNYCC's IT and Data Governance Committee established a governance model, and CNYCC also created a multi-disciplinary PHM System Selection Committee comprised of representatives of CNYCC partner organizations. Representation on the committee reflected the geographic distribution and diversity of CNYCC's partner network. In addition, CNYCC formed a PHM Executive Steering Committee, which contained members of both the PHM Selection Committee and the IT and Data Governance Committee as well as CNYCC staff.

The roles and responsibilities of each of these governing bodies were as follows:

- PHM System Selection Committee
  - Provide input on the system requirements for the request for proposals, vendor selection criteria, demonstration scenarios, and ranking and evaluating the system vendors
  - Choose a vendor to recommend to the PHM Executive Steering Committee
- PHM Executive Steering Committee
  - Align objectives, set guiding principles and lead the transformation process to realize the full value and benefits of the selection effort
  - Choose a vendor to recommend to the IT and Data Governance Committee
- IT and Data Governance Committee
  - Provide vision, direction, and goals for the IT planning process
  - Choose a vendor to recommend to the Board of Directors

Vendor Selection Timeline and Steps

The PHM governing bodies participated in all aspects of a vendor selection process that was designed to narrow down the original field of potential PHM vendors to two finalists. For each of those candidates, CNYCC developed total cost models and carried out additional due diligence efforts. The timeline and steps involved in this process are summarized below:

1. July-August 2015: CNYCC issued the request for proposals.
2. September 2015: Vendors provided online demonstrations for candidates.
3. September 2015: Vendor finalists provided on-site demonstrations.

In order to maximize partner engagement, all member organizations from both CNYCC and the Samaritan PPS were invited to participate in the on-site demonstrations.

Process Delays

Although CNYCC had executed a robust and inclusive PHM vendor selection process, after concluding the above steps, CNYCC had to undergo significant due diligence efforts from October 2015-May 2016. These efforts focused on the overall robustness and scalability of both PHM vendor candidate finalists and the partnership opportunities they presented to CNYCC. Specific areas of interest that CNYCC explored in-depth included:

- Master data management practices
- Availability of pre-built content
- Planned product enhancements and development prioritization
- Data access and control mechanisms
- Comparative partnering advantages

- Risk evaluation
- Data security

Identifying a Vendor

After completing the due diligence efforts, CNYCC elected to contract with IBM Watson Health for its PHM needs based on the vendor's ability to meet CNYCC's short- and longer-term requirements. CNYCC particularly appreciated IBM's proven experience with data management and their "big data" approach to analytics, its investments in PHM technologies and supporting resources, and the scalability and robustness of IBM's product. This decision was escalated through CNYCC's governing bodies, which formally approved both the vendor and the total cost model.

Contracting discussions with IBM are underway and are expected to conclude by the end of September 2016. CNYCC's planned licensing model will allow partner organizations to use the PHM infrastructure for their entire patient populations. In addition, CNYCC is in active discussions with the region's largest private payer regarding collaborative opportunities and a broader regional application of the PHM infrastructure. This new community investment will support regional collaboration by:

- **Enabling Coordinated Care Delivery**: Participating providers will receive access to pertinent clinical information from across the continuum of care to facilitate safe transitions, be able to develop common measures and metrics to monitor gaps in care and patient risk factors, and the ability to access and maintain a shared, multidisciplinary care plan that all members of a patient's care team can see.
- **Generating Actionable Analytics**: The PHM platform will provide prospective and predictive modeling to support clinical, fiscal, and operational decision-making and ensure that high-risk and high-utilizing patients can be proactively managed. Establishing roles- and rules-based reporting will facilitate access to meaningful data for CNYCC partners.
- **Tracking Patient Progress**: The PHM platform's registry functionality will help CNYCC and its partners track target populations, including their performance on the quality and outcome measures defined by the DSRIP initiative, as well as other indicators that are deemed appropriate as the program evolves. This will also allow CNYCC to monitor and measure projects' effectiveness, providing a critical feedback mechanism to the PPS.

Each PPS partner organization's ability to capture and share data locally will govern both the information that is available in CNYCC's centralized PHM infrastructure to support care coordination and integration across the continuum, and the analytics that can be applied to drive collective action. Recognizing this, CNYCC developed (1) an IT assessment and partner-specific planning process, (2) an EMR selection toolkit, and (3) a data dictionary to help standardize the capabilities and availability of data from electronic medical record (EMR) environments across eligible providers. Collectively, these efforts aim to help align existing EMR vendor capabilities around DSRIP and PHM goals and requirements and provide technical assistance for partners without EMRs to identify and implement robust vendor solutions.

IT Assessment

Between January and June of 2016, CNYCC's IT department prioritized partner engagement. In preparation for PHM platform implementation, CNYCC used a highly detailed assessment process to capture our partners' overall DSRIP readiness. Our approach to partner readiness assessment included two surveys, one

related to general IT and the other related to project-specific IT requirements. Results from these surveys allowed CNYCC to create customized IT project implementation plans for each partner.

To begin the partner-specific planning process, CNYCC inventoried and categorized all of the explicit and implicit project and program IT requirements into a consolidated list of functional areas. CNYCC then mapped the applicability of each task and functional area to the partners' New York State Department of Health-designated provider type and safety net status. In taking this approach, CNYCC was able to generate partner-specific requirement inventories based on their project participation, provider type(s), and safety net status.

CNYCC then mapped survey responses against the inventories to identify if a given partner had partially, fully, or not satisfied each of the applicable requirements. This approach has allowed CNYCC to systematically identify and communicate the gaps that need to be addressed by each of the partners, who are using this information to generate work plans that they will submit to CNYCC by mid-August 2016.

Additionally, the data gathered in the survey and assessment processes has allowed us to target specific groups of partners for engagement with our regional health information organization HealtheConnections, as well as identify like cohorts in the areas of EMR adoption, direct messaging capabilities, patient-centered medical home recognition, reporting, and population health management capabilities. Going forward, CNYCC hopes to address these cohorts collectively and to facilitate peer support among partners.

EMR Selection Toolkit

Initial data collected by CNYCC indicated that there was a significant gap in partner EMR adoption. As a result, CNYCC intended to perform a centralized EMR vendor evaluation process that would benefit partners that needed to implement a new EMR or replace their existing EMR. However, subsequent survey data and the refined approach to identifying partner-specific requirements showed that EMR adoption was much greater than originally anticipated. In light of these findings, CNYCC opted instead to develop a selection toolkit that partners could use to guide their independent EMR evaluations. This toolkit provided a comprehensive overview of a selection process and included templates to engage with and evaluate potential vendors.

Data Dictionary

To further assist planning and partner engagement, CNYCC created a data dictionary tool to facilitate review, discussion, and understanding of the data elements required to calculate the DSRIP performance and outcome measures and satisfy project requirements related to workflow and clinical documentation changes and care coordination. Similar to the approach used to generate the partner-specific work plans, the data dictionary associates each data element to the applicable provider types and projects, allowing CNYCC to generate a partner-specific inventory of required data elements. CNYCC distributed these inventories to each applicable partner and asked them to indicate which of the required data elements they currently capture and can report from their current EMR systems. This approach has allowed us to understand where gaps in data currently exist and will inform future work around clinical documentation improvement programs.

Conclusion

To thrive in the DSRIP program, maximize incentives, and move towards a value-based system, CNYCC must become a high-performing integrated care delivery system. Providers must work together across the

community to provide a seamless continuum of coordinated, patient-centered, population health-oriented services. To do this, CNYCC needs a health IT infrastructure that will allow for informed, data driven decisions and accessibility to pertinent clinical information. CNYCC will achieve this by introducing the capabilities of the centralized PHM platform outlined above, as well as by expanding the existing use of EMRs and regional health information organization services among our PPS partner organizations. This robust health IT and health information exchange infrastructure will ensure that the PPS can proactively react to the evolving needs of the Medicaid and uninsured populations it serves and maximize DSRIP projects' reach and efficacy.

Performance Reporting

Introduction

Performance Reporting and Monitoring is a core, expanding function of CNYCC. Before our PPS began reporting actively engaged patients to the Department of Health in DY1 Q2, partners needed to know what information was required to be able to count patients as actively engaged. CNYCC developed reporting requirement criteria for each project that defines the data elements needed for each project with an actively engaged target along with roster templates that partners are required to fill out with patient information and return via our secure file transfer protocol (sFTP) site. These documents and processes allowed CNYCC to streamline reporting efforts by making them easy to follow and use.

Partner Education

CNYCC conducted several webinars on reporting to train our partners to submit data. The training focused on not only uploading the data but also making sure that the data is correct. In June 2016, CNYCC held reporting re-engineering webinars to discuss quality issues that CNYCC had discovered through roster review in an attempt to make reporting easier for partners but to also ensure that the right information was being reported. In addition to these webinars, CNYCC often covered performance reporting topics during PIC meetings, where the project manager for data and reporting discussed reporting requirements directly with partners. These webinars addressed CNYCC's short-term project reporting, since we anticipate that once we implement the PHM platform, there will be more robust reporting capabilities available to the PPS.

Patient Engagement Dashboards

Beginning in DY1 Q3, CNYCC began preparing patient engagement dashboards to share with partners. These dashboards provided updates on which partners were submitting information to the PPS, how many patients were actively engaged based on review of the rosters, gap to goal for the quarter, and project challenges. CNYCC established a "stoplight color" technique to illustrate a projects' statuses, using green to indicate that the project was on track to meet the quarterly patient engagement goal, yellow to show that the project was at a potential risk of not meeting the quarterly target, and red to note that the project had a high risk of not meeting the target.

Since the early version of the dashboards, CNYCC has included graphics that indicate partner trends over time, using monthly and quarterly numbers and statements from project managers to identify potential causes of project under-performance as well as any efforts that are being made to mitigate against the risk of missing the target. CNYCC reviews the dashboards during PIC meetings, which occur either biweekly or monthly, to publicize which partner organizations are submitting data to support the project goals. Partner organizations are motivated by this information, which has driven many to begin reporting on a more timely and regular schedule.

In addition to PIC meetings, CNYCC shares patient engagement dashboards at meetings of its governance committees and board of directors. The dashboards are proving to be very effective, especially during board meetings, where they show partner CEOs, presidents, and executives whether their organizations are participating in actively engaged patient reporting, ultimately incentivizing those organizations improve their numbers or timeliness of reporting.

Performance and Outcome Dashboards

In addition to the patient engagement dashboards, CNYCC has begun to develop dashboards related to performance and outcomes measures that utilize data from the Medicaid Analytics and Performance Portal (MAPP) dashboards and the Salient Interactive Miner tool. However, a lack of available timely data has prevented CNYCC from moving forward with these dashboards: as of July 2016, CNYCC only has access to data from June 2015. CNYCC's project manager for data and performance and our data analyst have been working closely with Salient to try to get more information out of the Salient Interactive Miner tool to enhance reporting capabilities. CNYCC has used this tool to both determine disease prevalence among members and for "hot-spotting" activities.

Project Management Platform

CNYCC purchased and implemented a project management platform, DSRIP Tracker, back in DY1. Since implementation, CNYCC has been working with the vendor to make the platform as robust as possible. The project management system can house a variety of different data points and generate reports based on inputs. CNYCC worked with the vendor to create a document repository for partner contracts and has also used to the platform to gather patient engagement numbers.

CNYCC is currently working with the vendor to upload each participating partner organizations' project implementation templates, which will help project managers track project performance in a standardized tool. The tool also allows CNYCC to send "webforms" to the appropriate project contacts at partner organizations to upload documentation that needs to be submitted to the IA.

Clinical Quality and Performance Reporting Training

CNYCC is currently developing a training program for organizations and individuals that focuses on clinical quality and performance reporting in regards to both the actively engaged patients and the performance and outcomes measures. CNYC has created a business analytics unit, overseen by our chief information officer, that is responsible for business intelligence and analytics. The unit consists of a project manager for data and performance as well as a data analyst. Currently, the unit prepares reports on actively engaged patients, performance, and payments, as well as any ad-hoc analysis that needs to be completed to assist with project implementation. Once performance measures are more readily available and timely, the business analytics unit will begin to create dashboards for monthly review.

CNYCC will also include information on how to complete rapid-cycle evaluation in the above-mentioned training program. In order to improve our understanding of the process that partners will need to undertake, CNYCC has recently participated in rapid-cycle evaluation breakout sessions with a subject matter expert. We have researched the Plan-Do-Study-Act rapid-cycle evaluation model, but has also been looking at Lean Six Sigma strategies from supply chain business models. In order to conduct rapid-cycle evaluation, partners must have access to data at the provider, location, organization, region, and project

level. CNYCC's business analytics unit will ensure that partners have access to the correct data, even if it means that the first step of the first Plan-Do-Study-Act model is evaluating their current EMR data.

Workforce

Overview
CNYCC's former workforce workgroup has successfully transitioned into a recognized CNYCC committee. Thanks to the committee's guidance, insights, recommendations, and written materials provided by our workforce consultant, CNYCC has made significant progress in supporting our partners and forwarding the goals of DSRIP. These accomplishments include:

- Completing a highly-detailed and comprehensive compensation and benefits survey for our region
- Holding numerous webinars and on-site, one-on-one meetings with partners to build working relationships and assess the workforce spend and future state based on execution of the contracted projects
- Continuing to grow vendor relationships to support the PPS and our partners, which have yielded positive results for all stakeholders
- Hiring a full-time manager of workforce strategy in late June 2016 and continuing to engage our workforce consultant and platform vendor, Health WorkForce New York
- Implementing an automated workforce data input tool for Partners

Please find detailed information below on each of the Workforce Committee's target milestones.

Milestone 1: Target Workforce State
Partners participated in an extensive compensations and benefits survey that also captured the number of active employees per title as well as the vacancy rate per title. This completes CNYCC's compensations and benefits survey data collection requirement, and may also help aid the definition of our PPS's current state. Partners were asked to report current full-time employees per title associated with the engaged projects and their anticipated future numbers including unique new hires, redeployments, and retrained employees.

Milestone 2: Transition Road Map
This plan is being informed by the review of our PPS's current state, projected future state, and gap analysis, which are in process for future reporting. CNYCC anticipates that the transition road map will include a PPS-level staffing plan aligned with the project demands. This will reflect the staffing impact for transitioned workers, identify vacancies and fulfillment plans, and establish the training strategy required to have partners comply with best practices and develop a qualified bench of candidates.

Milestone 3: Gap Analysis
CNYCC is determining the PPS's current workforce needs and risks, which is being informed by the compensation and benefits survey results, the future state comparison, the availability of required human capital today. Interviewing partner human resource contacts has given us insight into the change drivers in the market, such as compensation, scheduling, quality of in-facility experience, development opportunities, and external quality of life issues. CNYCC is reviewing this wealth of information to determine what the PPS needs to deliver to ensure project success.

Milestone 5: Training Strategy

CNYCC will share its training strategy after we complete our gap analysis. The strategy will address the content required to educate all relevant staff to meet the requirements of our PPS's DSRIP projects and to ensure their effective implementation. CNYCC will also employ a tracking and reporting tool to monitor completion of required trainings by the staff of our partner organizations. In addition, CNYCC will detail training activities that are focused on building a future bench of appropriate talent.

Challenges

CNYCC has experienced several challenges during the above processes, including partners' incomplete understanding of what they were required to accomplish. Partners' reports are mixed in quality due to both misunderstandings about CNYCC's workforce reporting requests and a propensity for highly-conservative staffing reporting. The absence of a full-time CNYCC employee dedicated to workforce development created some challenges initially, which have been mitigated since CNYCC filled this key position. CNYCC has also faced challenges collecting and retaining information about trainings that have been completed and need to be reported to the Department of Health. While a learning management system or similar is sourced, we have yet to finalize a naming convention and consistent storage process for those records.

Future Considerations

The achievement value associated with the workforce spending is currently evaluated on an "all or nothing" basis, with one of the milestones that must be met the attainment of a workforce strategy spending target that was set in December 2014 based upon our best estimates and the guidance available at the time. Unfortunately, subsequent clarification has reduced the kinds of spending that can be counted towards that goal, and as a result, CNYCC missed that target and forfeited the entire workforce achievement value in DY1 Q4. Since performance against the workforce strategy spending target is evaluated in every Q2 and Q4 report, CNYCC is at high risk of forfeiting the workforce achievement value and associated PPS payment in every payment-driving quarter for the rest of the DSRIP program in spite of meeting all other workforce-related milestones. Not all achievement values are evaluated in the "all or nothing" manner and we would greatly appreciate the consideration of a similar approach to evaluation of the workforce achievement value in the future. This change would benefit other PPSs that either have or expect to face similar challenges in meeting the workforce strategy spending target in the future. A formal request has been advanced to the Department of Health for consideration.

Stakeholder Engagement

Overview

Since 2014, CNYCC has developed a comprehensive outreach and engagement strategy to foster effective and productive communications. The overall goal of the stakeholder engagement plan is to raise awareness and knowledge of CNYCC activities and to encourage widespread participation (both provider and public) in CNYCC goals and objectives. CNYCC's stakeholder engagement campaign supports the efforts of CNYCC through information sharing, making resources available to partner organizations, updates on program activities, opportunity to obtain feedback from the partner network, and a forum to provide regular updates on DSRIP-related activities.

Engagement Strategies

With so many different stakeholders, CNYCC's engagement strategies play a key role in fostering relationships, engaging partner organizations, and supporting project implementation. To date, CNYCC has

developed several engagement strategies to connect with various stakeholder groups throughout its network, including:

- **CNYCC Weekly Newsletter**: A PPS-wide weekly communication with updates on PPS activities, DSRIP program updates, upcoming events, and general news and information
- **CNY Cares Website**: An up-to-date website that provides general information about CNYCC's goals and objectives, a web-based platform for the public and partners to access resources and information, and DSRIP-related content and news
- **Webinar Series**: Weekly or bi-weekly web-based presentations on a wide-range of CNYCC-related subjects

In addition to these activities, one of CNYCC's most effective stakeholder engagement strategies has been our Regional Project Advisory Committees (RPAC). The RPAC series consists of quarterly meetings in each of CNYCC's six counties (Cayuga, Lewis, Madison, Oneida, Onondaga, and Oswego), where partner organization PAC representatives and other staff and members of the public can engage with CNYCC and provide feedback on DSRIP-related activities. RPAC meetings also provide a venue for partner organizations to discuss project participation and provide feedback to CNYCC staff.

CNYCC has also established an Executive Project Advisory Committee (EPAC) to support RPAC meetings and activities. The EPAC is composed of representatives from each of CNYCC's RPACs and will provide guidance on project implementation and performance and partner engagement activities through the RPAC structure.

Outreach
Another component of CNYCC's stakeholder engagement plan has been targeted outreach to local Community Benefit Organizations (CBOs). CNYCC has conducted several workshops with CBOs to increase awareness and provide education on DSRIP-related activities and the essential role CBOs will play in the success of these programs. CNYCC has also developed a strong relationship with the Human Services Leadership Council of Syracuse, a local coalition of nearly 65 human service not-for-profit agencies in the greater Syracuse and Central New York area. Through this partnership, CNYCC has been able to engage CBOs in several ways, including via "lunch and learn" workshops, one-on-one meetings, and information sharing to increase CBO participation in the PPS.

Incorporating Partner Feedback
Another key element of CNYCC's stakeholder engagement program has been gathering and then incorporating partner feedback collected through periodic surveys. The survey process allows CNYCC to both garner feedback and modify programming to meet our partners' needs. CNYCC has conducted several partner surveys on a wide range of topics, including partner communications. The most recent partner survey reviewed the effectiveness of CNYCC's PICs. The information collected from partners through the survey is being used to modify the existing PIC format and provide alternative methods of coordinating implementation efforts.

Formalizing Partner Participation
In 2016, CNYCC introduced a contracting process to define and formalize partner participation in the PPS. To date, more than 120 partner organizations have initiated contracts with CNYCC and committed to participating in project activities. In conjunction with the contracting process, CNYCC introduced a funds distribution model for DSRIP-related activities that outlined how partners would receive payments. In

February 2016, CNYCC initiated the "accelerated planning payment" program, allowing partner organizations to receive lump-sum payments for planning activities related to project selection, and has distributed over $3.5 million to partner organizations through the program. Our intent is to continue to work with partner organizations to facilitate contract execution and ensure robust partner participation across each project.

Hiring a Chief Medical Officer

Practitioner outreach will be an important component of CNYCC's overall stakeholder engagement plan, and key to this effort is CNYCC's plans to hire a chief medical officer (CMO). CNYCC is currently recruiting for this position, and will proceed with a comprehensive outreach plan, led by the CMO, to fully engage practitioners and clinical staff. An interim plan for practitioner outreach is currently underway, with support from a volunteer physician champion group, CNYCC's Clinical Governance Committee, and practitioners who participate in project implementation activities.

Next Steps

CNYCC plans to roll out a comprehensive communications strategy that will focus on delivering targeted campaigns to reach and connect with different audiences. CNYCC will employ various tactics within each campaign to engage each constituency group and effectively support organizational goals and objectives, with a special focus on three key areas: general awareness/promotion, continued partner engagement activities, and a coordinated public relations plan.

Cultural Competency and Health Literacy

Overview

An important aspect of the DSRIP program is the ability to embrace cultural competency and improve health literacy across the PPS network. Each PPS must demonstrate cultural competence by successfully engaging Medicaid members from all backgrounds and capabilities in the design and implementation of their health care delivery system transformation. CNYCC's ability to develop solutions to overcome cultural barriers and health literacy challenges is essential to successfully addressing healthcare issues and health disparities within our region.

Cultural Competency and Health Literacy Work Group

Cultural competency and health literacy (CC/HL) will play a key role in transforming healthcare across the PPS, and must be infused into all areas impacting care delivery, including staff training, community outreach and education, and partnerships with community based organizations. Due to the key role CC/HL will play in PPS programming, CNYCC created a dedicated CC/HL Work Group composed of representatives from partner organizations across the PPS. This work group met on a regular basis to formulate an approach to improving access to culturally competent and health literate services across the region.

The work group identified nationally-recognized standards to define the vision for culturally competent and health literate systems of care delivery, including *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* and *Ten Attributes of Health Literate Health Care Organizations.*

Program Milestones

Milestone #1

CNYCC's CC/HL program is based, in part, on two prescribed milestones outlined by the New York State Department of Health: Milestone #1, "Finalize a cultural competency/health literacy strategy," and Milestone #2, "Develop a training strategy focused on addressing the drivers of health disparities."
For Milestone #1, the CC/HL Work Group developed a plan that identifies priority groups experiencing health disparities in our PPS region and also looked at steps to improve outcomes.

The cultural competency and health literacy strategy is directed at two audiences: groups of people living in CNYCC's service area experiencing health disparities, and providers and other members of the workforce involved with the delivery of information and/or provision of care. These two audiences (and related DSRIP milestones) are unified in their aim of addressing healthcare disparities in a manner that reflects the diversity of needs and assets of the communities and providers in our region. Interventions proposed under the first milestone are designed to support community members' health and well-being outside of the clinical setting through the use of culturally- and socially-relevant assessments, tools, and community based interventions. Highlights of the CC/HL strategy include:

- An expanded definition of potential "at-risk" populations, to include not only race, ethnicity, and language, but additional demographics such as geographic location, socioeconomic status, and disability status
- A comprehensive review of available research to identify the region's greatest health challenges
- A cross-reference of prevalent health challenges based on geographic locations ("geographic hotspots")
- Identification of populations (based on the above expanded definition) most affected by health challenges within the prescribed geographic hotspots
- Identification of potential resources available to address specific health disparities and improve outcomes outlined in CNYCC's prescribed strategy

CNYCC's CC/HL strategy was presented and unanimously approved by the CNYCC Board of Directors in December 2015.

Milestone #2

Milestone #2 focuses on developing a training strategy for clinicians and other staff employed by our partner organizations in order to address the drivers of health disparities across the PPS. The CC/HL work group reconvened in spring 2016 to develop the training strategy and institute a series of "guiding principles" to establish norms, rules, and values to govern actions and recommendations throughout the training process. CC/HL work group members reviewed information from the original CC/HL strategy and initiated an assessment of current CC/HL practices already being advanced by partners within the PPS. This information provided insight on CC/HL readiness among partner organizations. The work group also acknowledged the natural "overlap" of cultural competency and health literacy in healthcare settings. In many instances, CC/HL trainings have traditionally been categorized as one or the other; however, the work group recommended that CC/HL trainings be conducted in a coordinated fashion where appropriate.

With over 120 partner organizations represented in the PPS, each with different levels of CC/HL programming, the work group determined that a highly prescriptive program may not be the most effective approach to meet the various training needs. Instead, the group determined that a training strategy that provides partners with CC/HL resources, training opportunities, and best practices at an organizational level,

while also providing content-specific CC/HL trainings within each of CNYCC's 11 project offerings, would be a more effective approach. This flexible method would offer a wide range of resources to partners regardless of their current state of CC/HL readiness. It will also provide an opportunity to reduce the level of duplication for organizations already instituting robust CC/HL programs, while leveraging best practices and resources for organizations seeking to develop more comprehensive CC/HL programs. This CC/HL training strategy was presented and unanimously approved by the CNYCC Board of Directors in June 2016.

Next Steps

The next steps for the CC/HL workgroup include providing implementation support for the overall CC/HL strategy and working closely with CNYCC's workforce program to include CC/HL curriculum in the overall workforce training strategy. CNYCC strongly recognizes the value of CC/HL, and through the approaches outlined above, aims to support partner organizations and their employees with resources and necessary skill development to deliver more culturally competent and health literate services.

Value-Based Payment

Educating Partners

CNYCC is increasingly focused on supporting our partners' transition from fee-for-service reimbursement to value-based payment. Early on, CNYCC identified education about value-based payment as a need across our partner network. To that end, we retained the consulting services of nationally-recognized subject matter experts through Bailit Health, who developed a series of educational white papers, PPS-wide webinars, and targeted board of directors presentations. This educational effort imparted information about the fundamentals of the New York State Value-Based Payment Roadmap and key value-based payment DSRIP milestones that CNYCC must meet. It also drew connections between our DSRIP projects and the IT infrastructure CNYCC is using DSRIP funds to acquire and the kinds of functions and activities that provider organizations need to succeed in value-based, at-risk arrangements.

Assessing Partner Transition Readiness

In order to further help partners evaluate their current capabilities necessary for success in value-based, at-risk arrangements, CNYCC has developed a series of assessments. As discussed in the IT Systems and Population Health Management section of this narrative, the customized IT current-state surveys included both questions about functions required to meet DSRIP project requirements and questions required to manage clinical and financial risk. The responses showed how few of our partner organizations currently have all IT capabilities necessary to assume clinical and financial risk for an attributed patient population. This identified gap is one CNYCC will address by implementing a regional, multi-payer population health management platform described in greater detail in the IT Systems and Population Health Management section of this narrative.

Next Steps

As a next step in the value-based payment readiness assessment process and to meet the value-based payment baseline DSRIP milestone, CNYCC has hired consultants from John Snow, Inc. and Bailit Health to develop a baseline value-based payment survey and cross-functional value-based payment self-assessment. Data collection efforts are currently underway, and the results will inform the kind of support CNYCC develops the capacity to offer its partner organizations. CNYCC staff have attended the New York State Department of Health's Value-Based Payment Bootcamp series in order to gather additional information

about the role that we as the PPS lead entity can play in facilitating our partners' transition from fee-for-service reimbursement to value-based payment arrangements.

CNYCC is currently entering into contracts for its role in the Value Based Payment Quality Improvement Program (VBP-QIP). The New York State Department of Health selected two of CNYCC's hospital partners to participate in VBP-QIP, and CNYCC is helping facilitate negotiations for each three-party contract, which are between CNYCC, the hospital, and the applicable managed care organization with whom CNYCC and the facility are partnered. CNYCC's DSRIP goals are aligned with the VBP-QIP program, and we perceive this as an opportunity to help move stakeholders and the related processes forward in the transformation to value-based payment. We have encouraged our VBP-QIP participant facilities to attend the New York State Department of Health's Value-Based Payment Bootcamp series, a source of valuable information.

Conclusion

As the above document and the attached project narratives show, CNYCC has accomplished much in its short time as an established DSRIP performing provider system. CNYCC's commitment to flexibility, both internally and with our partners, has helped it weather many challenges, including our partners' competing priorities and limited resources, changing state and federal regulations, and unanticipated data findings. Our thorough governance and compliance measures and comprehensive policies and procedures reflect our serious commitment to fiscal and regulatory due diligence. Finally, our extensive activities in quality improvement, workforce development, stakeholder engagement, and cultural competency and health literacy show our commitment to providing an innovative, efficient, and patient-centered operation. We look forward to continuing our meaningful work in the DSRIP program to improve patient outcomes and ultimately reduce health disparities and preventable hospitalizations in Central New York and across New York State.

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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: Central New York Care Collaborative, Inc.

Project: 2.a.i

Challenges the PPS has encountered in project implementation:
Core Application System CNYCC's initial plan to help standardize electronic medical record (EMR) systems across the PPS did not take into account the current high rate of adoption of EMR technologies: *"1) Core Application Systems – CNYCC will establish a "core application systems" enablement program focused on first, standardizing EMR environments across eligible provider's offices, as well as implementing a program to rollout EMRs to physicians without this capability."* **Population Health Management** One of CNYCC's stated goals since the beginning of DSRIP is to create an integrated delivery network (IDN). CNYCC feels that population health plays a central role when developing an IDN, as a major part of population health is applying healthcare data to provide new information that in turn will improve patient outcomes. CNYCC aims to establish a regional population health infrastructure to support our project activities and our community going forward. However, vendor negotiations and technical due diligence efforts over the past year have delayed our population health management vendor selection. **Current State Assessment** CNYCC initially gathered partner level health IT information in the early stages of DSRIP. However, due to changes in CNYCC's structure the overall rapid change in available technology, CNYCC decided to increase the scope and breadth of our information-gathering efforts. Gathering, maintaining, and tracking partner health IT readiness data became a larger process than CNYCC initially anticipated. CNYCC tried to uphold the published timelines, but ultimately had to extend them due to limited organizational resources and the amount of information gathered. **Patient-Centered Medical Home** Participating partners have been slow to engage in the transformative activities required to become patient-centered medical home (PCMH) accredited. Approximately 50% of our partners are unaccredited, many of them because they are short-staffed and unable to fulfill the project requirements. Many partners note that due to primary care resource shortages and uncertain financial outlooks, all of their available resources are focused on meeting their organizations' short-term financial goals. Further, primary care practices that are not designated as safety net providers (and are therefore subject to the 5% funding limit for non-safety partners) face additional challenges. In this subset of practices, there is a

lack of understanding of the PCMH model, especially at the ground level, which is a challenge to project implementation. These partners have noted that it is difficult to find resources to meet the foundational PCMH requirements, including enhanced access, population health management, care management, and care coordination. CNYCC may continue to face challenges in changing the culture of these practices until they have a better understanding of and solid evidence for the benefits of becoming PCMH-recognized.

Efforts to mitigate challenges identified above:

Core Application System

CNYCC mitigated the above challenges early on in the project. As a result, the will not impact the overall progress towards DSRIP goals in Project 2ai. Furthermore, CNYCC has reached out to partners with no EMRs and partners in the process of selecting new EMRs in order to provide them with vendor selection toolkits. The toolkits include timeline summaries, and requests for proposals and requests for information from vendors.

Population Health Management

Through our due diligence efforts and the resultant identification of gaps in both finalist PHM vendors' platforms' current state capabilities, CNYCC has proven to be a valued added resource for our vendor of choice, IBM. This partnership has allowed us to negotiate for improved functionality and affordability, and a stronger collaborative relationship to this point.

Current State Assessment

Thanks to CNYCC's extensive information gathering efforts, we were able to mitigate challenges in our partner assessments by combining state-provided information with information about the partner to more accurately track a partner's current state readiness to adopt project requirements. This allowed CNYCC to provide partners with project plans that reflect only their outstanding project requirements.

Patient-Centered Medical Home

To increase awareness of the PCMH model, CNYCC has sponsored four in-person PCMH trainings open to all partners since CNYCC was able to recruit a PCMH certified content expert onto its project management staff. This is in addition to our monthly project implementation collaborative sessions, where CNYCC has made partner education a primary focus. As part of the implementation planning phase of the project, CNYCC's PCMH certified content expert is conducting baseline assessments and working with partner project teams to inform their transformation activities. As CNYCC transitions our Project Implementation Collaboratives (PICs) into a new, improved Learning Collaborative model, there will be increased opportunities for CNYCC and our partners to learn from each other as well and to effect change through rapid cycle improvement.

To mitigate the non-safety net status of our partners that are serving some of our target patients, CNYCC is working with safety net providers to encourage subcontract agreements to facilitate funds flow to the partners that are engaging our targeted patients.

CNYCC has purchased and will implement a population health management platform that will improve data analytics, facilitate care coordination, identify vulnerable populations and health disparities, and drive care management to patients who can achieve improved health outcomes. This platform will help reduce the significant internal resources required when organizations inefficiently use care coordination and care

management resources, and will also help primary care practices target patients with the greatest potential to improve health outcomes.

In addition to discussing strategies in the project implementation and learning collaborative sessions, CNYCC's project manager continues to reach out to partners and prospective partners to get additional engagement in this project. CNYCC is making every effort to inform partners of the cross-project requirements and to alignment activities with the PCMH model and value-based payment models. This has been a focus on many of the project implementation collaborative discussions as well as one-on-one meetings and during PCMH training. As CNYCC's partners move through their transformation journeys and receive more clarity on upcoming value-based payment expectations, CNYCC expects to see an increased organizational focus on population health and provider engagement.

CNYCC is also currently reviewing the project implementation plans and identifying additional technical assistance that we may need to employ in order to help each partner successfully during this implement this project.

Implementation approaches that the PPS considers a best practice:

CNYCC considers its rigorous population health management platform selection process (described in depth in the IT Systems section of the preceding Organizational Narrative) to have been a promising practice, with many valuable lessons learned. Additionally, the regional and multi-payer approach to PHM implementation we intend to take is one that, if realized, will reduce the burden on partner organizations to implement and share information with multiple platforms, will avoid spending scare funding on duplicative infrastructure, and will improve the long term efficiency of administration and financial sustainability of the platform.

CNYCC's PCMH training series, made possible by CNYCC's fortunate recruitment of a PCMH certified content expert, will improve our ability to support practices through the PCMH recognition process in the short term and is another promising practice. Our ability to effectively manage the PCMH project implementation timeline at participating sites, especially those with the lowest readiness, is greatly enhanced when the project manager is also intimately knowledgeable about PCMH. In the long term, this capability will the ground work for the development of broader practice facilitation and direct technical assistance capabilities.

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

Primary Care Transformation and Health Information Technology Collaboration

CNYCC has used its health IT webinars and Primary Care Transformation webinars as avenues to correlate shared requirements. Additionally, we have exchanged shared resources, which allows us to note overlap between primary care transformation and health IT.

Patient-Centered Medical Home

CNYCC is redesigning our project implementation collaboratives, which have thus far been process-focused and CNYCC-led, into a learning collaborative model with a focus on cross-project implementation strategies and rapid cycle improvement by cross-functional teams. For example, the new design will feature an outpatient/ambulatory care learning collaborative with a focus on the significant overlap between project requirements and practice transformation activities. CNYCC will set up rapid cycle teams to develop and implement specific activities that are integral to project success.

CNYCC is also working collectively and strategically with our partners to inform and align cross-project requirements with aligned implementation strategies to achieve National Committee for Quality Assurance PCMH 2014 Level 3 recognition. These efforts will ensure that CNYCC's partner organizations implement processes that support multiple project activities, reducing confusion and redundancy. The collaborative sessions will be more partner-led, with project manager facilitation.

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

There have been no substantive changes to the target populations proposed in the initial application. However, our partners are adopting EMR technology at high rates. As a result, CNYCC has not had to use resources to implement the EMR technologies as proposed in the initial application.

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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: Central New York Care Collaborative, Inc.

Project: 2.a.iii

Challenges the PPS has encountered in project implementation:

Identifying Appropriate Patients

Partners are finding it difficult to identify individuals who have only one chronic condition for participation in the 2.a.iii project. The comprehensive needs assessment states that the "root of most inpatient admissions for those insured by Medicaid were depression, hypertension, drug abuse, diabetes, and asthma," and that a significant amount of Medicaid beneficiaries in CNYCC's service area were categorized with depression (30,413 individuals) or hypertension (30,885 individuals). However, this data fails to reflect the fact that the majority of these individuals in fact had a second chronic condition, making them ineligible for this project.

Partners also found that the vast majority of identified patients have two chronic conditions. To truly find an individual with a single chronic condition, partners must cross reference each chronic condition with another to determine if in fact an individual truly has only one chronic condition, an extremely time consuming and nearly impossible task. In addition, although managed care organizations often send lead health homes lists of patients with only one chronic condition noted, after doing outreach and completing an initial care plan, partners are discovering that these individuals have multiple chronic conditions, making them health home-ineligible. The above challenges required CNYCC to deviate from the original project design.

In addition, CNYCC had originally noted a different significant project challenge: engaging individuals who are considered high risk and have one chronic condition. However CNYCC was not able to specifically target high risk patients, as the majority of these individuals have two chronic conditions and are served under health homes, or are at high risk of utilizing services inappropriately but have no chronic conditions or are uninsured. These individuals can be counted as "actively engaged," but this limits their participation in the 2.a.iii project.

Care Coordination Capability

Partner organizations are finding that care coordination is still a relatively new concept for primary care providers working towards patient-centered medical home 2014 level 3 certification. Although the 2.a.iii project is meant to extend care coordination services for a target population, partners often do not have the capacity to provide care coordination for their current patient population. It has been challenging to ask partner organizations to go above and beyond what they are currently doing, because in many cases, CNYCC must first help partner organizations set up the fundamental building blocks of care coordination prior to any 2.a.iii project work.

Primary Care Provider Engagement
A health home care manager was originally asked to manage the 2.a.iii project as an extension of his or her current service to individuals with a single chronic condition. This responsibility has shifted from health homes providing care management to primary care providers targeting this specific population through their established care coordination teams. These new responsibilities have proven overwhelming for the primary care providers, who now must deal with both the 2.a.iii project changes and all of the other primary care-based DSRIP projects.

Lack of Health Home Awareness
CNYCC has encountered many partners with a lack of education and knowledge about health homes and the services they can provide to eligible Medicaid recipients. This lack of knowledge lends itself to low referrals to health homes even though many individuals could benefit from these services. Within central New York, there are three lead health homes to which a primary care provider can refer patients. However, many providers do not understand the difference between each health home, how to refer patients (as each health home has a different referral form), and how health homes may benefit their patients.

These challenges represent significant barriers to hitting actively engaged patient targets. As a result, although the project implementation collaborative has been working diligently to create this program and establish the services for this target population, these individuals are nowhere to be found.

Efforts to mitigate challenges identified above:

Identifying Appropriate Patients
To help partner organizations identify individuals with one chronic condition, CNYCC gave partners a list of ICD-10 codes to use when searching their emergency medical record (EMR) systems. This list included all codes under the major chronic condition categories that an individual could have to be eligible for services. This strategy has helped make partners aware of which conditions and codes are tied to a chronic condition, but utilizing these codes in an EMR search is very difficult.

CNYCC has also used its internal clinical staff to determine other solutions to finding individuals with one chronic condition. Since EMRs are valuable sources of patient information, CNYCC is working with partner organizations to look at individual patient problem lists to see if single chronic conditions have not been appropriately coded within the system. CNYCC is also working with partners to focus on certain risk factors that could be in fact coded as a single chronic condition. (For example, if an individual over a certain body mass index percentage in a defined age range could be coded as obese.) Because New York state is establishing children's health homes this October, CNYCC and its partners have also begun targeting children and youth to identify individuals with one chronic condition for the 2.a.iii project.

Care Coordination Capability
CNYCC is working to mitigate partners' lack of care coordination experience and infrastructure through cross-project collaboration. For example, partners that are implementing cardiovascular disease management and practice transformation are building systems and infrastructure to meet care coordination needs with multidisciplinary teams, and CNYCC has begun to weave these projects together in order to minimize the burden to partner organizations. In order to ensure that partner organizations understand how each requirement and project aspect ties together, CNYCC has started implementing one-on-one meetings with partners.

NEW YORK STATE | Department of Health

To help partners build a care coordination base, CNYCC and its partners have created a standard set of care coordination trainings that would be beneficial for all DSRIP care managers. (These trainings could also be beneficial for other projects and primary care providers that wish to improve or implement their practice care coordination.)

Implementation approaches that the PPS considers a best practice:

Basing Activities in Primary Care Practices

Basing 2.a.iii project activities in primary care settings allows partners to take ownership of project activities and to strengthen or begin to build a solid care coordination base within their practices. Because successful care coordination is essential to positive patient outcomes in addition to being a prerequisite for this project, building this competency is extremely important and allows partner organizations to have a single project that focuses on this core area. (This change in project ownership deviates from the original project plan, which was meant to help further develop the three existing health homes.)

Creating Universal Training Modules

CNYCC created universal training modules so that all DSRIP care managers can have the same base training. These training modules include information on care management skills, how to engage an individual (including motivational interviewing), how to create a care plan with an individual, and how to coordinate care for an individual with multiple providers. In addition to being a requirement for an individual providing DSRIP care management, these modules were viewed as imperative trainings across all the projects. CNYCC is working to produce these trainings for the entire PPS.

Using Established Information to Create Care Plans

Using care management plan elements created in this project as the base for all PPS projects requiring care plans will promote uniform treatment across the PPS and its partners. This uniformity will be extremely valuable once CNYCC implements a population health management system and partners within an individual's care team can all access the same care plan and coordinate care accordingly.

Creating a Universal Referral Form

CNYCC partnered with the three lead health homes to create a universal referral form for referring patients to care management services, including both DSRIP care management and health home care management. This universal referral form aims to make it easier for providers to refer patients and help them identify where to send a referral for services.

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

CNYCC is establishing strong relationships with the three lead health homes within central New York. These health homes have been extremely active in moving the 2.a.iii project forward. The three health homes have assisted CNYCC with presentations to educate partner, particularly primary care providers, about the services that are available through a health home.

CNYCC is strategically working to ensure cross-project alignment with project tasks and implementation strategies. CNYCC aims to ensure non-duplication of work and tasks for partner organizations. This is essential work for both project deliverables and also creating continuity and cohesive patient care. CNYCC hopes to ensure that partner organizations see the overlap and are implementing staffing structures that support multiple activities and functions.

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

Targeting Individuals With Serious Mental Illness

Based on changes identified through the community needs assessment, the 2.a.iii project attempted to target individuals with a diagnosis of serious and persistent mental illness. (Per health home eligibility standards, individuals with a serious mental illness are eligible to receive health home services.) In New York state, however serious mental illness and serious and persistent mental illness are considered the same diagnosis. Therefore, CNYCC cannot identify individuals with a SPMI as an eligible population for this target, as they are technically eligible for health home services.

Additionally, at the beginning of this project, uninsured individuals could be counted toward the target population. However, guidance from New York state showed this to not be the case. Therefore, eliminating this population reduced the number of participants that could be connected to much needed care coordination and management services. Since CNYCC cannot focus on this target population, it puts an additional strain on county care management services for individuals who are not insured by Medicaid.

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: Central New York Care Collaborative, Inc.

Project: 2.b.iii

Challenges the PPS has encountered in project implementation:
Making Changes Across Emergency Departments This project requires emergency departments (EDs) to make many changes in a large and structured environment. There are ten hospitals with twelve different functioning EDs. In central New York alone. Each ED has a different volume of patients, provides different specialty services (e.g. a designated trauma center), and has a different staffing structure to meet the needs of the presenting patients. As many EDs operate like a well-oiled machine, it is a challenge to implement a new workflow and protocols for a certain subset of the population entering the ED. **Primary Care Provider Capacity** Ready access to primary care providers is a challenge. Because many primary care providers are at capacity, it has been very difficult for patient navigators to schedule appointments with a patient's primary care provider within 30 days of the patient's ED presentation. Additionally, even if a primary care provider is accepting new Medicaid patients, they often have an extensive wait time for initial new patient appointments, and aren't able to see individuals during the 30 day timeframe. **Finding Appropriate Patients** Per New York state guidance, in order for ED visits to necessitate follow-up visits with primary care providers, individuals presenting at EDs must have ambulatory sensitive conditions or potentially preventable visits. However, primary care providers often determine that patients' conditions do not fit this description. Many times, patients' conditions clear up or are not relevant by the time the primary care appointment occurs. This has been frustrating to primary care providers who see these as unnecessary appointments that could have been utilized for patients who needed same-day care. Complicating this situation, patients themselves often feel that their conditions are resolved at the ED, and do not feel they have to attend their follow-up primary care appointments. Many patients ultimately fail to attend or cancel their established appointments, leading to increased no-show rates for primary care appointments that were scheduled within this project.
Efforts to mitigate challenges identified above:

Making Changes Across Emergency Departments
CNYCC and its partners identified central components that would constitute an ED care triage (or what CNYCC calls a "patient navigation" program). CNYCC worked with its partners to create a universal implementation plan template that delineates each activity that an ED would need to conduct to have a functioning patient navigation program. This plan template also helps EDs gauge where they are in completing and implementing these activities in order to have a functioning program.

Primary Care Provider Capacity
CNYCC is working strategically with partners to indicate an appropriate follow-up timeframe on discharge paperwork in order to determine an adequate timeframe to schedule primary care provider follow-up visits. Since each individual will have a different follow-up timeframe, this strategy will attempt to mitigate primary care overload and reduce no-show rates.

Finding Appropriate Patients
CNYCC is working with providers to develop additional strategies to reduce no-show rates. The current mitigation strategy is to reach out to the patient within two days of ED discharge to make the patient aware of their follow-up appointment with their primary care provider. This strategy is designed to create a "touch point" for patients that will both make them aware of their appointment and serve as a reminder that will have a Primary Care appointment occurring within the next 30 days. CNYCC will examine attendance and no-show rates to determine if this type of contact is beneficial for patients and practices.

Implementation approaches that the PPS considers a best practice:

CNYCC has established a two-day timeframe in which to notify patients of their scheduled primary care appointments. After receiving New York state's guidance for determining an actively engaged patient, CNYCC took this definition one step further. New York state noted that in order for a patient to be successfully redirected, the patient had and was made aware of an appointment within 30 days of his or her ED presentation and medical screening. After conducting literary research and partner interviews, the group determined that the majority of individuals return to the ED within 48-72 hours of discharge and present to the ED during weekdays, particularly Monday through Wednesday. Therefore, CNYCC established the two-day notification stipulation in order to curb patients' likelihood of returning to the ED before their scheduled primary care appointment.

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

Emergency Severity Index

Throughout this project, CNYCC and its partners have worked together to further stratify and define the target population that would most benefit from the patient navigation intervention. Because the project is attempting to target individuals who have a potentially preventable visit or ambulatory sensitive condition, CNYCC aims to help EDs decipher who would benefit the most from this project and who is truly using the ED inappropriately. This strategy has led partners to target individuals with certain Emergency Severity Index scores that correlate to conditions that are not true emergencies. Partners have agreed to use this patient stratification to identify individuals that are eligible for patient navigation.

Implementation Plan Templates

Each ED involved in this project is required to complete an implementation plan template that delineates each activity that an ED would need to conduct to have a functioning patient navigation program. This plan template allows partner organizations (as well as CNYCC) to see which activities are required in this patient navigation program, and also helps everyone gauge how well they have completed and implemented these activities in order to have a functioning program. From these results, CNYCC will begin to group organizations to form a learning collaborative that will help EDs share their implementation challenges and best practices.

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

CNYCC was forced to stop engaging uninsured individuals in this project. At the beginning of this project, uninsured individuals could be counted toward the target population, but guidance from New York state showed that this was not be the case. Eliminating uninsured patients reduced the number of participants who could be connected to a primary care provider who truly needed this connection. Since CNYCC cannot focus on this target population, it cannot help these individuals, who truly need primary care but are not the focus of the intervention.

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: Central New York Care Collaborative, Inc.

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:
Standardizing Patient Assessment Tools CNYCC initially found it challenging to come to a consensus with project partners on how to identify high risk patients. Partners have agreed that the current process for identifying target patients (individuals with a chronic condition who have received a discharge plan prior to discharge) is not sufficient, and as a result, the care transitions project implementation collaborative (PIC) thoroughly explored using risk stratification tools. Although the PIC ultimately decided on two tools, LACE and BOOST, to help identify the highest risk patients, partners could not agree on how to standardize these practices across all hospitals. Without standardized risk stratification tools, patient identification and patient assessment is often variable. Hospitals recognize that high utilizing patients often appear at multiple hospitals settings, and without a standardized means for identifying patients, high risk patients may be assessed differently in various settings. This increases the chances for missed opportunities to engage patients in appropriate care transitions services. **Standardizing Care Transition Interventions** CNYCC faced challenges developing standardized care transitions intervention protocols for its participating hospitals by partnering with a home care service or other appropriate community agency. This required developing a planning and implementation process for the participating hospitals. As a result, the hospitals have formed a hospital learning collaborative separate from the larger PIC to support one another in their efforts to accomplish the DSRIP initiatives. This group has determined that the CNYCC process for implementation planning does not meet their needs, resulting in a request to redesign the project implementation planning processes going forward. This has slowed the work toward meeting the requirement and has also impeded work group formation, as the hospital learning collaborative may become the means by which work will be completed.
Efforts to mitigate challenges identified above:

Standardizing Patient Assessment Tools and Care Transition Interventions

The project participants sought guidance from CNYCC's Clinical Governance Committee to mitigate this challenge. Partners told the committee that although standardizing evidence-based risk stratification tool implementation would help hospitals assess patients based on medical needs, it limited hospitals' ability to identify the social determinants of health known to factor into patient readmission. As a result, the Clinical Governance Committee recommended that the partners form a work group to identify key elements of care transitions plans and create standards for those elements.

Once the work group develops these standards, they will present them to the PIC for feedback, make any needed changes, and submit the standards to the Clinical Governance Committed for review and recommendation. The work group will then modify the standards as recommended and present the final product to the PIC for implementation. Since all participating hospitals are currently identifying and reporting on high risk patients for whom care plans have been developed, this work will focus on the care plan standards to highlight factors that would identify patients as at highest risk for readmission.

CNYCC has set up a meeting with the hospital learning collaborative and also invited partnering hospitals that do not participate in the learning collaborative. At the meeting, participants will discuss proposed solutions for implementation planning going forward. In addition, CNYCC is redesigning the PIC structure, and is looking to incorporate the hospital learning collaborative into a new structure that would focus on hospitals' work in care transitions and across the other PPS projects' initiatives.

Implementation approaches that the PPS considers a best practice:

CNYCC has shifted engagement practices in response to hospitals' concerns about standardizing risk stratification tools and implementation planning. Although not yet realized, the previously-mentioned work group may determine that a best practice for partner engagement is to suggest that partners be more instrumental in the "how" of protocol development and implementation in addition to the "what" for standard creation. CNYCC previously allowed for the "what," but was more directive in the "how." The 2.b.iv project is adjusting accordingly, and is anticipating stronger relationships with the hospital partners and CNYCC, which in turn will lead to more effective and efficient work.

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

The 2.b.iv project has experienced great success in forming care transitions coalitions. The CNYCC care transitions project manager has facilitated initial meetings with the hospital DSRIP coordinators, project leads, transitions staff, and quality improvement staff in conjunction with IPRO. IPRO has been instrumental in this process because of its significant experience assisting with care transitions coalition development across New York state. Currently, meetings have taken place with Onondaga, Lewis, Oswego, Madison, Rome Hospital (Oneida County), and Mohawk Valley Health System (Oneida County). Only Cayuga County has not held an initial meeting, but CNYCC has initiated discussions to engage Auburn Hospital in developing its community's coalition. Further, Lewis, Oswego, and Madison have had multiple meetings, and with each meeting they have identified additional community-based organizations (CBOs) to invite to their meetings.

During these meetings, communities have quickly identified areas for improving processes for care transitions, necessary CBO participation, and care gaps. In addition, the coalitions have presented specific

case studies for review, which have helped identify clear gaps in service, service provision duplication, and previously unknown or underutilized community resources.

Finally, forming coalitions within specific communities has allowed communities to share ideas and strategies for improving care transitions processes. For example, one community identified behavior health interventions (namely, deployment of peer support specialists to hospitals) as a potential strategy for working with high risk care transitions patients presenting with substance abuse issues. A neighboring community is currently developing a similar model, and the two communities are sharing information through this process, which will hopefully lead to successful implementation and outcomes.

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

The original 2.b.iv project application stated:

"The target population for this project is a one-year, count of attributed, utilizing and non-utilizing Medicaid members who are admitted as an inpatient to participating partner acute care hospitals with a chronic disease or behavioral health disorder, discharged with a care transitions plan. Excluded from this population are those (patients) readmitted within 30 days. Patients meeting these criteria who are admitted again during the same year, but not within 30 days of their most recent admissions are counted again for each qualifying admission."

The target population has not changed throughout the course of this project. However, using the New York State Department of Health definition for actively engaged patients, "The number of participating patients with a care transition plan developed prior to discharge," resulted in large numbers of patients being identified. This led CNYCC to recognize that more work needs to take place to narrow the focus for patient identification. As a result, CNYCC has undertaken significant efforts to assess and stratify those patients within the target population who are at greatest risk for readmission.

The project PIC has extensively explored evidence-based risk stratification tools and reviewed the merits and limitations of all identified tools. These tools have included LACE, BOOST, Project RED, and other tools in beta testing identified by the quality improvement organization IPRO. Through these activities, CNYCC hopes to help hospitals uniformly identify patients at risk for high hospital utilization and employ care transitions teams to help patients mitigate the medical and social determinants that may lead to readmission.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Central New York Care Collaborative, Inc.

Project: 2.d.i

Challenges the PPS has encountered in project implementation:
Implementation Delays The 2.d.i project is currently in the beginning phase of implementation. CNYCC initially proposed an implementation start date of April 1, 2016 to our partners, with the understanding that delays related to the partner contracting process would prevent some partners from beginning by that date. Therefore, only the partners that completed the contracting process and received all appropriate PAM trainings prior to April were able to begin on time. **Partner Preparedness** CNYCC anticipated that the majority of organizations who completed the contracting process before April would be prepared to begin implementation within that month. However, after monitoring partners through Insignia's Flourish system and starting targeted discussions with partners, CNYCC discovered that most partners were not implementing the project and in fact did not feel prepared to begin implementation. The partners reported needing more time to develop their implementation plans and being unsure how to implement this project within their organizations. **Difficulty Identifying Populations** As partners began implementation, some had difficulty identifying their target populations (uninsured individuals vs. low- or non-utilizing individuals). This was reported by community-based organizations within "hot spot" areas and by other partners. Originally, CNYCC developed a pre-screening questionnaire to help partners distinguish whether their project participants were uninsured or low-utilizing/non-utilizing Medicaid members. The partners reported that individuals were not qualifying as part of the targeted population based on the pre-screening questionnaire and that partners could therefore not administer the PAM survey. **Partner Recruitment** Currently, there are 39 organizations participating in the 2.d.i. project. CNYCC needs to increase this number in order to successfully meet the actively engaged targets.
Efforts to mitigate challenges identified above:

Implementation Delays, Partner Preparedness, and Difficulty Identifying Populations
In order to mitigate these challenges, CNYCC's patient activation project manager began having on-site project implementation meetings with partners. Priority was given to organizations who were already fully contracted and had received the appropriate trainings to begin implementation.

The project implementation meetings provide an avenue for organizations to brainstorm implementation strategies with the project manager. The meetings also give organizations the opportunity to ask organization-specific project questions and get clarity on areas of confusion. In addition, partners who had difficulty identifying their target populations are able to work collaboratively with the project manager during these meetings to identify outreach strategies that can help them gain access to the targeted population.

Partner Recruitment
CNYCC conducted a project-specific gap analysis in order to identify other potential partners to engage. Within this gap analysis, CNYCC specifically looked at both partners that were actively participating in our monthly project implementation collaborative meetings and partners who were not active in this project but would be beneficial to add, and began targeted outreach.

Implementation approaches that the PPS considers a best practice:

An approach that has been considered a best practice is establishing quarterly on-site project implementation meetings between CNYCC staff and each organization's project implementation staff. CNYCC's partner organizations have given CNYCC very positive feedback on these meetings and consider the meetings to be valuable for project implementation.

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

There are no additional details to report at this time.

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

There have been no substantive changes to the target populations proposed in the initial application.

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: Central New York Care Collaborative, Inc.

Project: 3.a.i

Challenges the PPS has encountered in project implementation:
State Information Partners cite changing state information across projects as a large barrier to implementation. Partners were initially interested in integrating under Model 2, but patient-centered medical home (PCMH) language in the implementation plan prevented them from contracting with the PPS for that model. Even with the adjustment and clarification of requirements, many providers had moved on from thinking that Model 2 was a reality. **Billing** The lack of alignment between integrating add-on services and the current fee-for-service billing structure has been challenging for partners, who are reluctant to rely solely on DSRIP funding for integrated services. Partners are vocally unhappy about population-based social work billing limitations. **Partnerships** Many behavioral health and primary care partners initially struggled to make connections and identify integration partners within their communities. Providers are also concerned about the lack of mental health and substance abuse services available to patients who need additional services outside of an integrated practice. **Engagement** Partner engagement is one of the biggest challenges in this project. We hold monthly large-format webinar-based project status calls, but participation at the provider level is limited; most participants are DSRIP coordinators for their organizations who are involved in multiple projects or are part of practice management. This lack of provider participation is also echoed in workgroup settings. This makes completing clinical deliverables challenging, as partners need additional time to take information back to their respective organizations for vetting. **Meeting Format** The web-based format of the monthly meetings has also posed unique challenges to this project. Although these meetings are essential for communicating on a large scale, sharing project updates, and providing project-related information, encouraging dialogue is challenging in a webinar format. Partners have been reluctant to share some of their work in that large group, and webinars lend themselves to multitasking. Generally, most partners are reluctant to discuss their challenges and successes in large-format meetings.

Therefore, in-person meetings at practices have been the best way to identify and address partners' challenges.

Cross-Project Coordination
Streamlining the experience for partners that have selected multiple projects has also been challenging. This is particularly difficult for primary care partners who are simultaneously undergoing PCMH certification and integrating behavioral health.

Provider Shortage
There is still a strong voice of concern about the shortage of prescribers and clinical social workers who can provide services in integrated settings. Additionally, the current billing limitations for social workers makes transitioning from a fee-for-service delivery system to value-based purchasing financially challenging for organizations. Primary care providers' discomfort with treating behavioral health also remains a challenge to implementation, although CNYCC is starting to see a positive shift in this regard.

Efforts to mitigate challenges identified above:

State Information
To mitigate this challenge, CNYCC has focused on increasing timely and targeted communication to its partners.

Partnerships
Early on CNYCC hosted a "speed dating" event that brought together partners from both behavioral health and primary care as a way to start conversations about integration. After that event, a number of organizations developed formal partnerships and are now working together toward integration. This work continues as needs are identified. CNYCC has seen great success in linking safety net primary care providers with a very flexible, innovation-minded non-safety net psychologist's practice.

As partners move toward integration implementation (for example, by make staffing and workflow choices), we have tried to link organizations so that partners can support each other through practice changes. We have also promoted partnership across organizations, helping partners connect with other like-minded organizations to encourage self-support and collaborative movement toward implementation.

Engagement and Meeting Format
CNYCC has established a cross-project shift in large-group format meetings. These meetings will change fundamentally in composition and move from information and update sharing to implementation and rapid cycle improvement. This shift will allow CNYCC to both improve its in-person meeting attendance and increase its one-on-one in-person, on-site conversations. Through these changes, CNYCC aims to better understand partners' successes and challenges and provide individualized support for implementation.

Provider Shortages
CNYCC's workforce strategy addresses training, education, recruitment, and retention in order to help address the question of provider shortages. CNYCC has also identified training to increase primary care providers' knowledge base a priority concern, and is developing training to address these needs.

Implementation approaches that the PPS considers a best practice:

Speed Dating
As described above, an event that brought together partners from behavioral health and primary care as a way to start conversations about integration. From that event, a number of organizations have developed formal partnerships and are working together toward integration.

Partner Spotlights
Partner presentations to the board of directors about project implementation successes and challenges. CNYCC shares these presentations, along with a more in-depth partner interview, in the CNYCC newsletter and on the CNYCC website. CNYCC's most recent partner spotlight was on Planned Parenthood of Mohawk Hudson and its involvement in the MAX Series. CNYCC hopes that publicizing these efforts and successes to other partners demonstrates that change is possible.

Monthly Partner Updates

On a smaller scale, CNYCC has tried to build in partner presentations on monthly project calls.

Cross-Project Collaboration

In striving to streamline partner experience, CNYCC project managers regularly meet to identify overlap and recognize where we can collaborate and jointly communicate overlapping expectations to our partners. We have started discussing with our partners the overlap in staffing models that could meet multiple project requirements. The shift in large group project calls will also support this work.

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

There is a great deal of momentum that is starting to build. We expect that, once partners move through some of the initial disruption of adding new services and staff, we will see widespread success and energy toward further development.

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

There have been no substantive changes to the target populations proposed in the initial application.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Central New York Care Collaborative, Inc.

Project: 3.a.ii

Challenges the PPS has encountered in project implementation:

Service Silos

Building a comprehensive program of linked services is challenging in an environment where partners aren't aware of the strengths and resources of other organizations in their region due to the historical disconnection between substance use and mental health services. Additionally, siloes exist between service lines and organizations (e.g., between mobile crisis services and outpatient services).

Concerns About Sustainability

Partners are willing to participate and are engaged in the process, but have real concerns about program sustainability after DSRIP funding and the downstate roll out of Home and Community Based Services waiver services. Partners also find the slow engagement of managed care organizations to be a challenge, as it relates to advocating for payment for traditionally non-billable services.

RFP Development and Approval Process

Because the RFP development and approval process is a new one for CNYCC, attending to this process has led to a delay in funding, and subsequently, a delay in project implementation.

Engagement of Children's Services

In the planning phases, children's services were engaged and involved in project discussions, but have not played a large role in the project to date.

Workforce

Partners have articulated concerns about psychiatric provider shortages as well as challenges in hiring individuals with Licensed Master Social Worker (LMSW) certification. Because mobile crisis services do not count toward the LMSW clinical hour requirement, partners find themselves hiring individuals with LMSWs out of school when clinical positions are not available, only to lose staff to clinical positions when they become available.

Additionally, partners have expressed challenges within the proposed peer workforce staffing models. Two of the six counties have robust peer workforce networks, while the other four do not. Partners are anticipating challenges in hiring to support new models of service.

NEW YORK STATE | Department of Health

Efforts to mitigate challenges identified above:

Service Silos
CNYCC has highlighted partners and their range of services within and across counties, both on the project calls and at regional cross-project county meetings. CNYCC acts very much as a broker for partners looking for resources, and widely shares information when available. Public forums for sharing

Concerns About Sustainability
CNYCC has worked very hard to factor sustainability into decision making. Models adopted so far will act as bridges or pilots as Home and Community Based Services are rolled out to the rest of the state.

Request for Proposal Development and Approval Process
CNYCC is updating and shifting its RFP processes so that review and approval can be streamlined.

Engagement of Children's Services
CNYCC continues to do targeted outreach to children's services. CNYCC has also seen a leveraging of DSRIP activities to support non-DSRIP related children's initiatives, like contributing funding to organizations funded for mobile crisis to provide children's crisis response.

Workforce
CNYCC partner AccessCNY has done a lot to coordinate and link peer workforce infrastructures across six counties. Additionally, AccessCNY is proposing a central clearinghouse for open peer service-related positions across the region to help connect interested individuals with open positions in a way that protects privacy.

CNYCC's workforce strategy addresses provider training, education, recruitment, and retention.

Implementation approaches that the PPS considers a best practice:

CNYCC partners have identified the Parachute NYC respite center program as a model to adopt. This model was chosen in collaboration with county planners and has widespread support and promise to impact project outcomes. This model incorporates peer services in a way that the communities haven't seen. This model also taps into and supports a developing workforce and infrastructure.

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

CNYCC aims to develop collaborative relationships between partners, both within communities and across counties.

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

There have been no substantive changes to the target populations proposed in the initial application.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Central New York Care Collaborative, Inc.

Project: 3.b.i

Challenges the PPS has encountered in project implementation:

Gaps in Chronic Care Approaches

After surveying the partners involved in this project, CNYCC found large gaps in their approaches to managing patients with cardiovascular disease and/or hypertension as compared to a more population health management approach. Using the Assessment of Chronic Illness Care Survey, CNYCC assessed partners' participation in the six core strategies of the Chronic Care Model (healthcare delivery system organization, community linkages, self-management support, decision support, delivery system design, clinical information systems, and integrating chronic care model components). The cumulative results showed only basic support for chronic illness care as it applied to managing the patient population with cardiovascular disease and/or hypertension.

Limited Partner Engagement

CNYCC has seen limited provider and clinical engagement in our clinical workgroups and web-based project implementation calls. Many of our primary care representatives have mentioned competing priorities as a reason for their limited engagement, and most of the participation has come from DSRIP coordinators or other administrative staff. This means that only a small group of individuals are on hand to discuss clinical best practices, and all other partner representatives must take suggestions back to their organizations for review and feedback. In addition, although the providers involved in the work group are dedicated to the project, they also see patients, and in the current fee-for-service environment, this limits their availability to participate in DSRIP workgroups or project meetings. As a result, CNYCC has only been able to convene this work group on a bi-weekly basis, yielding slow progress in developing standards of care.

Technology Challenges

Another challenge in this project has been the need for manual record review to validate documentation and review patient self-management goals. Partners are working with their internal and vendor IT contacts to upgrade systems to be able to record reviews of self-management goals with patients. These system upgrades take time to develop and implement, resulting in slow progress for reporting actively engaged patients. Although we have met our patient speed goals in the last two quarters, currently, tracking actively engaged patients is largely manual, and the funds flow is insufficient to cover the cost of staff time to compile actively engaged patients.

Gaps in Patient-Centered Care

Another challenge will be working helping our partners evolve toward more patient-centered self-management support. More than half of our providers are not currently patient-centered medical home (PCMH) accredited, and have to this point been likely to provide self-management support by distributing

written information or connecting patients to community based resources without providing follow-up. Partners require training in motivational interviewing or brief action planning techniques, as well as an increased awareness of available community resources. As further evidence of our partners' lack of systematic follow-up, partners predominantly distribute New York State Smokers' Quitline materials instead establishing a more organization-wide focus on following up with patients who smoke and using the more proactive "Refer to Quit" program.

Partners are currently not linking patients with community resources in any systematic way. Often, partners lack of awareness of resources to help promote self-management, and there is little collaboration between public health and the healthcare delivery system. For example, most partners are unaware of the best practice Stanford Model of Chronic Disease Self-Management classes, which are currently available in all six of our counties.

Establishing Care Coordination Teams

Another challenge for our partners is the project requirement to set up care coordination teams that would include bringing pharmacists, dieticians, behavioral health providers, and care management specialists to their practice sites. Most of our primary care sites do not have access to these members of the care team, and have historically done care coordination with a referral coordinator. Partners will have to seek partnerships or cooperative agreements to meet this functional requirement. CNYCC has observed an overall lack of resources to meet the demand and concerns that the current billing limitations and available financing will create a financial burden for partners.

Provider Shortage

There is a shortfall of engaged primary care providers in this project. Because they are operating under a fee-for-service payment model, partners have a competing priority to see as many patients as possible each day. The population health work that is integral to this project is not currently compensated to cover the cost of implementation and tracking. Engaging our primary care providers in this project work is critical, but CNYCC is currently falling below our established goal of 80% actively engaged providers. If providers are not engaged, patients will not have developed and documented self- management goals, affecting both their health and our patient engagement numbers. This is especially true of a number of non-safety net private practices that accept and treat Medicaid patients but do not consider the small amount of available funding worth their transformative efforts.

Efforts to mitigate challenges identified above:

Gaps in Chronic Care Approaches

One way to improve population management of chronic illness is through training. CNYCC has hired a full-time staff member dedicated to workforce and training facilitation. We are currently seeking multifaceted avenues to train our partners on the benefits of an organizational approach and evidence-based "best practices." In the next section of this document, we discuss one example of this sort of is the training planned for tobacco use as explained in the next section.

Limited Provider Engagement

In addition to discussing strategies in the project implementation and learning collaborative sessions, CNYCC's project manager continues to reach out to partners and prospective partners to get additional engagement in this project. CNYCC is making every effort to inform partners of the cross-project requirements and to alignment activities with the PCMH model and value-based payment models. This has

been a focus on many of the project implementation collaborative discussions as well as one-on-one meetings and during PCMH training. As CNYCC's partners move through their transformation journeys and receive more clarity on upcoming value-based payment expectations, CNYCC expects to see an increased organizational focus on population health and provider engagement. CNYCC is also currently reviewing the project implementation plans and identifying additional technical assistance that we may need to employ in order to help each partner successfully during this implement this project.

Technology Challenges

CNYCC staff met with staff from MEDENT, an electronic medical record (EMR) vendor used by a large group of healthcare delivery partners with the most prevalent EMR, to facilitate report build and workflow automation to meet project requirements. A small group of organizations has been testing the report and the data input in order to develop workflows and workflow automation that align with the reporting requirements and care planning needed for both cardiovascular disease mortality and PCMH. The next step is a MEDENT cohort, which is expected to meet next month to collaborate on establishing reports, workflow automation, and clinical decision supports that align with this project and with transformative activities required for PCMH recognition.

Gaps in Patient-Centered Care and Establishing Care Coordination Teams

CNYCC intends to purchase and implement a population health management platform that will improve data analytics, facilitate care coordination, identify vulnerable populations and health disparities, and drive care management to patients who can achieve improved health outcomes. This platform will help reduce the significant internal resources required when organizations inefficiently use care coordination and care management resources, and will also help primary care practices target patients with the greatest potential to improve health outcomes.

Implementation approaches that the PPS considers a best practice:

Collaborating with Other Organizations

CNYCC has developed a partnership with a community based organization, the Central New York Regional Center for Tobacco Health Systems. We are currently working on the implementation plan to roll out both EMR decision supports for the "5 As" of smoking and referrals to the New York State Smokers' Quitline. Although CNYCC does not plan on being prescriptive, we anticipate that our partners will choose the "Refer to Quit" over the "Opt to Quit" program due to the expense of implementing more significant changes to their existing systems. In addition, this partnership offers training to our ambulatory staff, along with continuing education credits on the "5 As" model, pharmacologic therapy and the New York State Smokers' Quitline. We anticipate producing web-based training from the live training in order to facilitate trainings to clinical staff to participate on their own schedule.

CNYCC is also pursuing a partnership with the Therapeutic Research Center to maintain up-to-date, evidence-based point of care pharmacotherapy for hypertension, consistent with the project requirement for fixed dose or combination therapy. This partnership will offer our clinicians access to the resources of Therapeutic Research Center with a simplified chart and access to further information through a web-based link maintained by pharmacists through the Therapeutic Research Center.

Best Practices Clinical Work Group

CNYCC has deployed a clinical work group to make recommendations on best practices and evidence-based medicine. Following approval by our clinical governance committee on evidence-based guidelines for

hypertension, elevated cholesterol, and fixed dose and combination hypertension medications, we are now working through copyright issues to be able to officially publish the algorithms ahead of the project requirement for training and clinical decision support.

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

CNYCC is redesigning our project implementation collaborative, which has thus far been project-focused and CNYCC-led, into a learning collaborative model with a focus on cross-project implementation strategies and rapid cycle improvement by cross functional teams. For example, the new design will feature an outpatient/ambulatory care learning collaborative with a focus on the significant overlap between project requirements and practice transformation activities. CNYCC would set up rapid cycle teams to develop and implement specific activities that are integral to project success.

CNYCC is also working collectively and strategically with our partners to inform and align cross-project requirements with aligned implementation strategies to achieve National Committee for Quality Assurance PCMH 2014 level 3 recognition. These efforts will ensure that CNYCC's partner organizations implement processes that support multiple project activities, reducing confusion and redundancy. The collaborative sessions will be more partner-led, with project manager facilitation.

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

The initial application identified that the target population for this project would be any adult Medicaid members in the six-county area with either pre-existing cardiovascular disease diagnoses or the risk factors of hypertension, hyperlipidemia, or smoking. CNYCC's community needs assessment identified cardiovascular disease and hypertension as prevalent diagnoses among the adult Medicaid patients in our six-county region. The clinical work group made the decision to focus on patients with existing cardiovascular disease and those with hypertension diagnoses, due to its more direct risk for cardiovascular disease in comparison to hyperlipidemia and smoking.

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: Central New York Care Collaborative, Inc.

Project: 3.g.i

Challenges the PPS has encountered in project implementation:
One of the most significant challenges encountered in project implementation has been the lack of primary care practice (PCP) engagement. There has been strong engagement from a small group of committed partners that includes DSRIP coordinators, hospice care physicians and staff, two physicians who are palliative care specialists not located in a patient-centered medical home (PCMH) primary care practice, and project leads, in addition to partners who have not signed addendums with CNYCC. However, it has been very difficult to engage physicians in the work group and project implementation collaborative (PIC) meetings whose practices will be implementing palliative care in their PCMH setting. CNYCC recently learned that this is primarily occurring because those partners who have signed contracts for 3.g.i. have been struggling to identify which PCPs in their respective organizations would be asked to participate in the project.
Efforts to mitigate challenges identified above:
CNYCC has employed several strategies to mitigate the lack of PCP engagement. The 3gi project manager initially sought feedback during PIC meetings in order to develop plans with PIC partners for PCP and physician engagement. After CNYCC determined the resulting feedback to be infeasible, the project manager asked to meet individually with DSRIP coordinators or project representatives to develop engagement strategies specific to their respective organizations. During these individual meetings, partners shared that they had not yet identified specific PCPs to approach for engagement in the project. In response, CNYCC changed the focus of these individual meetings. In the new iteration, the project manager and the partner representative identified PCPs that would be able and willing to implement the project, discussed strategies for approaching the PCPs, and identified organizational supports, such as administrators or other champions who could help promote the project within the organization. In addition, CNYCC's palliative care project manager has worked closely with CNYCC's practice transformation project manager to assist partners with the integration of palliative care into the PCPs.
Implementation approaches that the PPS considers a best practice:

Although this project is still in the early stages of development, CNYCC has developed a preliminary model, including an evidence-based assessment tool to help identify appropriate patients for palliative care services. This instrument, called the Supportive and Palliative Care Indicators Tool (SPICT) includes the inclusion of two or more general indicators of deteriorating health. These indicators include patient performance status, dependency due to physical or mental health issues, two or more unplanned hospital admissions in the past six months, significant weight loss or low body mass index, persistent symptoms despite optimal treatment, and direct patient requests to enroll or withdraw from treatment. SPICT also includes clinical indicators for palliative care, such as cancer, dementia and frailty, neurological disease, heart and vascular disease, respiratory disease, kidney disease, and liver disease.

Other best practice indicators determined by the palliative care project PIC include one general indicator (two or more emergency department visits in the past six months) and several clinical indicators (chronic pain, HIV/AIDS, and severe mental illness). Best practice, as it relates to PCMH, would dictate that providers would identify these patients prior to the patient's appointment as part of the PCMH pre-visit planning activities. Identification of patients who may be eligible for palliative care services will then be engaged in the completion of the Palliative Outcome Scale (POS). CNYCC is currently forming a work group to standardize palliative care standards and protocols to align with the New York State Department of Health-issued Palliative Outcome Scale.

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

CNYCC has identified a need for palliative care-specific training to help support project implementation. As a result, CNYCC and the palliative care PIC have explored training options, including workshops and seminars offered statewide through the Hospice and Palliative Care Association of New York State. CNYCC has also explored obtaining a Center to Advance Palliative Care membership to access the organization's literature clearinghouse and online trainings for continuing education units and medical education units.

In addition, recognizing the importance of the Medical Orders for Life-Sustaining Treatment and electronic Medical Orders for Life-Sustaining Treatment to help eligible patients prevent unwanted treatment, CNYCC reached out to Dr. Patricia Bomba, a recognized palliative and end of life care expert, for help implementing eMOLST across different care settings.

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

After implementing the SPICT tool for assessing patients for palliative care services, CNYCC made one change with respect to the project's initial proposed target population. The initial application noted that CNYCC partners would use the following assessment indicators to identify patients for palliative care: one or more emergency department visits, one or more inpatient visits, or three or more outpatient visits in three months.

The work group and PIC also decided to include the criterion of two or more emergency department visits in the past six months. The developed model did not include the number of outpatient visits as a potential indicator for palliative care service eligibility.

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: Central New York Care Collaborative, Inc.

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:
Collaboration Most of the challenges within this project involve cross-systems engagement. Although mental health and substance use systems currently prioritize infrastructure improvement, the same is not evident for medical providers, who play an integral role in prevention and in devising multi-disciplinary solutions to community health needs. **Cross-Project Coordination** This project has considerable overlap with all other CNYCC projects. Communicating and operationalizing those overlaps is challenging due to this project's complexity and open-endedness.
Efforts to mitigate challenges identified above:
Collaboration and Cross-Project Coordination CNYCC has initiated open and widespread dialogue with partners to identify parallel initiatives, identification of overlap when community initiatives are made known, and widespread communication back to partner groups in order to make others aware of good work being done in the community.
Implementation approaches that the PPS considers a best practice:
Local government units have been critical to developing activities and initiatives in this project. Their heavy involvement has created important momentum, as they have considerable knowledge about communities, including provider networks, patient/consumer needs, and challenges faced by all parties.
Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
CNYCC is identifying and creating synergies between existing coalitions that are forming across projects. New partner webinars serve as a communications tool across projects. Ultimately, the project aims to reduce the burden on providers and capitalize on existing meetings to accomplish similar goals.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
Initially, tobacco users were identified as a target population for this project, but CNYCC did substantial work to identify priorities for project activities given the broad scope. Priority areas include: depression/suicide, substance-use, and individuals with serious mental illness.

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: Central New York Care Collaborative, Inc.

Project: 4.d.i

Challenges the PPS has encountered in project implementation:

Clinician Participation

CNYCC encountered several challenges while attempting to assemble a clinical work group of partners to draft a definition for "high risk" patients and link to appropriate levels of prenatal care services. It was difficult to find clinicians who could accommodate the work group schedule. Having clinician participation was perceived as critical to our ability to formulate the "high risk" definition.

Maintaining Project Timelines

CNYCC had difficulty maintaining the project timeline for developing clinical standards protocols for prenatal care providers. It was important to seek subject matter expertise from a key local physician champion to assist with the development of a plan to create standardized protocols for prenatal care who had limited availability to participate at the proposed time when the partners were developing their plans.

Efforts to mitigate challenges identified above:

Clinician Participation

In order to mitigate the challenges identified above, CNYCC requested help from our partners in identifying a clinician who would be able to participate in the clinical work group. A practicing OB-GYN participated in our work group, along with both inpatient hospital providers and outpatient community-based prenatal care providers.

Maintaining Project Timelines

CNYCC adjusted our timeline to involve the key local physician champion, whose input proved to be valuable in developing the request for proposals for this project's clinical standards component. The physician champion and staff of the Regional Perinatal Center helped provided input on priority prenatal care data elements that have been useful in targeting prevention of preterm births.

Implementation approaches that the PPS considers a best practice:

An approach that CNYCC considers a best practice for this project is eliciting input from prenatal care providers within the participating region, particularly our Regional Perinatal Center. Their knowledge, accompanied by their enthusiasm and passion for this work, has proven to be valuable and provided pertinent insight into this project's targeted development.

NEW YORK STATE | Department of Health

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
There are no additional details to report at this time.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
There have been no substantive changes to the target populations proposed in the initial application.