



DSRIP Primary Care Plan

PPS Name: Bassett Medical Center

Fundamental Area: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs

Challenges the PPS has encountered in implementation:

Challenge 1: Recruitment

Like all PPSs in New York State, we are challenged with recruiting enough primary care providers (PCPs) to meet our patient demand. Most PCP partners in our PPS are primarily hospital-based, with only a few community-based PCPs. There are 264 primary care practitioners in the PPS region. Based on the recent Workforce Gap Analysis performed for our PPS region, there is a 44% vacancy rate among primary care physicians and a 30% vacancy rate among primary care nurse practitioners.

Challenge 2: Burnout

PCPs in our PPS struggle with "burning out" as a result of pressure to see more patients in a volume-based system. Combined with other factors, such as frustration with the use of electronic medical records (EMR), this issue is compounded. This fatigue is further exacerbated by the implementation of additional projects/programs such as DSRIP, PCMH, and MSSP ACO quality programs that put a focus on the PCP.

Challenge 3: Geography

The Bassett Medical Center PPS, (d/b/a Leatherstocking Collaborative Health Partners) is the second smallest PPS in the state, yet our geography spans well over 5,000 square miles. As such, the rural nature of our delivery system requires significant amounts of travel by our providers and patients.

Efforts to mitigate challenges identified above:

Mitigation 1: Recruitment

While partners in our PPS continue to successfully recruit and retain PCPs, some partners are finding it more difficult to attract certain types of PCPs than others. For example, physician PCPs have proven the most difficult to recruit. Overall, we have been more successful in the recruitment of nurse practitioners throughout our PPS. This model will likely continue to be expanded upon so our primary care capacity does not diminish. Additional ideas to increase the number of positions identified in our workforce survey as "shortages" include the following: (1) developing partnerships with universities to provide educational programs; (2) working with Area Health Educational Center (AHEC) consultants to identify gaps in the workforce with an emphasis on the most critical job titles and developing strategies to close those gaps; and (3) offering "retention-bonuses" or "housing stipends" for our critical positions.



Mitigation 2: Burnout

The transition to move into a value-based world has recently started, but full value-based reimbursement as the primary mode of payment will be several years away. As a result, the pressures to see more patients in a fee-for-service environment will continue. However, the PPS and its partners are addressing other burnout factors that cause significant dissatisfaction to PCPs today. For example, the use of scribes for many providers has improved their satisfaction with the EMR and overall workload. The lead-agency, Bassett Medical Center, validated this through the use of survey tools and other feedback mechanisms. Additionally, primary care practice administrators, physician leaders and PPS subject matter experts are working diligently to educate physicians and practitioners on the benefits of the advanced primary care models (such as PCMH), integration of behavioral health and medication assisted treatment. Despite being a “heavy lift” and seemingly putting more work on the PCPs, at least initially, it will ultimately provide practitioners with greater satisfaction in their work by working in a team-based model of care.

Mitigation 3: Geography

Traveling between sites within our very rural PPS daunting for our providers, particularly in the winter months. Other than reimbursement for travel, partners have made efforts to centralize providers to a site, whenever possible, in order to minimize the amount of travel necessary. This is coordinated in partnership with the administrative and clinical leaders at our partner sites and it is appreciated by PCPs and patients alike. For patients specifically, partnering with community-based organizations to access transportation to their appointments will be crucial. Ongoing PPS meetings with these key organizations occur regularly. Today, patient navigators are following up with patients to ensure they have adequate transportation prior to appointments and through referrals from PCPs. LCHP is a co-sponsor of an event designed to share challenges, best practices, and opportunities relating to transportation in the more rural areas of New York state where public transportation is not as robust as in larger more urban and suburban settings. ***Getting There: A conference on Bridging the Transportation and Healthcare Gap has an established goal*** of developing innovative solutions to mitigate challenges community dwelling access to not only medical transportation, but also to address community, social and needs that require attention.

Mitigation 4: Transformation

The PPS is undergoing a dramatic transformation through project implementation in the DSRIP program. Through the process of achieving NCQA PCMH 2014 level 3 recognition, 65 primary practices are developing strategies to increase capacity through new staffing models. For example, the introduction of care managers in the primary care setting has reduced the burden on primary care practitioners in ensuring routine follow up with their patients to address health and social needs prior to requiring acute intervention. The integration of behavioral health in the primary care setting further increases capacity and reduces practitioner burnout through “warm hand-offs” to a behavioral health specialist who has become part of the primary care team.

Implementation approaches that the PPS considers a best practice:

- Surveying PCPs regularly to obtain feedback surrounding burnout and resilience
- Co-sponsorship of the “Getting There ...” transportation conference. By providing patients and community dwelling beneficiaries with innovative and new transportation options, there will be fewer no-shows and likely greater adherence to care plans (medication, etc.)



PPS Name: Bassett Medical Center

Fundamental Area: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?

Challenges the PPS has encountered in implementation:

Challenge 1: Recruitment/Retention

As described in question one, recruitment of PCPs is a barrier that we continue to grapple with as we expand our capacity to meet our patient demands. Additional recruitment and retention barriers include ambulatory nurses (both RNs and LPNs), as well as frontline administrative staff.

Challenge 2: Operational Planning

In order to reach the PCMH standards of project 2a, developing the bandwidth to understand the extensive documentation requirements for NCQA submissions is a major challenge. Additionally, the heavy reliance on EMR reporting, population health, and care management functions are time consuming.

Challenge 3: Developing Champions

Due to the limited number of PCPs available in the PPS, finding time and interest to engage in training PCMH champions has been a challenge. The demands of the challenge require multiple levels of approval from administrative and clinical leaders to allow their PCPs to reach the certified content expert level. Additionally, hiring registered nurses as care managers and training them to be NCQA Certified Content Experts is a challenge.

Efforts to mitigate challenges identified above:

Mitigation 1: Recruitment/Retention

Several partners have recently made market adjustments to increase payments to nurses to help with retention and recruitment efforts. While PCP recruitment efforts are a struggle, the partners in our PPS have been able to manage their respective patient workloads. In line with NCQA 2014 Level 3 requirements, same day access and expanded hours have been made available to patients. In an effort to attract primary care physicians and practitioners, nursing staff will work to the "top of their license(s)" so physicians are able to more effectively manage their workload and utilize their expertise appropriately.

Mitigation 2: Operational Planning

In order to reach the PCMH standards of project 2a, our PPS has engaged in the use of the Primary Care Development Corporation (PCDC) to provide guidance and operational planning to our partners to reach NCQA 2014 Level 3 recognition. In the Bassett (LCHP's lead partner) system, all entities will utilize the same EHR effective 4/1/17. This will streamline processes for patients and ensure there is continuity of care. Additionally, Epic CareLink has been provided to all participating long-term care facilities within the PPS to further ensure the sharing of internal information and connectivity between and among referring providers. All entities have received training in



this regard. This dramatically reduces staff time by being able to electronically share and gather information as opposed to phone calls, faxes, etc.

Business intelligence software is being utilized to track and gather patient data to proactively assess potential issues (i.e., potential readmissions, etc.) Outpatient care managers have been strategically placed throughout the region to assist physicians in more effectively managing their patients.

Alternative ways to interact with patients are continually being explored. Presently, the PPS and Bassett leadership are working with University of Rochester Medical Center in their ECHO project – designed to bring behavioral health and other services to patients via telemedicine.

Mitigation 3: Developing Champions

Use of DSRIP funds to train identified champions has been successful in leading practices to obtain a practitioner with NCQA Certified Content Expert.

Implementation approaches that the PPS considers a best practice:

- Use of PCDC consultants to ensure we reach the PCMH 2014 standards has been tremendously successful to date.
- Use of Phytel to receive NCQA credit toward managing patients' chronic conditions provides a clear return on investment for primary care practices.



PPS Name: Bassett Medical Center

Fundamental Area: What is the PPS’s strategy for how primary care will play a central role in an integrated delivery system?

Challenges the PPS has encountered in implementation:

Challenge 1: Interoperability

The LCHP PPS is engaged in project 2.a.ii and is leading the project to attain NCQA Level 3 PCMH recognition for our partner PCPs. While a majority of the PCPs share the same EMR platform, several do not. Of those that share the same EMR, they reside within the Bassett Healthcare Network in an employed-practitioner model. The remaining hospital, Community Memorial Hospital, does not share the same EMR.

Challenge 2: Incentive & Quality System for PCPs

Most of the PCPs in our PPS are currently incentivized to participate in a “fee-for-service” environment in order to receive incentive bonuses. In some cases, falling under a FFS goal may result in a pay cut. Moving toward a value-based care and reimbursement environment, this compensation model needs to change. Measuring outcomes per provider will be essential, yet challenging for the PPS.

Challenge 3: Collaboration with Community-Based Organizations (CBOs) & Emergency Departments (EDs)

Interfacing with community-based organizations is still considered a new concept for many of our PCPs. Some have negative outlooks to such CBOs due to prior experience or a lack of a bi-directional dialogue. Re-establishing trust and communication for effective coordination of patient needs will be a challenge. A potential vision is to give our CBOs access to a version of PCP’s EMRs from a care management perspective. One example would be “Healthy Planet” from Epic.

Like CBOs, PCPs have tenuous relationships with EDs. Patients who often cannot get appointments with a PCP immediately opt to use the EDs for basic primary care functions. Re-establishing these communications in a manner that meets both caregivers’ operational needs will be a challenge.

Challenge 4: Primary Care Practitioner Engagement

Too often our health care system has been focused on acute care and/or specialty care and rewards overuse rather than prevention. Changing the mindset and ultimately practice of primary care practitioners requires cultural and practical change designed to improve engagement among this otherwise often disregarded group.

Efforts to mitigate challenges identified above:

Mitigation 1: Interoperability

In order to create meaningful linkages between partners, with a specific focus on healthcare providers (e.g., hospitals and PCPs), creating a shared EMR is ideal. This is the case with AO Fox Hospital and the Bassett Healthcare Network. As part of the six hospital network, Fox is now in the process of migrating into an Epic EMR system in order to make the network’s platform ubiquitous. There are cases where this is not feasible and other solutions are necessary. Leveraging HIXNY, a regional health information organization, or “RHIO,” is a choice for other providers and CBOs alike. Partners across the PPS have been engaged in setting up HIXNY integrated solutions and this continues to be a driving force for interoperability in our PPS.



Additionally, Bassett Medical Center is expanding access to its medical record through Epic CareLink, a secure web-based portal permitting providers outside of its network access to its medical record. In its current partnership with long-term care facilities, community health navigators and insurers throughout the PPS, Epic CareLink permits secure access for chart reviews, event alerts (i.e., admission, discharge, ED visit, appointment notifications, etc.) and messaging with Bassett providers. The goal of Epic CareLink is to connect providers caring for the same patient population, ensure continuity of care and reduce duplicate testing.

Mitigation 2: Incentive & Quality System for PCPs

As the value-based road map continues to be developed by the DOH, our PPS has been educating providers about the concepts of value-based payments. Some partners have set up compensation committees and have invited members of our PPS to participate knowing this change is coming. Additionally, some partners have created dashboards for real-time data review. While the dashboards are currently focused on DSRIP's pay-for-performance metrics, they will continue to evolve to focus on other areas. Teams of care managers and primary care providers regularly assess these systems to see what opportunity they have to provide optimal care to their patients.

Mitigation 3: Collaboration with Community-Based Organizations (CBOs) and Emergency Departments

As stated in early questions, our community-based organizations have played a big role in developing better communication between providers (ED and PCPs) and patients by assessing their social needs and not just their medical issues. Embedding this navigators in multiple venues, including EDs and clinics, has proven very successful. Early conversations to share care management software are underway, however understanding the licensure expense, legal contracts, and EMR limitations still need to be explored. There is optimism this issues can be mitigated and access shared eventually.

The MAX Series has afforded emergency room physicians and nurses and behavioral health providers to interact on a new level with their primary care colleagues. In the Little Falls emergency department where the MAX series was developed to address the "super utilizer" population, a new relationship was forged with colleagues in the nearby Herkimer Health Center (only a few miles away). Though under the same overarching corporate structure, the two entities had not interacted in a meaningful way prior to the MAX series being implemented. Not only did the new processes reduce the frequency of ED visits of "super-utilizers", it also helped integrate otherwise disparate primary care practitioners in the process of rapid cycle improvement.

Similarly, the MAX series program at Community Memorial Hospital was focused on the integration of behavioral health in the primary care setting. A new concept to the primary care group, this pilot established a multi-disciplinary care team led by the PCP which led to greater satisfaction due to increased collaboration among patients and practitioners.

The MAX Series will be an ongoing initiative in our PPS. Our PPS is currently planning to engage in the "train the trainer" and "topic four: admissions and super utilizers" of the MAX Series. The exact hospital for this project is still under review.

Mitigation 4: Engagement of Primary Care Practitioners

Primary care practitioners have had a strong voice in the implementation of DSRIP projects. Carlton Rule, MD (primary care/family practice) is the co-chair of our Executive Governance Body. Additionally, Dr. Rule co-chairs our Hospital-Home Care Collaborations project and has recently implemented an asthma pilot designed to reduce avoidable hospital use through a team-based approach to care that includes pharmacy, nursing and physicians, among others. Other projects – including Ambulatory Withdrawal, Asthma, Palliative Care and PCMH are appropriately co-chaired and staffed by primary care practitioners.



Despite the Bassett Network and Community Memorial Hospital primary care practitioners being considered “hospital-based”, many are employed by the hospital (corporately) yet practice in rural communities throughout the network. It is in these community-based practices that the integration of behavioral health, palliative care, medication-assisted treatment for substance abuse issues and other projects are being implemented and embraced by primary care practitioners.

Our PPS has had the distinct opportunity to collaborate with a primary care physician who has evolved her practice to include a “gender wellness center” focusing on the LGBTQ population. Dr. Carolyn Wolf-Gould has been very involved in our cultural competency/health literacy work, helping us develop our strategic plan (of which the LGBTQ population is a focus) and work with senior leaders throughout the PPS to embrace the health equity pledge.

James Dalton, MD, a primary care (internal medicine) physician is leading a *Disparities in Care* workgroup that is charged with developing a strategic plan for the Bassett Healthcare Network Medical Residency Program. The group includes key stakeholders from throughout the PPS including community-based organizations, the research institute, the New York Center for Agriculture and Health, PHIP program colleagues and senior leaders. Along with our PPS administration, Dr. Dalton and the Disparities in Care Workgroup are convening their first annual “Confronting Disparities in Care: An Evening of Practitioner Cultural Competency” designed to provide education and information for practitioners (including physicians, advance practice clinicians, and nursing staff) in the provision of culturally competent care. The event will be aimed at treatment for the LGBTQ population, substance abuse, and the elderly. Additionally, a panel of culturally diverse residents and nurses providing care to a largely homogeneous population will be featured. James Anderson, PhD (clinical psychologist leading integration of behavioral health/primary care efforts) is working with the residency program at Bassett Medical Center to educate medical staff on addressing the psychosocial aspects of primary care patients. Additionally, Dr. Anderson has served as a mentor for newly trained clinicians throughout the PPS.

Implementation approaches that the PPS considers a best practice:

- MAX Series
- Case review of ED referrals
- Disparities in Care workgroup and educational sessions



PPS Name: Bassett Medical Center

Fundamental Area: What is the PPS’s strategy to enable primary care to participate effectively in value-based payments?

Challenges the PPS has encountered in implementation:

Challenge 1: Financial Sustainability Milestone Finalization

As of 8/29/16, milestones 4-8 under the financial stability organizational project have been removed. New guidance will be issued at a later date. Without that guidance, it will be very difficult to set the speed and magnitude of engaging providers in value-based payment strategies.

Challenge 2: Educating Partners and Practitioners on VBP

Many practitioners and leaders of partner organizations are skeptical of the magnitude of VBP arrangements being mandated as a result of DSRIP. As a result, “buy-in” has been difficult when engaging these organizations.

Challenge 3: Collaboration with managed care organizations (MCOs)

Many MCOs are still getting started building their own infrastructures as it pertains to DSRIP and its requirements. As a result, there have been very few meetings with any MCO outside of mandated programs, such as VBP QIP (AO Fox Hospital, the PPS, and Excellus).

Challenge 4: Determining our Measures

While the PPS is likely to choose an arrangement that are either “Total Care of the General Population” (TCGP) or “Integrated Primary Care” (IPC), understanding which metrics to select and how to engage with an MCO has been a challenge. The DSRIP website does not provide clear guidance in this respect, nor does the VBP roadmap or VBP boot camps.

Efforts to mitigate challenges identified above:

Mitigation 1:

In the absence of new guidance, continued work toward VBP arrangements will progress by using the latest version of the proposed VBP roadmap. Presently, the PPS is working closely with a partner to assist them in making the transition to VBP through the VBP QIP program, utilizing the latest VBP roadmap as guidance. This work will serve as a “PPS roadmap” for all partners that adopt VBP in the coming years. The practice has chosen “Integrated Primary Care” for its VBP arrangement and plans to work closely with its long-term care facility to affect positive change in the utilization of ED and hospital services.

Mitigation 2:

Presentations and education on the core principles of VBP have been conducted and discussed widely with our PCP and hospital based partners. Continued education will be done with CBOs as the PPS identifies the best mechanism to include them in an arrangement. Some ideas include navigation services and



transportation. Additionally, an integrated behavioral health clinic is being piloted in a large primary care site within our PPS. The data gathered in this pilot will drive further integrated care models at other sites.

Mitigation 3:

While MCOs are still figuring out their own needs and structures as it pertains to DSRIP, engagement has been low. To address this issue, contracting leaders within the organizations are assisting by providing the PPS contacting information. To date, we have had meetings or phone calls with at least two MCOs. Additionally, the PPS is working closely with Excellus BC/BS to develop a model for Integrated Primary Care that will be replicative throughout the PPS with engagement from community-based organizations.

Mitigation 4:

Proactively contacting our payers, particularly those who we already have commercial ACO arrangements in place, has been a priority. The PPS is hoping to not “recreate the wheel” by using existing metrics already in place with the MCOs. Knowing we may be required to select some of the current pay-for-performance metrics (P4P) being used in DSRIP, we are evaluating which areas we have the strongest performance and targeting how we might utilize these metrics in either of the arrangements mentioned.

Implementation approaches that the PPS considers a best practice:

- Connect with MCO leaders as early as possible.



PPS Name: Bassett Medical Center

Fundamental Area: How does your PPS’s funds flow support your Primary Care strategies?

Challenges the PPS has encountered in implementation:

Challenge 1: Funding Equity

Each partner in our PPS brings a significant amount of influence to impact the health of our attributed Medicaid population. Accounting for each organization’s efforts while being able to earn all available dollars through DSRIP will be a challenge.

Challenge 2: Employed PCPs and Provider Type in MAPP

In the MAPP application, the bulk of the dollars are going to hospitals in our PPS. This may be misleading to the DSRIP independent assessor.

Challenge 3: Partner Use of Funds

When organizations earn the funds through their DSRIP activities, the PPS expects that those funds are reinvested into their workforce and other infrastructures to support additional DSRIP demands and future value-based payment requirements. The PPS has little influence over the actual use of these funds which should be considered a challenge.

Efforts to mitigate challenges identified above:

Mitigation 1: Fund Equity

Partners earn funds through achieving actively engaged (85%) and “citizenship” (15%) which rewards the contribution that CBOs and other organizations (not actively treating patients) make to the development of our PPS. We also have funds allocated for innovation (projects or programs not currently reimbursed by Medicaid that will enhance transformation), tobacco and mental health/substance abuse prevention programs. Funds flow directly to organizations which, other than CBOs and other community organizations, are hospitals with an employed physician model. At Bassett Hospital, for example, (the largest partner in the PPS), funds achieved for DSRIP projects are set aside in cost centers and are utilized for hiring and retraining staff and educational opportunities designed to enhance learning relating to the transformation.

Other partners have been educated about the funds flow model (including other opportunities for funding through innovation and grants).

For more details on the LCHP funds flow, please go to our website where you can read the step-by-step process for our most recent payment to our partners and the amounts each organization received:

<http://lchp.perflogic.com/document?s=PFN0cj4KMDEyNy8wMDAwMDAwMjU2LzEyMS9kb2N4CjwvU3RyPgo%3d>

Mitigation 2: Employed PCPs and Provider Type in MAPP

Where ever possible, our PPS adds narratives to explain why our funding to partner types may be misleading. In this case the hospitals in our PPS employ nearly all of the PCPs in our system. Therefore, under one organization, the funds go to the hospital even though PCPs have earned the funds directly. An example of this would be when a practitioner providers a preventive screening to a Medicaid patient in a PCMH eligible site, which would count



toward our actively engaged project definition for 2a ii, thus earning a portion of funds as described earlier. Under normal circumstances, these funds would be routed as a payment to the PCP category, however if the practitioner works for a hospital, the funds would be listed as payments under the hospital category. This is the case for nearly all PCPs in our PPS.

Mitigation 3: Partner Use of Funds

While the PPS does not have direct discretion over the use of DSRIP funds earned by an organization through its DSRIP activities, we do have access to their senior leadership team. In order to encourage a reinvestment of DSRIP funds into primary care (when applicable), education of the future requirements of the program are explained. This is done through presentations, dashboards, and other data review. To that end, these leaders have approved many positions for hire and are continuing to approve more as guided by our workforce analysis. Positions include care managers, community navigators, registered nurses, an addictionologist (psychiatrist), and more.

Implementation approaches that the PPS considers a best practice:

- We have posted our funds flow process and the amounts received by each organization on our website. If an organization wishes to know how to earn more funding, they simply need to reference this document.
- Funding model has resulted in over 75% of available funds being distributed to partners in the PPS.



PPS Name: Bassett Medical Center

Fundamental Area: How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?

Challenges the PPS has encountered in implementation:

Challenge 1: Interoperability & Prioritization

A significant amount of time and effort has been invested in creating an electronic medical record where progress notes can be shared with primary care providers, yet psychotherapy notes will remain protected. This subtle difference has required an immense amount of resource negotiation between partners, namely Bassett Medical Center, as they go through several parallel IT initiatives.

Challenge 2: Organizational Culture Change

Partner organizations in our PPS have never coordinated or shared data to the extent we need to be successful in the 3ai project, with specific attention to the interoperability functions mentioned in challenge #1. Many primary care providers are very interested in the medical management aspects of these patients' care plans, but many behavioral health (BH) providers want to be sure to share only the information that is required.

Challenge 3: MAX Series BH Patients

As part of our engagement in the "MAX Series, Topic 3: Super Utilizers," barriers have been identified for some of our BH patients who frequent the emergency department. Primarily, the need to be seen for a non-urgent issue at a time and location that works for them. Typically, there is very little lead-time to set up an appointment or schedule something in advance. While this challenge has only been officially studied at the one site participating in the MAX Series, Little Falls Hospital, we know anecdotally this challenge is a ubiquitous problem for all of the EDs in our PPS.

Efforts to mitigate challenges identified above:

Mitigation 1: Interoperability & Prioritization

After a great deal of discussion, negotiation, and making sure we are doing what is in the best interests of our patients, the 3ai project committee was able to connect with the Chief Clinical Officer of Bassett Medical Center to prioritize this change in the medical record. There are still some cultural obstacles to surpass (Challenge 2), but creating this basic function in the electronic medical record was a tremendous victory for the PPS, our PCPs, and our patients. Additionally, a pilot program is underway at one of our largest primary care partner sites. We intend to share the learning/successes from this experience to our other sites. Additionally, PPS leadership is in the process of contracting with a community-based organization to provide SBIRT training throughout our PPS.

Challenge 2: Organizational Culture Change

While educating behavioral health providers on the legalities of sharing the appropriate medical information with PCPs has been very successful, there remains uneasiness with the BH providers to do so. To mitigate this issue, we've connected with the clinical leaders of our partner organizations participating in 3ai to



obtain their buy-in to the concept. While there was some reluctance at first, we ultimately reached an agreement to establish an EMR solution to share this data. Future challenges include sharing this information between organizations. The success to date has been focused on systems that currently employ both BH providers and PCPs.

Mitigation 3: MAX Series BH Patients

To address the issue head-on in our EDs, we have integrated navigators in nearly all of our locations. While not focusing on the medical issues, the navigators will follow up with patients, provide them contact information in order to get transportation to an outpatient clinic instead of an ambulance to the ED, and address many other social determinants of health. Parallel to this work, the PPS has started focusing on training of behavioral health providers to refer patients who meet eligibility criteria to the Medicaid Health Home. While it is still too early to see any direct impact to the EDs and our primary care clinics, this initiative will lead us to better understand the needs of this population. MAX series experiences are being shared at partner meetings and other venues. The goal and intention is to begin new MAX series at other sites.

Implementation approaches that the PPS considers a best practice:

- MAX Series paring with community navigators to help better manage BH patients.