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DSRIP Independent Assessor

Mid-Point Assessment Report

North Country Initiative PPS

Appendix PPS Narratives

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

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DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Samaritan Medical Center

Highlights and successes of the efforts:

Governance:

All nine prescribed Governance Milestones are 100% complete. NCI has its governance structure fully in place, with a highly engaged clinician led Board of Directors, and a full committee structure that is representative of partners from across all sectors of the PPS including, hospitals, long-term care facilities, primary care practices, specialty practices, behavioral health, alcohol and substance abuse providers, OPWDD providers, prevention providers, independent living centers, advocacy groups, education partners, public health, FQHCs, local government units and multiple other CBOs serving the target population.

The North Country Initiative is hospital capitalized, physician led organization operating with a Delegated Model of governance. The North Country Initiative was originally formed in 2011 as a collaboration of hospitals and independent physicians who realized that change in the regions healthcare delivery system was needed. This group of forward thinking and engaged physicians and healthcare executives determined to create a vision and chart a new course for clinical care and for health in the region. The North Country Initiative partnering hospitals and physician leadership went through an intensive planning process in 2012 and 2013 and evolved into the basis for the existing governance through collaboration and trust focused on improving the regional healthcare delivery system. NCI has a robust history of success with implementing change, demonstrated through regional project implementation in areas like quality improvements, IT advancement, and physician engagement.

The executive governance body of the NCI is a representative Board of Managers which holds accountability for all aspects of Finance, Clinical, Compliance and IT governance. Through this model, transitions in governance structure have been realized which include adding behavioral health providers and community members to the Board of Managers expanding the committee structure to include the DSRIP Project Advisory Committee, a population health committee, behavioral health committee, health literacy and cultural competency committee, care connections committee and workforce committee and expanding and resourcing DSRIP goals and deliverables to each of the governance committee's responsibilities.

A best practice has been to have elected representation on the finance committee from each sector so that when funds flow decisions are made the representative groups can inform how those decisions will impact their sector with a clear understanding of the reimbursement or other funding structure of those they represent.

The speed and efficiency of the model of governance created by the NCI has been and will continue to be critical to DSRIP success. This governance has demonstrated that it is well-integrated, high functioning and prepared to implement new care delivery models and lead meaningful change on behalf of the people we serve.

NCI governance continues to push for a culture change in healthcare from encountered based reimbursement to a system focused on care plans, care coordination, and preventative medicine. NCI works through committees particularly the Population Health Management committee, the Health Literacy and Cultural Competency Committee,

the Medical Management Committee, the Board of Managers, and the Medical Directors to continue to shift the culture and beliefs of the region.

One of the best practices has been creating individualized Implementation Plans for each partner in the PPS and meeting in person to discuss their role in DSRIP. These plans have been well received by the PPS partners and give the partners a concrete basis for how to focus their efforts. Additional communication strategies that have been effective are the creation of customized DSRIP 101 video, Fast Facts and DSRIP in a Nutshell.

Workforce:
All 5 prescribed milestones are 100% complete and all training and new hire targets have been met. In consultation with workforce partners, the NCI outlined the current state of the workforce against the future needs to identify new hire or new training requirements. The transition roadmap, the compensation and benefits report and a detailed assessment of the job titles by licensure requirement were used to inform this process.

Sample trainings include:

- PAM: approximately 70 trained with ongoing refresher courses
- Blood pressure measurement: customized video created and launched via SurveyMonkey. Over 100 clinicians have been trained.
- DSRIP 101: customized video created and launched via SurveyMonkey. Over 3000 trained
- Bridges out of Poverty: approximately 55 trained. Collaborations with AHI PPS. NCI has developed 3 lifetime trainers in the region.
- Chronic Care Professional: 13 primary care nurse care managers trained, 10 in progress. Plans for 3rd cohort as this is a requirement for Primary Care Practices who will be resourced with funds for care management.
- SBIRT & Tobacco Dependence Treatment: 6 trainers in the region, over 200 trained. 3 Tobacco Dependence Treatment Specialists.
- Community Health Worker: 22 trained last April. Seeking to bring another training in the future.
- PCMH Certified Content Expert: 11 in the region including NCI project staff and one from each of the 6 hospitals, the 2 FQHCs and an independent PCP office.
- Depression Care Manager/Collaborative Care/IMPACT: 5 trained, 3 in progress. Intro webinar conducted (50 attendees). Coaching calls with AIMS Center. Dr. Meny's practice participating in OMH Learning Collaborative and identified as regional Subject Matter Expert. Onsite training with AIMS (25 attendees – PCMH staff, PCP, NP, RN, LPN and Office Manager), Consulting Psychiatrist hired (8 hrs/week).
- North Country Care Coordination Certificate Program: 75 completed training from SUNY Jefferson & SUNY Canton. Transitioning program from PPS to the SUNY colleges. Participation in NYS committee to develop state guidance. Dean of Continuing Education from JCC presented to SUNY Chief Academic Officers.
- Compliance: 104 entities – over 100 trained.
- Health Literacy, Cultural Competency, MEB Promotion, Prevention & Treatment: NCI customized video, evidence based practices identified, MEB promotion, prevention and treatment video and PSA development underway, Ask Me 3 Patient Education Campaign underway.
- Health Information Exchange & HIPAA, Privacy and Security: over 60 entities trained by HealtheConnections, over 50 trained on HIPAA, Privacy and Security (PMO Office).

The NCI developed a Provider Incentive Program to assist with the recruitment of primary care providers, behavioral health providers and dentists. In DY1, there were 12 awards totaling approximately $1.2M (2 NP, 4 PCP, 2 PA, 1 Psychologist, 1 Psychiatrist, 2 Dentist) and in DY2, there were 10 awards totaling approximately $1.5M (2 PCP, 1 PA, 1 Psychologist, 1 Psychiatrist). Another round of funding will be distributed in DY3.

The NCI is exploring the expansion of Graduate Medical Education to multiple regional facilities. The NCI would use DSRIP funds to support a resident slot and appropriate programmatic expenses. As a result, the resident would rotate through various settings within the region and commit to no less than 3 years to the region upon completion of their

training. Also, on behalf of the region, the Fort Drum Regional Health Planning Organization, a non-profit, will be submitting an application for the GME Development of Rural Residency Programs grant issued by NYSDOH (due Aug. 15th).

Compensation & Benefits Analysis: worked with Iroquois Health Alliance (IHA) to collect data. IHA worked with 6 PPS. NCI was the 1st PPS to finish the survey among the 6 PPS (78% participation rate). An Executive Summary was shared with partners and a 6 PPS aggregated report was shared with the PPS increasing our ability to see how our PPS compares and allowed us greater access to wage data as it relates to anti-trust rules.

The workforce roadmap was created early on and is used as a resource for implementation planning across projects.

Program proposals underway: resource funds to hospitals and primary care practices for care management, an LCSW recruitment program and a Certified Diabetes Educator recruitment program.

Other highlights: presented at All PPS workforce meeting in Albany (June), featured in DSRIP spotlight, participated in call with DOH (rural health council) regarding rural physician recruitment and retention and presenting at NYSARH conference in September.

Challenges/Concerns: workforce reporting burden (staff impacts) – cross walking: time requirement, limited value add, concern with validity of job title cross walked to state title, and ongoing reporting requirements although all training and new hire targets have been met.

Performance Reporting

All performance reporting milestones due have been 100% complete. The PPS has made significant progress in tracking PPS and Provider level progress after the acquisition of project management software, Performance Logic and the completion of individual implementation plans with each participating entity. Upcoming for the final milestone due September 30, 2016, a performance reporting training program is being developed that will train NCI project leads, DSRIP project coordinators, and providers in reporting on the Domain 2 & 3 Projects. A large part of this performance reporting training will cover the population health management tool, Lightbeam, recently acquired by the NCI PPS.

IT Systems

All five of the prescribed IT Systems milestones are 100% complete. This includes an assessment and gap analysis, an IT change management strategy, the development of the PPS roadmap to clinical data sharing, and engaging attributed members in the QE. Of particular note are the IT data security and confidentiality plan activities highlighted below:

- Health Information Exchange & HIPAA, Privacy and Security: over 60 entities trained by HealtheConnections, over 50 trained on HIPAA, Privacy and Security (PMO Office).
- Development of the SSP around the cloud-based PHM tool in order to fully secure the Medicaid data and integrate it with the clinical data to produce a comprehensive clinical decision support and cost-utilization platform to support DSRIP initiatives.
- PPS's Chief Information Officer shared best practices at the NYS Cybersecurity conference in Albany.
- A high-level security gap analysis has been completed and has allowed the PPS to focus efforts on higher-risk entities.
- A high-level security and data confidentiality plan has been completed.
- Currently engaging an outside, impartial entity to perform an independent security risk analysis for the PPS.

The NCI PPS continues to build upon initial investments to support the strategic value-based purchasing transformation for the region.

Practitioner Engagement

Each of the two Practitioner Engagement prescribed milestones are 100% complete. To date, three Medical Directors have been hired representing the three counties within the PPS. Within every project, a physician lead has been assigned to ensure clinically driven processes and outcomes. Providers are represented at all committees within the governance structure, which report to a physician led Board of Directors. The PPS includes a total of 44 Article 28, FQHC and Independent Primary Care Practices, each of which has received funds flow and substantially participate in projects.

Clinical Integration:

Each of the two Clinical Integration prescribed milestones are 100% complete. The Clinical Integration Strategy was created for PPS wide Implementation of the four pillars of Clinical Integration which are Provider Leadership (governance body with strong physician leadership, compliant legal structure, payer strategy, culture change, employ team of 3 part-time contributing Medical Directors), Aligned Incentives (physician compensation, program infrastructure, physician support), Clinical Care Management Programs (disease programs, case management protocols/care coordination, clinical metrics, population health management), and Technology and Data Infrastructure (Health Information Exchange, patient longitudinal record, disease registry, patient portal). It was adopted by the NCI Board in March 2016 and work continues. The NCI has been engaging in the building of these pillars since 2011 and is a physician lead, clinical driven initiative.

Cultural Competency and Health Literacy

Each of the two Cultural Competency prescribed milestones are 100% complete. The PPS HL & CC Committee has leveraged focus group feedback, health data, literacy rates, and provider information to develop a robust strategy to train providers and build patient capacity. Aligned with the PPS-wide strategy, a NCI customized provider-facing training video has been developed for regional deployment. Additionally, the PPS has begun curating patient education materials to ensure that at-risk community members will have the tools they need (and which were requested during focus groups) to sufficiently partner with their provider during the care experience. The PPS has also supported training for three partners to become master trainers for the Bridges Out of Poverty curriculum aimed at addressing the unique needs of the target population. In addition the PPS is developing a provider facing video training and public facing PSAs to promote MEB cultural competence in clinicians for assisting individuals with mental illness and substance abuse disorders and in the public for understanding and reduction of stigma.

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Population Health Management

All performance reporting milestones due have been 100% complete. The PPS has developed a Population Health Roadmap, to demonstrate the Performing Provider System's vision of an effective, high-quality delivery system. To this end, the Roadmap references the three critical components of impactful Population Health Management:

- Information-powered clinical decision support
- Primary care-led clinical workforce
- Patient engagement and community integration

The document outlines the implementation of the technology, the development of the team and the identification of the targets for our PPS Population Health Management approach. The PPS will leverage a robust disease-registry, PCMH-adoption, and ongoing patient engagement approaches to fulfill the tenets of the roadmap.

Budget and Funds Flow

All budget tasks and milestones are 100% complete. The PPS Finance Committee meets at least monthly and often bi-weekly to ensure that budget, finance and funds flow task and deliverables are on target and monitored. The PPS will continue to report funds flow and revisions to funds flow distribution policy and procedures. Every PPS signed Participating Partner Entity has received Phase one funds flow.

Financial Sustainability

All financial sustainability milestones due have been 100% complete. This includes the PPS finance and reporting structure, the current state and financial sustainability strategy and the compliance plan. Outstanding Financial Sustainability milestones are on target. The PPS continues to monitor financial stability of our essential partners. Financial Sustainability milestones regarding value-based payment have yet to define validation documents as well as define end dates. The PPS is moving forward with the tasks and pursuing the opportunity to become a VBP Pilot.


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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: Samaritan Medical Center

Project: 2.a.i

Challenges the PPS has encountered in project implementation:

1. Engaging MCOs – PPS had initial difficulty engaging MCOs
2. DIRECT – Multiple safety-net providers' EHRs have proprietary messaging systems and require additional financial or human resources for implementation to effectively communicate using a HISP in the DIRECT trust.
3. Bi-Directional Exchange – The majority of safety-net providers' EHRs are capable of sending and receiving CCD/CCDA messages to the RHIO/Qualified Entity however some exceptions apply due to vendor systems.
4. Population Health Management Tool (Patient Registries) - The PPS had to undergo a switch of PHM vendors, causing a delay in utilizing a PHM platform for DSRIP deliverables however the PPS is still on target to meet deliverables

Efforts to mitigate challenges identified above:

1. Engaging MCOs – Utilized various NYS meeting and other ACO networking opportunities to engage with MCO leadership and build the connection to begin the conversation. Now meeting with MCOs are underway.
2. DIRECT – Distributed instructions and recommendation to switch to the DIRECT trust with the option to use the RHIO web-based messaging capabilities as an alternative. Have escalated this through the CIO leadership group to NYS DOH for assistance with vendor system requirements.
3. Bi-Directional Exchange – PPS has leveraged HealtheConnections, to engage vendors due to the larger footprint that the RHIO covers (19 counties) and in the event a Safety-Net provider vendor cannot/will not provide bi-directional capability the PPS will leverage DIRECT for secure electronic care coordination.
4. Population Health Management Tool (Patient Registries) – Currently implementing the comprehensive registry and have high confidence that the tool will meet the DSRIP requirements and future needs of the PPS.

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Implementation approaches that the PPS considers a best practice:

1. Key performance indicators (KPIs) and regular contacts with project leads at each partners.
2. Use of Performance Logic performance management software and individual implementation plans for each signed partner.
3. PPS has engaged the RHIO and is fully leveraging the HIE capabilities point of care and coordination.
4. Partner engagement and involvement in the data documentation and acquisition is critical to successfully utilize a PHM tool.

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

Telemedicine is being deployed across the PPS region as a means to engage with specialty providers and provide access to consultation for Collaborative Care, Certified Diabetes Educators and for care management staff to network and provide comprehensive coordination across the delivery system.

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

There have been no changes to the proposed population served. Based on ongoing assessments of our community, conditions continue to align with outcomes reported in our community needs assessment. Through our work with health departments, community-based organizations, and hospitals, we intend to monitor community needs throughout the life of DSRIP.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Samaritan Medical Center

Project: 2.a.ii

Challenges the PPS has encountered in project implementation:

1. One entity with five sites became at risk of not achieving PCMH due to engagement and resource allocation.
2. An additional challenge is ensuring that the work completed by PCMH practice level contacts is being pushed through to completion or final approval status at larger entities with more complex adoption and approval processes.
3. A third challenge is ensuring the primary site is fully engaged to begin and fulfill the PCMH transformation.
4. Some vendors' EHRs do not currently have the functionality to fully support PCMH.

Efforts to mitigate challenges identified above:

1. The PPS has implemented an action plan and detailed timeline to keep entities at risk on track.
2. The PPS has established goals, timelines, and deadlines with the entities of concern to ensure work is pushed through to completion.
3. Regularly scheduled meetings have been set up with the primary sites to work on specific tasks; additionally, summary status updates are reported to executive leadership.
4. Challenges have been reported to New York State via CIO Leadership committee. NYS is hosting a vendor fair to engage vendors in supporting DSRIP requirements, including PCMH

Implementation approaches that the PPS considers a best practice:

1. NCI had built on previous experience and phased all primary care sites so that PCMH staff can spread apart the certification processes for the larger entities.
2. Capitalized on the success of the initial PCMH 2014 Level III implementation by including the champion provider in clinical leadership with all subsequent PCMH implementations.
3. Established clinical leadership in all three counties for the partners involved in the PCMH project for DSRIP.
4. NCI has engaged key personnel at PC Practices for PCMH training. To date 13 key personnel have completed NCQA PCMH Content Expert training.

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

1. NCI has detailed plans in place for all 42 participating primary care sites.
2. Two primary care sites have already achieved 2014 Level 3 PCMH certification.
3. Thirteen key personnel have completed the NCQA PCMH content expert training.
4. In support of 3.a.i. with cross support for the BH components of PCMH fifty partners completed the IMPACT Model webinar with the University of Washington AIMS Center, five individuals have been trained as Depression Care Managers and three are in the process of completing the training

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

Based on ongoing assessments of our community, conditions continue to align with outcomes reported in our community needs assessment. Through our work with health departments, community-based organizations, and hospitals, we intend to monitor community needs throughout the life of DSRIP.

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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: Samaritan Medical Center

Project: 2.a.iv

Challenges the PPS has encountered in project implementation:
1. Lack of capital funding – no capital awards in NCI region 2. November 2015 NYS DOH re-designation of providers created major challenge to meet Non-PCP speed and scale commitment
Efforts to mitigate challenges identified above:
1. The six medical villages project scope has been adjusted while still meeting deliverables a. Will still meet 8-Bed PPS reduction b. Projects in medical villages meeting multiple deliverables i.e. also 3.a.i. integration 2. Appealed for change of designation per appeals process – awaiting answer from DOH
Implementation approaches that the PPS considers a best practice:
1. Providing strategic and implementation plan templates to facilities ensuring they are addressing all required elements 2. Hospital CEO's are the Med Village project leads therefore ensuring buy-in and hospital board approval process is followed 3. CEO Executive Committee serving as service utilization monitoring team to ensure regional approach.
Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
1. Each facility is in planning process and having meetings both of the SUM Team, their internal team and the PPS Project lead. a. On track to have individual Strategic Plans completed and approved by Hospital Boards by September 30, 2016 and to SUM Team for NCI compilation to go to NCI Board by December 31, 2016 2. All but one have a Behavioral Health and/or integration of Primary Care as a component 3. All seek to increase access to care based on community needs assessment 4. Focus is moving to outcome rather than process measures

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
Based on ongoing assessments of our community, conditions continue to align with outcomes reported in our community needs assessment. Through our work with health departments, community-based organizations, and hospitals, we intend to monitor community needs throughout the life of DSRIP.

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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: Samaritan Medical Center

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:
1. Identifying members of the care team (care manager in particular) and an accurate primary care provider upon hospital or ED admissions is a challenge as this is not currently being requested or because it is based on patient provided information. 2. RHIO capabilities in regards to protocol development may present some challenges (i.e. inability to filter information (providers note they have information overload). 3. The lack of a universal care plan creates challenges, as there is not one single source of truth for providers across the integrated delivery system. 4. The transparency of health home quality data remains an issue. Patients and providers should be made aware of the quality of downstream providers and thus be given a choice of where they seek care.
Efforts to mitigate challenges identified above:
1. **Identifying members of the care team and PCP**: To overcome this barrier, part of the Care Transition Protocol requires staff to request this information from the patient at time of admissions. Additionally, NCI continues to determine opportunities for provider empanelment. 2. **RHIO Capabilities:** The PPS continues to engage the RHIO in dialogue to better understand its current and potential functionality for the future. The PPS is also exploring opportunities for providers to subscribe for patient alerts based on certain criteria (i.e. med-high risk patients only). The PPS will continue to engage partners to identify needs and guide the process in coordination with the RHIO. The RHIO has also been engaged through demonstrations, question and answer sessions with committees and trainings for users. 3. **Lack of universal care plan:** The PPS will continue to explore ways to leverage the Population Health Management tool in this regard. NCI will also require the use of direct messages or other as equally secure electronic means to ensure providers are communicating in a private, secure manner as it relates to the care management/coordination of patient information. 4. **Health Home data:** NCI continues to collaborate with the regional health home to identify opportunities for data sharing. Additionally, NCI has escalated the request for Health Home agency to be able to share data with PPS to NYS DOH.

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Implementation approaches that the PPS considers a best practice:

1. The NCI developed the North Country Care Coordination Program from the ground up. Front line staff, subject matter experts, clinical and academic partners were all engaged in program development and implementation. This program was utilized as a model for the development of NYS guidance related to Care Coordination training and the NCI served on the state workgroup responsible for developing this guidance document.
2. The CNY Health Home has embedded care managers at the hospital, public health, at an independent primary care practice, at the Watertown Urban Mission and at an FQHC. This has enhanced early identification of health home eligible patients and a smooth transition to care managers when a patient is outreached and successfully accepts the referral.
3. The NCI is resourcing care management dollars to hospitals, primary care practices and community health workers/patient navigators to help offset costs. These incentive funds are deliverable based (project specific). These care managers will complete necessary training to ensure they are adequately prepared for the defined responsibilities.

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

1. The Care Connections Committee has identified key components of the protocol and have just completed an IT feasibility assessment related to the draft protocol. The protocols have been approved by the Care Connections Committee and the NCI Medical Management Committee. Once adopted, appropriate staff will be trained and individual hospital meetings will be held with project leads, Chief Medical Officers and Chief Information Officers to ensure buy in and successful implementation.
2. Subject Matter Experts have been identified for the following care settings: primary care, hospital, community-based and nursing home. These experts have been instrumental in the development of protocols and incentive funds are flowing to these partners for their enhanced participation.
3. Each participating partner entity received an implementation plan indicating that they must identify and refer health home eligible patients. This is also incorporated into standardized protocols. The number of health home downstream providers has increased based on the increase of referrals and utilization of the health home. Agreements between health home and hospitals are underway, allowing care managers access to visit patients within the facility prior to discharge. Additionally, the health home has an embedded care manager in the hospital, at an independent primary care practice, at one of the FQHCs, at the Watertown Urban Mission and at Public Health. Discussions with other partners is underway to replicate this model.
4. The Care Connections Committee, Finance Committee and NCI Board have approved a budget to resource hospitals and PC clinics for care management. NCI executing MOUs with identified eligible entities. Additionally, NCI is developing a plan to resource CHWs, patient navigators and peer supports. We will then develop an inventory of all care managers in the region across care setting to ensure continuity of care and warm hand off across the integrated delivery system.
5. The NCI developed a Care Coordination Certificate Program in partnership with SUNY Jefferson and SUNY Canton. 39 students completed the program in cohort 1 and 36 students completed the program in cohort 2. Additionally, 13 individuals completed the Chronic Care Professional Training and 10 more are in the process of completing the training.

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
There have been no changes to the proposed population served. Based on ongoing assessments of our community, conditions continue to align with outcomes reported in our community needs assessment. Through our work with health departments, community-based organizations, and hospitals, we intend to monitor community needs throughout the life of DSRIP.

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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: Samaritan Medical Center

Project: 2.d.i

Challenges the PPS has encountered in project implementation:
1. One prevailing challenge with project 2.d.i. has been obtaining high-quality and valid survey responses from the target population. This PPS, much like several across the state, has received a high percentage of completed surveys which indicate minimal room for score improvement. These observations do not align with the expected survey results, nor with project goals. 2. Another challenge has been encountered as the PPSs attempt to develop a procedure to ensure the proper handling of PHI within Flourish by the community based organizations.
Efforts to mitigate challenges identified above:
1. The PPS has worked and is working with Insignia to secure additional trainings and improve the quality of trainings offered within the region by creating two master trainers who can maintain the fidelity of the trainings throughout the course of DSRIP. 2. To assure health information is protected, the PPS will be providing guidance, templates and tools to the community based organizations as needed.
Implementation approaches that the PPS considers a best practice:
To disseminate the PAM training and secure valid surveys, the PPS has trained coaches to provide on-site trainings within their organizations. This approach has ensured that each partner organization has the capacity to achieve their patient engagement targets.
Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
The PPS is on track to meet all process deliverables and is working to ensure fidelity in the surveys so improvements can be captured to meet outcome deliverables.

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
Based on ongoing assessments of our community, conditions continue to align with outcomes reported in our community needs assessment. Through our work with health departments, community-based organizations, and hospitals, we intend to monitor community needs throughout the life of DSRIP.

NEW YORK STATE | Department of Health

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PPS Name: Samaritan Medical Center

Project: 3.a.i

Challenges the PPS has encountered in project implementation:
1. Model 1 – Integration at Primary Care Site a. Still questions regarding separate Article 31 and Article 32 clinics providing co-located and integrated services onsite with Article 28 practices as proposed in the NCI application. b. DOH 3.a.i. guidance that Article 28 sites can only bill for LCSW for under 21 and post-partum has created confusion as Article 28 site can bill BH for all utilizing LCSW-R which has not been included in the guidance. This has slowed planning at some sites 2. Model 2 – Integration at Behavioral Health Site a. NCI had identified three Article 31 clinics serving the highest single site concentrations of Medicaid BH patients in the rural counties. However, due to the rurality of the region, the volume needed to support on-site Primary Care at each site is 4-8 hours per week. DOH came out with new guidance in July of 2016 that Primary Care would have to be on-site for at least 16 hours at the BH site to participate. NCI BH Clinics do not have the volume to support this. 3. Model 3 – Impact Model (Collaborative Care) a. Our small, rural primary care practices in most cases do not employ RNs or LCSWs, as such, the identified care managers are often times LPNs. Some treatment techniques such as Problem Solving Treatment are outside their scope of practice as LPNs.
Efforts to mitigate challenges identified above:
1. Model 1 – Integration at Primary Care Site a. Article 28 sites are redesigning their implementation plans and rather than co-locating and integrating with existing Article 31 and Article 32 are considering hiring LCSW-R to do the BH integration project. The concern has been raised to DOH regarding the billing for co-located integrated clinics. Contractual relationships are also being explored. b. After the initial confusion has cleared planning is back on target for those sites planning to utilize Article 28 billing. 2. Model 2 – Integration at Behavioral Health Site a. There may be no way to overcome this new requirement however the PPS is actively seeking ways to either mitigate the new requirement or serve the BH clinic clients with primary care as it is critical to outcomes. 3. Model 3 a. The PPS is exploring alternative techniques such as Behavioral Activation and Motivational Interviewing as a means to deliver high quality care for patients in the primary care setting. Additionally, if necessary, the PPS will explore potential contractual relationships with a

behavioral health provider to provide techniques such as problem solving treatment such the patient population require this type of care.

Implementation approaches that the PPS considers a best practice:

1. NCI included the IMPACT model as part of our 4aiii project, thus allowing this model to be applicable to the entire population, not just the Medicaid population.
2. NCI has secured a contract with the University of Washington AIMS Center to provide technical assistance with the implementation of model 3. Additionally, our subject matter expert for model 3 is participating in the NYS OMH Learning Collaborative for the IMPACT Model, thus equipping one of our 4 Primary Care Practices with the skills and resources needed to further define, refine and streamline regional efforts for implementation.

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

1. Every Primary Care site in the PPS is screening for PHQ2/9 as a standard of care.
2. The PPS has several sites that are leading in integrated primary care and behavioral health, which has helped in moving other providers in the right direction.
3. Subject Matter Experts for each of the three models of integration have been identified and the IMPACT Model SME is also practicing in a NYS Learning Collaborative for this model. Regulatory waivers have been submitted and more are being prepared with plans are underway for the integration of BH and PC (model 1 and 2).
4. The NCI has hired a consulting psychiatrist to work with the four primary care practices who have committed to the IMPACT Model/Collaborative Care. Depression Care Managers have been identified and trained at all Model 3 participating primary care practices and to serve as a SME to Model 1 and Model 2 projects.
5. Five individuals have completed the Depression Care Manager training and another three are in the process.
6. Fifty individuals completed an IMPACT Model/Collaborative Care webinar with the University of Washington AIMS Center and 4 primary care practices including physicians, nurse practitioners, care managers and a psychiatrist (approximately 25 total) will complete a full day, onsite training with the University of Washington AIMS Center on July 8th.
7. The NCI is facilitating ongoing coaching calls with the University of Washington AIMS Center and our IMPACT Model sites. Templates for workflow, task matrix, policies and procedures have been provided to all IMPACT sites.
8. All primary care practices will receive technical support from the NCI/FDRHPO project team. 2 practices in the region have already received PCMH Level 3, 2014 standards. Many others are in the process. Approximately 180 individuals have completed SBIRT training.

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

Based on ongoing assessments of our community, conditions continue to align with outcomes reported in our community needs assessment. Through our work with health departments, community-based organizations, and hospitals, we intend to monitor community needs throughout the life of DSRIP.

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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: Samaritan Medical Center

Project: 3.b.i

Challenges the PPS has encountered in project implementation:
Challenges: 1. Understanding and acceptance of blood pressure training and the need for annual training 2. Practice level workflow and EMR changes required to meet the milestones 3. Provider and PPS ability to meet project requirement 11: Prescribe once-daily regimens or fixed dose combination pills when appropriate. a. Specifically meeting the documentation and implementation for fixed dose combination drugs when those drugs are historically not covered. 4. NCI's partners have multiple EMR's causing challenges in understanding the EMR's capabilities or limitations on clinical decision support and template options to meet the selected national based guidelines
Efforts to mitigate challenges identified above:
Mitigation: 1. Blood Pressure Training: a. Medical Management Committee choose and approved a national clinically relevant guideline for blood pressure measurement b. Medical Management Committee developed an easily understood short blood pressure training video that encompassed the relevant portions of the guideline. c. Medical Management Committee fully supported and encouraged completion throughout the region Outcome: Currently NCI is making large strides to completing this year's blood pressure training requirement. There have been ~200 completed trainings. 2. Practice level workflow changes: a. NCI with assistance and partnership from FDRHPO sent out teams of data analysts, and PCMH implementation specialists to completely understand EMR capabilities, practice level workflow and assess the gaps towards meeting the required milestones and clinical integration goals. b. Standardized workflow processes with partners while meeting the demands of multiple initiatives (i.e. ACO, CIN) c. Worked with EMR vendors to assist in template development and quality measure mapping to ensure offices can properly and accurately capture quality measures and effectively track patients.

Outcome: All Primary care offices and EMRs have been evaluated and assessment taken. Many offices have gone through an extensive overhaul to ensure workflow is standardized and EMR is capturing accurately the quality measures. All offices will be completed by end of year and will have standardized approaches to PCMH, quality measures and other regional initiatives (i.e. ACO)

3. 3bi, project requirement 11: Prescribe once-daily regimens or fixed dose combination pills when appropriate
   a. Medical Management Committee with full support and leadership from one of our pharmacy partners aggressively evaluated the coverage of combination therapy: Findings of that evaluation was there was limited to no oral combination therapy agents covered by Medicaid that would support the outcomes of this project.
   b. Next steps are for Medical Management Committee to review class of drugs and disease states relevant to 3bi and create a list of drug therapies that would assist in adherence and improvement in quality
   c. Share list of potential combination drugs that would assist the state in meeting this milestone and improve adherence and quality with DOH to see about adding those therapies as an approved tier 1 or 2 therapy choice.

4. Multiple EMR's within our region and primary care practices
   a. Teams of subject matter experts within FDRHPO and NCI have been working to better understand the full capabilities of the EMR software.
   b. Our subject matter experts have tested and piloted the EMR's capabilities to ensure the software captures the appropriate clinical decision support and allows our clinicians the ability to create templates around the approved nationally approved guidelines.

Outcome: Currently a majority of our Primary Care offices have implemented templates and turned on the appropriate clinical decision support to the guidelines and 3bi's milestones.

Implementation approaches that the PPS considers a best practice:

Best Practices:

1. Creating opportunities to offer partners hands on assistance and subject matter experts
2. Spend the time to fully understand the EMR's building subject matter experts for each one
3. Created opportunities to hire and employ a part time medical director for each county our PPS serves
4. Created a strong Medical Management Committee wiling to serve and take the time that is needed to strategize and make clinical decisions that will positively impact our regions patients
5. Creating relevant, effective education/training material that is respectful of our partner's time
6. Medical Management Committee when selecting guidelines chose and will continue to choose Nationally recognized guidelines (don't try to create your own)
7. NCI is a physician led company and all decisions are based on clinical relevance that leads to positive outcomes for the patients we serve

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
Engagement of providers and our offices has been our ultimate strategy to assist in meeting our DSRIP, and Clinically Integrated Network mission and goals. NCI is seeing strong growth in engagement, providers are consistently improving in all categories from technology to positive clinical outcomes for patients.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
There have been no changes to the proposed population served. Based on ongoing assessments of our community, conditions continue to align with outcomes reported in our community needs assessment. Through our work with health departments, community-based organizations, and hospitals, we intend to monitor community needs throughout the life of DSRIP.

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PPS Name: Samaritan Medical Center

Project: 3.c.i

Challenges the PPS has encountered in project implementation:
1. At the Mid-Point assessment NCI is reporting no significant challenges with 3.c.i. Across our region, Diabetes was and will continue to be a disease state our providers, hospitals, and community based organizations will continue to focus on and improve the outcomes of our patients. NCI and its partners have committed to fully aligning our PCMH efforts around diabetes and this will continue to allow our region to make significant strides in closing the care gaps shown within our community needs assessment
Efforts to mitigate challenges identified above:
1. Diabetes will continue to be strategically aligned in all of our initiatives within our region from PCMH, to our ACO and eventually within our value based payment contracts.
Implementation approaches that the PPS considers a best practice:
1. Strong alignment for Diabetes within PCMH 2. Full community approach to addressing diabetes 3. Strong commitment to encourage and lead change from within practices and our community 4. Physician led organization allowing clinical decisions to be priority 5. Selection of 3.c.ii. has aligned community Diabetes prevention priorities with clinical priorities
Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
None noted. All diabetes activities on target.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Samaritan Medical Center

Project: 3.c.ii

Challenges the PPS has encountered in project implementation:
1. The only significant challenge the PPS has had with 3.c.ii. is securing an agreement with the Quality and Technical Assistance Center (QTAC-NY) which trains, licenses, and tracks program participation for the diabetes Prevention Program (DPP), Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program (DSMP) for the entire NYS. QTAC-NY has already received letters of support from our PPS partners indicating that the PPS should gain access to participant data.
Efforts to mitigate challenges identified above:
1. The PPS continues to work with PCG and other entities to fast-track the approval process with QTAC-NY.
Implementation approaches that the PPS considers a best practice:
1. Identifying and engaging CBOs and public entities that provide programs early 2. Assisting with training and other needs 3. Aligning with the Clinical project 3.c.i and PCMH so that community and primary care clinical priorities are aligned
Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
It is exciting to see how aligning clinical and community priorities brings a whole and holistic focus to chronic disease prevention and management that goes beyond checking the boxes and meeting DSRIP deliverables. It gets to the real meaning of delivery system reform.

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Samaritan Medical Center

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:
1. Determining the exact indicators to focus efforts on for 4.a.iii. with the large amount of data currently available, and determining data collection and dissemination has been a challenge. 2. Prevention culture change is one of the biggest challenges as current prevention efforts have primarily been funded and provided in isolation on a county by county basis, thus services have not always coordinated and not necessarily tied to regional health assessment data
Efforts to mitigate challenges identified above:
1. The PPS is working with the BH committee and PPS data specialists to refine key data elements, standardize dashboard displays and enhance partner understanding and use of data for strategic decision making and regional planning. 2. The PPS is overcoming barrier 2 by tying programing to regional data, adopting evidence based practices and monitoring improvement over time. 3. The PPS has multiple communication channels including with the BH Committee and continue with e-mails and follow up calls to ensure communications with partners to support and encourage participation and transparency. 4. Choosing appropriate programs from implementation for various entities is being addressed and determined by extensive planning with prevention councils and feedback from Behavioral Health Committee.
Implementation approaches that the PPS considers a best practice:
The project lead is currently collaborating with Prevention Directors, the PHIP Manager, Regional Suicide Prevention Coalition Coordinators and Regional CBO Community Coalitions to identify best practices currently being used and to identify and review best practice programs/innovative approaches that will have the most impact in addressing identified gaps while also meeting DSRIP deliverables. This effort is helping stakeholders understand and align DOH, OMH, and OASAS requirements for reporting.

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

1. Project 4.a.iii overlaps with other projects such as 3.a.i and Cultural Competency & Health Literacy.
2. The PPS works collaboratively with a well-established and well attended Behavioral Health Committee. The committee meets monthly and membership represents both clinical and community based organizations. The committee identifies local and regional gaps, develops strategies to address gaps and makes continual progress toward achieving DSRIP deliverables.
3. A draft metric database has been developed based on DSRIP metrics and Behavioral Health Committee feedback. Data collection will include Project 3.a.i 4.a.iii, regional substance abuse and mental health data as well as regional indicators impacting performance data. PPS data specialists are in process of reviewing databases and will create dashboards and timelines for data sharing with committee and PPS partners to assist with workflow optimization and outcome metrics.
4. In collaboration with the North Country Health Compass Partners, a regional Community Needs Assessment has been completed, thus assisting the PPS with monitoring progress and identifying gaps. Strategies will be developed around selected areas in need of improvement, including health literacy and cultural competency. The results of survey will be presented in August.
5. The PPS has developed a Health Literacy and Cultural Competency video for providers and is in the process of creating a video to create provider awareness around mental, emotional and behavioral health promotion, prevention and treatment. The PPS will also utilize footage to create Public Service Announcements for the community at large. Regional partners have also facilitated community forums to address substance use issues, to educate the public, to address concerns and provide updates on prevention and treatment efforts.
6. A Prevention Matrix was created to facilitate strategic planning with Prevention Council Directors from each county. It outlines current prevention programs being utilized/pending implementation in their respective regions, including research/evidence based programs not listed on the prevention agenda. A spreadsheet was also created to assist entities with cross walking their efforts with prevention programs in the region, thus providing the PPS with a regional snapshot of opportunities/challenges related to current programming and also assisting us with a resource to streamline efforts and avoid duplication of services. The identified needs and proposed implementation will be outlined in a prevention training plan.
7. The PPS has four sites that are implementing the IMPACT Model. A new consulting psychiatrist was hired and Depression Care Managers have been identified and trained. 5 individuals have completed the Depression Care Manager training and another 3 are in the process. 50 individuals completed an IMPACT Model/Collaborative Care webinar with the University of Washington AIMS Center and 4 primary care practices including physicians, nurse practitioners, care managers and a psychiatrist (approximately 25 total) will complete a full day, onsite training with the University of Washington AIMS Center on July 8th.
8. All primary care practices in PPS will receive technical support from the NCI/FDRHPO project team. 2 Many practices in the region have already received PCMH Level 3, 2014 standards. Many others are in the process. Approximately 180 individuals have completed SBIRT training.
9. Subject Matter Experts for each of the three models of integration have been identified and the IMPACT Model SME is also practicing in a NYS Learning Collaborative for this model. Regulatory waivers have been submitted and plans are underway for the integration of BH and PC (model 1 and 2).
10. Pivot (a PPS partner), a not-for-profit human service agency partially funded by the NYS OASAS to provide substance abuse prevention services, was awarded funding to establish a Recovery Community Center for the region. A key group of stakeholders held initial meeting to start research and planning for the Recovery Center.

11. The PPS is collaborating with Regional Suicide Prevention Coalition Coordinators to address identified needs and facilitate strategic planning sessions. Project Lead working on establishing relationships and providing assistance to regional community coalitions (Jefferson County: Alliance for Better Communities, Lewis County: Yeah!, St. Lawrence County: Massena Coalition).

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

There have been no changes to the proposed population served. Based on ongoing assessments of our community, conditions continue to align with outcomes reported in the NCI community needs assessment. Through our work with health departments, community-based organizations, and hospitals, we intend to monitor community needs throughout the life of DSRIP.

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PPS Name: Samaritan Medical Center

Project: 4.b.ii

Challenges the PPS has encountered in project implementation:
Challenges for this project have been minimal as the PPS designed the integration of preventive care and management to be integrated into the implementation of other projects thus timelines and goals are well aligned. The only challenge which has been addressed is: 1. Securing the services of certified/licenses tobacco cessation counselors across the geographic area served by the PPS.
Efforts to mitigate challenges identified above:
1. The PPS has initiated negotiations with the Central NY Regional Center for Tobacco Health Systems to gain support for the deployment of counselors across the region and the PPS has identified location that are currently offering services and willing to expand based on referrals and need
Implementation approaches that the PPS considers a best practice:
2. One best practice has been to incorporate systematic screening and referral at primary care practices into the workflow of care managers at the practices thus developing the means to ensure preventive services are recommended to all. 3. Additionally, the broad and early engagement of all of the CBOs in the regions providing preventive services has been critical to success. 4. Alignment of 2.a.i. PCMH implementations so the PCMH CCEs understand that the team based model is critical to 4.b.ii. and the screening and referrals to preventive services assist the PCMH requirements. 5. Finally a telephone Triage line and campaign for all available clinical preventive services is a best practice that ensures both practice care managers, community care coordinators and the general public have an easy method to identify the services available in the PPS region.
Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
The PPS has multiple CBO and clinical partners that are capable and willing to provide or offer space for preventive services.

A consulting psychiatrist was hired on June 10th. The NCI has identified at least 4 CDEs in the region. We will continue to explore a CDE consult agreement. The NCI is working with a representative from St. Joes to develop training resources and EMR templates for the 5 A's of tobacco control.

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

Based on ongoing assessments of our community, conditions continue to align with outcomes reported in our community needs assessment. Through our work with health departments, community-based organizations, and hospitals, we intend to monitor community needs throughout the life of DSRIP.