NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Community Partners of Western New York PPS

Appendix PPS Narratives

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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: Sisters of Charity Hospital of Buffalo, New York

Highlights and successes of the efforts:

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Sisters of Charity Hospital PPS, d/b/a Community Partners of Western New York (CPWNY) is confident in its completion of key milestones for the DSRIP Workstreams. Below is a summary of our work and plans moving forward:

Governance and Community Based Organization Outreach, Engagement

CPWNY has an engaged community based governance structure. The leadership team is pleased with the community's attendance and active participation in the work of the Executive Governing Board, the Clinical Governance Quality Committee, the Data IT Governance Committee and the Financial Governance Committee. Communication highlights of these groups include: a regular meeting schedule; published minutes and key decision documentation; and, advance publication of all meeting materials to facilitate two way communication. The meeting and attendee lists are provided quarterly to the Independent Assessor as part of the PPS's quarterly reporting process to New York State.

In addition to the involvement of the community at the governance level, CPWNY involves the community at large in its quarterly Project Quality Committees and Project Advisory Committee (PAC) activities. The PAC meetings consist of roundtable discussions with the community which include an exchange of ideas and review of the challenges of the DSRIP projects and Workstreams. CPWNY facilitates deep dives into the project issues and risks. CPWNY has

developed a regular group of Medicaid users who engage in the PAC meetings and the CPWNY team is pleased and grateful to have Medicaid user attendance and active participation in our meetings. The CPWNY PAC has been praised by its attendees for its transparency and open discussion about both project successes as well as challenges. CPWNY completed sessions with the PAC that included a detailed discussion of budget and the contracting process. The CPWNY team evaluates meetings regularly with post activity surveys and continually works to improve participation.

CPWNY has consistently communicated with partners and the community at large, and continues to seek earned media and public relations outreach where appropriate. Excellent examples include a planned Palliative Care Community Conversation, scheduled for September 17, 2016 and a Mental Health Awareness program completed on May 26, 2016 as an event sponsored in partnership with the Millennium Collaborative Care (MCC) PPS.

CPWNY's community based organization involvement is focused on helping community groups engage effectively with DSRIP initiatives and our integrated delivery system to prove value to the providers and patient populations. A key partnership is with the Community Health Worker Network of Western New York. This organization has assisted CPWNY with the Cultural Competency/Health Literacy workstream and the appropriate usage and implementation of the Community Health Worker Model.

CPWNY team partnered extensively with the P2 Collaborative of WNY on Medicaid patient outreach, on self-management tools, and on outreach to the community at large for the DSRIP projects. As part of the PPS's work with the NYS Prevention Agenda and Domain 4 projects, CPWNY actively promotes the Opt-to-Quit program - New York State Quitline for the 4bi project (based at the Roswell Park Cancer Institute campus) and 15 mental emotional and behavioral health teams/organizations for the 4ai project, among them are ECCPASA and the Mental Health Association of Western New York.

From a public sector engagement perspective, the CPWNY continues to reach out to formalize relationships with the Departments of Health & Mental Health in the three counties it serves. CPWNY has a tremendous partner in the Chautauqua County Department of Health for its 3fi project for maternal child health work. CPWNY seeks to establish strong relationships and on-going communication with the remaining two counties, incorporating them into the Cultural Competency/Health Literacy ad hoc committee and the quarterly PAC meetings. Additionally, CPWNY continues to work with the Niagara County Department of Mental Health on a partnership with primary care for the 3ai project, behavioral health and primary care integration.

CPWNY PMO team posts news and information regularly on the CPWNY website; the PPS team uses a robust email list to send targeted information to project teams regarding DSRIP bulletins and updates. From a project monitor and control perspective, the CPWNY reports status of projects to project teams on both the 1st and 15th of each month, and provides a copy of all status reports via its website. The PPS publishes a quarterly provider and community focused newsletter once a quarter. CPWNY's newsletter showcases project teams and workstream efforts in ensure the community knows about the depth and breadth of the work on DSRIP initiatives.

Collaborating with other PPSs

CPWNY PPS engages regularly with the Millennium Collaborative Care PPS, who has 100% geographic overlap with the coverage area of CPWNY. Several great examples of this collaboration are:

- The PMO Directors meet once per week to share collaboration efforts and seek opportunities for efficiency in project management and partner collaboration.

- The PPS PMO leadership teams meet formally, at least quarterly. Agenda items include collaboration and provider communication. The goal is that the community at large can understand the differences in the PPSs, but also that the two PPSs can speak with one voice where it is appropriate. For example, CPWNY and MCC extensively collaborate on workforce initiatives so that partners understand the PPSs are not doing redundant or competing data collection efforts.

- MCC and CPWNY clinical programming leadership met extensively in DY1. The goal of these meetings was to discuss practice level communication and primary care network activities. This coordination helped to avoid confusion in the community about PPS efforts and to leverage information sharing and work on common deliverables required across providers.

- CPWNY is working formally with MCC for project 4ai, Promote mental, emotional and behavioral health. This project which is shared across the two PPSs, with shared deliverables and similar implementation plans. CPWNY staff is particularly proud of this formalized collaboration. Catholic Medical Partners (CMP), as a PMO for the CPWNY PPS, is contracted with MCC to oversee all three program elements including Outreach, Information and Referral, and Media and Campaign. This arrangement assists both CPWNY and MCC in eliminating duplicative efforts when working on the 4.a.i Promote MEB project. It also builds a relationship for future projects that may develop inside or outside DSRIP.

PPS Financial Stability and Funds Flow Summary

CPWNY's Financial Stability Plan consists of an annual assessment of the partner hospital systems (including primary care clinics, rehabilitation clinics, hospital based nursing facilities, dialysis centers, offsite diagnostic and service locations, adult day care centers, home health care, employed and contracted providers) as well as the Catholic Medical Partners (CMP) provider network, and the PMO. This assessment involves reviewing the financial information of the hospital systems by reviewing the following metrics: days cash on hand ratio, debt ratio, operating margin, current ratio, cash flow to debt or excess revenue to expense. If the Days Cash on Hand is not met, and one of either of the Current Ratio, Operating Margin, or Cash Flow to Debt are not met, then the provider will be deemed financially fragile. A fragile partner will then be assessed on a quarterly basis vs. annually. The PPS will offer subject matter experts, financial training, performance improvement training, and financial assistance and/or support to assist the fragile providers. The physicians are assessed using credentialing, and review of regulatory sanctions. If a physician's practice is considered fragile it will be treated the same as a hospital system.

In the future the Finance Governance Committee (FGC) recognizes that it may be necessary to adjust the assessment procedure based on changing circumstances or future challenges. It may choose to survey additional partners, as needed, to determine if the organization has had:

- A going concern opinion
- Foreclosure or involuntary lien filing against the assets of the organization
- Filing of bankruptcy or bankruptcy protection
- Identification of a fraud investigation by a state or federal agency
- Organizational assets to monetize if required to sustain operations

The FGC and CPWNY have discussed the challenges of attaining the financial information from its partners due to the sensitive, competitive and confidential nature of the information. The members of the FGC and all support staff have signed a confidentiality statement, but attaining this information from the private entities included in the network still poses a challenge.

The CPWNY Funds Flow overall process is as follows:

1. Lead Organization, Sisters of Charity Hospital (SOCH), receives DSRIP grant funds directly.
2. SOCH then transfers the grant funds to a separate CPWNY bank account
3. Partners/organizations receive funding once they have a signed master service agreement (contract) which includes business associate agreements, data sharing detail as well as specific project requirements and deliverables (i.e. implementation plans, patient engagement commitments, and outcomes measures) and a detailed budget.
4. Partner organizations must comply with the approved CPWNY reimbursement process developed by the CPWNY Finance Committee.
5. Once reimbursement requests are approved by both the PMO and Sisters of Charity Hospital, funds are transferred to CMP to pay partners.
6. Catholic Medical Partners (CMP), is a Safety Net provider so all funds distributed through CMP comply with the 95/5 rule.
7. CMP serves as CPWNY project management office, managing the budget and distribution of funds.
8. CMP facilitates budget discussions with project leadership. Governing bodies approve the budget and funds flow processes.

CPWNY has had to adjust to the very significant changes in payment timing and methodology that occurred since the funding schedule was announced, since the PPS's budgets were developed based on the initial timing and distribution methods. Challenges were also encountered from changing reporting methods from NYS. CPWNY has worked hard to make the required changes within the given time frames and will continue to do so as necessary.

Other foreseeable challenges that still need to be vetted are the move to the Value Based Payment (VBP) system. Although SOCH and CMP (an IPA with majority of VBP arrangements) have already adopted this concept, it creates a new way of thinking for many of PPS partners, and pushes coordination across physicians and hospitals to provide higher quality care at lower costs. CMP is currently working to address these issues and taking positive steps to bridge any gaps.

Value Based Purchasing (VBP)

As stated above, the PPS financial governing body (or Finance Governing Committee) is comprised of community membership of many organizations. Some of these members currently participate in value based payment (VBP) arrangements through Catholic Medical Partners (CMP). CMP is an independent practice association (IPA) comprised of the Catholic Health System (CHS) which includes Mercy Hospital, Kenmore Mercy Hospital, Sisters Hospital, Mt. St. Mary's Hospital, along with more than 990 independent primary care physicians, pediatricians and specialists united in the common goal of improving the delivery of healthcare. Currently, CMP is the only member of the PPS participating in VBP arrangements targeted to the Medicaid managed care population.

The PPS established a VBP workgroup, a sub-set of membership from the PPS financial governing body, which will develop communication, education and guidance toward VBP goals as outlined in the NYS VBP roadmap. Members of the VBP workgroup affiliated with CMP meet regularly with MCOs in the local community which include Fidelis Care, Independent Health Association (IHA), YourCare, HealthNow NY, and WellCare. Of those MCOs, CMP participates in VBP arrangements for the Medicaid patient population with Fidelis Care (serving 25,000 PPS patients), IHA (serving 17,000 PPS patients), and WellCare, a new payer in the region building its patient market share. CMP will use the experience it has with VBP to educate and guide the PPS partners through the transition to VBP.

Short Term Next Steps: VBP

The PPS-wide VBP arrangement assessment is in progress. Based on current knowledge, however, it is believed that no entities outside of the member organizations and institutional partners in the CMP network have any VBP contracts with MCOs with one exception, the Chautauqua County Health Network (CCHN). CCHN is a PPS contracted partner and it has established VBP contracts with payers for other lines of business. CCHN's contracting entity is their IPA, the Chautauqua Integrated Delivery System. The scope and scale of those arrangements are in review by the PPS VBP workgroup and next steps for expansion of the PPS's VBP in Chautauqua County are under review with their input. CCHN has plans to pursue VBP contracts for Medicaid lines of business for its provider members and can serve as a vehicle for guidance as other partner's transition to VBP.

Long Term Next Steps: Outreach beyond primary care

Community based specialty providers and organizations are currently non-risk bearing institutional members of CMP (as well as members of CPWNY). They benefit as referral sources for the CMP's provider network, and receive educational seminars and engage in other clinical integration activities. Excellent examples of these partnerships include behavioral health providers like Catholic Charities, Spectrum Human Services and Horizon Health and institutions such as BryLin (substance abuse support services),Baker Victory (youth care), and Buffalo Hearing and Speech.

In working with community based providers and organizations, such as CBOs, the PPS VBP workgroup has come across challenges with gaps in knowledge about transitioning to VBP contracts. There are two particular scenarios outlined below:

First, for entities outside of the current CMP network, the business plans and process improvement initiatives for VBP arrangements need development. The PPS is able to provide guidance to these organizations, but there needs to be buy-in to this type of payment model. Examples of infrastructure that needs to be in place are electronic medical record systems, IT infrastructure, care management knowledge and staffing, and most importantly financial strength to take on risk.

Secondly, for the non-risk bearing affiliated organizations participating within the CMP IPA network, they will continue to benefit from referral agreements that provide warm hand offs from hospitals and primary care under their institutional partnership agreements. However, these entities may desire to transition to a form of VBP arrangement with the MCOs in the future. Initially, they may struggle with providing evidence or business plans to engage in these additional MCO arrangements but can benefit from the guidance and education provided by the VBP workgroup.

With these challenges known, the PPS is examining several information sharing opportunities as part closing the knowledge gaps with its institutional partners:

- CPWNY will connect CBO partners with PPS members applying for and championing the CBO Planning Grant; this grant will supply some needed business planning assistance to our PPS organizational contacts.

- CPWNY has made available the value based boot camp opportunities to the PPS Project Advisory Committee. The PPS will recruit organizations to both view the recorded session on the state website and attend in person the Region 3 boot camps.

- CPWNY will use its newsletter, website, and as appropriate, it's Project Advisory Committee, to teach its partners about the future trends in healthcare, including sharing examples of value-added process improvements and case studies of VBP arrangements.

- CPWNY will provide guidance and mentoring, where appropriate, to PPS partners who would like to be engaged in contracting with Medicaid MCOs. CPWNY will continue to support the efforts of the CCHN team in its pursuit of VBP arrangements (including risk based value added contracts) for its IPA, the Chautauqua Integrated Delivery System.

- CPWNY will continue to build partnerships with the CMP IPA and its existing VBP agreements. This will include recruiting new members to the CMP IPA so they may take advantage of the VBP arrangements in place now and in the future.

- The work of CPWNY equity contracts and the CMP IPA VBP contracts is shared with Catholic Medical Partners Board of Directors, CPWNY Executive Governing Body, CPWNY Financial Governance Body and Catholic Health & Catholic Medical Partners Managed Care Negotiations Team. This facilitates learning across many interest areas of the PPS and beyond.

PPS Compliance Program and Planning

A provider agreement is executed for all CPWNY contracted partners. In the provider agreement, partners agree to comply with the CPWNY compliance requirements, including adoption and implementation of the CPWNY Compliance Plan, training activities and reporting requirements. The CPWNY Compliance Plan is made available to all partners on the CPWNY website along with applicable training resources. Additionally, partners submitting invoices to CPWNY receive education about the reimbursement process.

CPWNY developed an internal control plan which integrates finance and compliance. The goals of the plan are to ensure: accurate and reliable financial reporting; operational effectiveness and efficiency; compliance with laws and regulations; safeguarding assets; and, monitoring several control activities, including segregation of duties related to the PPS. Routine audits are conducted on invoices submitted by the PPS partners, as well as monthly sanction checks to assure that all providers receiving funds are not sanctioned by OMIG.

Workforce Efforts

As part of the overarching DSRIP goal of a 25% reduction in avoidable hospital use (i.e. emergency department), CPWNY will retrain, redeploy and recruit direct care staff as well as clinical and administrative support staff. Physicians, nurses, pharmacists, dieticians, social workers, office managers, LPNs, and case managers will need to learn team based care work skills; evidence based practice and develop technology assisted workflows that optimize staff skills. The PPS lead, Sisters of Charity Hospital (SOCH), as a member of Catholic Medical Partners (CMP), has been engaged in a population health business model for approximately 10 years and has been training and redeploying clinical and administrative staff needed to be successful in this business model. As the selected project management team for CPWNY, Catholic Medical Partners will provide skills, training and resources for network support.

CPWNY does not anticipate that the declining hospital services volume for the Medicaid population will in itself have a major impact on the size of the workforce during the term of the DSRIP initiative. The partnering Catholic Health System (CHS) with 8500 employees did a comprehensive workforce reduction assessment for a 25% decrease in Medicaid inpatient & related services. Combined with normal attrition, CPWNY expects a limited and paced retraining/redeployment from acute care. For many of the new positions, CPWNY expects new hires & training will be required.

CPWNY has collaborated extensively with Millennium Collaborative Care (MCC) to align services surrounding Workforce in an effort to reduce the duplication of work requested of the primary care offices and organizations. Milestone timeframes, where possible, have been adjusted to align both PPS's work plans. Additionally, both PPSs contracted with the same third party vendor, Rural-Area Health Educational Center (R-AHEC), to further limit duplication of efforts.

CPWNY has assembled a Workforce Workgroup to lead the workstream. This workgroup is comprised of human resources representatives from the partnering Catholic Health System, members of the DSRIP team from CPWNY, human resources representation from other partner organizations across the counties involved, members of R-AHEC, and an executive director of a community based organization. The Workgroup has established its own charter and elected a chairperson for the group. This group meets on a monthly basis to collaborate and discuss needs, concerns, and issues meeting the deliverables of the Workforce initiative.

For CPWNY, R-AHEC has been tasked with assisting the workstream lead staff person in collection and housing of data across the Workforce workstream. R-AHEC has completed the required baseline assessment survey, and the first of the three required compensation and benefit surveys (Milestone #4). This information was housed by R-AHEC for the required 90 day time period, and will be submitted on the DY2 Q1 MAPP upload. Some issues identified during the collection of the compensation and benefit survey were; the partners had a difficult time matching their specific job titles to the state mandated titles; there was confusion as to what should be included as benefits, and unclear wage accounting because wages were required to be reported on an hourly basis. CPWNY and R-AHEC were able provide assistance, where possible, to rectify these concerns. The Workforce Workgroup, as well as the CPWNY Executive Governing Body will sign off and give their approval of the compensation and benefit survey before the document will be uploaded on the required quarterly submission.

For the remaining milestones of the Workforce workstream milestones (#1, 2, 3, & 5), the collaborative work is on track to meet the requirements and timeframes outlined in the CPWNY implementation plan. R-AHEC is assisting CPWNY with ongoing data collection for the Organizational AV's, (budget spending, retraining/redeployment, and new hires) which are required semi-annually, due for submission every Q2 and Q4. For the initial data collection, face to face interviews provided the group a level of familiarity. Going forward, the data collection process will be completed in the most convenient manner for the group, whether it continues via face to face, email, or phone conversation.

Recently, CPWNY successfully uploaded the DSRIP 5 year budget commitment, and completed the initial budget spend across the four NYS outlined spend categories. There was some initial trepidation within the PPS on meeting the minimum requirements outlined. However, after feedback from the State and further clarification of the definitions of allowed spending, CPWNY was not only able to meet the minimum requirements, but was able to exceed that threshold. The forecast by CPWNY to meet the 5 year budget commitment is exceedingly positive.

Cultural Competency/Health Literacy (CC/HL)

The CPWNY team decided that improving access and patient understanding of office appointments, as well as improving provider sensitivity to literacy and cultural diversity, must be undertaken by the PPS and all its clinical partners. Practices will need to evaluate their level of cultural competence if they are to realize improvements in both patient experience and performance measures. Partners will also need to utilize the "universal approach" to health literacy; tackling literacy issues first. Focus groups will include representation from Amish and Hispanic populations in Chautauqua County and African American populations in Erie and Niagara counties as indicated in the Community Needs Assessment. These focus groups will improve CPWNY's understanding of health disparities and provide ideas for new approaches to patient engagement. Millennium Collaborative Care PPS, many CBOs in Western New York and P2 Collaborative of WNY have been working together to ensure there is a unified approach to address this gaps in CC/HL in our region.

Milestone 1: Plan to Address Gaps and Health Disparities

CPWNY must first meet a basic need of organizations and clinical practices. CPWNY is providing information and resources on its website for PPS partners regarding the cultural needs of the people they serve. Highlighted efforts for this milestone are listed below:

- The CPWNY website is monitored at least weekly, updated, and also referred to at all meetings and marketed in all communications. CPWNY has added updates on all trainings that are available, including educational newsletters (with permission from the organization) on the Art of Communication and Listening. The website also provides information on interpreters.

- The CPWNY staff are instructing partner organizations on how to analyze their patient and client registries to determine the impact of language and cultural barriers on clinical quality and patient satisfaction surveys. This will expand the practitioner's knowledge about the health care disparities in their practice. To this end, the work will insure that evidenced based clinical guidelines are incorporated into the electronic medical record so that there is an immediate reminder of patient treatment needs. The use of the electronic health system will bring new guidelines to the point of care, thereby mitigating health care disparities. Currently, there are limitations on documenting language, race, sexual orientation etc via the EMR, but CPWNY's PMO staff are able to download this information to look at disparities. This work supports efforts to ensure that the organizations share information such as language, cultural beliefs, preference for patients regarding office appointments, how to get urgent care, and shared decision making.

- Population focus teams are in place for each county in the CPWNY network to assist with ease of use and understanding of self-management tools. Community forums are held, minimally quarterly, and will continue to be held for input and training on patient self-management tools.

- CPWNY works with P2 Collaborative of WNY (PHIP grant recipient) and Millennium Collaborative Care PPS to develop broad based solutions to reduce disparities. For example; the partner organizations held a large conference for community health workers, social workers, care managers and coordinators regarding Cancer Screening Services for all the counties of WNY; the two PPSs serve on joint steering committees for Chronic Disease and Population Health to develop collaborative solutions to reduce disparities in WNY; and the PPSs and partner organizations have engaged in shared MEB project work addressing topics such as Healthy Eating, and the Social Stigma of Behavioral Health & Drug Abuse.

- The PPS team has begun to download Medicaid patient data from practices utilizing Medent EHR to ascertain level of disparities for various measures.

- The PPS Cultural Competency team is working with every project. Examples of this project work include the MEB project (4ai: review of the substance abuse anti stigma campaign), Cardiovascular Care project (3bi: review and feedback on the BP screening self-management tools), Primary Care Behavioral Health integration project (3ai: discussion about access to depression screening), the ED Triage project (2biii: to ascertain self-management tools utilized that need to be evaluated by the focus groups and what needs to be improved upon).

- CPWNY and its network continue to participate in an effort called "Chew and Chats," which provides educational sessions at community/neighborhood venues to engage the population in self-management and health supporting initiatives.

Milestone 2: As part of New York State DSRIP program, CPWNY contracted with the Community Health Worker Network of Buffalo (CHWNB) to provide research, training, and evaluation of various aspects of health literacy and cultural competency to inform an integrated, comprehensive strategy addressing these areas. The process the PPS used included:

1. Review of previously conducted CPWNY survey of existing practice and provider needs and populations served.

2. In partnership with CPWNY Health Literacy and Cultural Competency (HL/CC) project lead, pilot sites and participants were identified.

3. The project team gathered the most up to date and relevant resources and research to tailor a cultural competency/health literacy curriculum that would be appropriate for specific practice sites and tracks (i.e. urban/rural, those with a high immigrant and refugee population, pediatric vs. chronic disease management, etc.).
4. Three training approaches and sites were piloted, as follows:
    a. a large group of providers and administrators in a 1.5 hour semi-interactive format (January 5, 2016)
    b. a large group of providers in a 1-hour didactic (i.e. lecture) format (February 9, 2016)
    c. a single practice site of 14 staff (providers and administrative staff) in a 2-hour interactive format (April 6, 2016)
5. A "Plan, Do, Study, Act" approach was utilized, as data was analyzed from each training and areas for improvement were integrated into the following session (Langley et al. 2009).

Key recommendations regarding PROCESS and FORMAT of health literacy and cultural competency training on an ongoing basis are as follows:

- Create opportunities for interactive formats and story sharing. In this pilot, participants that did not have training in an interactive format, asked for more time and more interaction. Even those who did receive training in an interactive format asked for more time and more interaction.
- Include face-to-face interaction and discussion of biases and stereotypes in a safe, non-judgmental environment. This requires small groups and trainers who are skilled in facilitating group process on difficult topics. It appears from this pilot (as well as other research) that cultural competency and health literacy programs have greater impact when such elements are included. Small groups allow for expressions of feeling and personal sharing, where participants commented that they would not have disclosed their own personal experience in a large group, but that the intimate nature of a small group allowed for this vulnerability and self-reflection. This benefited the whole group as well as the individual who shared his/her experiences.
- When larger groups are necessary, including interactive opportunities (e.g. as the listening activity and "4 corners" exercise did) and narratives or "stories from the field". This training included community members/Community Health Workers, supervisors and leaders in community-based organizations, a PhD, and an MD. Additionally, in the interactive and semi-interactive trainings, diverse members of healthcare teams were present (physicians, nurses, IT specialists, etc.) Various perspectives and experiences from the community as well as inside the healthcare system broadened participants' perspectives. Participatory activities and story-sharing substantially enhanced the training experience for respondents.
- ALL healthcare professionals should have basic "core competencies" related to health literacy and cultural competency. It has been standard practice to train different healthcare providers separately and differently, however this evaluation demonstrates the impact of this training approach on both healthcare providers and non-healthcare providers. While various members of the care team may need to apply basic knowledge and skills in these concepts differently, there is great value in having a universal approach to creating culturally competent practices and organizations. Additionally, diverse professionals learn from one another when opportunities are created to share their experiences, needs, and assets with one another. Alignment of the approach and commitment to a consistent experience for a patient between the front office staff, nurse, physician, and anyone else that touches the patient is critical.
- To test the impact of training in the future, patients should be surveyed to see if care is delivered to them in accessible, responsive ways; and providers should continue to help drive the format through which they receive information and training. This may include analysis of already implemented patient satisfaction surveys and a review of patient outcomes relative to screening and disease management.

Recommendations for Cultural Competency Literacy Training Content

Key recommendations regarding CONTENT of health literacy and cultural competency training on an ongoing basis are as follows:

- Listening and two-way communication are foundational skills for health literacy and cultural competency. Teaching and training providers on the myriad aspects of personal, family, and community cultural dynamics is difficult if not impossible. Building skills around effective listening and how to build effective, trusting relationships with patients is simpler, less time-intensive, and more impactful. Motivational interviewing, trauma-informed care, and other frameworks that support effective listening and understanding are becoming more well-established in the healthcare field, and should be integrated into health literacy and cultural competency when possible.
- Providing simple definitions, visuals, checklists, tool, and resources can help both patients and providers to understand one another better. Experiential and participatory learning should ALSO have clear learning objectives and be supplemented with simple but high-quality content, which will be more effective and relevant when paired with a high-quality training experience using multiple modes of learning (including interactive activities and story-sharing). Online learning resources from quality, research-based sources (i.e. Institute of Medicine, Institute for Healthcare Improvement, American Medical Association, SUNY Albany School of Public Health) are also helpful supplements. In some ways, more is less here, as streamlined and usable definitions and tools are more likely to be remembered and utilized.
- Structural competency, health equity, and social determinants of health are critical overarching concepts that must be integrated into health literacy and cultural competency. Ample research shows that the correlation of health status along a cultural, racial, and socio-economic gradient is in large part caused by the unequal distribution of power and wealth. Culturally competent care must be provided with awareness of the circumstances of people's lives—their access to health care, schools, and education, as well as their conditions of work and leisure: their homes, communities, towns, or cities. Understanding and assessing a patient's level of literacy, their need for translation and interpretation services, and providing care with respect in relation to a particular individual, family, and community's cultural and belief system is essential, however, this is not enough. Healthcare without the context of the structural determinants and conditions of the daily life of the patient (as the patient describes them, not based on assumptions) is necessary to create culturally informed and responsive healthcare settings and providers.

There are significant opportunities as well as challenges to integrating comprehensive and ongoing health literacy and cultural competency training to healthcare organizations, practices, and providers. As providers are being asked to increasingly respond to more measures on a state, federal, and payer level, it is essential that a logic model/theory of change is used to assess and measure short term, mid-term, and long term outcomes and impacts.

In the next phase of the CC/HL project, identifying particular patient populations and/or practices and a quantitative measure or set of measures aligned with DSRIP will be important in measuring impact and creating a case for change on the importance of training all health providers in health literacy, cultural competency, and social determinants of health/structural competency. The strategy for implementing the CC/HL training will consider the aforementioned recommendations and will include:

- The large Medicaid prevalent practices interactive on-site training
- Smaller practices through webinars and videos as well as interactive upon request
- An annual assessment and as new people into the practice a refresher upon request
- Examining patient experience survey responses by practice and in comparison to the organization
- Train the trainer sessions with champions at the offices to keep momentum and sustainability
- Completion of CCHL training is a mandatory requirement as a partner of CPWNY PPS.

Implementation of training to facilities will include key recommendations regarding PROCESS and FORMAT of health literacy and cultural competency training strategy on an ongoing basis. CONTENT, as indicated in the evidenced based information provided by Community Health Worker Network of Buffalo, will be incorporated into the CC/HL training of facility personnel. Input on training will be requested from the CPWNY PMO office. All partners are recommended to do an annual training with attestations sent to the CPWNY PMO office regarding completion of the trainings.

Information Technology (IT) Updates & Technical Systems' Analysis

CPWNY has established a committee comprised of various community members to serve as its Data IT Governance Committee (DIGC), which collectively provides leadership, oversight, and strategic level recommendations to the Executive Governance Body (EGB) in order to meet the requirements set forth by NYSDOH. This is an integral part of the governance structure of the PPS.

The DIGC Committee is held on a monthly basis with representatives from community based organizations, the local RHIO, physicians, vendors, hospice, hospitals, and project leads. In the first year of implementation, DIGC successfully implemented several key initiatives which align with the PPS workplan. Among them are TigerText (Secure Text Messaging), MobileMD patient portal, IT Gap Assessment, IT Security Assessment, IT Change Control Assessment, Crimson, RHIO engagement, and creation of a Patient Claims Data warehouse. A summary of those initiatives is below:

a.) TigerText

Tiger Text is a secure messaging solution that allows clinicians to communicate in a HIPAA-compliant manner. The PPS is currently working on two pilot programs with its partners: Women's Christian Association Hospital (WCA) and Hospice Buffalo. Hospice Buffalo has partnered with the Catholic Health System (CHS) to implement TigerText in the Palliative Care initiative. Benefits for TigerText users include communicating via preferred channel, enhancing the workflow, messaging Protected Health Information (PHI), improving patient satisfaction, and improving employee satisfaction. Functions of the application include the use of protected pictures, group text, recall messages, multiple inboxes, fast deploy, delivery escalation, message forwarding and message attachments. CPWNY is looking at other opportunities to extend the pilot program.

b.) IT Gap, Change Control & Security Assessment

To comply with the DSRIP initiatives outlined in its implementation plan, CPWNY and the Data IT Governance Committee contracted with an outside vendor, the Chartis Group, to help assist in the evaluation the PPS partners' current and future EMR capabilities. The Chartis Group was engaged to assist with performing an IT Gap assessment, Security Evaluation, and review of the Change Management Strategy of its Performing Provider Systems (PPS) partner network.

The IT Gap Assessment was conducted through a survey of 10 topics specifically focused on NYS DSRIP program requirements. Survey topics included: Meaningful Use (MU), Electronic Medical Record (EMR), Patient Portal, Reporting, Population Health Management (PHM), HEALTHeLINK Health Information Exchange (HIE), Telemedicine, Analytics, Change Management, and IT Resources and Staffing.

Because staff managing security are often specialists, the Security Evaluation was handled as a separate survey comprised of 10 topics specifically focused on NYS DSRIP program requirements and HIPAA security risk assessments. Security survey topics included: maintaining security program, identifying assets, managing integrity of electronic personal health information (ePHI), managing media, managing facilities, managing workforce, managing vendors, disaster recovery/business continuity, auditing, and managing incidents.

c.) IT Gap Assessment

The IT Gap Assessment was conducted through a 74 question online survey distributed to PPS partners beginning on January 6th and ending in late January. A series of emails were distributed to partners as reminders to complete the online survey, and additional follow-up phone calls were conducted prior to the close of the survey in order to maximize participation. These calls targeted highly engaged partners as identified by the IT Gap Survey workgroup.

IT Gap Assessment began with an audit of the PPS partners current IT capabilities and an assessment of their capabilities including EHR System, connectivity to local HIE, direct exchange capabilities, and Meaningful Use attestation status. At the end of the engagement, the PPS received an overall definition of gaps remaining between current and desired state of partners, a heat map with high/medium/low identified gaps, a summary of findings from each facility/entity with current state identified, interview data from each facility, and any actionable findings.

The PPS's local RHIO, HEALTHeLINK, was also a valuable partner that CPWNY engaged to better understand their capabilities, their preferred information exchange practices, and any resources they may have available to assist partnering organizations in the PPS. The main challenge Chartis had was the low response rate from PPS partners. To help increase the response rate, Chartis held webinars and did individual outreach to practices to answer any questions or concerns around completing the survey.

d.) IT Security/Risk Gap Assessment:

To support the primary objective for assessing security, the project team developed an Excel-based tool to assess the PPS partner's compliance based on currently established HIPAA Security standards. Because CPWNY is a virtual organization comprised of over 200 organizations and 1000 providers, exchanging and sharing health information among partners is significantly challenging to safeguard and control access to PHI, since patient data is spread across many systems in an inconsistent and fragmented way.

Participating CPWNY organizations use multiple EMR vendors, are at differing phases of implementation, and have varying degrees of security, confidentiality, and consent management. These inconsistences along with the NYSDOH DSRIP requirements caused CPWNY, CHS, and Chartis to work together to assess security policies and practices in place at partner organizations, compare them to New York DSRIP and HIPAA requirements, and identify gaps. Assessments took place through a combination of on-site, telephone, and online surveys combined with a security document/policy request and review.

The security evaluation tool was sent to 454 partners as identified by CPWNY with a request for each partner to complete and return it within 6 weeks (January 6th – February 12th, 2016). It contained 154 questions that were developed by the U.S. Department of Health and Human Services for performing HIPAA Security Risk Assessments. The security evaluation tool was sent out to the PPS partner network via email and further reviewed during three remote WebEx question and answer sessions. The most challenging issue Chartis expressed were the response rates. Majority of the partners did not have the time or knowledge to fill out the lengthy survey as many of the surveys were completed by office managers.

To help increase the response rates, Chartis held a series of webinars and conducted individual phone calls to help walk practices through the assessment. After receiving pushback from practices, Chartis agreed to accept practices Meaningful Use survey in lieu of filling out the Chartis security survey. Although Chartis agreed to accept Meaningful Use surveys, the response rate did not increase significantly.

e.) IT Change Management Strategy

A change management strategy is important to CPWNY because it helps define the approach and process needed to manage change for the organization. A change management strategy defines processes for submitting a change request, evaluation and approval, testing, communicating and training, and coordinating the actual implementation of the change. For CPWNY, a change management strategy was critical for coordinating change given the number of organizations and stakeholders involved.

With help from CHS and CPWNY, Chartis assessed the current change control process currently in place at CHS, identified its strengths and weaknesses, and determined its viability to extend to support the entire PPS group. Based on input received from the IT Gap Assessment, Chartis was also able to determine the impact of extending the CHS change control process to the PPS members while taking into consideration their current information systems.

The most significant change was applying the change control policy & procedure to smaller entities. Almost half of the PPS partners do not have an established change management process. This indicated that there are not many standard practices among CPWNY partner organizations. However, CPWNY's change management poses little risk as there is no direct data exchanged among the partners and most of the data is being held at CHS.

f.) Addressing Key Findings from IT Assessments & Surveys

After reviewing the results from the IT Gap Assessment, IT Security/Risk Assessment and the IT Change Management survey, CPWNY took Chartis' findings and recommendations back to its Data IT Governance Committee to discuss next steps and to create a change management strategy. DSRIP education and training in practices will be conducted as a result of the findings and the CPWNY Change Management Strategy was reviewed by the Data IT Governance Committee and is expected to be approved in August 2016.

g.) Hosted Data Storage Solution for State-Provided Medicaid Patient: Use of ClearData vendor

CPWNY has been challenged with IT resources needed to complete the required NYSDOH SSP Workbooks in order to receive the NYS Medicaid data. Due to the lack of internal staffing and resources, CPWNY has contracted with the vendor ClearDATA to achieve the DSRIP deliverables of adequate and secure storage of state provided patient data. As part of its work, ClearData reviewed and has led the completion of the System Security Plans (SSP) workbooks. ClearData architects also created a custom designed hosting environment to align with SSP requirements/delivery and conducted a mini security risk assessment for SSP required hosting environment, and continues its remediation planning to support SSP environment.

Currently, the CPWNY IT team and ClearDATA are working on revising the Independent Assessor (IA) returned SSP workbooks and have submitted 4 of the 13 workbooks back during the DY1Q4 remediation. CPWNY continues to have conversations with ClearDATA and Logan Tierny for further guidance on how to complete and pass the SSP workbooks.

By way of background, ClearDATA is a healthcare HIPAA compliant cloud computing company with the HealthDATA ™ platform and infrastructure designed to store, manage, protect, and share CPWNY's patient data and critical applications. By contracting with ClearDATA, CPWNY and its lead entity, Sisters of Charity Hospital, will have in place the secure data set-up to share data with its PPS partners. However, CPWNY does not currently plan on sharing any data outside of its core PMO team. The PPS plans to store data sent by the PPS partners in a secure sever which will be aligned with the NYS patient claims data. Therefore, no NYS Medicaid data will be shared downstream to PPS partners; only data originally sent by the partner will be returned.

Population Health Management

For the CPWNY PPS, the population health management effort is comprised of 4 aspects: 1. Population Health Program Description; 2. IT infrastructure to support the population health management approach; 3. Plans for addressing health disparities in accordance with the NYS Prevention Agenda; 4. Clinical Transformation of Practices to PCMH.

The goal of this workstream is to identify, select, and establish the required information systems and processes to facilitate an operational Integrated Delivery System (IDS) to enable transformation to a population health operating model health care system. This will include components such as data analytics, decision support software suites (such as analytics system), enterprise master patient index, and enterprise data warehousing. These components will perform numerous functions, including the advancement of quality goals and management of cost savings for defined patient populations such as Medicaid beneficiaries, and the development and operation of effective, collaborative care management efforts. Key components of the PPS population health management system are listed below:

a.) Crimson Population Risk Management and Crimson Quality Reporting

A pair of network and population management analytics and reporting applications are essential to monitor the sources of care for patients. The desired outcomes of these applications includes determination of patient care patterns to reduce unnecessary, emergency room, urgent care and hospital services, analysis of the feasibility of required metrics for the development of sustainable bundled payment methodologies and trend analysis to implement better measures to improve quality and reduce cost. They will also provide ongoing monitoring of outpatient care quality based on nationally recognized evidence based measures such as ACO, PQRS and HEDIS measure sets. As of December 31, 2015 a total of 22 eClinicalWorks, two Medent EHR practices have gone fully live with the Crimson Quality Reporting module.

b.) Crimson Care Management

The implementation of this care management application will provide access to complete and timely clinical information to all care management/coordination, physician and other medical service personnel in each patient's health care network. The implementation of this application will facilitate the development of a more comprehensive clinical data set accessible to all care providers, enabling a higher level of coordination. The desired outcomes include optimization of ambulatory care to prevent emergency department visits, initial inpatient admissions and readmissions, coordination of medication reconciliation, identification of at risk patients for follow-up to ensure required treatment and testing is performed and documentation of socioeconomic issues impacting care. This module went live on May 2, 2016. Care Coordinator staff are set up in 43 practices and roll out of the care management module is occurring in phases through the next several months. The PMO IT team intends to expand the population capacity of the Crimson Care Management system to accommodate attributed Medicaid lives.

c.) Enterprise Data Warehouse

Finally, the project will involve enterprise data warehouse selection and implementation to support ad hoc reporting and data analysis for both clinical and financial data at any required level of aggregation. The desired outcomes of this application include the ability to validate the outcome of treatment models to refine care pathways to reduce hospital admissions and other potentially unnecessary services, improve outcome quality and identify at risk populations, provide ad hoc reporting for needs not directly supported by other applications; and facilitate clinical and business analysts' access to data to model potential improvements in clinical workflows and payment mechanisms. Vendor selection for the delivery of an enterprise data warehouse is currently in progress.

e.) Crimson Continuum of Care and Surgical Profitability Compass

The first segment of the data component involves implementation of a cross continuum application to monitor and manage cost and quality of care provided. The system will include the ability to view details of the cost and quality of care at both a provider and patient level. The implementation of this application will facilitate the optimization of cost and quality of care provided to patients in the inpatient and emergency department settings. The desired outcomes are to reduce the cost of required care provided in each setting and to improve the quality of care resulting in better outcomes, greater patient satisfaction and a reduction in long term costs by supporting a higher level of health on a continual basis. The Crimson Continuum of Care (CCC) reports functionality went live on January 14, 2016 and the patient experience went live on May 2, 2016.

Working with the local RHIO/Health Information Exchange (HIE)

Health Information Exchanges are essential for information management in an Integrated Delivery System. Key components of CPWNY's efforts in HIE and RHIO collaboration are detailed below.

MobileMD is an HIE that provides comprehensive data exchange solutions enabling omni-directional communication between care providers and patients. *MobileMD* provides the primary tool to be rolled out to community based organizations who do not already have a patient or clinical portal for information such as real-time delivery of lab results, radiology reports, and transcribed documents. *MobileMD* will be directly integrated with HEALTHeLINK (the local community HIE/RHIO), will allow patients and clinicians to view pertinent health information from numerous data sources from the eight counties of Western New York, and will leverage the dial tone functionalities offered by HEALTHeLINK and the Statewide Health Information Network for New York (SHIN-NY) infrastructure (e.g., C-CDA/CCD exchange, alert and notify, and patient record look-up, including VA patients).

There have been four initial data sources outside of the Catholic Health System and Catholic Medical Partners for the HIE (ECMC Hospital, Kaleida Hospitals, Quest, Roswell Park) have had result delivery from HEALTHeLINK to MobileMD. The review for process of failed results has been completed. The tentative go live date is set for Summer 2016. These results will only flow if the partner attestation process is complete.

Another portion of the HIE component focuses on Western New York's Regional Health Information Organization, HEALTHeLINK. To accelerate transformational change to the region's health care system, HEALTHeLINK capabilities will be expanded in support of DSRIP project 2.a.i – Integrated Delivery System (IDS), with an emphasis on strengthening and protecting continued access to critical health care services and information. NYS DOH expects that each IDS will have/develop an ability to share relevant patient information in a timely manner through use of HIT technology so as to ensure that patient needs are met and care is provided efficiently and effectively. Any patients admitted to any hospital in the IDS should have access to well-coordinated discharge planning, including care coordination services. IDS should also employ systems for tracking care outside of hospitals, to ensure that all critical follow up services are in place and recommendations are followed.

This portion of the HIE component will function in support of the DSRIP PPSs operating in WNY in the following ways:

1. Engage and connect all PPS partners in the HEALTHeLINK network
2. Assure the full range patient data from all sources, in particular the partners practices, is available and accessible via the RHIO
3. Increase the number of practices that can meet 2014 PCMH Level 3 and Meaningful Use requirements for exchange of patient data by using the RHIO
4. Increase access to data for care coordination to reduce hospitalizations.

Leveraging the existing RHIO, HEALTHeLINK, will help accomplish DSRIP goals such as improving population health, supporting transformational change to the health care delivery system, and reducing costs of health care services (*e.g.*, through reducing duplicative testing) and leverages the significant state and capital dollars already invested in HEALTHeLINK to:

- Connect to all the significant sources of patient data, including health care practices, and
- Connect all the PPS partner practices with EMR systems for the bi-directional exchange of patient data via the RHIO.

This existing RHIO infrastructure will be further leveraged to extend the current HEALTHeLINK connections and functions to better connect the PPS partners to patient data, whether sourced from within the local PPS network, regionally outside the PPS network, or from across the state via the connection to the SHIN-NY.

The HEALTHeLINK portion of the Health Information Exchange component is centered on the acquisition and implementation of health information technology. To this end, the **first sub-project** is to acquire and implement a Data Quality Management facility to be used when any practice/hospital is preparing to upload continuity of care documents (CCDs) to HEALTHeLINK. Practice data about patients is uploaded to HEALTHeLINK in the form of a CCD (continuity of care document) at the close of each encounter. Each practice manages how it stores patient data in discrete data fields or as free form text. Additionally, each EMR vendor implements the CCD standards in slightly different ways. The result of this is inconsistent data being uploaded to HEALTHeLINK. When used in population health analytics, this inconsistency causes erroneous or incomplete results making it more difficult to assess the health of the population as a whole and to manage the health of the individuals. The Catholic Health System eClinicalWorks team (which represents many practices which are part of the CPWNY PPS) is working with HEALTHeLINK to help resolve some of the identified issues by testing the CCD sections. Testing is continuing and the first tentative go live for 2 practices is July 28, 2016.

The **second sub-project** is to acquire an automated terminology server; specifically, to purchase and implement a terminology server tool to automatically map all inbound data feeds to a normalized data set to allow storage in and retrieval from the health information exchange (HIE). HEALTHeLINK receives data from over 40 data sources including regional hospitals, labs, radiology providers, home health agencies, long term care and other sources in a mix of local terminology. Each source manages how it assigns data values and codes and each does it differently. The result of this is inconsistent data being uploaded to HEALTHeLINK. When used in population health analytics, this inconsistency causes erroneous or incomplete results making it more difficult to assess the health of the population as a whole and to manage the health of the individuals.

The **third sub-project** is to acquire an enhanced event notifications service within the HEALTHeLINK platform that is configurable to the practice/provider level and triggers notices from multiple event types, *e.g.* ADT values, lab types and values, and other clinical values as configured uniquely to the practice/provider. The overall goal of the DSRIP program is a 25% reduction in avoidable hospital admissions. Care Coordination staff need to be informed immediately if a patient under their care is admitted or discharged from any hospital. HEALTHeLINK is currently connected to every hospital in Western New York and receives ADT messages for all admissions and discharges. HEALTHeLINK will also be connected to SHIN-NY, which will broaden this capability to include the entire state. Currently, notifications can only be configured at the community level. Each Primary Care Provider, Care Coordinator, Care Transitions specialist, etc., has notifications requirements that are specific to their role and/or population being managed. These health care providers need a notifications configuration service that can be tailored to their needs. HEALTHeLINK is currently working on creating filters for the ADT notifications.

The **fourth sub-project** is to acquire software to create a communitywide directory that contains the DIRECT addresses of providers/practices across the community and that can be queried or downloaded to a local provider directory. Most EMR vendors support the DIRECT protocol. The proposed directory will facilitate the direct exchange of patient information between health care settings and will be readily accessible by any provider/users seeking to use secure messaging utilizing the DIRECT protocol. HEALTHeLINK currently offers a DIRECT message service based on the Mirth Mail product. Various DIRECT services can communicate with each other if the sender knows the recipients DIRECT address. CPWNY and HEALTHeLINK are continuing the support and expansion of DIRECT messaging.

The **fifth sub-project** is to acquire 500 authentication tokens to be deployed to CPWNY practices. Authentication tokens are used where alternate authentication methods are not an option. HEALTHeLINK requires the use of two-factor authentication for accessing patient data via HEALTHeLINK. There are currently three methods used to deliver the second factor to the user: 1) phone call to their dedicated business, 2) SMS text message, and 3) hard token. Many facilities do not have dedicated business phones for their staff and some do not allow the use of cell phones during work hours. This leaves only one option for the second factor, the hard token.

Performance Reporting

CPWNY, through the Clinical Governance Committee (CGC) and the Clinical Integration Standardization Group (CISG), provides continuous and on-going monitoring and evaluation of the quality improvement activities through functions defined in the Performance Reporting Quality Improvement Program Description. These committees are essential parts of the CPWNY PPS governance structure. Currently, meetings occur every other month and together they have a robust representation of providers. Review of activities address program satisfaction, special focus areas for monitored diseases, development or adoption of clinical care guidelines; physician and staff education and the quality of clinical care provided to patients with Medicaid coverage and the uninsured.

A Performance Reporting ad hoc team has been convened to facilitate and function in a consultative manner serving as an advisory workgroup to the CPWNY Project Management Office and CGC. The team is comprised of staff from Catholic Health System (of which Sisters of Charity Hospital is a member), Catholic Medical Partners (CMP) and CPWNY. Responsibilities of the team include: developing the performance reporting structure; defining metrics for the Conical Integration program; identifying data sources as needed; create executive and provider specific dashboards for performance reporting; identify potential training needs and training strategy recommendations; inform appropriate governance bodies regarding performance issues.

Inside the PPS PMO, the Clinical Transformation Team is responsible for reporting results of performance reporting metrics to the practices in relation to targeted goals/ thresholds and assist in the utilization of the Rapid Cycle Evaluation (RCE) process in formulating quality improvement plans. The Care Management Advisors explore population health based activities to improve the health of targeted populations. CPWNY has posted dashboards and reports on its website. CPWNY does not have specific provider reports from the state but it performs EMR downloads of the provider EMR system (MEDENT). These reports are done minimally semiannually and the providers and staff whose performance needs improvement complete quality improvement plans that are followed up by the CMP staff.

Practitioner Engagement & Clinical Integration (CI)

Practitioner professional groups are utilized in the PPS governance structure as detailed in the narrative above. These professional groups also serve to disseminate information to the practices in a systematic geographic allocation of resources. Professional Peer groups of CPWNY are:

- Catholic Medical Partners (CMP) Clinical Integration and Standardization Group (CISG)
- Catholic Medical Partners (CMP) Territory/Regional Lead meetings
- PPS Clinical Governance Committee (CGC)
- PPS Executive Governing Board (EGB)
- Catholic Health System (CHS) Clinical Quality Committee.

Clinical staff meetings occur semiannually to disseminate information and engage care coordinators regarding, but not limited to, the Clinical Integration (CI) program, program goals, Cultural Competency and Health Literacy, patient engagement, etc. CMP has a clinical integration strategy in place managed with input from providers (meetings with individual practitioner types). The CI program was modified to include DSRIP initiatives and CPWNY is currently enhancing payments to its providers based on engagement in DSRIP activities. CPWNY currently tracks on multiple spreadsheets on a quarterly basis which is converted to an access database. CPWNY will be able to ascertain what partners are engaged or not based on the access database.

Practitioner and partner engagement includes, but is not limited to:

1. Large group meetings (e.g. medical staff meetings, quality meetings, large management meetings at hospitals)
2. 1:1 meetings at offices with PMO staff and leads and CMP staff (e.g. Clinical Transformation staff, Care Management Advisors, and Territory Lead providers)
3. CPWNY brochures
4. CPWNY website
5. CPWNY quarterly newsletters

Discussions held at the engagements listed include practitioner involvement in projects, Value Based Contracting, Status reports of all workstreams and projects, Performance reporting, RCE, PCMH, MU, DSRIP outcome measures, CPWNY's collaboration efforts with Millennium Collaborative Care, and pending trainings. CPWNY has contracted with Chautauqua County Health Network to engage the Chautauqua County practitioners.

Chautauqua Area Expansion: CPWNY has focused outreach in the Chautauqua area. Since December 2015, CPWNY has contracted with 7 practices in the Chautauqua region; covering approximately 30,000 attributed lives. To better serve the Chautauqua county practices, CPWNY will be using Chautauqua County Health Network (CCHN) to facilitate tracking of the associated practices. CCHN will be tracking all of the required training and educational sessions on behalf of the CPWNY. In addition, CPWNY will be utilizing CCHN to assist with the delivery and implementation of the cardiovascular project in the Chautauqua area. CCHN will be taking the approved policies and procedures from CPWNY and rolling them out in the Chautauqua area to create uniformity across the PPS. Those practices include Jamestown Area Medical Associates, Medicor Associates of Chautauqua, Jamestown Pediatrics, Jamestown Primary Care, Southern Tier Pediatrics, Westfield Family Physician (Westfield & Sherman) and Family Health Medical Services.

Rapid Cycle Evaluation (RCE) Training Planning to Support PPS Partner Performance Improvement:

The RCE strategy for CPWNY is to utilize existing processes of CMP and expand RCE training in the following manner:

A. CMP practices will have a refresher on RCE/PDSA methods by assigned Clinical Transformation Team.
B. Practices not part of CMP will be offered centralized training through vendor services with follow up on utilization of the methodology. Those who did not attend will be offered alternate opportunities to receive training.
C. Practices not part of CMP who have had training in RCE/PDSA would attest to the training, have a refresher course and receive follow-up.

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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: Sisters of Charity Hospital of Buffalo, New York

Project: 2.a.i IDS

Challenges the PPS has encountered in project implementation:
The top four challenges identified by Community Partners of Western NY (CPWNY) in our IDS are as follows: 1. Engagement of providers to expand patient access and to use community organizations to support clinical care and services 2. Integration of community health workers and clinical teams 3. EHR interoperability and reporting to allow for the integration of claims and EMR data 4. Staff training in proactive, patient-centered care. CPWNY has experienced issues with obtaining 100% participation and PCMH achievement. CPWNY acknowledges that PCMH (patient centered medical home) can be a burden for smaller practices due to the amount of documentation required for each of the six standards, as well as the practice's having the appropriate staff.
Efforts to mitigate challenges identified above:
CPWNY will mitigate these challenges using registry and reporting systems to identify patients in need of interventions; these systems will be widely used by our care management team and regional lead team. CPWNY plans to build up its care management team with the addition of Community Health Workers. Together, they plan to engage the provider community, create new relationships and cultivate established linkages. Improving and reducing patient appointment "no shows," especially in primary care, will require creating linkages between clinical practices and community health workers so that CPWNY has active follow up. Improving interoperability, data and reporting will be a task delegated to the PPS's regional training teams, who will assess each practice's competencies and design intervention plans to achieve 100% lean interoperability over the next 2-3 years. The project management team will expand the existing training teams and create training modules, with its workforce partner Rural-AHEC, in the areas of patient centered care, best practices in preventing unnecessary admissions, rapid cycle improvement and team-based care. CPWNY will set reasonable expectations and ensure that the practice teams have the support needed to achieve early success and reward results. Sisters of Charity Hospital has a culture of accountability (responsibility with results) and we will leverage this to drive results in the CPWNY PPS.

In its original implementation plan, CPWNY planned to use the advanced primary care (APC) model to incentivize PCMH achievement, specifically for the smaller and solo practices. APC requirements and planning at the statewide level remains in progress, and guideline clarification likely will not align with DSRIP target completion dates. At the core of an APC is a Per Month (PMPM) payment to support care management and care coordination activities. Therefore, it continues to be a favorable option for implementation. CPWNY team will be waiting for more guidance on how APC can be effective across the PPS in both small and large practices. CPWNY is interested in hearing other PPS's experiences in implementing APC and what the process is for getting APC recognized in regards to the work already completed by a practice for PCMH designation. In addition to the recommendation for the potential of the APC model, the PPS continues to work with the practices with obstacles in obtaining PCMH status. Ongoing communication and recommendations are being made to assist the practice in developing the groundwork needed for PCMH.

The project team for IDS meets monthly to discuss project status and address any issues or barriers to implementation. CPWNY hosts a quarterly quality project team meeting with representation from the 10 projects, 11 work streams, and key committees such as finance, IT, governance, and workforce to provide an opportunity for any outstanding issues or concerns with this project to be addressed in collaboration with key stakeholders.

Implementation approaches that the PPS considers a best practice:

In an effort to avoid duplication across the same geographic area, the two area PPS's, CPWNY and Millennium Collaborative Care have divided the primary care physician population to work on integration and PCMH efforts. CPWNY is working with primary care physicians in the CMP network (some of whom were in Millenniums network) and Chautauqua area primary care physicians, while Millennium is focusing on the remaining primary care physicians in Erie and Niagara counties.

Health Information Exchanges (HIE) are essential for information management in an Integrated Delivery System. Key components of the PPS's efforts in HIE and RHIO collaboration are considered a best practice and are detailed below.

MobileMD is an HIE that provides comprehensive data exchange solutions enabling omni-directional communication between care providers and patients. *MobileMD* has been identified as the primary tool and has been be rolled out to community based organizations who do not already have a patient or clinical portal for information such as real-time delivery of lab results, radiology reports, and transcribed documents. *MobileMD* will be directly integrated with HEALTHeLINK (the local community HIE/RHIO), will allow patients and clinicians to view pertinent health information from numerous data sources from the eight counties of Western New York, and will leverage the dial tone functionalities offered by HEALTHeLINK and the SHIN-NY infrastructure (e.g., C-CDA/CCD exchange, alert and notify, and patient record look-up (including VA patients).

Another portion of the HIE focuses on Western New York's Regional Health Information Organization, HEALTHeLINK. To accelerate transformational change to the region's health care system, HEALTHeLINK capabilities will be expanded in support of the Integrated Delivery System (IDS), with an emphasis on strengthening and protecting continued access to critical health care information. NYSDOH expects that each IDS will have/develop an ability to share relevant patient information in a timely manner through use

of HIT technology to ensure patient needs are met and care is provided efficiently and effectively. Any patients admitted to any hospital in the IDS should have access to well-coordinated discharge planning, including care coordination services. IDS should also employ systems for tracking care outside of hospitals, to ensure that all critical follow up services are in place and recommendations are followed.

This portion of the HIE component will function in support of the DSRIP PPSs operating in WNY in the following ways: Engage and connect all PPS partners in the HEALTHeLINK network; Assure the full range of patient data from all sources, in particular the increase in data from ambulatory EMR's; Increase access to data for care coordination to reduce readmissions through care transitions.

Leveraging the existing RHIO, HEALTHeLINK, will help accomplish DSRIP goals such as improving population health, supporting transformational change to the health care delivery system, and reducing costs of health care services (*e.g.*, through reducing duplicative testing) and leveraging the significant state and capital dollars already invested in HEALTHeLINK to connect all the significant sources of patient data, and connect all the PPS partner practices with EMR systems for the bi-directional exchange of patient data via the RHIO.

This existing RHIO infrastructure will be further leveraged to extend the current HEALTHeLINK connections and functions to improve the PPS partners access to patient data, whether sourced from within the local PPS network, regionally outside the PPS network, or from across the state via the connection to the Statewide Health Information Network for New York (SHIN-NY).

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

In the first year of implementation, the CPWNY Data IT Governance Committee has successfully implemented or began planning for several IT initiatives that align with the PPS work plan. Among them are Tiger Text (e.g. secure text messaging across the care team), MobileMD patient portal, IT Gap Assessment, IT Security Assessment, IT Change Control Assessment, Crimson Population health tools, RHIO engagement, and creation of a Patient Claims Data warehouse.

Currently, Tiger Text has been piloted by two of CPWNY partners, WCA hospital and Buffalo Hospice, as is now available to many of our practitioners in the PPS, and we are looking to expand it to additional partners. These IT initiatives enable partners across the network to communicate in a HIPAA-compliant manner, identify gaps in our network and create linkages between organizations

CPWNY has used CMP's Medinsight and Crimson Population Health software to identify patient needs to produce practice specific reports on quality of care and hospital utilization. CPWNY is targeting the timeframe of end of 2016 for all of the Crimson modules to be implemented across CHS and CMP. As these software tools are rolled out and are proven successful, CPWNY will be looking at expanding the Crimson tool to other PPS partners.

The majority of our practices have received rapid cycle improvement training from the care management advisors and clinical transformation staff and they will continue to provide this training with a specific focus on care management for prevention and for improving care to the high risk population.

CPWNY has expanded its outreach in the Chautauqua area. Since December 2015, the PPS has contracted with 7 practices in the Chautauqua region. To better serve the Chautauqua county practices, we have

contracted with Chautauqua County Health Network (CCHN) to facilitate engagement of the contracted practices. CCHN will be tracking all of the required training and educational sessions on behalf of the CPWNY. In addition, CPWNY will be utilizing CCHN to assist with the delivery and implementation of the cardiovascular project in the Chautauqua area. CCHN will be taking the approved policies and procedures from CPWNY and implementing them in the Chautauqua area to create uniformity across the PPS. Those practices include Jamestown Area Medical Associates, Medicor Associates of Chautauqua, Jamestown Pediatrics, Jamestown Primary Care, Southern Tier Pediatrics, Westfield Family Physician (Westfield & Sherman) and Family Health Medical Services.

By providing training, our partners have made significant strides in becoming certified as NCQA 2014 PCMH Level III. Currently 42% of our primary care providers have already achieved PCMH Level III under 2014 standards. Benefits for practices receiving PCMH Level III are standardization of protocols (i.e., scheduling different kinds of appointments, following up, tracking referrals and lab work), implementation of population health management, and practice readiness for the transition to new payment models. CPWNY, CMP, and CCHN will continue to work with PPS partners on achieving PCMH and/or Advanced Primary Care (APC) certification.

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 not been any significant changes to the populations targeted for the IDS project. This project remains focused on efforts to incorporate medical, behavioral health, post-acute, long-term care, social service organizations and payers to transform the current service delivery system – from one that is institutionally-based to one that is community-based. This project will create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services.

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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: Sisters of Charity Hospital of Buffalo, New York

Project: 2.b.iii ED Triage

Challenges the PPS has encountered in project implementation:
A very significant challenge faced by the ED Triage project is the change in the final DSRIP definition of acceptable patient engagement. In CPWNY's initial DSRIP application, the PPS clearly indicated its intent to use the existing Health Home partnership to successfully redirect unnecessary use of the ED by its members. This included patients already linked to a Health Home as well as newly engaged patients. Although a recent clarification of the rule has been expanded to include Health Home redirection, it only applies to patients already linked to a Health Home. This DSRIP definition of the rule seriously challenges CPWNY's ability to meet previously committed patient engagement numbers. Documentation and tracking patient engagement is an on-going challenge due to the disparate and inadequate electronic medical record (EMR) systems used by partner hospitals. The two main EMR systems in use by the PPS's ED's do not have the ability to communicate effectively with each other. This has necessitated the time consuming manual extraction of potential data, leaving room for miscalculations and missed information. CPWNY discovered that during the data collection process for the DY1 Q4 patient engagement numbers, there was a miscalculation on the cumulative number of patient engagements previously reported. The CPWNY process for collecting this data is complex, using multiple data sources. The wrong data source was used, resulting in an incorrect number of patient engagements reported. Our internal team at CPWNY has revised the reporting methodology and will be submitting a corrected cumulative report for the entire DSRIP DY1. The regional shortage of Primary Care Physicians (PCP) also poses a serious challenge to successful project implementation. This shortage makes it difficult to connect patients to providers and puts additional stress on practices that already serve a disproportionate number of patients with high need. CPWNY is seeing a trend with the PCP's that they are either at maximum patient capacity and no longer accepting new patients or the practice or has a waiting time of several months for new patient appointments, which is well outside of the 30 day ED project criteria.
Efforts to mitigate challenges identified above:

As a result of the findings of the miscalculation of patient engagement numbers, the PPS has begun to do a deeper dive into the process flows and protocols being utilized. This information has brought to light some oversights on the part of the PPS, and CPWNY is beginning to take the necessary steps to rectify the error. The PPS has created an internal ED Triage team to address the need for a unified system/EMR to track patient engagements. The Crimson Care Management tool has been selected to be the mechanism going forward to track and house all pertinent metrics associated with this project. New process flows have been developed and were rolled out to CPWNY's ED's for implementation. The Crimson Care Management tool will enable all departments to see real time updates in a patients file and generate the necessary reportable metrics.

With the formation of new process flows and use of the Crimson Care Management tool, the Catholic Health System's *Health Connections* department has been identified as an essential asset to the overall success of the ED project. Health Connections is a patient call center which has the capability to identify and assist individuals who do not have a PCP and link them with an appropriate provider and other health/wellness resources. Health Connections will be given access to the Crimson tool to document patient's PCP, update personal information, and more specifically to the project, document the date of a patient's follow up PCP appointment and/or Care Manager appointment.

With the finalized definition, the PPS has continued to involve the Health Home partnership, as the PPS sees this as a contributing factor to the overall success of the project. The Health Home has been made aware of the newly released finalized definition, and plans are being made accordingly to ensure patient referrals are being managed and documented accurately.

CPWNY is looking at numerous options to boost overall project performance. Internal team meetings are ongoing to develop best practice models. One strategy under consideration is the use of community health workers to assist with patient identification and tracking. A key area that still needs to be addressed is how the handoff process to the community health worker will be accomplished and how the PPS will track and report the effectiveness of this model.

In an effort to collaborate and share best practices, CPWNY has set up ongoing monthly meetings with another area PPS, Millennium Collaborative Care (MCC). These meetings are designed to share new ideas among the project teams, as well as successes and failures.

The project team for ED Triage meets monthly to discuss project status and address any issues or barriers to implementation. CPWNY hosts a quarterly quality project team meeting with representation from the 10 projects, 11 work streams, and key committees such as finance, IT, governance, and workforce. These meetings provide an opportunity for any outstanding issues or ED project concerns to be addressed in collaboration with key stakeholders.

Implementation approaches that the PPS considers a best practice:

CPWNY expects that the current direction being taken by the PPS to implement this project will ensure success. The projected plan of incorporating additional departments, employing new skill sets (social workers, community health workers) and utilizing care management tools will make it possible to reach a greater scope of patients and achieve a higher level of patient engagement.

Collaboration among CPWNY and MCC PPSs has been beneficial to the overall project goal of reducing unnecessary ED use across the service area and in the development of best practices for the region. Both PPS's are collocated in a very small geographic area, with significant patient overlap.

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

Woman's Christian Association Hospital (WCA) is a key component of this project in the Chautauqua area. Unlike the Erie County region, where the lead organization for the PPS is located, the Chautauqua area has a larger number of PCP's accepting new Medicaid patients. This enhances WCA and its care manager's ability to connect ED patients with follow-up appointments with their current physician or a new community physician in a timely manner. Monthly meetings have been established with WCA to allow for constant communication across the project.

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

The ED project will target two specific overlapping patient populations: (1) Frequent ED users (defined as individuals with 4 or more visits per year) and (2) Persons with behavioral health and substance abuse issues, who form a particular sub-population of frequent ED utilizers. The project will be implemented in phases. The initial focus will target the six Catholic Health System emergency departments, some of which are located where the highest concentration of Medicaid members reside (zip codes 14218 and 14220). During this first year, the remaining five emergency departments will be set up virtually with additional resources deployed in subsequent periods. For example, at Bertrand Chaffee Hospital, CPWNY PPS will deploy virtual care management via electronic connectivity with "real time" care management staff until additional staff is recruited, trained and deployed

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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: Sisters of Charity Hospital of Buffalo, New York

Project: 2.b.iv Care Transitions

Challenges the PPS has encountered in project implementation:
According to the Community Needs Assessment (CNA) Community Conversations, one of the most common negative experiences and greatest challenges in healthcare is the lack of continuity in care. Providers interviewed also echoed the sentiment of lack of continuity made worse by lack of EHR/data integration and limited technology infrastructure across health care settings. Physicians and their care teams are often not notified a patient has been admitted to an inpatient hospital or discharged home. Another challenge has been the lack of standardization of electronic medical records which inhibits the sharing of patient information and coordination of care. CPWNY providers plan to develop and deploy a communication tool and/or integrate EMRs so that coordination of care can occur without added burden. This particular issue, given the nature of the work, is a very time consuming and costly challenge. Finally, PPS partners are challenged by their patients' refusal to participate in the CPWNY Care Transitions Program. The refusal rate for the Care Transitions Program averages 38% in the Medicaid population cohort.
Efforts to mitigate challenges identified above:

In an effort to get physicians on board with the implementation of this project, CPWNY's is using an inpatient care management team to physician approach, to Care Transitions. Physician input is key, as they can identify best practices. CPWNY partner, Catholic Medical Partners, with its base of 1000 providers, plays a vital role in the success of this strategy.

CPWNY has purchased the Crimson Care Management Tool to better assist with the unification of EMRs among CPWNY partners. This application using ADT notifications through the RHIO/HealtheLink to notify physician practices when a patient has a hospital admission and discharge. This supports the care team in providing more effective hospital tracking and post discharge transitional care. With the utilization of this tool, the primary care physicians will be able to receive admission and discharge notifications directly from all hospitals across the eight counties of WNY.

Population Health Management principles assist CPWNY practices in leveraging the resources of the entire practice to proactively identify and address patient needs to ensure optimal clinical outcomes and patient satisfaction while lowering the total cost of care in keeping with the goals of the Triple Aim. The Care Management Program used by CPWNY is a component of the population health management strategy that focuses on the patient population within the practice who have the most complex coordination of care needs, psychosocial and economic barriers to care and increased risk for hospital admission and/or emergency room visits. This program also emphasizes the importance of transition of care patient outreach and engagement to reduce hospital readmissions and/or ED visits.

The project team for Care Transitions meets monthly to discuss project status and address any issues or barriers to implementation. CPWNY hosts a quarterly quality project team meeting with representation from the 10 projects, 11 work streams, and key committees such as finance, IT, governance, and workforce to provide an opportunity for any outstanding issues or concerns with this project to be addressed in collaboration with key stakeholders.

Implementation approaches that the PPS considers a best practice:

CPWNY has implemented the Catholic Medical Partners developed patient centered Enhanced Care Management Program, including transition of care which is delegated to the physician practice. The office based Care Management Program is a team approach to patient care. The program is available to CPWNY family practice and internal medicine physicians. This program was initially implemented in CMP offices in 2008 as the "Care Coordination Program" which was based on the "Chronic Care Model" of the MacColl Institute. This model was considered in the development of care coordination along with the NCQA Patient Centered Medical Home standards and CMS transitional care management services. The Care Management program targets the population at increased risk of hospital admission, readmission, inadequate or poorly coordinated care.

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

Support from Catholic Medical Partners and CPWNY has decreased the burden of staff expense for the independent practice to perform care coordination and improve communication among health care providers across the continuum to reduce unnecessary services. Training on key aspects of the Care Management is provided by CPWNY. Training includes but is not limited to: patient registry development and utilization, adherence to evidence based guidelines, holistic patient assessment, and patient engagement and shared decision making methods, patient centric care plan development and utilization of the electronic medical record to provide proactive, effective patient care. The Care Management Program provides training to encompass all office care team members. As the practice engages in population care management and/or PCMH recognition, Enhanced Care Management focuses on management of the complex, high risk population. The Care Management Program is structured with policies, processes and reports in collaboration with Catholic Medical Partners. Catholic Medical Partners has care management and clinical transformation staff who provide regular on-site support. Rapid cycle process improvement is incorporated into the clinical transformation process within the office care team.

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

The target population continues to be Medicaid patients admitted to the hospital with a high risk for readmission who meet two or more of the 8 BOOST criteria. Medicaid patients are identified while in the hospital through the use of a TARGET assessment 8P scale developed by Project BOOST (Society of Hospital Medicine). The “P” items on the assessment tool include: Problem Medications; Punk/Depression-presence of depression either in screening or in history; Principal diagnosis and/or co-morbidities of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, cancer and stroke; Polypharmacy-number of medications as well as medications that increase the likelihood of adverse events post hospital discharge (66% of patients have at least 2 prescriptions); Poor health literacy-inability to teach back; Patient support-absence of caregiver or limited/lack of social supports; Prior hospitalization in the past six months; Palliative care-patients who have chronic disease management/symptom control needs. Our Community Needs Assessment indicated a high proportion of individuals at risk for re-hospitalization due to the prevalence of diabetes, CHF, cancer, stroke, COPD with co-morbid conditions, as well as behavioral health needs and lack of social supports. Individuals with low socio-economic status often have poor health literacy and therefore do not understand the instructions provided upon hospital discharge. McAuley Seton Home Care may be available to provide additional education and support for self-management in the patient’s home environment.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Sisters of Charity Hospital of Buffalo, New York

Project: 2.c.ii Telemedicine

Challenges the PPS has encountered in project implementation:

The PPS is struggling to meet the previously committed patient engagement numbers across the term of the DSRIP grant. Several barriers have been identified, and solutions are being evaluated to resolve these conflicts. As an example:

Securing payment from Managed Care Organizations (MCO) for telemedicine services for providers continues to be a challenge. On January 1, 2016, a NYS law was passed that designated telemedicine services as a reimbursable service, including the Medicaid Managed Care population, as long as the telemedicine service was not administered in the patient's home. Proper documentation via a HIPPA compliant device(s) has been arranged. There is still no clear delineation of how the services will be covered my MCO's, so there is significant angst to engage this service, without a clear revenue stream that guarantees sustainability.

The credentialing of providers for the telemedicine vendor, Specialist on Call (SOC), has been a significant challenge. The process is complicated and extremely time consuming. Woman's Christian Association Hospital (WCA), the organization leading this initiative, was not able to implement and go "live" with the pilot program until the end of January 2016, and just for some of the services that were originally contracted. With this delay, the PPS has not been able to meet the patient engagement requirement for any of the submission quarters to date. A constraint is the volume of Medicaid patients that are admitted to the hospital or evaluated in the ED and require the services (Approximately 20% on average)

WCA has expressed frustration over the lack of clarity of regulations surrounding chemical dependency and mental health as it pertains to the use of telemedicine. These clinical areas have been identified as essential to the success of the telemedicine project and a critical service need for the community surrounding WCA. Challenges include difficulty in securing/completing appropriate OMH forms: WCA completed and submitted the required paperwork provided by OMH, meeting all of the guidelines and submitting the final documents as directed. After submission, the hospital was notified that the form submitted was incorrect, even though it is the only form currently available. Another challenge has to do with OASAS in obtaining guidelines for telemedicine. After numerous unanswered contacts, WCA finally received a response stating that OASAS does not have specific guidance for telemedicine. WCA is still waiting to hear back from OASAS with final language.

Efforts to mitigate challenges identified above:

In an effort to circumvent the lengthy credentialing process, WCA Hospital is looking internally to amend their medical staff by- laws to allow for quicker physician credentialing. There is a waiver option available, that would allow the PPS lead to credential by waiver, however, the PPS lead, Sisters of Charity Hospital is currently not participating in this project. Since WCA is the only facility currently participating in the telemedicine project, this NYS waiver option does not provide any relief to the hospital. The intent is to delegate this responsibility to the vendor, who certifies their providers meet all eligibility criteria for proper credentialing at the Institution.

WCA hospital is continuing to work with the Office of Mental Health (OMH) as well as OASAS (Office of Alcoholism and Substance Abuse Services) on clarification of the regulations to allow WCA to implement a telemedicine program to serve this population.

CPWNY and WCA Hospital are looking at piloting another Telemedicine project, focusing on establishing a Maternal Fetal Medicine specialist (MFM) relationship to assist patients at WCA. The PPS has identified opportunities for use of a MFM Specialist for Nuchal Translucency scans to determine risk of anomalies such as Down's Syndrome, managing high risk pregnancies, identification of birth defects, and follow up appointments for ultrasounds for troubled pregnancies (twins, prior history of miscarriage, chronic medical conditions, etc.). WCA has identified a need for this type of service to address issues of low compliance with follow up visits and testing, and to assist patients having difficulty with transportation out of the WCA area for these type of appointments. The vision for this project is: WCA completes sonograms at their facility (technical component) and a MFM Specialist interprets the sonograms (professional component) at an offsite location in the Buffalo area. The Buffalo MFM Specialist is currently being selected and this individual/group will provide the necessary training for the WCA sonogram technicians. Currently, CPWNY and WCA are working through budget proposals, collecting information about the specifications of the WCA sonogram equipment, and reviewing the interoperability of the EMR. Once a better understanding of the specific needs and requirements have been established, the PPS will proceed with a vendor to assist with this project. The project lead at the PPS expects that this vendor selection will proceed on a timely basis, once the specifics have been identified. The anticipated volume and need is significant, to assist this rural area provide a higher level of service and quality.

We are in the final stages of implementing a Pilot Program for CPWNY in partnership with People Inc., a not-for-profit organization established to assist Developmentally Disabled (DD) individuals in living a healthier more independent live. The DD population are high users of the ED, due to the significant medical issues they have, and the regulations that govern the care of these patients in group homes. People Inc. has proposed using the telemedicine platform to serve as a service triage center. Our vision contemplates using the Telemedicine platform, and with the assistance of a registered nurse (RN) working face to face with a DD patient, obtaining consultation and assistance with a primary care physician, to discuss the medical issue at hand, and advise an appropriate solution, whether that is to proceed to the ED due to the severity of the problem, or possible redirection to the individuals primary care physician or other certified health care provider at a different date or time. CPWNY is especially enthusiastic about this opportunity because it establishes overlap across multiple projects. In addition to promoting the proper care and treatment for the patient and contributing to patient volume for telemedicine, it supports one of DSRIP's main objectives by redirecting unnecessary ED visits. CPWNY has a relatively small amount of DD population attributed to its patient attribution list. However, the PPS and People Inc. have identified that even though this is a relatively small attribution (less than 100 patients attributed), this population utilizes the ED unnecessarily more than 2 to 3 times more than the typical Medicaid patient. CPWNY is finalizing a contract with a primary care

office which has the ability to facilitate these services. CPWNY plans to have this pilot program up and running in DY2 Q2.

The project team for the telemedicine projects meets monthly to discuss project status and address any issues or barriers to implementation. CPWNY hosts a quarterly quality project team meeting with representation from the 10 projects, 11 work streams, and key committees such as finance, IT, governance, and workforce to provide an opportunity for any outstanding issues or concerns with this project to be addressed in collaboration with key stakeholders.

Implementation approaches that the PPS considers a best practice:

CPWNY has difficulty in assessing a best practice model at this point. The project is still in its infancy stages across multiple fronts, and thus cannot speak with any certainty about best practices. With that being said, CPWNY is very confident that once the efforts to mitigate the challenges faced have been implemented, the PPS will see great return from the additional programs. This will not only be seen in an increase in patient engagement numbers, but will also be displayed in its expanded program development.

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

Community Partners of Western New York is the only Performing Provider System to select Telemedicine as a project.
We have implemented a pilot program with one of our Chautauqua area partners, Woman's Christian Association Hospital (WCA). Specialist on Call (SOC) was selected to be the vendor of choice by both the PPS and WCA. There have been three clinical areas utilizing these services; inpatient neurology, outpatient neurology, and critical care. Credentialing has been finalized for 26 hospital physicians enabling them to participate in this project.

WCA hospital has successfully submitted patient engagement numbers, however, due in part to challenges outlined elsewhere in this document, has not yet met the required scale as committed by the CPWNY.

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

Our target population for this project continues to be patients who present to WCA hospital for both inpatient and outpatient neurology, as well as acute care. WCA and CPWNY are still looking to incorporate the outpatient chemical dependent and mental health patients once clarity surrounding guidelines has been established.
We are adding the target populations of the developmentally disabled patient who will benefit from this program by triaging their medical needs to more efficiently direct the plan of care. CPWNY is also adding the target population of expectant mothers, by incorporating a Maternal Fetal Medicine specialist to assist with the level of care throughout the pregnancy.


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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Sisters of Charity Hospital of Buffalo, New York

Project: 3.a.i Primary Care & Behavioral Health

Challenges the PPS has encountered in project implementation:
CPWNY has encountered challenges with the implementation of both model 1 and model 2 of this project. For Model 1, integrating behavioral health services into primary care sites, the biggest issue we have encountered has been the regulatory barriers around co-locating Article 31 services at an Article 28 hospital clinic that is not a Federally Qualified Health Center (FQHC). Our Article 28 hospital clinics provide primary care services to a large proportion of our Medicaid population and thus were our primary target for this project. The inability to integrate services at these clinics has presented a substantial barrier to reaching our highest need populations. Our second challenge with model 1 is around the sustainability of integrating a satellite clinic into practices with mixed payer profiles. The concern with this model is long term sustainability. If a practice does not have a high enough Medicaid percentage in their patient population or enough demand for behavioral health services, maintaining a satellite behavioral health clinic at that practice will not be sustainable after the DSRIP funding ends. For Model 2, integrating primary care into behavioral health practices, we have experienced challenges with developing an evidence-based and sustainable business model. Many of our participating behavioral health providers have made attempts at integration of primary care into behavioral health sites in the past and found that there was little patient demand and that the financial model was not sustainable. Our first challenge was identifying the true demand for primary care services at behavioral health sites, which we see as a small subset of patients who are unwilling or unable to go to traditional primary care settings. CPWNY has received data from many different sources – health plans, patient self-report, state CPA report, local RHIO, and hospital partners (visits/admissions data). CPWNY is in the process of determining the most accurate and useful data and how to integrate that data into an actionable work flow at the behavioral health provider sites. Another challenge is the lack of a sustainable evidence-based model for integrating primary care into behavioral health. Our primary goal is to link all patients with a primary care provider practicing in a traditional setting, but it is understood that some patients will not access care this way. CPWNY wants to ensure that the resources we devote to this project are going to make a positive impact on our population and we have been challenged to find a model that works for our providers and our patient population. Another project challenge is telemedicine regulations which restrict reimbursement for needed services. Telemedicine consults for mental/behavioral health are currently only eligible for reimbursement when they are provided between two Article 31 providers at different sites, and not from a primary care site to a behavioral health site. This limits the use of telemedicine as a solution for integration in areas with limited psychiatric providers such as rural communities.

Finally, changes in the funding structure of the DSRIP grant, particularly the addition of the EPP program, have disproportionately affected CPWNY's funding structure for this project. Two of the behavioral health metrics are now worth a significant amount compared to the total project valuation. Because of this, our strategy has had to shift to prioritize projects that will have a measurable impact on our outcomes performance versus focusing primarily on meeting DSRIP Domain 1 process requirements committed to in CPWNY's original implementation plans.

Efforts to mitigate challenges identified above:

CPWNY has taken steps to mitigate the challenges identified above.

For model 1, regarding the regulatory barriers, our project lead has been involved in statewide discussions on this topic and has provided specific examples from CPWNY PPS's experience to be included in a letter to CMS from the commissioners of DOH, OMH, and OASAS seeking relief on this regulatory barrier. In the meantime, our team has explored options such as the integrated licensing option, and has been in discussion with the leadership of the CHS hospital clinics. We are waiting to hear back from CMS on this topic before we move forward with our contingency plan. CPWNY has also chosen to universally implement PHQ-2/9 screenings at all of our PCMH practices and has established referral agreements between our primary care providers and key behavioral health partners for expedited access to mental and behavioral health services.

As an interim solution to both the Article 28/Article 31 issue, and the uncertainty around the sustainability of a satellite clinic at a mixed payer private practice primary care site, CPWNY has developed a model for key behavioral health partners to establish a counselor at designated primary care practice sites to do initial screenings, consultations, and connect patients with the appropriate level of behavioral health care within their organization. The counselor will also work with designated practice sites to educate them on mental and behavioral health and act as a consultant to the CPWNY team to help develop work flows and best practices for improving outcomes on our project 3ai performance metrics.

For Model 2, CPWNY has been exploring different levels of integration ranging from universal screening and referral, enhanced care coordination and navigation services, and formal referral agreements between behavioral health and primary care. We have asked our large mental and behavioral health providers to identify primary care practices that they currently have good relationships with to work with them to establish a formal agreement to see patients in need of primary care in a timely manner. We have also explored having primary care mid-levels from these designated practices set up a schedule to perform off-site primary care at behavioral health sites that have higher volumes of patients in need of primary care in an accessible setting. Our team meets monthly with our key mental and behavioral health providers as well as the other PPS in our region to establish standard workflows across the region for improving access to primary care for behavioral health patients. We have also explored using Community Health Workers (CHWs) to enhance the breadth of outreach available to our behavioral health providers. An initial proposal for implementing CHWs has been developed and offered as a pilot to key partners.

The project team for behavioral health integration meets monthly to discuss project status and to address any issues or barriers to implementation. CPWNY hosts a quarterly project quality team meeting with

representation from the 10 projects, 11 work streams, and key committees such as finance, IT, governance, and workforce to provide an opportunity for any outstanding issues or concerns with this project to be addressed in collaboration with key stakeholders.

Implementation approaches that the PPS considers a best practice:

CPWNY and Millennium Collaborative Care PPS (MCC) have a significant number of shared behavioral health partners signed up with both PPSs. CPWNY has been working very closely with MCC to ensure that our work flows and processes are consistent for all of our shared partners and for our region. We consider this close collaboration a best practice for our region. CPWNY and MCC wanted to make sure that our shared mental and behavioral health providers were not receiving different information or responsible for different processes and metrics for the different PPSs. Because of this, the project managers for CPWNY and MCC host a shared monthly work group meeting with key mental and behavioral health partners, coordinate on patient engagement submissions and training opportunities, and have worked closely on data sharing pilots and the development of shared screening policies. CPWNY and MCC also met jointly with the three local health plans to negotiate and align our selection of EPP metrics to minimize administrative burden both for the MCOs and for our key behavioral health partners working towards improving performance on selected outcomes measures.

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

In addition to the efforts included in the implementation plan, CPWNY engaged in a data sharing pilot between our key behavioral health partners and two of the managed care plans in our region. Prior to the pilot our behavioral health providers were relying on patient self-report for collection of key data points such as: primary care provider, chronic health conditions, current prescriptions, and hospital or ED visits. Our goal was to connect these providers with the managed care plans to attempt to get them more real-time information based on claims data, which represents the services and prescriptions that the patients had actually utilized rather than the patients' ability or willingness to provide this information. We were successful in establishing a data sharing process between three of our large behavioral health providers and one of our regional Managed Care plans.

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

This project continues to target all patients in primary care for initial mental and behavioral health screenings, and maintains a specific focus on those prescribed anti-depressants and those transitioning from inpatient BH settings to home or community settings. For Model 2, CPWNY is prioritizing patients who have not had a primary care visit in the past year, especially patients with comorbid chronic conditions such as diabetes, hypertension, and other cardiac conditions. Additionally, we have begun to prioritize patients who have had multiple ED visits or an inpatient admission for a mental or behavioral health condition and, due to the addition of the EPP metrics and their significant valuation, patients diagnosed with Schizophrenia that have been prescribed anti-psychotic medications.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Sisters of Charity Hospital of Buffalo, New York

Project: 3.b.i Cardio-Vascular

Challenges the PPS has encountered in project implementation:
Some of the challenges identified by CPWNY with project implementation include reaching, engaging and motivating the adult Medicaid patient population in the management of their cardiovascular disease. Low education level has influenced successful engagement of the area Medicaid population along with transportation and housing issues which negatively impact patient engagement in seeking healthcare. Another serious challenge is CPWNY partners' lack of consistency in following clinically accepted guidelines. Particularly challenging is the addition of new practices joining the PPS in the Chautauqua area. CPWNY is just in the early stages of becoming familiar with this region and building relationships with the established providers. CPWNY is working to provide timely training and educational materials to these providers as well as all others in the PPS's service area.
Efforts to mitigate challenges identified above:

The following actions will be taken to address the challenge of patient engagement and related barriers: 1) CPWNY will engage community outreach workers along with social workers, to assist in providing linkages to community resources such as legal aid, food banks, transportation, and provide blood pressure monitoring without charge, 2)The Health Home will provide integrated services in one setting for patients needing home care services and 3) PCMH practices will provide open appointment access.

In an effort to assist in the Chautauqua area with guidelines, educational materials, and trainings, CPWNY has partnered with Chautauqua County Health Network (CCHN). CCHN's main focus and responsibility is to work with the Chautauqua area practices on administering the approved policies and guidelines established by CPWNY. They will also provide additional outreach and trainings as needed for the area practices. Monthly meetings have been established with CCHN for ongoing communication along with remediation of issues and concerns.

The project team for the Cardiovascular project meets monthly to discuss project status and address any issues or barriers to implementation. CPWNY hosts a quarterly quality project team meeting with representation from the 10 projects, 11 work streams, and key committees such as finance, IT, governance, and workforce to provide an opportunity for any outstanding issues or concerns with this project to be addressed in collaboration with key stakeholders.

Implementation approaches that the PPS considers a best practice:

CPWNY has adopted national evidence based guidelines from the Institute for Clinical Systems Improvement (ICSI) for the cardiovascular conditions of Diabetes, Congestive heart Failure, Coronary Artery Disease Management, Depression, and Hypertension diagnosis and treatment.

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

In keeping with the Million Hearts Campaign, adopting a heart healthy lifestyle, receiving timely evidence based care and prescribing appropriate medications are included in the cardiovascular care management program developed by Sisters of Charity Hospital/Catholic Medical Partners Project Management Team. The PPS has chosen the Stanford Model program of chronic disease self-management to be implemented to promote patient engagement.

National evidence based clinical guidelines were adopted for the diagnosis and treatment of congestive heart failure, coronary artery disease and hypertension in ambulatory and community care settings. CPWNY partners are using office based electronic health records (EHRs) that enable the practice to create condition specific patient registries identifying patients with "Gaps in Care". Existing resources (the Care Team) include: (a) the clinical transformation team, which supports EHR implementation, maximizes EHR use in the medical office by developing patient registries, and facilitates the use of RHIO, enhancing complete patient health information, (b) social work resources, (c) pharmacist resources, (d) registered dieticians and (e) office based nurse care coordinators. Care coordinators initiate a patient assessment including risks and

barriers, self-management techniques including assessing readiness to change, adherence to treatment plan, lifestyle modification, confidence and conviction. The Care Team follows up on referrals to community based programs. Sisters of Charity Hospital/CMP Project Management Team has web based and in person training programs for care coordinators and materials to leverage across the PPS. Sisters of Charity Hospital/CMP Project Management Team developed a web based "tool kit" to perform an assessment, including health literacy, language/translation needs, and readiness to change. The tool kit provides self-management tools and shared decision making resources for patient engagement.

Tobacco Cessation services are provided by the NYS Quitline using the 5 A's approach since 49% of the Medicaid population are smokers. Patients are referred to nutritionists at community settings for education and budget meal planning promoting hypertension and cholesterol control. Pharmacists assist with promotion of once-daily regimens or fixed –dose combination pills. Patient reminder systems will be expanded and enhanced with secure text messages for blood pressure checks, lab work and office appointment reminders. CPWNY will provide ongoing competency training for all staff and patients on proper BP monitoring techniques. CPWNY will dedicate IT resources to drive improvement in the management of cardiovascular disease through data integration and system interoperability.

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

The target population continues to consist of Medicaid and uninsured patients >18 years attributed to CPWNY PPS in Erie, Niagara and Chautauqua counties with a cardiovascular disease diagnosis. The target population is estimated to be 12,707 individuals.

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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: Sisters of Charity Hospital of Buffalo, New York

Project: 3.f.i NFP

Challenges the PPS has encountered in project implementation:

The largest and most impeding challenge for implementing Nurse-Family Partnership (NFP) as planned has been the budgetary constraints on the program. With the shift in delivery of committed funding from New York State DOH, to a process through the health plans with the added stipulation of reaching HEDIS goals, it has forced CPWNY to first delay and ultimately revoke the plan to implement NFP in Erie County. NFP is a costly program to administer and it requires stable funding to ensure success long term. NFP would positively impact all of the maternal and child HEDIS measures that CPWNY is aiming to hit, but with the limited number of families that NFP can touch due to caseload caps, our scope and reach is limited. Without implementing NFP in Erie County, we will not hit our patient engagement numbers that were set out for DY2Q2, and beyond.

In Chautauqua County, where Nurse-Family Partnership is up and running, there have been some challenges along the way, although many of them minor, with no major implication on the success of the program. The greatest struggles in Chautauqua County are centered on managing the issues of the extremely high-risk, high-need, moms that are being served, in an area that is geographically vast, with scattered resources.

One major structural challenge that Chautauqua County NFP, along with all other agencies running NFP programs in the state have encountered, is the New York State requirement of NFP programs to run under a Licensed Home Care Service Agency (LHCSA). This requirement is specific to New York; most NFP programs outside of New York do not function under a LHCSA. In March 2016, Chautauqua County Department of Health had an unannounced visit from NYS to review charts under the LHCSA. They were cited for a few items, the most significant related to NFP charts not obtaining or utilizing “medical orders”. NYS LHCSA requires that a nurse obtain medical orders from a physician or health care provider before entering a home. This requirement works against some of the primary goals of DSRIP. DSRIP would like to get more people into preventive programs and into primary care, while decreasing the utilization of hospitals and emergency departments. NFP specifically works with a variety of agencies in the community with the hope of finding women who are pregnant but not in care yet, in order to get them established with a physician and into regular prenatal care. While a strong argument should be made for all NFP agencies to be removed from the purview of LHCSA, a waiver for NFP programs functioning under DSRIP funding should be strongly considered.

Efforts to mitigate challenges identified above:

Due to the uncertainty of the flow of funds from New York State, the need to touch more lives in Erie County, and the new stipulation of funds flowing through health plans based on improving specific HEDIS measures, it was determined that the focus and program funding in Erie County should be placed on improving care transitions. A model to improve maternal and child HEDIS measures is currently being developed within the scope of care transitions. This new model will utilize Community Health Workers in high-risk, low-income communities, to assist OB clinics in getting women into prenatal care early (in the first trimester), and keeping them in ongoing prenatal care, with the goal of decreasing the number of low birth weight babies. CPWNY has engaged and contracted with an organization called Community Health Worker Network of Buffalo to aid in the design of this model. We have also engaged another organization, Urban League of Buffalo, whom we intend on contracting with to utilize their Community Health Workers. We are in the early stages of development but hope to have this new program in place before DY2Q3. More discussion of this plan as it relates to the population in Erie County and HEDIS scores that we are looking to impact, can be found below in the last section discussing changes in the population based on needs.

In order to mitigate the challenges that the nurses in Chautauqua County face when dealing with the day-to-days struggles of their high-risk, complicated clients, the nurses receive ongoing reflective supervision to help support them and encourage them as they assist these very troubling cases. Some of the nurses need ongoing reminders of staying on the NFP track and not crossing the line into doing more for the client than is in the scope of work. The goal of the nurse is to make the client self-sufficient and empowered to take control of their lives. It is an ongoing battle for the nurses to be involved with these women, but not over-involved. In addition to regular reflective supervision, the nurses have been offered and trained in Motivational Interviewing. Motivational Interviewing is a learned skill that helps to guide and counsel clients into creating positive change in a client-directed approach that can help them gain better control of their own lives.

Chautauqua County Department of Health developed and submitted a response to New York State related to the LHCSA issues as it relates to NFP, asking for reconsideration of the structure and regulation overseeing NFP. Chautauqua County Department of Health is still awaiting feedback from New York State on their response. As mentioned above, all NYS NFP sites are currently required to work under the LHCSA requirements and are battling the same issues of Doctors' Orders. In order to handle this issue on a larger scale, we have teamed up with other agencies across the state. Amongst five other agencies who run NFP programs, we have created a Community of Practice team, where we hold quarterly meetings via conference call. In those meetings we have a standing agenda item related to the LHCSA issue where we are making concerted, albeit gradual efforts, towards gaining State attention on this matter.

Implementation approaches that the PPS considers a best practice:

The Community Partners of Western New York team successfully completed all of the steps to become a Nurse-Family Partnership implementing agency before the end of quarter 1 in DSRIP year 1. The application and letters of support were submitted to the national NFP office, and the NFP medallion was awarded in June 2015. We began meetings with local agencies and health care providers in both Chautauqua County and Erie County, early in DY1Q1, in order to map out referral systems and workflows. It was part of our strategic move to implement NFP in Chautauqua County first, followed by Erie County early in 2016.

The Administrator was hired in Q1 to oversee the work in both counties. The Chautauqua County NFP team, including: one Supervisor, 2.5 Nurse Home Visitors, and one .5 data support, were recruited, interviewed and selected by early Q2 of DY1.

There was a strong focus in Q2 and Q3 on community engagement in Chautauqua County in order to raise awareness of, and provide education about the program. We met with primary care centers, hospitals, WIC and social service agencies, and all of the OB/GYN practices in Chautauqua County. A Community Advisory Board (CAB) was established in order to advise and support NFP as we implemented and grew the program, and aid in sustaining NFP over time. Early in Q2, we identified a well-established and successful NFP program in Monroe County, NY (Rochester). We collaborated with the Monroe County team and they agreed to act as a mentor agency during implementation and beyond. With guidance from Monroe NFP, we developed and modified relevant protocols and policies for NFP to function within the Catholic Health System and the Chautauqua County Department of Health. Contract discusiions between Community Partners of Western New York and Chautauqua County Department of Health began early in Q2 and contracts were executed before the end of Q2.

We established several working groups in DY1Q2 that meet on an ongoing basis to provide administrative and quality oversight to the program. The Nurse Supervisor, Nurse Home Visitors, Data Assistant, and Program Coordinator meet weekly to discuss administrative items and receive education and/or in-services. Case conference is conducted every other week, to help support and advise the nurses and improve the quality of care for clients. A quality oversight committee consisting of: an OB/GYN, VP of Women's Services, a Social Worker, a Project Management Specialist, and a Public Health Professional, meet on a quarterly basis to review administrative issues and clinical status of clients involved in the program and to address any issues or barriers to implementation. This group reports to CPWNY's Clinical Governance Committee and works closely with the CPWNY Data/IT Governance Committee to oversee quality outcomes and implement new, or changed activities, as needed.

In order to gain greater awareness and provide information about of our local NFP program, a website was created for anyone to access for reference and referral purposes. When the program was being kicked off, and the first clients enrolled, a press release was sent out and picked up by two local Chautauqua County papers. The feedback from those articles was very positive and resulted in at least one referral to the program.

The Chautauqua team began enrolling clients in mid-September 2015. Referrals to NFP have been steady and the nurses have been on track with enrollment goals each month. Since September, 58 moms have been enrolled in the program and over 500 home visits have been conducted. The nurses have, without a doubt made positive impacts on all of the lives they have touched. We have had several moms successfully quit smoking with the "moms quit" program. One mom stayed on Suboxone and delivered a healthy baby. We have helped numerous moms find more stable living conditions which has allowed for improved health and safety for mom and baby. We also secured external grant funding to supply each family in the program with a new car seat and crib for safe sleep. The nurses feel that each mom in the program has been a success in one way or another, and for that, we feel very accomplished.

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

The development of the Community Health Worker program which aims to address HEDIS measures, has not been detailed in the Quarterly Reports and is still in the design phase. Background data and initial development plans are outlined below in the section discussing changes identified by community needs.

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

We conducted an environmental scan and collected qualitative and quantitative information from the community and the clinics that serve pregnant women in our PPS. While we do not see changes in the patient population in Erie, a basic assessment of need before implementing a new model to address maternal-child HEDIS measures was necessary.

The OB clinics that serve women in our PPS acknowledged that women not showing up for their prenatal appointments is one of the biggest barriers that they face in this population. A general theme emerged from all qualitative data, showing that staff perceived that patients missed appointments due to 4 main reasons:

1.) Lack of motivation or not understanding the value of the appointment ("I feel fine….")
2.) Underlying mental health issues
3.) Transportation issues
4.) Childcare or other responsibilities at home

Literature on this topic with this population states very similar findings of perceived reasons that women miss their prenatal appointments. The literature also showed that the perceived reasons for missing an appointment are not always the real reasons why someone misses their medical appointment. Many times there are underlying socioeconomic issues that cannot be altered with a medical office change or intervention. We feel that a bottom-up approach – working within the community, with Community Health Workers, will give us access and a new approach to a segment of the population that has traditionally steered away, or lacked trust in, the medical system. Community Health Workers will create a relationship and trust within the community, and then encourage, and assist women in navigating to prenatal appointments. This is a new approach for these clinics and they feel it could be very successful.

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PPS Name: Sisters of Charity Hospital of Buffalo, New York

Project: 3.g.i Palliative Care

Challenges the PPS has encountered in project implementation:

CPWNY has encountered several challenges with our palliative care project, including a lack of capacity at primary care practices to adopt new palliative care protocols, limited referral volume from primary care practices to palliative care providers, and an inability to meet patient engagement requirements. Our model for this project involves a collaboration between key community palliative care providers and designated primary care practices in our network. Our palliative care partners provide education and training to practices on what palliative care consists of and how to identify and refer palliative care eligible patients. While many practices accept the initial training and education sessions, few are willing to offer time and space to palliative care staff on an ongoing basis. At a few key practices, members of the palliative care team have scheduled time on site each week to perform consultations and make referrals. Our team has found that referral volume is much higher when the palliative care team member is physically present at the office and tends to trickle off when the palliative care team is off site. Initially our palliative care team was working with 5 key practices and has since rolled out to an additional 8 sites in Erie County and 3 sites in Chautauqua County. Despite project expansion, we have not seen sufficient referral volume to achieve our original patient engagement targets.

Additionally CPWNY palliative care team has had some concerns about the outcomes measurement for this project. The initial metrics did not align well with project goals and with the true purpose of holistic palliative care. Our team was a part of the advocacy for new measurement criteria through CAPC. While the outcomes measures were revised, and a new tool was selected, CPWNY's palliative care partners were confused about the selection process for the new tool. The survey tool that was selected has not been used by any of the palliative care programs in New York State to date, and still tends toward a volume-based intervention metric as a gauge for adequate performance. Our palliative care partners have begun to establish a work flow for survey implementation, but are concerned about the value of adding an additional measurement tool when they have already been collecting outcomes data using the Edmonton Symptom Assessment Scale – a common tool used across the state.

Efforts to mitigate challenges identified above:

CPWNY has leveraged existing relationships with primary care practices through Catholic Medical Partners (CMP), the largest IPA in the CPWNY PPS, to advocate for the palliative care program among its primary care providers. As of January 2016, CMP has added palliative care services to its overall clinical integration program goals across payer groups, which has helped to increase awareness and incentivize providers to participate more actively in this project. The palliative care team has provided educational sessions to 18 primary care practice sites in Erie and Niagara counties, CMP's team of care management advisors, and CMP's physician leadership group. The team has been working closely with our Western New York PHIP grant palliative care initiative to promote education and awareness of the value of palliative care in improving the patient experience, health outcomes, and overall cost of care for eligible patients. Our palliative care leads have also presented at a large primary care physician meeting hosted by Chautauqua County Health Network, another partner IPA/ACO in the CPWNY PPS network, and have provided training materials and shadowing sessions to partner palliative care programs in Niagara and Chautauqua Counties. Our Chautauqua County palliative care team has signed on as of April 1, 2016 and has begun outreach and educational sessions to 6 practices in Chautauqua County and has received a favorable response.

In response to the notable increase in volume when palliative care staff are present at the practice sites, our palliative care program in Erie county has established a weekly schedule at key high-volume Medicaid sites to ensure a continued presence and to offer consultations and referrals for eligible patients. CPWNY will look to replicate this model in Chautauqua and Niagara as their palliative care programs get further along in their implementation. Our palliative care partner in Erie County is also in the process of piloting a patient identification tool. This tool will identify patients who may be eligible for palliative care services (based on top 20 diagnosis codes and care history), enabling practices to have palliative care staff available at the time of these patients' scheduled visits.

In order to improve our patient engagement performance, CPWNY has explored options to develop and expand automated patient identification tools and training for primary care providers to perform initial palliative care consults. By equipping our primary care providers to do basic palliative care at the practices, without having to rely on staff from an outside palliative care program, we expect we will be able to engage more eligible patients in palliative care services.

In an attempt to address concerns around the survey tool and selected outcomes measures, our palliative care project leads continue to advocate at a state level in partnership with CAPC and other PPSs across the state that have selected similar projects. We plan to revisit the measurement tool and outcomes selection to better align them with the goals of providing successful, holistic palliative care services.

The project team for integration of palliative care into the PCMH model meets monthly to discuss project status and to proactively address any issues or barriers to implementation. CPWNY hosts a quarterly project quality team meeting with representation from the 10 projects, 11 work streams, and key committees such as finance, IT, governance, and workforce to provide an opportunity for any outstanding issues or concerns with this project to be addressed in collaboration with key stakeholders.

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Implementation approaches that the PPS considers a best practice:

For this project, CPWNY chose to implement our palliative care program on a gradual roll-out basis, starting in one county with one palliative care program partner and a few key primary practice sites to serve as a pilot for perfecting the program before expanding to additional practices and counties. This enabled a controlled approach to implementation, minimizing confusion and providing partners in the later phases of implementation to benefit from the lessons learned from the trials and errors of the early adopters. The roll-out approach also enabled CPWNY to seamlessly incorporate new palliative care partners to work with practices in additional counties by offering them an established, replicable model for integrating palliative care into the primary care work flow.

Another best practice for this project is the use of established palliative care providers and programs in the community to provide the trainings and ongoing palliative care services at the primary care sites. CPWNY's focus has been on building the relationships between primary care and palliative care providers rather than attempting to retrain primary care staff to become proficient in palliative care. Eventually, through continued education and exposure to palliative care, primary care offices may become comfortable enough to offer basic palliative care services using their own staff. However, initially, offering primary care sites and their patients access to expert palliative care staff has eased some of the discomfort around palliative care and enhanced the adoption of palliative care initiatives by primary care practices.

Finally, CPWNY's lead partner organization has developed a report to track the impact of the DSRIP project on designated outcomes not captured by the Palliative Care Outcomes Scale (POS) tool. The palliative care project team was concerned that the POS tool selected by the DOH was not sufficient to demonstrate the overall impact of the project on the target population. The project team developed a report that aligns directly with the proposed outcomes of the palliative care project as well as the greater goal of the entire DSRIP program. The report tracks important metrics including the reduction in unnecessary hospitalization and emergency room visits, completion of Advanced Directives, and referral to hospice, many of which are absent from the POS assessment tool. This report allows CPWNY to demonstrate the measurable impact of the DSRIP palliative care project in our region and allows our PPS to assess the project in a meaningful way to inform project improvement.

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

In addition to the project implementation efforts detailed in CPWNY's implementation plan, the palliative care project team has participated in several additional initiatives in the WNY community focused on increasing awareness of palliative care, training providers to engage in difficult end of life discussions, advocating for expanded coverage for palliative care services, and creating systematic processes for identifying eligible patients who may benefit from palliative care services. Members of CPWNY's key palliative care partner organizations work closely with the P2 Collaborative of WNY, the regional recipient of the Population Health Improvement Program grant, and other key community stakeholders to develop educational materials, promote community awareness, and develop training programs for physicians to better address the palliative care needs of their patients. These programs and initiatives are offered to the entire WNY community, and serve as an opportunity for our palliative care partners to offer some level of education to non-CPWNY providers and organizations that would not be educated through this specific DSRIP palliative care project.

Concurrent with the efforts of our lead palliative care partner to develop a universal patient identification tool, there are discussions happening among key stakeholders in the WNY community, including

representatives from local health plans, to develop a more systematized approach to determining eligibility and facilitate enrollment for palliative care programs. There is considerable interest in the WNY community to expand awareness and access to palliative care services across all payer and product lines, due to its demonstrated benefit in improving outcomes and reducing unnecessary hospital use. Our palliative care team has been active in these discussions around improved patient identification, facilitated access, and coverage of palliative care services in the WNY community.

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

There have not been any significant changes to the populations served by this project. CPWNY has successfully engaged with palliative care programs serving patients in Erie, Niagara, and Chautauqua counties and continues to prioritize primary care practices with high Medicaid volumes. This project continues to target patients with cardiovascular diseases and COPD, as well as other severe chronic illnesses including dementia, terminal cancer, and end stage renal disease.

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DSRIP Mid-Point Assessment - Project Narratives

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PPS Name: Sisters of Charity Hospital of Buffalo, New York

Project: 4.a.i MEB

Challenges the PPS has encountered in project implementation:

The primary challenge that Community Partners of WNY PPS (CPWNY) faced in the implementation of this project was a significant delay in the contracting process due to the complexity of our collaboration with Millennium Collaborative Care (MCC) PPS, our neighboring PPS in Western New York (WNY), and the unique arrangement for CPWNY to assume the full project management and subcontracting responsibilities on behalf of both PPSs.

CPWNY and MCC jointly completed the initial Community Needs Assessment requirement for WNY. Through this process we recognized that we would be addressing similar issues and the same target populations in our region. From the beginning, CPWNY and MCC planned to work with the same key partners to design and implement programs to address identified gaps across the 8 counties. Thus, it made sense to collaborate and pool our resources to strategically and efficiently implement programming across the WNY region.

MCC's lead entity is a public hospital which is required to issue an RFP for each program the PPS's were planning to implement (15 different organizations and programs). This would have caused a notable delay and restricted our ability to work with some of our highly engaged stakeholders had they lost the proposal process. This situation inspired the decision for CPWNY to hold all of the subcontracts for programming on behalf of both PPSs. Due to the unique nature of this contract, developing the agreement structure took a significant amount of time and discussion.

Delays in the contracting between CPWNY and MCC also meant delays in the subcontracts with partners to implement programming to address identified community needs. Due to delays in subcontracting, many of the school-based programs are unable to implement DSRIP programming until the 2016-2017 school year. Other programs experienced loss of qualified candidates due to the delays, and are still in the process of hiring and training staff to carry out identified programs.

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Efforts to mitigate challenges identified above:

Understanding that the contracting process would be lengthy for such a unique alignment, our team worked to prepare all of the programming and subcontracts in advance so everything would be ready to go once the agreement between MCC and CPWNY was signed. We worked closely with our lead partner organizations to identify additional key partners, select evidence-based programming, and develop program budgets in advance of the finalized agreement. CPWNY held informational meetings for all of the organizations that would be program subcontractors to prepare them for implementation once the agreements were finalized. Partner organizations were sent drafts of the subcontract for advanced review so that edits could be accommodated and ready for execution once the MCC-CPWNY agreement was finalized. All partner organizations received training on the funding structure and reimbursement process to prepare them for implementation. This preparation and advanced training allowed our team to quickly execute subcontracts and implement programming once the MCC CPWNY contract was executed.

The project team for Promote Mental, Emotional, and Behavioral Health, including representation from our lead partners and from MCC, meets monthly to discuss project status and to address any issues or barriers to implementation. CPWNY hosts a quarterly project quality team meeting with representation from the 10 projects, 11 work streams, and key committees such as finance, IT, governance, and workforce to provide an opportunity for any outstanding issues or concerns with this project to be addressed in collaboration with key stakeholders.

Implementation approaches that the PPS considers a best practice:

For this project we relied heavily on our lead partner organizations to assist in program design and budget allocations. CPWNY understood that our lead partners had an in-depth understanding of the prevention environment including which programs were effective, where there were gaps in programming in our region, and which organizations would be apt to expand programming and address the needs in our community.

Additionally, we consider our partnership with Millennium Collaborative Care PPS a best practice. The intention of this project is to have a community-wide impact on mental, emotional, and behavioral health. For this project in particular, it did not make sense to work as separate PPSs because of the community-wide nature of the need and the potential benefits. Due to our significant geographic overlap, as well as a multitude of shared partners, CPWNY and MCC knew that we would have the most efficient and effective impact if we joined together to promote a unified message and shared programming throughout our region.

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

In addition to implementing evidence-based programming and a regional public awareness campaign, as detailed in our quarterly reports, the Mental, Emotional, and Behavioral Health project team participates in regional efforts targeted at reducing prescription drug abuse and promoting healthy communities. Representatives from CPWNY participate on the Erie County Opiate Task force, a community effort to address the opiate epidemic in our region. The project team also works closely with the P2 Collaborative, the recipient of the PHIPs grant in Western New York, to align our strategies for promoting mental, emotional, and behavioral well-being. Our public awareness campaign team works closely with other regional campaigns to align messaging and to leverage opportunities for collaboration in overlapping communities.

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 significant changes to our target population for this project. Our program selections and public awareness campaign have been designed to address identified community needs around substance abuse, binge drinking, depression and suicide.

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PPS Name: Sisters of Charity Hospital of Buffalo, New York

Project: 4.b.i Tobacco Use Cessation

Challenges the PPS has encountered in project implementation:
The primary challenges with our tobacco cessation project include misperceptions among providers of the importance of tobacco cessation for patients and perceived barriers with implementation of the NYS Smokers' Quitline automatic referral Opt-to-Quit program. This program allows patients to be automatically referred to the Quitline for free counseling and cessation medication starter kits unless they specifically choose to opt out. Staff from the Quitline assist practices and health care providers adopt a universal referral policy, build automatic referral capabilities and direct exchange from the provider EMRs, and set up capacity for receiving follow up information. Many practices do not appreciate the importance of tobacco cessation; those who do see the value are often unable to devote time to setting up the program and tracking the progress of patients.
Efforts to mitigate challenges identified above:
Representatives from the NYS Smokers' Quitline have been invited to present at CPWNY's project quality team meeting, primary care physician meetings, and meetings of key behavioral health provider groups in order to educate providers about the program and the value it adds for the patient population. The Quitline has hired staff to assist interested provider groups in setting up the automatic referral process and working through some of the technical aspects in order to reduce the burden on the practice staff. Representatives from the Quitline are engaged with key EMR vendors to develop automatic reports based on patient smoking status in order to streamline the referral process and make it easier for physicians to participate. The promote tobacco cessation project team meets regularly to discuss project status and to address any issues or barriers to implementation. CPWNY hosts a quarterly project quality team meeting with representation from the 10 projects, 11 work streams, and key committees such as finance, IT, governance, and workforce to provide an opportunity for any outstanding issues or concerns with this project to be addressed in collaboration with key stakeholders.
Implementation approaches that the PPS considers a best practice:

CPWNY has enlisted local experts on tobacco cessation to lead this community-wide initiative. Roswell Park Cancer Institute in Buffalo, NY has been identified as our lead partner for this project. Roswell Park is the host organization for the NYS Smokers' Quitline, offering counseling and free cessation medications to smokers across New York State. The Roswell Park Cancer Institute Department of Health Behavior is a leader in tobacco research and partners with local organizations and coalitions to promote tobacco-free indoor and outdoor air policies and to raise awareness of the dangers of tobacco products and electronic cigarettes. CPWNY has leveraged the success Roswell Park has had in the past to expand and develop new initiatives to promote tobacco cessation and reduce health disparities from tobacco use in our community.

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

Our lead partner, Roswell Park Cancer Institute, has begun outreach to each of the leads for the 10 CPWNY projects to identify areas for collaboration and potential assistance with tobacco cessation in the targeted project populations. Roswell Park has also presented to project leads from Millennium Collaborative Care PPS to offer their support on tobacco cessation efforts for our neighboring PPS. While MCC did not specifically select the tobacco cessation project, tobacco cessation aligns with many project efforts and benefits the overall health of our community.

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

There have been no significant changes to our target population for this project. We are still looking to identify tobacco-using patients through physician offices and multi-unit housing properties. The project continues to prioritize patients with low socio-economic status and poor mental health but will continue to provide support and tools to any community members interested in quitting tobacco use.