Central New York Care Collaborative
Regional Project Advisory Committee

Oneida County DY1Q4 Meeting

Thursday, March 3, 2016

Oneida County Department of Mental Health
120 Airline Street, Suite 200
Oriskany, NY 13424
Delivery System Reform Incentive Program (DSRIP)

In April 2014, New York State announced approval of a waiver to allow NYS to reinvest $8 billion in federal savings generated by the Medicaid Redesign Team (MRT)

Federally funded initiative that provides NY with funding to support hospitals and provider organizations to change how care is provided to Medicaid beneficiaries.

$7.62 billion for Delivery System Reform Incentive Payments (DSRIP)
$1.08 billion for other Medicaid Redesign purposes

The DSRIP program promotes community-level collaborations via performing provider systems (PPSs) and focuses on system reform

<table>
<thead>
<tr>
<th>Goals of DSRIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce avoidable hospital readmissions and emergency department use by 25% over the next 5 years</td>
</tr>
<tr>
<td>Preserve and transform the State’s fragile health care safety net system</td>
</tr>
</tbody>
</table>

Performing Provider Systems (PPS)

- Adirondack Health Institute, Inc.
- Advocate Community Providers, Inc.
- Albany Medical Center Hospital
- Alliance for Better Health Care, LLC
- Bassett Medical Center
- Bronx-Lebanon Hospital Center
- Central New York Care Collaborative, Inc.
- Finger Lakes Performing Provider System, Inc.
- Maimonides Medical Center
- Millennium Collaborative Care
- Montefiore Medical Center
- Mount Sinai PPS, LLC
- Nassau Queens Performing Provider System, LLC
- New York City Health Hospitals Corporation
- NYU Lutheran Medical Center
- Refugee Community Health Collaborative
- Samaritan Medical Center
- SBH Health System
- Sisters of Charity Hospital of Buffalo, New York
- Southern Tier Rural Integrated Performing Provider System, Inc.
- Staten Island Performing Provider System, LLC
- State University of New York at Stony Brook University Hospital
- The New York and Presbyterian Hospital
- The New York Hospital Medical Center of Queens
- Westchester Medical Center
CNYCC: Who we are

The Central New York Care Collaborative (CNYCC) is a partnership that connects healthcare and community based service providers in six counties across Central New York.

- New Corporation/Independent Agency
- 170 Partner Organizations
- 1400 Service Providers
- Nearly 200,000 Medicaid Members

The primary goal of the collaborative is to serve the population by improving the coordination of healthcare services, enhancing the quality of performance outcomes, and creating an overall better system of care for patients.
CNYCC: At a Glance

6 COUNTIES
Cayuga, Lewis, Madison, Oneida, Onondaga, and Oswego

9,700 SQUARE MILES

170 Partner Organizations

Nearly 200,000 MEDICAID SUBSCRIBERS

1,400 HEALTHCARE AND COMMUNITY-BASED SERVICE PROVIDERS

New Corporation
PPS Lead Agency

CNY CARE COLLABORATIVE
CNYCC Governance

SUNY Upstate Medical University
Syracuse Community Health Center
Hillside Children’s Center
Crouse Hospital
Loretto
Community Memorial Hospital
Oneida Healthcare
East Hill Family Medical
St. Joseph’s Health Center
Oswego County Opportunities
CNY Health Home
Regional Primary Care Network
Auburn Hospital
Sitrin Home Services
CNY FQHC Collaborative
Faxton-St. Luke’s

Corporate Members
(4 Co-Leads)

Board of Directors
(22 Members)

Board Committees

- Executive Committee
- Finance Committee
- Clinical Governance Committee
- Nominating Committee
- Compliance Committee
- IT/Data Governance Committee

Executive Project Advisory Committee (EPAC)
- RPAC Cayuga County
- RPAC Lewis County
- RPAC Madison County
- RPAC Oneida County
- RPAC Onondaga County
- RPAC Oswego County
Welcome & Agenda

Introductions

Agenda:
1. Review of RPAC Structure & Roles
2. EPAC Nominations & Review of Voting Process
3. Project Updates
4. Questions & Answers
5. Next Steps & Wrap-Up
RPAC Structure & Roles
RPAC Structure & Roles

**Purpose:**

- Serve as an advisory entity within CNYCC; the RPAC offers recommendations and feedback on CNYCC initiatives including DSRIP project plans.
- Act as liaison among the community, local projects and the EPAC.
- Act as liaison among the Partner Organizations and CNYCC.
- Provide an interactive process for purposes of learning, problem solving, project implementation and / or ongoing DSRIP success.
- Respond to queries from the EPAC.
- Provide a forum for all stakeholders to engage in the DSRIP activities.

Source: PAC/RPAC/EPAC Interim Principles & Procedures (September 2015)
RPAC Structure & Roles

Structure:

• There are six (6) RPACs, each covering one of the counties in CNYCC (Cayuga, Lewis, Madison, Oneida, Onondaga, and Oswego).
• Each RPAC meets on a quarterly basis.
• CNYCC, with input from its partner organizations, creates agendas and produces meeting minutes. During this interim period, the development of the RPACs is an ongoing agenda topic.
• All subcommittees of the RPACs maintain appropriate records of all activities and subsequently report out at the monthly RPAC meetings.

Source: PAC/RPAC/EPAC Interim Principles & Procedures (September 2015)
RPAC Structure & Roles

Representatives-Membership

a. Each partner organization has at least one RPAC representative.
b. Each partner organization with more than 50 employees have both a managerial RPAC representative as well as a non-managerial employee representative. Organizations that are unionized and have over 50 employees must select a union representative to participate in the RPAC. If a particular union represents workers from multiple organizations, one representative from that union is sufficient.
c. Partner Organizations serving more than one county may have representatives on each of the relevant RPACs.
d. Partner organizations are responsible for selecting their own representative(s).
e. Partner organizations will notify CNYCC staff of any changes in representatives.

Source: PAC/RPAC/EPAC Interim Principles & Procedures (September 2015)
RPAC Structure & Roles

Representatives-Membership (continued)

f. Representative requirements:
   i. Representatives commit to attending RPAC meetings. Representatives who are unable to maintain regular attendance are replaced.
   
   ii. Organizations that participate in DSRIP projects across multiple counties are encouraged to have a RPAC representative at each relevant regional meeting. If resources are restrictive, such organizations may have one representative who may attend one or more of the relevant RPAC meetings.
   
   iii. RPAC representatives are liaisons for their organizations and CNYCC.
   
   iv. RPAC representatives are responsible for communicating agendas and discussions of the RPAC back to their respective organizations (i.e. their employer).

CNYCC RPAC Representatives
Cayuga County – Kathleen Cuddy
Lewis County – Penny Ingham
Madison County – Teisha Cook
Oneida County – Rebecca King
Onondaga County – Mat Roosa
Oswego County – Nicole Kolmsee

Source:
PAC/RPAC/EPAC Interim Principles & Procedures (September 2015)
EPAC Nominations & Voting Process
EPAC Structure & Roles

**Purpose:** The Executive Project Advisory Committee (EPAC) is the liaison between the CNYCC Board, CNYCC staff and the RPACs. The EPAC is responsible for:

- Monitoring all aspects of the DSRIP process from the Partner/Regional perspective.
- Providing information to the CNYCC Board and staff regarding local priorities and concerns through communications that are vetted with the RPACs.
- Receiving project-specific data and performance indicators and CNYCC level priorities and concerns and communicating these to the RPACs.
- Responding to queries from the CNYCC Board of Directors and its Corporate Committees.
- Facilitating communication among the Board and regions.

Source: PAC/RPAC/EPAC Interim Principles & Procedures (September 2015)
EPAC Structure & Roles

Structure
a. The EPAC is comprised of two (2) representatives from each of the RPACS.
b. The EPAC will meet monthly.
c. The EPAC maintains minutes of all meetings and disseminates them to the CNYCC Board, staff and RPACs following each meeting.

Membership
a. Each RPAC will have two (2) representatives on the EPAC
   i. The county representative.
   ii. An additional partner organization representative.
      1) Each RPAC will select the EPAC representative through a voting process.
      2) No one organization can have multiple EPAC representatives.

Source: PAC/RPAC/EPAC Interim Principles & Procedures (September 2015)
EPAC Nominations & Voting Process

Request for Nominations:
- Process
  - Who can be nominated? Any Oneida County RPAC representative
  - How to submit nominations?
- Deadline: April 4, 2016

Voting
- Process
  - Who can vote? All Oneida County RPAC representatives
  - Via SurveyMonkey
- Deadline: April 25, 2016
Project Updates
CNYCC Project Implementation Plan

**System Transformation** (Domain 2)
- Integrated Delivery System (2ai)
- DSRIP Care Management (2aiii)
- ED Care Triage (2biii)
- Care Transitions (2biv)
- Patient Activation (2di)

**Clinical Improvement** (Domain 3)
- Behavioral Health/ Primary Care Integration (3ai)
- Behavioral Health Community Crisis Stabilization Services (3aii)
- Cardiovascular Disease Management (3bi)
- Palliative Care Integration (3gi)

**Population Health** (Domain 4)
- Behavioral Health Infrastructure (4aiii)
- Reduce Premature Births (4di)
Integrated Delivery System (2ai)

Key Project Components

• Development of a HIT infrastructure to support the Integrated Delivery Network
  • Community Wide Analytics & Care Coordination
  • Health Information Exchange & Interoperability
  • EMR Adoption, Optimization & MU Attestation

• Practice Transformation
  • Primary Care Practices meet PCMH 2014 Level 3 or APC Standards
Integrated Delivery System (2ai)

**Progress to Date:**

- HIT Infrastructure
  - HIT Environmental Assessment
  - Continued Development of Data Security Policies and Procedures
  - Community Wide Population Health, Analytics and Care Coordination
  - Vendor Selection in process
- Practice Transformation
  - Baseline Assessment of PCMH and Meaningful Use status completed
Integrated Delivery System (2ai)

On the Horizon:

- HIT Infrastructure
  - Continue IT Partner Readiness Assessment
  - Identification of Vendor of choice for Community Wide Population Health, Analytics and Care Coordination Platform
- Practice Transformation
  - PCMH Partner Readiness Assessment and Implementation Plan
  - Learning Collaborative Sessions
  - Joint HIT/Primary Care Transformation

PIC March 25, 2016
Cardiovascular Disease Management (3bi)

Key Project Components

• Adopt clinical protocols/guidelines for hypertension, elevated cholesterol and related clinical processes
  • Provide opportunity for easily accessible, no co-pay BP F/U visits
  • High-risk patients linked to Health Homes for care management services
  • Practices trained on protocols, equipment use, community based resources and patient-centered care
• Adopt strategies from the Million Hearts Campaign
• Multi-Disciplinary Care Coordination Teams
Cardiovascular Disease Management (3bi)

Key Project Components Continued:

• HIT/HIE systems which align with project goals
  • Identify, manage and track patients with chronic disease and associated risk factors
  • Documentation of patient self-management goals
  • EHR connections with Health Information Exchange and interoperability
  • Meaningful Use Certification
  • Provider Prompts for 5 A’s of Tobacco Control, Chronic Disease Protocols and NYS Smoker’s Quit line

• Primary Care Practices meet PCMH 2014 Level 3 or APC standards
Cardiovascular Disease Management (3bi)

Progress to Date

- Identified evidence based guidelines for treating patients with hypertension and elevated cholesterol
- Protocol recommendations for hypertension, elevated cholesterol and related medication treatments approved by Clinical Governance Committee
- Defined patient eligibility and engagement criteria
  - Alignment with existing key clinical measures (NQF;CMS;PQRS)
  - Includes diagnostic eligibility and self management goals
- Developed recommendations for minimum standards for care coordination teams
- Finalized reporting protocols based on eligibility components
Cardiovascular Disease Management (3bi)

On the Horizon:

- Engage practices in implementation of approved protocols and integrate into PCMH plan
- Implement programs for training primary care providers and staff
- Complete assessment of current system capabilities
- Complete assessment of current CVDM practices compared to approved best practice
- Complete assessment of community CVD needs, resources and service/system gaps
- Meet DY1 Q4 Reporting Target-300 Engaged Patients
Cardiovascular Disease Management (3bi) Reporting

Who is Eligible to Report:
- Organizations providing primary care that treat patients with Cardiovascular Disease or Hypertension

Reporting Criteria:
- Adult Medicaid patients with active applicable CVD diagnosis with a documented self-management goal in their health record
- Encounter date where self-management goals are documented

Payment for Reporting
- $60.99 (net)/$71.75 (gross) PMPY

Does this sound like your organization?
Michele Treinin, Project Manager for Data and Reporting
michele.treinin@cnycares.org
Cardiovascular Disease Management Reporting

DY1 Q4 Targets

<table>
<thead>
<tr>
<th>Q DUE</th>
<th>Target</th>
<th>Actual</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY1 Q4</td>
<td>300</td>
<td>0</td>
<td>RED</td>
</tr>
</tbody>
</table>

Oneida County Partners Engaged in Reporting
• Mohawk Valley Health System
• Oneida Healthcare
• Rome Memorial Hospital

Organizations that appear in orange are actively reporting engaged patients
DSRIP Care Management (2aiii)
ED Care Triage (2biii)

Kate Weidman – Project Manager
DSRIP Care Management (2aiii)

Key Project Components

• Creation of a DSRIP Care Management Model
  • A level of service that falls between PCMH for the general population and Health Home for the complex super-utilizer population.

• Integration of DSRIP Care Management services in PCMH Setting
  • Various Options for Integration

• Primary Care Practices meet APC or PCMH 2014 Level 3 standards
DSRIP Care Management (2aiii)

Progress to Date

• Actively Engaged Patient Definition
  • Individual with a “new or updated Comprehensive Care Management Plan”
  • Standard elements in a Comprehensive Care Management Plan

• Universal Referral Form to refer patients to DSRIP Care Management

• DSRIP Care Management Core Activities

• Actively Engaged targets met for Q2 (200 Patients) & Q3 (650 Patients)

• DY1Q4 Target: 1,100 Patients
DSRIP Care Management (2aiii)

On the Horizon

- Delineation and formalizing of roles for:
  - Health Homes
  - Downstream Care Management Agencies
  - Primary Care Practices (PCMH 2014 Level 3)

- Creation of DSRIP Care Management training - a collaboration between Health Homes, Downstream CMA's, and PCMH 2014 Level 3

- Begin activities of DSRIP Care Management in PCP setting
DSRIP Care Management (2aiii) Reporting

Reporting Actively Engaged Patients

Who is Eligible to Report an Actively Engaged Patient:
- Lead Health Homes
- PCMH 2014 Level 3 with a MOU with a lead Health Home (lead Health Home reports)
- Downstream CMAs with a MOU with a lead Health Home (lead Health Home reports)

Reporting Criteria:
- New or updated Comprehensive Care Management Plan
- Not currently enrolled in a Health Home

Payment for Reporting:
- $20.59 (net)/$24.22 (gross) PMPM

Does this sound like your organization?
Michele Treinin, Project Manager for Data and Reporting
michele.treinin@cnycares.org
# DSRIP Care Management (2aiii) Reporting

## DY1 Q4 Targets

<table>
<thead>
<tr>
<th>Q DUE</th>
<th>Target</th>
<th>Actual</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY1 Q4</td>
<td>1,100</td>
<td>931</td>
<td>169</td>
</tr>
</tbody>
</table>

**Oneida County Partners Currently Reporting**

- Central New York Health Home, Inc. (CNYHHN)
- Onondaga Case Management Services
- St. Joseph’s Health Home Network

Organizations that appear in orange are actively reporting engaged patients.
ED Care Triage (2biib)

Key Components

• Creation of an ED Care Triage program
  • ‘Patient Navigator’ Program in the ED:
    • Connection/Referral to Primary Care
    • Education and Connect to Community Resources
    • Connection to Health Home Care Manager (if applicable)

• Connection between ED’s and Primary Care Practices

• Primary Care Practice engaging patients- patients not returning to ED for an ambulatory sensitive condition
ED Care Triage (2biii)

Progress to Date

- Actively Engaged Patient definition: Modified
- Presentation by St. Joseph’s Hospital about their ED Navigator Program
- PCP Scheduling Resource: [https://cnycares.org/get-involved/pcp-resource](https://cnycares.org/get-involved/pcp-resource)

On the Horizon

- Finessing Services to be received by patient in ED through Patient Navigation Program
- Establishing connection between Primary Care Practice and ED
- Reporting for DY1 Q4
ED Care Triage (2biii) Reporting

Reporting Actively Engaged Patients

Who is Eligible to Report an Actively Engaged Patient:
• Emergency Departments

Reporting Criteria:
• Medicaid patient in ED deemed to have an ambulatory sensitive condition or potentially preventable condition
• ED schedules and appointment for an individual with a Primary Care Provider:
  • Appointment made with their current PCP or matched to a provider that meets their needs
  • Notifies individual within 2 calendar days of appointment
  • Appointment date must be within 30 calendar days of ED visits

Payment for Reporting
• $148.13 (net)/$174.27 (gross) PMPY

Does this sound like your organization?
Michele Treinin, Project Manager for Data and Reporting
michele.treinin@cnycares.org
ED Care Triage (2biii) Reporting

DY1 Q4 Targets

<table>
<thead>
<tr>
<th>Q DUE</th>
<th>Target</th>
<th>Actual</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY1 Q4</td>
<td>1,600</td>
<td>100</td>
<td>1,500</td>
</tr>
</tbody>
</table>

Oneida County Partners Engaged in Reporting

- Oneida Healthcare
- Mohawk Valley Health Center
- Rome Memorial Hospital

Organizations that appear in orange are actively reporting engaged patients
Care Transitions (2biv)
Palliative Care Integration (3gi)

Lauren Wetterhahn – Director Program Operations
Tammy VanEpps – Project Manager
Care Transitions (2biv)

Key Project Components

- Standardized protocols for Care Transitions Intervention Model (evidence-based) with all participating hospitals, partnering with other appropriate community and health agencies
- Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols
- Early notification of planned discharges and the ability of the transition care manager to visit the patient while in the hospital
- Establish protocols that include care record transitions with timely updates provided to the members' providers
Care Transitions (2biv)

**Progress to Date**

- Inventory of evidence-based practices (EBPs) for care transitions
- Partner discussions/presentations regarding their experience with EBPs, sharing of tools used
- Presentation regarding technology supporting transitions
- Actively Engaged Patient Definition for reporting purposes
- Review and development of criteria for planning
  - Convene community coalition; Review of patient medical and social qualities/risk factors; Gap analysis of area resources to meet patient risk factors; Development of plan for infrastructure development and operation
- Identifying neutral partners to convene local planning coalitions
Care Transitions (2biv)

On the Horizon
- Convene community/regional planning coalitions
- Report engaged patients
Care Transitions (2biv) Reporting

Who is Eligible to Report:
• Hospitals (Article 28 and Article 31) with patients who have a Care Transition Plan developed prior to discharge
  • 12 out of the 15 (80%) elements of the Continuity of Care Document (CCD)
  • Details on Post-Acute Providers

Reporting Criteria:
• Medicaid patients with a range of chronic conditions, the required elements of the care transitions plan

Payment for Reporting
• $199.44 (net)/$234.64 (gross) PMPY

Does this sound like your organization?
Michele Treinin, Project Manager for Data and Reporting
michele.treinin@cnycares.org
Care Transitions (2biv) Reporting

DY1 Q4 Targets

<table>
<thead>
<tr>
<th>Q DUE</th>
<th>Target</th>
<th>Actual</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY1 Q4</td>
<td>1320</td>
<td>1957</td>
<td>Goal Met!</td>
</tr>
</tbody>
</table>

Oneida County Partners Currently Reporting

- Mohawk Valley Health System
- Rome Memorial Hospital

Organizations that appear in orange are actively reporting engaged patients.
Palliative Care Integration (3gi)

Key Project Components

• Integrate Primary Palliative Care services into PCPs that have, or will have achieved NCQA PCMH and/or APCM certification

• Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice

• Develop and adopt clinical guidelines agreed to by all partners including services and patient eligibility criteria

• Engage staff in trainings to increase role-appropriate competence in palliative care skills

• Engage with Medicaid Managed Care to address coverage of services
Palliative Care Integration (3gi)

Progress to date
• Partners shared work in this area including existing screening and assessment tools
• Review and development of criteria for regional planning activities and regional planning team composition
• Clinical Workgroup convened to address
  • Patient inclusion criteria; Patient screening and assessment tools; Clinical algorithms; Approaches/standards for care coordination and integration between partners; Scope and definitions of program services

On the horizon
• Analysis of Medicaid data defining the target population
• Compare and contrast CNYCC population needs to existing programs and models
Behavioral Health/Primary Care Integration (3ai)

Behavioral Health Community Crisis Stabilization Services (3a(ii))

Behavioral Health Infrastructure (4aiii)

Kelly Lane – Project Manager
Primary Care/Behavioral Health Integration (3ai)

Model 1: Behavioral Health into Primary Care
Model 2: Primary Care into Behavioral Health
Model 3: IMPACT Model (BH into Primary Care)

**Key Components:**

- Integration of services – sharing of information
- Evidence-based Preventative Screenings
- Primary Care Practices meet APC or PCMH 2014 Standards
Primary Care/Behavioral Health Integration (3ai)

Work to Date:

- Presentations from local and state leaders on implementation
- Resources provided about licensing
- “Speed Dating” event for providers
- Providers identifying which model to integrate under, what conditions to focus on, and billing
- Actively Engaged Patient Definition for reporting purposes
- Reporting started 2/1/16
Primary Care/Behavioral Health Integration (3ai)

MAX Series – Planned Parenthood Mohawk Hudson

- A 12-month intensive learning collaborative sponsored by the DOH
- Places front-line clinicians in a position to lead change
- Work will generate measurable improvements, develop process improvement capacity and accelerate change
- First workshop in February 2016

On the Horizon:

- Unification under evidence-based standards of care
- Establishing protocols and workflows
- 2/1/2016 start reporting speed
Primary Care/Behavioral Health Integration (3ai) Reporting

Who is Eligible to Report:
• Primary Care Providers who screen patients for mental health or substance use
• Behavioral Health Providers who screen patients for medical issues

Reporting Criteria:
• Evidence-based behavioral health screening from PPS list
• Evidence-based primary care screening from USPSTF Grade A/B Recommendations list

Payment for Reporting
• $37.99 (net)/$31.15 (gross) PMPY

Does this sound like your organization?
Michele Treinin, Project Manager for Data and Reporting
michele.treinin@cnycares.org
Primary Care/Behavioral Health Integration (3ai) Reporting

DY1 Q4 Targets

<table>
<thead>
<tr>
<th>Q DUE</th>
<th>Target</th>
<th>Actual</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY1 Q4</td>
<td>6700</td>
<td>(5035)</td>
<td>NEED</td>
</tr>
</tbody>
</table>

Oneida County Partners Currently Reporting
• Oneida Healthcare – Verona Health Center

Organizations that appear in orange are actively reporting engaged patients.
Behavioral Health Community Crisis Stabilization Services (3a ii)

**Key Project Components:**

A comprehensive program that includes:

- Mobile Crisis
- Intensive crisis service (residential short term stabilization, community-based observation, among others)
- A central, public line to gain access to a variety of services
- Diversion to community based services
- Outreach and Education
Work to Date:

- Actively Engaged Patient Definition for reporting purposes
- Identification of a model of crisis stabilization services to use as basis for service expansion.
- Development of the Crisis Stabilization Services Expansion RFP

On the Horizon:

- Continued emphasis on reporting
- RFP Dissemination and Project Awards
Behavioral Health Crisis Stabilization (3aii) Reporting

Who is Eligible to Report:
• Mental health and substance abuse service providers

Reporting Criteria:
• Encounter of crisis service from PPS identified list
• Categories: Community and clinic-based crisis services, same day access, residential-based crisis services, home-based crisis services, mobile crisis services, community-based substance related services

Payment for Reporting
• $8.36 (net)/$9.83 (gross) PMPM

Does this sound like your organization?
Michele Treinin, Project Manager for Data and Reporting
michele.treinin@cnycares.org
Behavioral Health Crisis Stabilization (3aii) Reporting

DY1 Q4 Targets

<table>
<thead>
<tr>
<th>Q DUE</th>
<th>Target</th>
<th>Actual</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY1 Q2</td>
<td>500</td>
<td>642</td>
<td>EXCEEDED</td>
</tr>
<tr>
<td>DY1 Q3</td>
<td>2500</td>
<td>1754</td>
<td>NOT MET</td>
</tr>
<tr>
<td>DY1 Q4</td>
<td>4500</td>
<td>(2375)</td>
<td>NEED</td>
</tr>
</tbody>
</table>

Oneida County Partners Engaged in Reporting
- The Neighborhood Center
- Mohawk Valley Psychiatric Center
- Rescue Mission of Utica

Organizations that appear in orange are actively reporting engaged patients.
Behavioral Health Infrastructure (4aiii)

Key Project Components:

- Collaboration among leaders, professionals, and community members working in mental, emotional, and behavioral health promotion;
- Substance use and other MEB disorders and chronic disease prevention, treatment and recovery;
- The strengthening of infrastructure for MEB health promotion and MEB disorder prevention
Behavioral Health Infrastructure (4aiii)

Progress to Date:

• Workgroup established to:
  • Identify structure for implementing cross-county, cross-systems initiatives
  • Identify a strategic initiatives
• Identification of existing community resources to support infrastructure work
• Strategic activities identified, pending approval

On the Horizon:

• Strategic plan will inform the development of Request for Proposals
Patient Activation (2di)
Reduce Premature Births (3gi)

Kelsie Montaque – Project Manager
Patient Activation (2di)

Key Project Components

Increase patient activation related to health care paired with increased resources that can help the uninsured, non utilizing, and low utilizing populations gain access to and utilize primary and preventive care services.
Patient Activation (2di)

The Plan:

- Screening
  - Screen uninsured and non/low utilizing Medicaid members using the Patient Activation Measure (PAM®) Tool

- Coaching
  - Coach screened individuals based on their level of activation and connect with appropriate preventive primary care and community-based services, and others as needed.

- Community Engagement Forums
  - Conduct “Listening Sessions” in the six Central New York Counties on an annual basis

- Train individuals as Coaches to conduct PAM® screening and Coaching For Activation®
- Participate in Cultural Competency/Health Literacy Training Strategy
Patient Activation (2di)

Work To Date:

- Identified the uninsured, low/non-utilizing “hot spot” areas by zip codes within the six Central New York Counties
- Identified the Community Based Organizations within the “hot spot” areas to contract with
  - We will contract with a broad coalition of partner organizations that see a large number our targeted population (uninsured, low- and non-utilizing)
  - Community-based organizations, FQHCs, care management agencies, hospitals, behavioral health & primary care providers, etc.
- PAM® Training “Supervisor’s Overview” Session conducted
- Drafted Training-of-Trainer Protocol Developed
- “Listening Sessions” RFP has been released!
Patient Activation (2di)

On The Horizon:

- PAM® Training “Screeners” Sessions:
  - Wednesday, 03/30/16 1:00 pm – 4:30 pm
  - Thursday, 03/31/16 8:30 am – 12:00 pm

- Subsequent PAM® Trainings Scheduling

- Development of the Training-of-Trainer Manual

- Begin PAM® screenings on April 1, 2016
Reduce Premature Births (4di)

Objective:

• By December 31, 2017, reduce the rate of preterm birth in NYS by at least 12% to 10.2%

✓ The March of Dimes reports that in 2013, 1 in 9 babies (10.7% of live births) was born preterm in NY

We are On Our Way!
Reduce Premature Births (4di)

The Plan:

Clinical Standards Component
- Identify a consensus, evidence-based clinical standards and protocol
- Provide provider education, technical assistance, and quality assurance related to the adoption and implementation of consensus clinical standards & protocols

CenteringPregnancy®
- Implement new CenteringPregnancy® Programs and provide additional funding support to existing CenteringPregnancy® Programs
- Provide “Peer Support” to new CenteringPregnancy® Programs
Reduce Premature Births (4di)

**The Plan Cont.:**

- Development of Community Health Workers and Evidenced-Based Home Visiting Programs
- Development of Common Resource and Referral Platform
- Standardize and integrate intake, enrollment, referral, follow-up, and coordination process and protocols to the extent allowed by existing technologies
Reduce Premature Births (4di)

**Work To Date:**
- Developed a Draft “At Risk For Preterm Births and Adverse Pregnancy Outcomes” Definition Template
- Developed RFPs
  - ✓ Clinical Standards Educational Protocol and Adoption Support
  - ✓ CenteringPregnancy®

**On The Horizon:**
- Release of RFPs
- Present the “At Risk For Preterm Births and Adverse Pregnancy Outcomes” Definition to the Clinical Governance Committee for Approval
Questions & Answers
Next Steps & Wrap-Up
Next Steps & Wrap-Up

• Selection of second EPAC representative
  • Nominations due: April 4, 2016
  • Voting begins: April 6, 2016
  • Voting ends: April 25, 2016

• 2016 Oneida County RPAC meeting schedule:
  • DY2Q1: June 2, 2016
  • DY2Q2: September 1, 2016
  • DY2Q3: December 1, 2016

• Agenda for Next RPAC meeting:
  • Roll-out of RPAC Project Dashboards
  • First CBO Spotlight
  • Report from Beneficiary Listening Forum
Thank You

www.cnycares.org