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DSRIP Independent Assessor

Mid-Point Assessment Report

Westchester Medical Center Health PPS

Appendix PPS Narratives

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

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DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Westchester Medical Center

Highlights and successes of the efforts:

Governance

The WMCHealth PPS has successfully built a robust governance infrastructure focused on transparency and accountability. In August of 2014, WMCHealth PPS convened its first meeting of the Executive Committee. Throughout DSRIP Year 1, the PPS governance structure expanded to include 5 additional subcommittees including: the Finance, Nominating, Quality Steering, IT, and Workforce Committees. In response to implementation needs, WMCHealth PPS has also established one workgroup and one taskforce reporting to the Finance Committee (i.e. Financial Sustainability Workgroup, Value Based Payment Task Force) in addition to one workgroup of the IT Committee (i.e. Interoperability Workgroup).

Each of these committees and workgroups are comprised of a diverse blend of community based providers (CBPs), local government units (LGUs), behavioral health providers, hospitals and primary care network partners. Each committee operates within the boundaries of a defined set of by-laws as articulated in each committee's charter. Each committee utilizes two-way communication strategies so that input and feedback from network partners and workgroups are communicated to the appropriate committees and Executive Committee.

WMCHealth PPS has created a clinical governance structure that includes nine Project Advisory Quality Committees (PAQC) and three behavioral health subcommittees established around DSRIP projects. All PAQCs report directly to the Quality Steering Committee which provides oversight on clinical guidelines and ensures successful completion of all clinical quality milestones. Outcomes and information from PAQCs and the Quality Steering Committee is shared with network partners at the Annual WMCHealth Quality Summit in addition to provider webinars. The 2015 Annual Summit had over 200 partners attend in-person.

WMCHealth PPS has engaged and collaborated with regional PPS partners through participation in five Hudson Region cross-PPS and one statewide committee. These are: Hudson Region DSRIP Public Health Council, Hudson Region DSRIP Behavioral Health Crisis Leadership Group, Hudson Region DSRIP Clinical Council, Hudson Region DSRIP Partner Engagement Subcommittee, Hudson Valley Health Regional Officers Network (HVHRON) Meeting and the New York Diabetes Coalition.

WMCHealth PPS has placed a high emphasis on engaging regional community based providers and has contracted with 96 CBPs as well as local government units. WMCHealth has hired dedicated staff, including a Senior Manager, Community Engagement, who has led efforts to create a thorough community engagement plan developed in keeping with results from the Community Needs Assessment and input from subject matter experts.

WMCHealth has created a learning platform supporting various PPS training needs including cultural competency & health literacy trainings. The latest training, "Achieving Equitable Health Outcomes" was given in a "lunch and learn" format and provided a new approach to garnering training and feedback. The training webinar featured multiple educational techniques to engage learners with divergent modes of learning.

WMCHealth, in consultation with Markowitz consulting, facilitated three Community Engagement sessions focused on Latinos/a recent immigrants and established Latino communities in priority neighborhoods. The sessions augmented the findings in the Community Needs Assessment conducted in 2014 to probe more deeply into the healthcare needs and experiences of Latinos/as to inform the development of culturally competent, client-centered healthcare.

Workforce & CC/HL

The WMCHealth PPS' Workforce Training and Education development approach is one of collaboration and inclusion across the WMCHealth PPS network. The PPS Cultural Competency and Health Literacy (CC/HL) Training Strategy, in alignment with Workforce development, serves to enhance culturally and linguistically appropriate awareness, education and inter-professional collaboration of all providers in our network, in an effort to foster an organizational culture that promotes the provision of equitable, person-centered health care and services for all members of our communities. Secondly, it serves to create an environment that facilitates the reduction of target PPS regional health disparities by providing points of two way conversations and by serving as a resource to partners for education and training around the core elements and universal protocols of Cultural Competency, Health Literacy and Social Determinates of Health. Overall, the Training and Education strategy is intended to reach clinicians, other workforce segments and community stakeholders of the PPS region.

During DSRIP Year 1, members of WMCHealth PPS' Workforce Committee and the Community Engagement Quality Committee, comprised of leadership from Community Based Providers, Training and Education Fund of 1199SEIU, Catskill Hudson Area Health Education Center, 1199SEIU, NYSNA, KPMG and CSEA labor unions, began to collaborate on the creation and implementation of training and education. From our community engagement focus groups, literature review, community needs assessment (CNA) and current state assessment (CSA) survey of PPS partners, specific population needs and effective patient engagement approaches were and will continue to be incorporated in training and education development. The PPS Workforce and Cultural Competency and Health Literacy training is delivered using a variety of different learning mediums intended to improve performance in DSRIP project work.

The PPS launched its learning management online platform and this site is the primary source of e-learning courses and access to training materials accessible to all network partners and stakeholders. Users are able to self-manage trainings and access educational and training materials. We introduced our introductory "Achieving Equitable Health Outcomes" and the "Lunch and Learn" series which is the companion training workshop to the e-course. "Achieving Equitable Health Outcomes" addresses subjects such as how to adapt to the diversity of serviced populations, behaviors and communications, workplace application of best practices, implications of best practices and protocols in achieving improved health outcomes and finally the ways in which Cultural Competency and Health Literacy are connected. In DSRIP year 2, we continue to collaborate with identified key stakeholders on training and education initiatives including community stakeholder innovation.

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The WMCHealth PPS collaborated with the Westchester Community Foundation and Markowitz Consulting on the Leveraging Opportunities in Healthcare Delivery System and Payment Reform Learning Lab. This Learning Lab was held for local community-based organizations and providers. This was opportunity for participants to gain the knowledge and practical skills needed to participate strategically in the evolving healthcare environment and prepare for the transition to Value Based Payment (VBP). 11 community based organizations and providers attended. The Lab met biweekly between April 21 and June 16. Another training highlight, is our PPS collaboration with HealthlinkNY and the PHIP initiative on the Blueprint for Health Equity event series (Poverty simulation) with emphasis on understanding Poverty and other SDOH that are apart of understanding the community, the client and identifying systematic changes that need to be addressed. Attendees of this event are leaders and other segments of staff from all facility types. Examples of training and education developed and launched are below:

Patient Activation Measure (PAM) Training for Community Based Providers.
Medicaid Accelerated eXchange Series-Creating Interdisciplinary Team; workshop.
Achieving Equitable Health Care Outcomes: Building a Health Literate and Culturally Competent Organization e course available on learning platform and accompanying lunch and learns.
Asthma Educator Certification Preparation Training Workshop.
Lung Force Exposition registration sponsorship for primary care staff.
Medical Neighborhood Community Meeting Series. Medical Neighborhood Meetings are central to our theme of a well-functioning, avenue of coordinated care, regular communication, and collaboration.
CEU Educational Symposium sponsorship in collaboration with the Catskills AHEC: 1. Improving Healthcare for Lesbian, Gay, Bisexual, and Transgender Individuals 2. EMS Management, Beyond Patient Care for EMS professionals.
Leveraging Opportunities in Healthcare delivery System and Payment Reform Learning Lab Series for leadership of Community Based Providers.
PDSA. Plan, Do, Study, Act trainings. Performance Improvement Training.
InquisitHealth Diabetes Peer to Peer Mentoring.

Opportunities for Educational Symposiums will continue to be part of our workforce professional development strategy. Promotion of the introductory Cultural Competency and Health Literacy e-course “Achieving Equitable Health Outcomes” and the “Lunch and Learn” series will continue to be offered to PPS regional community and network partners. In collaboration with key stakeholders and aligned with the PPS projects deliverables our strategy and plan will introduce opportunities for professional development, in-services, certificates of completion, skill enhancing certificates, continuing education units (CEUs and CMEs) credits, and trainings that offer degree pathways. Cultural Competency and Health Literacy education and trainings opportunities will continue to offer components on awareness, establish knowledge base, demonstrate and review cultural competency and health literate responsive protocol, and provide practical steps in workplace application. We anticipate launching our Career Pathways initiative summer 2016 through a training partnership with Mid-Hudson Regional Certified Home Health Services to offer home

health aide trainings in Poughkeepsie, NY.

You may access the PPS learning management platform by clicking on the following link: https://www.crhi.training.wmchealth.org. The WMCHealth PPS CRHI Cultural Competence and Health Literacy webpage (http://www.crhi-ny.org/center-for-regional-healthcare-innovation/cultural-competence) houses general information, articles, webinars and promotes our e-course to our network partners and community members.

Value-Based Payment Task Force

To better educate the PPS and Partners and to complete the Value-Based Payment milestones, the PPS Finance Committee made a recommendation to the Executive Committee to contract with Manatt, Phelps, & Phillips, LLP healthcare consulting group. Known nationally for their experience, they were called upon to provide their expertise on the PPS's VBP strategy. Manatt and GNYHA have presented the VBP Roadmap and strategy to the Executive and Finance Committees of the PPS. The recommendation to form a Value-Based Payment Task Force was made and implemented. The VBP Task Force comprised of key executives of network partner organizations and Medicaid managed care plan representatives, meets routinely to discuss and systematically implement steps in the PPS's VBP timeline. The Task Force reports to the Finance Committee.

The Task Force has met to review the NYS Value-Based Payment Roadmap and other guidance to begin the process of developing the PPS's value-based contracting strategy. In coordination with Manatt, the PPS has developed and administered a baseline assessment to determine the current structure and capacity for value-based contracting for key network partners.

For example, MVP, a key health plan in the Hudson Valley with participants on the Executive and Finance Committees of the PPS, is operating VBP programs among a number of network partners and across all markets in the Hudson Valley. MVP uses a Core Toolkit to develop and inform VBP arrangements and track provider performance. Manatt has conducted baseline interviews with Fidelis Health Plan, FQHCs and a multi-specialty medical ACO in our PPS, and shares their findings with the Task Force. Some network partner organizations are pursuing the formation of IPAs in anticipation of VBP contracting models.

Financial Sustainability and VBP status surveys have been sent to network providers to assess their financial strength or fragility and approach to value-based contracting. These surveys will be repeated annually.

The PPS has received recognition for its creation of a VBP Learning Lab aimed at educating leadership staff at CBOs and their Board of Directors on understanding VBP, how to demonstrate value for essential services they offer, and defining appropriate outcome measures for those services. In addition, other Network partners have spoken at the NYS VBP Boot Camps regarding their VBP experience and lessons learned.

The PPS is actively engaged with MVP and Fidelis Health Plan's VBP Quality Improvement Program (VBP QIP) Steering Committees in contracting with Bon Secours Community Hospital, Good Samaritan Hospital, and HealthAlliance. On monthly conference calls, discussions regarding the Hospitals' Transformation Plans and next steps for implementation. Transformation Plans include plans for program implementation and governance, types and levels of VBP arrangements, VBP targets and measurement reporting, sustainability measures, and DSRIP goal alignment. The collaboration with the MCOs' on the Transformation Plans and the

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Hospitals has been very productive.

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DSRIP Mid-Point Assessment:
Project 2.a.i: Creating an Integrated Delivery System

PPS Name: Westchester Medical Center

Project: 2.a.i

Challenges the PPS has encountered in project implementation:

- PCMH: An integrated delivery system thrives on connectedness and meaningful exchange of information. The structural framework provided by National Committee on Quality Assurance's (NCQA) 2014 Patient Centered Medical Home (PCMH) recognition requirements for Primary Care practices align well with the requirements needed to create such an Integrated Delivery System. However, the effort and resources required by a primary care practice are considerable and some practices may not be able to reach the goal. We remain committed to using DSRIP resources to help those willing to try. However, one barrier to success cannot be overcome by any amount of hard work. Specifically, the project requires a certain number of PCPs or Safety Net PCPs attain Meaningful Use (MU) and PCMH Level 3 recognition. This number was provided to us by NYS, but it appears that the method used by NYS to identify PCPs does not mirror the definition of a Primary Care Provider eligible for PCMH. Since many of our projects are tied to PCMH implementation this discrepancy in the actual number of PCPs proves to be a handicap to meeting the Provider engagement numbers around this and other projects, particularly 2aiii, 2biv, 3ci and 3diii.

- QE connections: New York State has invested significantly in building the State Health Information Network for New York (SHIN-NY) to support Health Information Exchange (HIE) and clinical interoperability and WMCHealth PPS seeks to build on that investment for the infrastructure that will connect providers and ensure better, more consistent care for patients. However, we have encountered significant confusion among PPS partners and concerns about associated costs and technical requirements including management of the consent process and the risk of security breaches. We have learned there is variability among EHR vendors regarding readiness to address interoperability and in fees charged to build interfaces and/or exchange data. Concerns have also been raised re data quality and completeness, the inadequacy of CCDs and CCDAs.

- Reporting: Some potentially significant barriers to project success are related to technicalities surrounding DSRIP reporting and cut across all DSRIP projects. For reporting project implementation scale NYS counts providers by provider type at the level of an identification number associated with Medicaid billing: the MMIS or NPI number. Reporting of funds flow relies on NPI or a state assigned entity ID number; Operating Certificate numbers are used to identify hospitals in documents addressing determination of safety net status; license numbers are required in some of the IA

specified documentation requirements. Unfortunately two provider attributes that are important for DSRIP reporting, provider type and safety net status, are not consistent for a single organization across the different identifiers. WMC PPS recognizes the challenge faced by the State in determining a reporting mechanism that would apply to the myriad of providers and organizations within each PPS, which range from a single practitioner to health care systems with subsidiaries across many locations. An ongoing challenge of PPs reporting stems from this complexity of the healthcare delivery system and the many different and sometimes inconsistent ways that providers are identified.

Efforts to mitigate challenges identified above:

- PCMH and Counting PCPs for project deliverables:
  - We have engaged Taconic Pro, an organization with a proven track record, to assist the PPS in assisting practices in the transformation to PCMH.
  - NYS recently clarified that PCMH recognition is required only for those PCPs that meet NCQA eligibility criteria for PCMH. We will therefore begin a work plan to evaluate the PCMCH eligibility of every provider identified as a PCP in the NYS Provider Import/Export Tool (PIT).
  - We propose that those found ineligible as PCPs according to NCQA's definition be removed from our target number requirement for all PCP related scale requirements including: MU, PCMH, establishing Qualifying Entity connections, and Clinical Interoperability.
- QE Connections:
  - We are part of the DSRIP CIO Steering Committee convened by KPMG and have collaborated with other PPSs and with the NYS DOH to synthesize issues related to interoperability. We endorse the proposal made by DOH during the recent "listening tour" to focus our efforts around connectivity on those practices and organizations that are motivated to connect but need assistance/encouragement.
  - We work closely with the QE and other PPSs in our region to review the current state and to prioritize practices for outreach and connection. We have established a communication plan for the PPS and the QE to share feedback on facilitators and barriers to connecting.
  - We have established a relationship with NYeC, wherein we leverage information to assess partner status and eligibility for PCMH, MU, and QE connections and to refer appropriate PPS partners to NYeC for financial assistance based on applicable incentive programs.
  - We monitor developments regarding patient consent and communicate them to our partners. We are developing a culturally competent training curriculum aimed both at Medicaid members and the clinic staff who may not be clear on data sharing and how consent works but are nevertheless asked for clarification by patients. We plan to develop and deliver this content throughout the region using the distance learning platform.
  - QE-based alerting is currently being piloted in our region. We will monitor developments related to alerts and based on the results, identify and implement a going-forward plan.
- Reporting technicalities:
  - To address challenges related to reporting we have implemented Sales Force to manage information about partner organizations, the individual practitioners affiliated with those partners and the many different identification numbers associated with each.
  - If a project milestone requires activity at the level of a partner organization but reporting at the level of individual participants, we will document what the organization has done and report the activity for all the NPI and MMIS numbers affiliated with that organization.

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Implementation approaches that the PPS considers a best practice:

- The PPS IT Committee has been a valuable forum for communicating and addressing challenges. The QE is an active member and as such has used the opportunity to explain to IT leaders and stakeholders the current status, challenges, upcoming functionality, etc. The IT Committee has also enabled PPS partners to share experiences.
- Our use of a CRM application, Salesforce, to track partner status, activity, communication, engagement and other factors has greatly enhanced our ability to monitor partner progress manage the network.

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

Despite our initial concerns, ICD10 has not proved to be an implementation challenge to Project 2ai so far. WMCHealth PPS is utilizing the concept of “Medical Neighborhoods” as means of deploying DSRIP projects, including the 2.a.i Create an Integrated Delivery System focused on Evidence Based Medicine and Population Health Management project, across our provider network. The "medical neighborhood," as referenced in the Agency for Healthcare Research and Quality (AHRQ) white paper[1], provides a framework for structured, reciprocal relationships that integrate specialty care and extend the principles of the medical home to all practicing physicians. Being able to understand the patterns of growth and needs of a network is tantamount to creating an integrated network, and Medical Neighborhoods provides us the optimal vehicle to doing so. To address confusion regarding QE requirements and functionality, we have found success in meetings with network partners to explain how IT interoperability fits in to DSRIP overall and is a critical success factor in establishing an IDS. Talking points will be promulgated at standing “medical neighborhood” meetings and formulated into FAQs which will be made generally available to the wider PPS partner community.

[1] Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. June 2011.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
Not applicable

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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: Westchester Medical Center

Project: 2.a.iii

Challenges the PPS has encountered in project implementation:

- Our PPS includes Health Home (HH) agencies as well as FQHC partners who are also providers of Health Home (HH) services and other primary care groups who have implemented their own care management to support Patient Centered Medical Home (PCMH) and/or Accountable Care Organizations (ACO) arrangements. We have relied on these partners during the first year of DSRIP project implementation to share their expertise and experience and to report Actively Engaged Patients for this project. However, to fully reach our goals for this project we will need to build care coordination/ care management support for primary care practices, large and small that have no prior experience with HH or care management. Of course, WMCHealth provides hospital based care management to patients being discharged but did not have a care management organization to support ambulatory practices prior to DSRIP.

- New York State has significant investments in both Health Homes and Patient Centered Medical Homes and building effective collaboration and the capacity for information sharing between Health Homes and PCPs is a fundamental to DSRIP success. Both primary care practices and care management agencies vary in size, models of delivery and degree of sophistication with Health Information Technology (HIT). , We have learned that some of the organizations designated by NYS as provider type “Health Home/Care Manager” do not provide Health Home services. We are tremendously excited about this project to expand care-coordination/care management services more broadly to the Medicaid population and to do so in such a way that we both support Patient Centered Medical Homes and strengthen links between community providers of primary care and care management services. We have also learned that is important to proceed carefully and thoughtfully, to take time to understand our partners’ current status and needs to ensure that the models we develop will help to support and tie together the many activities surrounding DSRIP projects.

- Some potentially significant barriers to project success are related to QE connections and to technicalities surrounding reporting DSRIP milestones by provider type, particularly the number of PCPs. These issues are discussed in detail in project 2ai.

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Efforts to mitigate challenges identified above:

- We have contracted with Nurse Leaders experienced in the development of Care Management Programs to work with our Program Manager, an MSW, to interview our partner organizations in this project to identify best practices to share as well as barriers to implementation: needs for IT support, screening tools or training; work flow issues or other barriers. These interviews will inform development of training material specific to different roles within participating practices and Health Homes.

- We have identified all the organizations identified by NYS DOH as Health Home/Care Managers. We will work with these agencies to learn what they do and craft a participation agreement that is applicable to the various specific roles in the continuum of care.

Implementation approaches that the PPS considers a best practice:

- Our approach to expanding care management for primary care is linked closely to PCMH transformation and will also seek to provide existing Community Based Care Management Agencies a new line of business consistent with workforce goals.

- In the Hudson Valley the two largest PPSs with the greatest overlap of partners collaborated on developing criteria for reporting actively engaged patients to reduce reporting burden for partners and to align for patient goals.

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

- We are planning an all-day training session for care coordinators/navigators, care managers linked to our annual PPS Summit and Quality meeting in early November. Last year our Summit included a speaker from Community Care of North Carolina who was very well received. This year's all day training session will allow a much more detailed exploration of models to deliver care coordination/care management linked to primary care and in conjunction with PCMH.

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

- Analysis of cost and Clinical Risk Group stratification for a Medicaid population demonstrated that the relative cost index for the Health Home population (Two or More Chronic Conditions) is 3.4 compared to a cost index of 1.1 for the Health Home at risk population (Single Chronic Condition). While we have not modified our targeted population based on this analysis, we now know that to be sustainable, any care coordination intervention for the Health Home at Risk population has to be more streamlined and efficient than the care management approach currently used by Health Homes.

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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: Westchester Medical Center

Project: 2.a.iv

Challenges the PPS has encountered in project implementation:
The announcement of CRFP awards for both Bon Secours and HealthAlliance Medical Village projects was delayed until March 2016. As a result, capital planning and construction was stalled, creating longer project lead times that necessitated revisions to the completion timelines. Due to the broad scope of the HealthAlliance project (closing a hospital, consolidating services, and subsequently building the medical village) it is anticipated that completion will go beyond DY5. The Bon Secours Medical Village is anticipated to be completed prior to DY5. Since the submission of CRFP applications, the WMCHealth Network has taken ownership of Health Alliance and is the managing, majority owner of Bon Secours Charity Health System. Plans for both projects have been modified to enhance access, create better patient flow and experience while maintaining all the elements of the original CRFP submission. WMC Health has met with DOH, DASNY and the Grants Management Bureau and approval of modifications is expected. Another consequence of the unanticipated delay in the announcement of CRFP awards is the unanticipated prolonged process to determine which providers will be on site at the Medical Villages. This will potentially impact reaching target numbers for actively engaged patient reporting, meeting speed and scale targets for practitioner engagement, and meeting requirements for the number of network partners needed to be connected to the QE. Lastly, individuals in the community may be impacted by potential disruptions in care delivery during the transition period.
Efforts to mitigate challenges identified above:
Although the announcement of CRFP awards was late, both Medical Village project teams continue ongoing implementation meetings and discussions with potential providers in both communities. Currently, both Medical Villages are working with community providers and organizations to create “virtual” Medical Villages. The PPS is in the process of engaging providers through contracting to ensure participation in the project and to meet practitioner speed and scale targets. The PPS also continues to work with vendors and network partners to establish connections to the QE. To mitigate potential disruptions in care delivery, both Medical Villages are conducting comprehensive community engagement and planning to identify needs, assets, health behavior, and utilization patterns and perceptions. Both will continue efforts to promote awareness and access to new services and outreach programs will focus on identified health needs of the community and will include marketing and communication efforts.

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Implementation approaches that the PPS considers a best practice:
The PPS is pioneering the creation of "virtual Medical Villages" to support DSRIP goals and deliverables while physical plant construction and plans are being finalized. This will give Community Based Providers the opportunity to engage in DSRIP initiatives to form healthy communities and manage the care of shared patients and consumers. Before the CRFP was awarded to Bon Secours, they began working with Cornerstone Family Healthcare to get HRSA approval to open a site in the Medical Village. Also during this time, HealthAlliance began preparations to launch an Ulster County educational platform and medical simulation center housed in existing space on the Broadway Campus.
Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
Bon Secours is working on an organizational plan for including other providers in the Medical Village. They are holding weekly meetings to discuss the scope and what it means to participate. Bon Secours is looking at providers that are currently providing services to individuals in the community in their consideration for a "virtual Medical Village." HealthAlliance is in the process of establishing care transitions and care management pathways among their providers, understanding that it is an essential part of value-based purchasing. At a recent presentation, they learned from RUPCO's board that they have received funding from DOH for supported housing with embedded care managers and are currently examining this model.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
No changes to the population to be served have been identified.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Westchester Medical Center

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:

We encountered the following challenges while implementing the 2biv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions project:

This project requires hospitals to identify health home eligible patients and link them to services. We conducted surveys to gauge the knowledge and understanding, among hospitals, of health homes including referral processes through discussions with the Project Advisory Quality Committees. It was surfaced that hospitals may not be aware of these referral processes. This is our educational opportunity.

This project requires standardized protocols to manage overall population. Through Project Advisory Quality Committee discussions, we are surfacing current practices to identify where standardized processes and protocols across organizations would support the care transitions process.

An integrated delivery system requires and flourishes on interconnectedness and meaningful exchange of information. The National Committee on Quality Assurance's (NCQA) 2014 Patient Centered Medical Home (PCMH) recognition requirements provide a structural framework for Primary Care practices which aligns with the Integrated Delivery System requirements. Some challenges faced while trying to meet the requirements of the milestones of this project:

- <u>The scalability requirement for PCPs to achieve PCMH 2014 Level 3 recognition:</u>

The project requires a certain number of PCPs or Safety Net PCPs to attain PCMH Level 3 recognition. NYS provided this number to us and we have since used this number for scalability across all our project deliverables, including meeting the target number for 2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions. The method utilized by NYS to arrive at the target numbers for PCPs is unclear and does not reflect the eligibility definition of a Primary Care Provider for PCMH recognition as defined by NCQA. As most of our projects are deployed across the Primary Care sector, this lack of clarity around the number of eligible PCPs (Safety Net or otherwise) proves to be a handicap to meeting the Provider Engagement numbers around this project.

Efforts to mitigate challenges identified above:

Our plan to address the challenges listed above:

In regard to having hospitals make appropriate linkages to health homes, we brought together hospitals, primary care providers, non-primary care providers, and health homes to provide an overview of the history of health homes, eligibility criteria, and the referral process. We will continue training and education.

In a combination of group, and Project Advisory Quality Committee meetings, and individual organization meetings we are assisting in the development of organization specific transitions of care processes and workflow. These meetings include process mapping spanning admission through post discharge follow up.

In a recent communication, NYS clarified that the PCMH recognition requirement is required only for those PCPs that meet the eligibility criterion for PCMH. In order to better understand the PCP numbers that NYS originally provided to us as targets, we will initiate a separate work plan to evaluate every provider identified in the NYS Provider Import/Export Tool (PIT) for PCMH eligibility. We propose that the number of providers found ineligible for PCMH, according to NCQA's definition of Primary Care, be removed from our target number requirement.

Implementation approaches that the PPS considers a best practice:

Here are some of the strategies that have had a positive impact on the project:

- Among the tools we are utilizing to support care transitions are (1) the Society of Hospital Medicine Better Outcomes by Optimizing Fare Transitions (SMH BOOST) and (2) the Patient Activation Measure (PAM) survey tool. The BOOST tool provides the ability to risk assess the Medicaid population. The PAM tool enables us to incorporate self-management and patient engagement. We will continue training and education on both tools.

- WMCHealth PPS is utilizing the concept of "Medical Neighborhoods" as a means of deploying DSRIP projects, including the 2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions project, across our PPS Provider Network. The "medical neighborhood," as referenced in the Agency for Healthcare Research and Quality (AHRQ) white paper1, provides a framework for structured, reciprocal relationships that integrate specialty care, primary care, acute care, and social services. The principles of the medical home are extended to all practicing physicians.

- A core principle of the "medical neighborhood" is the Patient Centered Medical Home (PCMH) which offers a promising model for providing comprehensive, coordinated, continuous care and thus, operationalizes effective transitions of care in partnership with the hospitals. By providing assistance to practices to achieve the National Committee for Quality Assurance (NCQA) PPCMH Level 3 Standards smaller practices are better prepared for the transformation of healthcare delivery and payment methods.

1 Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare
Research and Quality. June 2011.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
N/A
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
N/A

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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: Westchester Medical Center

Project: 2.d.i

Challenges the PPS has encountered in project implementation:
We encountered the following challenges while implementing the 2di project: • As implemented to date, our PPS has worked with our partners according to evidence based practice that suggests that activated patients experience better health outcomes and are associated with lower costs.[1] Establishing these practices, focused on coaching and coordinating care, poses as a challenge and requires us to work more slowly than was anticipated. • This project gave the WMCHealth PPS the opportunity to engage and build relationships with community based providers and organizations in the Hudson Valley. We had to work on building relationships and getting community based providers and organization interested in participating in the 2di project as well; in some case this process took several months. • Since PAM is new to our partners, implementation proceeded at a slower pace to accommodate differences in work flow, staff functions, and IT support at each site.
Efforts to mitigate challenges identified above:
Our plan to address the challenges listed above: • We created a scope of work that provides step by step instructions on how to execute the PAM project. • To get more reach we are allowing all network providers the opportunity to participate in the PAM project. The PAM tool is especially beneficial for those primary care practices in the process of transforming into a Patient Centered Medical Home (PCMH).[2] It assists practices identify those Medicaid patients who can self-manage their chronic illnesses, thus allowing practices to effectively tailor their patient engagement and education efforts. • We are supporting some of our CBOs that have high volumes of Medicaid clients by offering to help administer PAM surveys and also providing online community resources tool to help meet needs of the transit Medicaid clients.

[1]J. H. Hibbard, J. Greene, and V. Overton, "Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores,'" Health Affairs, Feb. 2013 32(2): 216–22.
[2]L. Blash, C. Dower, S. Chapman, "PeaceHealth's Team Fillingame Uses Patient Activation Measure to Customize the Medical Home,"© UCSF Center for the Health Professions, May 2011, Revised December 2011.

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Implementation approaches that the PPS considers a best practice:

Here are some of the strategies that have had a positive impact on the project:

- Our use the Community Needs Assessment (CNA) helped us identify priority neighborhoods.
- We researched and contracted with a variety of CBOs in our priority neighborhoods. Our provider types range from food pantries, Local Government Agencies, FQHCs, Hospital ERs, Substance Abuse, and Behavioral Health agencies. We were able to assure we have coverage in our priority neighborhoods.
- Our Community Engagement Quality Advisory Committee (CEQAC) vetted the 2di launch plan before we recruited partners to participate in the project.
- We have incorporated 2di Milestones into our Community Engagement Plan which has provided more opportunities to understand the needs of Medicaid Beneficiaries and the uninsured.

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

WMCHealth PPS is utilizing the concept of Medical Neighborhoods as means of deploying DSRIP projects, including the PAM project, across our provider network. The "medical neighborhood" provides a framework for structured, reciprocal relationships that integrate specialty care and extend the principles of the medical home to all practicing physicians.

We are exploring how the PAM model can be implemented in a sustainable way with our partners; there may be restrictions however given the proprietary nature of training and Flourish licensing.

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

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Our Community Engagement Quality Advisory Committee (CEQAC) is working on Milestone 8 (Include Beneficiaries in development team to promote preventive care) using the PDSA problem solving model with a focus on developing a Diabetes Prevention Plan. It was brought to our attention by the CEQAC committee that we need to include the Maternal Infant & Child Health population because there are a growing number of women being diagnosed with gestational diabetes in the Hudson Valley.

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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: Westchester Medical Center

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

- We have encountered tremendous enthusiasm among Primary Care practices for incorporating behavioral health services into their practice. Those who are part of an FQHC or a multi-specialty group often have on site Behavioral health services and are interested in a more integrated mode of service delivery along the lines of the collaborative care model. Some small practices want to offer Behavioral Health services but are challenged by regulatory and reimbursement constraints and the costs and resources required to meet some of the project milestones.

- A key component of this project is that BH services are available at the primary care site. We believe it is also important that PCPs engaged in screening for BH conditions have back-up expertise for patients whose mental health conditions are too acute or complex to be managed in a primary care setting. That belief was reflected in the number of BH providers we planned to engage in this project which included both those BH clinicians located at the primary care sites as well as BH clinicians located at collaborating sites to provide more specialized BH services.

- The Goal is for 90% of patients to receive appropriate BH screenings at participating primary care sites. This requires a full set of appropriate screening tools for the population of patients; trained staff; procedures (work flow) that ensures screenings are completed and documented; a method of tracking screenings and appropriate follow-up; ongoing measures of performance; improvement strategy and intervention as needed. While all participants were already doing depression screening with PHQ2 & PHQ9, none have all of these elements in place.

Efforts to mitigate challenges identified above:

- The goal of the project is to implement the collaborative care model and we are working with a group of practices to achieve that goal. However, we are encouraging other practices to continue to participate with the committee, even if they may not be able to successfully complete all project milestones. One small pediatric practice sublets office space to an independently practicing Licensed Clinical Social Worker. With patient consent the pediatricians and the social worker are able to collaborate and the patient has an integrated care experience even though the practices are separate.

- We are collecting information on the number and type of BH professionals located within participating primary care practices and on the BH practices and agencies our primary care partners refer to when they encounter patients whose BH needs cannot be addressed within the primary care group. Our approach will be to address work-flow to ensure a "warm hand-off" from the primary care practice to more specialized BH care when it is indicated.

- We spent time exploring models to support on-site BH in a small pediatric practice. One PPS partner Pediatric practice shares office space with a BH clinician who bills separately. The arrangement allows patients to experience integrated care although the BH and Pediatric practice are legally separate entities. The small pediatric practice looking to add BH was bought by a larger participating multi-specialty organization that already had on-site Behavioral Healthcare. Unfortunately, due to the merger activities, the pediatric practice is no longer participating in the project but the parent organization is.

- The committee initially endorsed the PHQ2 & PHQ9 as appropriate depression screening tools for adults and identified modified PHQ-9 for use in adolescents. Next the committee discussed other screenings that would be appropriate in a primary care setting and agreed on screening tools for Substance Use. These will be incorporated into Actively Engaged Patient reporting. The committee has also decided on other areas that might be appropriate (ADHD, anxiety, sleep disorders.) Initially only practices with more developed IT support reported actively engaged patients for this project. Each quarter more practices are trained on how to report actively engaged patients and additional screenings will be added as they are adopted by the committee. The committee with representatives from participating practices also received training in PDSA quality improvement. Practices will receive feedback from the PPS on the number of patients screened and help in identifying opportunities for achieving the 90% goal.

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Implementation approaches that the PPS considers a best practice:

- All participating practices will be interviewed by a team of a Psychiatrist and the project Program Manager (MSW) to identify workflow issues and other barriers, best practices to share, need for additional screening tools and training. These interviews will inform development of training material specific to different roles within participating practices.

- In the Hudson Valley the two largest PPSs with the greatest overlap of partners collaborated on developing criteria for reporting actively engaged patients to reduce reporting burden for partners and to align for patient goals.

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

- The project is guided by the Integration sub-committee of the Behavioral Health Project Advisory Quality Committee which reports to the WMCHealth PPS Quality Steering Committee. We recently did outreach to all committee members and all participating practices to ensure that the committee representation was up to date and aligned with participants.

- The Project Advisory Quality Committee developed a survey to be completed by any organization that was participating in this project. The survey helped to identify current status and best practices among network partners. Additionally, committee meetings included presentation of current practices and challenges from a variety of network partners again to assist in identifying best practices.

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

Not Applicable

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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: Westchester Medical Center

Project: 3.a.ii

Challenges the PPS has encountered in project implementation:
The PPS is working with 7 counties in the Hudson Valley to strengthen the Behavioral Health Crisis intervention system. County based crisis services are funded through a variety of mechanisms including local tax levies, OMH & OASAS funding, and other grant funding. As a result, county specific crisis systems are uneven with varying levels of resources and services. For instance, 2 Counties lack mobile crisis teams and although some providers in different Counties may provide mobile crisis services, they lack the ability to provide 24/7 access. Implementation efforts across 7 counties may be challenging. There are 2 Counties with only 1 hospital having a NYS OMH licensed inpatient psychiatric unit, and these hospitals are not part of the WMCHealth PPS Network due to affiliation with Montefiore Medical Center. There is a shortage of psychiatrists in rural or remote locations of the Hudson Valley resulting in decreased access to behavioral health services. Smaller CBPs without resources and technical infrastructure may have challenges connecting to the QE. Other behavioral health providers have concerns with confidentiality and consent, and are reluctant to connect to the QE. Both of these factors may impact the ability of the PPS to meet speed and scale targets for this deliverable. Lastly, the PPS may have difficulty meeting speed and scale targets for safety net mental health clinicians and safety net clinics due to the differences in the way DOH and the PPS counted clinics in the region. During the application submission process in 2014, the PPS counted behavioral health sites by the number of OMH and OASAS operating certificates, and used these numbers to justify speed and scale targets. DOH is counting clinic sites by organizational NPI number, which significantly impacts the speed and scale targets.

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Efforts to mitigate challenges identified above:

In order to coordinate efforts across all providers in the Hudson Valley region, the 3 PPSs in the area – WMCHealth PPS, Montefiore Hudson Valley Collaborative, and Refuah Community Health Collaborative – are working together as a regional Behavioral Health Crisis Leadership Group to share research and discuss ways to implement services and reach quality measures, regardless of network affiliation. This group holds meetings regularly to share updates and to strategize ways to impact the behavioral health population through shared resources and evidence-based protocols. The PPS also holds regular meetings with County Mental Health Commissioners, community service providers, and hospitals to strengthen and promote access to alternative options to the ER.

WMCHealth has telepsychiatry capacity, as do other providers in the PPS network. They are working with OMH to discuss ways of expanding telepsychiatry services through regulatory waivers.

To meet speed and scale targets, the PPS is engaging safety net providers through a contracting process to ensure meaningful participation and completion of DSRIP goals and deliverables.

The PPS is also requesting that DOH acknowledge the number of OMH and OASAS certified provider clinic sites with operating certificates that were originally counted by the PPS.

Implementation approaches that the PPS considers a best practice:

All 3 PPSs – WMCHealth PPS, Montefiore Hudson Valley Collaborative, and Refuah Community Health Collaborative – have established the Hudson Region DSRIP Clinical Council to meet with all network partners including hospitals, CBOs, FQHCs and MCOs to coordinate efforts to meet the 16 Behavioral Health HEDIS measures being tracked in the MAPP. This group has scheduled a series of meetings to develop clinical criteria and workflows that can assist providers in meeting Behavioral Health HEDIS measures.

The PPS is working with PCG and GNYHA in the 3.a.ii Behavioral Health Crisis Work Group that will begin meeting regularly to contribute lessons learned and innovations from the NYS PPSs involved in the project.

The PPS also has an active Behavioral Health Crisis Sub-Committee, comprised of a diverse group of organizations, that meets monthly to review and discuss best practices, literature, and evidence-based protocols to be used for adoption and implementation in the Hudson Valley. The Sub-Committee has also formed smaller work groups to discuss substance use disorders, managed care, and value-based contracting.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
PMO staff attends a variety of meetings held by network partners to learn about concurrent projects related to DSRIP. The PPS actively participates on the Dutchess County Diversion Committee and supports the Dutchess County Stabilization Center project. The Dutchess County Stabilization Center is set to open in the Fall of 2016 to serve as a 23 hour crisis center where individuals can voluntarily walk-in to access behavioral health crisis services including counseling, detox, peer support, and linkage to community services. Police in Dutchess County will also be retrained to deliver individuals in crisis to this center, as an alternative to the ER. PMO staff also attends regular meetings with the Hudson Valley Mental Health Commissioners to discuss ongoing DSRIP efforts. The Commissioners also meet quarterly for a Hudson Valley Regional Health Officer Network (HVHRON) meeting with the 3 PPSs for communication and updates on DSRIP projects and initiatives. The PPS has attended meetings with OMH to learn about their statewide efforts with crisis stabilization. The PPS also meets periodically with Medicaid Managed Care partners Beacon and MVP to discuss value-based contracting, the expanded Medicaid Managed Care benefits for behavioral health coverage, including Health And Recovery Plans.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
No changes to the population to be served have been identified.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Westchester Medical Center

Project: 3.c.i

Challenges the PPS has encountered in project implementation:

- The first milestone for this project involves adopting evidence based guidelines for management of adults with diabetes. While the Diabetes Project Advisory Quality Committee agreed that practices should follow the recommendations of the American Diabetes Association (ADA), the full ADA guideline is very long and detailed and a summary version is needed to guide implementation. For many years the New York Diabetes Coalition (NYDC) produced a one page summary guideline that the New York State Department of Health endorsed and distributed. But the NYDC summary guideline had not been updated since 2012.

- Because consistent, ongoing, life-style modifications are critical to successful management of diabetes, we want to support evidence based programs like the Stanford Diabetes Self-Management program, however members of the PPS knew from past experience that most organizations providing this course had difficulty sustaining the program when grant funding expired and even when managed care plans were willing to pay the program was not set up to handle PHI or bill for services. We wanted to explore ways to support patient engagement that could be sustainable beyond DSRIP.

- This project is one of several to require a "clinical interoperability system" which was not defined.

- Some potentially significant barriers to project success are related to QE connections and to technicalities surrounding DSRIP reporting by provider type which are discussed in detail in project 2ai.

    - As detailed under project 2ai, initially, the number of PCPs was provided to us by NYS and included Pediatricians who do not care for adults with diabetes as well as other doctors not eligible for PCMH. This project required that 80% of that number be included in the project and, to be consistent, we submitted the same PCP engagement number for other projects linked to primary care. Because the method used by NYS to identify PCPs does not mirror the definition of a Primary Care Provider for PCMH recognition the discrepancy around the actual number of PCPs is a barrier to meeting the Provider engagement numbers for this project.

Efforts to mitigate challenges identified above:

- Guidelines—see best practices.

- We have identified partners among clinical providers and community based providers who offer or would like to offer either the Stanford Diabetes Self-Management Program (DSMP) or the Chronic Disease Self-Management Program (CDSMP) and we are speaking with QTAC about PPS supported training for interested partners. We understand that Stanford DSMP will become a Medicaid benefit in 2017 and we look to PPS support of these programs in 2016 as a way to build capacity to provide this Evidence Based program when it becomes a Medicaid benefit.

- In October of 2015 the Office of the National Coordinator for Health Information Technology (ONC) issued the final version of the Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0. The roadmap sets out period goals to achieve interoperability for 2015-2017 as follows: Send, receive, find and use priority data domains to improve health care quality and outcomes. For project 3.c.i. we will address these goals as follows:
    - Partners in the diabetes project will find and use data to identify patients with diabetes and, as appropriate, send the data elements needed to report actively engaged patients.
    - Within the constraints of Privacy and security regulation, partners will be able to send and receive data relevant to the management of diabetes. (For example: BH partners may obtain consent from their patients to share information with the patient's PCP; the BH partner may then notiy the PCP that the patient is on a BH medication that increases risk of metabolic syndrome; the PCP is able to share information with BH partner that A1C is monitored and controlled.)

- As described in 2ai, we will review every provider identified as a PCP in the NYS Provider Import/Export Tool (PIT) and propose that those found ineligible as PCPs according to NCQA's definition and those whose practice is limited to children be removed from our target number requirement for all PCP related scale requirements for this project.

Implementation approaches that the PPS considers a best practice:

- Dr Scott Hines, Chief Quality Officer and Medical Director of Medical Sub-Specialties at Crystal Run Health is the chair of the WMCHealth Diabetes Project Advisory Quality Committee (Diabetes PAQC) and is chairing the New York Diabetes Coalition (NYDC) which is comprised of all 10 PPSs engaged in the 3ci project. From 1999-2012 the NYDC produced a one-page tool summarizing the American Diabetes Association Treatment Guidelines for Diabetes which was widely used by providers, medical groups and Health Plans in New York (and beyond) but was last updated in 2012. WMCHealth PPS approached PCG and the New York State Department of Health about reconvening the NYDC to update the guideline tool for use in the 3.c.i project. The reconvened NYDC has met once in person and several times by phone and has reviewed changes to the ADA guidelines since the last update in 2012. The goal of the new NYDC is to meet quarterly with the next meeting scheduled for July 20th to obtain consensus on the final revisions proposed for the guideline tool and to discuss recommendations for formatting and distributing the new tool and develop a work plan for the next period.

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

- The Inquisithealth Peer- to- Peer mentoring program is unique in that it combines chronic disease management, workforce development, and patient and community engagement. Patients with well controlled diabetes are offered the opportunity, with training, a secure, private, interactive platform and expert support, to serve as paid peer-coaches to patients with poorly controlled diabetes. A typical enrollment period lasts 6 months and includes phone calls, text messages and the sharing of education content. Two independent randomized clinical trials at UPenn and UCSF have shown that phone-based, peer-to-peer mentoring can reduce A1C significantly (Annals of Medicine, 2012: Annals of Family Medicine, 2013) with a 1.1-point drop in A1C for the peer mentoring arm vs 0.01 - 0.3 drop in the control group with normal care (p, 0.01).
    - WMCHealth PPS is pilot testing the program first at Crystal Run Health with a goal to enroll approximately 100 patients with poorly controlled diabetes. All WMCHealth PPS project advisory quality committees have had training in the Plan, Do Study Act approach. When the first calls to patients were made to announce this program, patients were concerned because they did not know why they were being called. The implementation protocol was then modified to be sure that all patients will receive notice from their Crystal Run doctor about the program before any calls are made by the platform vendor.
    - Three additional PPS partners are interested in this model and we hope to add another 150 patients to the program to accommodate the interested practices.
    - The PPS will measure “contact per mentee/per month” and annual eye exams to assess the project impact.

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

Based on clarification from PCG we will be focusing on adults with diabetes.

From Salient data we know that for the attribution period of 7/14-6/15, we have: 10,607 total unique patients with a primary and/or secondary diagnosis of diabetes. Of these, 229 (2%) are 0-17 yrs old; 10,378 (98%) are 18+ yrs old; 3,374 (32%) are over the age of 65. The impact of excluding those under 18 from this project is small.

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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: Westchester Medical Center

Project: 3.d.iii—**Asthma Management**

Challenges the PPS has encountered in project implementation:

- Early in this project roll-out, Dr. Alan Dozer, the chair of our Asthma Project Advisory Quality Committee (APAQC), presented on the value of an Asthma Action Plan (AAP) in caring for children and adults with asthma. Most primary care partners in this project were already providing Asthma Action Plans but all agreed that capturing the documentation that an AAP was given to a patient was a challenge. Barriers mentioned include: conflicting templates for an AAP, formats requiring color while office printers are black and white, no coding for an AAP, MU requirement that patients receive a visit summary that may include but not highlight the AAP or may not be at an appropriate literacy level.

- While recognizing the importance of the AAP in the care of asthma, the APAQC believes strongly that to improve asthma care, other aspects of asthma management need to be addressed. We are particularly interested in improving access to Asthma Specialty care and in meeting needs from primary care physicians for additional training in asthma management.

- This project is one of several to require a "clinical interoperability system" which was not defined.

- Some potentially significant barriers to project success are related to QE connections and to technicalities surrounding DSRIP reporting by provider type which are discussed in detail in project 2ai.

Efforts to mitigate challenges identified above:

- The APAQC agreed on the minimum content to be included in an AAP and determined that the content, but not a particular format, was required for an AAP. Partner organizations have been working on ways to identify that an AAP has been given to a patient to allow easier documentation of actively engaged patients and to monitor performance.

- Practices working on PCMH with support from Taconic Pro will be encouraged to include asthma as an area of focus and the PPS will identify or develop Asthma related training for primary care that aligns with requirements for meeting the Standards of PCMH: Team Based Care, Population Health management, Care management/support, Performance measurement and Quality improvement. Asthma care specialists within the PPS have developed education and training resources for adult and pediatric primary care physicians. To further assess training needs and need for better access to specialty care we have engaged an experienced asthma management physician expert to conduct interviews with participating practices. One focus of the

interviews will be the potential of telemedicine solutions to improve access to asthma specialty care.

- In October, 2015 the Office of the National Coordinator for Health Information Technology (ONC) issued the final version of the Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0. The roadmap sets out period goals to achieve interoperability for 2015-2017 as follows: Send, receive, find and use priority data domains to improve health care quality and outcomes. For project 3.d.iii. we will address these goals as follows:
    - Partners in the asthma project will find and use data to identify patients with asthma and, as appropriate, send the data elements needed to report actively engaged patients. The practices will receive feedback from the PPS to reflect the performance of the practice in providing AAP to their patients with asthma to allow the practice to improve healthcare quality and outcomes.
    - Implementation agreements with participating partners will include the requirement to put a clinical interoperability system in place.

Implementation approaches that the PPS considers a best practice:

- The PPS has leveraged existing relationships with the regional Asthma Coalition and the American Lung Association of the Northeast to offer Asthma Educator workshops once every quarter. These two day workshops provide prep work and study materials for Asthma Educator certification exams, and are taught by experts in the field. The curriculum covers topics such as Assessing, Diagnosing & Monitoring Asthma, Spirometry, cultural competency elements around addressing patient barriers to medication adherence and effective patient education strategies including age-appropriate teaching strategies. The workshop has been attended by physicians, registered nurses, respiratory therapists and licensed practice nurses within various practices and is helping towards addressing the Milestone 3 deliverable goal. The PPS is also providing exam codes for the workshop participants to take the Asthma Educator certification exam, within 30 days of workshop attendance. With the high frequency of the AE training offerings and the subsidized AE exam codes, we are planning to increase the number of certified Asthma Educators within the PPS along with addressing the workforce training component.

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

The Inquisithealth Peer- to- Peer mentoring program is unique in that it combines chronic disease management, workforce development, and patient and community engagement, patients, or parents of patients, with well controlled diabetes or asthma are offered the opportunity, with training, a secure, private, interactive platform and expert support, to serve as paid peer-coaches to patients, or parents of patients, with poorly controlled diabetes or asthma. A typical enrollment period lasts 6 months and includes phone calls, text messages and the sharing of education content. Two independent randomized clinical trials in St Louis and Milwaukee demonstrated that phone-based telephone peer coaching for parents could reduce children's asthma risk.(In Press: 42% decrease in ED visits for children on Medicaid; Pediatrics, 2009: significant reduction in asthma exacerbations and ED visits.)

- WMCHealth PPS is pilot testing the program first for patients with diabetes in a large multi-specialty practice with a goal to enroll approximately 100 patients with poorly controlled diabetes.
- If the pilot implementation is successful the PPS plans to implement the program for parents of pediatric patients at a Community Health Center.

- We are participating with other PPSs and QEs in a Greater New York Hospital Association sponsored pilot to explore how a care plan may be exchanged between providers using the QE for Health Information Exchange. Specifically we will work with selected partners around the feasibility of exchange of an asthma action plan as a use-case for care plan exchange.

- WMCHealth has invested in state of the art telemedicine technology and is exploring options for expanding the use of telemedicine to the ambulatory setting. Our Technology Partner, Philips, has an international team working on monitoring technology to support patient care for asthma and we were able to host representatives from France, Spain, and the US to meet with the Chair of our Asthma Project Advisory Quality Committee and the Director of Telemedicine at WMCHealth for a discussion of how DSRIP goals could be furthered with use of advanced monitoring technology. The Philips project falls outside of the CMS definition of telemedicine and will not address the milestone requirements for this project but all agreed to remain in touch and to consider how any new technology developed could incorporated to support asthma care for Medicaid beneficiaries.

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 remains Medicaid beneficiaries treated by primary care and specialty providers associated with the PPS.

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DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Westchester Medical Center

Project: 4.b.i. Tobacco Cessation

Challenges the PPS has encountered in project implementation:

1) Evidence Based Guidelines

Implementing the 5A's –Although this is a project requirement, consensus was not reached by the PHC that the 5A's were the only or best approach to engaging patients around tobacco cessation. Motivational Interviewing is another evidence-based approach to working with patients toward Tobacco Cessation that identifies a person's readiness to change as the trigger for goal setting around a change plan. The spirit of Motivational Interviewing emphasizes the importance of accepting a patient where they are, which means respecting their autonomy if they are not ready or willing to quit smoking. This is counter to the 5A's strategy which emphasizes the need to "advise" every patient to quit regardless of readiness.

2) IT Challenges: Quit Line Referrals and Implementing the 5A's into EMR

Quitline Referrals: Interfaces with the NYS Quitline were not available for every practice: operational, technical and cost barriers.

3) EMR Variation: Implementing the 5A's

The large variance in EMRs, clinical workflows, and reporting capabilities among partners has created challenges in implementing all the goals of the project. Identifying all partner sites and existing policies of those sites has also been a challenge.

Efforts to mitigate challenges identified above:

1) Evidence Based Guidelines- Review of literature and consensus that more than one Evidence Based approach is acceptable.

2) IT Challenges: Quit Line Referrals and Implementing the 5A's into EMR- Each participating practice to review best mode of connecting patients to resources, including NYS Quitline. Whenever possible, automated referral to NYS quitline through HER is preferred. We are working closely with the Quitline to share data that will help us capture the impact of our population health strategies.

3) EMR Variation: Implementing the 5A's Partnership with Center for Excellence has allowed us to leverage the work they are doing on 5A's in EMRs. PDSA's targeting workflows among the Public Health Council members have helped align workflows and share best practices. A partner survey conducted by the Public Health Council has helped identify partner locations and existing campus policies.

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Implementation approaches that the PPS considers a best practice:

Cross PPS Collaboration, CBO and Provider Engagement:

Creation of the Public Health Council

The Hudson Region DSRIP Public Health Council (HRD-PHC) represents a collaborative effort between the three Hudson Valley PPSs (Montefiore Hudson Valley Collaborative, Westchester Medical Center PPS, and Refuah Community Health Collaborative) to develop an infrastructure to engage our partners around our Domain 4 Public Health initiatives.

The Goals of the HVD-PHC include:

- Decrease tobacco use in target populations of focus identified in our CNA (youth and people with SMI)
    - We know that 23% of smoking diagnoses are for beneficiaries below the age of 30.
- Increase delivery of high quality cancer screening prevention and management services
- Create linkages to connect patients to community preventative resources throughout the Hudson Valley region.
- Share best practices, align on initiatives and identify gaps in patient and provider engagement.

HRD- PHC Membership includes representation from the 3 PPSs and multiple stakeholder groups including:

- Behavioral and Mental health providers,
- Primary care providers, FQHCs,
- LGUs and
- Other community agencies

Targeted Ad Campaigns

An advertising campaign targeted to teens and their caregivers, to inform them of the harmful effects of the newly popular electronic smoking devices was launched.

- Collaborative effort between the 3 PPSs and Student Assistant Services Corporation (a community based organization focused on substance abuse prevention in schools and communities)
    - Campaign targeted
        - approximately 116,860 students attending 137 public high schools and middle schools in the eight county region and their parents
    - Ads were disseminated to different school districts across the Hudson Valley region.
        - Local CBOs in each county were engaged by SAS to aid ad dissemination efforts
    - Ads can be downloaded freely for use in other regions and to support other initiatives in multiple formats from the HRD-PHC website.

- The Council recognized that the social use of these smoking devices among teens is rising rapidly.
    - Teens are misinformed about the harmful effects these devices have in relation to combustible cigarettes.
    - Parents lack information about these devices including: their appearance, and the negative implications that they have on their children's health.

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

MCO Coverage and reimbursement for Smoking Cessation therapies: There are differences between MCO's in their coverage patterns for various tobacco cessation medications. Because providers and patients are sometimes confused about smoking cessation and NRT coverage and reimbursement, WMCHealth reached out to the Medicaid health plans servicing the Hudson Valley Region to participate in the Hudson Region DSRIP Public Health Council. WMCHealth received two responses, one from United Health Care and MVP Health Care who agreed to join the committee.

Quitline Engagement

Establishing a baseline for smoking rates and overall Quitline usage across the Hudson Valley.

- Regional analysis of data shared by New York State Smokers Quitline completed
- Results shared with PHC members and local government organizations at the August 27, 2015 Hudson Valley Health Regional Officers Network (HVHRON) meeting.
- Analysis identified that 28.53% of patients that contacted the Quitline were age 34 and younger.
    - The council recognized that an opportunity to target interventions towards the casual and young smokers.
- The Council recognized that the social use of these smoking devices among teens is rising rapidly.
    - Teens are misinformed about the harmful effects these devices have in relation to combustible cigarettes.
- Parents lack information about these devices including: their appearance, and the negative implications that they have on their children's health.

Plan Do Study Act Training

The WMCHealth PPS Trained all of their Project Advisory Quality Committee on PDSA method for Quality Improvement. This approach has been widely used in healthcare quality improvement initiatives as a way to ensure that new ideas are sufficiently tested and that interventions can be effectively adapted to local conditions. The PAQCs are responsible to oversee projects and knowledge of the PDSA approach can inform their guidance to Partner organizations.

PDSA at Planned Parenthood around referrals to the NYS Quitline. Planned Parenthood is collaborating with the Center for a Tobacco Free Hudson Valley to develop training regarding referring patients to the quitline.

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

The introduction of e-cigarettes presented a new challenge, particularly for young people: Therefore developed campaign around "vaping" targeting youth.

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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: Westchester Medical Center

Project 4.b.ii – Cancer Screening

Challenges the PPS has encountered in project implementation:

1. Communications platform to connect partners from 3 PPSs
   Our implementation plan proposed using The Mix to facilitate collaboration in the region. Though we did make an effort to enroll participants on The Mix, it did not prove to add value, committee members preferred established modes of communication.

   Evidence Based Guidelines
2. Provider participants voluntarily reported on cancer screening rates: practices used different methods for tracking screening rates so it was difficult to compare results.

Efforts to mitigate challenges identified above:

1. Communications platform to connect partners from 3 PPSs
   Committee participation from all three PPS in the Hudson valley and from county health departments, partner provider organizations and other stakeholders through a combination of face-to-face and web/phone meetings. The Hudson Region DSRIP Public Health Council has a private Linked In group for all committee members to share information and best practices with one another.

2. Evidence Based Guidelines
   The group agreed on USPSTF protocols for cancer screening and NYS 2018 Goals and will continue to discuss best practices for how to monitor screening rates.

Implementation approaches that the PPS considers a best practice:

Cross PPS Collaboration, CBO and Provider Engagement:

The Hudson Region DSRIP Public Health Council (HRD-PHC) represents a collaborative effort between the three Hudson Valley Performing Provider Systems (PPS)-Montefiore Hudson Valley Collaborative, Westchester Medical Center PPS, and Refuah Community Health Collaborative- to develop an infrastructure to engage our partners around our Domain 4 Public Health initiatives.

The Goals of the HRD-PHC include:

- Increase delivery of high quality cancer screening prevention and management services
  - Specifically increase screening rates for cervical, breast, and colorectal cancers
    - Screening rates for these cancers are lower in the Hudson Valley than the State

average
    - Enhance patient cancer screening education and empowerment
        - Twenty-five percent of members do not know where to go for cancer screening
    - Enhance provider screening protocols and adherence to timely follow-up of abnormal test results
    - Create linkages to connect patients to community preventative resources throughout the Hudson Valley region.
- Share best practices, align on initiatives and identify gaps in patient and provider engagement.
- Decrease tobacco use in target populations of focus identified in our CNA (youth and people with SMI)
    - We know that 23% of smoking diagnoses are for beneficiaries below the age of 30.

HRD- PHC Membership **includes representation from multiple stakeholder groups including:**

- Behavioral and Mental health providers
- Primary care providers, FQHCs
- LGUs, and
  Other community agencies

Provider Education

The Cancer Prevention Workgroup integrated targeted, dedicated cancer screening community based organizations into the Workgroup to have a continuous flow of best practice sharing and collaboration. The Cancer Prevention Workgroup also deployed a provider education workshop focused on using the Plan/Do/Study/Act (PDSA) model to increase cancer screening rates within their institutions. The PDSA model will enhance partners' ability to track outcome measures which are the pathway to participation in value-based arrangements.

- Cancer Services Program (CSP) - Shared information on Care Management Resources
- American Cancer Society (ACS) – Shared past and current initiatives, available resources, and extended invitations for future collaborations.
    - On June 7, 2016, Dr. Durado Brooks, Director of Prostate and Colorectal Cancers, Cancer Control Science at the American Cancer Society, presented to local FQHCs regarding best practices and methodologies for colorectal cancer screening.
- PDSA Cancer Screening Workshop – Although participants differed in their current involvement with cancer screening, (the populations they serve and opportunities for improvement) the PDSA model offers a common process that all organizations can use to introduce changes in practice and improve patient outcomes. The workshop focused on implementing the first stages of PDSA that would emphasize improving adherence to cancer screening.
- Plan Do Study Act Training-The WMCHealth PPS Trained all of their Project Advisory Quality Committee on PDSA method for Quality Improvement. This approach has been widely used in healthcare quality improvement initiatives as a way to ensure that new ideas are sufficiently tested and that interventions can be effectively adapted to local conditions. The PAQCs are responsible to oversee projects and knowledge of the PDSA approach can inform their guidance to Partner organizations.

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

In the first year of project implementation, the Cancer Prevention Workgroup focused their efforts on:

- Sharing current practices,
- Aligning on screening goals and guidelines
  - Adoption of the NYS Prevention Agenda 2018 Goals for cervical, breast, and colorectal cancer screening.
- Launching PDSA workshops and structured PDSA coaching technical assistance.
- Building community partnerships to facilitate the adoption of available resources to help us reach the larger project goal of increasing access to high quality chronic disease prevention and management.

Low Cancer Screening Rates

With the current Hudson Valley baseline screening rates in mind, the Cancer Prevention Workgroup initiated project implementation by setting goals for the MHVC network, sharing best practices, and identifying areas for improvement:

- The Cancer Prevention Workgroup reviewed and adopted the NYS Prevention Agenda 2018 Goals for cervical, breast, and colorectal cancer screening

Cancer Type	Cervical	Breast	Colorectal
NYS Prevention Agenda 2018 Goals	88%	80.5%	80%

- Dr. Daren Wu, Chief Medical Officer of Open Door Family Medical and Co-Chair of the workgroup, led a discussion with the workgroup reviewing the United States Preventive Task Force (USPSTF), the American Cancer Society (ACS), and the American Congress of Obstetricians and Gynecologists' (ACOG) cancer screening guideline recommendations
- Workgroup members shared their current organizational screening guidelines and existing care models (included current workflows and follow up protocols).

Patient Education and Empowerment

The workgroup is focusing their efforts on patient education, empowerment, and advocacy through the use of community resources and care management services.

The workgroup recently invited two members from the Albert Einstein College of Medicine to present on their proven community based cancer screening initiatives. These hands-on approaches to patient education and empowerment will assist the workgroup in their future initiatives and education strategies. Presenters include:

- Bruce Rapkin, PhD Presentation: Queens Library Health Link Project – Community based approach to improving cancer prevention and screening among underserved populations.
  - Tailored participatory programs
  - Culturally and linguistically competent patient education
  - Increased patient knowledge of the importance of early detection, awareness of free screenings, and increased the number of patients seeking cancer information
- Rosy Chhabra, PhD Presentation: Cervical Health in the Community (C.H.I.C) Project
  - Peer Driven Intervention focused on reaching and educating Latina women in the Bronx between the ages of 18-50 about HPV and the importance of cervical cancer prevention.
  - Trained participants to be peer health advocates for family and other women in their communities and social networks.

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
In our original application we postulated that access to a prescription for a mammogram might be a barrier to breast cancer screening and hypothesized that a “one-stop” Breast Cancer Screening model might address this barrier. If that were the case, we would attempt to identify partners to pilot test this model. The Gap analysis is not complete (due 12/31/2016) but discussions to date have not identified partners who see a benefit to testing this model.