NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Albany Medical Center Hospital PPS

Appendix PPS Narratives

November 2016

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Prepared by the DSRIP Independent Assessor

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Albany Medical Center Hospital

Highlights and successes of the efforts:

Introduction: This section of the AMCH Mid-Point Assessment provides highlights, successes and the current status of all organizational workstreams. The narrative that follows includes sections on governance, finance, value based purchasing, compliance, workforce, cultural competency and health literacy, IT systems and processes, performance reporting, population health, clinical integration, practitioner engagement and community and consumer engagement. To be successful and sustainable, the PPS recognizes the critical importance of integrating these workstreams into a cogent structure. The synergy developed by this integration fosters a strong and dynamic delivery network prepared to move forward with systems transformation over the remaining years of DSRIP activity. The Project Management Office (PMO) of the PPS supports all of this work with proficient project staff. Participating partners are actively engaged in every workstream component. As demonstrated by the submission of this quarterly report as well as all previous quarterly reports, the PMO and the PPS believe that all workstreams are on track, milestones and tasks have and will be met where and when required and transformation will proceed to improve access to high quality care, reduce costs and prevent the prevalence of disease for the region's Medicaid population.

Governance: Albany Medical Center Hospital PPS continues to operate under a delegated contract model. AMCH serves as the lead applicant and funding conduit. The AMCH PPS submitted a request to have lead applicant status moved to a newly created subsidiary corporation of Albany Medical Center – Better Health for Northeast New York (BHNNY). At the time of this submission, the AMCH PPS is waiting for CMS approval of the VAPP application that will effectuate the transfer. As a solely owned corporate structure, whether under the AMCH PPS or BHNNY identity, this governance arrangement has numerous advantages over other designs in place in other PPSs. Having a sole owner facilitates decision-making, streamlines reporting responsibilities, consolidates fiscal management and compliance requirements, facilitates rapid response and allows for more efficient use of public funds. In addition, it potentially simplifies complex requirements, like the development of IT infrastructure and value based purchasing contracting, by organizing activities that are harder to manage in shared partnership arrangements. In order to continue to obtain active participation from organizational stakeholders, the AMCH PPS recognizes that it must effectively communicate with all partners, develop a high level trust relationship, provide transparency to its decision-making processes, particularly regarding funds flow, and share responsibility for community and consumer engagement. The governance system and structure in place does all of these things, as described below.

The Albany Medical Center Board of Directors has delegated authority for the continued management and oversight of DSRIP operations to an acting Board. The Board will be created on a more permanent basis once BHNNY is approved as lead applicant. This PPS Board of Directors meets every two weeks to discuss policy, receive updates from the PMO on project implementation status, review and approve contracts, review and approve various documents, roadmaps and strategies, and conduct other pertinent business brought before it. A key responsibility of the PPS Board is to provide oversight and direction to the PMO. The CEO of the PMO is an ex officio member of the Board. Board meetings are supported by PMO executive staff. There are seven Committees (finance, technology and data management, audit and compliance, workforce coordinating council, clinical and quality affairs, cultural competency and health

literacy and consumer and community affairs) reporting to the PPS Board. In addition, governance structure includes the PAC Leadership Committee, the PAC, seven Subcommittees and six workgroups.

The PAC Leadership Committee meets monthly. Consistent with the Committee's mission, it provides advice and counsel to the PPS Board, it reviews proposed policy, reviews the annual operating budgets for the PPS, works to educate and engage community stakeholders through a community-building approach and offers a platform for members to openly discuss challenges, successes and other issues related to DSRIP. It is an interactive group that is committed to the success of DSRIP. PAC Leadership has two co-chairs. Dr. Elizabeth Whalen, Commissioner of the Albany County Department of Health, who was elected community co-chair in October 2015, and Courtney Burke, Senior Vice President and Chief Strategy Officer, who was elected institutional co-chair in September 2015. The Committee has 21 elected members, including representatives from CBOs, hospitals, large private provider groups, FQHCs, public agencies, OMH and OASAS-licensed providers and health planning organizations. In addition, each chair or co-chair of the standing committees has a non-voting seat on the committee. Its deliberations are recorded and minutes of every meeting are made public. While it has limited decision-making responsibility, it serves an important role and has significant direct and indirect influence on the Board.

The PAC Committee includes representatives from every participating organization in the PPS. Every county in the regional delivery system is represented as are all provider types. In addition, unions actively participate, representing their membership. The PAC meets monthly. Meetings alternate between webinars and face-to-face meetings. The webinars are generally ninety minutes long and provide routine updates from the standing Committees, progress reports from the clinical and project Subcommittees and other pertinent information all members need to know. The face-to-face meetings are generally at least three hours long and include detailed presentations and discussions of significant issues. For example, the last face-to-face PAC meeting dealt with partner payments and the clinical integration strategy. The primary purposes of the PAC meetings include information dissemination, partner engagement, education & training, questions and answers and relevant updates from the DOH.

The seven standing Committees, the Subcommittees and workgroups, which collectively comprise the remaining governance structure, are discussed as part of the sections below. In each and every instance, partners participate in the work of the Committees, Subcommittees and workgroups.

Finance: While Committees have equal standing, the PPS and PMO recognize the unique role and responsibilities of the Finance Committee. It must develop the annual operating budget, approve expense caps, develop and approve financial management policies, assist members with financial sustainability issues, direct the efforts of the value based purchasing workgroup, the Audit and Compliance Committee and the budget sub-committee. It provides direct oversight and support to the PMO's chief fiscal officer and executive leadership. Nominations for membership to the Finance Committee were solicited via email and PAC meetings. Members were chosen based on the appropriate experience and background with representation from across the five-county region. The roster includes representation from the three hospitals, as well as financial leadership from six other organizations ranging from Medicaid service providers to community-based organizations. The Executive Vice President/Chief Financial Officer of Albany Medical Center was elected to serve as Chair of the Committee. The membership roster was endorsed by the PAC and PAC Executive Committee in July 2015 and by the PPS Board in September 2015. The Committee has met a total of thirteen times from July 2015 through July 2016.

A mission statement/charter was created to guide the role and goals of the Committee. The mission statement was reviewed and approved by the Finance Committee, PAC Leadership, and the PPS Board in August 2015. Additionally, there are six guiding principles of funds flow that the PPS follows as payments are distributed

to partners. These include: Transparency, Patient attribution centered, Project driven, Fair/Equitable, Meets the providers needs and Formulaic. A Financial Budgeting, Management, and Reporting Structure policy was developed to serve as guidance for funds flow and to provide a system of checks and balances internally. This policy was reviewed and approved by the Finance Committee and PPS Board in September 2015.

The Financially Distressed Provider Policy and Financial Sustainability Plan were created in collaboration with the PMO, the PPS Compliance Officer, and legal counsel. The purpose of the policy is to outline the path to financial sustainability, identify any known financial restructuring efforts required, articulate how the PPS will identify and work with fragile safety-net providers to achieve a path of financial sustainability, and describe how the PPS will sustain the outcomes of health systems transformation after the conclusion of the DSRIP grant program. In an effort to monitor the PPS's financial sustainability, an annual assessment will be conducted to evaluate the financial health of the PPS partners against previously established baseline measurements. Additionally, the PMO will routinely request financial information to monitor financial capacity from partners and request that these organizations self-report directly to the PMO changes in their finances such that they meet criteria established by the DOH to be deemed in financial distress. The PPS will provide technical assistance and guidance in addressing the issues affecting the sustainability or performance of the PPS. The PPS may provide assistance to organizations deemed critical to the success of DSRIP based on an assessment of available alternatives, capacity and willingness of other organizations and the ability to meet speed and scale or other DSRIP reporting measures on a case-by-case basis. However, the PPS will not assume financial liability on behalf of any organization or participating provider, but is committed to ensuring continuity of services as necessary to meet milestones and goals of the DSRIP program. These policies were reviewed and approved by the Finance Committee, PAC Leadership, and the PPS BOD in December 2015. To maintain transparency and keep our partners informed, the policy was emailed to the PPS network in January 2016.

The PMO developed a funds flow model in October/November 2015 based on approved budgets, lag analysis, annual expense caps, project specific timelines, and deliverables. A Budget Subcommittee, which is comprised of thirteen members of the Finance Committee, was convened to discuss and develop the funds flow methodologies while following the guiding principles approved by the Finance Committee. The Subcommittee met weekly for six weeks to review the potential sources of data, the lag analysis, contract revenue by project, budgets by project, and the attribution by provider. The result of these meetings and discussions was an in-depth analysis of each project and proposed funding methodologies. The Subcommittee made a recommendation to the Finance Committee to approve these individual budgets by project. Each project that had unique deliverables was allocated funds designed to ensure continuous and successful implementation. These budgets were approved by the Finance Committee in November 2015 and by the PPS Board in December 2015. Additionally, these budgets were emailed to the PAC and posted on the PPS website.

Following the approval of the budgets by project, there were several discussions about the need to redefine and elaborate on the deliverables to ensure the funding methodology was in line with fair market value and various regulatory concerns. Several people were involved in these discussions including the PMO, the PPS Compliance Officer, the Finance Committee, the PPS Board and legal counsel. With the approval of the Finance Committee and PPS Board, the PPS executed a contract in April 2016 with COPE Health Solutions to refine the funds flow methodology. COPE is a healthcare consulting firm that currently is assisting six other PPS's with their funds flow methodology and contract process. Over the course of the first phase of this contracting process, refined deliverables were created that range from project or work stream specific to reporting or engagement. The deliverables are delineated based on provider type. However, several of the deliverables are required regardless of provider type. The funds are allocated based on project participation, safety-net designation, and attributed lives. Contracts for the first phase of contracting were emailed to all

partners that have an executed partner agreement and business associate agreement and have expressed interest in project participation. The term of these agreements is April 1, 2015 – December 31, 2016. Partners will receive a retrospective payment for work that was completed prior to contract development in August 2016. The PPS is in the process of engaging COPE Health Solutions in the second phase of contracting, which will be largely focused on transitioning the PPS towards value-based purchasing.

The PPS PMO developed a comprehensive baseline assessment that was distributed to over 175 partners. The survey included several financially-based questions in an effort to update the original assessment performed during the planning phase, to obtain baseline financial information about the PPS network, to identify any partners that may be in financial distress, and to assess the network's willingness and ability to pursue value-based purchasing (VBP) payment models. Many questions were asked, including whether organizations process their own payroll, their amount of working capital, current ratio, days of cash on hand, debt ratio, debt-to-equity ratio, debt service coverage, and the organization's top business and financial challenges. A total of 60 organizations completed the assessment. Their data was analyzed and aggregated into presentation materials. The purpose of these materials was to detail the results while maintaining the anonymity of the partners. In the absence of published benchmarks, the PMO used general guidelines in an attempt to analyze the data and draw inferences regarding the overall financial well-being of the network.

Financial Indicators and Benchmarks:

Financial Indicator	Definition	Calculation	Benchmark
Working Capital	The capital of a business that is used in its day-to-day operations. Working Capital is a measure of both a company's efficiency and its short-term financial health.	Current Assets - Current Liabilities	25% operating reserve or 3 months of the annual expense budget
Current Ratio	An indication of a company's ability to meet short-term debt obligations. A Current Ratio of less than 1 means there are greater current liabilities than there are current assets to pay them.	Current Assets/Current Liabilities	1
Days of Cash on Hand	The days cash on hand represents the number of days of operating expenses that an organization could pay with its current cash available.	(Cash + Unrestricted + Investments)/((Total Operating Expense - Depreciation)/365)	At least 90
Debt Ratio	A financial ratio that measures the extent of a company's leverage. A high value can suggest liquidity problems and, just as it would for an individual, may be perceived as a risk by creditors.	Total Debt/Total Assets	<1
Debt-to-Equity	A measurement of a company's financial leverage. In general, a high debt-to-equity ratio indicates that a company may not be able to generate enough cash to satisfy its debt obligations.	Total Debt/Total Equity	About 1
Debt Service Coverage R	The measure of the cash flow available to pay current debt obligations. A debt coverage ratio of less than 1 indicates that the income generated by a property is insufficient to cover operating expenses.	(Net Income + Depreciation + Interest)/(Principal + Interest)	>1

The comprehensive baseline assessment also included value-based purchasing questions in an effort to identify which partners already have VBP contracts in place and which compensation modalities are being used, the percentage of revenue currently linked to VBP, the interest of the PPS in transitioning to a VBP system and the estimated timeline in which these organizations believe this could occur.

Aggregate data compiled from the survey, a financial assessment report, and a VBP assessment report were sent to the Finance Committee, PAC Leadership, and the PPS BOD and was approved in December 2015.

Under the direction of the Finance Committee, the PPS formed a value-based purchasing workgroup whose primary mission is to provide the PPS with VBP-related education and guidance, as well as develop the VBP roadmap, due in March 2017, that will outline a plan to achieve a minimum of 80% value-based payments by year 5 of the waiver. The group has been meeting monthly since April 2016. The member roster, which includes 25 individuals, is comprised of three MCOs, three hospitals, and nine other partner organizations ranging from Medicaid service providers to community-based organizations. The workgroup elected the Vice President of Integrated Delivery Systems at Albany Medical Center Hospital and the Vice President of Physician Contracting at Capital District Physicians' Health Plan to serve as co-chairs.

The Audit and Compliance Committee was created in June of 2015 and is populated with representatives from all five counties within the service area. The AMCH PPS Compliance Officer, Noel Hogan, was elected to serve as the Chair of the Committee. In August 2015, the PPS's Compliance Officer, in collaboration with legal counsel and with input from the Committee, developed a Compliance Plan (CP) and Code of Conduct (COC). The CP and COC were reviewed and approved by the PAC Leadership Committee, the PAC, and by the PPS Board in September 2015. In December 2015, the Committee, in collaboration with the Workforce Coordinating Council, created a Compliance Program Training Strategy for the PPS. The strategy contained the projected plan for PPS compliance training. Also in December 2015, the PPS received our annual Compliance Plan certification from the Office of Medicaid Inspector General. In January 2016, the PPS Board approved the AMCH PPS Fraud, Waste and Abuse Policy and the Anti-Trust Policy. These policies were developed by the Compliance Officer and Legal Counsel, with advisement from the Committee. These documents were reviewed and approved by the PAC and PAC Leadership Committee. In April 2016, the Compliance Officer, in collaboration with the Committee, developed the Compliance training curricula and training delivery system for the PPS. The PMO received compliance training in April 2016, and the AMCH PPS Board received training in July 2016. Also in July 2016, the Committee approved the implementation of a PPS Compliance Program training video for distribution to the PPS. The Committee also clarified the definition of employees who are affected by DSRIP and, therefore, need compliance training.

Workforce: The AMCH PPS created the Workforce Coordinating Council (WCC) to oversee the development of the healthcare workforce expected as a result of DSRIP. Since its initial meeting on June 26, 2015, the WCC has accomplished several objectives and it continues to evolve. The Committee brings together key stakeholders from labor, management, the workforce and vendors who represent diverse organization types, creating a comprehensive perspective on the healthcare workforce.

In addition to creating an inclusive Committee, the WCC and members of the PMO have partnered with and continue to collaborate with other PPSs, including Montefiore Hudson Valley Collaborative, Alliance for Better Health Care (AFBHC) and Adirondack Health Institute (AHI). In March 2016, the workforce Committees from the AMCH PPS and AFBHC held a combined meeting to discuss overlapping projects, collaboration of training and curriculum development, emerging titles definitions and coordination of training for Certified Asthma Educators. These topics continue to be discussed with both AFBHC and AHI in an effort to create efficiencies and consistency across the region. In a new endeavor, the WCC will bring together the workforce leads and the cultural competency leads from the three PPSs to dialogue about best practices in cultural competency and health literacy training. Collaboration across the overlapping PPSs is a critical component that will allow all three PPSs to maximize our resources and to synchronize the training requirements for our shared partners. Understanding that both patients and members of the workforce move within the region, potentially accessing services or employment from more than one PPS, we are working

together toward developing training programs that will reduce duplication of effort by our providers and will provide consistent content, ensuring patients receive the same care and employees are given the same opportunities for growth and development.

In a manner similar to the importance of the Finance Committee, the PPS recognizes the critical importance of having a successful, integrated and coordinated approach to workforce needs. To this end, the WCC is engaged in internal collaboration, drawing together the leads for those areas with required training strategies, including clinical integration, practitioner engagement, cultural competency and health literacy, performance reporting, and information technology. The clinical project teams and project Subcommittees also continue to participate in discussions about project-specific training and workforce needs. This integrated approach to workforce recognizes the critical role that staff play in health and human services. Unlike other industries, like manufacturing, health care is driven by interactions with compassionate, caring individuals whose mission is to serve.

In September of 2015, the PMO disseminated a Workforce Readiness Assessment Survey. The survey requested information on FTE counts and minimum experience and education requirements for selected positions, along with information related to current training programs and technologies. During the current quarter, a smaller workgroup within the WCC will develop a more detailed current state training assessment to assist with the identification of training gaps across the five counties, as part of the development of the PPS' workforce training strategy.

Understanding the current state of the PPS's workforce has been a critical step in developing plans for recruitment, training, and redeployment. The PPS executed a contract with Iroquois Healthcare Association (IHA) to perform a compensation and benefits survey of all participating provider organizations. The contract also required Iroquois to provide the aggregate data and an analysis of the survey results. Through additional analysis within the PMO, a narrative summary of these results was developed, identifying areas of high need, primarily through analyzing vacancy rates by job title, wage bracket, and organization type. The DSRIP PPS Compensation and Benefit Analysis report produced by Iroquois was approved by the WCC on June 23, 2016 and approved by the PPS Board on June 30, 2016. Iroquois also produced an aggregate analysis of the six PPSs for which they performed the compensation and benefits survey. In the current quarter, the PMO will generate a comparative analysis between this report and the AMCH PPS survey results to assess differences in vacancies and wages; to understand, relative to the region, where we are more successful in recruitment and retention; and where we may need to revise our strategies.

Identifying future state needs has been the next step in planning the efforts of the WCC and as such, BDO Consulting was contracted to produce the Target State Workforce Report. Using data-driven project assumptions, national benchmarks and current state workforce and market share information, this report was generated in tandem with IHA, who used the inputs in a microsimulation modeling tool. The microsimulation produced anticipated staffing changes in the PPS by project and by care setting based on the status quo and on the intended effects of DSRIP. The net effects of these changes were summarized to develop the target state. While the PPS recognizes that there are many unknown variables that may impact the workforce needs of the health and social service provider network, anticipated reductions in staffing across the PPS are minimal. The more important issues and concerns relate to how to recruit and retain selected positions where known shortages already exist.

Using current state information and future state needs, in the current quarter the WCC is working to develop gap analyses between the two ends and strategies for transitioning from current to future state. BDO will use the Compensation and Benefits Analysis and a companion document, the Current State Workforce Summary, to complete a comparative analysis of the 6-PPS aggregate compensation and benefits information and the

Target State Workforce Report to develop a workforce gap analysis and a transition roadmap, as required by the implementation plan.
The PMO's management staff have also begun assessing the future workforce training needs by project and by workstream, including an assessment of new roles required by DSRIP and the corresponding training program needs. In collaboration with the WCC and other overlapping PPSs, the PMO will perform a gap analysis of training programs and develop the PPS' training strategy, focusing on improving existing programs and developing needed programs where warranted.

Despite the fact that the training plan is under development, the PPS has begun to address some key training needs. In June, clinicians and administrators were trained by Accenture on a clinical integration model, introducing them to key concepts around care coordination. In early July, more than 30 employees from participating organizational partners attended a two-day training hosted by HANYS in Saratoga Springs, NY. The course, "Primary Care Practice Transformation- People, Process, and Technology" was well received by the attendees, as it addressed not just the nuts and bolts of PCMH standards, but concepts around how to create meaningful and sustainable transformation within the practice setting. Additionally, the AMCH PPS, in collaboration with the Alliance for Better Healthcare PPS, is sponsoring six participants from various partner organizations to attend the Kettering review course for the Certified Asthma Educator (AC-E) exam. With low national pass rates, the PMO felt it important to prepare eligible candidates for the exam in order to move forward with our strategy for enhancements in asthma care. The PMO continues to provide extensive additional training on other important aspects of DSRIP, including webinars on contracts management, performance reporting and deliverables. Several of the clinical Committees have provided training on issues including asthma care management, health home provider services, cardiovascular disease management and conducting baseline assessments/screenings for mental health and substance use. Finally, AMCH PPS contracted with HealthStream to provide a Learning Management System for the delivery of online training programs to the workforce. As additional training needs are identified and other needs evolve, the PMO expects to provide training on VBP readiness, fundamentals of population health management, contracting, and related topic areas. The PMO expects to contract with additional vendor(s) to address training needs that may require a level of expertise or sophistication currently unavailable to best meet the needs of the future workforce.

The WCC has successfully engaged key stakeholders and is working together to both meet the requirements set forth by NYSDOH and to make a meaningful transformation within the healthcare workforce through training and development, the fashioning of patient-centered models of care, and through thoughtful recruitment and retention strategies designed to address shortage areas essential to the success of system transformation.

Cultural Competency and Health Literacy: There are clear linkages between health outcomes and race and ethnicity. Racial disparities in care have many root causes, including institutional racism, stigma, and barriers to care that are based on culture, language and literacy. The Cultural Competency and Health Literacy Committee (CCHLC) was established in May 2015 with various representatives from PPS partner organizations. This Committee meets regularly, generally monthly, to develop strategies and recommendations for culturally and linguistically appropriate services to meet DSRIP goals. Chaired by Tandra LaGrone, the Executive Director of In Our Own Voices, the CCHLC has successfully delivered two milestones, including the Cultural Competency/Health Literacy Strategy and the Cultural Competency Training Strategy. These two documents continue to guide the AMCH PPS's future implementation of various CC/HL-related trainings and organizational changes.

In addition to meeting CC/HL milestones, several partners were engaged as CC/HL champions who will

drive CC/HL-related changes within their respective organizations. The initial engagement of CC/HL champion began in May 2016 via an introductory webinar, followed by an in-person meeting in June with lively discussions and dialogues. This group will continue to meet and discuss actionable steps and best practices to implement items discussed in the two strategy documents, while the AMCH PPS continues to assist partners in making practical and meaningful organizational changes. The CCHLC provides expertise and insight for project implementation, project documentation, as well as project trainings. The CC/HL Champion meetings will focus on evaluation and training needs across the PPS in collaboration with both project Subcommittees and the Workforce Coordinating Council. In addition, working with WCC to help identify recruitment strategies needed to insure that new hires are culturally and linguistically appropriate for the communities where they work will be addressed. There is also significant overlap between this workstream and the practitioner engagement workstream. A key set of contract deliverables included in all funded partner organizations requires them to demonstrate completion of mandatory cultural competency and health literacy training by the end of December 2016. Linking financial incentives to address this need is only one component of the overall approach. While this training is important, it is inadequate by itself to address the complex issues associated with CC/HL. Utilizing the CC/HL champions at each provider organization is an important element in helping to address biases and prejudices that still exist in many organizational settings. Implementing best practice guidelines to insure that health literacy levels are assessed and addressed is an additional fundamental element.

IT Systems and Processes: In 2015 the PAC Leadership Committee in concert with the PPS Board, approved the creation of the Technology and Data Management Committee (TDMC), which is charged with advancing the milestones associated with the IT Systems and Processes Workstream. TDMC membership is representative of the various provider types and geographic regions as each member has invaluable IT knowledge and expertise. Through the work effort of the PMO and TDMC membership, considerable progress has been made in advancing the goals of the IT workstream.

A comprehensive current state survey was developed by the PMO and sent out to partners on September 30th, 2015. The IT section of the survey included data elements relating to the SSP Workbooks, RHIO connectivity, security, patient portal, care management systems, population health systems, PCMH readiness, interoperability and Meaningful Use. Results from the survey provided the PPS and PMO with valuable insights into our partner organizations' IT infrastructure and systems readiness. The survey allowed the PMO to create a comprehensive picture of the current state of information capture, storage, analysis, reporting and utilization.

In addition to the regularly occurring TDMC meetings, the AMCH PPS participated in the Capital Collaborative IT TOM Project, a pilot between capital area PPSs and the DSRIP Support Team (DST) for projects 2.a.i & 3.a.i. Patient-centric use cases reflecting real world scenarios were evaluated from a business requirements and system requirements perspective by a multidisciplinary team over a series of weeks, resulting in a target operating model which once implemented would improve clinical outcomes. These meetings led to additional data sharing discussions where HIXNY was engaged and identified valuable details regarding IT capabilities within the PPSs and the region as a whole.

To assist in our efforts, the PPS engaged the consulting services company Accenture to complete the PPS IT current state assessment and evaluate responses to the IT portion of the comprehensive survey. In addition, they also conducted detailed interviews with numerous individuals from key organizations within the PPS Network. Their finalized assessment was reviewed at TDMC meetings as well as by PAC Leadership in

November 2015, and included a detailed vision of the IT current state, as well as gaps in terms of readiness for data sharing and the implementation of interoperable IT platform(s).

After completion of the current state assessment, Accenture assisted the PPS in an RFI process and subsequent vendor demonstrations to identify a partner for implementing the future state of an interoperable IT system across the continuum of care. Utilizing information from a variety of sources, fourteen vendors participated in the RFI process, and four were invited to present and demonstrate how a DSRIP use case would be supported by their solution. A payer and our RHIO were also invited to sit in on the demonstrations and provide insights from their unique perspectives. Ultimately two vendors advanced from the demonstrations and reference checks were performed with the goal of having a vendor selected when capital funding was released.

Unfortunately, no capital funding was awarded by the NYSDOH for IT development to AMCH's PPS or either of the overlapping PPSs. Due to this lack of capital funding, the AMCH PPS was forced to develop a homegrown solution focusing on HIXNY connectivity and various Care Management Providers, which has become known as the "Conceptual Solution." Still in final stages of development, the conceptual solution incorporates the following themes / assumptions: RHIO Connectivity for PPS members, care management providers having access to EHR systems and the RHIO for clinical context review, care plans being pushed through HIXNY to caregivers, utilization of the HIXNY Portal, and the creation of a data warehouse where analytics can be performed to inform the care management and population health processes.
AMCH will be applying for capital funding based on RFA #1607010255 – Statewide Health Care Facility Transformation Program. If funded, capital support will be provided to move this and the other projects forward in terms of IT systems solutions, population health and related data management issues

Another key consideration of the Conceptual Solution is alignment of the technology with clinical processes. Utilizing the PPS Clinical Integration Strategy and the IT Roadmap, data elements, system requirements, and integration formats were defined for each project based on project specific business / clinical processes. The work product created is being utilized to define HIXNY integration specifications as well as affiliate EHR build requirements. It will be utilized when onboarding participating provider organizations for the Integrated Delivery System.

The current state assessment also drove a work plan to achieve effective clinical data sharing, connectivity to HIXNY, and interoperable systems across the PPS network. The IT Roadmap resulting from this work defines a low cost solution for ensuring timely milestone completion. Focus areas of this roadmap are described below:

Focus Area	Category	Category Description & Example Capabilities
Business	Care Management and Care Delivery	Managing the patient care plan and transitions of care across the continuum through care coordination, referrals, provider-to-provider communication and utilization management; utilizing clinical workflow, care protocols and interventions, clinical decision support, evidence-based care guidelines and health / community services
	Population Health Management	Managing aggregate population, cohorts, high-risk interventions, through programs and managing gaps of care; perform outreach / navigation activities
	Patient Engagement	Patient access to information (portal, mobile), with enhanced convenience through cultural competency, involvement, education, communication
Analytics / Reporting	Operational and Quality Reporting	Near real-time reporting, identify gaps in care, dashboards with quality metrics, compliance and risk management, and program financial management
	Performance Management and Quality Improvement	Monitor / analyze performance to NCQA / HEDIS targets, provider efficiency, effectiveness of care protocols / interventions, risk stratification and cost of care
Technical	Data Exchange	Interoperability, send/receive data, terminology services, connectivity to external HIEs, EMPI/RLS
	Security	Security and privacy compliance, access controls and role based access

Figure 1, Table of Focus Areas within IT Roadmap

The IT Roadmap also contains a training plan that emphasizes the importance of providers playing an active role in the established delivery system, comprised of evidence based guidelines to ensure proper care coordination and improved quality of care. As previously noted in the workforce discussion, above, the WCC is working closely with IT staff and TDMC members to coordinate these training needs across the PPS.

In order to ensure that there is a proper framework for data exchange across the continuum of care, a three part contractual agreement has been developed and disseminated to participating network partners. Included in contracts are the Partner Organization Agreement, the Business Associate Agreement, and the more specific project deliverables incorporated into the Master Project Agreement. While all of these documents have important linkages to IT, the BAA is the most significant in terms of information sharing among and between the PMO and participating partner organizations.

Data Security has been and will remain a key consideration of AMCH PPS as implementation of an IT solution progresses. All SSP workbooks have been submitted, leading to the completion of MS5 - a quarter earlier than its projected due date. The focus of many of these workbooks related to computers in our secure data room. These dedicated and secured computers are disconnected from network access. They house NYS DOH claims data for attributed patients. The work effort for the SSP workbooks involved internal and external stakeholder discussions over the course of several months as well as open discussion during TDMC meetings, ensuring that the submitted Data Security and Confidentiality Plan is completely aligned with the needs of the DSRIP specific work environment. Additionally, detailed audit and compliance training was conducted for the entire PMO with a portion pertaining to HIPPA requirements and the need to secure and protect confidential patient health information.

The PPS has also made considerable strides in understanding our partner network and attributed population. In advance of claims data being provided by the state in June of 2016, the PMO began utilization of other state provided tools. Eight PMO staff members have undergone Salient training, with many of those staff routinely accessing the miner and attending additional trainings and information sessions that Salient has hosted. The MAPP Performance Dashboards also contain a wealth of information regarding our PPS and are routinely consulted in project planning and to inform PPS members of vital information.

There is still significant work to be done to complete the IT roadmap. The PPS understands the importance of shared patient information. It is an important tool needed to improve quality of care through a coordinated approach, to reduce costs by eliminating duplication, improve population health by risk stratification and a more targeted approach to those most in need of care. The PMO and the PPS believe that progress will continue to be made, that IT deliverables will continue to be met and that with continued financial support the strategies included in the IT roadmap will be realized.

Performance Reporting: The AMCH PPS established a performance reporting workgroup in December 2015 in order to align and address performance reporting needs across the PPS. DOH provides a variety of data sources to all PPSs in a public facing format, as well as on a secure platform. The AMCH PPS will utilize Salient claims data, MAPP Dashboards, DOH Public Facing Dashboards, and DOH reported performance measures. Additionally, the PPS is leveraging patient registries as required by several projects. The use of this data, as outlined in the Performance Reporting Strategy, will be used to highlight best practices and identify areas of improvement necessary to reach goals as outlined by both the PPS and DOH. AMCH PPS recognizes the critical value of effective performance reporting in improving outcomes and access, driving rapid cycle evaluation, fostering improvement, and demonstrating milestone completion and AVs earned.

Performance dashboards are under development for all projects. These dashboards include basic demographics, diagnosis, PCP assignment for patients, as well as geographic information, utilization patterns, and other Performance measures as defined by DOH. Dashboards are utilized by the PMO's project teams and Subcommittees to focus on target populations and presented, as needed, to Committees and the PPS Board. Dashboards are also utilized to target areas of improvement for our annual performance measures. A quarterly dashboard for organizational specific patient engagement has been created and presented to all reporting organizations with a POA and BAA in place. This dashboard is shared with the PAC Leadership Committee and PPS Board as well. An aggregate dashboard is shared at our quarterly PAC meeting after each reporting month.

Performance reporting focuses on data utilization, data quality, data collection, and overall evaluation of outcomes as well as opportunities for improvement. There is a close integration with performance reporting and all workstreams including the Technology and Data Management Committee, the Clinical and Quality Affairs Committee, the Finance Committee, and all active project Subcommittees. In terms of finance, the contracts executed with all participating providers have detailed deliverables, many of which require specific reporting of various performance measures as an element in obtaining payment.

Reporting is necessary to evaluate the transformation effort, and to improve and maintain performance metrics and other workstream outcomes, advance quality improvement, promote engagement, drive payment, and improve patient satisfaction. Reporting for DSRIP is both extensive and complex and therefore requires the basic understanding of data elements, data requests, data collection, data storage, and data utilization. In order to ensure that performance reporting is accurate and standardized, the Performance Reporting Workgroup has also created an extensive Performance Reporting Training Strategy to provide guidance and direction to participating providers and their partner organizations within the AMCH PPS. The training

program has a set of base elements for all organizations as well as specific trainings based on provider type and project participation by a given partner organization. These training modules are available through a variety of mediums, both through a web based platform and via trainings conducted by the AMCH PMO. The Performance Reporting Training Strategy also has alignment with the AMCH PPS Workforce Communication and Engagement Plan, and recognizes the need to coordinate with the Workforce Coordinating Council and our training vendor to track trainings for compliance. The PMO has completed training for all participating provider organizations on the Master Project Agreement and Exhibit A project and workstream deliverables. This recorded webinar provided extensive detail regarding performance reporting and how it links to the organization's ability to "earn" DSRIP funding by submitting reports completely, accurately and on time.

Population Health: The AMCH PPS created a Population Health Workgroup to assume direct responsibility for activities required to meet population health tasks and milestones. This workgroup consists of executive leadership, staff from planning, the PMO and regional health planning organizations. The workgroup developed the outline and components of the strategic workplan which lays out the strategies that AMCH PPS will undertake to directly address population health during the DSRIP project period. The Roadmap was approved by the Chairpersons of the Consumer and Community Affairs Committee and the Cultural Competency and Health Literacy Committee prior to receiving approval from the PPS Board and PAC Leadership Committee in June 2016.

The Roadmap provides guidance to the PPS in terms of the overall direction that the PPS will follow in preparing organizations for population health management. This includes their ability to develop population health data registries to forecast and manage chronic diseases, particularly those that are preventable. Rather than a specific patient-centered focus, the Roadmap requires organizational participants to consider broad approaches to improving the health and well-being of all residents of the five county region.

The Population Health Management Roadmap includes: IT infrastructure required to support a population health management approach, such as the creation of a population health dashboard based on available data sets and registries; Plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations, such as by using a learning collaborative for the necessary training and support to attain PCMH certification; Identification of priority target populations and defined plans for addressing their health disparities by establishing goals that reflect the State of New York's Prevention Agenda; A list of PCMH 2014 Level 3 certified provider organizations.

While there is still substantial work to be done, the PMO believes that with the submission of the Population Health Roadmap in concert with funding incentives provided to participating organizations to develop nascent patient registries, the PPS is poised to ultimately create a population health database. Working with MCOs and HIXNY to build this requires careful integration of the activities of this workgroup with the PPS's IT activities and the approaches taken in value-based purchasing. The importance of this database in helping to stratify risk and identify need will facilitate a more targeted approach to distribution of DSRIP funds. It will be a very important tool allowing participating organizations to develop predictive models to identify where early interventions might help prevent disease and infection, among other things.

Clinical Integration: The AMCH PPS recognizes the critical role of a clinically integrated system in achieving its core DSRIP objectives. As such, in collaboration with participating providers and Accenture Consulting Group, we developed a comprehensive Clinical Integration (CI) needs assessment, current state assessment, and the Clinical Integration Care Coordination Model (CICCM) strategy in order to support the implementation of relevant project-specific initiatives. Between September 2015 and June 2016, various clinical and technical workgroups took part in an extensive analysis of current CI landscape across our PPS,

and met on many occasions to develop the future state CICCM strategy. Specific activities and outputs included: mapping the providers in our network and their requirements for clinical integration, identifying key data points for shared access and the key interfaces that will impact clinical integration and identifying other potential mechanisms needed to drive clinical integration. The PMO developed and disseminated a survey-based comprehensive clinical integration needs assessment for our affiliates and potential partner organizations (payer/HIE). Furthermore, working closely with Accenture Consulting Group, the PMO conducted a supplemental Current State Assessment (CSA), which involved interviews and focus groups with partner organizations. This assessment process allowed the PMO to define the current state for Care Management/Population Health Management/Patient Navigation, and to identify gaps in clinical practices. The results were used to analyze the gaps between the organizational current state and goals of the PPS. Some key findings from the gap analysis included: lack of expertise and experience related to population health and care management, lack of leveraged care teams, significant lack of population health management functions, fragmented care coordination processes and elements of care plans, lack of standardized processes with significant manual functions due to lack of or ineffective utilization of technology capabilities, limited data exchange and utilization of HIXNY (RHIO), limited access to primary care and behavioral health services, inconsistent communication across the continuum, limited availability of services, and social barriers to care.

Based on the analysis of the above assessments and feedback from various workgroups, the PMO developed a comprehensive CICCM strategy, which was approved by both the PPS Clinical and Quality Affairs Committee (CQAC) and the PPS Board at their respective meetings in June 2016. In developing the CICCM, the PMO used several guiding principles as the foundation for achieving PPS goals. We paid particular attention to the fundamental function of care coordination. Moreover, we focused on ensuring appropriate care at the right time, in the right setting, at the right cost, and to the right patient, while taking into account that there is no "wrong door" for any patient. The CI workgroups reviewed findings from available literature and the current state findings, and assisted with the development of the future state CICCM. Key outputs gained from this workgroup consisted of: standardizing ED/observation processes, transitions of care processes, readmission management, risk identification/stratification, and the standardization of clinical and supporting information exchanged at care transitions across the continuum. Additionally, utilizing the future state CICCM and IT Roadmap, the PMO defined the data elements, system requirements and integration formats for each project based on the project specific-clinical/business processes. The final output included recommendations on ED/in-patient staffing models to support the future state Transitions of Care functions and processes. Following the development of the final draft of the CICCM, training was conducted for practitioners and operation staff across the PPS. The training was well attended, with 15 participants in the practitioner session, and 38 participants in the nursing/operations staff session. The training included orientation to: key elements; functions, processes and protocols; and tools and templates that were developed by the workgroup. Special emphasis was given to transitions of care in hospital and community settings, use of real time alerts for data exchange and notification, and the role of patient navigator/community health worker in the future state model. Pre and post tests were administered, which demonstrated a marked increase in the staff's knowledge base after the training.

Successful clinical integration is a critical building block required for the PPS to proceed. With the completion of the various plans and strategy documents, the PMO is moving forward rapidly with specific implementation activities. It is also important to recognize that the building blocks come together to form a solid structure, one that is built on a solid foundation. These blocks include finance, workforce, IT and governance, to name a few. There is also a critical link between clinical integration and practitioner engagement.

Practitioner Engagement: AMCH PPS recognizes the importance of engaging a wide variety of providers

in the design and transformation of a regional system of integrated care. In order to improve understanding of the health of the patient population, and also to deliver high quality patient-centered care across the continuum of service delivery, it is imperative to have a communication and engagement plan with which the PMO can efficiently and effectively deliver information among and between practitioners.

In April 2015, the AMCH PPS hired a Medical Director to lead the practitioner communication and engagement outreach efforts. Individual meetings with key clinical leadership and stakeholders were held to orient and engage clinicians to DSRIP activities. The leadership at participating organizations was assigned the responsibility of ensuring the participation of their clinicians, and also for identifying practitioner champions to lead the initiatives at their respective entities. Additionally, the Clinical and Quality Affairs Committee (CQAC) was formed as part of the PPS Governance structure, and the PPS Medical Director was elected as the chair of CQAC. The CQAC, along with the PMO, have assumed the overall responsibility for implementation of the practitioner communication and engagement plan. Some key themes within the plan include: engagement of practitioners across the PPS in DSRIP initiatives in order to achieve the collective goal of improving health care for the population served; increase engagement to support the development and implementation of evidenced based clinical protocols and processes; and promote practitioner engagement in activities that will ultimately improve health outcomes and lower avoidable utilization. The CQAC approved the Practitioner Communication and Engagement plan and the Practitioner Training and Education Plan on December 16, 2015. Based on this endorsement, the plans were approved by the PAC Leadership Committee as well as the PPS Board on December 30, 2015.

Under the auspices of the CQAC, six clinical Subcommittees were formed to support the implementation of respective clinical projects, in collaboration with the PMO and the participating partners. Practitioner champions and PMO staff were identified as co-chairs of each of the Subcommittees to lead the efforts based on milestones and deliverables as identified by the PPS project implementation plan. The Subcommittees meet on a consistent basis and have been focused on project roll out and delineating time frames to meet milestone completion. Some of the areas of focus include the approval and adoption of clinical guidelines for management of conditions such as hypertension, asthma, depression screening, and opiate prescriptions in emergency room settings.

Recognizing the importance of practitioner training and education to achieve its core objectives, the approved Practitioner Training and Education plan includes a curriculum consistent with the 1115 waiver attachments I and J. This plan focuses on training and educating physicians and non-physician practitioners (practitioners) across the AMCH PPS on the DSRIP goals, objectives, and activities in a timely manner. This plan is also focused on increasing practitioners' awareness of the DSRIP clinical project-specific performance milestones and requirements. Additional objectives include: increasing practitioner engagement in the implementation of evidence-based best practice guidelines and clinical protocols to improve health outcomes and lower unnecessary utilization, and increasing their knowledge in performance measures and performance reporting.
As part of the training initiatives, project-specific Subcommittee webinars were held to orient partners to the intent of the projects in order for them to make informed decisions on which projects they would like to participate. Additional training activities have focused on increasing practitioner awareness of evidence-based guidelines related to hypertension, asthma, depression screening, and opiate use in emergency departments. In May 2016, formal training sessions were conducted for practitioners and operations staff across the PPS on the newly developed and approved Clinical Integration Care Coordination Model (CICCM) strategy, and included orientation to key elements, functions, processes, protocols, tools and templates.

To promote the transformation of primary care practices across our PPS, the Workforce Coordinating Council supported practitioner participation in a 2-day HANYS-led training on PCMH Transformation. A total of 39 participants from our PPS including physicians, non-physician practitioners, and operations staff attended

these training sessions.

The PPS is on track in terms of the incremental steps needed to fully engage practitioners across the five-county regional area. Executed contracts with participating organizational partners reinforce engagement by requiring deliverables and documentation of active participation and engagement activities throughout phase 1 of the contract term. In fact, physicians and non-physician providers are incentivized via the contracts to become engaged in specific ways.

Community and Consumer Engagement: The AMCH PPS established a Consumer and Community Affairs Committee (CCAC) in May 2015. This Committee is comprised of organizations that represent the interests of Medicaid Beneficiaries and is open to the public including Medicaid beneficiaries and their families. The intent of this Committee is to represent the interests of Medicaid recipients and the uninsured; to provide feedback and recommendations to the PAC regarding the unique needs of consumers and how these needs can be met during the planning and implantation phases of DSRIP. It is also designed to engage community based organizations in the transformation of the delivery system. Due to the challenges of getting Medicaid recipients to the table, the CCAC has sponsored listening sessions across the five-county region where Medicaid beneficiaries can speak openly and honestly about their concerns and how DSRIP can have a positive impact on them and their community. AMCH PPS is the sole PPS to fund proposals dedicated to Consumer Listening Sessions. In the Spring and early Summer of 2016, fifteen listening sessions were held across four counties. All but one of the host organizations that received funding were community based organizations.

In addition, the CCAC hosted several regional forums for DSRIP informational purposes throughout the five-county region. These forums are community focused and have been held in collaboration with overlapping PPSs to ensure alignment of a clear and concise message to participating providers, community organizations, and Medicaid beneficiaries. The CCAC continues these discussions as they host their monthly Committee meeting in our northern, southern, and central hub locations, allowing for face-to-face participation in each sub-region.

In December 2015, the CCAC developed a Community Engagement Plan, designed to be a dynamic document that outlined the community served by the PPS, identified hot spots, detailed strategies to engage the community, consumers and CBOs as well as a communication plan for outreach activities. With support from project staff in the PMO, the CCAC uses the engagement plan to provide direction for additional community activities. The CCAC and the PMO have been invited to numerous community events, where information has been disseminated about DSRIP and the development of an improved system of care. For example, the PPS has participated in several community led events and also holds a seat at many community based meetings including COReSTAT, LEAD, HCDI, PHIP, SHIP, and CHIP. The AMCH PPS has collaborated in events such as the CUT Hypertension initiative, The Delaware Ave Community Street Fair, Albany Community Action Partnership 50th Anniversary Block Party, and many others.

The PPS recognizes that the voice of the community and consumers are extremely important building blocks needed to improve the delivery system. If planners and other stakeholders create a new system that does not address the unique needs of the communities served, a significant opportunity to improve the health of our communities may be lost.

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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: Albany Medical Center Hospital

Project: 2.a.i

Challenges the PPS has encountered in project implementation:
The Albany Medical Center PPS, like many other PPSs, have encountered its fair share of challenges when implementing the 2.a.i project. However, the PMO believes that excellent progress has been made in integrating a complex regional health care system. Contracts have been executed with a wide variety and type of providers who comprise the PPS network. All funded organizations must participate in 2ai, insuring that partners are engaged in the transformation effort. While the PPS has faced a few challenges, including an aggressive speed and scale timeline matched with the absence of EHR Connectivity and Capital funds to promote advanced technology and innovation, the PMO remains confident that these challenges will be overcome, as described in the next section. As we proceeded with an RFP and Vendor selection, we received word that we did not receive capital funding and therefore had to refocus our efforts into the development of a shorter term, less expensive solution. Without the proper funds required to implement systematic changes and / or the ability to conduct a complete overhaul of the current information technology infrastructure utilized in various organizations; connectivity – as required by the Domain One Requirements specific to the Integrated Delivery System project – may be a struggle for the PPS. The PMO, in close collaboration with the Technology and Data Management Committee, remains focused on furthering the conversation and progression with Hixny while engaging and encouraging our members to consider sharing data with this HIE. Given that the speed and scale numbers were due to the NYSDOH prior to the release of the domain one requirements, the AMCH PMO opted to adhere to a framework with an incredibly aggressive speed and scale timeline. Furthermore, the development of our network was created at a time when we felt the AMCH PPS may cover a 9 county region; however, as awards were announced, we received funding to implement projects in only five of those counties, leaving many providers in counties that we no longer serve. Our network itself therefore proves to be a challenge to meet scale commitments. Nonetheless, the AMCH PMO will utilize the open enrollment periods to our utmost advantage being that it provides the opportunity to not only add valuable and accessible partners to our network, but to eliminate providers in the network who have not been engaged or simply fall out of the geographic catchment area. The final challenge that this project has encountered, is the workforce as a whole. Being that the creation of an integrated delivery system meticulously involves not only connectivity with physicians across the network, but thorough and comprehensive engagement with patients attributed to the PPS. As such, there is a rising need to not only complete the development of job roles and responsibilities and hire patient navigators who are dedicated to improving care coordination. The lack of resources may cause some difficulty in successfully hiring additional staff as designated by the work plan (community navigators, resources, etc.); however, thorough current state and projected future state assessments of the workforce have been developed and will be utilized as the projects continue to roll-out. Training documents and educational seminars will take place to not only accommodate a seamless workforce transformation, but to engage and inform current staff of any and all changes.

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Efforts to mitigate challenges identified above:

The AMCH PMO is aware of the challenges and the potential barriers that exist given that the PPS network includes a multitude of provider types and varying levels of information technology capabilities. That being said, the PMO has engaged the expertise of Accenture – a leading global consultant firm – to help generate a list of "Tier 1" Affiliates, mainly those who already have executed contracts with the PMO, whereupon a detailed and accurate analysis has been done to better understand both the current state of each organization as it relates to their dependence on IT and the amount of projected time, effort, and plausible dollars it may take to get from gap to goal. Accenture's work has been carefully documented into a roadmap that is being utilized by the systems experts within the PMO for project roll-out. The PMO has also been engaged with the Clinical and Quality Affairs Committee members and representatives from the local RHIO – HIXNY – to better understand their current capabilities and to gauge those already connected and sharing data with HIXNY.

In an effort to incentivize organizations to participate in the Integrated Delivery System, the PMO has structured the project addenda and contractual language to reflect exactly what will be expected of each organization that participates in this and every other project. Recognizing that the Integrated Delivery System is an all-encompassing project and is not only necessary for the success of the DSRIP program to truly be realized, but obligatory to make the required performance reporting seamless, integrated, and accurate, the PMO remains committed to educating our partners about what exactly it means to be part of the IDS while continuing to be willing, able and available to address any concerns or questions.

The PMO is working behind the scenes to ensure that integration between projects and work-streams is continuing, and that subject matter experts are being utilized whenever and wherever possible. Further clarification from KPMG and PCG is currently underway regarding restrictions on speed as it relates to this project. Workgroups like the Primary Care Advisory Group (PCAG), EHR (which falls under TDMC), Value Based Purchasing and Clinical Integration, among others, are meeting regularly in an effort to continue to make progress towards successfully completing and adhering to all project requirements for each milestone.

Strategic planning for ongoing training needs is underway and with the help of a Workforce Vendor, resources, materials, and access to training are being provided to all staff to ensure they are comfortable with the potential shift in roles and responsibilities. Ongoing baseline assessments of the current workforce, operations, and Information Technology capabilities have been collected, reviewed and analyzed, in a thorough manner, to understand in greater detail the resources that will be needed to ensure a successful implementation.

Implementation approaches that the PPS considers a best practice:

The PMO continues to collaborate with numerous other PPSs, both that overlap our regional area and others, to share information and approaches. As a result, the joint efforts of the engaged PPSs are following as well as developing best practices.

Recognizing the importance of the role of consumers in transformation, the PMO developed a best practice in terms of obtaining real-time feedback from Medicaid eligible recipients. In the Spring of 2016, the PMO issued a Request for Proposal (RFP) to the entire PPS network to encourage organizations to facilitate consumer listening sessions. Seven partner organizations, six of which were Community Based Organizations, responded and received funding for conducting fifteen individual listening sessions in four counties. These sessions were used to obtain feedback from Medicaid beneficiaries, as well as the uninsured, on access to medical insurance and medical care, barriers encountered within the healthcare system, frequency of utilizing healthcare services, etc. Additionally, the PMO recently issued another RFP to the network to facilitate more consumer listening sessions this Fall.

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

Progress continues to be made in moving the PPS forward regarding project implementation activities.

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

There are no significant changes to the population in comparison to the variables identified in the community needs assessment.

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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: Albany Medical Center Hospital

Project: 2.a.iii

Challenges the PPS has encountered in project implementation:

The PPS has made substantial progress in moving this project forward. Like all PPSs, the AMCH PPS has faced some challenges, but most of these were expected as components of the complexity of transforming a diverse, disintegrated and inefficient group of health and social service providers toward an integrated regional delivery system. The PMO is committed to the goals of the health home at risk project and will work to overcome the barriers and challenges identified below.

PCMH 2011 Standards: a core requirement for Primary Care Providers participating in this project is that they must be a NCQA 2011 accredited, Level 3, Patient Centered Medical Home, and they must commit to achieving NCQA 2014 Level 3 PCMH or becoming an Advanced Primary Care practice in the first two years of DSRIP. Within our PPS only 20% of PCPs currently meet the PCMH 2011 standards. This challenges the project because it limits our ability to focus our efforts on our identified hot spot areas while also making it difficult for the PPS to reach its patient speed and scale commitment.

Primary Care Capacity: Coupled with the challenge of having a limited number of PCMH Primary Care providers able to participate in this project is their lack of capacity to handle the increase in referrals associated with this project. The lack of capacity is directly correlated to the lack and need of Primary Care Physicians in our service area.

Centralized Care Management/Care Coordination Services: The lack of a centralized care management/care coordination service challenges this project's ability to identify the necessary At-Risk population and to refer the At-Risk population to the appropriate PCMH providers.

Health Home Downstream Provider Capacity: In addition to a lack of capacity within our PCMH provider sites, our HH downstream providers face the same lack of capacity to manage the increase in referrals generated by this project. Unlike the PCP challenge of a limited workforce, our HH CC providers face the challenge of a clear and sustainable payment source for the appropriate work force.

Understanding the NYS DOH Health Home Model: There is a significant lack of knowledge among our provider population in understanding the referral process and the services provided by the NYS DOH Health Home program.

Delay in the implementation of the Pediatric Health Home: The delay in the implementation of the pediatric HH challenges our PPSs ability to influence the Domain 2 P4P pediatric outcome measures.

Interoperability: A challenge to this project is that not all of our providers have an EMR, our partners have different EMRs which are not compatible, and not all of our partners EMRs are connected to our local RHIO, HIXNY. While this is significantly easier to resolve than the previous challenge, the RHIOs have not demonstrated their readiness to develop the interoperability and care coordination components needed to meet speed and scale within the identified timeframes. This has been compounded by significant delays in many other aspects of this project, including delays in announcing capital funding awards and delayed receipt of useful data from MAPP.

Efforts to mitigate challenges identified above:

PCMH 2011 Standards: To mitigate the risk of the limited number of Primary Care sites available to participate in this project due to the PCMH NCQA 2011 requirement, the AMCH PPS is developing a PCMH work group to assist our practices who are transitioning towards PCMH recognition. The AMCH PPS will offer financial and technical assistance to our PCPs seeking PCMH recognition. Financially, we will incentivize our partners to achieve PCMH status through bonus payments based on PCMH recognition. The PPS will is also provide technical assistance to our PCPs who lack the technical expertise needed to complete the necessary steps for PCMH recognition. In the interim the PPS is actively recruiting all PCMH 2011, level 3 Primary Care Providers within our PPS to participate in this project.

Primary Care Capacity: To mitigate this challenge, our PPS is developing a Primary Care plan that will address the limitations in capacity, which will lead to increased access for our At-Risk population. The Primary Care plan is being developed in collaboration with the primary care providers and will include strategies to increase access to our current providers while simultaneously working to increase our provider base.

Centralized Care Management/Care Coordination Services: We are currently negotiating with a provider to provide centralized care management/care coordination services for our PPS.

Health Home Downstream Provider Capacity: To mitigate this risk we will continue to work with our HH providers in our sub-committee meetings, as well as individually, to develop strategies to increase the workforce which will increase our provider's ability to accept the increase in referrals associated with this project.

Understanding the NYS DOH Health Home Model: In our sub-committee meetings we will continue to provide our Primary Care, ED, and Behavioral Health providers with information related to the referral process and the services provided by the Health Home.

Delay in the implementation of the Pediatric Health Home (PHH): We will continue to rely on our PHH providers to provide the PPS with information and education related to the PHH services and updates on when the PHH will begin accepting referrals.

Interoperability: Utilizing the Accenture CI/CM Model the PPS is implementing a short term IT connectivity strategy that will allow the participating Primary Care Providers to risk stratify the Health Home At-Risk population by developing patient registries. The PPS has developed a process for Primary Care Providers and Care Management providers to coordinate referrals and is developing a longer term process for providers to become bi-directionally connected to HIXNY.

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Implementation approaches that the PPS considers a best practice:

The AMCH PPS hired the Accenture Consulting Group to Develop a Clinical Integration Care Coordination Model. The CI CCM was developed through a collaborative effort by PPS stakeholders the PMO and Accenture and includes standardized, timely, and effective processes and guidelines to drive enhanced care coordination. The model was developed using a current state assessment of the PPS' clinical integration/care coordination capabilities and by defining and designing the future state CI CCM model. The current state assessment included the identification of the PPS stakeholders and designing a governance model, understanding the current care management/care coordination processes across the PPS by reviewing over 100 documents, and interviewing over 80 stakeholders from 20 affiliate organizations. The future state model was developed using evidenced-based best practice care coordination tools and protocols and five half day workshops consisting of 30 representatives from 12 partnering organizations. The future state vision for Care Coordination across the PPS aligns to the AMCH DSRIP Mission and is expected to accelerate quality, utilization, patient engagement and financial outcomes. Some of the key elements of the CI CCM Future state model are to provide and deliver: the right care at the right time at the right place for the right cost; targeted interventions for high risk populations; visibility to care plans; continuum focused care approach; patient, family, caregiver engagement; a focus to identify and eliminate barriers to care; coordinated communication; embedded/virtual community CC; and a leveraged care team with patient navigation.

Embedded in the CI CCM was the development of a Health Home At-Risk Intervention project process work flow that ensures Care Management/Care Coordination/Patient Navigation is aligned with the PPS' high/at-risk population. The work flow articulates how patients are identified for this project, establishes a Centralized Care Coordination Organization that manages referrals and determines if patients are attributed to the PPS. The process also clarifies how a patient will be referred from the PCMH to a Health Home Care Management provider or if a patient meets the criteria, how the PCMH will refer to the local Health Home.

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

The PMO has provided previous information in terms of implementation efforts in submitted quarterly reports. In addition, the PMO has provided presentations to the sub-committee and the PPS, as follows:

An overview presentation of the Health Home At-Risk Intervention project included the core components of the project, the roles and responsibilities of the committee members, and a project summary document that includes project implementation plan milestones and steps.

The next presentation addressed the differences between pay for reporting and pay for performance standards and when the transition from P4R to P4P occurs. The PMO focused on the outcome performance measures and what steps the committee and project partners need to take in order for the PPS to be successful in meeting our prescribed performance metrics.

A third presentation addressed the Clinical Integration Care Coordination Model, highlighting the HHARI work flow process. The PMO provided detailed information about how referrals would be generated, reiterated the DOH requirement that only PCMH 2011 PCPs can participate in this project, and emphasized how this requirement limits our ability to reach our entire At-Risk population.

Finally, the Alliance for Positive Health presented to the sub-committee on the NYS Health Home project. The presentation covered patient eligibility requirements, the HH referral process, and the types of care coordination services provided by the care coordination providers. The Health Home At-Risk Subcommittee is leveraging the knowledge of our pediatric HH providers to provide the other HHARI providers with education on the referral process and the services being provided by the Pediatric HH.

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 application, we committed to serve individuals at high-risk who do not otherwise qualify for enrollment in health home services. We continue to identify these patients based on claims data and risk stratification. We are targeting at-risk populations with diagnoses such as high risk pregnancy, hepatitis C, diabetes, cancer and behavioral health needs. While these targets are slightly different than those identified in our community needs assessment, they do not represent significant change in population focus. One of the deliverables in our executed contracts with participating partners requires them to develop patient data sets that are helping to risk stratify patients at risk for the development of complex co-morbid conditions. The addition of the NYS Pediatrics HH is an additional population not previously identified through our community needs assessment.

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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: Albany Medical Center Hospital

Project: 2.a.v

Challenges the PPS has encountered in project implementation:

The AMCH PPS is the only PPS in New York State that chose project 2av. The PMO has successfully engaged numerous licensed nursing homes in this project and expects to meet the speed and scale deliverables in the required timeframe. The project, however, has posed a few challenges. Perhaps the biggest relates to the lack of capital funding, creating a disincentive for nursing homes to want to incur the costs needed to retrofit space for medical village use. Without available capital, the successful creation of an effective IT infrastructure, proper electronic health record/ secure messaging/ alerts/ patient record look up functionality, and appropriate utilization of data security protocols may not occur in a timely fashion, and will likely impede project success. Of all provider types, nursing homes are the least connected and the least likely to have a viable EHR. The AMCH PPS is dedicated and determined to achieve connectivity, where possible, and create an effective and secure integrated delivery system among the network partners.

The AMCH PPS utilized graduate students enrolled in Clarkson University for their Strategic Capstone Course to identify community needs in the medical village spaces. They found that there are medical needs within our identified hot spot neighborhoods that may not align properly with the potential services to be added to each Medical Village. The largest gap is based on insufficient mental health resources within our PPS. Access to participating Medical Villages may also prove to be a challenge, but not a barrier to success given that the PPS is diligently working behind the scenes to capitalize on the report generated from these students in a timely and efficient manner. Given that this is one of the last projects to roll-out, the PPS feels they will have adequate time to re-align services, if needed, and to successfully implement Medical Villages where deemed appropriate as a means to reduce avoidable ED readmissions.

Efforts to mitigate challenges identified above:

The AMCH PPS has several Skilled Nursing Facilities who are participating in the Medical Village project. Discussions are underway as to how to best utilize the space without capital funding. These stakeholder meetings have involved detailed conversations with skilled nursing facilities, urgent care providers, Community Based Organizations, as well as one Health Home in the area. For connectivity to be effective, the AMCH PPS has also worked to improve connectivity and interoperability without capital funding. The AMCH PMO has engaged the expertise of Accenture – a leading global consultant firm – to generate a list of “Tier 1” Affiliates, mainly those who already have executed contracts with the PMO, whereupon a detailed and accurate analysis has been done to better understand both the current state of each organization as it relates to their dependence on IT and the amount of projected time, effort, and plausible dollars it may take to get from gap to goal. Accenture’s work has been carefully documented into a roadmap that will be utilized by the systems experts within the PMO once the roll-out begins. The PMO has also been engaged with the Clinical and Quality Affairs Committee members and representatives from the local RHIO – HIXNY – to better understand their current capabilities and to gauge those already connected and sharing data with HIXNY;

this data will be helpful in outlining, creating, and adhering to a strategic plan for connectivity.
In order to ensure that proper community resources are utilized for this project, the PPS collaborated with Clarkson Graduate Students to conduct further analysis of existing data and relevant resources. This has been done to better understand the fourteen identified hot spot neighborhoods and their proximity to each of the potential participating organizations and their anticipated medical needs. The PMO then identified steps required to properly align recommended service pairs with the needs of the closest community.
Submitting an approved Certificate of Need to the NYSDOH can take a significant amount of time and energy. The Project Management Office will work closely with each of the participating organizations to ensure that all CONs are completed and submitted in a timely fashion to ensure that the deliverables are all met promptly; staff will be made available to address any questions or concerns throughout the process.

Implementation approaches that the PPS considers a best practice:

While risks do exist, the project management team not only anticipated these barriers and was conscious of them during the assessment of speed and scale, but continues to actively mitigate these as best as possible to ensure that proper success of this project comes to fruition. Once issues such as capital funding are addressed, the PPS intends on reviewing and adopting several best practice approaches for the creation of medical villages / alternative housing utilizing existing nursing home infrastructure. In an effort to stay streamlined and cohesive, most, if not all, of these best practices will stem from the extensive work done by the Clinical Integration Workgroup as it relates to Care Coordination
Additionally, a best practice that we are proud of is the ten-week collaboration effort with Clarkson University Graduate students for their Strategies in Healthcare Capstone Course (The introductory meeting was held Friday, April 1st and the analysis was completed on June 2nd, the deliverable due date); students were given four tasks directly from the finalized implementation plan and asked to compile these in a strategic and streamlined fashion for the project management office to review. The students went well beyond the need for a Medical Village Needs assessment. Instead they took a quantitative approach to the survey responses and the data collected by creating a realistic scoring methodology and using that to rank each of the SNFs in an effort to provide a realistic current to future state analysis of locations, resources, current state, and overall need.
A best practice that holds true across all projects is that the AMCH PPS has hosted project specific webinars for educational purposes across our PPS. The 2av webinar was held on Wednesday, March 30, 2016 as a means to draw attention to the project and to educate potential partners about what would be expected of them and how this project can benefit the population at large. The meeting agenda included a proper introduction of the project team, the meeting purpose which was to (1) communicate project specific information to interest PPS partners, (2) identify what our partners understand their roles to be, and gain further insight into their level of interest, and (3) provide clarity around any project specific questions our PPS partners may have related to 2av, a general overview of the DSRIP Program and its alignment to the AMCH PPS, Project 2av overview/implementation plan/performance measures, and finally project next steps.

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

The AMCH PPS held a ten-week collaboration effort with Clarkson University Graduate students for their Strategies in Healthcare Capstone Course (Friday April 1st: introduction with students – June 2nd: deliverable due); students were given four tasks directly from the finalized implementation plan and asked to compile these in a strategic and streamlined fashion for the project management office to review. As such, the students took a quantitative approach to the survey responses and the data collected by creating a realistic scoring methodology and using that to rank each of the SNFs in an effort to provide a realistic current to future state analysis. The Milestones, tasks and efforts are listed below:

i. **Milestone 1, Task M1:1** "*AMCH PMO will survey and review all of the existing SNFs and Long Term Care Facilities in our PPS to determine current bed capacity, bed utilization, financial sustainability, and willingness to participate in 2av.*"
    1. Project Leads research best practice initiatives towards better understanding what would be needed in a Medical Village and aligned their survey questions to these; once created, the survey was disseminated to all SNFs in the PPS network. The survey responses were then analyzed by the Capstone Team with the guidance of the Project Leads which covered topics like – the type of current staffing model, operations, services offered, information technology, and finance as it relates to capital funding.

ii. **Milestone 1, Task M1:2** "*AMCH PMO will analyze the Community Needs Assessment and other relevant sources to determine current gaps and highest demand (hot spots) for services provided, number of excess nursing home beds by county, current hospitalization/ED utilization rates, and Medicaid patient breakdown.*"
    1. Pairing the survey responses with the data found within the Community Needs Assessment and other relevant data resources (Census Data, SPARCs Data, etc.) – demographic data was collected as it relates to the fourteen identified hotspot neighborhoods. This data included meticulous detail relating to race breakdown, educational status, residents below poverty level, health insurance coverage, total Medicaid beneficiaries (broken down by dual eligible, children and adult by zip code), total admissions, Total ER visits, and total PQI admissions, among others.

iii. **Milestone 5, Task M1:1** "*Using existing relevant sources, AMCH PMO will determine which health services are in the highest demand for each participating SNF in order to strategically plan what services should be implemented at each location.*"
    1. The students analyzed the hotspot map to determine which hotspots are within the closest proximity to each of the SNFs who indicated their project interest through the completion of the SNF Survey. Further analyses ensued as a means to better understand the current state of each hotspot along with the most common reasons behind why residents of each SNF is brought to the Emergency Department. Understanding the current services provided vs. the needs of the community at large provided a platform for the students to provide thoughtful and justifiable recommendations to the project management office relating to potential services to be implemented in each Medical Village.

iv. **Milestone 5, Task M1:2** "*Using existing relevant sources, AMCH PMO will determine which community-based resources, community navigators, and community outreach programs are current in the highest demand and are feasible to be developed in space available, if capacity exists or could be created and are financially feasible.*"
    1. The creation of linkages between the community based organizations in our network, their proximity to each potential SNF/Hotspot neighborhood, and their willingness to participate in the DSRIP initiative for this project was a challenging endeavor given that project participation – especially for 2av – is very limited. However, upon understanding the potential services to be offered in each medical village based primarily off of community need and comparing that to the services offered within various CBOs, the students were able to identify a few core community based

organizations and resources that could be utilized to help foster the growth of said Medical Village.

Additional efforts beyond our quarterly requirements also include project specific educational webinars. The 2av Project Specific Webinar – hosted on Wednesday, March 30, 2016 as a means to draw attention to the project and to educate potential partners about what would be expected of them and how this project can benefit the population at large. The meeting agenda included a proper introduction of the project team, the meeting purpose which was to (1) communicate project specific information to interest PPS partners, (2) identify what our partners understand their roles to be, and gain further insight into their level of interest, and (3) provide clarity around any project specific questions our PPS partners may have related to 2av, a general overview of the DSRIP Program and its alignment to the AMCH PPS, Project 2av overview/implementation plan/performance measures, and finally project next steps.

The AMCH PPS has had collaborative discussions and meetings with a local CBO to discuss NORCs – Naturally Occurring Retirement Communities in our area and grant funding that the NY Statewide Senior Action Council is pursing. This meeting was held on Thursday, March 31st, 2016 with Gail Myers, Deputy Director of the NY Statewide Senior Action Council with discussion centered around Ms. Myers expertise in understanding the ins and outs of NORCs in Albany Medical Center PPS's catchment area. The discussion was also a chance to engage with this partner and to not only learn more about the community based resources they offer, but to address any questions or concerns they may have prior to committing to partner in this initiative, given their strong ties in the communities and hotspot neighborhoods we serve.

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

The initial community needs assessment has been updated as part of this project. While there are no significant differences in terms of the population being targeted, the updated assessment was essential to identify discrete health, mental health and social service needs of various neighborhoods within our five county regional area.

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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: Albany Medical Center Hospital

Project: 2.b.iii

Challenges the PPS has encountered in project implementation:

The PPS has made substantial progress in moving this project forward. Like all PPSs, the AMCH PPS has faced some challenges, but most of these were expected as components of the complexity of transforming a diverse, disintegrated and inefficient group of health and social service providers toward an integrated regional delivery system. The PMO is committed to the goals of the ED Care Triage project and will work to overcome the barriers and challenges identified below.

AMCH PPS has good provider representation at the project sub-committee level, stakeholder engagement and Primary Care Physician participation in this project. Like many projects in DSRIP, a broad spectrum of provider types is necessary. The PPS has a robust and successful project subcommittee established for this project and has engaged all three Emergency Departments as leaders in their respective communities for project implementation. As this project continues to be implemented, the PMO will continue to recruit Primary Care Providers to participate in the project sub-committee.

The PMO has identified several challenges that if left unaddressed, may cause barriers to successful project goal completion. Connectivity between health and social services providers is a critical component of this project. Without capital funding, the PPS is challenged to identify sufficient resources to fund real time interoperability and connectivity to facilitate communication between the EDs and all other participating partners. Several organizations are hesitant to participate knowing that they may not have the capital funding and other resources needed to adopt the policies, procedures and best practices associated with secure interoperability and proper data sharing along the continuum of care.

Speed and scale commitments for this project, generated by the PMO initially in late 2014, may prove to be an additional challenge. Given the delays in so many other aspects of DSRIP implementation, including prolonged opt out period, patient level data supplied by DOH that was delayed repeatedly, more recent announcements that radically change the definition of who qualifies as a PCP safety net provider, delays in workforce deliverables, among several other things, have created an environment that makes it difficult to reach speed and scale targets, especially when they may have been aggressive to begin with.

In the Project Plan Application, the PPS committed to serve frequent ED users by diverting them to alternate care settings such as PCMHs. Although the patient population proposed to be served is unchanged, a diversion model mentioned in the application is undergoing additional review. Partners have expressed EMTALA-related concerns and felt uncomfortable allowing first responders to divert patients. This model will continue to be reviewed for potential implementation when improved IT connectivity exists between first responders and the EDs.

Lastly, educating patients to how they utilize healthcare services is an additional challenge. Many patients seek care

through the emergency department for non-emergent symptoms as they cannot navigate the system appropriately in order to receive the most appropriate care. This proves to be challenging as we strive to reach the overarching goal of DSRIP, which is to reduce avoidable ED and hospital use by 25%; improving patients' understanding of true emergency is important and necessary. Part of the solution to this rests outside the domain of this project, requiring expansion of primary care sites, hours of operation, and improved access, resulting in viable alternatives to the use of the three participating EDs.

Efforts to mitigate challenges identified above:

The PMO has made several efforts to increase practitioner engagement and strategized activities that would add value to this project's success.

In order to increase practitioner engagement, the PMO created the ED Care Triage Subcommittee. This subcommittee consists of ED directors and representatives from all three hospitals in our PPS region, and has met monthly since the first meeting held in December 2015. The PMO has convened a Primary Care Advisory Group, which is playing a critical role in helping to increase PCPs' involvement in ED Care Triage. As part of practitioner engagement efforts, the PMO has formed a Value-Based Purchasing (VBP) Workgroup, under the Finance Committee. This Workgroup is well-attended by various partners including practitioners, CBOs, and MCOs, all of whom are engaged in active conversations about the transition towards VBP. These conversations seem to increase interest and engagement of practitioners who are often not engaged in our project implementation.

The PMO is aware of the challenges and the potential barriers that exist given that the PPS network includes a multitude of provider types and varying levels of information technology capabilities. To address this, a low cost solution is being implemented to insure that key stakeholders are connected to HIXNY and that interoperability, allowing care plans and other important protected patient information, will be shared across the participating provider network. In addition, AMCH will be applying for capital funding based on RFA #1607010255 – Statewide Health Care Facility Transformation Program. If funded, capital support will be provided to move this and the other projects forward in terms of IT systems solutions, population health and related data management issues

To respond to the difficulty of shifting patients' perception and culture around the use of EDs, the ED Care Triage Subcommittee has recently reviewed several patient education materials that will be distributed in various settings such as EDs and PCP offices. This information consists of a one-page visual material that lays out symptoms that are appropriate for care in ED, urgent care, and PCP settings. This educational intervention is only one of several that have been developed by the PMO, although not all of them have been implemented. In addition, the Cultural Competency/Health Literacy Strategy outlines the AMCH PPS's plan of developing and/or distributing patient education materials that are culturally and linguistically appropriate.

Implementation approaches that the PPS considers a best practice:

The AMCH PPS embraced the opioid epidemic as an urgent public health issue that the EDs in our region can take an action on. Therefore, the ED Care Triage Subcommittee adopted a revised version of the NYC ED Discharge Opioid Prescribing Guidelines to create a PPS-wide guideline. This guideline was reviewed and approved by the ED Care Triage Subcommittee and the Clinical and Quality Affairs Committee, and is being implemented at all three EDs in our region.

We consider the PPS's Clinical Integration Strategy/Care Coordination Model as a best practice that creates a framework of both current and future systems of integrated care within our PPS. Extensive involvement of partners from over 20 PPS organizations resulted in the final product with future state process flows and data requirements, standardized tools and assessments, and vivid description of the current care coordination system. The recommendations and findings are being used in continuing the successful implementation of this project.

Lastly, the ED Care Triage Subcommittee and the PMO have drafted the ED Care Triage Program Action Plan that was reviewed and approved as draft in June 2016. This action plan has a four-pronged strategy, which includes expansion of access to primary care and alternate settings, focused effort on frequent ED users and at-risk individuals, expansion of access to behavioral health services, and delivery of culturally, linguistically, and socially relevant patient education on the appropriate use of EDs. This document lays out our PPS's direction of this project's implementation beyond meeting milestone requirements.

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

Following the distribution of the AMCH PPS comprehensive current state assessment survey in September 2015, the PMO convened ED directors and case management representatives from all three hospitals on December 7, 2015 to provide education and training as well as gain engagement from providers. During this meeting, partners were provided with a detailed overview of DSRIP and the ED Care Triage project. This was also an opportunity for organizations to confirm their interest in participating on monthly subcommittee meetings.

The ED Care Triage Subcommittee met again on February 1, 2016 and then on the first Monday of each succeeding month. The subcommittee is chaired by Dr. Denis Pauze, who is the Associate Medical Director of Albany Med ED. After establishing the subcommittee's roles and responsibilities, members participated in several discussion topics, including the following:

- Draft job descriptions of patient navigators
- DSRIP outcome measures impacted by EDs' activities
- Current referral and triage patterns
- PPS-wide opioid prescribing guideline
- Barriers to making PCP appointments for ED patients
- Clinical integration model in ED settings
- Patient education materials on appropriate ED use

In addition to the subcommittee engagement, the PMO recognized the need to educate larger number of practitioners who will carry out the implementation of this project. Therefore, the PPS Medical Director presented at all three hospitals in January and February 2016 to various groups, including hospital leadership and ED faculty members and providers. These meetings evoked positive feedback and active engagement of practitioners who often had not heard of DSRIP before. The PMO continues to educate and present to various partners on an ad hoc-basis to increase providers' knowledge about DSRIP initiatives.

The subcommittee members continue to provide monthly updates on their progress of recruiting ED patient navigators. They have reported that draft job descriptions shared and discussed during the subcommittee meeting were utilized to begin their recruitment process. All three hospitals are actively recruiting for both RN level and non-RN level patient navigators.

The PMO is currently exploring an option of collaborating with the United Way/211 for a regional resource directory. Such directory would be a valuable tool for ED patient navigators when connecting patients to various medical and social services. The PMO continues to gather information about 211's service capacity and how it can align with DSRIP needs.

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

There are no significant changes between the current target population and the identified needs in the community needs assessment.

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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: Albany Medical Center Hospital

Project: 2.d.i

Challenges the PPS has encountered in project implementation:

The original 2.d.i implementation plan stated that the project management office ("PMO") anticipated facing four challenges in realizing full project phase-in. The most significant risks focused on: 1) lack of community/patient engagement, 2) relevant real-time claims data, 3) a possible shortage of Patient Activation Measure ("PAM")-trained staff, and 4) secure IT data sharing and communication. Most of these initial challenges have been addressed through the project team's work and the work of several committees. While other challenges may be on the horizon, the PMO remains confident that it will succeed in engaging a sufficient number of patients with this project to meet speed and scale requirements going forward.

The biggest risk, and the issue which the project aims to pronouncedly transform, is the degree to which patient engagement is lagging in the five-county PPS. Lack of engagement (or "activation" in the PAM realm) makes it difficult for individuals to take an active role in planning their own care. A lack of patient engagement may be due to language barriers, understanding medical conditions, cultural differences, age, gender, sexual orientation and/or socio-economic status. This leads to disparities in care and disparate health outcomes.

Secondly, in order to effectively track patient activation levels of the LU, NU and UI, relevant real time claims data is a necessity. While improvements have been made, real time data is not yet available to identify the low, non-utilizing and uninsured population. Claims data will only have limited utility in helping to identify these individuals so that targeted interventions can be launched to engage them in care and self-management.

The PMO's project staff have trained a significant number of individuals in over 20 partnering organizations and is no longer concerned about a potential staff shortage.

Another anticipated challenge was the project's reliance on IT infrastructure, needed to support communication, data collection, and reporting. Many CBOs lack high-level IT infrastructure including secure messaging, data storage, interoperability, and RHIO connectivity. This poses a risk in their abilities to keep pace with DSRIP changes, manage data, and meet project deliverables. With the aforementioned challenges, and others which are unforeseen, the PMO has established a plan for risk mitigation.

One barrier to full project implementation has been the limited DOH network "window" that would allow new providers to formally join the AMCH PPS. Engagement of key CBOs and expansion of the provider network is crucial to the project and to DSRIP success.

Another newly realized risk to project success has been the perceived, relative inflexibility of the Flourish data system (where PAM data is logged and reports generated). There are several instances of this inflexibility in fully meeting the 2.d.i project demands. Flourish's perceived limitations impede the ability to manage subsequent PAMs, especially if not conducted by the original assigned "coach."

At the project management level, to-date, the PMO has been unable to extract any patient demographic and address data from the Flourish system. This has been a challenge to conducting in-depth analysis of PAM data (answering "who" the project is successful with).

Efforts to mitigate challenges identified above:

The PMO has taken many steps toward actively addressing challenges and making measureable progress with project milestones and metrics. The PMO also realizes there is much work to be done.

The PMO has taken on the task of facilitating PAM training for provider personnel that work in all of the five counties that the PPS encompasses. There has been great success to-date. Over 150 "coaches" who are able to train other individuals (in the "train the trainer" model) are located in provider sites throughout Warren, Saratoga, Columbia, Greene, and Albany counties. The team has continually reached out to CBOs, hospitals, social service providers, and other organizations, with an emphasis on those that work closely in the CNA-designated hot spots and can connect with the 2.d.i target populations.

With an emphasis on reaching its commitment to project speed and scale, the project team has continually engaged and trained providers that have expressed interest in patient activation. Other providers that fit well with the project goals have been reached by the project team, from clinics to social service providers, across the spectrum of network providers.

Related to the Flourish data system, the PMO has actively advocated for the necessary changes it feels are needed, based on the challenges enumerated in the previous section.

Further collaboration with CBOs is integral to project success. Placement of trained navigators at hot spots is an imminent undertaking. Talks have been initiated with the key CBOs that have expressed project interest. These providers have exhibited ongoing PPS involvement and are wholeheartedly engaging in this process.

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Implementation approaches that the PPS considers a best practice:

The "best practice" approaches to implementation have been with those practices that have been deliberative and thoughtful in project roll-out.

Engagement of providers has not been as rapid as expected, most notably with the hospitals. The complexity of interjecting a new intervention technique into already fast-paced and packed workflows has translated in many instances to a gradual phasing-in implementation process. To the AMCH providers' credit, most have been highly deliberative and thoughtful in how to best implement the patient activation technique, and the supplemental coaching for activation ("CFA"), in a meaningful, long-lasting way.

Understanding that the 10-item PAM assessment has the vital CFA component conjoined with it, providers have worked to interweave CFA into patient encounters.

Another best practice to project implementation has been the multi-faceted approach to identifying the key CBOs and providers with resources available to participate in PAM training. In Fall 2015, a provider survey was used to assess CBO and provider interest and capacity to fully implement the 2.d.i project. Each organization's general interest in the project was evaluated, with multiple elements considered.

Over the course of the quarter, discussions were held with several key CBOs (e.g., Catholic Charities) located in hot spots in the five county service area. The purpose of the meetings was to provide the organizations with project expectations, including detail related to Insignia's PAM and CFA. Other project components, such as the training and utilization of patient navigators, were also covered.

Over the last three months, multiple strategy sessions were held with executive-level and ED personnel of the PPS hospitals – Saratoga Hospital, Albany Medical Center, and Columbia Memorial Hospital. These sessions explored ED workflow and the potential for meaningful project implementation. Stemming from these discussions, key personnel were identified and subsequently trained to administer PAMs.

In recent months, smaller CBOs, social welfare agencies, clinics, and other providers have been pulled into the project. It has been this phasing in of the project that has worked well. Giving providers' time to understand any workflow concerns and address them has meant that a fuller integration of the PAM has led to more meaningful patient encounters. The project team has then gone on to engage other providers and assist them in training and PAM logistics.

Recognizing the importance of the role of consumers in transformation, the PMO developed a best practice in terms of obtaining real-time feedback from Medicaid eligible recipients. In the Spring of 2016, the PMO issued a Request for Proposal (RFP) to the entire PPS network to encourage organizations to facilitate consumer listening sessions. Seven partner organizations, six of which were Community Based Organizations, responded and received funding for conducting fifteen individual listening sessions in four counties. These sessions were used to obtain feedback from Medicaid beneficiaries, as well as the uninsured, on access to medical insurance and medical care, barriers encountered within the healthcare system, frequency of utilizing healthcare services, etc. Additionally, the PMO recently issued another RFP to the network to facilitate more consumer listening sessions this Fall.

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

- Developed and forwarded survey to PPS partner to identify those interested in project engagement
- Engaged smaller CBOs with their focus on 5-county hot spots (e.g., Trinity Alliance and Alliance for Positive Health)
- Collaboration - Met at several points with the 2.d.i project coordinator from AHI to discuss best practices for partner and consumer engagement
- Linked AHI project coordinator with an AMCH 2.d.i provider "champion" to glean knowledge regarding best practices for hospital and other provider roll-out of the project
- Formed a best practice work group consisting of partners who have implemented PAM and CFA
- Participate in multiple ongoing PAM and CFA online trainings
- Attend Greater Hospitals of NY patient activation forums
- Monitored and responded to quality-control issues with Flourish data set
- Provided train-the-trainer PAM/ CFA training to over 20 providers, local government entities and CBOs, including :
  - Albany Medical Center
  - Saratoga Hospital
  - Columbia Memorial Hospital
  - Catholic Charities
  - Planned Parenthood
  - Koinonia Primary Care
  - Community Health Center
  - Greene County Family Planning
  - Healthy Capital District Initiative
  - St. Catherine's
  - Community Caregivers
  - Independent Living Centers of the Hudson Valley
  - Trinity Alliance
  - Alliance for Positive Health

- Community Healthcare Consortium

- In collaboration with Albany Medical Center Hospital personnel, Brick's Barbershop, Alpha Phi Alpha Fraternity and George Biddle Kelley Education Foundation, Consumer and Community Affairs members participated in the CUT Hypertension Initiative in Albany, NY (September, 2015). This was a community outreach initiative used to address head-on a major health issue facing African American members of our community and communicate the goals of DSRIP.

  - Participate in the all PPS monthly 2.d.i Collaboration workgroup meetings

AMCH PMO, in collaboration with neighboring PPSs, Alliance for Better Healthcare and Adirondack Health Institute, provided a "Train the Trainer" PAM workshop. The workshop was facilitated by Insignia at Saratoga Hospital on July 16,' 2015. There were a total of 20 AMCH PPS Partners in attendance. Attendees included; AMCH PMO staff, and participating CBO staff and healthcare providers. To date, seven (7) PAM refresher webinars have been provided. Webinars were held as follows:

1. PAM Administration Refresher- August 28, 2015
2. DSRIP: PAM Coaching for Activation- September 28, 2015
3. DSRIP: PAM Administration- September 30, 2015
4. DSRIP: PAM 101- October 2, 2015
5. PAM Administration Refresher- November 2, 2015
6. DSRIP: PAM Coaching for Activation- November 4, 2015
7. DSRIP: PAM Administration- November 6, 2015

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
There have been no significant changes to the population served in this project. The target population is consistent with groups of individuals identified in the community needs assessment.

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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: Albany Medical Center Hospital

Project: 3.a.i

Challenges the PPS has encountered in project implementation:
AMCH's PPS has made substantial progress in terms of the integration of primary and behavioral health care. Contracts have been executed with both primary and behavioral health care providers that will result in numerous milestones being met. The PMO, however, has faced challenges and concerns in moving this project forward. Several of these concerns remain, the first being that capital funding would be necessary for this project. It was estimated that funding would be necessary for IT infrastructure, computer equipment, space renovation, and additional equipment in order to successfully co-locate primary care services into behavioral health providers. Moreover, a number of participating providers have indicated that obtaining the required EHR technology would be a significant financial undertaking. The absence of capital funding for EHR Connectivity and to promote advanced technology and innovation is particularly challenging. Several organizations are hesitant to participate knowing that they may not have the resources available including capital, staff, and time needed to adopt the policies, procedures and best practices associated with secure interoperability and proper data sharing along the continuum of care. A second identified challenge is ensuring that safety net primary care sites would be 2014 NCQA Level 3 PCMH certified by DY3Q2. Achieving such certification entails significant work in a short period of time. DOH indicated that they would provide learning symposium material for PCMH certification but unfortunately there has only been one. A third challenge is that participating providers have identified an insufficient regional supply of primary care providers and certain behavioral health providers (e.g., psychiatrists) as a likely obstacle to project implementation moving forward. Work completed by our workforce vendor, BDO, indicated a significant gap in behavioral health providers in our 5 county region, making the integration project increasingly more challenging. Fourth, during the application phase, the PPS Behavioral Health subcommittee decided to implement all 3 models of the 3ai project. Participants felt that the IMPACT Model would be beneficial to several participating organizations. Due to added stresses and hesitancy to engage, the AMCH PPS put the IMPACT Model on hold at the beginning of DY1 but has since met with several key stakeholders to understand their hesitancy. This took a lot of time and effort to educate stakeholders but the PMO believes there is participation in all 3 models of integration. Participating organizations feel that the licensure threshold could raise ongoing concerns for implementation of this project. A number of participating providers have expressed questions and concerns regarding how to provide integrated services without exceeding their respective licensure thresholds, regardless of education and resources that the subcommittee has provided. Lastly, participating organizations specializing in SUD have expressed concern in participation of this project. Data privacy and treatment concerns tend to be the cause for hesitancy and although the PMO has assured organizations that all proper data security measures are in place, there is still resistance from this provider type as a whole.
Efforts to mitigate challenges identified above:

Numerous steps have been taken by the PMO and the PPS to address the challenges, concerns and barriers identified. The PMO has engaged the expertise of Accenture to better understand both the current state of each organization as it relates to their dependence on IT and the amount of projected time, effort, and plausible dollars it may take to get from gap to goal. A low cost solution has been identified that will address the lack of capital funding for IT connectivity and interoperability. Second, regarding the challenge of PCMH Certification: As per recent guidance from the Independent Assessor, for projects requiring PCMH recognition, only *eligible* primary care practices will be required to meet 2014 NCQA Level 3 PCMH requirements. The AMCH PPS has conducted a site specific analysis of PCMH for our safety net Primary Care Providers. This data has helped us target key stakeholders to understand their challenges or hesitancy to apply for 2104 NCQA Level 3 PCMH certification. Internal PMO conversations continue in order to understand what internal resources may be needed vs the additional needs required from participating organizations.

Third, regarding the challenge of insufficient provider supply: AMCH PPS engaged a workforce consulting firm to conduct a compensation and benefits analysis in order to generate a current state assessment, and also to project the Workforce Target State. The identification of a current and target state constitutes a fundamental first step in the development of sufficient regional workforce. Next steps in this process include using the Current State and Target state to perform a gap analysis, with which we will develop the Workforce Transition Roadmap. Moreover, the PPS has established a Workforce Coordinating Council as a governance committee to oversee current and future state resource needs across the PPS. This committee consists of HR representation from multiple stakeholders and provider types, union representation, as well as subject matter experts. Also, the PMO has engaged participating organizations in conversation about their interest in furnishing such providers for co-location/integration at other sites, and is supporting ongoing conversation at the Project 3.a.i sub-committee level between organizations about this possibility.

Fourth, the PMO has employed other strategies to support partner and provider participation. First, as detailed in the below sections, the PPS has formed a Project 3.a.i Sub-Committee, consisting of approximately 40 clinicians, administrators, and content-area experts representing primary care and behavioral health organizations throughout the PPS. Moreover, and more broadly, the PPS Clinical and Quality Affairs Committee has developed a Practitioner Communication and Engagement Plan, and a Practitioner Training and Education Plan, both of which share a fundamental aim of engaging clinical stakeholders representing participating member organizations.

Fifth, engagement in the IMPACT model has increased after the PMO provided additional training and education via a webinar to the PAC and the Project 3.a.i Sub-Committee. Additional presentations on the particular benefits of the IMPACT Model, and guidance documents on the rationale, benefits, implementation, and training needs of the model have been ongoing agenda items at the 3ai project subcommittee meeting. Moreover, the PMO has continued to meet with participating organizations to discuss the benefits of this model, as well as strategies to address any barriers to implementation. At this point, a number of participating providers have expressed significant interest in implementing Model 3.

To address participating providers questions and concerns regarding how to provide integrated services without exceeding their respective licensure thresholds, the PMO has provided education on licensure thresholds, the DSRIP Project 3.a.i Licensure Threshold, and Integrated Outpatient Services regulations through providing and presenting the NYS DOH 4/18/16 FAQ document for Approaches to Integrated Care, which includes guidance on each of these issues, as well as through the Project 3.a.i Sub-Committee. AMCH PMO staff and subject matter experts have attended several informational webinars as provided by DOH.

In order to increase participating providers' interest in providing integrated/co-located substance abuse treatment, the PMO has provided education via webinar to executive leadership at participating organizations regarding the regional need for substance abuse treatment and the benefits for co-location of such treatment. Moreover, the PMO has had ongoing conversations with participating providers both individually and within Project 3.a.i Sub-Committee meetings to support participation in this aspect of Project 3.a.i, and to proactively address any barriers to implementation. Presently, a number of participating providers have expressed interest in ultimately providing treatment for substance abuse disorders after they develop or expand their abilities to provide co-located/integrated mental health and primary care services.

Implementation approaches that the PPS considers a best practice:

One approach that the PMO considers an implementation best practice is the use of a Comprehensive Baseline Survey and Practice Evaluation for Participating Providers tool. The PMO initiated partner engagement and current state assessment with a comprehensive baseline assessment that was distributed to all PPS partners on September 30, 2015. This assessment allowed the PPS to identify initial interest in participating in Project 3.a.i. Moreover, it assessed partners on a range of activities directly relevant to this project and its deliverables, including: the type and number of behavioral health and primary care providers at each organization; patient registries; electronic health record, behavioral health electronic health record, and population health management application; NCQA PCMH status/eligibility; and whether the organization offered staff training in mental illness, crisis management, health behavior, care coordination, motivational interviewing, medication adherence, and measuring and evaluating health outcomes. The PMO will conduct annual updates to this comprehensive assessment. Moreover, the PMO is currently developing a Project 3.a.i Practice Evaluation for Participating Providers, in order to collect further in-depth information on participating providers' current state capabilities, resources, and goals for service integration. Such in-depth practice-specific assessment is considered a best practice approach to project implementation.

A second approach that the AMCH PPS considers an implementation best-practice is our 3.a.i. sub-committee/workgroup structure. The AMCH PPS has formed a Project 3.a.i Sub-Committee consisting of approximately 40 clinicians, administrators, and content-area experts representing organizations throughout the PPS, which is overseen by the Clinical and Quality Affairs Committee. The Sub-Committee consists of separate workgroups for primary care site-based models of integration and behavioral health site-based models of integration. The Sub-Committee's fundamental aims are to support project implementation, the achievement of project deliverables, and to provide content-area expertise regarding standards of care (see below) for integrated services and best clinical practices. The systematic involvement of these experts and stakeholders is felt to be a best-practice.

A third approach that the AMCH PPS considers an implementation best-practice relates to the focus on Standards of Care and preventative care screenings. A fundamental role of the above-described Project 3.a.i Sub-Committee and Workgroups is the identification/development and dissemination of evidence-based standards of care for service integration, which was a best practice identified in our Project Plan Application. To that end, the sub-committee has approved a proposal for preventative care behavioral health screenings for depression for adults and adolescents, which has been approved by the Clinical and Quality Affairs Committee. Moving forward, they will develop proposals for such topics as pediatric behavioral health preventative care screenings, substance use disorder screenings, and evidence-based standards of care for medication management and care engagement processes.

A fourth approach that the AMCH PPS considers an implementation best-practice relates to our Clinical Integration Effort. Supporting the development of effective care coordination and optimal clinical integration – both of which are fundamental to effective integrated care – is considered an implementation best-practice. To that end, members of the PMO's Project 3.a.i team have been, and will continue to be, integrally involved in the development of the AMCH PPS Clinical Integration Strategy as members of the Clinical Integration Workgroup, Clinical Integration Leadership team, and Clinical Integration Steering Committee. This involvement ensures a focus on the coordination of physical and behavioral health services, which is vital to the successful implementation of this project.

A fifth approach that the PMO considers an implementation best-practice is inter-PPS collaboration: As all PPSs have elected to participate in Project 3.a.i, and as the AMCH PPS overlaps with two other PPSs, we consider collaboration with our overlapping and neighboring PPSs to be a best-practice for implementation. The AMCH PPS participated in the IT-TOM project along with the 2 other overlapping PPSs in the region. There were large discussions regarding business and systems processes aimed at ensuring successful integration across the 3ai project. PPS collaboration continues with these overlapping PPSs, as we meet regularly to discuss patient engagement reporting and overlap amongst providers in our region. In addition to these overlapping PPSs, we also collaborate regularly on projects and workstreams with other PPSs, including the Montefiore PPS, FLPPS, and Bassett. Such collaboration addresses a variety of activities, including sharing best practices, implementation ideas, and documentation.

A sixth approach that the AMCH PPS considers an implementation best-practice relates to workforce development. Much of the success of this project is predicated on the availability of behavioral health providers, primary care providers, and case managers/care coordinators. To that end, the AMCH PPS engaged a workforce consulting firm to conduct a compensation and benefits analysis in order to generate a current state assessment, and also to project the Workforce Target State. The identification of a current and target state constitutes a fundamental first step in the development of sufficient regional workforce. Next steps in this process include using the Current State and Target state to perform a gap analysis, with which we will develop the Workforce Transition Roadmap. Moreover, AMCH PPS has established a Workforce Coordinating Council as a governance committee to oversee current and future state resource needs across the PPS. This committee consists of HR representation from multiple stakeholders and provider types, union representation, as well as subject matter experts.

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

AMCH PPS has held monthly 3.a.i Sub-Committee meetings (03/24/16; 04/12/16; 05/19/16), and the inaugural 3.a.i Workgroup meetings for the behavioral health site-based model of integration (06/24/16) and the primary care site-based models of integration (06/30/16). Moving forward, the workgroups will meet monthly, while the full-subcommittee will meet quarterly. Topics presented and discussed at sub-committee meetings have included: Project 3.a.i overview, including deliverables, reporting requirements, and outcome measures; Project 3.a.i Sub-Committee Charter; Project 3.a.i Workgroup aims; The Practice Evaluation for Participating Providers; DSRIP Project 3.a.i Licensure Threshold; best-practices for preventative care behavioral health screenings, including screening for depression and problematic substance use; policies, procedures, and protocols for behavioral health screenings; recommendations for AMCH Clinical Integration Workgroup regarding the role of behavioral health screening in the future state model of clinical integration/care coordination; and interventions to support PPS-wide progress on performance measures. Topics discussed at the workgroup meetings include: the current state of service integration among participating providers; goals for project participation; perceived barriers to successful implementation of Project 3.a.i.; and strategies for identifying primary care and behavioral health providers available for co-location/integration. The project 3.a.i sub-committee has approved a proposal for preventative care behavioral health screenings for depression for adults and adolescents, which has been approved by the Clinical and Quality Affairs Committee. Furthermore, the PMO developed and presented two webinars that detailed Project 3.a.i, national and local data on comorbid physical and behavioral health conditions, problems associated with non-integrated treatment, and benefits of integrated/co-located treatment models. Additionally, the AMCH PPS has demonstrated ongoing stakeholder engagement efforts with participating providers and interested organizations in order to support optimal project participation, identify perceived barriers to participation, and develop mitigation strategies to address such barriers.

Moreover, the PMO is developing Practice Evaluation for Participating Providers, in order to collect in-depth information on participating providers' current states capabilities and resources, as well as goals for service integration. Finally, the PMO staff members continue to attend a range of presentations and workshops regarding primary care and behavioral health integration, including DOH/OMH/OASAS's "Understanding Changes to Medicaid Behavioral Health Care in New York"; HANYS Behavioral Health SWAT "Understanding the Complexities of Reform"; and Mount Sinai's Project 3.a.i presentation at April's all-PPS meeting.

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

There are no significant changes in terms of target populations between the work currently being done and the community needs assessment conducted in 2015.

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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: Albany Medical Center Hospital

Project: 3.a.ii

Challenges the PPS has encountered in project implementation:

Crisis stabilization services need to be expanded and better coordinated. The PPS has identified numerous partners who have executed contracts to participate in this project. Although substantial progress continues to be made, there are three significant challenges.

Lack of capital funding for partners has been a challenge for this project. Partners have expressed that lack of capital funding has hindered their ability to purchase, install and staff short-stay, sub-acute crisis-stabilization beds; expand mobile crisis services; and develop the IT infrastructure necessary to track engaged patients. Moreover, developing necessary IT infrastructure is a challenge without capital funding.

In the AMCH PPS Project Plan Application, the PPS identified that establishing agreements with the Medicaid Managed Care Organizations to provide coverage under this project might be a challenge. While, beginning July 1, 2016, organizations now have the ability to bill for crisis services, many do not yet have the infrastructure in place to track or report this patient specific data. Prior to July 1, organizations did not collect patient specific information during a crisis situation and may not have the patient name, Medicaid number, or other pertinent information.

A third challenge relates to an insufficient regional supply of behavioral health service providers. Work completed by our workforce vendor, BDO, is aligned with the Community Needs Assessment (C.N.A.) completed in 2014. Both analyses indicate a significant gap in behavioral health providers in our 5 county region making provision of crisis stabilization services increasingly more challenging.

Efforts to mitigate challenges identified above:

The AMCH PMO is aware of the challenges and the potential barriers that exist given that the PPS network includes a multitude of provider types and varying levels of information technology capabilities. That being said, the PMO has engaged the expertise of Accenture, a leading global consultant firm, to help understand both the current state of each organization as it relates to their dependence on IT and the amount of projected time, effort, and plausible dollars it may take to get from gap to goal. The PMO has also been engaged with the Clinical and Quality Affairs Committee members and representatives from the local RHIO – HIXNY – to better understand their current capabilities and to gauge those already connected and sharing data with HIXNY. This engagement and the resulting data will be helpful.

The concern in regards to Medicaid reimbursement for this project will resolve over the next several months for many

organizations. Beginning July 1, 2016, a range of behavioral health services was carved into Medicaid managed care including Crisis Intervention Services. This effectively mitigates the above-identified challenge regarding Medicaid Managed Care organizations providing coverage. As per a 6/13/16 presentation by CDPHP at the AMCH Project 3.a.ii Sub-Committee meeting, the covered Crisis Intervention Services include preliminary assessment of risk; mental status evaluation; evaluation of medical stability and the need for further evaluation and/or mental health services; contact with consumer, family members, or other collateral; crisis resolution, consultation, and debriefing; referral and linkages to appropriate behavioral health services including short term crisis respite or intensive crisis respite; and follow-up with the individual and the individuals' family/support network, possibly by a Peer Specialist. The PMO staff and subcommittee leads will ensure appropriate education and resources are made available to participating providers on this new opportunity for payment regulation.

Third, regarding the challenge of insufficient provider supply: the PMO engaged a workforce consulting firm to conduct a compensation and benefits analysis in order to generate a current state assessment, and also to project the Workforce Target State. The identification of a current and target state constitutes a fundamental first step in the development of sufficient regional workforce. Next steps in this process include using the Current State and Target state to perform a gap analysis, with which we will develop the Workforce Transition Roadmap. Moreover, AMCH PPS has established a Workforce Coordinating Council as a governance committee to oversee current and future state resource needs across the PPS. This committee consists of HR representation from multiple stakeholders and provider types, union representation, as well as subject matter experts.

As detailed in the below sections, we have formed a Project 3.a.ii Sub-Committee under the oversight of the Clinical and Quality Affairs Committee, consisting of approximately 34 clinicians, administrators, and content-area experts representing organizations providing crisis intervention and stabilization services throughout the PPS. A fundamental charge of this group is development and dissemination of written treatment protocols for crisis stabilization services. To this end, regularly scheduled formal meetings have begun. The group has already begun reviewing national best-practice models of behavioral health crisis stabilization services, with the ultimate aim of developing and disseminating treatment protocols. Finally, we have established a smaller Project 3.a.ii Core Components workgroup, whose charge is in part to propose the core components, including relevant treatment protocols, of a behavioral health crisis stabilization system throughout the AMCH PPS.

Phase 1 contracts have been sent out to participating providers. The PMO has employed other strategies to support partner and provider participation. First, in order to facilitate and support participation, we have formed a Project 3.a.ii Sub-Committee under the oversight of the Clinical and Quality Affairs Committee. This sub-committee consists of approximately 34 clinicians, administrators, and content-area experts representing Crisis Stabilization Service organizations throughout the PPS. Second, and more broadly, the AMCH PPS Clinical and Quality Affairs Committee has developed a Practitioner Communication and Engagement Plan, and a Practitioner Training and Education Plan, both of which share a fundamental aim of engaging clinical stakeholders representing participating member organizations.

As noted above, the PMO has formed a Project 3.a.ii Sub-Committee under the oversight of the Clinical and Quality Affairs Committee, consisting of approximately 34 clinicians, administrators, and content-area experts representing organizations providing crisis intervention and stabilization services throughout the PPS. Within this group, we have facilitated inter-organization communication. We also have established a smaller Project 3.a.ii Core Components workgroup of the larger sub-committee. Also, optimal inter-organization communication and coordination was a key area of focus in the AMCH PPS Clinical Integration Strategy. To that end, members the PMO's Project 3.a.ii team have been, and will continue to be, integrally involved in the development of the PPS Clinical Integration Strategy as members of the Clinical Integration Workgroup, Clinical Integration Leadership team, and Clinical Integration Steering Committee. This involvement ensures a focus on optimal communication and coordination between crisis

intervention and stabilization service providers, which is vital to the successful implementation of this project.

Implementation approaches that the PPS considers a best practice:

Initially, it was vital that the PMO collect key baseline data that would be fundamental to designing an optimally useful behavioral health crisis stabilization system throughout our PPS. As such, a community needs assessment (CNA) was conducted by the Healthy Capital District Initiative in 2014, and the AMCH PPS conducted focus groups of providers and Medicaid beneficiaries before writing the Project Plan Application. These tools provided a range of valuable baseline data, including behavioral health conditions driving ED visits, incidence of preventable ED visits, and geographic and demographic distribution of behavioral health-related ED visits. This key data informed the subsequent AMCH PPS current state assessment of behavioral health community crisis stabilization services current state assessment, and continues to inform the development of behavioral health crisis stabilization services aimed at meeting the region's geographic, demographic, and diagnostic needs.

The AMCH PPS 3aii subcommittee has had discussions and plans to break into regional workgroups in order to best align efforts in project implementation based on regional need. This plan has not been implemented but after meetings with many key stakeholders in our different hubs, it is clear that this will be a best practice to follow in order to achieve this projects full potential.

The PMO initiated partner engagement and current state assessment with a comprehensive baseline assessment that was distributed to all PPS partners on September 30, 2015. Building off of the data collected in the above-mentioned CNA and focus groups, such practice-specific assessment is considered a best practice approach to project implementation. This assessment allowed the PPS to identify initial interest in participating in Project 3.a.ii. Moreover, it assessed partners on a range of activities directly relevant to this project and its deliverables, including: the type and number of behavioral health providers at each organization; patient registries; electronic health record, behavioral health electronic health record, and population health management application; whether the organization offered staff training in mental illness, crisis management, care coordination, motivational interviewing, medication adherence, and measuring and evaluating health outcomes.

The PMO has formed a Project 3.a.ii Sub-Committee overseen by the Clinical and Quality Affairs Committee, and which consists of approximately 34 clinicians, administrators, and content-area experts representing organizations throughout the PPS. The Sub-Committee's fundamental aim is to support project implementation, the achievement of project deliverables, and provide content-area expertise regarding treatment protocols for crisis intervention and stabilization services and best clinical practices. Furthermore, a core-components workgroup has been established within this sub-committee, with the charge of using identified national best-practice models of crisis stabilization services to propose the core elements and optimal phasing of a behavioral health crisis stabilization program throughout our PPS. The systematic involvement of these experts and stakeholders is felt to be a best-practice. Supporting the development of effective care coordination and optimal clinical integration, both of which are

fundamental to an effective behavioral health crisis stabilization system involving a myriad of organizations, is considered an implementation best-practice. To that end, members the PMO's Project 3.a.ii team have been, and will continue to be, integrally involved in the development of the AMCH PPS Clinical Integration Strategy as members of the Clinical Integration Workgroup, Clinical Integration Leadership team, and Clinical Integration Steering Committee. This involvement ensures a focus on the coordination and communication between the range of behavioral health crisis stabilization providers, which is vital to the successful implementation of this project.

As the AMCH PPS overlaps with two other PPSs, one of which also is undertaking Project 3.a.ii, we consider collaboration with our overlapping and neighboring PPSs to be a best-practice for implementation. We continue to have ongoing conversations with the Alliance For Better Health as well as Adirondack Health Institute in order to ensure alignment with project implementation. Moreover, we continue to collaborate and partner with Montefiore Hudson Valley Collaborative PPS to a variety of aims. An example of such collaboration is the use of the Montefiore Hudson Valley Collaborative PPS Project 3.a.ii Crisis Stabilization Addendum, which was developed for use as a guide for participating providers for reporting of crisis stabilization services in the community. The PMO Project 3.a.ii sub-committee is considering adoption of this document for use, after which it will be presented to the Clinical and Quality Affairs Committee for adoption.

We have a range of partnerships with key behavioral health crisis service providers throughout our PPS. Our partnership with the Capital District Psychiatric Center, the region's specialist psychiatric hospital, is particularly vital. As noted in our Project Plan Application, CDPC's expertise in specialty psychiatric and crisis services make them an ideal candidate for a leadership role. To that end, and in addition to serving as one of AMCH PPS's participating providers, CDPC executive leadership is represented on the Project Advisory Committee, Clinical and Quality Affairs Committee, Project 3.a.ii Sub-Committee, and Project 3.a.i Sub-Committee. Such involvement by the region's key behavioral health crisis service provider is considered a best practice. Moreover, we have partnerships with four mobile crisis services throughout our PPS.

Much of the success of this project is predicated on the availability of a variety of staff, including behavioral health and medical providers, case managers/care coordinators, and peer specialists. To that end, the PMO engaged a workforce consulting firm to conduct a compensation and benefits analysis in order to generate a current state assessment, and also to project the Workforce Target State. The identification of a current and target state constitutes a fundamental first step in the development of sufficient regional workforce. Next steps in this process include using the Current State and Target State to perform a gap analysis, with which we will develop the Workforce Transition Roadmap. Moreover, AMCH PPS has established a Workforce Coordinating Council as a governance committee to oversee current and future state resource needs across the PPS. This committee consists of HR representation from multiple stakeholders and provider types, union representation, as well as subject matter experts.

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

The Project 3.a.ii Sub-committee is chaired by Tyleia Harrell LCSW-R, Albany County Department of Mental Health & Brendon Smith, PhD, AMCH PPS, overseen by the AMCH PPS Clinical and Quality Affairs Committee. It consists of approximately 34 clinicians, administrators, and content-area experts representing organizations throughout the PPS. We have held monthly sub-committee meetings (03/31/2016; 05/09/2016; 06/13/2016). A Project 3.a.ii Sub-Committee Core Components workgroup has been established, with the charge of using identified national best-practice models of crisis stabilization services to propose the core elements and optimal phasing of a behavioral health crisis stabilization program throughout AMCH PPS. This workgroup should begin meeting shortly. Several key topics have been presented and discussed at sub-committee meetings. These important items include, but are not limited to the following: project 3.a.ii overview, including deliverables, speed and scale requirements, reporting requirements, and outcome measures; project 3aii Sub-Committee Charter; Core Component workgroup aims; Montefiore Hudson Valley Collaborative PPS's Project 3.a.ii Crisis Stabilization Addendum; Maryland Health Commission's White Paper: Best Practices: Crisis Response and Diversion Strategies; CDPHP Medicaid Redesign Presentation, including relevant changes in coverage for Crisis Interventions Services. The sub-committee is currently considering adoption of the Montefiore Hudson Valley Collaborative PPS's Project 3.a.ii Crisis Stabilization Addendum, pending approval from Clinical and Quality Affairs Committee.

AMCH PMO developed and presented a webinar that detailed Project 3.a.ii, national and local data on behavioral health conditions as drivers of emergency department usage, a review and limitations of behavioral health crisis services throughout AMCH PPS, the related benefits of developing a behavioral health crisis stabilization system, and national exemplary models of such systems.

One of our partners, Northern Rivers Family Services, received a capital funding award for the creation of a Crisis Stabilization Center. The AMCH PMO also holds ongoing stakeholder engagement efforts with both individual and regional groups of participating providers, to support optimal project participation, identify perceived barriers to participation, and develop mitigation strategies to address such barriers. Partners include, but are not limited to, County Health and Mental Health departments as well as several large participating organizations.

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

No significant changes have been identified in terms of the target population.

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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: Albany Medical Center Hospital

Project: 3.b.i

Challenges the PPS has encountered in project implementation:

The PPS has made substantial progress in moving this project forward. Like all PPSs, the AMCH PPS has faced some challenges, but most of these were expected as components of the complexity of transforming a diverse, disintegrated and inefficient group of health and social service providers toward an integrated regional delivery system. The PMO is committed to the goals of the Evidence-Based Strategies for Disease Management in High Risk/Affected Populations project and will work to overcome the barriers and challenges identified below. While the AMCH PPS has good provider representation at the project sub-committee level, stakeholder engagement and Primary Care Physician participation, the PMO continuously looks to identify additional providers to participate in this project. Like many projects in DSRIP, a broad spectrum of provider types is necessary. A core requirement for Primary Care Providers participating in this project is that they must be a NCQA 2011 accredited, Level 3, Patient Centered Medical Homes, and they must commit to achieving NCQA 2014 Level 3 PCMH or becoming an Advanced Primary Care practice in the first two years of DSRIP. Within our PPS only 20% of PCPs currently meet the PCMH 2011 standards. This challenges the project because it limits our ability to focus our efforts on our identified hot spot areas while also making it difficult for the PPS to reach its patient speed and scale commitment.

While the PPS has faced a few challenges, including an aggressive speed and scale timeline matched with the absence of EHR Connectivity and Capital funds to promote advanced technology and innovation, the PMO remains confident that these challenges will be overcome, as described in the next section. As we proceeded with an RFP and Vendor selection, we received word that we did not receive capital funding and therefore had to refocus our efforts into the development of a shorter term, less expensive solution. Without the proper funds required to implement systematic changes and/or the ability to conduct a complete overhaul of the current information technology infrastructure utilized in various organizations; connectivity, as required by the Domain One Requirements, may be a struggle for the PPS. The PMO, in close collaboration with the Technology and Data Management Committee, remains focused on furthering the conversation and progression with Hixny while engaging and encouraging our members to consider sharing data with this HIE.

The lack of a centralized care management/care coordination service challenges this project's ability to identify targeted population and to refer the population to the appropriate PCMH providers.

Efforts to mitigate challenges identified above:

The PMO is aware of the challenges and the potential barriers that exist for project implementation but have a multitude of mitigation strategies and best practices in place in order to ensure project success. While we have good representation and participation at the subcommittee, we continue our efforts to engage more primary care physicians. Now that contracts are executed, this will assist the efforts. The project sub-committee is led by a highly motivated physician focused on cardiovascular health.

To mitigate the risk of the limited number of Primary Care sites available to participate in this project due to the PCMH NCQA 2011 requirement, the PMO has created a PCMH work group to assist practices who are transitioning towards PCMH recognition. The PMO is offering financial and technical assistance to our PCPs seeking PCMH recognition. Financially, we will incentivize our partners to achieve PCMH status through bonus payments based on PCMH recognition. The PPS is also providing technical assistance to our PCPs who lack the technical expertise needed to complete the necessary steps for PCMH recognition. In the interim, the PPS is actively recruiting all PCMH 2011, level 3 Primary Care Providers within our PPS to participate in this project. Additionally, the AMCH PPS Workforce Coordinating Council sponsored primary care practices within the PPS to participate in a HANYS PCMH transformation learning collaborative. The PMO is currently in the process of refining an RFP to send out to vendors to assist with transformation efforts.

Two partner provider organizations are participants in a grant program that is in alignment with DSRIP integration opportunities and the Million Hearts Campaign.

The population health system identified practices and is working with HIXNY to develop and enhance the registry systems currently in place. We have identified registry elements working with individual practices at the subcommittee level. We are also in the process of working with HIXNY to implement a pilot hypertension registry to leverage for population health purposes.

The PPS is currently working with an outside entity to facilitate the implementation of a centralized care management/care coordination services for our PPS.

Finally, AMCH will submit a request for capital funding in response to RFA# 1607010255, Statewide Health Care Facility Transformation Program. If awarded, capital funds will be provided to the PPS to assist with the development and implementation of IT solutions, population health management, health care data analytics and connectivity and interoperability. Capital funding will help resolve several challenges faced by this and other related domain 2 and 3 projects.

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Implementation approaches that the PPS considers a best practice:

In March 2016, the Cardiovascular Project team created a CVD project subcommittee. This subcommittee is comprised of several key stakeholders and experts across our PPS who represent the project's participating provider organizations. The subcommittee will support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions. The first Subcommittee meeting was held in DY1Q4. The main objective of this committee is to support and facilitate implementation of evidence-based practices for adults with cardiovascular conditions. Providers have shared their best practices, policies for repeating blood pressure readings, documentation, and tracking needs to date.

During a subcommittee meeting and a subsequent Clinical and Quality Affairs Committee, the ABCs Framework/Chronic Care Model was recommended as a best practice model for project implementation. Subcommittee members and stakeholders have reviewed and approved this framework for project success. After significant research and discussion, the subcommittee, and subsequently the Clinical and Quality Affairs Committee, recommended the *Albany Medical Center's Lifestyle Goals* and *the Million Hearts' Measure Up Pressure Down®* self-management plans for use across the PPS as a best practice measure. The committee discussed the high success rate associated with the use to the tool, as well as how partners can implement this in EHRs for standardized electronic documentation of self-management goals. This document, as well as patient registries and other documents have been presented to our Technology and Data Management Committee to ensure documentation is completed within each organization's EHR. Based on the executed contracts, each participating organization is required to prepare and submit a registry for this project. These patient registries will provide: 1) a comprehensive list of all Medicaid patients who have been diagnosed with hypertension or cardiovascular disease and 2) a collection of REAL (Race, Ethnicity, and Language) data to risk stratify patients and address health disparities. The PMO will unduplicate the list and create a patient registry that will form the base of a population health registry.

A partnering organization, Albany County Department of Health, presented at a subcommittee meeting their involvement in the Local Initiatives for Multi-Sector Public Health Action (IMPACT) program for educational and adoption purposes. This initiative aligns with many of the CVD project's goals as well as the Million Hearts Campaign. Not only is this a best practice, but it also instills the necessity for collaboration and communication with public sector agencies to ensure initiatives are aligned in the region.

The PPS engaged the Accenture Consulting Group to complete a Clinical Integration Care Coordination Model (CI/CCM). In developing the CI/CCM, Accenture defined the current state of care coordination needs and availability of care coordination services in our PPS. They identified several challenges in our care coordination system, including disparate care coordination processes, systems lacking integration, limited weekend/evening care coordination coverage, and limited patient navigation and behavioral health care coordination. A training was held on May 26 for both Practitioner and operational staff on the clinical integration care coordination model

Blood pressure measurement policies and procedures, which allow patients opportunities for follow up blood pressure checks without a scheduled appointment or copayment, used by partnering PCPs have been shared and presented at the Subcommittee meeting as best practices. The AMCH PPS Workforce Coordinating Council sponsored primary care practices within the PPS to participate in a HANYS PCMH transformation learning collaborative. The PMO is currently in the process of refining an RFP to send out to vendors to assist with PCMH transformation efforts.

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

Subcommittee work has gone above the implementation plan requirements in order to ensure an avenue for best practice sharing as well as detailed discussions from experts as topics pertain to implementation and success. Many subcommittee meetings have occurred and have included informational sessions such as: JNC-8 guidelines, self-management plans, and Chronic Care Model/ABCs Framework. In March, 2016 the Chair/Co-chair were proposed and approved, an initial participant list was distributed, the subcommittee charter was reviewed, and the project summary document was reviewed, and opportunities for rapid cycle improvement were discussed. In May 2016, the Medical Director provided an overview of the Chronic Care Model and the subcommittee co-chair presented sample self-management plans, the EHR structured fields and ICD-10 codes for Hypertension were reviewed. In June 2016, the *Albany Medical Center's Lifestyle Goals* and *the Million Hearts' Measure Up Pressure Down*® self-management plans were recommended for use by the providing organizations, and the DY2Q1 deliverables were reviewed and a proposed phased roll-out was presented. Subcommittee members have been very proactive in achieving the deliverables from delivering presentations on best practices within their organizations to providing training to their clinical staff on walk-in blood pressure measurements and follow-up for patients without advance appointments.

Through ongoing research and discussion, the PMO began coordinating efforts with University at Albany's Center for Excellence in Aging and Community Wellness to deliver Stanford Model training in order to go above and beyond to pursue a non-applicable implementation metric. These collaboration meetings were a way to gain knowledge on the Stanford Model, collaborate with a local CBO with expertise in the subject, and potentially provide training to additional organizations. Due to conflicting grant opportunities, the Center for Excellence put this collaboration on hold until awards were announced from other resources outside of DSRIP. The aforementioned self-management plans will be implemented into the EHRs for ongoing, recorded self-management.

The PMO continues to gather information from participating partners for referral support, for medication adherence, nutritional support, and lifestyle change, to name a few. This documentation is both a contract deliverable and pertinent to the project's success.

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

The population remains as previously defined in the Project Plan Application: we will target patients living in poverty between the ages of 19-64 in our 5 county catchment area with known cardiovascular diagnoses and co-morbid behavioral health conditions. We will target our efforts at patients with behavioral health conditions, as there is a marked disparity in cardiovascular outcomes in this patient population, as described above. Additionally, we will also target those patients who have had elevated blood pressure readings in the past but without a hypertension diagnosis in order to develop a treatment plan for an undiagnosed condition. We will follow the guidelines provided by the Million Hearts Campaign in terms of clinical processes and treatment. A majority of these adults who are in care live in Albany County and are followed by AMC. Geographically, Columbia County has heart disease mortality rates significantly higher than the NYS average. Although almost 39% of our network's primary care practitioners fall outside of the AMCH PPS catchment region, our efforts will continue to reach as many of the targeted patient population as possible.

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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: Albany Medical Center Hospital

Project: 3.d.iii

Challenges the PPS has encountered in project implementation:

While there are challenges with this project, the PPS believes that they are resolvable and that progress will continue to be made. The implementation of Evidence-Based Medicine Guidelines for Asthma Management by the AMCH PPS provides an opportunity for many fragmented pieces of healthcare and community-based (asthma) resources to come together and provide enhanced and coordinated care for asthma patients in ways that have been piloted, or implemented on a smaller scale within pockets of the region, on a much larger scale.

The AMCH PPS has several opportunities to leverage and expand upon the somewhat limited resources available within the PPS. These have their own unique challenges but also great potential based on past success. The PMO has been working with the Asthma Coalition of the Capital Region (ACCR) since Year 0. There are substantial benefits to participation, including access to the membership which consists of content experts with significant experience in their respective fields and communities, and familiarity with the Medicaid population identified for this project. The ACCR has facilitated active participation from providers in Albany, Columbia, Greene and Saratoga Counties and retains an important role in successful collaboration both within the PPS and across overlapping PPSs.

This project has a focus on telemedicine if and where there is a defined need. Without capital funding, the PPS will need to look at utilizing existing telemedicine services that may be provided by other specialties. In addition, there are overall inconsistencies in technology utilization amongst specialty groups.

At this time, one of three major MCO's in the region provides reimbursement for home-based services for asthma. The PPS plans to help with the development and strengthening of linkages to home-based services for asthma patients. The asthma project will also be linked to the Health Home At Risk Project with asthma as an eligible condition for this patient enrollment, further strengthening services and linkages for asthma patients.

The availability of data in a consistent and meaningful format has also been a challenge. Currently providers are tracking and gathering data for asthma guideline compliance metrics but their approach varies widely with differing EHRs. The completeness and ability to report on asthma action plans consistently has been a challenge due to time restraints as well as the need for a paper document. A scanned document is difficult to manage and impossible to accurately report in a meaningful way, and creates a labor-intensive process.

The PMO continues to seek consistent representation from specialists for the project subcommittee. Due to limited incentives many providers in this realm face challenges when confronted with an additional request for their time as they already have limited available capacity.

Efforts to mitigate challenges identified above:

There are many opportunities with ACCR, as a number of PPS partners and asthma subcommittee members participate with the Coalition, the PPS's Medical Director continues to be a leader of the group, and the lead agency for ACCR is a PPS partner and participant in the Subcommittee. The asthma action plan form that was developed by ACCR, with significant input from their partners/ physician champions, has been shared with the Subcommittee at meetings. Currently our partners are looking at their current workflows and opportunities for improvement with the use of the asthma action plan since incentives are tied to completion and documentation of this form. A request has been put out to partners such that if they have a current AAP they are using and that works, to continue with their process. Should partners need more support and/or are interested in implementing the form developed by ACCR, this can be facilitated by the project team. This is also a contract deliverable for participating organizations, driving funding to them for task completion.

ACCR has also implemented a number of innovative projects with the goal of decreasing ED visits and/ or increasing medication adherence. This includes working with school-based health centers in Albany City Schools District, as well as the Albany College of Pharmacy & Health Sciences and community-based pharmacies.

In order to ensure that appropriate expertise is available to the Asthma subcommittee, an allergist and a pulmonologist have been engaged by the subcommittee. When added to the existing structure where adult and pediatric PCPs participate, this allows for a broad spectrum of specialties to provide expertise.

The PMO is currently conducting a detailed data assessment utilizing DOH provided dashboards, the CNA, Salient data, as well as publicly available demographic data, to better understand the extent to which telemedicine might reach patients in our rural areas, as well as what partners currently have telemedicine capabilities via TDMC, and whether the PPS has funds available for piloting. Columbia Memorial Health has used telemedicine in their stroke center and the subcommittee will explore utilizing and expanding upon this service. The pulmonologist also has experience with telemedicine from a program in West Virginia and believes it to be a valuable and useful approach.

The PMO is aware of the challenges and the potential barriers that exist given that the PPS network includes a multitude of provider types and varying levels of information technology capabilities. That being said, AMCH PMO has engaged the expertise of Accenture to help understand both the current state of each organization as it relates to their dependence on IT and the amount of projected time, effort, and plausible dollars it may take to get from gap to goal. Accenture's work has been carefully documented into a roadmap that is being utilized by the systems experts within the PMO.

AMCH PPS has created an EHR Subcommittee, which reports to the Technology and Data Management Committee. The first priority for the subcommittee is the asthma project, and working with those partners, as the PPS works towards a PPS-wide registry in order to take a population health approach to managing its asthma patients. The PPS is receiving data from participating providers that is forming a nascent population registry. Again, the requirements for this are specified in the executed contracts with each participating organizational partner. With assistance from the Asthma and EHR subcommittees, use of updated and consistent asthma templates will allow for identification of patient cohorts. Furthermore, all practices participating in the asthma project have EHRs and agreements with HIXNY. The challenge will be in "flipping the switch" to ensure that information is flowing through this channel.

Implementation approaches that the PPS considers a best practice:

The Guidelines for the Diagnosis and Management of Asthma (EPR-3) is by and large considered a best practice. During the May Asthma Subcommittee meeting, participants endorsed the EPR-3 Guidelines. The Clinical and Quality Affairs Committee formally endorsed these guidelines at their May meeting the following week. However, as previously mentioned, if partners are interested in implementing the form provided by the Asthma Coalition of the Capital Region, this can be facilitated. Albany Family Medicine adapted the asthma action plan upon joining the DSRIP Program. While AAPs do not have to be electronic in order for them to count for actively engaged, the practice chose electronic. When they complete the Asthma Action Plan Order in their EHR they are able to see patients with a completed AAP in the last year. Among the barriers to integrating these forms into a workflow, there tend to be challenges with implementing AAPs in EHRs – printing, scanning, many times even locating and using the form.

Another important discussion topic at the project subcommittee level has been around the Chronic Care Model. This model has been presented for consideration as a best practice for project implementation across our 5 county region. This model, which provides elements designed to activate and inform both patients and providers, is essential to the projects of ACCR and the other Regional Asthma Coalitions throughout the state as they strive to translate the EPR-3 into practice.

AMCH implemented an asthma pathway for pediatric asthma hospital visits in 2015. This will be expanded to the adult asthma population in summer 2016. The pathway provides a standardized approach to treating patients in the ED so that there is a greater likelihood that the patients will be able to be discharged from the ED and not admitted to the hospital. VNA referrals are part of AMCH's ED discharge process. In recent years the VNA, ACCR and CDPHP collaborated with the VNA Asthma Education Home Visit Program: visits for patients who were recently discharged from the hospital, or patients whose asthma is poorly controlled and are at risk for an ED or hospital visit. This is modeled based on programs in Seattle and Boston. There exists a gap between asthma patients with hospital admissions and those patients who receive home visits and the intent is to increase the number of referrals to, and utilization of the VNA's program. The EDs at Saratoga Hospital and Columbia Memorial have expressed interest in learning more about this pathway process. This will be a collaboration of the Asthma Project Subcommittee and the ED Care Triage Project Subcommittee.

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

Subcommittee meetings have included informational sessions: EPR-3 guidelines, asthma action plans, Chronic Care Model. The Subcommittee has met in the months of March, May, and June. In March the Chair/Co-chair were proposed and approved, an initial participant list was distributed, the subcommittee charter was reviewed, the project summary document was reviewed, and opportunities for rapid cycle improvement were discussed. In May the subcommittee chair provided an overview of the NHLBI EPR-3 Guidelines (also adopted by the subcommittee at this meeting) and asthma action plans, the Asthma Coalition of the Capital Region and the Alliance PPS provided updates on their asthma projects, and medication measures were reviewed. After this meeting, subcommittee members received a questionnaire assessing asthma action plan work flows. In June the questionnaire responses were reviewed – only 1 was received prior to the meeting, but additional feedback was provided during this meeting and after, and the Chronic Care Model was presented as a framework for implementing 3diii.

Several PMO staff attended a 2 day asthma summit hosted by the New York State Public Health Association in order to ensure ongoing education of project experts. Staff provided a full debrief to the project committee and chairs. As opportunities like this arise, project experts and committee members will have opportunities to attend meetings and conferences to ensure the most up to date information is available for project success.

This project implementation includes a strong collaboration with the Alliance for Better Healthcare PPS since the application phase. Project teams talk frequently and there is bidirectional subcommittee participation with the Alliance for Better Health Care PPS. This allows for a clear understanding, as the projects are not identical yet they have similarities that both PPSs will need to focus on. This collaboration will continue to ensure that there is alignment in areas where each PPS has overlapping participation from organizations. One area is provider education,

in which both PPSs are invested. The Alliance PPS has arranged a 2-day asthma educator exam preparation course with Kettering National Seminars. AMCH PPS is supporting the endeavor and is sending their own partners to the session. There is also a long-standing course operated by St. Peter's Health Partners that teaches the information needed in order to prepare for, and sit for the asthma educator exam. AMCH PPS is also looking to Physician Asthma Care Education (PACE) as an opportunity for providers to participate in free education. This program is evidence-based and has been used in the region in the past. The PPS may also use DVDs that have been available through DOH in the past, called Asthma in the Primary Care Practice.

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

The population remains as previously defined in the Project Plan Application: There are concentrations of both adult and pediatric patients in Arbor Hill, West Hill and South End neighborhoods of the City of Albany that will be an initial focus. An additional target population is the cohort of asthma patients enrolled in Medicaid/Medicaid Managed Care and uninsured/underinsured with high service utilization for asthma. Specifically, the project will aim to target the following groups: low income children and adults with diagnosed asthma residing in PPS service area; low income children with asthma enrolled in schools located in the PPS service area; patients with a recent asthma related visit to an emergency department/urgent care/hospitalization; high-risk asthmatics as identified and referred by their primary care/specialist provider, Managed Care Organization, Health home and/or pharmacy; patients with poor medication adherence; and patients with current tobacco exposure, primary or secondary. School based health clinics and school nurses will also serve a dual role of identifying target patients for enrollment and intervention and being the first line of support to address onset of illness, consistent with their scope of practice and license requirements. In the CNA updated for 2016, asthma remains a major health concern for the Capital Region. In the high risk neighborhoods, ED visits occur at 2-5 times the rate of Upstate NY, and hospitalizations occur 2-6 times the rate of Upstate NY.

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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: Albany Medical Center Hospital

Project: 4.b.i

Challenges the PPS has encountered in project implementation:

The PPS has made substantial progress in moving this project forward. Like all PPSs, the AMCH PPS has faced some challenges, but most of these were expected as components of the complexity of transforming a diverse, disintegrated and inefficient group of health and social service providers toward an integrated regional delivery system. The PMO is committed to the goals of the population health workstream and both Domain 4 projects as they directly align with the NYS prevention agenda. The PMO will work to overcome the barriers and challenges identified below. The PPS has encountered several challenges in terms of Domain 4 project implementation. Population Health projects are not directly linked to attributed lives but are impacted by population-wide approaches and best practices. The PMO has frequently met with and collaborated with our local task force teams, HCDI, PHIP, SHIP, as well as overlapping PPSs to ensure we are aligned with population health initiatives in the Capital Region. Based on conclusions drawn from the Community Needs Assessment data, which was conducted by the regional PHIP contractor, the PPS selected project 4.b.i. as one of its two population health projects. The current priorities identified by PHIP do not fully align with DSRIP, but there is still great momentum in the community for undertaking these projects, namely with the Capital District Tobacco Free Coalition.

The first challenge that we have encountered in the Tobacco Cessation project is that there is a general lack of understanding of cessation medications and counseling amongst current tobacco users, as well as an overall lack of referrals to the NYS Smokers' Quitline from participating providers. Patients also tend to inaccurately report their daily tobacco intake and therefore providers may miss an opportunity for referral.

In line with the first challenge, there is also a lack of time spent providing tobacco cessation counseling and education to patients in both primary care and behavioral health locations. The current lack of integration between primary care and behavioral health providers is also a barrier, although this is being addressed by other projects being implemented.

The absence of EHR Connectivity and Capital funds to promote advanced technology and innovation is a tricky combination. Our PPS's participation in the IT-TOM Pilot gave us a clear insight as to what would be necessary, technology wise, in order to be successful with true connectivity across our 5 county region. As we proceeded with an RFP and Vendor selection, we received word that we did not receive capital funding and therefore had to put efforts into development of a shorter term, less expensive solution. Without the proper funds required to implement systematic changes and/or have a complete overhaul of the current information technology infrastructure utilized in various organizations, connectivity, as required by the Domain One Requirements, will be more difficult. As we will demonstrate, these challenges were largely anticipated and the PMO and the PPS have taken affirmative steps to address them.

Efforts to mitigate challenges identified above:

The PMO has taken several steps to mitigate the challenges faced when implementing this project. A population health workgroup has been formed to ensure alignment with local tobacco cessation initiatives. The project team has also provided specific agenda items to relevant project subcommittees for updates and discussion with experts. This includes the BH projects as well as the Asthma and CVD project groups.
The PMO and Subcommittees have identified opportunities to meet multiple project milestones related to tobacco use cessation with cross-cutting requirements in EHR tracking and Behavioral Health.
The PMO is working with the Workforce Coordinating Council, Cultural Competency and Health Literacy Committee, and appropriate project subcommittees to provide resources and materials to organizations and providers for collaboration, coordination, and patient engagement. The PMO is providing training and resources, as appropriate, for current workforce and participating providers to ensure cessation counseling is provided in a culturally and linguistically appropriate way.
The PMO will continue to collaborate with Tobacco-Free NY contractors to refine our current state and identify additional local/regional resources. This work will be completed in conjunction with our collaborative efforts with the Asthma Coalition and alignment with the Alliance for Better Health Care and their projects.
Lastly, the PMO will create EHR prompts within current EHR systems throughout the PPS to prompt the "5 A's" as required in the CVD project Milestone 5. The project subcommittee has proposed next steps and action items to the Technology and Data Management Committee for adoption and implementation. Best practices will be actively shared between providers to accurately track and report tobacco assessment.

Implementation approaches that the PPS considers a best practice:

The PMO has formed a Population Health Workgroup in order to ensure deliverables, actions, and documentation is aligned with initiatives within the region. This workgroup presents updates to the Consumer and Community Affairs Committee as well as PAC and PAC Leadership where appropriate. Several key stakeholders have played an active role in formulating a plan to ensure alignment amongst PHIP, SHIP, and DSRIP. HCDI has regular standing meetings with the PMO to ensure success. The PMO also participates in the Asthma Coalition meetings on a routine basis.

The AMCH PPS and the PMO are working collaboratively with Tobacco Free NY contractors to identify best practices that have been implemented with their Capital Region partners, as well as with surrounding PPSs. There is a great deal of momentum in the community around this initiative. Under the Capital District Tobacco Free Coalition's leadership, all counties in the PPS have tobacco-free recreation areas that include parks, playgrounds, beaches, and athletic fields; Albany County has recently passed legislation that bans selling tobacco products and e-cigarettes to individuals under age 21; and several public housing units in the region, including those within Albany Housing Authority have banned smoking in their units. The success with these initiatives in various NYS counties, as well as across the country, gives momentum to these efforts in the Capital Region. The PMO regularly attends The Alliance for Better Health Care's Asthma and Tobacco workgroup. This collaborative effort is vital to the success of this project as the PPSs can both work with the Coalition to help align systems-level changes and policies that support a much larger regional approach to this population health issue.

In line with the Cardiovascular project, the PMO will be implementing standardized practices to document the 5 A's (Ask, Assess, Advise, Assist, and Arrange). The proposed fields for the asthma and CVD registries include exposure to environmental tobacco smoke, and smoking status for patients age 13+ as well as smoking cessation counseling and services. At this time these fields, while not yet populated, will create a long-term population health solution. NYS Quitline also allows providers to login and track patients' progress in their quit efforts. Asthma, tobacco, and CVD align further at the subcommittee level in that PMO experts consistently attend the subcommittee meetings and are available for clarification or to help field Q&A where there is milestone/metric/task overlap or an opportunity to share a best practice.

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

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In DY2 Q1, AMCH PPS completed the Population Health Management Roadmap. The Roadmap was required to address several items including “identification of priority target populations and defined plans for addressing their health disparities by establishing goals that reflect the State of New York's Prevention Agenda” which includes tobacco use cessation. The Population Health Workgroup met with stakeholders, including the regional PHIP contractor who provided the Community Needs Assessment data for AMCH PPS and the Alliance for Better Health Care PPS.

The PMO is represented on several local coalitions that include Capital District Tobacco Free Coalition Partners, Albany County Strategic Alliance for Health, Albany County Mental Health Tobacco-Free Living Workgroup, Asthma Coalition of the Capital Region and Healthy Capital District Initiative.
PMO staff have also met with Capital District Tobacco Free Coalition to discuss available resources and opportunities for potential support to the PPS. The two Domain 4 project teams have also met internally to insure that population health domain requirements would be coordinated and integrated with domain 2 and 3 project activity.

This project requires continued input and collaboration from other committees including: WCC, CQAC, CCAC, TDMC and EHR Subcommittee.

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 for this project remains as previously described per the CNA: the PPS will target 3 sub-groups. First, patients who use tobacco products and have behavioral health diagnoses, including mental health and substance abuse diagnoses. Population-based studies have shown that individuals with mental illness smoke at approximately double the rate of the general population (41% versus 23%); there are even higher rates among the seriously mentally ill and those with additional addictions (Lasser et al. 2000, Rohde et al. 2003). Cigarette smoking rates vary among those with mental illness diagnostic groups, with particularly high rates among individuals with schizophrenia, bipolar disorder, and co-occurring alcohol and illicit drug disorders (de Leon et al. 1995, Lasser et al. 2000, Prochaska et al. 2004b). Second, the PPS will focus on members with low socioeconomic status, as there continue to be high smoking rates in this population, with significant disparities in outcomes, when compared to patients with commercial insurance. Third, the PPS will target smoking cessation efforts toward providers caring for those with disabilities.

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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: Albany Medical Center Hospital

Project: 4.b.ii

Challenges the PPS has encountered in project implementation:

The PMO is confident that it will succeed in implementation of this project. Like every PPS and every project, some barriers and challenges were anticipated and others have occurred unexpectedly. None of them will impact implementation to any significant degree.

The original 4.b.ii implementation plan stated that the PMO anticipated barriers identified in the five-county community needs assessment, including: wait time for appointments, lack of specialists, transportation, and stigma. Patient engagement in identifying and managing chronic disease conditions might also be negatively impacted by cultural differences, age, sex and socioeconomic status. Such factors leave community members at a disadvantage. An additional risk identified by the PMO was the capability to obtain and facilitate training, education and workforce resources. The PMO recognized at the time that it is vital to provide ongoing education, training, and support to the AMCH PPS network of providers, a network that spans over 170 miles.

Provider and non-provider staff members must be trained and continually demonstrate competency in preventive care initiatives. Community-based training resources will also need to be developed. Steps have been taken to overcome these challenges and are referenced in the following sections.

Another identified risk in the original 4.b.ii implementation plan relates to the technological capabilities across the span of PPS providers and the degree of EHR compatibility across the network. IT capabilities and capacities vary greatly across the PPS Network.

A number of partnering organizations lack the sophisticated IT infrastructure and EHR system connectivity, necessary elements in facilitating this project. The PMO will need a robust set of protocols, consents, care teams, IT infrastructure, etc., for project success. Maximizing connections to RHIO/HIXNY/SHINY are vitally important in addressing this population health risk.

In DY1, capital funding awards were announced in the State Capital Restructuring Finance Program and Essential Health Care Provider Support Program. Though the AMCH PPS and certain providers applied for IT infrastructure funding, none was awarded. This clearly impacts and increases the level of risk for the 4.b.ii project's success – that a number of partnering organizations lack sophisticated IT infrastructure and EHR system connectivity, necessary elements in facilitating this and other PPS projects.

Efforts to mitigate challenges identified above:

To mitigate the identified challenges, the PMO has done the following:

- Activate WCC to provide resources to providers for collaboration, coordination, and patient engagement.
- Through the PMO workforce training vendor, provide extensive resources for the current workforce.
- Assist patients with their health care needs (with the work of health navigators).
- Work with MCOs to ensure that cancer screenings are affordable and accessible.
- Utilize protocols to track patient appointments and screening results, through the work of care teams.
- Advocate for the deployment of mobile breast cancer screening vans in the regional "hot spots."
- Take advantage of developing EHR capabilities and EHR prompts.
- Utilize follow-up calls, health navigators and other case managers to process and address abnormal cancer screening results.
- Enhance IT infrastructure when capital funding is realized.

In DY1, the PMO devised a communication strategy that was shared with the PPS network of providers related to the PMO's intention to take action, working to increase patient access to high quality chronic disease preventive care and management – expressly with cervical, colorectal, and breast cancer screenings. The AMCH PPS providers were all invited to collaborate with the PMO. Thirty-nine organizations confirmed that they would be actively involved in the project's implementation across the five counties. Contracts have been executed with these partners to provide incentive funding to them for specific project deliverables and overall project implementation.

Additionally, during DY1, the PMO monetary resources committed to 4.b.ii activities were published in the project budget that was shared with the AMCH PPS board, committees, and the public.

The State Capital Restructuring Finance Program and Essential Health Care Provider Support Program awarded no IT infrastructure funding to the AMCH PPS and the providers within the network that had applied for these much-needed monies. This profoundly impacts and increases the level of risk for the 4.b.ii project's success – across the AMCH network, our partnering organizations lack sophisticated IT infrastructure and EHR system connectivity, necessary elements in facilitating this and other PPS projects.

In the current state, with a number of partnering organizations that do not have advanced IT infrastructure, capable of interconnectivity and EHR system connectivity, a "low cost" re-configuration of the IT strategy had to be devised. The PMO has been working with Accenture, a leading global professional services company, in defining the IT current state and to finalize a roadmap. The next step in the process was to develop a work plan to achieve effective clinical data sharing, connectivity to HIXNY, and interoperable systems across the network.

With the roadmap in hand, the PMO will continue to work with all of its participating PPS providers at the greatest functioning technology level that they possess. This will aid the PPS in establishing alerts and other forms of electronic communication that promote necessary, age-recommended cancer screenings, follow-up communication regarding abnormal screening results, etc. Population health matters are all-encompassing across the span of geographical area and across the PPS network of providers. The AMCH PPS will succeed, provider by provider, in putting in place a preventive care and management system that dramatically increases consumer access to clinical and community resources to proactively address their chronic disease needs.

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In an effort to meet the challenge of obtaining in-depth training resources, education and workforce support materials, AMCH engaged BDO Consulting (“BDO”), in collaboration with Iroquois Healthcare Association , Inc. (“IHS"), as its workforce vendor. The vendor worked with AMCH to define the PPS’s target workforce state. To achieve the goals of the 4bii project and the ten others that are in the AMCH menu, the vendor, in collaboration with the project management office, identified AMCH PPS’s projected workforce needs by the end of the DSRIP program in 2020. Gaps were identified between the reported current workforce state and the projected target workforce state. A workforce transition roadmap was developed. The transition roadmap will be used by AMCH PPS to inform workforce planning and training to address any identified workforce gaps as a result of the DSRIP program and to make progress on the Domain Four population health concerns.

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Implementation approaches that the PPS considers a best practice:

Implementation approaches that the PPS considers best practice are innumerable. From the Cancer Services Program, to the American Cancer Society, to the work of vital practices such as New York Oncology and Hematology, there are a wealth of organizations and programs that embrace preventative care and active attentiveness with necessary cancer screening.

The delivery of high-quality chronic disease preventive care and management is occurring throughout the five county network, in a cost-effective manner. The AMCH project management office has held discussions with the State Cancer Services Program and the American Cancer Society to determine where project resources can best reach those sub-populations that have yet to embrace preventive care.

An important step, currently in the formative stage, is the work that must be done to increase provider and care team knowledge of screening protocols and clinical practice guidelines. The PMO is strategizing on how to best leverage its resources, such as its workforce vendor, to engage and support its providers. The project team will work with the CQAC to review, recommend, and distribute screening protocols to participating providers. The PMO will encourage participating providers to adopt policies and protocols and make EHR updates to alert and remind patients in need of follow-up for abnormal results.

So, this "best practice" is a multi-pronged approach and one that is developing as the AMCH network moves into DSRIP year two:

1. Engaging and helping to educate all providers in the AMCH network related to preventive care and cancer screening guidelines.
2. Working to get as many providers up-to-speed, technology-wise, so the more advanced integrated care mechanisms can be employed to alert applicable consumers to the proper steps and follow-up related to the management of their health.
3. Leveraging any and all resources, such as the workforce vendor, to ensure that adequate staffing is in place as health care is transformed and that personnel at all levels are educated regarding preventive care.
4. Working with population health vendors, as well as Health Departments and others, to collect and analyze baseline rates of cancer screenings conducted across the network for the target population.
5. As an extension of item 4 above, working with identified community partners and population health IT platforms to monitor performance and disseminate results in a real-time, meaningful manner.

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

Additional project implementation details include:

- September, 2015 - The PMO developed and forwarded survey to PPS partner to identify those interested in project engagement.
- May, 2016 - The project team met with St. Peter's Cancer Services Program leadership to discuss the implementation of cancer screening activities and education for the uninsured and Medicaid populations in the five-county hot spots.
- March, 2016 - The project team attended the Nancy Clemente Cancer Support Services dinner. This was an invaluable opportunity to network and engage providers and community residents.
- June, 2016 - The project team forwarded invitations to interested partners to meet and discuss collaboration opportunities for identifying where DSRIP project resources can fill in any gaps in this critical population health matter (expressly cancer screening and abnormal screening follow-ups for breast, cervical, and colorectal screenings).
- June, 2016 – The project team met with American Cancer Society regional representatives to discuss the implementation of cancer screening activities and education for the uninsured and Medicaid populations across the five-county catchment areas.

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
There are no significant changes to the population identified in the community needs assessment.