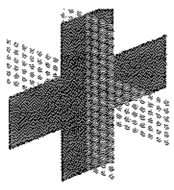
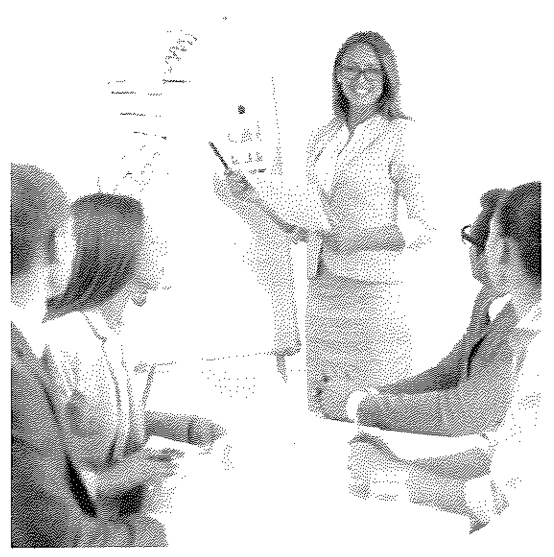
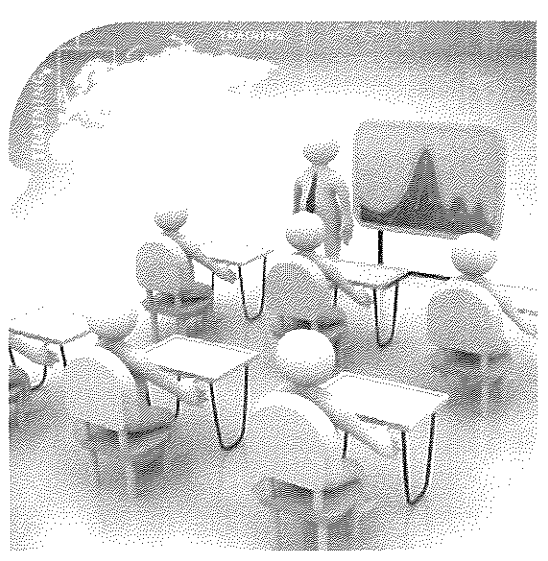


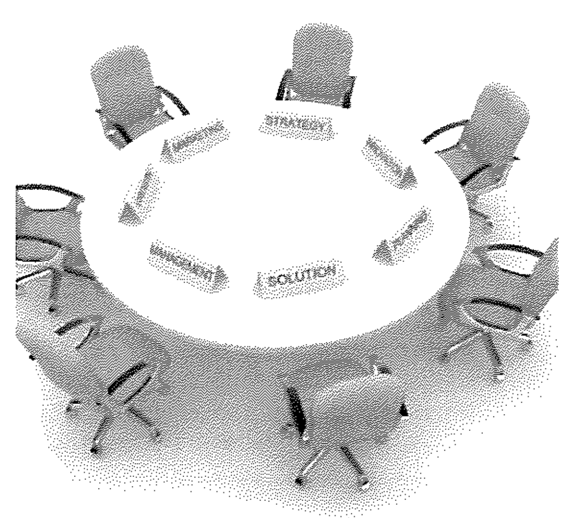
COMMUNITY PARTNERS OF WNY

Performing Provider System

TRAINING STRATEGY







Prepared by WNY R-AHEC

November 2016

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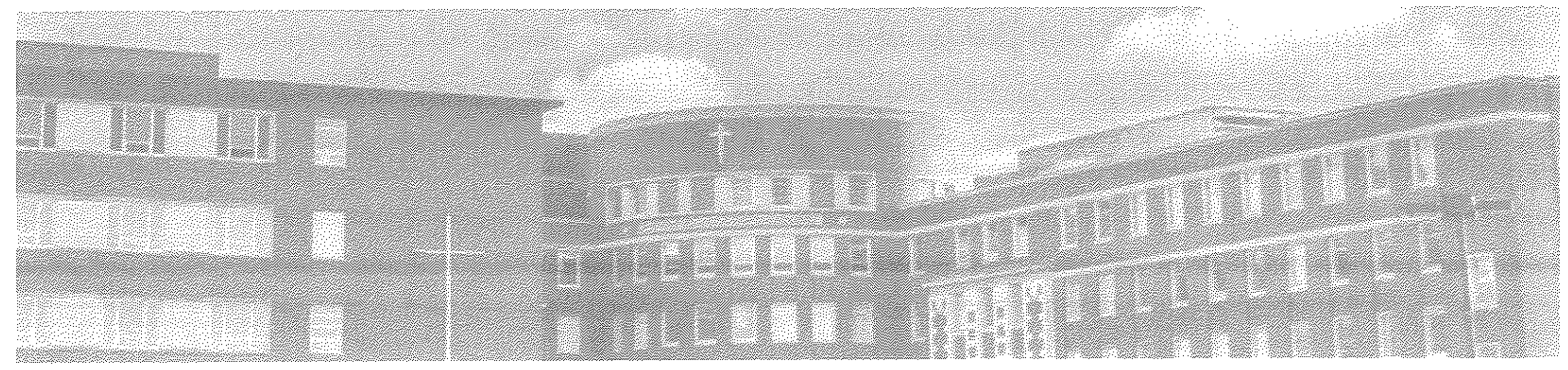


Introduction

Community Partners of WNY (CPWNY) is a network of more than 100 health, human service, and educational organizations; the Catholic Health System plus five community hospitals; and over 1,000 physicians from across the region. CPWNY will focus on transforming the delivery of healthcare in Western New York. This community-wide effort is governed by a representative board established by the lead organization, Sisters of Charity Hospital, and supported by the project management team at Catholic Medical Partners. Our goals are to improve clinical care and service to the Medicaid population and to achieve a measurable reduction in the burden of illness on our population, while achieving the New York State target of a 25% reduction in avoidable hospital use over a five-year period.

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

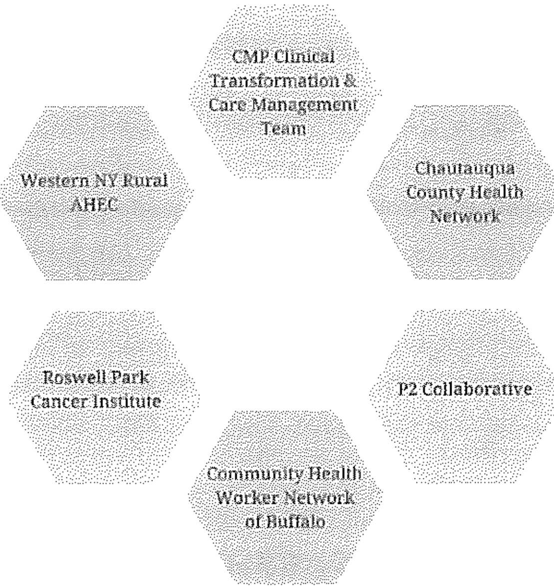
Engaging Our Stakeholders

A key part of implementing this training strategy is engaging and working with our stakeholders. In addition to leveraging the CMP Clinical Transformation and Care Management staff, CPWNY has contracted with the Chautauqua County Health Network (CCHN) to expand training to the 7 contracted practices in Chautauqua County. CCHN facilitates communication and training to the practices on behalf of the PPS. Other key stakeholders that assist CPWNY in delivering trainings to the PPS network include P2 Collaborative, Community Health Worker Network of Buffalo (CHW), and Roswell Park Cancer Institute. These contracted organizations have been playing a vital part in targeting all levels of our partners (practices, providers, hospitals, organizations, CBOs, Medicaid members, etc.) to train in various topics such as self-management, tobacco cessation, cultural competency, health literacy and other areas CPWNY identifies as needed.

To address PPS partners that wish to receive training or may not have trainings in place, CPWNY has utilized its community forums, e-mail, newsletters, and website to promote training conducted by P2, CHW, or trainings conducted through the CPWNY website.

To access and house these various trainings, CPWNY has contracted with WNY Rural Area Health Education Center (R-AHEC) to assist the PPS in the collection and housing of training data from the providers, practices, and organizational outreach efforts.

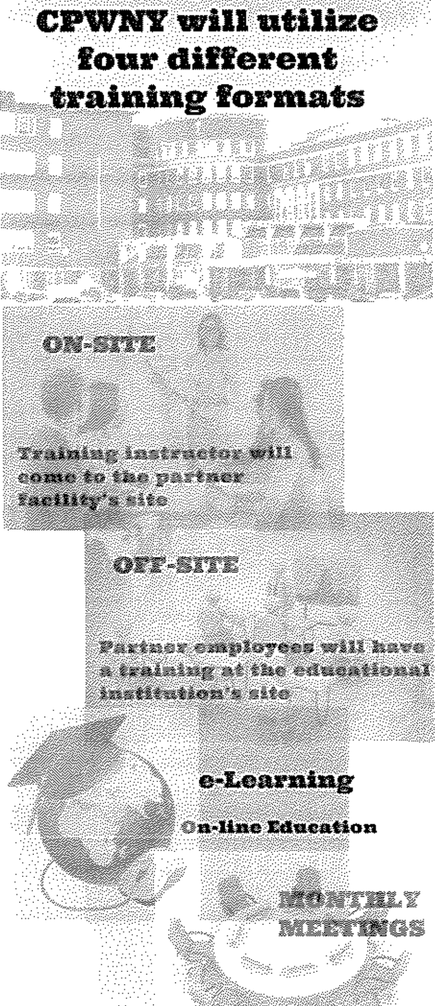
This approach enables us to have a strategy that meets the needs of local employers and training providers in addressing changes with DSRIP implementation as well as to meet the legal requirements for storing sensitive information.



Delivering Our Strategy

CPWNY covers 3 Western New York counties: Chautauqua, Erie and Niagara, which overlap with Millennium Collaborative Care PPS (Millennium). CPWNY and Millennium have been working together on projects that both PPSs have in common.

As it was previously mentioned, we will be working closely with our stakeholders to train the workforce in our catchment area. Our training strategy will be delivered to the 9 occupational subgroups established by the New York Department of Health:



- Physicians and Physician Assistants
- Nurse Practitioners, Midwives, Nurses and Clinical Support
- Allied Health Professionals
- Behavioral Health Professionals
- Social Workers (including Case/Care Managers)
- Non-licensed Care Coordinators, Patient Navigators, Community Health Workers and Health Educators/Coaches
- Administrative Staff and Administrative Support
- Health Information Technology Specialists
- Home Health/Personal Care

CPWNY will utilize four different training formats: on-site (training instructor will come to the partner facility's site), off-site (partner employees will have a training at the educational institution's site), e-Learning (on-line education) and monthly meetings (seminars and PAC meetings).

Our individual staff trainings will be conducted by the CMP Clinical Transformation, Chautauqua County Health Network, P2 Collaborative, Community Health Worker Network of Buffalo (CHW), Roswell Park Cancer Institute, and WNY Rural AHEC.

Our multi-disciplinary teams will be trained through various conferences, seminars and Project Advisory Committee (PAC) meetings.

By working in partnership with health facilities, community based organizations and educational institutions, we will continue to build and strengthen our relationships. These partnerships will help us to meet our DSRIP implementation goals of a 25% reduction in avoidable hospital use and improving the health and patient experience of the Medicaid population. We will work jointly with other PPSs by sharing our experiences and attending DSRIP conferences and webinars. Additionally, we will continue to seek guidance from the New York Department of Health to ensure that we are on track with all milestones.

Our Network's Training Needs

Our PPS has identified required training needed for five projects that CPWNY is involved in:

- 2ai – Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management;
- 2biv – Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions;
- 2cii – Expand Usage of Telemedicine in Underserved Areas to Provide Access to Otherwise Scarce Services;
- 3bi – Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only);
- 3gi – Integration of Palliative Care into the PCMH Model;

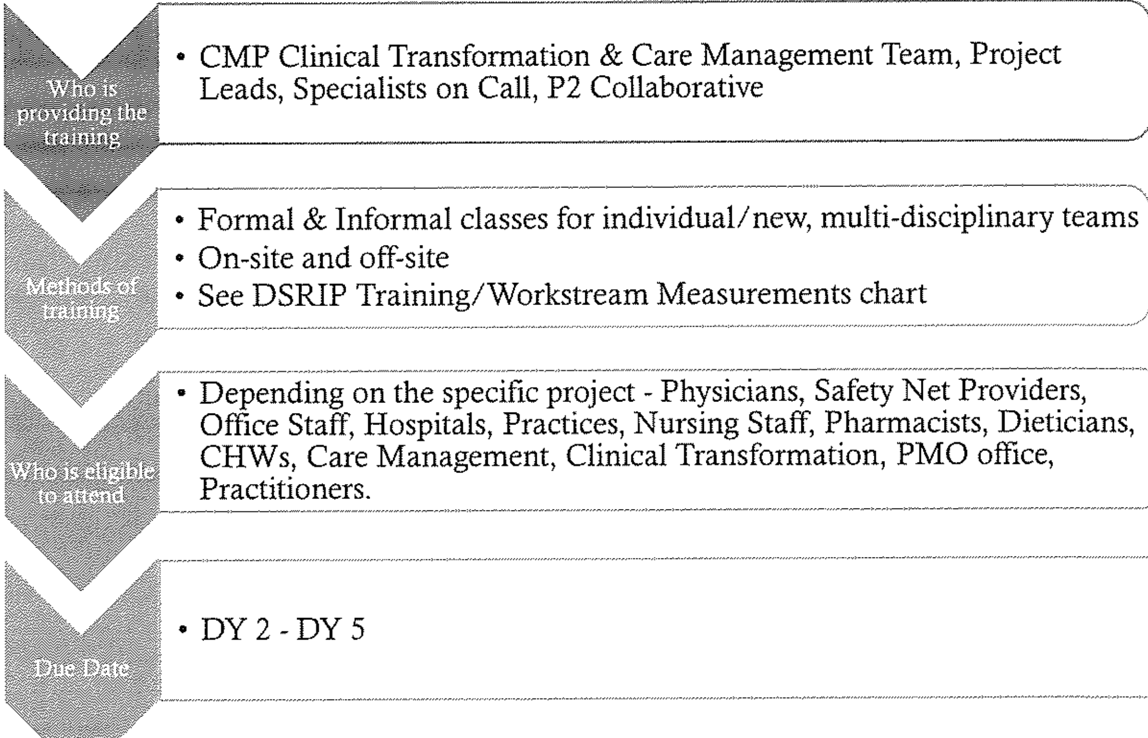
The detailed description of specific trainings by project and plans to deliver them may be found in the DSRIP Training/Workstream Measurements chart. In addition to these specific trainings, each partner organization is required to view the DSRIP 101 video.

As part of the overall Training Strategy, CPWNY identified the following trainings as necessary for successful achievement of the DSRIP's goals:

- Cultural Competency and Health Literacy
- Practitioner Engagement
- IT Systems and Processes
- Performance Reporting
- Clinical Integration
- Population Health Management

Trainings by Project

As was mentioned above, CPWNY has identified specific trainings for five different projects for this Training Strategy. All trainings are based on project requirements and will have their own audience, delivery methods and training providers.



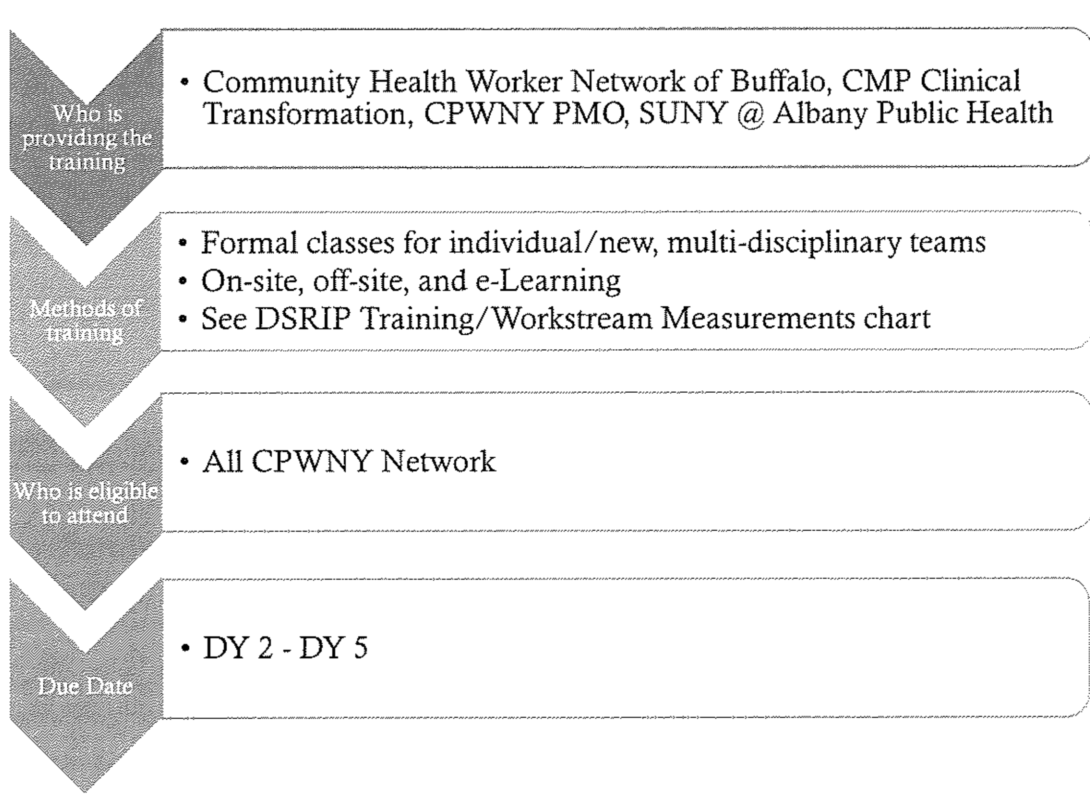
For more details please see DSRIP Training/Workstream Measurements chart.

Trainings by Workstream

Cultural Competency and Health Literacy

In achieving the goal of reducing the avoidable emergency room visits, it is essential to have a workforce that is aware of and understands that different patients can react differently to medical care or treatment. One of our priorities is to develop a workforce that is trained to be culturally sensitive and mindful of the different beliefs and backgrounds of its patients and how this effects the care that they receive.

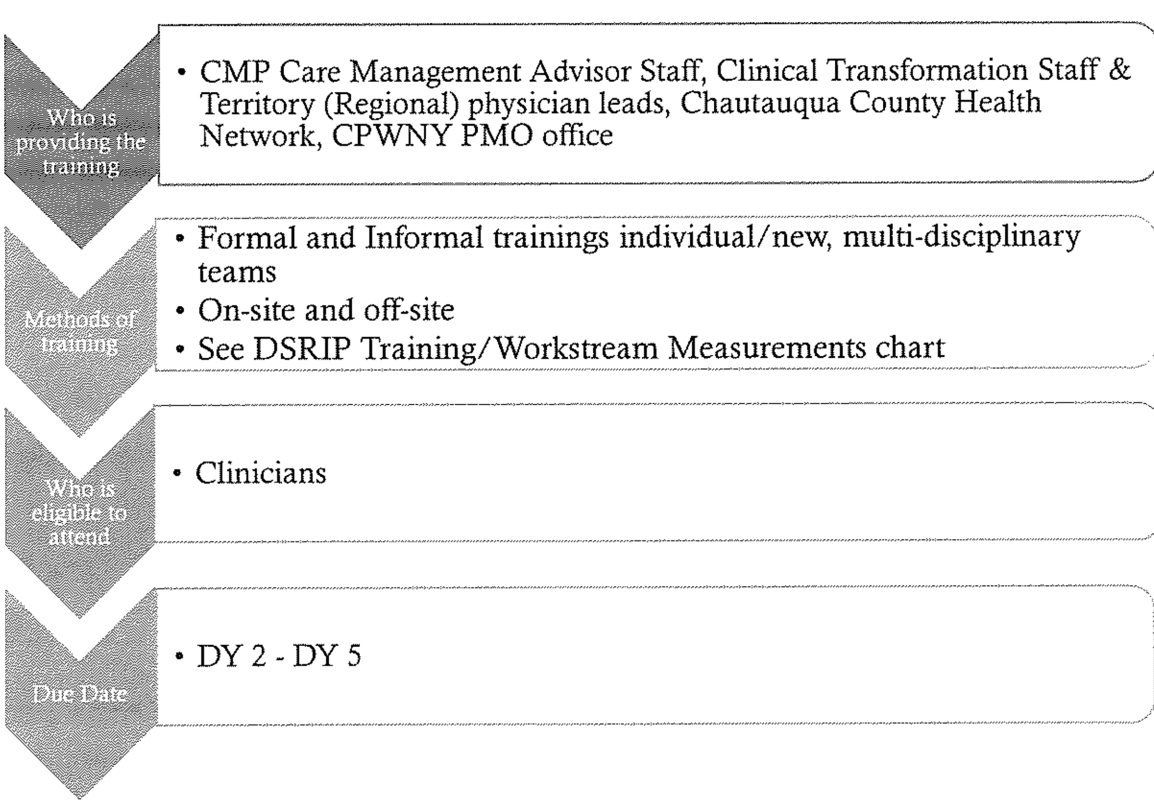
Additionally, it is vital that we address the effects of health literacy on patient care. Our staff needs to understand what health literacy is, the importance of assessing health literacy levels, and what strategies to use or how to effectively communicate information to patients with low health literacy skills.



For more details please see Attachment A.

Practitioner Engagement

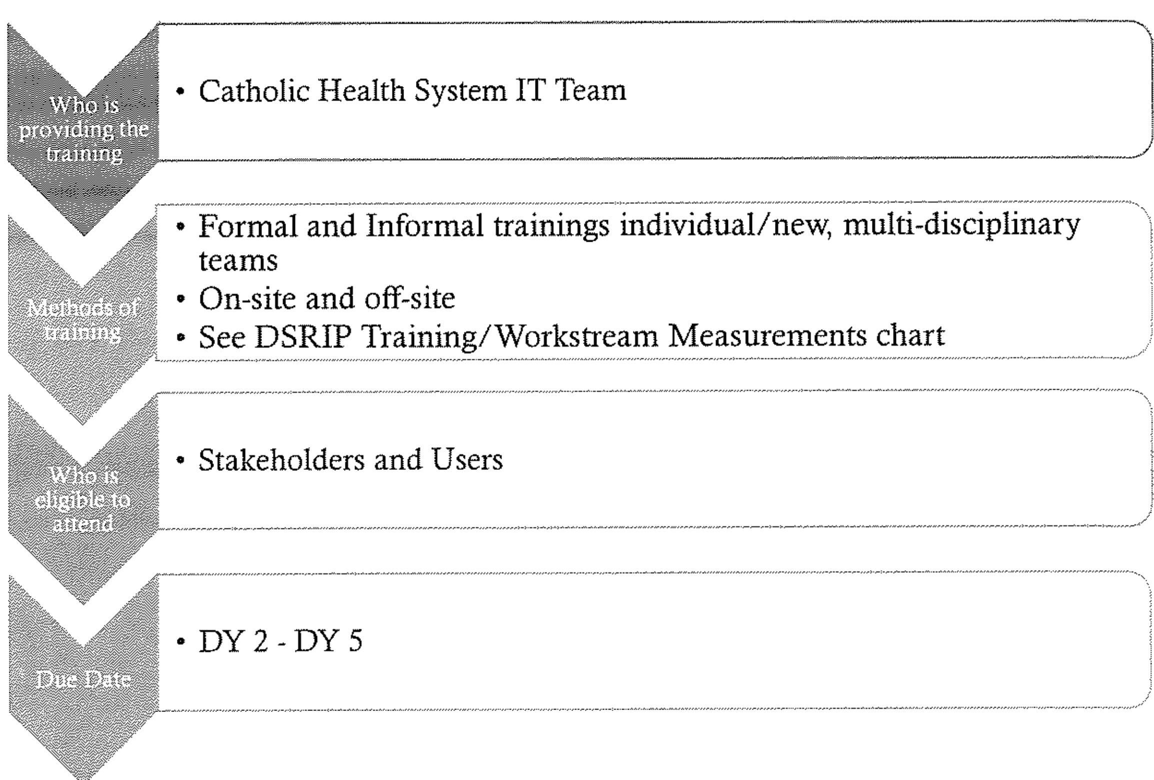
Another key element in reducing avoidable hospitalizations while implementing DSRIP is to involve as many physicians and practices as possible. CPWNY has been engaging physicians and practices in the DSRIP program since 2014. Practitioner Quality Improvement Plan/RCE/PSDA training is ongoing and was originally initiated in 2015 by Catholic Medical Partners IPA for CMP board members and the CMP Quality Committee.



For more details please see Attachment B.

IT Systems and Processes

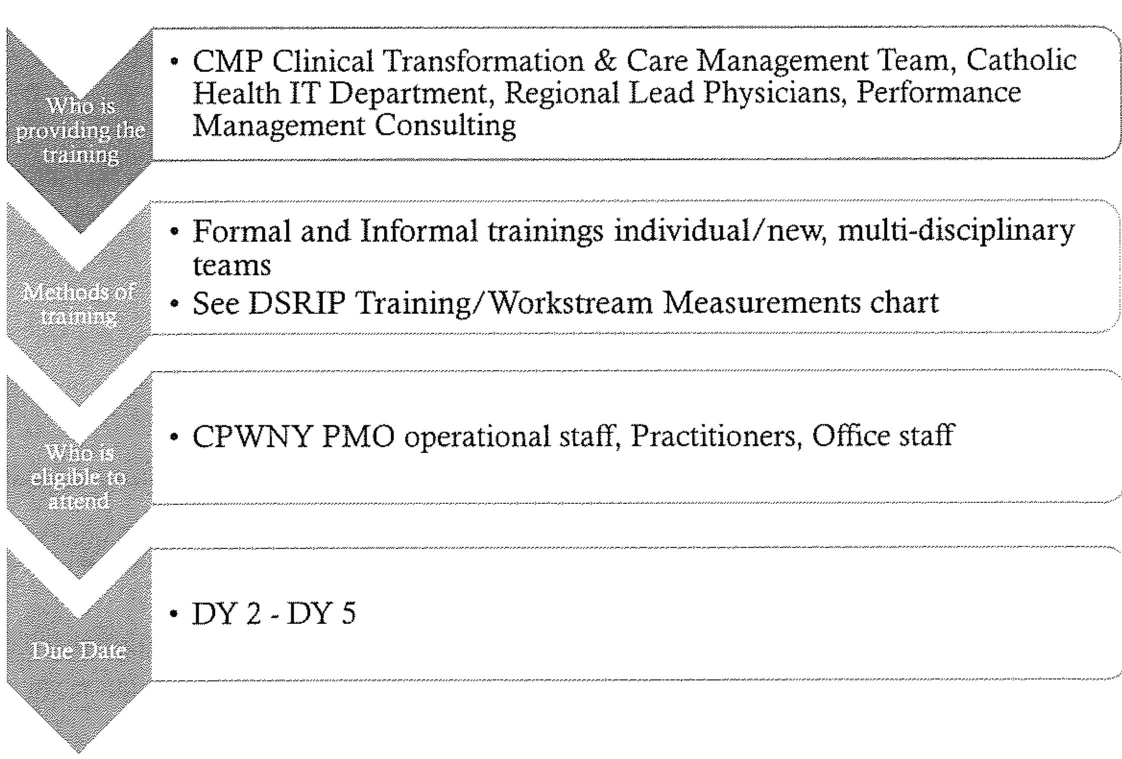
For our network to be able to function without disruptions, it was necessary to develop an IT Change Management Strategy. The strategy that would formalize a process to be used by the CHS Information Technology Department (IT) to ensure that there is a consistent method for the intake, review, and approval of all proposed changes to IT tools used by the CPWNY.



For more details please see Attachment C.

Performance Reporting

CPWNY's goal is to make sure that all partners are on track with the DSRIP implementation and provide high quality care to their patients. The Performance Reporting Training Program utilizes two types of detailed assessments to ascertain the necessity of training and expected outcomes of the training toward DSRIP goal achievement. The first assessment is a detailed electronic medical record capabilities assessment. The second assessment is a National Committee of Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) 2014 assessment grid. This assessment is ongoing and gauges practice readiness for obtaining PCMH or renewing the recognition under the 2014 standards. CPWNY will insure that the DSRIP goals are achieved by providing PCMH classes and individualized training on areas needing improvement in order to meet the PCMH standards. This work stream is in reference to Rapid Cycle Evaluation (RCE) and quality outcomes. RCE is required training.

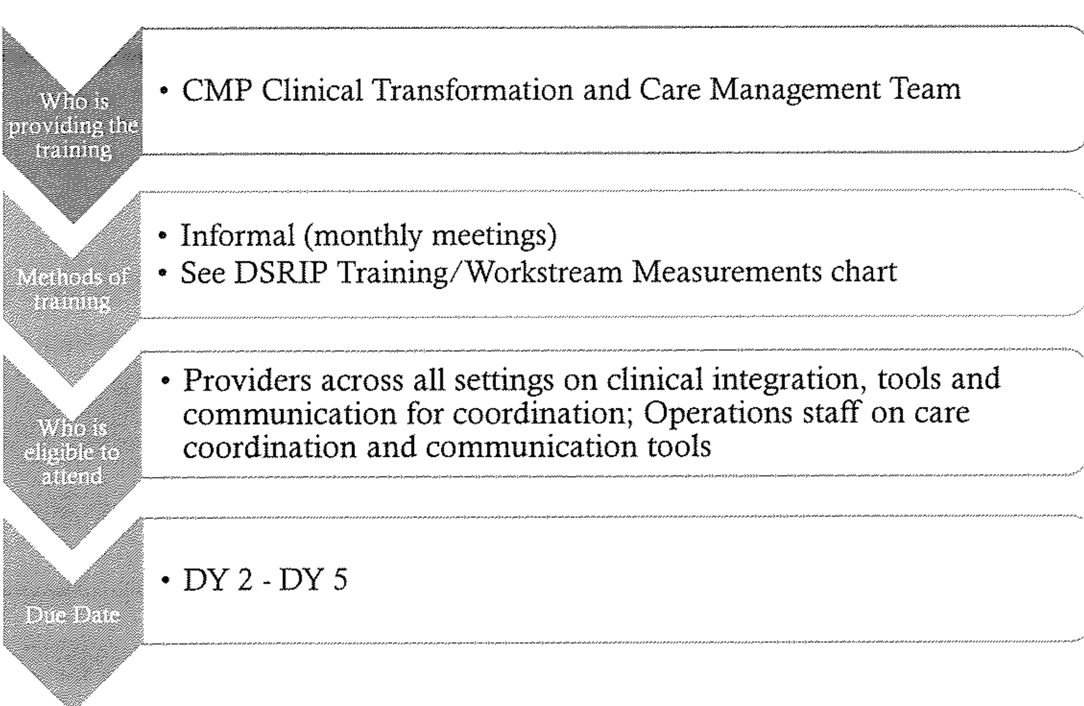


For more details please see Attachment D.

Clinical Integration

One of the first steps to a high performing health system is the development of the high performing physician network. Catholic Medical Partners' (CMP) physician-led, patient focused approach is based on bringing together people, facilities, technology and ideas for the singular purpose of improving the health of our patients and the delivery of care in our community.

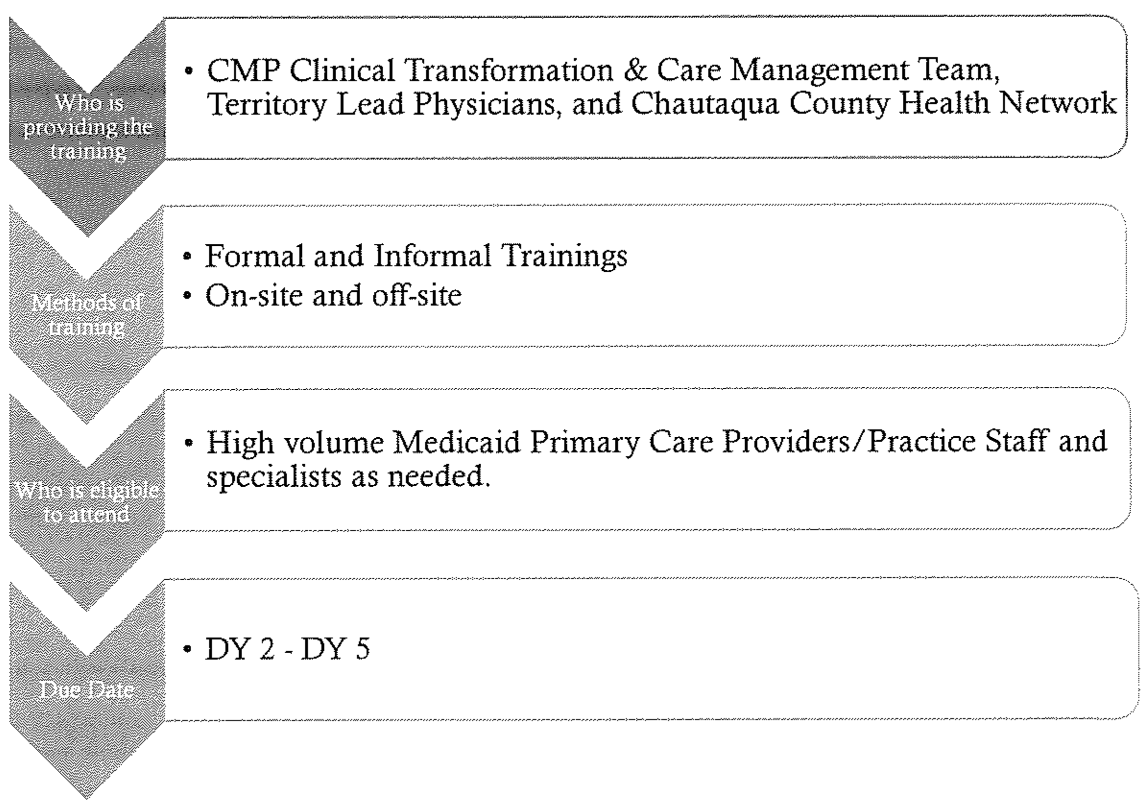
The building of a clinically integrated network must encompass the engagement of physicians capable of attaining the organization's goals, focusing on the Triple Aim – lower cost, improved care, and better health.



For more details please see Attachment E.

Population Health Management

Population Health Management principles assist CPWNY practices in leveraging the work of the entire practice to proactively identify and address patient needs to ensure optimal clinical outcomes and patient satisfaction. In turn, this lowers the total cost of care and keep with the goals of the Triple Aim.



For more details please see Attachment F.

Training Tracking

CPWNY contracted with WNY Rural AHEC (R-AHEC) to track its network's training completion progress. In the summer of 2016, R-AHEC successfully developed a database in accordance with CPWNY's training tracking requirements and needs. Currently a designated R-AHEC employee receives the CPWNY training updates on a regular basis and enters new information into the database. Topics which are currently being tracked include Performance Reporting and Practitioner Engagement, Cultural Competency, Health Literacy, Patient Centered Medical Home, Population Health and Clinical Integration, Ongoing IT Platforms and Processes, Meaningful Use, Community Organization Referrals, Care Transition Protocol, Policies and Procedures for Discharge Documentation, Care Coordination and Workflow Process, Treatment Protocols, and Documentation of Self-Management Goals.

This tracking of specific topics allows our PPS to ensure that our providers are getting the education/information required to adhere to the successful completion of the projects CPWNY has elected to execute.

Documentation *DSRIP Training / Workstream Measurements*

Training across Projects/Workstreams

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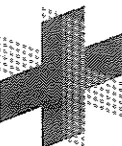


COMMUNITY PARTNERS OF WNY

Performing Provider System

Cultural Competency and Health Literacy (CCHL) Training Strategy all other CPWNY Partners

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

1. **Hospitals, Nursing Homes**

A survey was completed on what was already in place for cultural competency and health literacy at the facilities in our network. Only one hospital had training in place for cultural competency and health literacy for staff. Training methodologies were assessed and input obtained from facility education departments on expectations, mandatory trainings currently in place, and assessing effectiveness. It was determined that a comprehensive mandatory interactive video be developed for all facilities to utilize. It will include pre and post test questions. A team will be convened to put together this video with further assistance from Elizabeth Campisi, SUNY of Albany Public Health offerings. List of facilities that overlap with the Millennium Care Collaborative PPS have been reconciled so there will not be duplicate efforts.

2. **Community Based Organizations**

List of facilities that overlap with the Millennium Care Collaborative PPS have been reconciled to avoid duplicate efforts. Community Based Organizations will be offered the following choices:

a) Facility based video
b) Webinars that are on the SUNY Albany website:
http://www.albany.edu/sph/cphce/advancing_cc.shtml
c) In person trainings that will be contracted with Community Health Worker Network as needed.

All partners are recommended to do an annual training with attestations sent to the CPWNY PMO office regarding completion of the trainings.

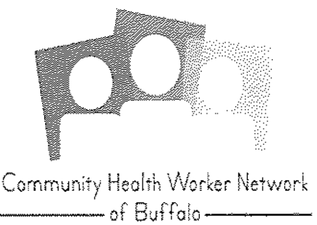
Proprietary

Training plans for clinicians, focused on available evidence based research addressing health disparities by particular groups identified in cultural competency strategy

Cultural Competency/Health Literacy Training Results of Phase I

Prepared for Community Partners of WNY PPS
By Community Health Worker Network of Buffalo
Jessica Bauer Walker, CHW, Executive Director
Renee Cadzow, PhD, Evaluator
Denise Walden, CHW, Trainer

April 29, 2016



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EXECUTIVE SUMMARY

Research shows that health literacy and cultural competency are critical to quality and outcomes related to patient care, and promotes effective patient/provider communication (Scholle et al, 2010). The National Institutes of Health has provided evidence that the concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients. Health literacy, in conjunction with cultural competency, insures that an individual possesses the skills to understand basic health information and services and use them to make appropriate decisions about their healthcare needs and priorities. As part of New York State DSRIP (Delivery System Reform Incentive Payment) program, Community Partners of Western New York PPS (Performing Provider System) contracted with the Community Health Worker Network of Buffalo to provide research, training, and evaluation of various aspects of health literacy and cultural competency to inform an integrated, comprehensive strategy addressing these areas.

For the purposes of this report, the following definitions of these concepts are used:

Health Literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (U.S. Department of Health and Human Services, 2000; Institute of Medicine, 2004).

Cultural Competency in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs (Betancourt et al., 2002).

Structural Competency was also integrated into the initial pilot training sessions as a way to tie together health literacy, cultural competency, and social determinants of health. This concept, proposed by Helena Hansen and Jonathan Metzl in *Social Science & Medicine* (2014), focuses on listening and an openness to learn about another individual's world view through the lens of social determinants of health. Additionally, it provides a framework for recognizing and acknowledging the structural barriers to opportunity and equity, i.e. the hierarchy of institutional care as a structural barrier to caregiving in the community. This broader view of multicultural education focuses less on knowledge, attitudes, and skills; and rather an ability to think critically and consciously about oneself, others, and the world (Johnson et al, 2008).

Key findings from this project include the following:

Training plans for clinicians

- **Experiential frameworks in small group settings** are ideal. Additionally, a minimum of 2 hours/session allows participants to adequately address substantial topics with a greater degree of efficacy.
- **Blended groups of various providers** allow for multiple perspectives and shared learning (i.e. physicians, nurses, front desk staff, etc.).
- **Online learning can be important and helpful supplements to in-person training.** Available programs vary in quality, but there are some excellent resources available (included in the "references and resources" section in this document).
- **Large group presentations can be a good middle ground in between small group/experiential training and online learning.** They provide more personal connection, and when some interactive and personal components can be woven in (i.e. an engaging activity, presenters with diverse experiences and stories from the field), they can be helpful in building knowledge and creating interest for additional training and support on health literacy and cultural competency.
- **Health literacy and cultural competency "champions" at various levels of an institution and practice can greatly assist engagement of the workforce on these issues.** When physicians are engaged by physicians, nurses by nurses, practice managers by other practice managers, and/or there is a practice or clinic-based lead, engagement is much higher.
- **Fostering health literacy in a patient population and cultural competency amongst providers is an ongoing process.** This should be ongoing, integrated, and sequential; with feedback from all stakeholders- including patients and the wider community- being integrated into a process of continuous learning and development.
- **Measuring impact of health literacy and cultural competency training and development takes time, and must include both qualitative as well as quantitative measures.** The focus of this project was on short term shifts in knowledge, beliefs, and some skill-building. There is significant literature to suggest that these shifts can impact quality, cost, and population health. Furthering complicating measuring efficacy is the focus on **content** (i.e. the textbook definitions of "health literacy" and/or "cultural competency") versus the **process** that helps a patient be more health literate and a provider more culturally competent (i.e. effective listening, two-way communication, use of visuals, understanding patient needs and assets in a socio-ecological or "social determinants of health" model, etc.).

PROGRAM DESCRIPTION

Background and Program Objectives:

The aim of this project was to develop the curriculum and logistics for a basic 1.5-2 hour training as well as additional learning opportunities (i.e. online learning) for all practice/provider teams in each Community Partners of WNY (CPWNY) site in a cultural competency/health literacy framework. Various training approaches and content areas were tested as they related to facilitating basic skills and knowledge on patient engagement in a culturally informed and responsive manner. Objectives of CC/HL training, as described in the CPWNY grant application, are (but are not limited to):

1. Ascertain provider abilities and comfort level to meet the needs of their population;
2. Realize the impact of language and cultural differences not as barriers but influences upon clinical quality and patient satisfaction;
3. Identify patient preferences and needs through the art of listening;
4. Enable providers to define the scope of the health literacy problem and combat it with a "no shame" environment.

The figure below indicates how cultural competency and health literacy training can lead to a more prepared, proactive practice team and more productive interactions with patients. These productive interactions empower a patient to become more informed and activated. This improved communication and interaction productivity leads to improved health outcomes.

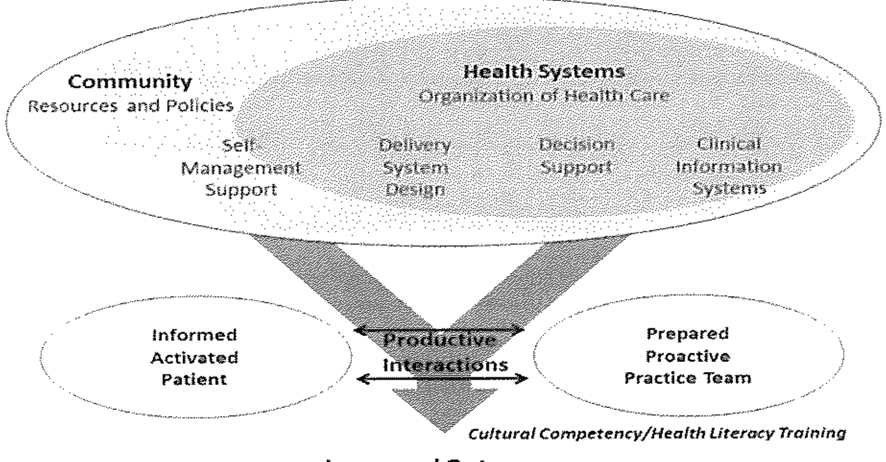

Figure 1: Chronic Care Model (Wagner, 1998)

5

Implementation Process

The process we used included:

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

This report is organized according to the above listed steps. First, a review of provider needs and populations served is presented, which includes the perceived strengths and needs of a sample of providers with the CPWNY PPS. This is followed by a brief description of the content of each of the trainings (supporting documentation included within the appendices). A report of the results of evaluation of the three pilot trainings is presented, followed by recommendations for Phase 2 of the project.

Table 1 is a logic model of the CPWNY PPS cultural competency/health literacy training. It provides an overview of where Phase 1 activities of the project fit in the context of the overarching aim to improve health outcomes through improved provider-patient communication and interaction. Areas in blue font reflect the work and the outcomes reported in the following pages.

Training plans for clinicians addressing health disparities by particular groups identified in the CCHL strategy

Table 1: Cultural Competency/Health Literacy Training Logic Model/Evaluation Plan-Phase 1

Inputs (same as Resources)	Activities/Strategies	Outputs (with Measures) (same as Process Objectives)	Short Term Outcomes (with Measures) (same as Outcome Objectives)	Long Term Outcomes /Impact (Same as Goals) **Addressing health disparities by particular groups identified in CCHL strategy**

• DSRIP funds
• Community Partners Administrative Coordinators
• Training Space
• Training Team from CHWNB
• Online Training Resources
• University Library System for Current Research
• Baseline Survey Data (July-Nov 2015)
	• Pilot Training January 5, 2016 (location – Canisius College)
	• Pilot Training Feb 9, 2016 for practice-based care managers (location – Catholic Health Administrative Building)
	• Pilot Training April 9, 2016 for single practice (location – practice site)
	• Ongoing trainings (1.5+ hours each) TBD at practices and community based organizations
	• Follow up provision of reading materials, supplemental training materials
		• # trainings held
		• # people attending trainings
		• Demographics of trainees
		• Demographics of agencies trainees affiliated with
		• # patients/clients affiliated with agencies whose staff participate in training
			At the individual level
			• Increase in perception of organizational readiness to meet cultural, racial, ethnic, socioeconomic needs of population
			• Increase in perception of staff comfort in discussion of plans with clients that considers cultural preferences, health literacy, and lifestyle
			• Increase in understanding of how to elicit and incorporate cultural preferences related to health care
			• Increase in understanding of how to elicit and incorporate communication strategies and general literacy skills to improve health status of patients/clients
			• Increase in understanding of health disparities
			• Increase in comfort with effective communication strategies
			• Increase in knowledge of bias and stereotyping and strategies of how to control/recognize it without allowing it to impact care
			At the practice/organization level
			• Increase in the inclusion of cultural competency training and implementation in staff evaluations
			• Increase in the use of interpreter services that meet needs of clients/patients (and are not the relative/friend of client/patient
			• Increase in the number of practices that document cultural and health literacy preferences in EHR/medical records/files
			• Increase in the number of practices that have identified a cultural competency champion to monitor activities and advance practice
			• Increase in the number of practices that offer annual opportunities for staff development related to cultural competency and health literacy
				• Improve provider-patient communication
				• Increase patient/client adherence to provider guidance/ recommendations
				• Increase patient satisfaction with health care/services received
				• Improve health of population (particularly vulnerable populations including racial & ethnic minorities/ immigrants/ refugees, people with disabilities and low SES populations)
				• Diminish health care disparities in accordance with NYS Prevention Agenda- specifically low-income populations (< $25000) in Niagara, Erie counties, with a focus on African American/Black and Hispanic populations
				  ○ Cancer screening rates (breast, colorectal, cervical)
				  ○ Blood pressure screenings and control

**The phase in which this phase falls as well as what short term outcomes were measured is noted in bold blue font in the table above.*

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Review of Provider Needs and Populations Served (CPWNY 2015 Survey)

Between July 8 and November 11, 2015, approximately 103 providers within the Community Partners of Western New York PPS completed a survey to assess baseline cultural competency. This survey was implemented by CPWNY PPS and results were shared with the CHWNB to inform the design of the Cultural Competency/Health Literacy training content and methodology.

Description of Respondents and Patient Population

Survey respondents ranged across the Western NY region; about one third were located in Buffalo. Over a third were primary care providers, followed by specialists, community based organizations, behavioral health, long term care, hospital, pharmacy, urgent care and other. The practices represented by these respondents serve a racially, ethnically and cultural diverse population. Two thirds of practices indicate they have patients who are black/African American and Hispanic, over half reported that they had patients who identify as Asian and just fewer than half see patients who identify as American Indian/Native American. Approximately a third of responding practices see patients who are immigrants, just less than a third have patients identifying as Hawaiian or other native Pacific Islander and just under 20% see patients who are refugees to this country.

About 80% of respondents indicated that their practice collects demographic data on race, ethnicity, and primary language. About 35% reported that they collected information on cultural preferences, 45% said that they did not and 20% were uncertain.

Past Cultural Competency/Health Literacy Training

Ninety-two (92) of the respondents answered questions about their previous exposure to cultural competency and health literacy training. One third (34%) participated in cultural competency training at orientation, while two thirds did not. A third (33%) participated in ongoing cultural competency education, while two thirds did not. Regarding health literacy training, fewer indicated previous exposure. Less than a fifth (17%) participated in health literacy training at orientation; 80% did not. Similarly, about a fifth (20%) reported participating in ongoing health literacy training while 80% did not. Most of those who had participated in training indicated that it was between 1 and 4 hours long and approximately once per year.

Perceived Cultural Competence Status of Respondents

Strengths

Eighty-six (86) respondents indicated their level of agreement with statements about their practice's current cultural competence. Most agreed or strongly agreed that:

1. Our organization is ready to meet the cultural, racial, ethnic needs and preferences of our population.
2. Our staff feels comfortable discussing plans with our clients that take into consideration cultural preferences, health literacy, and lifestyle.

Additionally, two thirds reported that they strive to recruit staff who represent the cultures that they serve, two thirds have a system to identify clients who need interpreter services and two thirds maintain information on the ethnicity of their clients in order to plan treatment that takes into consideration their individual needs, culture, health literacy, and beliefs.

Needs

The most frequently relied on source of interpretation/language assistance used by the practices of respondents was their patients' families or significant others. Less than a third reported using certified interpreters or language line. Less than a quarter indicated that cultural competency training and implementation are factors in staff evaluation, though about half are considering it or have considered it. Finally, only 15% have identified a cultural competency champion from within their staff to monitor the activities and advancement in cultural competency.

The respondents listed their needs related to cultural competency and health literacy. They appear below in order of most frequently mentioned to least.

1. Cultural preferences related to health care 54%
2. Communication strategies and general literacy skills to improve health status 51%
3. Knowledge of Health Disparities 47%
4. Effective communication skills, such as teach back 38%
5. Knowledge of bias and stereotyping 33%
6. Use of interpreters 32%

The above assessment as well as additional planning meetings with CPWNY PPS leadership staff informed the design of this pilot phase of cultural competency health literacy training. Additionally, the concepts of social determinants of health, health equity, and structural competency were introduced based on emerging research that social determinants of health and multicultural education are not separate issues, and that cultural competency training can sometimes lead to stereotypes and assumptions, i.e. Chinese patients like the color red, Latino families want family members in the exam room with them, Muslim women should be spoken to through their husbands, etc. Structural competency (proposed by Hansen and Metzl in *Social Science & Medicine*,2014, and utilized as the overarching framework in SUNY Albany's cultural competency online program), focuses on listening and an openness to learn about another individual's world view through the lens of social determinants of health. This broader view of multicultural education focuses less on knowledge, attitudes, and skills, and more on the ability to think critically and consciously about oneself, others, and the world.

Curriculum Development: Description of Pilot Training Content, Length, and Trainers

This training program aligned with:
CPWNY CC.HL Strategy Milestone 1 – Culturally Competent Care (Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other common needs.

Specifically, the piloted trainings emphasized defining plans for two-way communication with the population using didactic, semi-interactive, and small-group interactive approaches. Each session addressed stigma and stereotyping, and helped participants address biases. Participants were encouraged and guided to think about social determinants of health, health literacy, and culturally/structurally competent approaches to care delivery. Implementation of skills and knowledge acquired during this training should improve patient care, and ultimately may lead to a decrease in health disparities experienced by priority groups (refugee/immigrant populations, people of color).

The following is an overview of the specific content, covered using varying techniques, of each of the three pilot training sessions.

Listening as a Foundation for Effective Communication

Each session began with an interactive activity related to listening. This involves a trainer sharing several stories and asking questions afterward to gauge how well the participants listened to the stories. In all groups, participants were surprised that they had considered themselves good listeners but missed critical components of the stories. This led to a discussion about the differences between hearing and listening and the importance of listening carefully to patients in order to capture critical components of their health and/or illness explanations. Listening and two-way communication is an essential component for health literacy and cultural competency, and this activity and discussion sets the tone for the content in the remainder of the training.

Health Literacy and Cultural Competency

Various approaches were used to cover these topics. In the more didactic training; definitions, models, and checklists were provided regarding these concepts, supplemented by "stories from the field". In the experiential model(s), participatory exercises were utilized to allow participants to have a direct experience assessing their own perceptions, ideas, biases, and paradigms of privilege; as well as to hear from and learn from one and other. This approach gave participants practice in participating in a format that required listening, sharing information, and questioning assumptions- just as a provider would need to do in an interaction with a patient. Participants discussed how limiting simple yes/no questions can be compared to eliciting more detailed information, the importance of working with interpreters and translators as needed, and how to be more aware of one's own cultural biases regarding religion, education, income, age, and other experiences. For example, care providers and administrators may consider thinking about "why" patients might miss an appointment, rather than simply tracking that they

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did miss an appointment. Providers may make assumptions about the "why" based on their own experience, not the patient's.

Trainers then introduced the concept of "Structural Competence," which entailed further exploration into the systemic and structural issues related to barriers to health and healthcare. These include the social determinants of health, as well as the way in which systems are structured and how many are left at a disadvantage. Navigating systems can be difficult: issues to tackle include how to ask questions – both of patients to care providers and vice versa. Generalizations and stereotypes are often pervasive in systems or institutions; working to dispel them, or at least make them less routine, is a component of providing culturally and structurally competent care.

Participants discussed the barriers to cultural/structural competence. These included time and care continuity as well as financial resources. Participants discussed the disconnect between US healthcare expenditures (very high) and the US ranking in health outcomes (very low). Related to this, there was discussion about how other countries invest more funds in education. This was tied back to the Institute for Healthcare Improvement's "Triple Aim" (quality, cost, and population health).

Privilege and Power

The third training format allowed for a discussion on privilege, and its relation to health literacy and cultural competence. An interactive activity was utilized where participants were able to examine a definition of privilege (and the difference between "earned" and "unearned" privilege), and whether they had more or less privilege associated with their race, culture, and level of income. This was then debriefed to reflect how privilege and the power that goes along with having more privilege impacts bias and the patient/provider interaction. This exercise and subsequent conversation allowed for a deeper and more personal experience that confronted individual bias and helped connect providers to the experience of their patients, who generally have less privilege than providers do.

Recognizing Patient Strengths and Assets

In addition to the above described content, the third training format with the practice site also allowed for an interactive activity on identifying assets and strengths in patients, regardless of their level of needs and backgrounds. Participants were asked to pair up with a partner and ask one and other about their favorite food, hobby, sport, etc. and a "hidden talent." This gave participants practice in how to equalize power in the patient/provider dynamic, and build relationships with patients based on their stated strengths and goals. This was shared as a "universal approach" across diverse patient populations.

TRAINING EVALUATION DESIGN AND METHODOLOGY

Process Evaluation (Outputs)

The team conducted three cultural competency/health literacy trainings from January to April 2016 using a PDSA approach (Plan Do Study Act). These trainings were conducted in different formats, with different lengths and at varying locations. Content remained consistent in all trainings, but was delivered using slightly different approaches. The evaluation tool was slightly modified for each to capture the changes in delivery method; however most components were maintained in order to effectively compare the approaches. The table below provides a summary of the three trainings. Materials related to each training are included in the appendices (Appendix A).

Table 2: Details of Pilot Training Sessions January-April 2016 (total trained = 145)

Training Date	January 5, 2016	February 9, 2016	April 6, 2016
Training Format	Semi-Interactive	Didactic	Interactive
Number of Participants	49	82	14
Roles of Participants	Half providers and half administrative staff	Mostly providers (nurse case managers)	Mostly providers
Training Location	Canisius College	Catholic Health 144 Genesee Street	Practice Site
Training Length	90 minutes	60 minutes	120 minutes
Trainers Present	Jessica Bauer Walker Denise Walden Deirdre Wright Grace Tate Ebony Davis-Martin Shakira Martin	Jessica Bauer Walker Denise Walden Deirdre Wright Grace Tate Katie Grimm, MD Renee Cadzow, PhD	Jessica Bauer Walker Denise Walden Renee Cadzow, PhD
Training Agenda/Content	Agenda included: Communication/Listening Cultural/Structural Competence Health Literacy Interactive Activities included 4-corners exercise where participants indicated level of agreement to a set of statements	PowerPoint Topics included: Communication/Listening Health Literacy Cultural Competency Social Determinants of Health Health Equity Structural Competency Stories from the Field	Agenda included: Expectations Communication/Listening Cultural competence/ bias Health literacy Strengths-based Approaches Privilege

Outcome Evaluation

Formal and informal strategies were used to gauge the impact of the training on participants. Informal strategies included asking about expectations at the beginning of the training and "checking in" with

participants at the end of training about what they liked and what they would change. Formal strategies included a pre and post survey that

1. Measured level of familiarity with the content to be covered in the training,
2. Measured level of agreement to statements that were either aligned or not aligned with a culturally competent approach to patient care,
3. Measured satisfaction with different components of the training, whether it will impact their work, and whether they would recommend any changes (post-survey only).

Expectations

At the start of two of the three training sessions, trainers asked what participants expected from the training. Respondents had varying levels of knowledge about the reasons they were in the session, ranging from "no idea" to statements about imparting outside the box thinking to providers. This exercise was not conducted in the didactic session due to the group size and time limitations (60 minutes). General content of statements are listed in Table 3.

Table 3: Expectations of Participants in Cultural Competency/Health Literacy Training Sessions

Semi-Interactive Session January 6, 2016	Interactive Session April 9, 2016
✓ Increased awareness of cultural diversity ✓ How our own values and perceptions interact with or affect our perceptions of others values and beliefs ✓ Skills to work with diverse populations ○ Increase level of awareness ○ Increase level of diversity ✓ Increase comfort level ✓ Impart outside the box thinking to providers (social determinants of health) ✓ Provide a larger context ○ To ask the questions rather than make assumptions	✓ How to understand patient cultural background and how it impacts on health ✓ More information about health literacy and the connection to cultural competency ✓ Working diverse population ○ Arabic ○ Culturally diverse ○ Mental health/substance abuse issues ✓ Help patients help themselves/ address barriers to patient compliance ✓ Share more, work as a team ✓ No idea ✓ Here to learn- open!

** Expectations were not asked at the didactic session due to group size and time constraints*

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RESULTS

Outcome Evaluation Summary

- OVERALL PERCEPTION: Nearly all respondents provided ***positive feedback*** about the training as a whole and the specific components of it. On a scale of 1-5, the average score was between 4 and 5 for all agenda items covered in the training.
- KNOWLEDGE AND AWARENESS: The activities in the session resulted ***in statistically significant positive changes in reported knowledge/awareness*** of social determinants of health and structural competency.
    - Participants in all training types increased their knowledge of **Social Determinants of Health**. The change was highest for the small group (though not statistically significant; likely due to small sample size).
    - There is no statistically significant difference in the frequency with which respondents report asking about social determinants of health. This will make follow-up comparison between the groups possible. For example, trainees in the different training types can be asked this same question in a few months to determine if the training had varying levels of lasting impact of reported behavior.
    - None of the groups were very familiar with the concept of **Structural Competency** prior to the training. Training increased knowledge/awareness substantially and significantly.
    - Awareness of **Health Literacy** increased in the two groups who were asked at pre and post training. It was statistically significant for the didactic group and not for the small interactive group, likely due to small sample size.
- PERCEPTIONS INCREASINGLY ALIGN WITH TENETS OF CULTURAL/STRUCTURAL COMPETENCY:
    - Agreement with statements reflecting an understanding of key components of health literacy and structural/cultural competency ***increased in all groups for most of the statements***. The least amount of change was seen in the level of agreement to the statement "The differences in power experienced by the provider and the patient affect how well they communicate." This may indicate a need to increase the discussion/content about privilege and power in future trainings.

      Statements on pre and post tests included:

      When I am listening to a patient or client and something they say does not seem to make sense in the situation, I often try to think of more than one possible interpretation

      Effective communication is possible even when the provider and patient do not speak the same language.

      The differences in power experienced by the provider and the patient affect how well they communicate.

      There are many social and structural influences that are related to an individual's health status.
    - Disagreement with statements that reflect a lack of understanding of key components of health literacy and structural/cultural competency ***increased in the semi-interactive and small interactive***

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groups but not substantially or at all in the didactic group. The other two training types allowed for the sharing of opinions/perspectives. The lack of this opportunity in the didactic group may have resulted in this lack of change.

Statements on pre and post tests included:

- *I feel it is possible for someone who is very aware and conscientious to completely eliminate his or her own prejudices or biases about people that they encounter.*
- *For the most part, an individual is responsible for his or her own health status.*
- *Once an organization's staff has gone through cultural competency training, the leadership can assume that there will no longer be any instances of cultural misunderstandings or provider insensitivity.*

- TRAINING EFFECTIVE WITH HEALTHCARE PROVIDERS AS WELL AS OTHERS: Changes in awareness and understanding occurred among ***those who provide direct healthcare as well as respondents who did not***.
- RECOMMEND TRAINING: ***Nearly all respondents said they would recommend this training to others***.
- DESIRE LONGER AND MORE TRAINING: Respondents frequently commented that they would like ***to have a longer training session and/or more trainings*** with this team in order to go more in depth in the topic and discuss example/scenarios to assist with implementing skills and knowledge.
- ENJOY INTERACTIVE TRAINING AND RECOGNIZE IMPORTANCE OF MATERIAL: A ***majority of comments*** expanding on their ranking reflected the participants' ***appreciation for the interactive nature*** of the training (e.g. opens your mind to experiences and opinions outside your own") as well as the importance of the content (e.g. "our city needs this – our society needs this").

Outcome Evaluation Details

Training Agenda Feedback

Quantitative:

Following the session, participants ranked the different components of the training agenda. On a scale of 1-5 with 5 being the highest, respondents ranked the Welcome/Expectations activity 4.4, the Hearing and Listening activity 4.7, Health Literacy 4.5, Cultural Competency 4.5 and Structural Competency 4.5 (Table 4). Because the agenda and format of content varied by group, the evaluation questions varied slightly. For example, rather than asking about cultural or structural competency in the small group, the survey asked about the specific activities that related to these topics (understanding assets and understanding privilege). Rankings of these activities were also good – between 4.3 and 4.5. The highest ranking was given to "Stories from the Field" which involved the sharing of examples in which an understanding of communication strategies and cultural differences affected the way care was delivered.

Table 4: Ranking of Training Agenda by Training Group Type

	Small Group	Semi-Interactive Group	Didactic Group	All Groups Combined
Welcome/Expectations (n=132)	4.6	4.2	4.5	4.4
Communication/Listening (n=132)	4.7	4.6	4.8	4.7
Health Literacy (n=85)	4.4	NA	4.6	4.5
Cultural Competency (n=118)	NA	4.3	4.6	4.5
Structural Competency (n=70)	NA	NA	4.6	4.6
Understanding Assets (n=14)	4.3	NA	NA	4.3
Understanding Privilege (n=14)	4.5	NA	NA	4.5
Summary/Overview (n=14)	4.4	NA	NA	4.4
Social Determinants of Health (n=71)	NA	NA	4.6	4.6
Health Equity (n=71)	NA	NA	4.7	4.7
Stories from the Field (n=71)	NA	NA	4.8	4.8

Qualitative:

Participants responded to open-ended questions about what they liked the best, whether and how it will impact their work and what specific recommendations they have for the training team.

<u>Liked Best</u>

Participants in the didactic session overwhelmingly commented on the examples and stories provided during the training sessions ("personal stories-gives a different perspective"). In comparison, participants in the small group session mostly commented on the interactive nature of the small group training as a highlight ("small setting, interaction, and group dialogue"). The information in general was appreciated by many respondents and the listening exercise was eye-opening to several respondents who had previously thought of themselves as good listeners. Respondents also mentioned that the content was

understandable; they liked that it would help them better connect to patients and think about the many environmental factors affecting their lives.

Impact of Participation

Nearly half of the responding participants indicated that they would become better listeners or listen more intensely with their patients. This was a common response in all training group types. Participants also stated that they now had increased awareness about their patients' experiences and will help them "explore barriers to care more thoroughly." Interestingly, participants in the small group setting also stated that it increased their awareness about their colleagues' own personal views. Many said that they would ask about social determinants more frequently (e.g. housing, food access, etc.). Others said that it reinforced knowledge or served as a good reminder. Finally, several respondents in the two less interactive sessions stated that it was good, but they needed more ("look forward to setting up a training at our office") and they liked the interactive nature of it ("face time with others - listening to others' thoughts"). See Table 5 for additional comments by theme.

Table 5: Participants Responses to "How has your participation in this training impacted you? What will you take back and apply to your daily work?"

Theme	Example Comments
Awareness/Conscious	• I feel more aware of the biases I may already have • Opens thought processes when dealing with others • Try to be more aware and sensitive to others • I will try to put myself in my patients shoes and ask them more about their social and financial situations and environments
Listening	• Hearing and listening are two different things • I will try to listen more intently • Listen more and assume less • Taking more time to listen and be more aware of patients environment and impact on their health
Learned	• Helped learn more about cultural competency. • Interesting to think of situation in a new way.
Reinforced Knowledge	• Reinforced previous knowledge. • Reiterates my view on motivational interviewing and how necessary 2-way communication is • Remind coworkers of importance of differences
Interactive	• Face time with others - listening to others' thoughts. • It was very eye opening. It also showed me that even though staff has their own personal views they still treat patients great
Need More	• Good - skimming the surface. • Great impact, would love more knowledge

Specific Feedback for Training Team

Nearly half of those responding to this question indicated that they thought the content and delivery was all "great" or "excellent." The most common comment was that they needed more time; this was even common among those participating in the longer more interactive session. In addition to more time and more in-depth sessions, many said they needed more training sessions with additional content concerning how to put the tools learned into practice. Respondents wanted more stories from the field as well as more examples or scenarios about how to implement new skills (e.g. listening, addressing health literacy) and more sources for referral. Participants mentioned wanting interaction and role play opportunities. Finally, a few participants offered suggestions to clarify the questions in the 4-corners exercise (statements to which the participants agree or disagree and discuss), use of a microphone in bigger spaces to hear other participants, providing pre-reading, and making sure to wear nametags.
The following sections summarize the comparison of evaluation surveys between the three piloted training types.

Knowledge/Experience with Concepts of Cultural/Structural Competency and Health Literacy

Quantitative:

SOCIAL DETERMINANTS OF HEALTH: In the pre and post session evaluation, participants indicated the extent to which they were familiar with the concept of social determinants of health. Responses ranged from Not At All (1) to Very Aware (5). Analysis of all participants in all trainings found that the mean of the responses increased from 4.21 to 4.35, reflecting that most respondents were somewhat aware of social determinants of health and there was a slight increase in awareness after the training. Between 4% and 7% pre-training indicated they were not aware or had heard the term. Post training, 0% reported this. In the small group, the number saying they were somewhat or very aware increased the most (86% to 100%) compared to the semi-interactive group (81% to 92%) and the didactic group (87% to 92%). The mean also increased the most in the small group (4.21 to 4.5) compared to the semi-interactive group (3.98 to 4.13) and the didactic group (4.13 to 4.29). Paired samples t-tests found that the change in the small group was not statistically significant and that it was statistically significant for the semi-interactive group and for all groups combined (Table 6).

Table 6: To what extent are you aware of the SOCIAL DETERMINANTS OF HEALTH (one's housing, food, income, relationships, neighborhood, etc.)?

	Small Group – 120min (n=14) (p=0.365)		Semi-interactive- 90min (n=49) (p=0.028)		Didactic -60min (n=82) (p=0.165)		All Pilot Training Groups (n=135) (p=0.002)	
Response	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
Not At All	0%	0%	0%	0%	2.40%	0%	1.4%	0%
Have Heard The Term	7.1%	0%	4.20%	0%	2.40%	0%	3.4%	0%
A Little Aware	7.1%	0%	14.60%	8.20%	8.4%	8.50%	10.3%	7.6%
Somewhat Aware	42.9%	50%	60.40%	44.90%	53%	53.70%	54.5%	46.8%
Very Aware	42.9%	50%	20.80%	46.90%	33.7%	37.80%	30.3%	39.1%
Mean (Scale 1-5)	*4.21*	*4.50*	*3.98*	*4.13*	*4.13*	*4.29*	*4.21*	*4.34*

ASK ABOUT SOCIAL DETERMINANTS OF HEALTH: Participants were asked whether they routinely ask about social determinants of health when (if) they see patients. About 62% of respondents who see patients (n=57/92) indicated that they ask about social determinants most of the time or always (Table 7). This varied slightly by training group, with participants in the didactic group having the greatest tendency to do so and those in the small group having the least tendency to do so. An ANOVA test found that the difference between these groups was not statistically significant.

Table 7: If you are a health care provider, about how often do you ASK YOUR PATIENTS ABOUT THEIR SOCIAL DETERMINANTS OF HEALTH?

	Small Group – 120min (n=9)		Semi-interactive- 90min (n=22)		Didactic -60min (n=61)		All Pilot Training Groups (n=92)	
Response	**N**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Not at all	1	11.1%	0	0%	1	1.60%	2	2.2%
Rarely	0	0%	4	18.18%	3	4.90%	7	7.6%
Some Of The Time	4	44.4%	5	22.73%	17	27.90%	26	28.3%
Most Of The Time	3	33.3%	10	45.45%	31	50.80%	44	47.8%
Always	1	11.1%	3	13.64%	9	14.80%	13	14.1%
Mean (Scale 1-5)	*3.00*		*3.33*		*3.46*		*3.38*	
Mean difference between groups not statistically significant: ANOVA test, p=0.411								

STRUCTURAL COMPETENCY: Similarly, participants were asked to rank their level of awareness about the concept of structural competency.
Overall, at the start of the sessions, awareness was relatively low, with 21% indicating somewhat or very aware (average ranking of 2.42). At the end of the sessions, the average awareness ranking increased to 3.8; 74% indicated they were somewhat or very aware of the concept. The greatest increase in awareness occurred in the small group, where the mean ranking of awareness increased from 2.29 to 3.7 (1.41 points) compared to the semi-interactive group (1.38 point change) and the didactic group (1.31 point change). A paired samples t-test found that this increase was statistically significant in all participants with a p-value of <.001 (Table 8). In the pre-training survey, 43% of those in the small group indicated they were not at all aware of the term structural competency compared to 27% in the semi-interactive group and 25% in the didactic group. This decreased to 0-1% in the post-training survey.

Table 8: To what extent are you familiar with the concept of STRUCTURAL COMPETENCY?								
	Small Group – 120min (n=14) (t-test; p<0.001)		Semi-interactive-90min (n=49) (t-test; p<0.001)		Didactic -60min (n=82) (t-test; p<0.001)		All Pilot Training Groups (n=145) (t-test; p<0.001)	
Response	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
Not At All	42.9%	0%	27.10%	0.00%	24.70%	1.20%	27.3%	.7%
Have Heard The Term	14.3%	0%	27.10%	6.10%	17.30%	0%	20.3%	2.1%
A Little Aware	14.3%	28.6%	27.10%	22.40%	37%	22%	31.5%	22.8%
Somewhat Aware	28.6%	71.4%	16.70%	59.20%	19.80%	64.60%	19.6%	63.4%
Very Aware	0%	0%	2.10%	12.20%	1.20%	12.20%	1.4%	11%
Mean (Scale 1-5)	*2.29*	*3.7*	*2.40*	*3.78*	*2.56*	*3.87*	*2.42*	*3.81*

HEALTH LITERACY: The didactic and small group participants were asked about their familiarity with the concept of health literacy. This reflected a change in the survey tool following the first pilot training to reflect the aims of the training more accurately. Those reporting that they had no awareness or had heard the term decreased from about 14% in both groups to 0-1%. The mean ranking increased from 3.21 to 3.75 (.54 points) in the didactic group and from 3.07 to 3.43 (.36 points) in the small group. A paired samples t-test found that the change was statistically significant for the didactic group (p<0.001) but not the small group (Table 9).

Table 9: To what extent are you familiar with the concept of HEALTH LITERACY? *(*not asked at Interactive 90 min session)*				
	Didactic -60min (n=72) (t-test; p<0.001)		Small Group – 120min (n=14) (t-test; p=0.174)	
Response	**Pre**	**Post**	**Pre**	**Post**
Not At All	6.10%	1.20%	14.3%	0%
Have Heard The Term	8.50%	0%	0%	0%
A Little Aware	43.90%	30.90%	50.0%	28.6%
Somewhat Aware	36.60%	56.80%	35.7%	71.4%
Very Aware	4.90%	11.10%	0%	0%
Mean (Scale 1-5)	*3.21*	*3.75*	*3.07*	*3.43*

CHANGE IN PERCEPTION FROM PRE TO POST: The pre and post session evaluations also included seven statements related to cultural and structural competency. Respondents indicated their level of agreement on a scale of 1-5. For questions 1, 3, 6 and 7, a higher level of agreement reflects a stronger affinity or understanding of the key components of cultural/structural competency. For questions 2, 4, and 5, a higher level of disagreement reflects a stronger affinity or understanding of cultural/structural competency. Changes in the level of agreement to the statements varied by training group type and size. In response to ***whether they try to think of more than one possible interpretation when listening to a patient,*** the level of agreement with that statement increased by nearly 29 percentage points for the small group, not at all for the semi-interactive group and by about 11 percentage points for the didactic

group. It was only statistically significant for the didactic group, likely due to the small sample size of the small group (Table 10).

Table 10: Pre and Post Training Agreement with Statements Aligning with Cultural Competency/Health Literacy

Agreement with statements 1,3, 6, and 7 reflects affinity for/understanding of cultural/structural competency.	Group Type	Agree/ Strongly Agree Pre-Session	Agree/ Strongly Agree Post-Session	Change	Statistical significance of difference from pre to post (t-tests)
1. When I am listening to a patient or client and something they say does not seem to make sense in the situation, I often try to think of more than one possible interpretation.	Small Group (n=14)	64.3% Mean=3.5	92.9% Mean=4.0	28.57%	n.s
	Semi-interactive (n=49)	87.80% Mean=4.12	87.80%* Mean=4.10	0.00%	no change
	Didactic/Lecture (n=81)	84.30% Mean=4.13	95.10%* Mean=4.45	10.80%	p<.001
	All Pilot Trainings (n=135)	Mean=4.05	Mean=4.30		p<.001
3. Effective communication is possible even when the provider and patient do not speak the same language.	Small Group (n=14)	69.2% Mean=3.62	78.6% Mean=3.85	9.34%	n.s
	Semi-interactive (n=49)	51.00% Mean=3.27	71.40% Mean=3.61	20.40%	p<.01
	Didactic/Lecture (n=81)	37.10% Mean=3.05	73.20% Mean=3.68	36.10%	p<.001
	All Pilot Trainings (n=132)	Mean=3.16	Mean=3.70		p<.001
6. The differences in power experienced by the provider and the patient affect how well they communicate.	Small Group (n=14)	53.8% Mean=3.23	50.0% Mean=3.46	-3.85%	n.s.
	Semi-interactive (n=49)	63.20% Mean=3.61	63.20% Mean=3.59	0.00%	n.s.
	Didactic/Lecture (n=81)	58.80% Mean=3.51	65.80% Mean=3.63	7.00%	n.s.
	All Pilot Trainings (n=130)	Mean=3.52	Mean=3.60		n.s.
7. There are many social and structural influences that are related to an individual's health status.	Small Group (n=14)	92.9% Mean=4.23	100.0% Mean=4.57	7 14%	n.s.
	Semi-interactive (n=49)	95.90% Mean=4.39	100.00% Mean=4.57	4.10%	n.s.
	Didactic/Lecture (n=81)	96.40% Mean=4.50	98.80% Mean=4.72	2.40%	p<.01
	All Pilot Trainings (n=134)	Mean=4.47	Mean=4.67		p<.001

The perception about the ***possibility of effective communication with patients who do not speak the same language*** improved from pre to post training in all groups (3.16 to 3.7, $p<0.001$). The change was greatest in the didactic group; however this group also started out with the lowest level of agreement with this

statement (37% compared to 51% in the semi-interactive group and 69% in the small group). At post training, agreement with this statement was highest in the small group (nearly 79% compared to 71% in the semi-interactive group and 73% in the didactic group). The change in agreement was statistically significant for the semi-interactive and didactic groups but not the small group (Table 10).

Reflecting on ***whether differences in power experienced by provider and patient affect how well they communicate***, the level of agreement to this statement did not change significantly from pre to post in any of the training groups (Table 10). Overall, mean agreement increased from 3.52 to 3.6, which trends in the anticipated direction; however those agreeing or strongly agreeing to the statement stayed the same in the semi-interactive group, increased slightly in the didactic group, and decreased slightly in the small group. None of the changes were statistically significant.

In response to the statement "***there are many social and structural influences that are related to an individual's health status***" there was a high level of agreement at the start among all training participants (Mean =4.47). Agreement increased to nearly 100% of respondents agreeing in all groups (Mean = 4.67). This increase was statistically significant. The level of agreement was the lowest at pre-training in the small group (93%) compared to 96% in the semi-interactive and the didactic groups. This left slightly more room for increase; 7 percentage points compared to 4 and 2.4 in the semi-interactive and didactic groups. The change was statistically significant for these latter to groups but not the small group (Table 10).

As previously stated, for questions 2, 4, and 5, a higher level of disagreement reflects a stronger affinity or understanding of cultural/structural competency.

In response to ***whether someone can completely eliminate his or her own prejudices or bias***, responses at pre-training varied by group, 36% of those in the small group disagreed with this statement compared to 45% in the semi-interactive group and about 21% in the didactic group. The change was the greatest among participants in the semi-interactive group (28.6 percentage points) and there was no change in the didactic group. The difference from pre to post was significant for the semi-interactive group, approached significance for the small group, and was not significant for the didactic group (Table 11).

Respondent agreement about ***whether an individual is responsible for his or her own health status*** decreased slightly from pre to post training in all groups. The change was the greatest in the small group (disagreement increased from 15% to 38%), followed by the semi-interactive group (23% to 32%) and the didactic group (17% to 20%). None of the changes were statistically significant (Table 11).

Table 11: Pre and Post Training Disagreement with Statements Not Aligning with Cultural Competency/Health Literacy					
Disagreement with statements 2, 4, and 5 reflects affinity for/understanding of cultural/structural competency.	**Group Type**	**Disagree/ Strongly Disagree Pre-Session**	**Disagree/ Strongly Disagree Post-Session**	**Change**	**Statistical significance of difference from pre to post (t-tests)**
2. I feel it is possible for someone who is very aware and conscientious to completely eliminate his or her own prejudices or biases about people that they encounter.	Small Group (n=14)	35.7% Mean=3.29	42.9% Mean=2.86	7.14%	*p=.054*
	Semi-interactive (n=49)	44.90% Mean=2.84	73.50% Mean=2.20	28.60%	p<.001
	Didactic/Lecture (n=81)	20.50% Mean=3.40	19.70% Mean=3.47	-0.80%	n.s.
	All Pilot Trainings (n=134)	Mean=3.24	Mean=2.91		p<.001
4. For the most part, an individual is responsible for his or her own health status.	Small Group (n=14)	15.4% Mean=3.77	35.7% Mean=3.00	20.33%	n.s
	Semi-interactive (n=49)	22.50% Mean=3.10	31.80% Mean=2.65	9.30%	n.s.
	Didactic/Lecture (n=81)	17.10% Mean=3.62	19.50% Mean=3.78	2.40%	n.s.
	All Pilot Trainings (n=131)	Mean=3.47	Mean=3.47		n.s.
5. Once an organization's staff has gone through cultural competency training, the leadership can assume that there will no longer be any instances of cultural misunderstandings or provider insensitivity.	Small Group (n=14)	71.4% Mean=2.36	78.6% Mean=2.29	7.14%	n.s.
	Semi-interactive (n=49)	85.70% Mean=1.82	95.90% Mean=1.59	10.20%	p<.05
	Didactic/Lecture (n=81)	61.80% Mean=2.25	64.20% Mean=2.35	2.40%	n.s.
	All Pilot Trainings (n=133)	Mean=2.08	Mean=2.01		n.s.

Finally, ***regarding whether an organization that has gone through cultural competency training can assume that there will be no more cultural misunderstandings***, the level of disagreement increased in all groups. The greatest change was seen in the semi-interactive group, though they already had a relatively high level of disagreement with the statement at the start. Disagreement to the statement increased in the small group from 71% to 79% and from 62% to 64% in the didactic group. The change was only statistically significant in the semi-interactive group (Table 11).

COMPARISON OF IMPACT ON HEALTHCARE PROVIDERS AND NON-HEALTHCARE PROVIDERS: CPWNY PPS aims to conduct CC/HL training sessions with personnel in healthcare facilities as well as associated community based organizations. For this reason, the impact of the training was compared by whether the

participants were healthcare providers or not. This demonstrates the generalizability of the training to numerous settings and contexts.

Responses to the statements were compared between the participants who indicated they see patients and those who did not. This was based on the responses to the question "If you are a health care provider, about how often do you ask your patients about their social determinants of health?" Respondents who said "Not applicable" were coded as non-healthcare providers and respondents who answered the question were coded as healthcare providers. There were a total of 40 non healthcare providers and 92 healthcare providers; 13 participants did not answer the question.

At pre-training, there were three questions for which there was a statistically significant difference in response among healthcare providers compared to non-healthcare providers. Non healthcare providers were less likely to agree with statements that did not align with principles of cultural competency and health literacy. Specifically, non-healthcare providers were less likely from the start to agree that one could eliminate their bias with enough effort, that an individual is responsible for their health status, and that an organization, once trained in CC/HL can assume there will no longer be instances of cultural misunderstandings or insensitivity. Conversely, healthcare providers were more likely to agree with these statements at pre-training.

There were statistically significant changes in both groups for several of the statements. Table 12 shows the p-values for the statements for which participants' mean responses changed significantly. Questions 3, 7, and 2 changed positively in both groups; mean response to question 1 changed positively only for the direct healthcare providers. Also of note, while there were differences between the groups at pre-training in responses to questions 2, 4, and 5, this difference was maintained only for question 2 (feel it's possible to eliminate bias). This may indicate that the training was able to bring participants up to a similar level of understanding even when they started at different levels.

Table 12: Comparison of Training Impact on Healthcare Providers and Non-Healthcare Providers								
Agreement with statements 1,3, 6, and 7 and Disagreement with statements 2, 4, and 5 reflects Improvement	Non direct healthcare providers				Direct Healthcare Providers			
	Pre	Post	Change	Sig. (t-tests)	Pre	Post	Change	Sig. (t-tests)
1. When I am listening to a patient or client and something they say does not seem to make sense in the situation, I often try to think of more than one possible interpretation.	4.000	4.175	0.175	n.s.	4.036	4.337	0.301	**p=.001**
3. Effective communication is possible even when the provider and patient do not speak the same language.	3.000	3.538	0.538	**p=.003**	3.259	3.790	0.531	**p=.000**
6. The differences in power experienced by the provider and the patient affect how well they communicate.	3.700	3.850	0.15	n.s.	3.481	3.519	0.038	n.s.
7. There are many social and structural influences that are related to an individual's health status.	4.375	4.625	0.25	**p=.006**	4.537	4.683	0.146	**p=.045**
2. I feel it is possible for someone who is very aware and conscientious to completely eliminate his or her own prejudices or biases about people that they encounter.*#	2.800	2.375	-0.425	**p= .013**	3.398	3.120	-0.278	**p=.021**
4. For the most part, an individual is responsible for his or her own health status.*	3.200	3.275	0.175	n.s.	3.638	3.613	-0.025	n.s.
5. Once an organization's staff has gone through cultural competency training, the leadership can assume that there will no longer be any instances of cultural misunderstandings or provider insensitivity.*	1.800	1.775	0.538	n.s.	2.160	2.037	-0.123	n.s.
* indicates the difference between the non-healthcare providers and the healthcare providers mean response is statistically significant at pre-training (independent samples t-test; p<0.05) #indicates the difference between the non-healthcare providers and the healthcare providers mean response is statistically significant at post-training (independent samples t-test; p<0.05)								

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CONCLUSION AND RECOMMENDATIONS

As illustrated in the chronic care model (Figure 1) and what is driving the patient centered medical home movement, patient engagement in their care is critical to improved health outcomes. According to a report on patient engagement, "Asking patients and families what matters most to them is critical to engaging them in care" (Scholle et al, 2010). Patients engaged in their care are more likely to ask questions to clarify their treatment plans and are more likely to trust the decisions and recommendations of their care team. While this requires effort on both the side of the provider team and the patient, the providers are in the position to initiate the change and create a climate at the practice that is conducive to partnership. Better patient engagement requires communication and information sharing. An understanding of variations in health literacy and the social/structural determinants that impact access to resources and opportunities for health will improve the provider's ability to connect with the patient, to meet the patient where they are and to make recommendations that are responsive and considerate of the patient's context and life circumstances.

Training plans for Clinicians

Recommendations for Process and Format

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

- **Create opportunities for interactive formats and story sharing.** In this pilot, participations that did not have an interactive format asked for more time and more interaction. Even those who did receive training in an interactive format asked for more time and more interaction.
- **Include face-to-face interaction and discussion of biases and stereotypes in a safe, non-judgmental environment. This requires small groups and trainers who are skilled in facilitating group process on difficult topics.** It appears from this pilot (as well as other research) that cultural competency and health literacy programs have greater impact when such elements are included. Small groups allow for expressions of feeling and personal sharing, where participants commented that they would not have disclosed their own personal experience in a large group of people, but that the intimate nature of a small group allowed for this vulnerability and self-reflection. This benefited the whole group as well as the individual who shared his/her experiences.
- **When larger groups are necessary, including interactive opportunities (e.g. as our listening activity and "4 corners" exercise did) and narratives or "stories from the field".** This training allowed for a team of community members/Community Health Workers, supervisors and leaders in community-based organizations, a PhD, and an MD. Additionally, in the interactive and semi-interactive trainings, diverse members of healthcare teams were present (physicians, nurses, IT specialists, etc.) Various perspectives and experiences from the community as well as inside the healthcare system broadened participants' perspectives. Participatory activities and story-sharing substantially enhanced the training experience for respondents.
- **ALL healthcare professionals should have basic "core competencies" related to health literacy and cultural competency.** It has been standard practice to train different healthcare providers separately and differently, however this evaluation demonstrates the impact of this training

approach on both healthcare providers and non-healthcare providers. While various members of the care team may need to apply basic knowledge and skills in these concepts differently, there is great value in having a universal approach to creating culturally competent practices and organizations. Additionally, diverse professionals learn from one another when opportunities are created to share their experiences, needs, and assets with one another. Alignment of the approach and commitment to a consistent experience for a patient between the front office staff, nurse, physician, and anyone else that touches the patient is critical.

- **To test impact of training in the future, patients should be surveyed to see if care is delivered to them in accessible, responsive ways; and providers should continue to help drive the format through which they receive information and training.** This may include analysis of already implemented patient satisfaction surveys and a review of patient outcomes relative to screening and disease management.

Recommendations for Content

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

For all segments of the PPS workforce (clinicians and others as appropriate): effective patient engagement approaches

- **Listening and two-way communication are foundational skills for health literacy and cultural competency.** Teaching and training providers on the myriad aspects of personal, family, and community cultural dynamics is difficult if not impossible. Building skills around effective listening and how to build effective, trusting relationships with patients is simpler, less time-intensive, and more impactful. Motivational interviewing, trauma-informed care, and other frameworks that support effective listening and understanding are becoming more well-established in the healthcare field, and should be integrated into health literacy and cultural competency when possible.
- **Providing simple definitions, visuals, checklists, tool, and resources can help both patients and providers to understand one and other better.** Experiential and participatory learning should ALSO have clear learning objectives and be supplemented with simple but high-quality content, which will be more effective and relevant when paired with a high-quality training experience using multiple modes of learning (including interactive activities and story-sharing). Online learning resources from quality, research-based sources (i.e. Institute of Medicine, Institute for Healthcare Improvement, American Medical Association, SUNY Albany School of Public Health) are also helpful supplements. In some ways, more is less here, as streamlined and usable definitions and tools are more likely to be remembered and utilized.
- **Structural competency, health equity, and social determinants of health are critical overarching concepts that must be integrated into health literacy and cultural competency.** Ample research shows that the correlation of health status along a cultural, racial, and socio-economic gradient is in large part caused by the unequal distribution of power and wealth. Culturally competent care must be provided with awareness of the circumstances of people's lives—their access to health care, schools, and education, as well as their conditions of work and leisure: their homes, communities, towns, or cities. Understanding and assessing a patient's level of literacy, their

need for translation and interpretation services, and providing care with respect in relation to a particular individual, family, and community's cultural and belief system is essential, however, this is not enough. Healthcare without the context of the structural determinants and conditions of the daily life of the patient (as the patient describes them, not based on assumptions) is necessary to create culturally informed and responsive healthcare settings and providers.

There are significant opportunities as well as challenges to integrating comprehensive and ongoing health literacy and cultural competency training to healthcare organizations, practices, and providers. As providers are being asked to increasingly respond to more measures on a state, federal, and payer level, it is essential that a logic model/theory of change such as we have drafted here (p. 8) is used to assess and measure short term, mid-term, and long term outcomes and impacts.

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

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

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RESOURCES:

U.S. Department of Health and Human Services:
http://health.gov/communication/literacy/quickguide/

Institute for Healthcare Improvement:www.ihi.org

National Center for Cultural Competence: http://nccc.georgetown.edu/

A Physician's Practical Guide to Culturally Competent Care: https://cccm.thinkculturalhealth.hhs.gov/

Structural Competency: http://structuralcompetency.org/

WHO Commission on Social Determinants of Health: http://www.who.int/social_determinants/en/

Prevention Institute: http://preventioninstitute.org

Teaching Tolerance: http://www.tolerance.org/

Unnatural Causes: http://www.unnaturalcauses.org/

SUNY Albany School of Public Health:
http://www.albany.edu/sph/cphce/advancing_cc.shtml

American Medical Association:
https://www.youtube.com/watch?v=BgTuD7I7LG8 *(short version video)*
https://www.youtube.com/watch?v=cGtTZ_vxjyA *(longer version video)*

Institute of Medicine:
http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2016/SDH-Resources/SDHeducation-RiB.pdf

Cultural Competency and Health Literacy (CCHL) Training Strategy all other CPWNY Partners

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

1. **Hospitals, Nursing Homes**

A survey was completed on what was already in place for cultural competency and health literacy at the facilities in our network. Only one hospital had training in place for cultural competency and health

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literacy for staff. Training methodologies were assessed and input obtained from facility education departments on expectations, mandatory trainings currently in place, and assessing effectiveness. It was determined that a comprehensive mandatory interactive video be utilized for all facilities. . It will include pre and post test questions. A team will be convened to put together to either develop the video or search for a comprehensive training video with further assistance, as needed, from Elizabeth Campisi, SUNY of Albany Public Health offerings and the Community Health Worker Network of Buffalo. List of facilities that overlap with the Millennium Care Collaborative PPS have been reconciled so there will not be duplicate efforts.

2. **Community Based Organizations**

List of facilities that overlap with the Millennium Care Collaborative PPS have been reconciled to avoid duplicate efforts. Community Based Organizations will be offered the following choices:

a) Facility based video
b) Webinars that are on the SUNY Albany website: http://www.albany.edu/sph/cphce/advancing_cc.shtml
c) In person trainings that will be contracted with Community Health Worker Network as needed.
d) P2 Collaborative (PHIPS grant recipient) presentations with the collaboration of the DSRIP grant recipients in WNY.

All partners are recommended to do an annual training with attestations sent to the CPWNY PMO office regarding completion of the trainings.

Approved: EGB May 5, 2016

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Milestone #2

Practitioner Engagement Training Program

CPWNY has been engaging the physicians and practices regarding the DSRIP program since 2014. Information regarding the NYS DSRIP program and CPWNY involvement has been proliferated to all our partners. This is evidenced at the Catholic Medical Board, the CHS Medical Staff meeting, all partner offices received a brochure (Attachment A) regarding NYS DSRIP and CPWNY program with participating provider the CPWNY/CMP Clinical Transformation Specialists (NCQA PCMH certified trainers) and Care Management Advisors (R.N.'s certified in Case Management) working with each practice on a 1:1 basis, providing information related to the goals of the DSRIP program. NCQA 2014 Standards in PCMH encompass Patient Centered Access, Team-Based Care, Population Health Management, Care Management and Support, Care Coordination, Care Transitions, DSRIP Performance Measurement and Quality Improvement. CPWNY will insure that the DSRIP goals are achieved by providing information related to projects, for all providers/practices including but not limited to:

A. Electronic Health Records (EHR)

The types of reports an EHR generates is key to helping a practice actively manage patients, track operational indicators, and meet meaningful use (and subsequently PCMH recognition). Depending on the type of report, it can be at the practice or provider level, but starting with the practice level is a good way to identify alerts that require drilling down to the provider level. These data can be powerful motivators for provider change, as providers see how they are performing against the practice as a whole and other providers, as well as positive reinforcement for those exceeding expectations. Training involves office staff, provider—Training conducted by CMP staff super user specialists.

B. Population Health – Population health seeks to improve the health outcomes of a group by monitoring and identifying individual patients within that group. It aggregates data as well as providing a comprehensive clinical picture of each patient. Using that data, providers can track, and hopefully improve, clinical outcomes while lowering costs and identifying patient care opportunities. Training involves clinical staff, providers. Training conducted by CMP staff -- specialists.

C. Practice Management Tools – Practice Management tools provide the capability to create reports such as patients with specific conditions or a patient appointment report. An example of this would be to determine patients with hypertension and have not had a visit in the last 12 months. This would alert a practice to reach out to these patients to close gaps in care. Office managers trained, training conducted by clinical transformation specialists.

D. Analytics – Healthcare organizations are increasingly using analytics to consume, unlock and apply new insights from information. Analytics can be used to drive clinical and operational

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improvements to meet business challenges. From a baseline of transaction monitoring using basic reporting tools, spreadsheets and application reporting modules, analytics in health care is moving toward a model that will eventually incorporate predictive analytics and enable organizations to "see the future", create more personalized healthcare, allow dynamic fraud detection and predict patient behavior. Initially training conducted by Catholic Health IT department -- Training involves CMP staff, office managers /designees/ care managers (clinical staff)

Training in Performance Reporting and Clinical Quality

The CPWNY training program will utilize the CMP Leadership Series. This series builds and assists in the clinical transformation of practices to become "high performing" practices. The program consists of review (completed at the office by the Clinical Transformation and Care Management staff) for those who previously attended classes for attainment of PCMH and it is offered to any new staff at those offices. CMP, as part of an ACO accreditation status, maintains oversight of its practices to insure that the processes in place for the high performing practice are maintained. This type of oversight will continue for partners of CPWNY. CPWNY contracted services of Performance Partners to implement RCE method to practices unfamiliar with PCMH and this model of quality improvement.

Additional Training on Clinical Quality and Performance Reporting

CMP Physician Territory Leads, Clinical Transformation Specialists and Care Management Advisors provide training on quality improvement, RCE, PDSA, , tobacco cessation , treatment protocols , care coordination process, documentation of self-management goals. IT platforms, PCMH, Meaningful use, secure messaging, population health. – audience varies by practice and topic. If the office has a care coordinator nurse then that clinical person is responsible for clinical coordination of care, engagement in self-management with motivational interviewing, guideline adoption. CMP Care Management Advisors teach clinical office staff about community organizations, heath homes, care transitions, tobacco control, guidelines and protocols. CMP social workers assist and teach with CBO warm handoffs, what community organizations are available and how to refer to them. Ongoing training via webinars also occurs.

Training and Education Plan Regarding DSRIP program and PPS Specific Quality Improvement Agenda

1. Contains goals of the DSRIP program and the benefits of an IDS in achieving those goals.

NYS DSRIP Program: Key Goals

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Transformation of the health care safety net at both the system and state level (implementation plans and performance outcomes through CI program and engagement)

•Reducing avoidable hospital use and improve other health and public health measures at both the system and state level (projects and workstreams)

•Ensure delivery system transformation continues beyond the waiver period through leveraging managed care payment reform (sustainability)

•Near term financial support for vital safety net providers at immediate risk of closure

Practitioner Engagement and Training will:

- Enhance an organizational structure with committed leadership, clear governance and communication channels, a clinically integrated provider network, and holistically address the health of the attributed population to reduce avoidable hospital activity. Avoidable hospital activity is defined as potentially-preventable admissions and readmissions (PPAs and PPRs) that can be addressed with the practitioners referring to community-based services and interventions.
- Assist in incorporating medical, behavioral health, post-acute, long term care, social service organizations in the care of the patient– from one that is institutionally-based to one that is community-based.
- Create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services.
- Eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes.

Implementation:

Practitioner training was initiated in 2015 and is ongoing. Catholic Medical Partners IPA initiated the training for CMP board members and the CMP quality committee. As the implementation of the grant progressed, the CPWNY CMO, Dr Santos, had numerous meetings with non-CMP practitioners, focusing on Chautauqua County. As indicated on pages 1 and 2 of this paper, CMP Care Management Advisor staff, Clinical Transformation staff and Territory (Regional) physician leads continue to train the practitioners. CPWNY has contracted with Chautauqua County Health Network (CCHN) to assist in training practitioners (reinforcing the messaging from the CMO) in Chautauqua County regarding DSRIP initiatives and the PPS Quality Improvement Plan.

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DSRIP Program Principles
DSRIP Overview

Patient-Centered	• Improving patient care & experience through a more efficient, patient-centered and coordinated system.
Transparent	• Decision making process takes place in the public eye and that processes are clear and aligned across providers.
Collaborative	• Collaborative process reflects the needs of the communities and inputs of stakeholders.
Accountable	• Providers are held to common performance standards, deliverables and timelines.
Value Driven	• Focus on increasing value to patients, community, payers and other stakeholders.

NYS DSRIP Plan: Key Components

Key focus on reducing avoidable hospitalizations by 25% over five years.

DSRIP Program Elements	Impact on Practices	Forum used to discuss DSRIP program	Measure of Success-PPS Quality Improvement	DRSIP Principles
Organizational components:				
Workforce Strategy	Information needed to ascertain workforce impact – training, hiring,	Letters, Meetings – 1:1 and group	Information expected by the PMO is	Transparent

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	redeployment, unemployment information	Phone calls Newsletters	obtained from practices//New scope of workers accepted by practices	
Governance	Providers are expected to partake in PPS governance structures	Informational and personal outreach to partake and participate	Representation on committees-Involvement around DSRIP ultimate goal of reduction in hospital admissions via success of projects.	Transparent Collaborative Accountable
Cultural Competency and Health Literacy	Must attend a training session; know how to perform an annual assessment; train new personnel as they present.	Interactive in person classes at office or at a central location Video viewing	Patient satisfaction improvement Decrease "no shows' at offices	Patient - Centered
Financial Sustainability and funds flow	Inform on finances , funds flow	Webinars Group presentations such as PAC and Board	Lack of Complaints from partners- project advancement	Value Based Transparent
Performance Reporting	PPS Aggregate reports and provider specific reports- PDSA approach to improvement/competition	Aggregate – Clinical Governance Committee, Website, newsletters, Provider specific – 1:1 meetings to providers needing improvement efforts (by Territory leads, Care Management	Improvement in outcome measures / Process improvement and emphasis on PPS QI Plan	Patient centered; Transparent; Collaborative; Accountable; Value Driven

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		Advisors and Clinical Transformation Staff)		
IT System and Processes	Coordination of care across the continuum (CCD)/ timely patient interventions	Large group introduction; at office will be customized engagement at practices ; newsletters, website	Utilization of IT services; decrease admissions and readmissions to hospital	Patient centered; Value Driven
Population Health Management	Identification of high risk patients with timely interventions; performance incentive	Large group and office custom training	Utilization of population health modules/ performance improvement plans/ Improved patient outcome measures	Patient centered; Accountable; Value Driven
Clinical Integration	Providers expected to identify goals of IDS, Performance and participation incentives	Large group meetings, website info; webinars, newletters and practice training-by care management advisors, territory physician leads and clinical transformation staff	PPS quality plan understood with engaged and involved practitioners; Improved outcome measures based upon the CI plan	Accountable; Value Driven
2ai- IDS	Focus on community based care rather than institutionally based care through collaborative relationships (referral	Large group professionals and 1:1 practice training	Engaged and involved practitioners therefore success in	Patient centered; Transparent; Collaborative; Accountable;

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	agreements) and provides the full continuum of patient care needs, enhancing quality improvement, enhanced primary care. Insure data integrity and compliance.		projects and improved outcome measures	Value Driven
2biii- ED Triage	Demand on practices for increased access abilities to get patients scheduled appointments.	Large group meetings, 1:1 trainings, ED department trainings	Patients establish relationship with physician to avoid ED- improved outcome measures r/t project	Patient centered; Collaborative
2biv- care transitions	Continuity of patient care across the continuum – impacts appointments at PCP	Large group meetings; want provider offices to follow up with patients; website reinforcement	Reduction in readmissions	Patient centered; Transparent; Collaborative; Accountable; Value Driven
2cii - telemedicine	Impacts rural physicians /hospitals. Rural doctors and providers will have assistance in care of the patient with accessible specialty consultations via telemedicine.	Group training of providers at WCA hospital (ED physicians, neuro physicians); As program grows training will encompass other specialties -- training will continue.	Patients do not need to be transferred from rural hospital to receive specialty care; decrease cost; decrease duplicate tests	Collaborative Value driven
3ai – Behavioral health and primary care integration	Survey of practices by care management staff regarding which behavioral health providers they currently work with, if they are	Reach out to practitioners interested in project by the lead of the project –	Facilitates the "no Wrong Door" policy for the practices by having behavioral	Patient centered; Transparent; Collaborative; Accountable; Value Driven

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	satisfied, and if interested in a new provider. Training on depression screening and guideline adherence.	educating about the project, deliverables and expectations; Website, webinars and newletters as reinforcement to training	health services readily available-pts. receiving care. Depression screening process measure improvement	
3bi – cardiovascular health	Practice adoption of protocols and competency trainings on BP – self management by patients with follow up	1:1 practice on Guideline instruction, EMR; website	BP early detection and maintenance of measurement levels-improved control of BP	Patient centered; accountable
3fi – Maternal & Child Health	Impact on OB GYN and pediatric practices – additional resource for at risk mom and children	Engagement of practices for referrals	Decrease ER visits and hospitalizations	Patient centered;
3gi- Palliative care	Presence of palliative care personnel at office; difficult conversations addressed; training value for practices	Engagement of practices for referrals	Decrease ER visits and hospitalizations	Patient centered; value driven
4ai - MEB	More resources and assistance for patients	Provider toolkits	Improved behavioral health interactions; increased awareness of community resources; increased practitioner interventions	Transparent; Collaborative
4bi – tobacco cessation	More resources and assistance for patients	Provider toolkits; engagement of practices for referrals	Engaged Medicaid beneficiaries; Increased awareness of	Transparent; Collaborative

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			community resources; increased practitioner interventions	

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COMMUNITY PARTNERS OF WNY

POLICY AND PROCEDURE

<table>
<tr><td colspan="2">TITLE:
IT Change Management Strategy</td><td colspan="2">POLICY NUMBER:
CMP-001</td></tr>
<tr><td colspan="2">PREPARED BY:
Change Management Strategy Workgroup</td><td colspan="2">POLICY LEVEL:
PPS</td></tr>
<tr><td rowspan="2">APPROVED BY:

Peter Capelli</td><td colspan="2" rowspan="2">RESPONSIBLE DEPARTMENT:

Information Technology</td><td>EFFECTIVE DATE:
7/1/2016</td></tr>
<tr><td>LAST REVISED DATE:
2/10/2016</td></tr>
<tr><td colspan="4">This document is not intended to create, nor is it to be construed to constitute a contract between CHS and any of its Associates for either employment or the provision of any benefit. This policy supersedes any policy previous to this policy for any CHS organizations and any descriptions of such policies in any handbook of such organization. Personnel failing to comply with this policy may subject to disciplinary action up to and including termination and/or appropriate legal action.</td></tr>
</table>

PURPOSE: To define and formalize a process to be used by CHS Information Technology Department (IT) to ensure that there is a consistent method for the intake, review, and approval of all proposed changes to IT tools used by the Community Partners of Western New York PPS (CPWNY). The process categorizes and reviews changes to reduce risk and minimize disruptions. The review process also ensures that changes to applications and systems are well understood, tested, and communicated to the end users.

This policy will outline the CPWNY PPS Change Process, the role of the Data IT Governance Committee (DIGC), and highlight key components of the change process.

SCOPE: This policy focuses on processes and IT solutions under the direct oversight of the CPWNY program. IT processes and solutions owned by partner organizations are not included in this policy. However, the use of this policy applies to any future design that may result in a CPWNY use of systems owned by partners. Any changes the partner owner needs to make are must be coordinated with consideration of use by the CPWNY program (e.g. a data feed or IT application used by the CPWNY but supported by a partner). Modifications to systems owned by partners and used by CPWNY should be coordinated through the Change Control Policy to minimize unscheduled disruptions and to ensure CPWNY can communicate the change to key stakeholders and appropriately coordinate any required change for other dependent systems.

APPLIES TO: All CP-WNY PPS organizations, staff, and those who install, maintain, upgrade or remove IT assets in associated/integrated/interfaced with the CPWNY IT Production environment or Test environment, must adhere to this policy.

POLICY: In order to maximize the benefits and minimize the overall risk for all CPWNY PPS partners, system custodians and end users, the DIGC, under the direction of the CPWNY CIO, created this IT Change Management Strategy (Policy) and supporting procedures that must be adhered to when implementing changes to assets or their configuration items in the CPWNY IT Production environment. A "change" is defined as the introduction of any new asset, a repair, configuration item change or enhancement to any existing asset, or the removal of any asset from the IT production environment.

This policy uses standardized Information Technology Infrastructure Library (ITIL) methods, processes and procedures to manage change and ensure that only authorized changes are promoted to the IT Production environment. Strict adherence to the procedures detailed within this policy is intended to improve the overall reliability, availability, serviceability and functionality of all assets in the IT Production environment, and when properly followed the policy will facilitate a well-organized and prompt handling of change and maintain the proper balance between the need for change and the potential risk/impact of the change.

OVERVIEW: Change Management is primarily a function of the CPWNY DIGC. The change process reduces unexpected and uncontrolled system failures and improved end user preparedness. The CP-WNY Change

Management process provides a documented, repeatable, and predictable process for IT staff to follow that will ensure changes are appropriate and needed. The process requires the Change Requestor to work with the Change Owner to provide documented carefully prepared plans. Change Requestors identify the changes that need to take place and work with a Change Owner to complete requests that contain the following information:

- the need for the change
- which systems which will be changed
- which locations and users will be impacted and what specifically will be changed
- whether the proposed change was tested in a test environment
- whether there is a back-out plan
- how the change is being communicated to the end users

After the CPWNY DIGC has reviewed a proposed change it is either approved or sent back to the Change Owner for additional information.

Because the CPWNY PPS IT infrastructure is primarily hosted by CHS, changes will be coordinated through both the CPWNY DIGC and the CHS CAP (Change Advisory Panel) process. Communication for changes to facilitate communication to end users by publishing approved changes to public calendars and sending announcements to users via email and RSS feeds to most CP-WNY users for changes that will require system downtimes or interruptions.

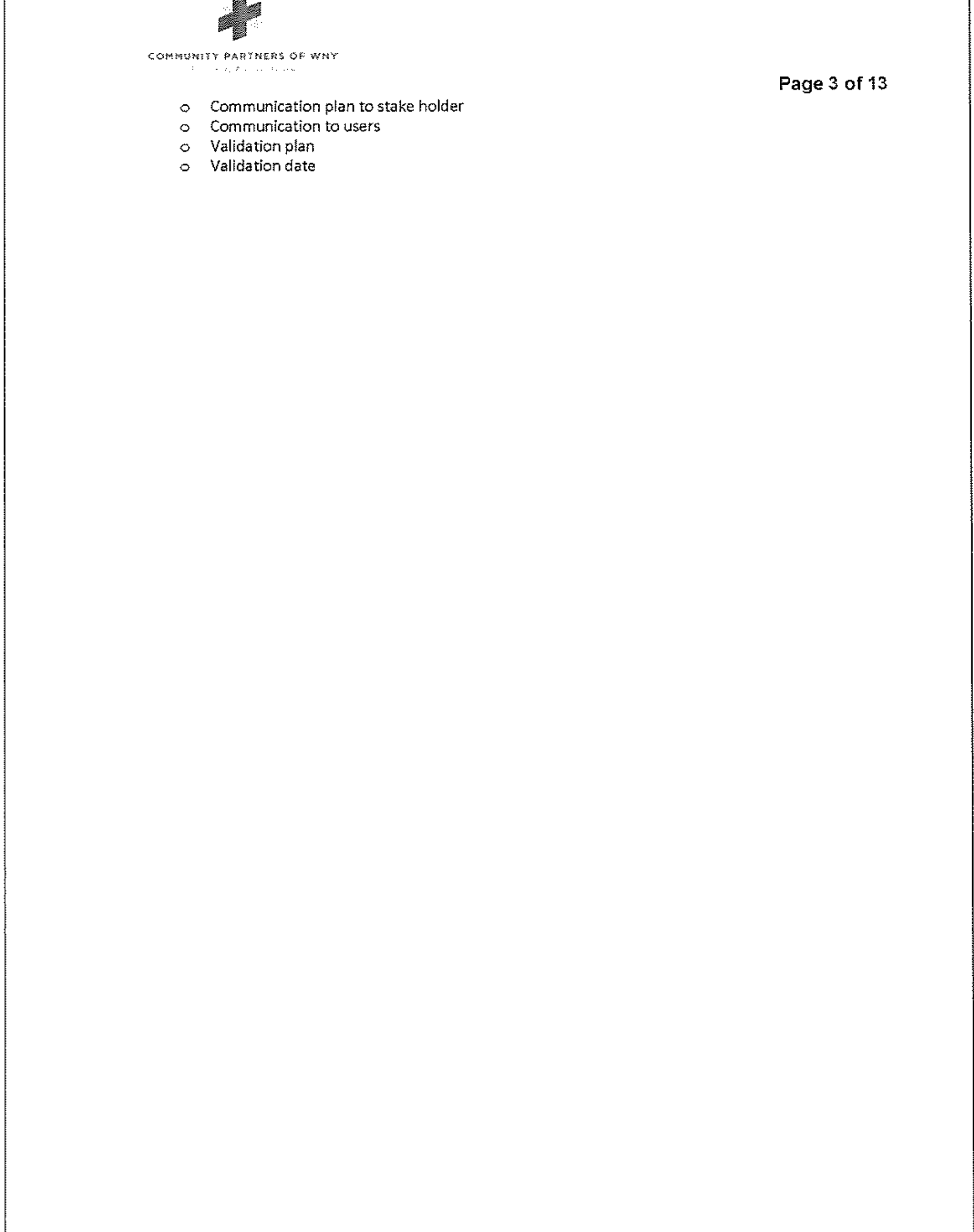
The final step of the Change Management Strategy is for the Change Requestor and a member of the CPWNY DIGC to review and validate completed changes and ensure that change happened as specified. This validation should ensure that changes have been updated and that any problems or incidents arising from the change are addressed.

BUSINESS RATIONALE FOR CHANGES: Requests for changes to CPWNY PPS IT tools can originate from a number of different sources. The following are the more common sources for change requests:

- Required resolution of an incident or problem in the IT Production environment
- Routine maintenance
- End user request for service or solution enhancements
- Government organizations that create new regulatory laws
- IT vendors who provide new products, upgrades, patches and bug fixes
- Business partners and suppliers
- Changes in performance or capacity requirements
- End-of-life cycle

Standard Change Evaluation Criteria (not including pre-approved changes)

- Change Requestor
- Business Owner
- Why change is needed (Rationale)
- What is being changed (Description)
- Who is making change (Owner Team, Assigned to)
- Date and time of change
- Secondary date and time of change
- Summary of change / Detailed description
- Business rationale
- Impacted resource (CI's identified)
- Priority - type of change
    - Non- production emergency / production emergency
    - Scheduled
    - CAP preapproval evaluation
- Locations
- Departments
- Users
- Outage
- Outage duration (cannot be undefined or open ended)
- Downtime announcement needed
- Additional required support for change (teams, helpdesk, vendors, business staff)
- Back out plan
- Test plan/tested


COMMUNITY PARTNERS OF WNY

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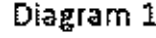
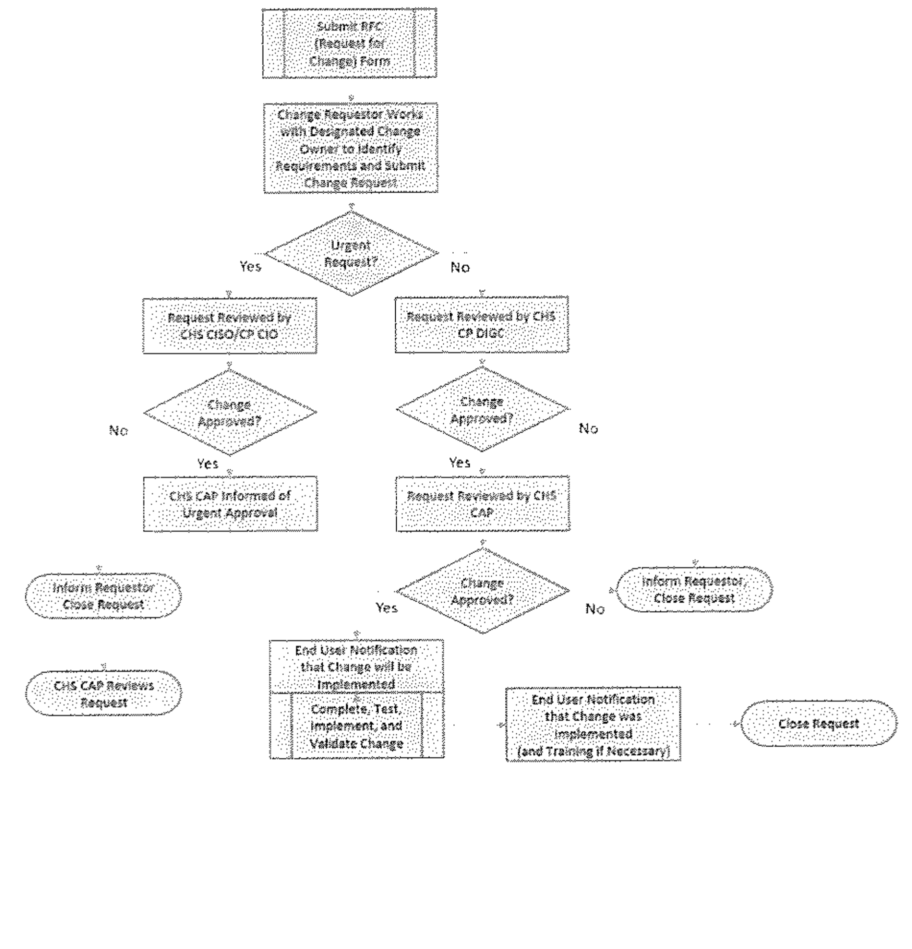
- Communication plan to stake holder
- Communication to users
- Validation plan
- Validation date

CHANGE PROCESS SUMMARY: Once a Business Rationale has been identified, the change process begins with the Change Requestor working with a designee from the Business Analytics Team (Change Owner) to initiate a Change Request ticket. Because the CPWNY PPS is leveraging CHS IT resources, the change must be entered in the ChangeGear ticket management system to enter the review and approval process. If the Change Owner has access to the ChangeGear they will directly enter the request into the system. Submission through the ChangeGear ticketing system ensures that consistent and completed details are entered for each proposed change. The standard evaluation criteria are outlined below.

Change Management Strategy Workflow

Diagram 1





TESTING:

When possible, all changes should be installed and tested in a dedicated test environment or development environment. These environments should be exact copies of the production environment with similar capabilities and duplicable real-world test load. Testing must also include a means of validation or User Acceptance Testing (UAT) to ensure that the intended changes occurred and that the change meets the intended specifications.

This policy acknowledges that all configuration items, applications, or pieces of hardware cannot be tested in a test or development environment. When it cannot be tested the change owner must be prepare and present plans to mitigate this additional risk and describe how the production system would be restored in the event that the change fails or malfunctions. The plan must also include a means of validation or UAT to ensure that the intended changes and specifications are in place and all dependent systems are still functioning to their specification.

Once Testing has been completed successfully, the details in the RFC ticket should be reviewed for accuracy and then the RFC can be submitted through the ChangeGear ticket management system for review by the CAP.

TRAINING PLAN:

Since a change request will affect how things operate in the IT Production environment, the Change Owner is responsible for working with the Change Requestor to determine whether a training plan is necessary so that end users are prepared with the change once it has been deployed. It is expected that the complexity of the training plan will be directly related to the complexity of the change. Training options can range from notification emails describing the change to providing online or in-person training classes. It is expected that the Change Owner will work with the appropriate CPWNY PPS Committee to assess training needs, identify the training strategy, work with identified resources to design the training program, and ensure appropriate training is available to end users.

CPWNY training focus is directed to operational support of current systems and implementation of new systems. Catholic Medical Partners staff supports the efforts of DSRIP PPS in changes to current systems and implementation of new systems. PPS reserves the right to engage community-based organizations in training efforts as required by its needs.

Clinical transformation staff for Catholic Medical Partners support DSRIP training efforts to practice staff (primarily non-licensed staff) inside the PPS. Care Coordination and Management staff from Catholic Medical Partners support efforts directed to provider network with the PPS network. Catholic Health System staff implement additional training as needed for new systems that effect the hospital and provider network (e.g., changes to population health management tools or major EHR changes). A list of current training opportunities and attendees is available for review upon request from DSRIP program staff by contacting Amy White-Storfer, Director, Community Partners of WNY at awhitestorfer@chsbuffalo.org.

COMMUNICATION PLAN:

Effective communication is critical when deploying any type of change in an organization. The goal of the communication plan is to provide a framework for managing and coordinating communication and to obtain business user buy-in and commitment to the success of the RFC. Communication to end-users needs to be relevant, accurate, consistent, and timely. It is expected that the complexity of the communication plan will be directly related to the complexity of the change. Communication plans should include informing end users by leveraging CPWNY communication resources including email distribution lists, standing committee meetings, newsletters, and organizational representatives.

DSRIP program has a formal communication plan and community engagement plan for its PPS network and it is available for review upon request from DSRIP program staff by contacting Amy White-Storfer, Director, Community Partners of WNY at awhitestorfer@chsbuffalo.org.

CHANGE SUBMISSION, EVALUATION, AND APPROVAL PROCESS:

The CPWNY DIGC is responsible for the initial review and approval for all change requests related to CPWNY IT systems. The CPWNY DIGC meets the first Thursday of each month. Change requests should be submitted the previous Monday so that they can be added to the agenda. The Change Requestor should work with Scott Kitchen or a designee from the Business Analytics Team to complete the CPWNY Change Request and submit to the CPWNY CIO for consideration and ensure it is added to the CPWNY DITGC agenda. Because the CPWNY makes use of CHS IT infrastructure to support IT tools, once it has been approved by the CPWNY DIGC the change is submitted to the CHS CAP for review and coordination with other approved system changes.

The CHS Change Advisory Panel (CAP):
The CAP was established to oversee changes and ensure integrity for all systems in the IT Production environment. The CAP members known as Change Control Coordinators (CCCs) serve in an advisory capacity to the Change Control Manager (CCM), who ultimately makes the decision whether to approve a proposed change request. CAP membership is a collection of IT representatives from multiple CHS teams responsible for the oversight and operation of CHS infrastructure, security, and applications. Changes submitted to CAP for review and approval must be submitted by Friday at noon to be reviewed in the weekly CAP meeting on Tuesdays at 11:00a. Approval of the proposed RFC allows the change owner to proceed with the work plan described in the change request.

Emergency Changes:
If a change is urgent and must be completed before the next review and scheduled downtime window, the Change Requestor must contact the CPWNY CIO (or CH CSIO, Chief Security Information Officer) to explain the change. The CPWNY Change Request Form should be completed to provide the CPWNY CIO with required information. If the CIO or CISO approve the change as an emergency change, the Change Requestor must approach the CAP Change Control Manager (CCM) with the approved change for scheduling and execution. If the CIO or CISO do not approve the change as an emergency change, it should be submitted as a non-emergency change through the standard change request process.

<Need to add form>

IMPLEMENTING APPROVED CHANGE REQUESTS

Throughout the process of implementing an approved change request, the change owner is expected to maintain reasonably detailed progress notes and record relevant information. This information should be recorded in the change ticket for historical and audit purposes. Once the work is completed and verified, the status of the RFC should be updated to a status of completed. Any irregularities or specification not within acceptable tolerance must also be noted. The change request will then progress to a validation stage where the ticket details are reviewed and verified by the requestor/end user or member of the CAP for any discrepancies. Discrepancies will be noted and the Change Requestor will work with the CAP to resolve any discrepancies.

CHANGE EVALUATION CRITERIA

Change Requests are evaluated for approval based on the criteria listed below. Consideration is given to the risk, number of users and systems impacted, and required resources.

- **State of IT Production Environment:** The CAP is going to subjectively evaluate the performance and availability of each system in the IT Production environment during the prior weeks as consideration for determining if a particular RFC should be approved. If the IT Production environment has been reliable with few incidents to introduce risk, then the CAP is more likely to approve RFCs that provide new functionality or changes that may have a higher risk of potential failure. However, if incidents affecting system availability have taken place approvals make focus on corrective changes until reliability is achieved.

- **Priority Level:** Priority level is examined as part of the approval process along with the detail information and instructions attached to the RFC. The attachments should detail the associated risk, impact, and urgency of the change. Particularly important are the subjective comments provided by the Change Requestor indicating the rationale for the assigned priority level.

- **Aggregate Effect of All Proposed Changes:** While each of the RFCs that the CAP reviews may pose a low or moderate individual risk, it is possible that the collective risk for all requests within a given downtime window are too high. In these circumstances some changes may be postponed to the next downtime window. The CAP will work with the Change Requestor to identify a schedule for the change if this situation arises.

- **Resource Availability:** The CAP will assess the availability of people, time, and system resources when scheduling and approving RFCs.

- **Criticality:** Many systems share hardware infrastructure, interfaces, or have dependencies on other system(s). The CAP will consider these dependencies during the evaluation process to ensure potential impact is understood and considered. If a potential conflict is detected, the CAP will work with the Change Requestor to identify a solution and ideal schedule for the change.

- **Risk:** Risk evaluates the probability of success with consideration for difficulty and complexity of the implementation, back-out procedures, and potential disruption of business operations associated with implementing the change. Considerations include:

    a. Certainty that the change will be implemented successfully the first time
    b. Confidence that back-out procedures will return the system to prior state if the change is unsuccessful
    c. Successful testing in a test environment before the change is moved to the production environment
    d. Ensure that unrelated items / configuration items have their own RFC and are not being combined

- **Impact:** Analyze the potential overall disruption and inconvenience to the organization due to possible issues introduced by the change that will require resources to resolve. Considerations include:

    a. End-users affected by the change
    b. Time involved to implement the change
    c. Ease of back-out procedure

- **Installation Time:** Consideration for the overall implementation time or recover from a failed change. Changes that cannot be implemented or potentially backed out within a downtime window are evaluated as higher risk and may be considered for alternatives such as potential division into smaller changes.

- **Communication Requirements:** Take into account how many operational sites and/or users must be notified of the change and whether the proposed communication plan is adequate or can be met with available resources (e.g., use of Help Desk to coordinate response, etc.).

- **Documentation:** Assess the degree to which standard operational procedures and other support materials for the change must be updated to adequately describe what has changed.

- **Education and Training Needs:** Consideration for how significant an impact the change will have on end-users and their ability to accommodate the change.

- **Downtime:** Consideration for the overall amount of downtime required and potential impact for operational and clinical areas for the PPS.

- **Additional CAP-Specific Complexity Review Considerations:**
  a. Core Network changes - 2 week notice (must be reviewed in minimally 2 CAP meetings)
  b. OpenLink Changes - 2 week notice (must be reviewed in minimally 2 CAP meetings)
  c. Very large or complex changes may require additional review at more than one CAP meeting
  d. Verification for the following documentation:
     i. Documentation updated
     ii. Scans completed for new equipment (security review)
     iii. Additional configuration items created for new changes or systems
     iv. Edit configuration items for changes
     v. Decommissioning systems

- **Pre-Approved Changes:** Pre-approved changes are used to facilitate and record small administrative or routine changes. Pre-approved changes tend to be low risk, low impact, and smaller in scope. For these reasons the request only requires general details (shorter request process) to record and review the change. If the pre-approved evaluation conditions are met and the CAP agrees, the change will execute as a normal scheduled change. If the change request is low risk and low impact the CAP will approve the evaluation, deeming the change to have pre-approved status. Otherwise the change request will undergo the usual review process.

- **Note:** It is possible that the CAP may provide a conditional approval upon review of a request for change. Most often this is done for the following reasons:
  - A minor detail that CAP would like the Change Requestor to follow up on before a change is deployed
  - In cases of late submission review the CAP may offer to review change requests that do not are submitted past the due deadline in order to avoid a potential emergency change request or unscheduled downtime
  - Depending on other change activity, the change request may be delayed due to a Freeze Window. Freeze windows occur for the following reasons:
    - Staffing /Support concerns during holidays
    - When there is concern that changes could negatively impact or interfere with larger organization or system changes
    - During pending weather emergencies
    - During disasters natural or otherwise

SUPPORTING DOCUMENTATION FOR CHANGE REQUESTS:

1. **User Requirements Specifications:** The Change Owner should work with the Change Requestor to identify, define, and include all functional requirements and specification for the RFC. This ensures that the change requirements are fully understood and can be evaluated before development work begins. These requirements will also be the basis for the final testing to ensure that once the change is made that

it is functioning as expected.

2. **Testing Plan and Test Results:** Change Owners are responsible for creating a testing plan and ensuring changes are appropriately tested in development and or test environment before deployment to production. The testing process may involve user acceptance training and should include testing of any other dependent systems that might be impacted by the change. The test plan and results should be documented throughout the testing process. If testing is not possible in a development or test environment the change owner should identify this as a risk and how the production system(s) can be restored if the change is not successful.

3. **Implementation plan:** The implementation plan should include details about the resources needed, the estimated time to complete, cost estimates, if appropriate, and timelines which include milestones for building, configuring, integrating, and testing the solution.

4. **Back-out plan:** A back-out plan must be developed for each change request in case the change cannot be completed within the expected maintenance window, if the change is unsuccessful, or if the change produces unexpected or unpredictable results in the IT Production environment. The back-out plan should be reviewed as part of the change request review and approval process.

   The back-out plan must detail all the actions that will need to be taken in order to restore the system back to its prior state before implementation. Plans should include a preparation step where a system backup/snapshot is performed prior to any changes being made. The backup should include all configuration and data needed to restore a system to its pre-change state. The back-out / restore plan must also ensure that the back-out plan can be performed within the specified outage/downtime window.

CHS Maintenance Windows

The maintenance window for PPS related changes will follow the currently established principles and guidelines created by CHS. For more information regarding this policy it is available for review upon request from DSRIP program staff by contacting Amy White-Storfer, Director, Community Partners of WNY at awhitestorfer@chsbuffalo.org.

DEFINITION OF TERMS:

Application Developer: Person is responsible for supporting applications and systems providing required functionality for IT services. This includes the development and maintenance of custom applications as well as customizations to off-the-shelf products from external vendors.

Back-Out Plan: A plan that the Change Owner develops which documents all actions that will need to be taken to restore a system configuration to its status prior to the implementation of the change in the event that the move to production fails or produces unexpected or unplanned results. The plan may call for full or partial reversal, and in extreme cases may require the use of IT Disaster Recovery and/or Business Continuity Plans.

Business Owner: Manager or agent responsible for the function which is supported by the change and is responsible for oversight and use of the system(s) and/or business use of the information generated from the system. The Business Owner is also responsible for establishing the controls that provide security. Where appropriate, ownership may be shared by managers of different departments.

Change: In the CHS IT Production environment, a change is defined as the introduction of any new asset or CI, a repair or enhancement to any existing asset or configuration item, or removal of any asset or configuration item from that environment.

Change Advisory Panel (CAP): Cross-functional team that meets weekly to evaluate change requests for business needs, priorities, costs/benefits, and potential affects to other systems or processes. The CAP also makes recommendations for approval for implementation, identifies if further analysis is required, and identifies any need to defer or cancel requests. This team reviews and advises the Change Control Manager on proposed change requests.

Change Owner (Change Builder): This person is responsible for packaging and implementing the change request. The Change Owner works with the Change Control Manager to ensure that all issues surrounding the change have been resolved and communicated to all essential areas, manages the installation of the change as well as back-out if necessary, and updates the Remedy ticket in a timely manner with appropriate status and results.

Change Control: Refers to the process of planning, communicating and executing technology changes into the IT Production environment successful to maintain the highest possible level of service and system availability.

Change Control Coordinator (CCC): Functional role that a team member fulfills when appointed to the CAP. This person documents and submits change requests, is responsible for gathering and documenting details required for impact and risk assessment, ensures that all required signoffs are obtained at each step of the process, ensures that post-implementation review details are added to the change request in an accurate and timely manner, and follows the change through the entire process and recommends revisions or updates as required. This individual also functions in the role of technical expert for their particular area when reviewing all RFCs and is expected to address any technical issues from change requests that overlap into their area of expertise. They also have voting rights on the CAP when reviewing change requests.

Change Control Manager (CCM): Policy guardian for the change management process responsible for standards, issuance and revision of policy, and revisions to procedures and forms. Also executes, manages, and reviews change management process activities on a daily basis. Chairs both the CAP and Emergency CAP teams to ensure that all changes are considered for approval. The CCM can approve minor changes if necessary. The CCM provides training on the change management process and communicates any enhancements or modifications to the process to the entire IT team. The Director of IT Controls serves in this capacity for CHS.

Change Management: The practice of controlling changes to the hardware, software, firmware, data, outputs and documentation to ensure that configuration items are protected against improper modifications before, during and

after system implementation.

Change Owner: The individual within the organization who originates the change request, is responsible for identifying business requirements, drives the proper business justification, and is responsible for the final signoff of a change at post-implementation review.

Change Requestor: Anyone who originates a change request to resolve problems that arise or to address new functionality that is needed in the IT Production environment. The requestor can be anyone internal or external to the organization who needs an IT functionality issue/shortfall addressed within the IT Production environment.

Configuration Item (CI): Includes all the procedures, system documentation, equipment, facilities, software, and data that are designed, built, operated, and maintained to create, collect, record, process, store, retrieve, display, and transmit information. Hardware CI's include but are not limited to mainframes, AS/400s, Intel, UNIX or LINUX based servers, PCs, notebook and laptop computers, hand-held computers, printers, modems, magnetic storage media such as internal or external hard drives, network attached storage, storage area networks, removable storage media as well as firewalls, routers, switches, hubs, load balancers, wireless access points wireless access controllers, PBXs, key systems, voice mail systems. Software CI's include but are not limited to source code, compiled objects and executables, scripts, procedures, command files, batch files, utilities, ASP hosted programs, integration engines. Data CI's include all databases, data files and data structures that reside on any of a variety of storage devices including. Network and Telecommunication environment CI's include, all varieties of data circuitsT1, DS1, DS3, Ethernet Point-to-Point and any type of dark fiber circuits, POTS, Ring-Down and T1 circuits, as well as cellular and satellite circuits, and include any of the services that may be provided on those circuits.

Development Environment: IT environment where Change Owners initially design, build, and test their changes before moving them to the Test environment for user acceptance testing.

Data Information Technology Governance Committee (DITGC): The board comprised of PPS Partners, HIE members, and CHS representatives who are responsible for overall data IT governance of the CPWNY PPS and their partners.

Emergency Change Request: An urgent change request that must be handled before the next scheduled meeting of the CAP. Typically these occur due to IT Production environment problems or are potential security risks that can be exploited if not mitigated immediately.

Fixed Asset: Defined as purchased or otherwise tangible property with an individual value of $500 or more and an estimated useful life of 3 or more years.

Freeze Window: Identifies time windows when change activities are not allowed to be applied to IT Production environments. The intention is to lock down the IT Production environment during usage periods to ensure high availability for business customers.

Maintenance Window: A known recurring time-window mutually agreed upon by IT and end users/business customers where systems may be taken offline to apply changes such as routine maintenance. Setting these windows allows the customer to prepare for possible service disruptions or prepare for any major changes to the functioning of the service.

Request for Change (RFC): Formal documentation submitted by the business or IT personnel requesting an adjustment to a production configuration item or asset. Requests should contain a description of the change, affected components, business needs, cost estimates, risk assessment, resource requirements, and the approval status.

Production Environment: Normal IT operating environment that all CI's being utilized by the business customers for day-to-day operations reside. Changes to this environment are managed by the Change Management policy and there are a limited number of people who can make any type of changes to this environment. The environment is

tightly managed to ensure stability and reliability for business users.

Project Manager (PM): Individual responsible for planning and coordinating the resources to deploy a major release within the predicted cost, time, and quality constraints.

Test Environment: Separate IT operating environment that ideally replicates the IT Production environment. This environment is where the user acceptance training occurs to test applications, procedures, scripts, tasks and other activities that the Change Owner is working on to ensure that they are working correctly and that the expected outcome is what the requestor had intended. Once validation is done and user signoff has been received, the change is locked and the process is started to move the change to the IT Production environment.

User: Anyone who uses or depends on IT services provided by the system.

CAP Primary Members	
Role	**Position/Area of Responsibility**
Change Control Executive Sponsor	CHS CIO
Change Control Executive Sponsor	CHS CSO
Change Control Manager	CHS Manager IS and Technical Operations
Change Control Manager	CHS Help Desk Project Coordinator
Change Control Coordinator	Director Security Controls
Change Control Coordinator	Network Analyst – ISSRs
Change Control Coordinator	Manager – Integration
Change Control Coordinator	Programmer Analyst – Revenue Cycle
Change Control Coordinator	Application Manager – General Financials
Change Control Coordinator	Director – Lab Information Systems
Change Control Coordinator	Network Engineer – Security
Change Control Coordinator	Programmer Analyst II – Clinical Applications
Change Control Coordinator	Programmer Analyst – Soarian Clinical
Change Control Coordinator	Telecommunications Analyst III – Telecom
Change Control Coordinator	Director – IT Project Management
Change Control Coordinator	Network Engineer – Engineering
Change Control Coordinator	Programmer Analyst II – Soarian Financials

Change Request Template Example

COMMUNITY PARTNERS OF WNY

POLICY AND PROCEDURE

TITLE: CP-WNY IT Change Management Strategy		**POLICY NUMBER:** <TBD>
PREPARED BY: <TBD>		**POLICY LEVEL:** System
APPROVED BY: <TBD>	**RESPONSIBLE DEPARTMENT:** Information Technology	**EFFECTIVE DATE:** <TBD> **LAST REVISED DATE:** <TBD>

This document is not intended to create, nor is it to be construed to constitute a contract between CHS and any of its Associates for either employment or the provision of any benefit. This policy supersedes any policy previous to this policy for any CHS organizations and any descriptions of such policies in any handbook of such organization. Personnel failing to comply with this policy may subject to disciplinary action up to and including termination and/or appropriate legal action.

ORIGINATION/EFFECTIVE DATE:								
	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials
REVIEWED:								
REVISED:								

PPS should explain the basis/rationale for their training program, or the how and why they PPS decided upon the elements of the training they are implementing. For example: the PPS developed their training program based upon x,y,z criteria; the training program is responsive to x, y, z identified needs; the training program will assist the PPS in achieving their x, y, z objective and goals.

Milestone #2 – Details of each training program according to type of provider and PPS

Performance Reporting Training Program

Two types of detailed assessments are utilized to ascertain the necessity of training and expected outcomes of the training toward DSRIP goal achievement. The first assessment is a detailed electronic medical record capabilities assessment. This assessment determines, for example, the EMR and IT capabilities, reporting mechanisms, use of evidenced based guideline alerts, monitoring of patient gaps in care and production of a variety of patient care registries (Attachment A). The second assessment utilized by CPWNY is a National Committee of Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) 2014 assessment grid (Attachment B). This assessment is ongoing and gauges practice readiness for obtaining PCMH or renewing the recognition under the 2014 standards. CPWNY/CMP Clinical Transformation Specialists (NCQA PCMH certified trainers) and Care Management Advisors (R.N.'s certified in Case Management) work with each practice on a 1:1 basis, providing attention and expertise in performing a "gap analysis" and formulating plans for training to close those gaps. NCQA 2014 Standards in PCMH encompass Patient Centered Access, Team-Based Care, Population Health Management, Care Management and Support, Care Coordination, Care Transitions, Performance Measurement and Quality Improvement. CPWNY will insure that the DSRIP goals are achieved by providing PCMH classes and individualized training on areas needing improvement in order to meet the PCMH standards Catholic Medical Partners has found that by providing classes as needed, combined with 1:1 attention, focusing on resistance to change and being a change agent, will steer the providers in the direction of the high performing health system. For practices / practitioners having difficulty with change, we utilize our Territory Lead Physicians to enhance communication to a meaningful level (physician to physician). Education for practices/practitioners who already have NCQA PCMH Level 3 designation in the 2014 standards CMP provides ongoing engagement with the offices concentrating on quality improvement. We also provide webinars to keep information and communication up to date.

Training topics for all providers/practices include but not limited to:

A. Electronic Health Records (EHR)

Basis /rationale

The types of reports an EHR generates is key to helping a practice actively manage patients, track operational indicators, and meet meaningful use (and subsequently PCMH recognition). Depending on the type of report, it can be at the practice or provider level, but starting with the practice level is a good way to identify alerts that require drilling down to the provider level. This data can be powerful motivators for provider change, as providers see how they are performing against the practice as a whole and other providers, as well as positive reinforcement for those exceeding expectations. Training involves office staff, provider—Training conducted by CMP staff super user specialists.

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Basis/ rationale

B. Population Health – Population health seeks to improve the health outcomes of a group by monitoring and identifying individual patients within that group. It aggregates data as well as providing a comprehensive clinical picture of each patient. Using that data, providers can track, and hopefully improve, clinical outcomes while lowering costs and identifying patient care opportunities. Training involves clinical staff, providers. Training conducted by CMP staff -- specialists.

Basis/ rationale

C. Practice Management Tools – Practice Management tools provide the capability to create reports such as patients with specific conditions or a patient appointment report. An example of this would be to determine patients with hypertension and have not had a visit in the last 12 months. This would alert a practice to reach out to these patients to close gaps in care. Office managers trained, training conducted by clinical transformation specialists.

Basis/ rationale

D. Analytics – Healthcare organizations are increasingly using analytics to consume, unlock and apply new insights from information. Analytics can be used to drive clinical and operational improvements to meet business challenges. From a baseline of transaction monitoring using basic reporting tools, spreadsheets and application reporting modules, analytics in health care is moving toward a model that will eventually incorporate predictive analytics and enable organizations to "see the future", create more personalized healthcare, allow dynamic fraud detection and predict patient behavior. Initially training conducted by Catholic Health IT department -- Training involves CMP staff, office managers /designees/ care managers (clinical staff)

Training in Performance Reporting and Clinical Quality

The CPWNY training program will utilize the CMP Leadership Series. This series builds and assists in the clinical transformation of practices to become "high performing" practices. The program consists of review (completed at the office by the Clinical Transformation and Care Management staff) for those who previously attended classes for attainment of PCMH and it is offered to any new staff at those offices. CMP, as part of an ACO accreditation status, maintains oversight of its practices to insure that the processes in place for the high performing practice are maintained. This type of oversight will continue for partners of CPWNY.

Detailed Training plan – involves practitioner champions, office managers, and designees.

Session 1:

- Focus on choosing a practice project lead
- Perspective from Primary Care practice that achieved PCMH and MU Designation
- (Patient Portal)-Physician perspective
- Review of Training program, schedule, logistics and expectations – why is achieving PCMH important?
- Overview of PCMH Standards (2014)
- Principles of leadership, accountability, and organizational structure

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- Principles of Project Management, managing timelines and milestones, staff accountability, meeting management
- Wrap up, assignments and review/evaluation
  - Homework consists of : get physician buy in for PCMH and attending session 3
  - Review of standard 1
  - Begin to create timeline/project plan
  - Complete DISC

Session 2:

- Follow up on homework, group discussion on communication plan with practices
- Previous experience implementing PCMH –office manager perspective
- **PCMH Standard 6 and 3D review**
  - **Standard 3B – Use of data for population health**
  - **Standard 6 – Performance Measurement and Quality Improvment**
- Learn your individual communication style and how to adapt your communication style, DISC
- Stages of Development: Current state of development, individual development cycle, team development cycle, delegation and motivation to stay on the path to success.
- Workplan discussion and wrap up , assignment evaluation – implement 1 factor from standard 3B and 6; begin project plan with timeline; physician buy in for session 3

Session 3:

- Group discussion on project planning; factor implementation – standard 6 & 3D; were quality measures identified?
- Review of **PCMH Standard 4 – Care Management Standards**
- Problem solving through consensus decision making
- Wrap up assignments: care coordination staffing plan; define high risk population; bring back a % of population for all conditions to discuss.

Session 4:

- Group discussion to share progress made on project plan, discuss issues, obstacle and barriers
- Record Review workbook
- Review **PCMH Standards 1- Patient Centered Access** ; and **Standard 5 – Care Coordination and Care Transitions**
- Review **PDSA model (RCE) ****
- **Break out – begin creating quality plan/discuss progress if already started for the office; which measures are you going to select; who is going to be part of the quality team, how are you going to communicate to the practice, etc.**
- Wrap up assignments : **Create the quality plan for office – create a PDSA for how you want to improve 2 measures; project plan** ; purchase PCMH tool

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** The RCE method will include videos:
https://www.youtube.com/watch?v=_-ceS9Ta820
https://www.youtube.com/watch?v=eYoJxjmv_QI

Teaching procedure/Instructional Events (PLAN):

- **The educator will explain that the purpose for today's session is to come up with a goal or "aim" to use for improvement in the office.**
- **The educator will distribute a packet of information to representatives from the practice reflecting current measures in that practice.**
- **The participants will be asked to examine their data as a group.**
- **The participants will be asked to select one area for improvement based on the data that they have just examined. This will include demographic population and an area for improvement within that population.**
- **The educator will lead a group discussion where he/she will ask each group "what is your aim?"**
- **The educator will then ask each group what data they used to reach their aim.**
- **The educator will finally ask how they believe the aim will reduce unnecessary costs (could be related to inpatient stays, ER visits, etc.).**
- **The educator will explain that for the next time period that practice will record and examine the data in their aim.**
- **Revisit with intervention – office will receive follow up by Clinical Transformation team members.**

Session 5:

- Practice presentations on project plans – discussion of barriers and successes
- Walkthrough of purchasing PCMH application tool
- Show example of Quality Improvement workshop
- Delegation and Motivation
- Where are you now?
- Insure long term project and team success, tie things together, where have you seen the practice evolve: Comparison of Pre/Posts PCMH Checklist/ Pre/Post D1-D4 evaluation; Pre/Post Team Development Evaluation
- Celebrate success

Additional Training on Clinical Quality and Performance Reporting

CMP Physician Territory Leads, Clinical Transformation Specialists and Care Management Advisors provide training on quality improvement, RCE, PDSA, , tobacco cessation , treatment protocols , care coordination process, documentation of self-management goals. IT platforms, PCMH, Meaningful use, secure messaging, population health. – audience varies by practice and topic. If the office has a care coordinator nurse then that clinical person is responsible for clinical coordination of care, engagement in self-management with motivational

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interviewing, guideline adoption. CMP Care Management Advisors teach clinical office staff about community organizations, heath homes, care transitions, tobacco control, guidelines and protocols. CMP social workers assist and teach with CBO warm handoffs, what community organizations are available and how to refer to them. Ongoing training via webinars also occurs.

Performance reporting: Milestone #2, Describes Mode, technology, or infrastructure utilized by the PPS to track trainings.

Tracking of Training

CPWNY has developed an excel tracking grid that encompasses all the training initiative contained in DSRIP milestones. **ATTACHMENT C.** Meetings have occurred to explain the training grid to the Clinical Transformation team and the Care Management Advisors and how to document all the training endeavors in our PPS. The information will be collected quarterly and transcribed, where necessary, to the mandatory training templates. We will track this information against the entire PPS network to compare who is attending trainings and who is not. Training is completed for PCMH on a volunteer basis first, as our incentives drive the attendance for trainings. Trainings will not be made mandatory until year 3, quarter 1 but by then we will have had most attending the trainings.

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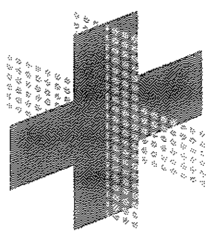
Proprietary



COMMUNITY PARTNERS OF WNY

Performing Provider System

Clinical Integration Strategy

Approved Clinical Quality
Governance Committee 9/8/16

1

The CPWNY Clinical Integration Strategy encompasses the following

1. Formation of a Successful Clinical Integration Program
2. Designing Impactful performance initiatives and incentives
3. Extending resources for enhancing performance that includes clinical and other information for sharing and data systems and interoperability
4. A specific Care Transitions strategy, including hospital admission and discharge coordination, and care transitions, coordination and communications among primary care , mental health and substance abuse providers

Formation of a Successful Clinical Integration Program

One of the first steps to a high performing health system is the development of the high performing physician network. Across the country patients have the same basic needs from our health care system better health better care and lower costs. Catholic Medical Partners (CMP) is delivering solutions for those needs. Our physician led patient-focused approach is based on bringing together people, facilities technology and ideas for the singular purpose of improving the health of our patients and the delivery of care in our community. Catholic Medical Partners is a membership organization comprised of the Catholic Health System Mercy Hospital Kenmore Mercy Hospital, Sisters Hospital, Mt St. Mary's Hospital and over 990 independent primary care physicians pediatricians and specialists united in the common goal of improving the delivery of healthcare. The commitment of CMP is to provide high-quality, coordinated care to the patients who chose us by utilizing best practices, harnessing technology, and employing a team-based, proactive and patient-centered approach to clinical care

Catholic Medical Partners is the largest group of independent practicing physicians in Western New York, with a governing board led by practicing physicians. Catholic Medical Partners has been serving the needs of the Western New York community since 1996 and has made significant investments in technology to help its member physicians engage their patients as active participants in their own care. Today, all Catholic Medical Partners' physicians have adopted the use of Electronic Medical Records in their practices. Catholic Medical Partners furthered its commitment to fortifying the clinical office by supporting office-based care management and by assisting more than 60 primary practices in achieving

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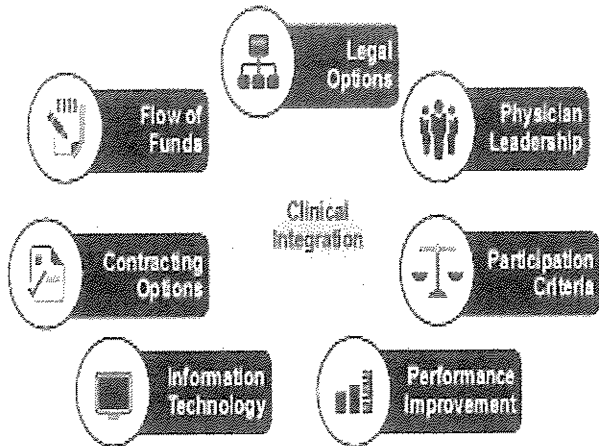
the highest level (Level 3) of recognition under the National Committee of Quality Assurance (NCQA) Patient Centered Medical Home program. In 2010, Catholic Medical Partners designed and implemented Care Transitions, a program to improve the discharge process and to reduce hospital readmissions. In 2012, Catholic Medical Partners was one of the first 27 organizations across the country chosen to participate in the federal Medicare Shared Savings Accountable Care Organization (ACO) program. Through the end of 2013 the Catholic Medical Partners ACO has saved Medicare over 27 million dollars. The success of Catholic Medical Partners IPA is the framework by which Community Partners of WNY (CPWNY) bases its Clinical Integration program.

The building of a clinically integrated network must encompass the engagement of physicians capable for attaining the organization's goals, focusing on the Triple Aim of lower cost, improved care and better health. CMP has maintained this balance and is able to attract physicians through physician led communication regarding advantages for primary and specialty care practitioners involvement with CMP and the CI program. Practitioners are involved in board meetings, strategic development, network operations and committee oversight of the programs. This level of involvement promotes a unified purpose and faith in the direction of the organization. CMP and CPWNY network must limit its membership to the right partners that will contribute high quality low cost patient care, collaborates with the other partners in the organization and has a volume of patients in the area or has a specialty area relevant to program goals. The provider must sign a participating agreement, commit to the Clinical integration initiatives and be accountable to CPWNY performance management.



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Designing Performance Initiatives and Incentives

Catholic Medical Partners, IPA (CMP) has built a Clinical Integration (CI) program that has been in place for 10 years At the time of the CMP CI development, all specialties, facilities and primary care providers were engaged in the choice of performance metrics, focusing on what areas need improvement and what interests our payers CMP continues to gain input from it's Board Committees and Quality teams on changes to the clinical integration plan, with the main focus on achieving better outcomes on CMS ACO, HEDIS, and other population health metrics With the advent of CPWNY and DSRIP, those metrics were compared to existing and those that are overlapping with the current CI plan were selected for the CPWNY CI plan (ATTACHMENT A) In addition to the CI metrics, additional metrics were selected for the equity payment program (EPP) in which we are collaborating on with the local Medicaid health plans

The CI plan is implemented in an incremental fashion, starting with CMP incorporating DSRIP deliverables into its existing CI program for primary care practitioners For non-CMP primary care practitioners a PMPM payment is in place based on volume of Medicaid patients as well as resources through the Chautauqua County Health Network CPWNY is starting simple to build in physician comfort with the program

The Clinical Integration performance initiatives are chosen to generate value without overwhelming the workload of the physician and being too difficult to monitor, which would impede any positive behavior change The goal is to automate the data collection which has already begun with practices that have Medent and eClinical Works EMR's We are working to build a Population Health Database using Crimson Quality Management Tool This tool takes information from EMR's and generates quality reports for HEDIS-type measures It provides benchmarking against goals and gives priority targets for providers and practices to focus on

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Extending Resources for Enhancing Performance that includes Clinical and other Information for Sharing, Data Systems and Interoperability

Interoperability is a necessary requirement of electronic medical record adoption incentive programs The continuity of care document (CCD) is one such structure for the exchange of clinical information While designed to enhance communication between providers during transitions of care, coded data in the CCD can be re-used to aggregate data from different providers [1] Interoperability for CPWNY for clinical integration is more than having the CCD Clinical Integration includes methods for data sharing encompassing disease registries, a data warehouse and health information exchange The following features of the CPWNY system **(ATTACHMENT B)** includes

- Data Analytics –Decision Support Software System to provide monitoring to improve cost and quality, plus a care management /coordination work flow and analytics tool
- Enterprise Master Patient Index – to facilitate the aggregation of clinical data from multiple sources.
- Enterprise Data Warehouse – to provide an analytical suite(business intelligence tool BI) that will help aggregated, normalize, organize, and assimilate data from numerous data sources.
- Health Information Exchange (HIE), to provide a patient and clinical portal plus other features and functions, along with integration with the RHIO (Regional Health Information Organization), leveraging its features and functions

These are considered the foundational information technology solutions and tools required for the transformation of health care The overarching goal is an integrated delivery system functioning in a data-driven paradigm through which the highest quality care is provided to patients in the most cost-effective setting with a focus on prevention and maintenance of health care

Care Transitions Strategy

According to the Community Needs Assessment (CNA) Community Conversations, one of the most common negative experiences and greatest challenges in healthcare is the lack of continuity in care

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[1] D'Amore John D MS, Sittig, Dean F PhD Wright, Adam PhD, Iyengar M. Sriram PhD, Ness Roberta B MD PhD The Promise of the CCD Challenges and Opportunity for Quality Improvement and Population Health", AMIA Annu Symp Proc 2011 285-294 Published online October 22 2011

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Providers interviewed also echoed the sentiment of lack of continuity made worse by lack of EHR/data integration and limited technology infrastructure across health care settings. Physicians and their care teams are often not notified when a patient has been admitted to an inpatient hospital or discharged home. Another challenge has been the lack of standardization of electronic medical records which inhibits the sharing of patient information and coordination of care. CPWNY plans to develop and deploy a communication tool and/or integrate EMRs so that coordination of care can occur without added burden. This particular issue, given the nature of the work, is a very time consuming and costly challenge.

Finally, PPS partners are challenged by their patients' refusal to participate in the CPWNY Care Transitions Program. The refusal rate for the Catholic Health Care Transitions Program averages 38% in the Medicaid population cohort. In an effort to get physicians on board with the implementation of this project CPWNY's is using an "inpatient care management team to physician "approach to Care Transitions. Physician input is key, as they can identify best practices. CPWNY partner Catholic Medical Partners plays a vital role in the success of this strategy.

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

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

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CPWNY has implemented the Catholic Medical Partners developed patient centered Enhanced Care Management Program, including transition of care which is delegated to the physician practice. The office based Care Management Program is a team approach to patient care. The program is available to CPWNY family practice and internal medicine physicians. This program was initially implemented in CMP offices in 2008 as the "Care Coordination Program" which was based on the "Chronic Care Model" of the McColl Institute. This model was considered in the development of care coordination along with the NCQA Patient Centered Medical Home standards and CMS transitional care management services. The Care Management program targets the population at increased risk of hospital admission, readmission, inadequate or poorly coordinated care. Support from Catholic Medical Partners and CPWNY has decreased the burden of staff expense for the independent practice to perform care coordination and improve communication among health care providers across the continuum to reduce unnecessary services. Training on key aspects of the Care Management is provided by CPWNY. Training includes but is not limited to: patient registry development and utilization, adherence to evidence based guidelines, holistic patient assessment, care transitions, patient engagement and shared decision making methods, patient centric care plan development and utilization of the electronic medical record to provide proactive, effective patient care. The Care Management Program provides training to encompass all office care team members. As the practice engages in population care management and/or PCMH recognition, Enhanced Care Management focuses on management of the complex, high risk population. The Care Management Program is structured with policies, processes and reports in collaboration with Catholic Medical Partners.

Catholic Medical Partners has care management and clinical transformation staff who provide regular on site support to practices. Rapid cycle process improvement is incorporated into the clinical transformation process within the office care team. The staff also supports the practices on better use of technology and creation of templates, standardizing documentation, reporting, and workflow redesign.

The target population for care management continues to be Medicaid patients admitted to the hospital with a high risk for readmission who meet two or more of the 8 BOOST criteria. Medicaid patients are identified while in the hospital through the use of a TARGET assessment 8P scale developed by Project BOOST (Society of Hospital Medicine). The "P" items on the assessment tool include: Problem Medications, Punk/Depression-presence of depression either in screening or in history, Principal diagnosis and/or co-morbidities of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, cancer and stroke, Polypharmacy-number of medications as well as medications that

increase the likelihood of adverse events post hospital discharge (66% of patients have at least 2 prescriptions), Poor health literacy-inability to teach back; Patient support-absence of caregiver or limited/lack of social supports, Prior hospitalization in the past six months; Palliative care-patients who have chronic disease management/symptom control needs. Our Community Needs Assessment indicated a high proportion of individuals at risk for re-hospitalization due to the prevalence of diabetes, CHF, cancer, stroke, COPD with co-morbid conditions, as well as behavioral health needs and lack of social supports. Individuals with low socio-economic status often have poor health literacy and therefore do not understand the instructions provided upon hospital discharge. Home Care is available to provide additional education and support for self-management in the patient's home environment.

The coordination and communication among primary care, mental health and substance abuse providers occurs as a result of multiple systems and processes: HEALTHeLINK, Continuity of Care Documents (CCD) and Crimson Care Management. HEALTHeLINK will provide a community based patient event notification service that keys on multiple event types and is configurable to the practice/provider level. When this is accomplished it will trigger notices from admissions, discharges and transfers, lab values and other clinical values needed to coordinate care during transitions. This HEALTHeLINK task is on track to be completed by June 1, 2017. In the meantime the CPWNY network utilizes its relationships between and amongst providers to transfer information in a timely manner based on a policy (ATTACHMENT D) as well as the function of care coordination to exchange patient information during transitions of care. The use of referral agreements assists in helping to better outline preferred communication channels as well as sets up expectations amongst referring and co-managing providers. One caveat for the exchange of information regarding behavioral health and substance abuse treatment is the Federal Registrar Title 42 that requires a patient consent. If the client is in a Health Home then the behavioral health and substance abuse information is shared via the RHIO between providers due to the all-encompassing consent form (NYS DOH form 5055) utilized.

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

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ATTACHMENT A

2016 Clinical Integration Program: Internal Medicine and Family Practice

Participation Requirements

Adherence to Clinical Integration Principles	Participation in Accurate ICD-10 Coding Programs (where applicable)	Maintain Referral Agreements	Diabetes Documentation	DSRIP projects, surveys, training, and chart reviews (including MU & HeL participation)

Quality/HPHS

Practice Status	Monthly HPHS Payment		Measure
	Fixed	At Risk	
PCMH as of 1/1/2016	PMPM	PMPM	Chronic Disease and Preventive Measures [illegible]
Non PCMH	PMPM	PMPM	

*January-June HPHS Payment based upon quality outcomes composite for last cycle of 2015
July-December HPHS Payment based upon first cycle of 2016 (second cycle for EMR reporters)

Measures		Goals			
		0%	50%	100%	110%
Preventative Measures	Influenza Immunization (6mo+)	[illegible]	[illegible]	[illegible]	>90
	Pneumococcal Vaccination (65+)	<50	50.00-69.99	70.00-90.00	>90
	Depression Screening (12+)	[illegible]	[illegible]	[illegible]	[illegible]
	Colorectal Cancer Screening (50-75)	<50	50.00-69.99	70.00-90.00	>90
	Mammography Screening (50-75)	[illegible]	[illegible]	[illegible]	[illegible]
	Tobacco Use; Screening and Counseling 18+	<50	50.00-69.99	70.00-90.00	>90
	Falls Risk Screening (65+)	[illegible]	[illegible]	[illegible]	[illegible]
	Annual Physical (65+)	[illegible]	[illegible]	80.00-90.00	>90.00
		0%	50%	100%	110%
Diabetes Age 18-75	HBA1C < 8	<64.[illegible]	[illegible]	[illegible]-79.99	>79.99
	Medical Attention for Nephropathy	<81.8	81.8-85.91	85.92-89.6	>89.6
	Eye exam	<50.24	50.24-59.30	59.31-70.19	>70.19
		0%	50%	100%	110%
Heart Failure	Beta Blocker Therapy for LVSD (18+)	<50	50.00-69.99	70.00-90.00	>90
		0%	50%	100%	110%
Hypertension	BP control(<140/90) for patients with hypertension (18-85)	<65.69	65.69-[illegible]	[illegible]-79.65	>79.65
CAD	ACE or ARB Use (*CAD&DM or LVSD) (18+)	<75.[illegible]	[illegible]	[illegible]-91.67	>91.67
IVD	Aspirin Use (18+)	<50.00	50.00-69.99	70.00-90.00	>90
		0%	50%	100%	110%
Care Management Measures	Annual Assessment Completed	<70	70-85	85.01-95	>95
	Care Plan Completed	<50	50-75	75.01-90	>90
	Care Transitions Phone Call for all admissions	<50	50-75	75.01-90	>90

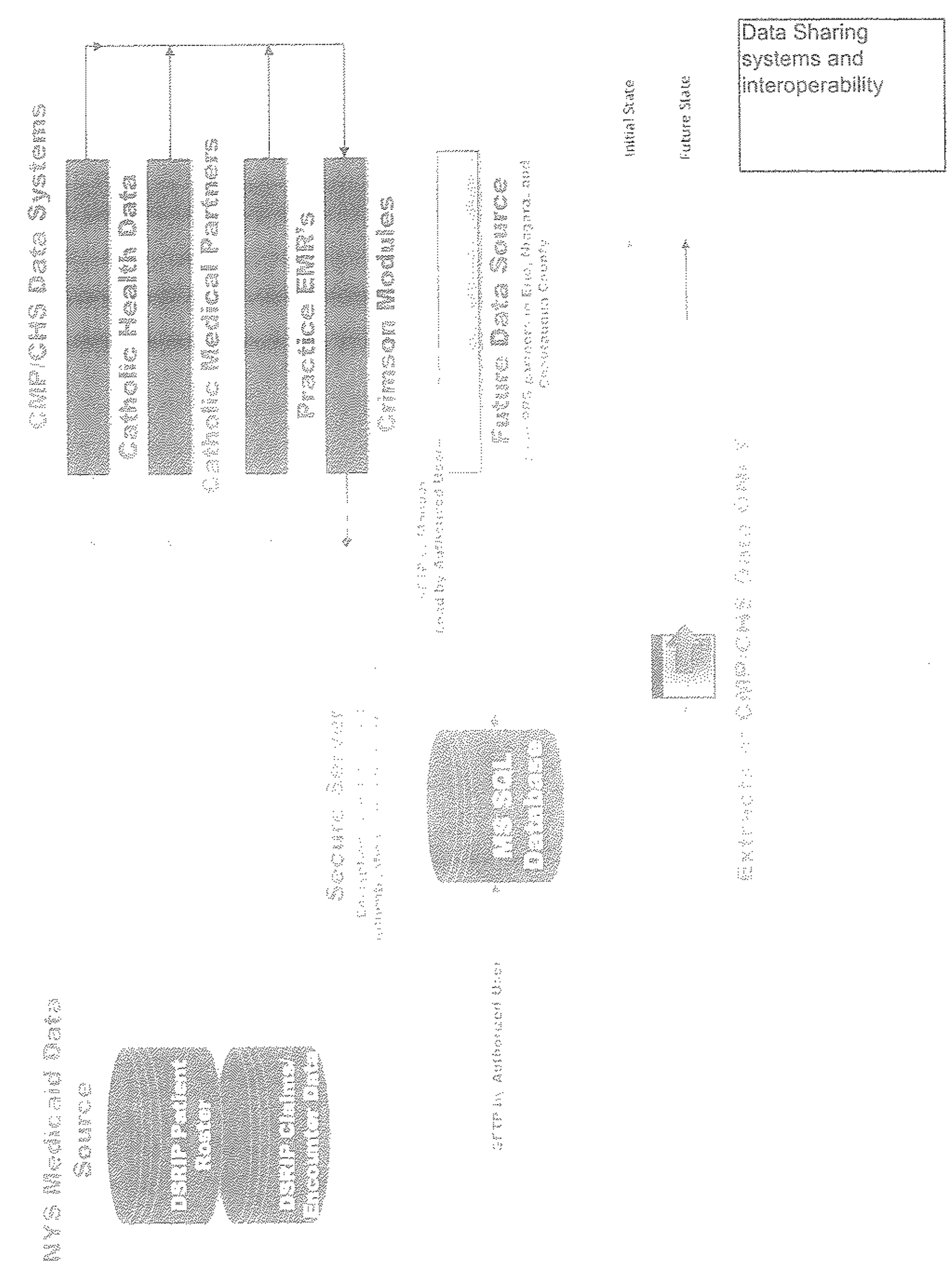
	• Care Transitions Office Visit w/in 7 days for High Complexity* Medical Admissions	<50	50-75	75.01-90	>90
	• Care Transition Med Rec for all admissions	<50	50-75	75.01-90	>90

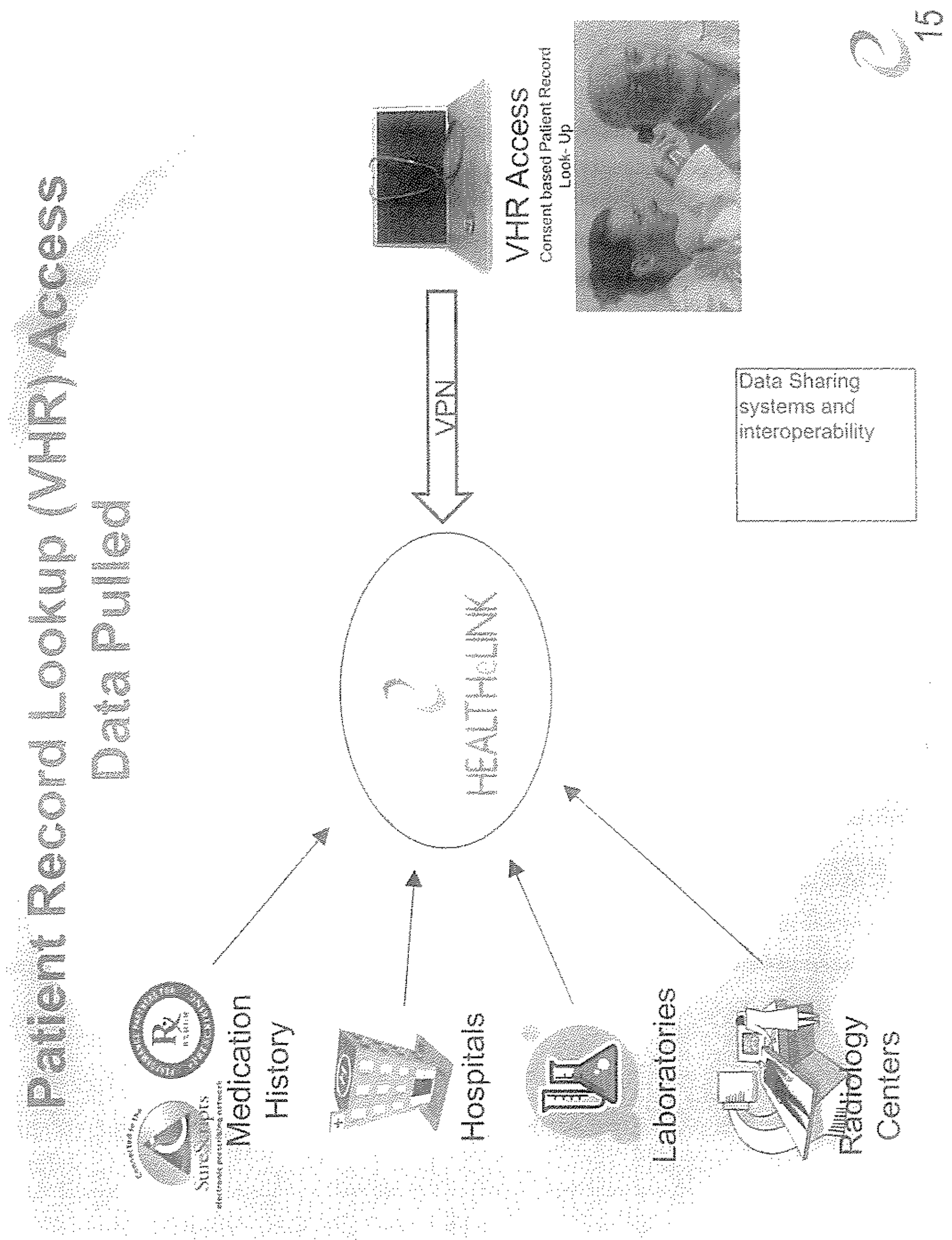
*High Complexity includes CHF, COPD, CKD stage 4 & 5

Infrastructure Support

Meaningful Use	HIPAA Training	HCC Coding/ Improved Documentation	Practice & Quality Improvement/PCMH	Care Management (where applicable)

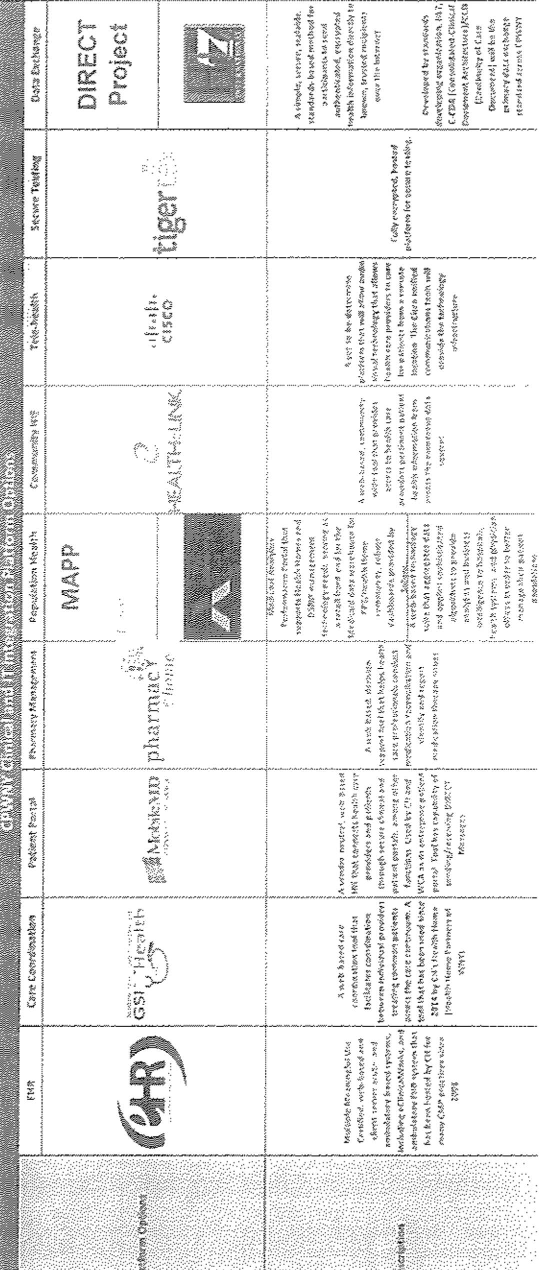
ATTACHMENT B


CMP/CHS Data Systems
Catholic Health Data
Catholic Medical Partners
Practice EMR's
Crimson Modules
Future Data Source
Secure Server
MS SQL Database
NYS Medicaid Data Source
DSRIP Patient Roster
SFTP by Authorized User
Initial State
Future State
Data Sharing systems and interoperability



Patient Record Lookup (VHR) Access
Data Pulled
Medication History
Hospitals
Laboratories
Radiology Centers
HEALTHeLINK
VPN
VHR Access
Consent based Patient Record Look- Up
Data Sharing systems and interoperability
15

Data Sharing Systems and Interoperability



CPWNY Clinical and IT Integration Platform Options									
	EHR	Care Coordination	Patient Portal	Pharmacy Management	Population Health	Community HIE	Tele-health	Secure Texting	Data Exchange
Platform Options	eHR	GSI Health	MobileMD	pharmacy home	MAPP	HEALTHeLINK	cisco	tiger	DIRECT Project; HL7
Description	Multiple Meaningful Use Certified, web-based and client server acute and ambulatory based systems, including eClinicalWorks, and ambulatory EHR system that has been hosted by CH for many CMP practices since 2008	A web based care coordination tool that facilitates coordination between individual providers treating common patients across the care continuum. A tool that has been used since 2014 by CH's Health Home (Health Home Partners of WNY)	A vendor neutral, web based HIE that connects health care providers and patients through secure clinical and patient portals, among other functions. Used by CH and WCA as an enterprise patient portal. Tool has capability of sending/receiving DIRECT Messages	A web based decision support tool that helps health care professionals conduct medication reconciliation and identify and report medication therapy issues	Medicaid Analytics Performance Portal that supports Health Homes and DSRIP management technology needs, serving as a retail front end for the Medicaid data warehouse for FFS/Health Home community, robust dashboards provided by Salient A web-based technology suite that aggregates data and applies sophisticated algorithms to provide analytics and business intelligence to hospitals, health systems, and physician offices in order to better manage their patient populations	A web-based, community-wide tool that provides access to health care providers pertinent patient health information from across the connected data sources	A yet to be determined platform that will allow audio visual technology that allows health care providers to care for patients from a remote location. The Cisco unified communications tools will provide the technology infrastructure	Fully encrypted, hosted platform for secure texting.	A simple, secure, scalable, standards-based method for participants to send authenticated, encrypted health information directly to known, trusted recipients over the Internet Developed by standards developing organization, HL7, C-CDA (Consolidated Clinical Document Architecture)/CCD (Continuity of Care Document) will be the primary data exchange standard across CPWNY

Data Sharing Systems and Interoperability Status update

PROJECT NAME: Integrated Delivery System for Population Health Management

CONTRACTOR SFS PAYEE NAME: Catholic Health System, Inc.

CONTRACT PERIOD: From: 4/1/2015

To: 3/31/2020

Provide an overview of the project including goals, tasks, desired outcomes and performance measures:

The goal of this project is to establish the required information systems, tools, and processes to facilitate an operational integrated delivery system (Section III., A., 8.) to facilitate transformation to a population health operating model health care system. This will include the following:

- **Implementation of** ***Data Analytics /Decision Support Software Suite*** will provide monitoring to improve quality and cost, plus a care management/coordination work flow and analytics tool.
- **Implementation of** ***Enterprise Master Patient Index*** will facilitate the aggregation of clinical data from multiple sources,
- **Implementation of** ***Enterprise Data Warehouse*** will provide an analytical suite (business intelligence tool kit) that will help aggregate, normalize, organize, and assimilate data from numerous sources.
- **Implementation of** ***Health Information Exchange (HIE)*** will provide a patient and clinical portal plus other features and functions, along with integration with the RHIO (HEALTHeLINK), and leveraging its features/functions,
- **Acquisition of** ***Pharmacy Decision Support Software*** will support population health management initiatives, improve patient safety and reduce avoidable pharmacy costs by integrating pharmacy data across the IDS care continuum.
- **Acquisition of** ***Home Care Devices and Care Coordination Applications*** will support communication across the provider network for the purpose of the case management functions associated with many regional DSRIP projects,
- **Implementation of** ***"Management of Information" Network Hardware and Software*** will further build the technology infrastructure to care for our patient population.

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- **Configuration and Deployment of *Personal Computers, Laptops, and Tablets*** will provide the desktop and laptop computers and tablets that will be needed for accessing Integrated Delivery System applications,
- **Deployment of *Installation Personnel Resources* Related to Integrated Delivery System** will mobilize the personnel necessary to install Integrated Delivery System information technology,
- ***Training of Trainers*** will educate in-house trainers on the specifics of an Integrated Delivery System management information system, including all associated hardware and applications, and

These are considered the foundational information technology solutions and tools required for the transformation. The overarching goal is an integrated delivery system functioning in a data-driven paradigm through which the highest quality care is provided to patients in the most cost-effective setting with a focus on prevention and maintenance of healthcare. The goal also includes ongoing optimization of utilization at all level of care to avoid unnecessary and redundant services.

Care management and coordination will be a primary driver. The systems and processes implemented and optimized as part of this project will be designed to provide communication and access to clinical data to patients and clinicians in these roles from all service levels within the PPS. With this access and communication, patients and clinicians will be able to collaboratively work better together: clinicians will be able to detect at-risk patients of adverse health events, identify those missing appointments or other maintenance testing, and ensure timely ambulatory follow-up care for patient receiving inpatient care. Performance measures will be based on reductions in emergency and inpatient utilization, increase quality measure performance for outpatient measures.

ATTACHMENT C - WORK PLAN

DETAIL

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES	STATUS
Data Analytics/Decision Support Software Suite Implementation of a cross continuum application to monitor and manage cost and quality of care provided	Other	a. Data acquisition	i. First Productive Use of inpatient data interfacing; Target date 4.1.2015	Complete
			ii. First Productive Use of ambulatory (hospital based) data interfacing. Target date 4.1.2015	Complete
			iii. First Productive Use of physician practice (medical group) data interfacing. Target date 4.1.2016	Complete (CHS Primary Care Only)
		b. User acceptance testing	i. Inpatient cost and quality analytics. Target date: 6/1/2015	Complete
			ii. Ambulatory (hospital based) cost and quality analytics. Target date 6.1.2015	Complete
			iii. Physician practice (medical group) cost and quality analytics. Target date 6/1/2016	Complete (CHS Primary Care Only)
		c. User roll-out and first productive use	i. Inpatient cost and quality analytics; Target date: 6/30/2015	
			ii. Ambulatory (hospital based) cost and quality analytics; Target date 6/30.2015	Complete
			iii. Physician practice (medical group) cost and quality analytics; Target date. 6/30/2016	Complete (CHS Primary Care Only)
b) Implementation of a care management application to provide access to complete and timely clinical information to all care management/coordination, physician and other medical service personnel in each patient's healthcare network	Other	a. Data acquisition	i. First Productive Use of in network results and Admission/Discharge/Transfer (ADT) alert data. Target date. 3.1.2016	Complete
			ii. First Productive Use of physician practice (medical group) data interfacing. Target date 6.1.2017	Revised Target
			iii. First Productive Use of HEALTHeLINK (SHIN-NY) results data. Target date 1.01.2017	On schedule
			iv. First Productive Use of HEALTHeLINK (SHIN NY) Admission/Discharge/Transfer (ADT) alert data. Target date 3.01.2017	On schedule
			v. First Productive Use of community care results and Admission/Discharge/Transfer (ADT) alert data. Target date. 5.1.2017	On schedule
		b. User acceptance testing	i. In network results data and Admission/Discharge/Transfer (ADT) alert. Target date. 5.1.2016	Complete
			ii. Physician practice (medical group) data interfacing; Target date 8.1.2017	Revised Target
			iii. HEALTHeLINK (SHIN-NY) results data. Target date 2.01.2017	On Schedule
			iv. HEALTHeLINK (SHIN-NY) Admission/Discharge/Transfer (ADT) alert data. Target date 5.01.2017	On Schedule
			v. Community care results and Admission/Discharge/Transfer (ADT) alert data. Target date 7.1/2017	On schedule
		c. User roll-out and first productive use	i. In network results data and Admission/Discharge/Transfer (ADT) alert. Target date 6.1.2016	Complete

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OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES	STATUS
			ii Physician practice (medical group) data interfacing; Target date 9/1/2017	Revised Target
			iii HEALTHeLINK (SHIN-NY) results data Target date, 4/01/2017	On schedule
			iv HEALTHeLINK (SHIN-NY) Admission/Discharge/Transfer (ADT) alert data, Target date 6/01/2017	On schedule
			v Community care results and Admission/Discharge/Transfer (ADT) alert data, Target date 8/1/2017	On schedule
c) Enterprise master patient index selection and implementation to facilitate the integration of data from multiple sources through a common unique patient identifier	Other	a Selection	i Issue request for proposals to a minimum of three quality vendors. Target date, 9/30/2015	Complete
			ii Perform complete and formal review and evaluation; Target date, 3/1/2016	Complete
			iii Section and contract completion, Target date: 12/30/2016	Revised date, due to EMR selection process
		b Installation	i First Productive Use of base installation. Target date TBD	Revised data, due to EMR selction process To be determined
		c Interfacing	i First Productive Use of hospital system interfacing; Target date TBD	Revised date, due to EMR selection process To be determined
			ii First Productive Use of community care system interfacing, Target date TBD	Revised date, due to EMR selection process To be determined
			iii First Productive Use of Physician practice (medical group) interfacing; Target date TBD	Revised date, due to EMR selection process To be determined
			iv Other care providers interfacing, Target date TBD	Revised date, due to EMR selection process To be determined
		d User roll-out and first productive use	i Hospital systems Target date TBD	Revised date, due to EMR selection process To be determined
			ii Community care systems, Target date TBD	Revised date, due to EMR selection process To be determined
			iii Physician practice (medical group) systems, Target date TBD	Revised date, due to EMR selection process To be determined
			iv Other care providers systems Target date TBD	Revised date, due to EMR selection process To be determined
d) Network and population management analytics and reporting application to monitor the sources of care for patients	Other	a Data acquisition	i First Productive Use of inpatient data interfacing, Target date 2/1/2015	Complete
			ii First Productive Use of ambulatory (hospital based) data interfacing, Target date 7/1/2015	Complete
			iii First Productive Use of physician practice (medical group) data interfacing, Target date 7/1/2016	Complete
		b User acceptance testing	i Inpatient analytics, Target date 9/1/2015	Complete
			ii Ambulatory (hospital based) analytics; Target date 9/1/2015	Complete
			iii Physician practice (medical group) analytics; Target date 9/1/2016	On Schedule
		c User roll-out and first productive use	i Inpatient analytics, Target date 9/30/2015	Complete
			ii Ambulatory (hospital based) analytics; Target date 9/30/2015	Complete
			iii Physician practice (medical group) analytics, Target date 9/30/2016	On schedule

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OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES	STATUS
e) Enterprise data warehouse selection and implementation to support ad hoc reporting and data analysis for both clinical and financial and any required level of aggregation	Other	a. Selection	i. Issue request for proposals to a minimum of three quality vendors, Target date: 9/30/2015	Complete
			ii. Perform complete and formal review and evaluation. Target date: 12/1/2016	Revised date, due to EMR selection process
			iii. Section and contract completion. Target date: TBD	Revised date, due to EMR selection process
		b. Installation	i. First Productive Use of base installation. Target date: TBD	Revised date, due to EMR selection process
		c. Interfacing	i. First Productive Use of hospital system interfacing; Target date: TBD	Revised date, due to EMR selection process
			ii. First Productive Use of community care system interfacing, Target date: TBD	Revised date, due to EMR selection process
			iii. First Productive Use of Physician practice (medical group) interfacing. Target date: TBD	Revised date, due to EMR selection process
			iv. Other care providers interfacing, Target date: TBD	Revised date, due to EMR selection process
		d. User roll-out and first productive use	i. Hospital systems. Target date: TBD	Revised date, due to EMR selection process
			ii. Community care systems. Target date: TBD	Revised date, due to EMR selection process
			iii. Physician practice (medical group) systems, Target date: TBD	Revised date, due to EMR selection process
			iv. Other care providers systems, Target date: TBD	Revised date, due to EMR selection process
Health Information Exchange *A. MobileMD* Provide comprehensive data exchange solutions that enable omni-directional communication between care providers and patients	Other	Roll out Patient Portal to PPS members without EHRs	i. Roll out to first PPS member, 2016 ii. Roll out to other PPS members, 2016	Complete
		Roll out Clinical Portal to PPS members without EHRs	ii. Roll out to first PPS member, 2016 ii. Roll out to other PPS members, 2017	Complete. The Clinical Portal is the RHIO, HEALTHeLINK
		Integrate MobileMD with HEALTHeLINK • Virtual Health Record (VHR) query • Results Push • Results Delivery • VA CCD Query • CCD Upload • CCD Query Single Sign-On with Context	i. Integration complete: 2016	7/30/16 Update: CCDA formatted Transition of Care docume is live from MMD to HEALTHeLINK. Complete VHR Query - HEALTHeLINK Functionality required, schedule date pending Results Delivery - Scheduled VA CCD Query HEALTHeLINK Functionality required schedule date pending CCD Upload - HEALTHeLINK Functionalit required schedule date pending CCD Query - Complete Single Sign- on with patient context - Complete
		Integrate MMD with PPS EHRs	i. Integrate with first PPS EHR, 2017	Date may be revised, due to EMR selection

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OBJECTIVE	BUDGET CATEGORY DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES	STATUS
			ii. Integrate with other PPS EHRs, 2017-2019	
		Ordering	i. Enable lab ordering, 2017	Date may be revised, due to EMR selection
		Referral Processing	i. Enable Referral Processing, 2018	Date may be revised, due to EMR selection
B. HEALTHeLINK 1. Implement a Data Quality Management facility to verify key sources of data to the exchange and assure the quality and consistency of that data is sufficient for use by treating providers and to support population health analytics across health care settings		Data Quality Management facility - Build and implement a Practice Data Quality Management facility to be used when any practice/hospital is preparing to upload CCDs to HEALTHeLINK HEALTHeLINK is responsible for this task and will work with PPSs to set performance measures for scope and scale of deployment	i. Practice Data Quality Management facility implemented by 6/1/2016. Every health care entity that uploads CCDs to HEALTHeLINK will have an assessment performed on the content, structure, and format of its CCDs. Any CCDs that do not meet a quality threshold set by the PPSs will not be accepted into the exchange	Complete
			ii. Performance measures for scope and scale of deployment set for each PPS with the first year	Complete
			iii. Performance measures achieved by end of grant period	On track
2. Implement a separate repository for holding 42 CFR Part 2 data and acquire software to control access to the data that is compliant with 42 CFR Part 2 disclosure requirements so that access to data is sufficient for use by treating providers		Build/acquire a separate repository for holding Part 2 data and build/acquire software to control access HEALTHeLINK is responsible for this task and will work with PPSs to set performance measures for scope and scale of deployment	i. By 10/1/2017 sufficient controls in place to manage access to Part 2 data according to federal regulations governing disclosure of this data	On Track – active with planning sessions wit our HIE Vendor Mirth.
			ii. Performance measures for scope and scale of deployment set for each PPS with the first year	Delayed
			iii. Performance measures achieved by end of grant period	On track
3. Implement a terminology server tool to automatically map all inbound data feeds to a normalized data set to improve storage in and retrieval from the health information exchange (HIE)		Automated terminology server for mapping of clinical code sets and other data on inbound feeds to provide a normalized data set to drive interoperability and quality reporting HEALTHeLINK is responsible for this task and will work with PPSs to set performance measures for scope and scale of deployment	i. By 6/1/2017, HEALTHeLINK receives data from hospitals, labs and a variety of other sources in a mix of local terminology. Automatically map all inbound feeds to a normalized data set and persist in the exchange	On Track – active with evaluation of vendor tools to work with Mirth.
			ii. Performance measures for scope and scale of deployment set for each PPS with the first year	On track
			iii. Performance measures achieved by end of grant period	On track
4. Provide a community wide patient event notification service that keys on multiple event types and is configurable to the practice/provider level		Build an enhanced event notifications service within the HEALTHeLINK platform that is configurable to the practice/provider level and triggers notices from multiple event types, e.g. ADT values, lab types and values and other clinical values	i. By 5/1/2017 PPS care coordinators, PCPs, and other providers involved in managing the health of Medicaid patients are able to notification parameters unique to their practice and use case.	On track – active with planning sessions with HIE vendor Mirth and other 3rd Parties
			ii. Performance measures for scope and scale of deployment set for each PPS with the first year	On track
			iii. Performance measures achieved by end of grant period.	On track

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES	STATUS
		HEALTHeLINK is responsible for this task and will work with PPSs to set performance measures for scope and scale of deployment		
5. Increase the number of PPS partner organization providers and staff have the ability to securely and readily exchange patient data using DIRECT		Build a directory that contains the DIRECT address of providers/practices across the community. This would facilitate the direct exchange of patient information between health care settings and would be readily accessible by any provider/user HEALTHeLINK is responsible for this task and will work with PPSs to set performance measures for scope and scale of deployment	i. 8.1.2017 All PPS providers and staff with DIRECT Addresses have their DIRECT Addresses in the regional directory of DIRECT addresses	Using Mirth's directory called Open PD. Requires EMR vendors to sign a directory sharing agreement and to access the community directory from within Their EMR. Would ask for a list of providers/practices from CPWNY for follow up
			ii. Performance measures for scope and scale of deployment set for each PPS with the first year.	On track
			iii. Performance measures achieved by end of grant period	On track
6. Increase the number of PPS partner organization providers and staff have secure, two-factor authentication access to HEALTHeLINK		Purchase 500 authentication tokens to be deployed to PPS practices. Authentication tokens are used where alternate authentication methods are not an option HEALTHeLINK is responsible for this task and will work with PPSs to identify practices needing tokens	i. 2.1.2017, 500 additional PPS providers and staff will have secure, two-factor authentication access to HEALTHeLINK	On track. HEALTHeLINK will maintain a supply of tokens and will order more as needed
Pharmacy Decision Support Software Implement *PHARMACeHOME* software system	Other	*PHARMACeHOME* IT staff for implementation, upgrades and maintenance Catholic Medical Partners and CCNC Services are responsible for this task.	i. Improvement in medication possession ratio indicating improved medication adherence 2016-2020	This project was removed from the work pla
			ii. Reduction in number of discrepancies (omission, commission, sig mismatch, wrong drug) upon transitions of care 2016-2020	Removed
			iii. Drug therapy problems identified and percent resolved 2016-2020	Removed
			iv. Improvement in ED, preventable admissions, readmissions 2016-2020	Removed
			v. Improvement and physician and patient satisfaction scores surrounding medication use and information 2016-2020	Removed
Establish Attending Pharmacist Team	Other	Integrated Healthcare Delivery Reform Considerations: • Establishing the "Attending Pharmacist Team" to transform the expectations of pharmacist role and performance expands the reach of pharmacy support and creates a team more capable of function as part of other healthcare teams Catholic Medical Partners is responsible for this task	i. Establishment of team modeled after the "Layered Learning Model" akin to that established by UNC 2016-2020	In-progress
			ii. Measurement of breadth and depth of various healthcare worker utilization 2016-2020	CMP has expanded the number of pharmacy students taken on 6 week modules as well as increased the number of pharmacy residents 3 per year We continue to explore how to utilize this team based structure to perform existing and new clinical pharmacy services. Exploring where each discipline fits in the team structu for various activities is ongoing. We continue to explore how to mimic this layered model approach with the inpatient clinical pharmacy team at Mercy hospital of

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February 2015

OBJECTIVE	BUDGET CATEGORY DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES	STATUS
				Buffalo The inpatient clinical pharmacy team has increased the number of preceptors taking students as well as the number of students taken on 6 week modules as well. We have taken step further in developing rol and responsibilities for an attending pharmacist and Mercy Hospital of Buffalo ha created a staff development position, part of which will address how to prepare staff to work in such a layered learning model.
Home Health Devices and Care Coordination Applications Facilitate the optimization of communication among hospital discharge and ED diversion staff, Health Homes and Primary Care offices	Other	a. Provide access to software to downstream providers	Purchase additional Licensure and determine which downstream providers should be given access. First Productive Use by 6-1-2016	Decided to utilize Crimson CM instead of GS
		b. Define the necessary tools that will be used for communication and build these documents into the system	Meet with project leads for Transitions, Palliative and Nurse Family Partnership to determine what types of communication will be needed to facilitate care among providers as well as what reporting tools will be required to capture on going data. First Productive Use by 6-1-2016	Decided to utilize Crimson CM instead of GS
		c. User roll-out and first productive use	Provide Education to newly participating providers, implement test environment and determine if all required elements are functioning, begin use 8/30/2016	Decided to utilize Crimson CM instead of GS
Management of Information a) Implementation of an electronic health record at CHS member of the PPS	Other	Soarian Clinicals and Financials upgrades	i. First Productive Use of upgrades, 2016-2020	On track
		MEDHOST upgrades	i. First Productive Use of upgrades, 2016-2020	On track
		Maternal Child Documentation module	i. Implementation of system, 2016	On track
		syngo.Workflow upgrade	i. First Productive Use of upgrades, 2016-2020	On track
		syngo.Dynamics upgrades	i. First Productive Use of upgrades, 2016-2020	On track
		Integration of MEDHOST to Soarian Clinicals	i. First Productive Use of integration, 2016-2016	Date may be revised, due to EMR selection
		Image Sharing and Archiving implementation	i. First Productive Use of upgrades, 2016-2017	Complete
		syngo.Imaging to syngo Plaza conversion	i. First Productive Use of conversion, 2016-2017	On track
		Upgrades to ancillary systems (Pharmacy, Radiology, Laboratory)	i. First Productive Use of upgrades, 2016-2020	On track
b) Implementation of applications and projects to increase system stability/security	Other	Implementation of a secure texting application (*TigerText*) to provide for secure real time communications between caregivers at all levels of the care continuum a. Data acquisition	i. Collection of all users that will use the TigerText solution, 2016-2017	7.29.2016 – Data acquisition in process
		TigerText implementation b. User acceptance testing	i. Testing of the current system in place at CHS with a pilot group of users in the greater PPS, 2016	7.29.2016 – In process with WCA
		TigerText implementation c. User roll-out and first productive use	i. Rollout to first PPS member, 2016 ii. Rollout to subsequent PPS members, 2016-2017	7.29.2016 – In process with WCA
		VMWare server farm extension	i. Expansion of farm completed, 2016-2020	7.29.2016 – In process
		Wheelis replacement	i. Replacement of 20% of eldest wheelies annually, 2016-2020	7.29.2016 – In budget cycle

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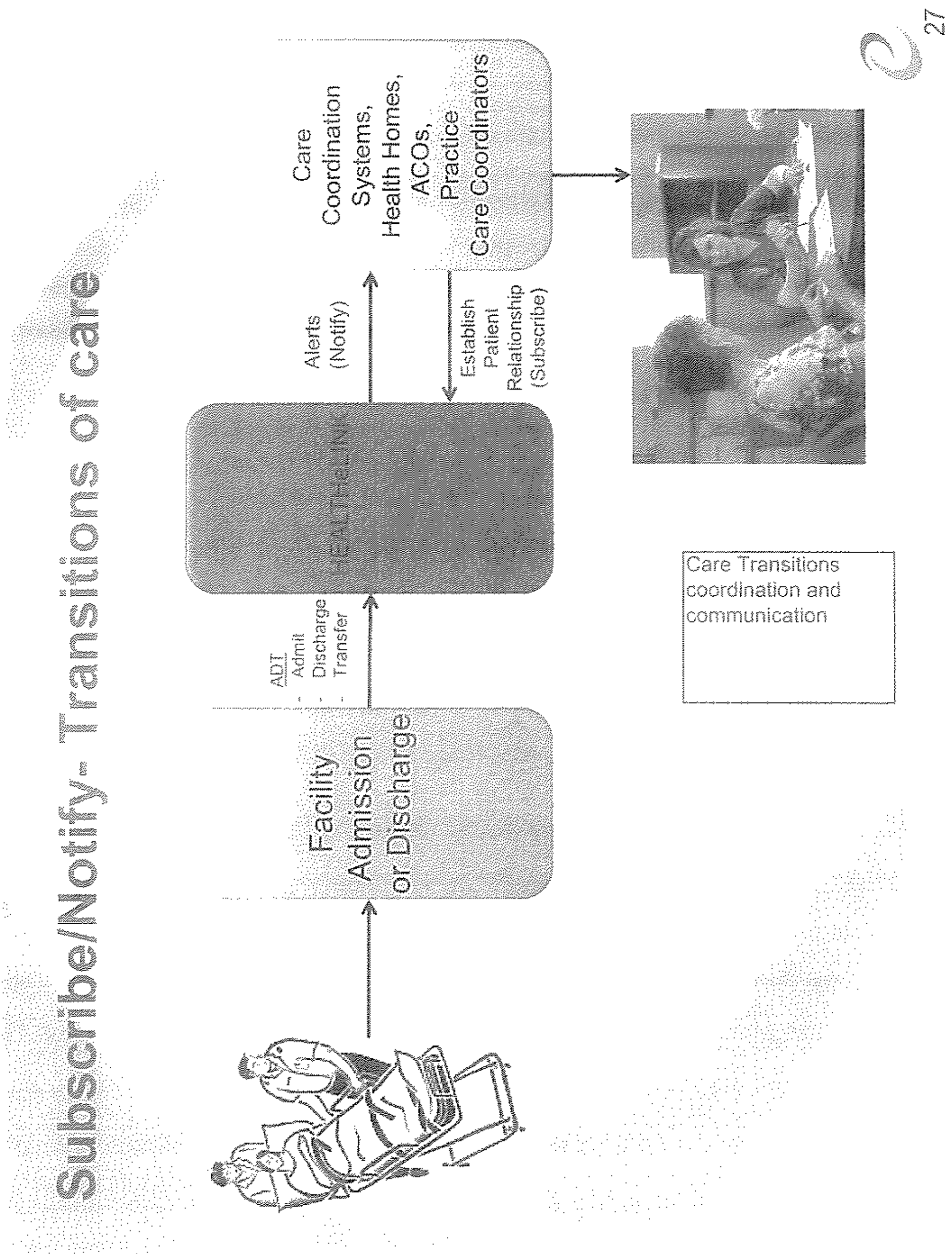
February 2015

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE* (if applicable)	TASKS	PERFORMANCE MEASURES	STATUS
		SoftLab server replacement	i Replacement of SoftLab servers, 2020	7.29.2016 – In budget cycle
		SAN Expansion	i Expansion of SAN, 2016-2020	7.29.2016 - SAN refresh in process
		Virtual Desktop Infrastructure (VDI) expansion	i Expansion of VDI farm, 2016-2020	7.29.2016 - In budget cycle
		Enterprise Backup expansion	i Expansion complete, 2016-2020	7.29.2016 - In budget cycle
		Network Intrusion Detection (NIDS) implementation	i Implementation of NIDS, 2016	7.29.2016 – In budget cycle
		Server replacement	i Replacement of 20% of oldest servers annually, 2016-2020	7.29.2016 - In budget cycle
		Datacenter upgrades	i Upgrades to the network and physical layout of the DC, 2016-2020	7.29.2016 – In budget cycle
		Identity and Access Management (IAM) updates	i Updates to the IAM system, 2016-2020	7.29.2016 - In process
c) Implementation of patient safety systems	Other	Massimo Safety Net system	i Implementation of Massimo patient monitoring system across CHS, 2016-2020	
		Implementation of a *Single Sign-On (SSO)* application across the members of the PPS a. Acquisition of the SSO system	i First Productive Use of review of needs, 2016	7.29.2016 – Rolled into EMR update
		SSO implementation b. Implementation Integration	i Project plan created and reviewed with vendor, 2017 ii Implementation kick-off, 2017 iii Integration with selected EMRs and applications, 2017-2018	7.29.2016 - Rolled into EMR update
		SSO implementation c. User roll out and first productive use (FPU)	i FPU at CHS, 2017 ii Roll out to first PPS partner selected, 2017 iii Rollout to remainder of PPS, 2017-2018	7.29.2016 – Rolled into EMR update
d) Implementation of other systems not otherwise categorized above	Other	Data Center expansion	i. Expansion of OLV Data Center 2016-2020	7.29.2016 – In budget cycle
		System identity and TTE replacement	i Replacement of TTE and system identity implemented 2016-2017	7.29.2016 – In process
		Laptops for work from home project	i Laptops deployed 2016	Complete
		Hybrid computer lab	i Computer lab built 2016	Complete
		Kronos expansion	i Licenses expanded 2016	Complete
		Additional scanners	i Scanners purchased 2016	Complete
Provision of Personal Computers, Laptops, and Tablets Disseminate to the providers devices needed to perform their work as efficiently and effectively as possible	Other	Assessment	Needs of PPS members identified, 2016	Delayed
		Configure	Devices purchased and configured, 2016-2018	Delayed
		Deploy	Devices deployed to end-users	Delayed
IT Systems Installation Identify and deploy IT human resources to implement the infrastructure, systems, and devices across the PPS to ensure that PPS members have the proper tools to help	Other	Identify the scope of work	i Create Statement of Work, 2016	Delayed
		Create a work plan	i. Create a work plan, 2015	Delayed
		Identify the resources	i Identify types of resources needed 2016 ii Hire resources, 2016-2017	Delayed
		Deploy the resources	i Resources assignments made, 2016-2017	Delayed

OBJECTIVE	BUDGET CATEGORY DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES	STATUS
better care for the patient population				
Training of Trainers Ensure that there is an adequate core group who are trained on the various applications, devices, and processes	Other	Assessment	1 Needs of PPS members assessed, 2016-2017	Delayed
		Hire	1 Resources hired, 2016-2017	Delayed
		Deploy	1 Work plan and resource assignment developed	Delayed

ATTACHMENT C


Subscribe/Notify - Transitions of care
Facility Admission or Discharge
ADT
- Admit
- Discharge
- Transfer
HEALTHeLINK
Alerts (Notify)
Establish Patient Relationship (Subscribe)
Care Coordination Systems, Health Homes, ACOs, Practice Care Coordinators
Care Transitions coordination and communication
27

COMMUNITY PARTNERS OF WNY

Policy Name: Exchange of Clinical Information for Coordination of Care	Policy Number: CPWNY -204	Revision:
Effective Date: October 28, 2015	Revised Date:	Reviewed Date: October 15, 2015 October 28, 2015
Implemented By: CPWNY Project Management Office	Signature: [signature]	Care Transitions-coordination and communication

PURPOSE:

To provide guidance for the exchange of information communication and transition of care between practitioners and other care settings in order to provide continuity and coordination of care

DEFINITIONS:

- Continuity and coordination of care The communication between a patient s primary care practitioner specialists acute and post acute providers and facilities to improve quality of care and patient safety
- Timely exchange of information For the purpose of this policy, the timely exchange of pertinent patient information is seven days for routine care and non urgent care visits and one business day for urgent or emergent visits

POLICY:

The practice care team facilitates the timely and confidential exchange of pertinent patient clinical information among the practitioners

- After an initial consult or evaluation
- If the patient has a significant change in clinical presentation or treatment

PROCEDURE:

1. When a practitioner sends a patient to a specialist or external site for care the practice care team will make every effort to send all clinically important information through one of the following means:
    a. **Primary care physician** will provide pertinent clinical information including diagnosis, medication list and medication allergy list in the form of an office note or summary including any pertinent diagnostic reports in a timely manner
    b. **Specialist** will provide information to the PCP from an office note or documented phone call. The information will include diagnosis with associate ICD 9/10 coding, treatment plan and summary of reports including diagnostic reports
    c. **Facility** (hospital, ER, Urgent Care, Subacute, SNF, Home Care Agency, etc) will provide to the PCP a discharge summary, including diagnostic reports or ongoing care management reports as required by the patient's condition
2. If the patient is not referred by the PCP to the specialist or facility, the PCP is responsible for timely exchange of information as soon as they are aware the patient is receiving care from an external site. An agreement for timely exchange of information can be utilized to facilitate the exchange of information for non participating providers. Specialists are required to have evidence of the date the report was sent to the PCP. The PCP is responsible to have documentation of the date the report was received and that it was reviewed by the PCP

ATTACHMENT D

COMMUNITY PARTNERS OF WNY

Performing Provider System

Process Name: Coordination of Transitional Care	**Process Number:** CPWNY- 305	
Effective Date: October 28, 2015	**Revised Date**	**Reviewed Date:** October 15, 2015 October 28, 2015
Implemented By: CPWNY Project Management Office	**Signature:**	Care Transitions Coordination

PURPOSE:

To provide guidance on the exchange of information during transitions of care among care settings in order to provide continuity and coordination of care to optimize patient safety and clinical outcomes

DEFINITIONS:

Continuity and coordination of care:

Is the communication between a patient's primary care practitioner, acute and post acute providers and facilities to improve quality of care and patient safety

Timely exchange of information: For the purpose of this policy, the timely exchange of pertinent patient information is seven days for routine care and one business day for urgent or emergent care

Pertinent clinical information (care summary/care plan):

Includes minimally diagnosis, medication list, vaccinations, medication allergy list and pertinent diagnostic reports and other information appropriate to patient care such as goals and instructions.

Transition of Care:

The movement of a patient from one setting of care to another as their health status changes

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Planned Transitions:
Transitions of care that are proactively made known to the primary care practice such as elective surgery or admission to a long term care facility

Unplanned Transitions:
Transitions of care are those that are urgent or emergent, without a referral from the primary care physician

POLICY:
Practitioners and staff will identify patients who are known to be receiving care at external sites in a timely manner with use of hospital IT systems, notification by family, or receipt of diagnostic or lab results. Staff will request or provide pertinent clinical information, schedule follow up appointments, and coordinate care as medically indicated to improve the quality of care and patient safety

PROCEDURE:

1. Members of Community Partners of WNY (CPWNY) have referral agreements across care settings to promote coordination of care with timely exchange of pertinent patient information to improve patient care and safety. The referral agreements facilitate timely exchange of information. These agreements include expectations of timeframes which are within seven days for routine care and one day for urgent and emergent care (1). All referrals, labs, diagnostics are tracked at Primary Care with resultant referral notes obtained for the patient medical record

2. If the patient is not referred by the PCP to the facility, the PCP is responsible for timely exchange of information as soon as they become aware the patient is receiving care from an external care site. This information, preferably in electronic format, shall include but not be limited to diagnosis list, current medications, medication allergies, vaccinations, pertinent test reports and treatment plan. The practice will document information sent to external site of care in a triage note, including date, method of transmission and external site of care recipient.

3. The external site of care is encouraged to contact the primary care practice for pertinent patient information to facilitate safe, effective care from the external site of care

4. If a patient is known to be at an external site of care and has not been discharged, the practice staff will add the patient to their "Hospital Tracking" process to ensure timely

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outreach upon discharge. This process includes an "acute care to do" which creates a patient list that is monitored by the practice daily to ensure timely outreach to patients and/or their family for follow up.

5. As soon as the practice is made aware of the patient's discharge the practitioner will direct their staff on individual coordination of care needs. The patient is contacted by telephone within 48 hours of discharge from the external care site to arrange a follow up appointment within 7 days of discharge, as indicated by patient condition, determine how the transition back to home is progressing, and aid patient/family in this process as indicated.

6. In preparation for the follow up visit, the practice staff will obtain information from the external site of care including discharge notes, medication list, medication allergies and follow up instructions. This information may be obtained by the practice via electronic records such as Soarian, InfoClique, and Citrix. In absence of electronic exchange of information, the practice will contact the external site of care to obtain relevant patient information and/or records.

7. The practice will complete a "Transitional Care" note and send this documentation to the practitioner via a triage note in the practice EMR.

8. Sample of the Transitional Care questions
   a. *What brought you to the hospital?*
   b. *Did you contact your primary care office prior to going to the hospital?*
   c. *How well do you understand your discharge instructions?*
   d. *While at the hospital were you started on any new medicine? If so, do you have them now to take at home? How will you take your medicine?*
   e. *Do you have someone readily available?*
   f. *Do you know what symptoms/changes to report to your doctor's office if they occur?*
   g. *What would it take to keep you safe and comfortable at home?*
   h. *Are there any reasons you may not keep your appointment?*

9. The practitioner will review information sent from the external site of care, including discharge summaries or ongoing progress notes prior to the patient's follow up appointment.

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10. The practice does not close the tracking reminder (eg in Medent "acute care to-do") until the discharge information has received and reviewed and the follow up appointment has occurred.

11. Based on the patient's risk stratification and individual patient needs the practice shall determine additional outreach frequency and method to ensure the patient understands their care plan and does not need further assistance

OVERSIGHT:

CPWNY will perform a quarterly audit on a random patient sample of the following:

A. Timely exchange of information has occurred between providers for care coordination and care transitions.

B. Sharing of care plan within a time frame specified in policy.

C. Notification of usual practitioner (PCP or Specialist or both) within a time frame specified in policy.

D. Communication with patient or caregivers about the care transition process within 24 hours prior to transfer.

E. Communication with the patient or the caregiver about changes to the patient's health status and plan of care occurred within 48 hours of discharge

(1) Referral Agreement Policy and Exchange of Information Policy

See attached Care Transition Process Flow

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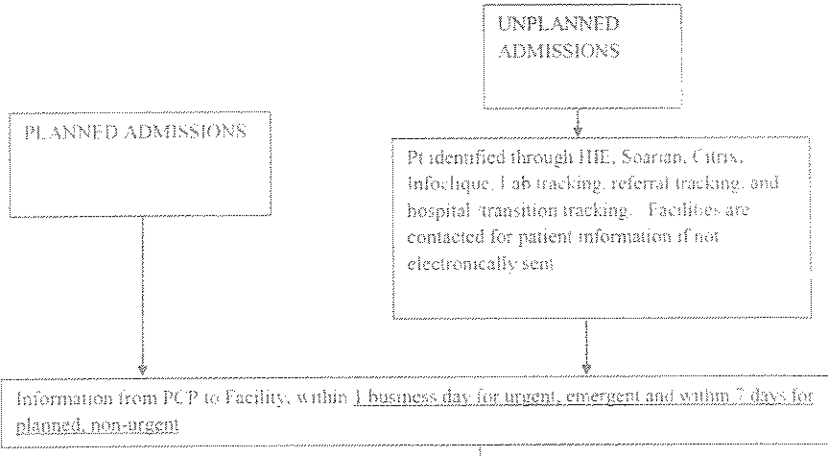
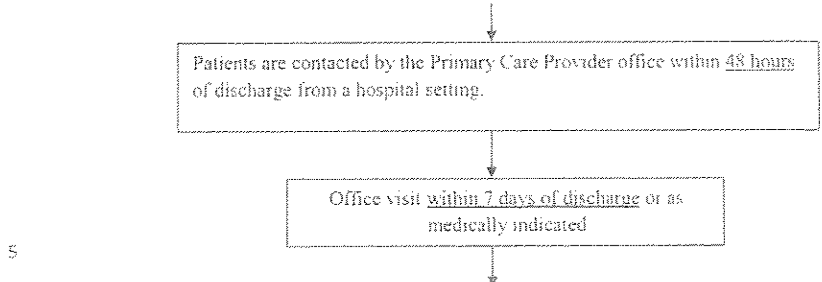
CARE TRANSITION PROCESS FLOW



HOSPITAL COMMUNICATION

Communication occurs between hospitalist and primary care providers, ER providers and primary care providers, office care management staff and hospital care management staff. Information is provided electronically, verbally or fax. The primary care office tracks information exchange. Hospital care management staff also communicates with the patient family about changes to the patient's health status and plan of care /transitions of care



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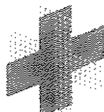

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Summaries of care, (may include minimally, problem list, med list, med allergies, vaccinations, diagnostic test results, care plan as need) are exchanged electronically to other care settings, <u>seven days for routine care and non urgent care visits and one business day for urgent or emergent visits.</u>

Tracking of transitions. Summaries of care sent by Primary Care Providers are electronically recorded in medical record system. **CPWNY oversight annually**

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Proprietary

CPWNY POPULATION HEALTH MANAGEMENT ROADMAP

EGB approved 5/4/16

Population health is defined by researchers Kindig and Stoddart as the "health outcomes of a group of individuals, including the distribution of such outcomes within the group." This definition is often used to promote interventions that address health outcomes for geographic populations, health disparities, and broader social determinants of health.

Gauthier, John, "Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in US Health Care Today" Internet Accessed 4.25.16 http://www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?List=81ca4a47-4ccd-4e9e-89d9-14d88ec59e8d&ID=50.

CPWNY Population Health Management Roadmap is comprised of the following:

1. Population Health Care Management Program Description
2. IT Infrastructure to support the population health management approach
3. Identify priority populations and define plans for addressing their health disparities by establishing goals that reflect the state of the NY Prevention Agenda.
4. Clinical Transformation of practices

CPWNY Population Health/Care Management Program Description

COMMUNITY PARTNERS OF WNY POPULATION HEALTH /CARE MANAGEMENT

PROGRAM DESCRIPTION- 2016

Program Purpose	Population Health Management principles assist Community Partners of WNY (CPWNY) practices in leveraging the work of the entire practice to proactively identify and address patient needs to ensure optimal clinical outcomes and patient satisfaction while lowering the total cost of care in keeping with the goals of the Triple Aim. Care Management is a component of the population health management strategy that focuses on the patient population within the practice who has the most complex coordination of care needs, psychosocial and economic barriers to care and is at increased risk for a hospital admission and/or emergency room visits.
Population Relevance	The Community Needs Assessment conducted in 2014 for CPWNY and Millennium Collaborative Care (MCC) provides a picture of the population needing care management approaches. On broad composite measures of health status as framed by the New York State Prevention Agenda, Western NY does relatively poorly. Across sub-categories of chronic disease , health status disparities, creating a healthy and safe environment , preventing HIV, sexually transmitted diseases and other infectious diseases, promoting mental health and preventing substance abuse, and promoting the health of women, infants and children, the region performs generally below par. The region has as relatively low composite ranking for the subgroup for chronic disease with higher incidences of hospitalization for complications of diabetes complications of juvenile diabetes and for heart attacks. Rates for preventable ER visits, the WNY region as a whole performs just below the statewide average, but at the county level unnecessary ER use is higher across the Southern Tier counties of Chautauqua, Cattaraugus and Allegany.
Program Description	Population Health and Care Management is structured with policies, processes and reports for the PPS. Catholic Medical Partners has care management and clinical transformation staffs who provide regular support as requested. Rapid cycle process improvement is incorporated into the clinical transformation process within the office care team. The Population Health/Care Management Program measures include:

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	• Holistic assessment of the patient, inclusive of psychosocial elements and development of an individualized care plan in collaboration with the patient (i.e. behavioral health assessment inclusive of depression and drug/alcohol abuse screenings. • Transitional Care including a follow up appointment provided prior to hospital discharge*, a phone call from the office to the patient/care giver within 2 days of discharge, to include medication reconciliation and an office visit within 7 days of discharge to home (i.e. inclusive of hospital follow up tracking) • Documentation of coordination of care among specialists and primary care practitioner (i.e. referral tracking) • Quality and Utilization measures included in the evolving CPWNY Clinical Integration Program. As part of CPWNY ongoing management and progression of the Delivery System Redesign Incentive Payment (DSRIP) program, patients are provided with face-to-face contact with the office care team, telephonic outreach, mailings and secure messaging through the patient portal. Patients are also provided with easy to understand educational and self management tools and materials. Office care team members focus on education, self-management, shared decision making and patient centric goal setting. Pre-visit planning is routinely done to ensure all of the medical information is collected and is available in EMR for the medical office appointment. Key components of the CPWNY patient centered Population Health and Care Management are: • Coordinated and integrated care by the office based primary care team, (i.e. evidence based care interventions are tracked through each care context); • Comprehensive care through a team approach across the care continuum and specialties thereby avoiding unnecessary tests and visits; • Evidenced based guidelines; • Population health management principles inclusive of a review of outcomes data by practice and/or chronic condition;

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	• Patient engagement; • Quality of care improvement utilizing Rapid Cycle Evaluation strategies; • Practitioner and patient intervention tools such as, but not limited to, patient portals for communication, text reminders and mobile apps; • Education of the office care team which emphasizes a strong relationship with at risk patients; • Collaboration between the office based care teams and Catholic Medical Partners care management staff regarding patient interventions and community resources on a case by case basis. • Providing performance reports as they become available *currently at Catholic Health Hospitals.
Guideline Source	The following are national evidence based guidelines CPWNY has adopted; practices may adopt additional guidelines and community standards in the management of the "high risk" population. **Diabetes**- The diabetes evidenced based guidelines are adopted from Fifteenth edition, Institute for Clinical Systems Improvement **Congestive Heart Failure** – The congestive heart failure guideline is adopted from the Institute for Clinical Systems Improvement (ICSI) **Coronary Artery Disease Management** – The CAD guideline is adopted from the Institute for Clinical Systems Improvement (ICSI). **Hypertension Diagnosis and Treatment** – The guideline is adopted from the Institute for Clinical Systems Improvement (ICSI) **Chronic Obstructive Pulmonary Disease** –American College of Physicians guidelines **Depression** – The Major Depression in Adults in Primary Care Guideline is adopted from the Institute for Clinical Systems Improvement (ICSI.

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	Asthma –National Institutes of Health. **Chronic Kidney Disease** – Michigan Quality Improvement Consortium. **Clinical Practice Guidelines for Quality Palliative Care** , 3rd edition, National Consensus Project
Program Oversight	Design, monitoring and improvement of the program are under the direction of the CPWNY Chief Medical Officer, and Executive Board Group. The Clinical Integration and Standardization Group assists as the peer team and is composed of board certified practitioners from relevant specialties and primary care. They provide input into policies, procedures, guideline adoption, progress and efficacy of the CPWNY program. The Project Advisory Committee, comprised of, but not limited to, community based organizations, practitioners, Medicaid beneficiaries, union leaders, stakeholders, and the public sector, provides input into the workstream and project design utilizing 2-way communication. Catholic Medical Partners is responsible for (if delegated too), but not limited to, : 1. Population Health and Care Management, ensuring that it is consistent with the current clinical practice guidelines 2. Evidenced based guideline adoption, communication, systematic review and revisions based on new information 3. Data integration for population health management 4. Designing patient interventions 5. Evaluating patient materials 6. Providing shared decision making aides and patient self management tools 7. Communication of the program description to providers 8. Enforcement of patient rights and responsibilities, including confidentiality. 9. Coordination of care 10. Quality improvement activities

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Program Objectives	1. Improve the care of patients with complex medical needs through a proactive approach in the clinical office setting. 2. Assist the physician office to establish a plan of care according to patient needs and evidenced based guidelines. 3. Facilitate practice development of a Population Health and Care Management Models which are patient centered. 4. Provide information that can be used by the office care team to empower the patient to manage their condition. 5. Enhance the patient and care team relationship. 6. Provide performance data to the practice for continuous improvement. 7. Assist in providing resources to patients with the use of the Health Home and Community Based Organization partners.
Program Design Identifying priority population, goal monitoring and addressing gaps in care	<u>Identification of Patients for the Population Health/ Care Management Programs</u>: A. Patients in the office based Population Health/ Care Management programs are identified through review of medical claim information and/or NYS Department of Health attribution model. The care team at the office is pivotal for providing collaborative care, incorporating 'real time' decision support to practitioners. The office based Population Health /Care Management programs utilize a registry and reporting system generated from the practice electronic medical record to monitor patient care and suggest interventions for patients not meeting targeted goals according to the evidence based guidelines that have been adopted by CPWNY. Information is incorporated into the patient electronic medical record by the care team that includes specialist reports, a holistic patient assessment, a care plan and patient reported information. Patient self-management materials are evaluated by CPWNY Medicaid member focus groups when new information is made available. B. Community forums are utilized to (but not limited to) impart information regarding the CPWNY redesign of health care delivery through project and workstream updates, patient self-management tools, the cultural competency and health literacy

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	strategy. Forums also provide an opportunity to receive feedback on activities undertaken by CPWNY . C. <u>Availability and Access to Population Health/ Care Management Program</u>: Patients are identified for the program through engagement in their primary care physician office. Patients who do not wish to receive any education about their condition or follow up calls can make their request known to the care team at the physician office or indicate preference for communication. Office based Population Health/ Care Management is available to the patient in conjunction with physician office hours. *For care management urgent calls, the patient is advised to contact their primary care physician office and follow the triage instructions that are available to patients 24/7. Assistance is provided with the use of the Health Home and Community Based Organization partners.* D. <u>Continuity of Care</u> Activities of treating practitioners, specialists, and healthcare facilities, encompassing the care continuum are incorporated into the care of the patient in the office based Population Health/Care Management program. The care team is responsible for timely exchange of patient information.
Program Information	*The CPWWNY Population Health/Care program functions through delegation to the physician offices. Catholic Medical Partners and CPWNY do not advertise market or promote products or services to patients or practitioners. Catholic Medical Partners and CPWNY have no financial ownership arrangements with other entities. Additional information regarding CPWNY is available at* wnycommunitypartners.org. *Primarily, patients are advised to contact the physician office for any questions regarding the care management /population care management program.* <u>Physician Rights</u>: Practitioners participating in the Catholic Medical Partners/CPWNY Population Health/ Care Management programs

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	have the right to: 1. Obtain information about CPWNY organization, its staff and its staffs' qualifications and any contractual relationships. 2. Be informed of how CPWNY expects the office to coordinate interventions with treatment plans for individual patients 3. Know how to contact the person responsible for managing and communicating with the practitioner's patients. 4. Be supported by Catholic Medical Partners and CPWNY to make decisions collaboratively with patients regarding their care. 5. Receive courteous and respectful treatment by the Catholic Medical Partners staff. 6. Communicate complaints to Catholic Medical Partners or CPWNY.
Patient Rights and Responsibilities and Expectations	The Patient has the right to : 1. Have information about the physician office and Catholic Medical Partners, its staff and its staffs' qualifications and any contractual relationships (including programs and services provided on behalf of Catholic Medical Partners); 2. Decline participation or disenrollment from the programs and services offered by Catholic Medical Partners or CPWNY; 3. Know which staff members are responsible for managing their enhanced care management services and from whom to request a change; 4. Actively participate in collaborative making decisions about their health care; 5. Receive complete information on treatment options 6. Be informed of all enhanced care management options included or mentioned in the clinical guidelines, even if a treatment is not covered, and to discuss treatment options with practitioners; 7. Have personal identifiable data and medical information

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	kept confidential; know what entities have access to their information; know procedures used by the doctor office , Catholic Medical Partners and CPWNY to ensure security, privacy and confidentiality; 8. Be treated with respect and recognition of their dignity and their right to privacy; 9. Voice complaints about the organization or the care it provides; 10. Receive understandable information The Patient is expected to: 1. Follow plans and instructions for care that they have agreed to with clinicians; 2. Participate in developing a care management plan and carrying it out; 3. Provide the physician office with information necessary to carry out its services;
Measurement and Quality Improvement	CPWNY Population Health/ Care Management Programs are monitored for outcomes and effectiveness through the physician directed CISG, the CPWNY Clinical Governance/Quality Committee (CGC) and by the CPWNY Executive Governance Board (EGB). The CGC program addresses measurements in place, analytical resources, interventions and re-measurements of CPWNY project activities.
Reviewed by Committee	December 17, 2015 /Approved December 21, 2015

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IT INFRASTRUCTURE

IT infrastructure required to support a population health management approach, such as creation of a population health dashboard based on available data sets and registries

Population Health for an Integrated Delivery System

Population Health Technology Road Map Executive Summary

The goal of this project is to identify, select, and establish the required information systems and processes to facilitate an operational Integrated Delivery System to enable transformation to a population health operating model health care system. This will include the following features:

1. **Enterprise Data Warehouse**, to provide the data source basis that will aggregate, normalize, organize, and assimilate data from numerous data sources for use by other features in this road map;
2. **Enterprise Master Patient Index**, to facilitate the aggregation of clinical data from multiple sources by linking data at a patient level based on a common patient identifier;
3. **Data Analytics-Decision Support Software System**, to provide monitoring and analytics capabilities to improve quality and cost, establish a care management/coordination work flow and determine target populations based on health disparities;
4. **Health Information Exchange (HIE)**, to provide a patient and clinical portal plus other features and functions, along with integration with the RHIO (Regional Health Information Organization) data, leveraging its features and functions;

To implement these features, the project will engage the expertise of IT specialists to install and prepare the hardware and software described above, and educate in-house trainers on the specifics of an Integrated Delivery System management information system, including all associated hardware and applications.

These are considered the foundational information technology solutions and tools required for the transformation of health care. The overarching goal is an integrated delivery system functioning in a data-driven paradigm through which the highest quality care is provided to patients in the most cost-effective setting with a focus on prevention and maintenance of healthcare. The goal also includes ongoing optimization of utilization at all level of care to avoid unnecessary and redundant services.

The Project will address the Western New York community's need for transformation from a largely inpatient-based health care system to a system characterized by accessible primary and preventive services. This can be quantified as a reduction in preventable inpatient admissions, readmissions, and ED visits. The specific service delivery area will be the counties of Erie, Niagara and Chautauqua.

The desired outcomes will be a system where clinicians will be able to detect patients at risk of adverse health events, identify those missing appointments or other maintenance testing, and ensure timely ambulatory follow-up care for patients receiving inpatient care. Emergency and inpatient utilization will be reduced while quality performance for outpatient measures will be increased. In this way, the Project will support the DSRIP program goals of improving population health, supporting transformational change to the healthcare delivery system, reducing the overall cost of health care services, increasing access to appropriate and high quality health care for all, reducing avoidable hospital use, improving other health and public health measures, ensuring that delivery system transformation continues beyond the waiver period, preserving essential safety net providers, and to the extent permitted by CMS, encouraging widespread DSRIP participation throughout the state.

Population Health Technology Map

The goal of this project is to identify, select, and establish the required information systems and processes to facilitate an operational Integrated Delivery System to facilitate transformation to a population health operating model health care system.

This will include the following components:

Data Analytics-Decision Support Software Suite, including Analytics System, Enterprise Master Patient Index, and Enterprise Data Warehouse

These components will perform numerous functions, including the advancement of quality goals and management of cost savings for defined patient populations such as Medicaid beneficiaries, and the development and operation of effective, collaborative care management efforts. The item supports the overall project by reducing the cost of required care provided in each setting, improving the quality of care resulting in better outcomes, greater patient satisfaction and a reduction in long-term costs by supporting a higher level of health on a continual basis, optimizing ambulatory care to prevent unnecessary ED visits, inpatient admissions and readmissions, coordinating medication reconciliation, identifying at-risk patients for follow-up to ensure required treatment and testing is performed, documenting socioeconomic issues impacting care, analyzing the feasibility of required metrics for the development of sustainable bundled payment methodologies, and informing trend analysis to implement better measures to improve quality and reduce costs.

Crimson Continuum of Care and Surgical Profitability Compass

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

Crimson Care Management

The implementation of this care management application will provide access to complete and timely clinical information to all care management/coordination, physician and other medical service personnel in each patient's health care network. The implementation of this application will facilitate the development of a more comprehensive clinical data set accessible by all care providers, allowing for a higher level of coordination. The desired outcomes include optimization of ambulatory care to prevent emergency department visits, initial inpatient admissions and readmissions, coordination of medication reconciliation, identification of at risk patients for follow-up to ensure required treatment and testing is performed and documentation of socioeconomic issues impacting care.

Enterprise Master Patient Index

A third segment of the project will be enterprise master patient index (EMPI) selection and implementation to facilitate the integration of data from multiple sources through a common unique patient identifier. The desired outcomes include ability to match clinical and claims data in a more complete, accurate and timely manner and authenticate patients at presentation for treatment to prevent fraudulent service provision.

Crimson Population Risk Management and Crimson Quality Reporting

Fourth, a pair of network and population management analytics and reporting applications are essential to monitor the sources of care for patients. The desired outcomes of these applications includes determination of patient care patterns to reduce unnecessary, emergency room, urgent care and hospital services, analysis of the feasibility of required metrics for the development of sustainable bundled payment methodologies and trend analysis to implement better measures to improve quality and reduce cost. They will also provide ongoing monitoring of outpatient care quality based on nationally recognized evidence based measures such as ACO, PQRS and HEDIS measure sets.

Enterprise Data Warehouse

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

Health Information Exchange (HIE)

Health Information Exchanges are essential for information management in an Integrated Delivery System. *MobileMD* is an HIE that provides comprehensive data exchange solutions enabling omni-

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

Other exchange solutions provided by *MobileMD* include: 1) sending and receiving secure messages via the DIRECT Protocol; 2) connecting/integrating to numerous EHRs, both acute and ambulatory based; 3) electronically ordering lab tests from various lab companies; 4) specialty referral processing and management; and 5) providing patient education. In addition, this tool will likely help reduce the cost of required care provided in each setting because of easily accessible and real-time data; improve the quality of care resulting in better outcomes and greater patient and clinician satisfaction; optimize ambulatory care to prevent unnecessary ED visits, inpatient admissions, and readmissions; coordinate medication reconciliation; reduce diagnostic testing redundancy; and reduce costs.

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

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

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

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

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

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

The HEALTHeLINK portion of the Health Information Exchange component is centered on the acquisition and implementation of health information technology. To this end, the **first sub-project** is to acquire and implement a Data Quality Management facility to be used when any practice/hospital is preparing to upload CCDs to HEALTHeLINK. Practice data about patients is uploaded to HEALTHeLINK in the form of a CCD (continuity of care document) at the close of each encounter. Each practice manages how it stores patient data in discrete data fields or as free form text. Additionally, each EMR vendor implements the CCD standards in slightly different ways. The result of this is inconsistent data being uploaded to HEALTHeLINK. When used in population health analytics, this inconsistency causes erroneous or incomplete results making it more difficult to assess the health of the population as a whole and to manage the health of the individuals.

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

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

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

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

IT Implementation Workplan

Population Health Technology Work Plan

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
Data Analytics/Decision Support Software Suite a) Crimson Continuum of Care and Surgical Profitability Compass - Implementation of a cross continuum application to monitor and manage cost and quality of care provided. Crimson Continuum of	Other	a. Data acquisition	i. Inpatient and emergency department data interfacing; Date: 4/1/2015
			ii. Ambulatory (hospital based) data interfacing; Date: 4/1/2015
		b. User acceptance testing	i. Inpatient and emergency department cost and quality analytics; Date: 6/1/2015
			ii. Ambulatory (hospital based) cost and quality analytics; Date: 6/1/2015
		c. User roll-out and first productive use	i. Inpatient and emergency department cost and quality analytics; Date: 7/15/2015
			ii. Surgical (hospital based) cost and quality analytics; Date: 7/15/2015
b) Crimson Care Management - Implementation of a care management application to provide access to complete and timely clinical information to all care management/coordination, physician and other medical service personnel in each patient's healthcare network.	Other	a. Data acquisition – Phase I	i. In network Admission/Discharge/Transfer (ADT) alert data; Target date: 5/1/2016
			ii. Risk adjusted patient data (claims based) interfacing; Date: 1/1/2016
			iii. Medications and diagnosis (claims based) interfacing; Date 3/15/2016
		b. User acceptance testing – Phase I	i. In network results data and Admission/Discharge/Transfer (ADT) alert; Target date; 5/1/2016
			ii. Risk adjusted patient data (claims based) interfacing; Date: 2/1/2016
			iii. Medications and diagnosis (claims based) interfacing; Target date 4/15/2016

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
		c. User roll-out and first productive use – Phase I	i. In network results data and Admission/Discharge/Transfer (ADT) alert; Target date: 5/1/2016
			ii. Risk adjusted patient data (claims based) interfacing ; Target date: 5/1/2016
			iii. Medications and diagnosis (claims based) interfacing; Target date 5/1/2016
		a. Data acquisition – Phase II	i. HEALTHeLINK (SHIN-NY) Admission/Discharge/Transfer (ADT) alert data; Target date: 10/31/2016
		b. User acceptance testing – Phase II	iv. HEALTHeLINK (SHIN-NY) Admission/Discharge/Transfer (ADT) alert data; Target date: 11/30/2016
		c. User roll-out and first productive use – Phase II	iv. HEALTHeLINK (SHIN-NY) Admission/Discharge/Transfer (ADT) alert data; Target date: 12/31/2016
		a. Data acquisition – Phase III	i. physician practice (EMR) data interfacing; Target date: 7/31/2017
			ii. In network lab results; Target date: 7/31/2017
			iii. HEALTHeLINK (SHIN-NY) lab results data; Target date:7/31/2017
			iv. Gaps in care processing and workflows; Target date: 7/31/2017
		b. User acceptance testing – Phase III	i. physician practice (EMR) data interfacing; Target date: 8/31/2017
			ii. In network lab results; Target date: 8/31/2017
			iii. HEALTHeLINK (SHIN-NY) lab results data; Target date: 8/31/2017
			iv. Gaps in care processing and workflows; Target date: 8/31/2017

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
		c. User roll-out and first productive use – Phase III	i. physician practice (EMR) data interfacing; Target date: 9/30/2017
			ii. In network lab results; Target date: 9/30/2017
			iii. HEALTHeLINK (SHIN-NY) lab results data; Target date: 9/30/2017
			iv. Gaps in care processing and workflows; Target date: 9/30/2017
c) Enterprise master patient index selection and implementation to facilitate the integration of data from multiple sources through a common unique patient identifier.	Other	a. Selection	i. Issue request for proposals to a minimum of three quality vendors; Target date; 3/31/2016
			ii. Perform complete and formal review and evaluation; Target date: 6/30/2016
			iii. Section and contract completion; Target date: 7/31/2016
		b. Installation	i. First Productive Use of base installation; Target date: 9/30/2016
		c. Interfacing	i. First Productive Use of hospital system interfacing; Target date: 12/31/2017
			ii. First Productive Use of community care system interfacing; Target date: 3/1/2017
			iii. First Productive Use of Physician practice (medical group) interfacing; Target date: 12/31/2017
			iv. Other care providers interfacing; Target date: 3/31/2018
		d. User roll-out and first productive use	i. Hospital systems; Target date: 1/1/2017
			ii. Community care systems; Target date: 4/17/2017

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
			iii. Physician practice (medical group) systems; Target date: 1/1/2018
			iv. Other care providers systems; Target date: 7/31/2018
d) Crimson Population Risk Management and Crimson Quality Reporting - Network and population management analytics and reporting application to monitor the sources of care for patients.	Other	a. Data acquisition	i. First Productive Use of Claims data interfacing; Target date: 12/1/2015
			ii. First Productive Use of physician practice (medical group) data interfacing; Target date: 5/1/2016
		b. User acceptance testing	i. Inpatient analytics; Target date: 9/1/2015
			ii. Ambulatory (hospital based) analytics; Target date: 9/1/2015
			iii. Physician practice (medical group) analytics; Target date: 9/1/2016
		c. User roll-out and first productive use	i. Inpatient analytics; Target date: 9/30/2015
			ii. Ambulatory (hospital based) analytics; Target date: 9/30/2015
			iii. Physician practice (medical group) analytics; Target date: 9/30/2016
e) Enterprise data warehouse selection and implementation to support ad hoc reporting and data analysis for both clinical and financial and any required level of aggregation.	Other	a. Selection	i. Issue request for proposals to a minimum of three quality vendors; Target date: 3/31/2016
			ii. Perform complete and formal review and evaluation; Target date: 6/30/2016
			iii. Section and contract completion; Target date: 6/30/2016
		b. Installation	i. First Productive Use of base installation; Target date: 9/30/2016

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
		c. Interfacing	i. First Productive Use of hospital system interfacing; Target date: 12/31/2016
			ii. First Productive Use of community care system interfacing; Target date: 3/31/2017
			iii. First Productive Use of Physician practice (medical group) interfacing; Target date: 1/31/2016
			iv. Other care providers interfacing; Target date: 3/31/2018
		d. User roll-out and first productive use	i. Hospital systems; Target date: 1/1/2017
			ii. Community care systems; Target date: 4/1/2017
			iii. Physician practice (medical group) systems; Target date: 2/1/2018
			iv. Other care providers systems; Target date: 6/31/2018
Health Information Exchange *A. Patient Portal* Provide comprehensive data exchange solutions that enable omni-directional communication between care providers and patients.	Other	Roll out Patient Portal to PPS members without EHRs	i. Roll out to first PPS member, 2016 ii. Roll out to other PPS members, 2016
		Roll out Clinical Portal to PPS members without EHRs	ii. Roll out to first PPS member, 2018 ii. Roll out to other PPS members, 2019
		Integrate Patient Portal with HEALTHeLINK • Virtual Health Record (VHR) query • Results Push • Results Delivery • VA CCD Query • CCD Upload • CCD Query Single Sign-On with Context	i. Integration complete, 2016

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
		Ordering	i. Enable lab ordering, 2019
		Referral Processing	i. Enable Referral Processing, 2019
B. HEALTHeLINK 1. Implement a Data Quality Management facility to verify key sources of data to the exchange and assure the quality and consistency of that data is sufficient for use by treating providers and to support population health analytics across health care settings.		Data Quality Management facility - Build and implement a Practice Data Quality Management facility to be used when any practice/hospital is preparing to upload CCDs to HEALTHeLINK. HEALTHeLINK is responsible for this task and will work with PPSs to set performance measures for scope and scale of deployment	i. Practice Data Quality Management facility implemented by 6/1/2016. Every health care entity that uploads CCDs to HEALTHeLINK will have an assessment performed on the content, structure, and format of its CCDs. Any CCDs that do not meet a quality threshold set by the PPSs will not be accepted into the exchange. ii. Performance measures for scope and scale of deployment set for each PPS with the first year. iii. Performance measures achieved by end of grant period.
2. Implement a terminology server tool to automatically map all inbound data feeds to a normalized data set to improve storage in and retrieval from the health information exchange (HIE).		Automated terminology server for mapping of clinical code sets and other data on inbound feeds to provide a normalized data set to drive interoperability and quality reporting. HEALTHeLINK is responsible for this task and will work with PPSs to set performance measures for scope and scale of deployment.	i. By 6/1/2017, HEALTHeLINK receives data from hospitals, labs and a variety of other sources in a mix of local terminology. Automatically map all inbound feeds to a normalized data set and persist in the exchange. ii. Performance measures for scope and scale of deployment set for each PPS with the first year. iii. Performance measures achieved by end of grant period.
3: Provide a community wide patient event notification service		Build an enhanced event notifications service within the	i. By 6/1/2017, PPS care coordinators, PCPs, and other providers involved in

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OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
that keys on multiple event types and is configurable to the practice/provider level		HEALTHeLINK platform that is configurable to the practice/provider level and triggers notices from multiple event types, e.g. ADT values, lab types and values and other clinical values. HEALTHeLINK is responsible for this task and will work with PPSs to set performance measures for scope and scale of deployment.	managing the health of Medicaid patients are able to notification parameters unique to their practice and use case. ii. Performance measures for scope and scale of deployment set for each PPS with the first year. iii. Performance measures achieved by end of grant period.
4: Increase the number of PPS partner organization providers and staff have the ability to securely and readily exchange patient data using DIRECT.		Build a directory that contains the DIRECT address of providers/practices across the community. This would facilitate the direct exchange of patient information between health care settings and would be readily accessible by any provider/user HEALTHeLINK is responsible for this task and will work with PPSs to set performance measures for scope and scale of deployment.	i. 8/1/2017 All PPS providers and staff with DIRECT Addresses have their DIRECT Addresses in the regional directory of DIRECT addresses. ii. Performance measures for scope and scale of deployment set for each PPS with the first year. iii. Performance measures achieved by end of grant period.
5: Increase the number of PPS partner organization providers and staff have secure, two-factor authentication access to HEALTHeLINK		Purchase 500 authentication tokens to be deployed to PPS practices. Authentication tokens are used where alternate	i. 3/1/2017, 500 additional PPS providers and staff will have secure, two-factor authentication access to HEALTHeLINK .

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
		authentication methods are not an option. HEALTHeLINK is responsible for this task and will work with PPSs to identify practices needing tokens.	

Crimson Care Management

Rollout of Training on Population Health Care Management Module

CHS Training Schedule Options

General Notes

Please review suggested training options and confirm with your Program Consultant which option will be serve your needs, or discuss if a combination is preferred.

Dates and start times can be adjusted. Please discuss with your Program Consultant if you need to adjust a 4-hour block so that training agendas/content can be adjusted accordingly.

Onsite

Session	Date/Time	Care Setting	Content
#1	Tuesday April 26th 8:00 AM – 12:00 PM EST	Inpatient/ED Care Managers	Inpatient/ED End User Training Option #1
#2	Tuesday April 26th 12:00 PM – 4:00 PM ST	Office Care Coordinators	Office Care Coordinator End User Training Session#1
#3	Wednesday April 27th 8:00 AM – 12:00 PM EST	Office Care Coordinators	Office Care Coordinator End User Training Session#2
#4	Wednesday April 27th 12:00 PM – 4:00 PM EST	Office Care Coordinators	Office Care Coordinator End User Training Session#3
#7	Friday April 28th 8:00 AM – 12:00 PM EST	ANY – SUPER USERS	Super User Training
		Total	28 Hours
		Remaining Virtual Options	20 Hours

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IT detailed workplan in relation to actual practice implementation and status monitoring

Generated on behalf of Craig Jaffe on Tuesday, April 26, 2016 6:08:29 AM

Work Plan

State	Status	# of Cases	# of Predecessors	Name	Current Status	Duration
Active	On Track	31		CHS Buffalo CCM Populations	Final Compr UAT scheduled 4/18 and go live 5/2 following cutovers week of 4/25. Ongoing work with Healthe Link ADT to get live and sample messages. Upon receipt of messages we will review timeline Proj Critical: Due to delay in files/information from CHS regarding Health E Link ADT	330 d
Active	On Track			Training	Scheduled 4.25	70 d
Active	At Risk			Onsite Training		1 w
Active	On Track			Phase I First Files Comprehensive UAT	On Pace	18 d
Active	On Track			Comprehensive Testing		16 d
Active	On Track	4	1	Internal QA/Spot Check		10 d
Active	On Track			Fix: ED/IP Organizations Workflow		10 d
Active	On Track			Hot Patch	Need confirm from Chris R	1 d
Active	On Track	3		Phase I Cutover Go Live (Population, CHS ADT, Meds, Diag)	Cut over occurring same week as training 4.25	10 d
Active	On Track		1	Population Implementation		10 d
Active	On Track	1		Prepare Instructions, Schedule Load Slot, and Test Plans for Cutover		1 w
Active	At Risk			Load into Production	Actual on 4/25	1 w
Active	At Risk			Final Production Verification		1 w
Active	On Track		1	Population Go Live		1 w
Active	On Track	5	1	ADT Implementation		6 d
Active	On Track			Prepare Instructions, Schedule Load Slot, and Test Plans for Cutover		1 d
Active	On Track			Load into Production	Actual on 4/29	1 d
Active	On Track			Final Production Verification		1 d
Active	On Track		1	ADT Go Live		1 w
Active	On Track		1	Diagnosis Implementation		10 d
Active	Off Track			Prepare Instructions, Schedule Load Slot, and Test Plans for Cutover		1 d
Active	On Track		1	Load into Production	Actual on 4/27	4 d
Active	On Track		1	Final Production Verification		4 d
Active	On Track		1	Claims Diagnosis Go Live		1 w
Active	On Track	1		Medications Implementation		10 d
Active	At Risk		1	Prepare Instructions, Schedule Load Slot, and Test Plans for Cutover		1 w
Active	At Risk			Load into Production	Actual on 4/26	1 w
Active	At Risk			Final Production Verification		1 w
Active	On Track		1	Claims Diagnosis Go Live		1 w
Active	On Track			Phase I Subsequent File Logic	Pacing to CPRM file delivery. Targeting receipt 4.14	85 d
Active	On Track			Subsequent Development		65 d
Active	On Track	1	1	Load File into Stage		11 w
Active	On Track		1	Subsequent Testing		20 d

	A	B	C	D	E	F	G
42	Active	On Track			Internal Testing		20 d
43	Active	On Track	2		Perform Validation		1 w
44	Active	On Track		1	Resolve Validation		1 w
45	Active	On Track		2	Re-load into stage (inclusive of alerts release)	Need to wait until comprehensive uat is concluded as that is priority. Once done we will load into stage	2 w
46	Active	On Track			Phase I Subsequent Files Comprehensive UAT	Pacing to CPRM file delivery. Targeting receipt 4.14	10 d
47	Active	On Track		1	UAT	Require 2 weeks live using orig first files to ensure quality	10 d
48	Active	On Track			UAT with Member		1 w
49	Active	On Track		1	Resolve UAT Issues		1 w
50	Active	On Track		1	Phase I Cutover Go Live (Subsequent Files)	Pacing to CPRM file delivery. Targeting receipt 4.14	5 d
51	Active	On Track			Subsequent Implementation		5 d
52	Active	On Track			Load data into Production		1 w
53	Active	On Track	3		Phase II HEALTHe LINK ADT	Shankar in progress of reviewing data with Prasad (member) and constructing IDD	65 d
54	Active	On Track			ADT Development		50 d
55	Active	On Track			Integration Development		50 d
56	Active	On Track	1	1	Review File and Build IDD	Shankar in progress of reviewing data with Prasad (member) and constructing IDD	5 w
57	Active	On Track		1	Member Signs Off on Final IDD		1 w
58	Active	On Track		1	Submit Ticket for Development		1 d
59	Active	On Track		1	Internal Review of Mapping Guide		5 d
60	Active	On Track			Walk Through of Mapping Guide and Test Plans with IDES		1 w
61	Active	On Track			Validation of Specifications		1 w
62	Active	On Track			Resolve IDES Validation Issues and Get Sign off with Member		1 w
63	Active	On Track		1	Build Integration		15 d
64	Active	On Track			Develop and Test Mirth		1 w
65	Active	On Track		1	Implement Interface Code		1 w
66	Active	On Track		1	Complete Code Review		1 w
67	Active	On Track		1	Configure Monitor and Set Up Environment		1 w
68	Active	On Track		1	Load Data into CERT		1 d
69	Active	On Track		1	ADT Testing		15 d
70	Active	On Track			Internal Testing of Stage Environment		15 d
71	Active	On Track			Build/Code Review		1 w
72	Active	On Track		1	Perform Validation		1 w
73	Active	On Track		1	Workflow Review		1 w
74	Active	On Track		1	Resolve Validation Issues		1 w
75	Active	On Track		1	Phase II HealtheLink ADT Comprehensive UAT		10 d
76	Active	On Track			UAT		10 d
77	Active	On Track			Prepare Environment for UAT		1 w
78	Active	On Track			UAT with Member		1 w
79	Active	On Track		1	Resolve Post UAT Issue		1 w
80	Active	On Track		1	Verify Post UAT Fixes		1 w
81	Active	On Track		1	ADT Sign Off		1 w
82	Active	On Track		1	Phase II HealtheLink ADT Cutover Go Live		5 d
83	Active	On Track			ADT Implementation		5 d
84	Active	On Track			Prepare Instructions, Schedule Load Slot, and Test Plans for Cutover		1 w
85	Active	On Track			Load into Production		1 w
86	Active	On Track			Final Production Verification		1 w
87	Active	On Track			ADT Go Live		1 d
88	On Hold	Not Active	1		Phase III Labs ADT	Needs further scoping Marie/Kimbra working with Jeff S - May be taken care of from EMR (following O	5 d
89	On Hold	Not Active			ADT Labs Development		5 d
90	On Hold	Not Active			Integration Development		5 d
91	On Hold	Not Active			Send Labs file to CCM		1 w
92	On Hold	Not Active			Set up CDA and Extract Member Data		1 w
93	On Hold	Not Active			Review File and Build Data Mapping Guide		1 w
94	On Hold	Not Active			Member Signs Off on Final DMG		1 w
95	On Hold	Not Active			Submit Ticket for Development		1 d
96	On Hold	Not Active			Internal Review of Mapping Guide		5 d

	A	B	C	D	E	F	G
97	On Hold	Not Active			Walk Through of Mapping Guide and Test Plans with IDES		1 w
98	On Hold	Not Active			Validation of Specifications		1 w
99	On Hold	Not Active			Resolve IDES Validation Issues and Get Sign off with Member		1 w
100	On Hold	Not Active			Build Integration IDES		5 d
101	On Hold	Not Active			Write Post Load Script and Extract Data in CDA		1 w
102	On Hold	Not Active			Implement Interface Code		1 w
103	On Hold	Not Active			Complete Code Review		1 w
104	On Hold	Not Active			Configure Monitor and Set Up Environment		1 w
105	On Hold	Not Active			Load Data into CERT		1 d
106	On Hold	Not Active			ADT Labs Testing		5 d
107	On Hold	Not Active			Internal Testing of CERT Environment		5 d
108	On Hold	Not Active			Internal Testing Based on Test Plans		1 w
109	On Hold	Not Active			Perform Validation		1 w
110	On Hold	Not Active			Resolve Validation Issues		1 w
111	On Hold	Not Active			UAT		5 d
112	On Hold	Not Active			Prepare Environment for UAT		1 w
113	On Hold	Not Active			UAT with Member		1 w
114	On Hold	Not Active			Resolve Post UAT Issue		1 w
115	On Hold	Not Active			Verify Post UAT Fixes		1 w
116	On Hold	Not Active			ADT Labs Sign Off		1 w
117	On Hold	Not Active			ADT Labs Implementation		5 d
118	On Hold	Not Active			Prepare Instructions, Schedule Load Slot, and Test Plans for Cutover		1 w
119	On Hold	Not Active			Load into Production		1 d
120	On Hold	Not Active			Final Production Verification		1 d
121	On Hold	Not Active			Claims Visits Go Live		1 d
122	On Hold	Not Active			Phase IV EMR	Following CQR Needs further scoping Marie/Kimbra working with Jeff S	
123	On Hold	Not Active			Phase V Gaps In Care	Following CQR Needs further scoping Marie/Kimbra working with Jeff S	

	H	I	J	K	L	M	N	O	P
1									
2									
3									
4									
5									
6									
7									
8	Start Date	Due Date	Resources	Level					
9	05/04/15	08/05/16	$CCM- Admin, $CCM- Integration & Delivery Engineer, $CCM- Integration Client Engineer, $CCM- Project Manager, $CCM- Resource Manager, $CCM- Services Manager, $CCM- Workflow Consultant, $Coordinator, $Member- Project Lead, $Member- Technical Lead, $Project Manager, Barbara Bartosch, Craig Jaffe, Dhananjay Singh, Frank Kopankiewitz, Gurjyot Dhaliwal, Katie Ormand, Kirbhashankar Prabhakaran, Marie Laurenza, Rory Costigan, Stephanie Nachlas, Umesh Singh	0					
10	01/25/16	04/29/16		1					
11	04/25/16	04/29/16	Katie Ormand	2					
12	04/04/16	04/27/16		1					
13	04/06/16	04/27/16		2					
14	04/14/16	04/27/16	Kirbhashankar Prabhakaran	3					
15	04/14/16	04/27/16		4					
16	04/27/16	04/27/16		5					
17	04/25/16	05/06/16		1					
18	04/25/16	05/06/16		2					
19	04/25/16	04/29/16	Umesh Singh	3					
20	04/25/16	04/29/16	Umesh Singh	3					
21	04/25/16	04/29/16	Kirbhashankar Prabhakaran	3					
22	05/02/16	05/06/16	Craig Jaffe	3					
23	04/29/16	05/06/16		2					
24	04/29/16	04/29/16	Gurjyot Dhaliwal	3					
25	04/29/16	04/29/16	Gurjyot Dhaliwal	3					
26	04/29/16	04/29/16	Kirbhashankar Prabhakaran	3					
27	05/02/16	05/06/16	Craig Jaffe	3					
28	04/25/16	05/06/16		2					
29	04/25/16	04/25/16	Umesh Singh	3					
30	04/28/16	04/29/16	Umesh Singh	3					
31	04/26/16	04/29/16	Kirbhashankar Prabhakaran	3					
32	05/02/16	05/06/16	Craig Jaffe	3					
33	04/25/16	05/06/16		2					
34	04/25/16	04/29/16	Umesh Singh	3					
35	04/25/16	04/29/16	Umesh Singh	3					
36	04/25/16	04/29/16	Kirbhashankar Prabhakaran	3					
37	05/02/16	05/06/16	Craig Jaffe	3					
38	03/07/16	07/01/16		1					
39	03/07/16	06/03/16		2					
40	03/21/16	06/03/16	Umesh Singh	3					
41	06/06/16	07/01/16		2					

Attachment F

	H	I	J	K	L	M	N	O	P
42	06/06/16	07/01/16		3					
43	06/06/16	06/10/16	Kirbhashankar Prabhakaran	4					
44	06/13/16	06/17/16	Umesh Singh	4					
45	06/20/16	07/01/16	Umesh Singh	4					
46	07/04/16	07/15/16		1					
47	07/04/16	07/15/16		2					
48	07/04/16	07/08/16	Craig Jaffe	3					
49	07/11/16	07/15/16	Umesh Singh	3					
50	07/18/16	07/22/16		1					
51	07/18/16	07/22/16		2					
52	07/18/16	07/22/16		3					
53	04/04/16	07/01/16		1					
54	04/04/16	06/10/16		2					
55	04/04/16	06/10/16		3					
56	04/04/16	05/06/16	Kirbhashankar Prabhakaran	4					
57	05/09/16	05/13/16		4					
58	05/13/16	05/13/16	Kirbhashankar Prabhakaran	4					
59	05/16/16	05/20/16		4					
60	05/16/16	05/20/16	Kirbhashankar Prabhakaran	5					
61	05/16/16	05/20/16	Dhananjay Singh	5					
62	05/16/16	05/20/16	Kirbhashankar Prabhakaran	5					
63	05/23/16	06/10/16		4					
64	05/23/16	05/27/16	Dhananjay Singh	5					
65	05/30/16	06/03/16	Dhananjay Singh	5					
66	06/06/16	06/10/16	Dhananjay Singh	5					
67	06/06/16	06/10/16	Dhananjay Singh	5					
68	06/10/16	06/10/16	Dhananjay Singh	4					
69	06/13/16	07/01/16		2					
70	06/13/16	07/01/16		3					
71	06/13/16	06/17/16	Dhananjay Singh	4					
72	06/20/16	06/24/16	Kirbhashankar Prabhakaran	4					
73	06/27/16	07/01/16	Craig Jaffe	4					
74	06/27/16	07/01/16	Dhananjay Singh	4					
75	07/04/16	07/15/16		1					
76	07/04/16	07/15/16		2					
77	07/04/16	07/08/16	Umesh Singh	3					
78	07/04/16	07/08/16	Craig Jaffe, Kirbhashankar Prabhakaran	3					
79	07/11/16	07/15/16	Umesh Singh	3					
80	07/11/16	07/15/16	Kirbhashankar Prabhakaran	3					
81	07/11/16	07/15/16		3					
82	07/18/16	07/22/16		1					
83	07/18/16	07/22/16		2					
84	07/18/16	07/22/16	Umesh Singh	3					
85	07/18/16	07/22/16	Umesh Singh	3					
86	07/18/16	07/22/16	Kirbhashankar Prabhakaran	3					
87	07/18/16	07/18/16	Craig Jaffe	3					
88	08/01/16	08/05/16		1					
89	08/01/16	08/05/16		2					
90	08/01/16	08/05/16		3					
91	08/01/16	08/05/16	SMember- Project Lead	4					
92	08/01/16	08/05/16	Kirbhashankar Prabhakaran	4					
93	08/01/16	08/05/16	Kirbhashankar Prabhakaran	4					
94	08/01/16	08/05/16		4					
95	08/01/16	08/01/16	Craig Jaffe	4					
96	08/01/16	08/05/16		4					

	H	I	J	K	L	M	N	O	P
97	08/01/16	08/05/16	Kirbhashankar Prabhakaran	5					
98	08/01/16	08/05/16	Umesh Singh	5					
99	08/01/16	08/05/16	Kirbhashankar Prabhakaran	5					
100	08/01/16	08/05/16		4					
101	08/01/16	08/05/16	Umesh Singh	5					
102	08/01/16	08/05/16	Umesh Singh	5					
103	08/01/16	08/05/16	Umesh Singh	5					
104	08/01/16	08/05/16	Umesh Singh	5					
105	08/01/16	08/01/16	Umesh Singh	4					
106	08/01/16	08/05/16		2					
107	08/01/16	08/05/16		3					
108	08/01/16	08/05/16	Umesh Singh	4					
109	08/01/16	08/05/16	Kirbhashankar Prabhakaran	4					
110	08/01/16	08/05/16	Umesh Singh	4					
111	08/01/16	08/05/16		3					
112	08/01/16	08/05/16	Umesh Singh	4					
113	08/01/10	08/05/16	Craig Jaffe, Kirbhashankar Prabhakaran	4					
114	08/01/16	08/05/16	Umesh Singh	4					
115	08/01/16	08/05/16	Kirbhashankar Prabhakaran	4					
116	08/01/16	08/05/16		4					
117	08/01/16	08/05/16		2					
118	08/01/16	08/05/16	Umesh Singh	3					
119	08/01/16	08/01/16	Umesh Singh	3					
120	08/01/16	08/01/16	Kirbhashankar Prabhakaran	3					
121	08/01/16	08/01/16	Craig Jaffe	3					
122	08/01/16	08/01/16		1					
123	08/01/16	08/01/16		1					

Screenshots or reports from the IT system used to support the PPS population health management roadmap.

Crimson Technology

Executive Briefing

Cost, Quality, Care Coordination and Physician View Capabilities

[illegible] The [illegible] • advisory.com

Crimson Technology Briefing

Performance Improvement Infrastructure

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Page 5: Physician Performance Profiles

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Page 7: Measure Compliance

Contract Management and Care Transformation

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Network Referral Management

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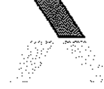
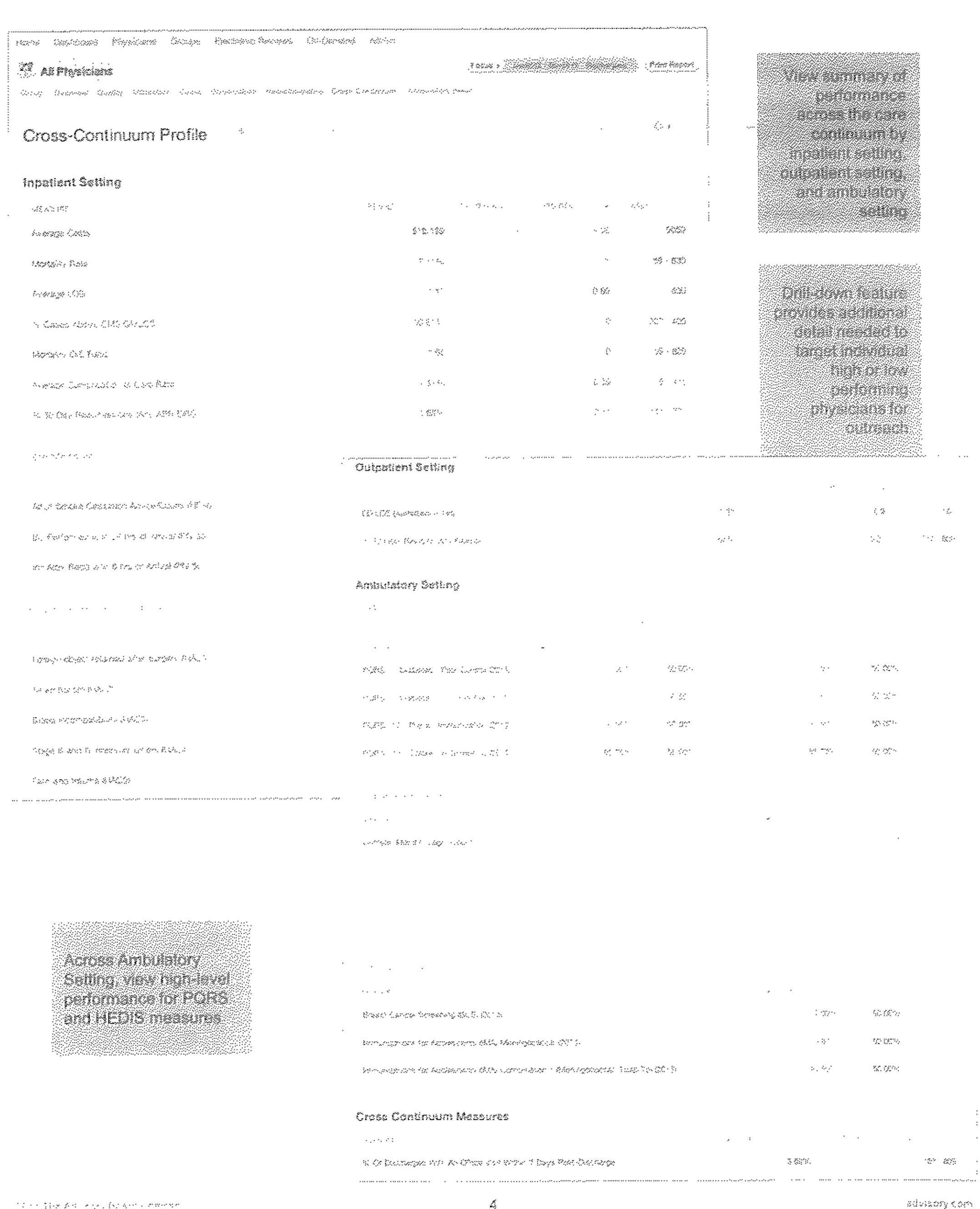


Performance Improvement Infrastructure

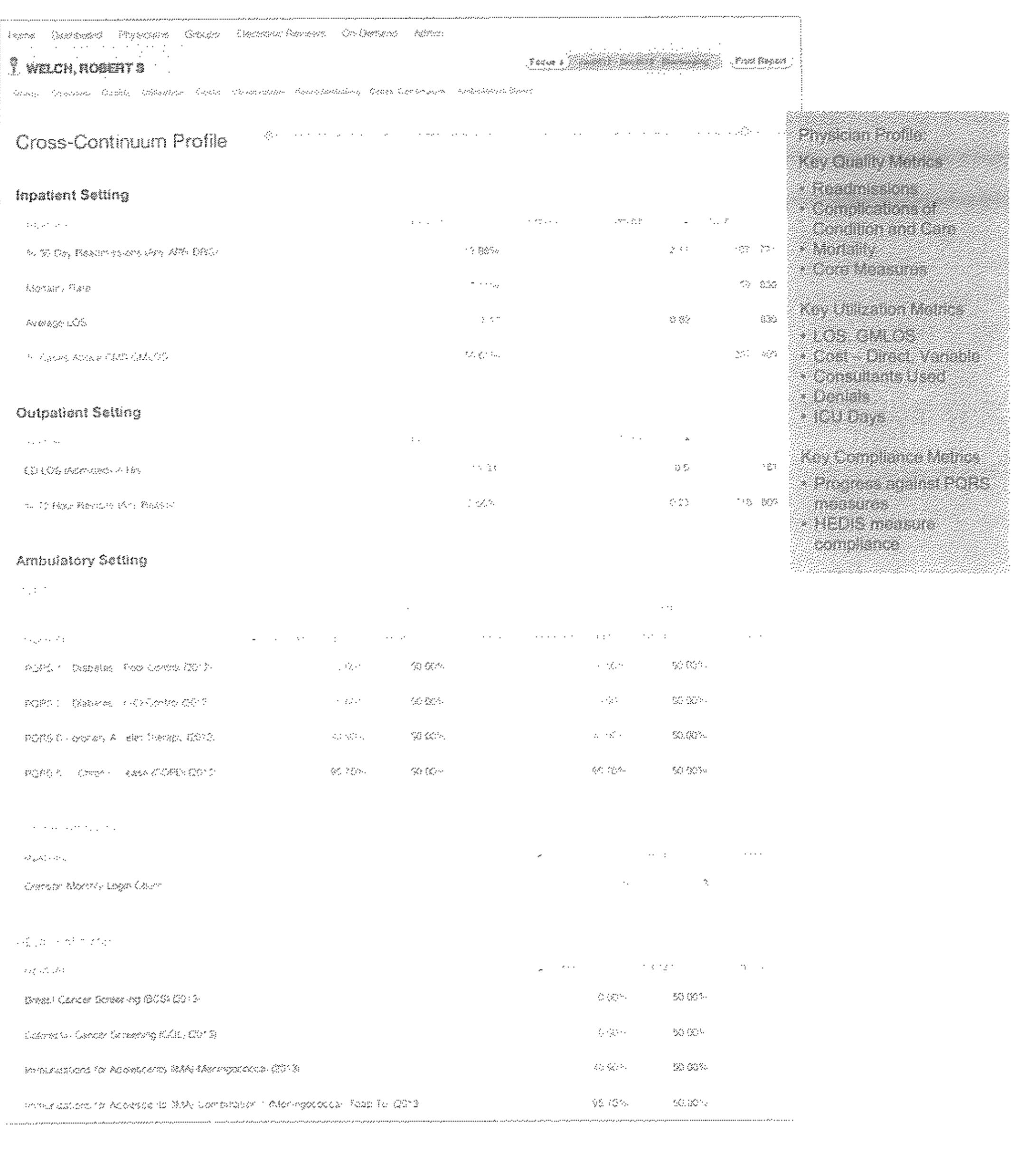
Performance Improvement Infrastructure: Network Performance Dashboard

Profile Performance of All Physicians Across Network



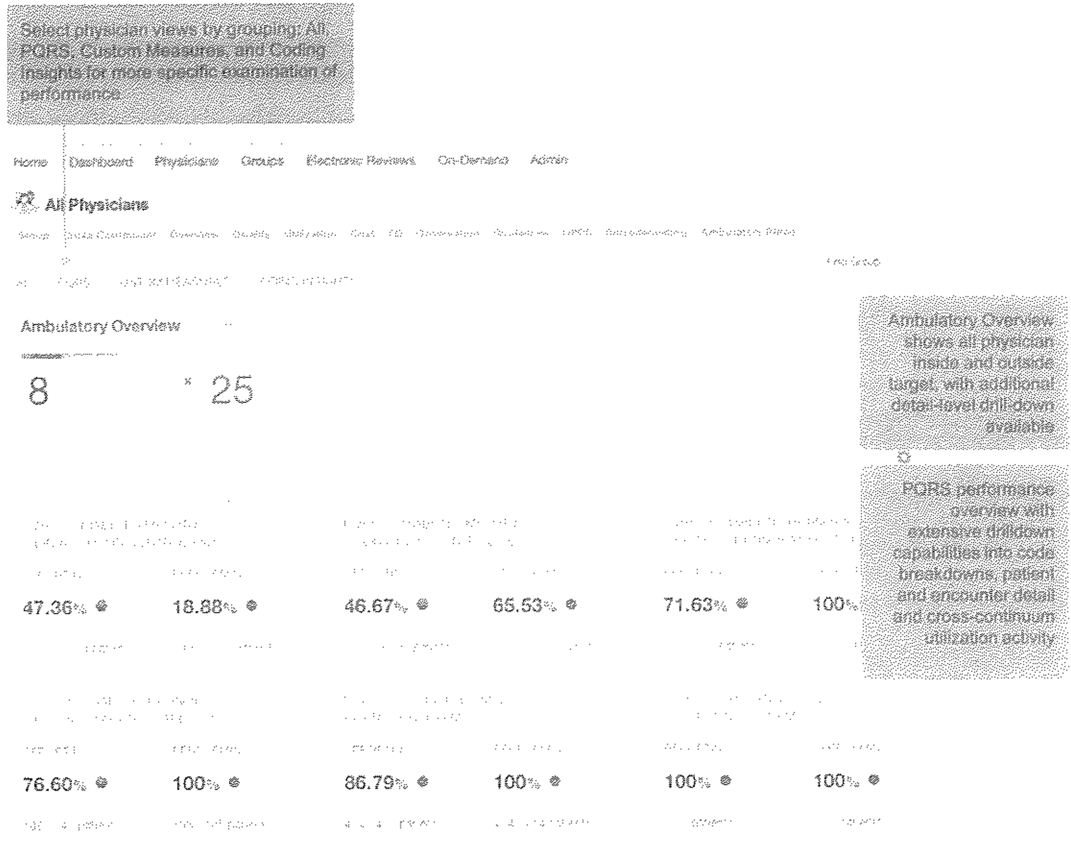
Performance Improvement Infrastructure: Physician Performance Profiles

Profile Individual Physician Performance



Performance Improvement Infrastructure: Ambulatory Performance Overview

Ambulatory Overview of Performance Against Targets

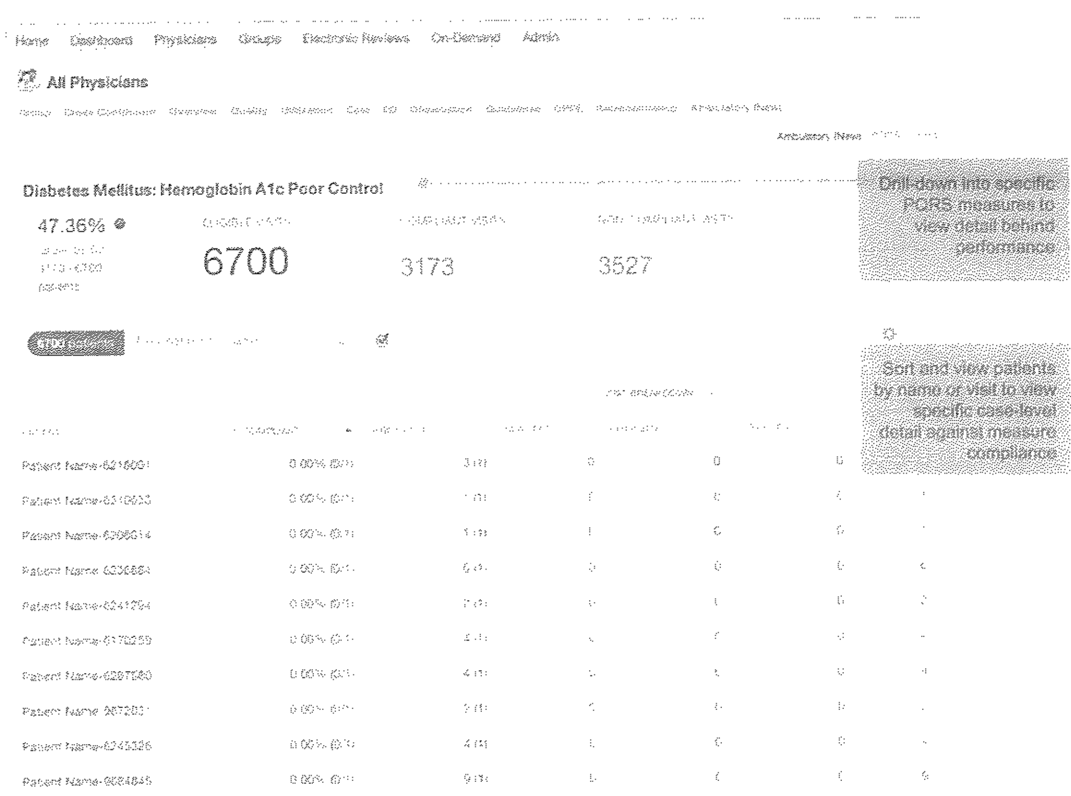


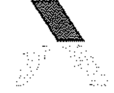
6

Performance Improvement Infrastructure: Measure Compliance

Detailed Measure Compliance Dashboards

Drill-Down to Specific Measures to View Case-Level Contributing Details





Contract Management and Care Transformation

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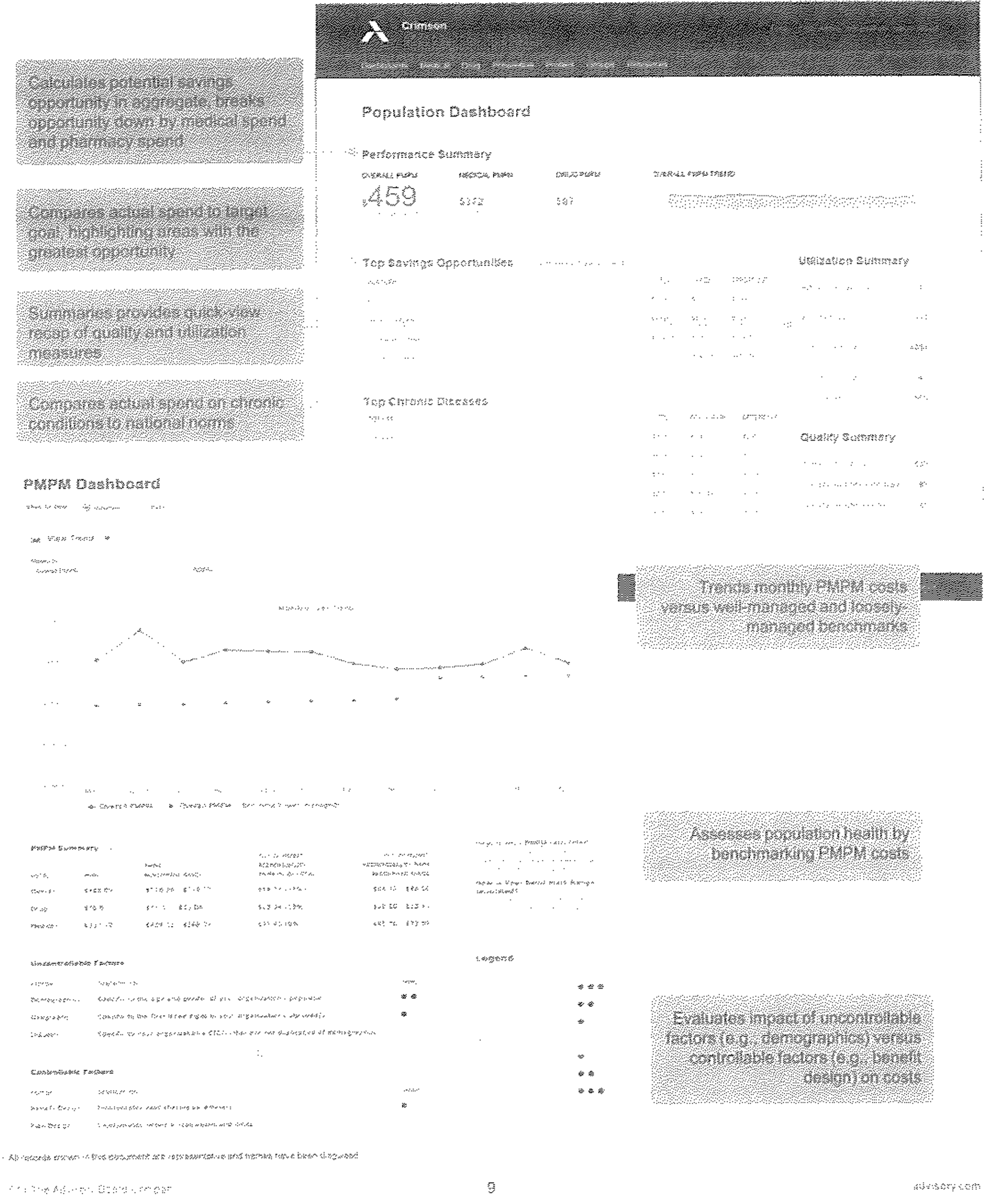
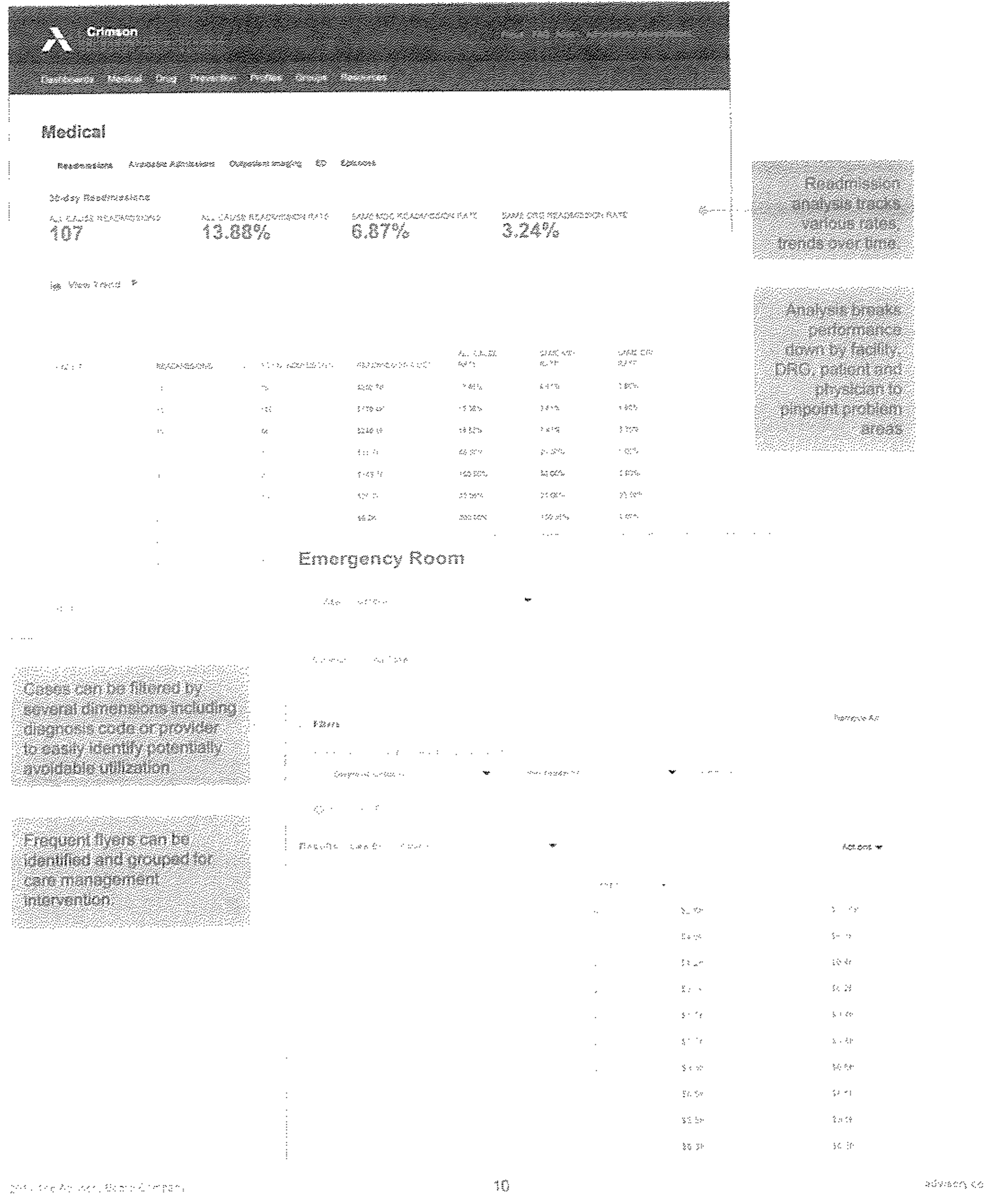

Contract Management and Care Transformation: Performance Tracking
Performance Dashboards Surface Key Savings Opportunities
Customized Benchmarks[1] Spotlight High-Priority Metrics
Calculates potential savings opportunity in aggregate, breaks opportunity down by medical spend and pharmacy spend
Compares actual spend to target goal, highlighting areas with the greatest opportunity
Summaries provides quick-view recap of quality and utilization measures
Compares actual spend on chronic conditions to national norms
Crimson
Population Dashboard
Performance Summary
$459
Top Savings Opportunities
Utilization Summary
Top Chronic Diseases
Quality Summary
PMPM Dashboard
Trends monthly PMPM costs versus well-managed and loosely-managed benchmarks
Assesses population health by benchmarking PMPM costs
Evaluates impact of uncontrollable factors (e.g., demographics) versus controllable factors (e.g., benefit design) on costs
9


Contract Management and Care Transformation: Avoidable High-Cost Utilization
Reduce Unnecessary Utilization
Identify Avoidable Readmissions, Admissions, ED visits and Imaging Utilization
Crimson
Medical
107
13.88%
6.87%
3.24%
Readmission analysis tracks various rates, trends over time
Analysis breaks performance down by facility, DRG, patient and physician to pinpoint problem areas
Emergency Room
Cases can be filtered by several dimensions including diagnosis code or provider to easily identify potentially avoidable utilization
Frequent flyers can be identified and grouped for care management intervention
10
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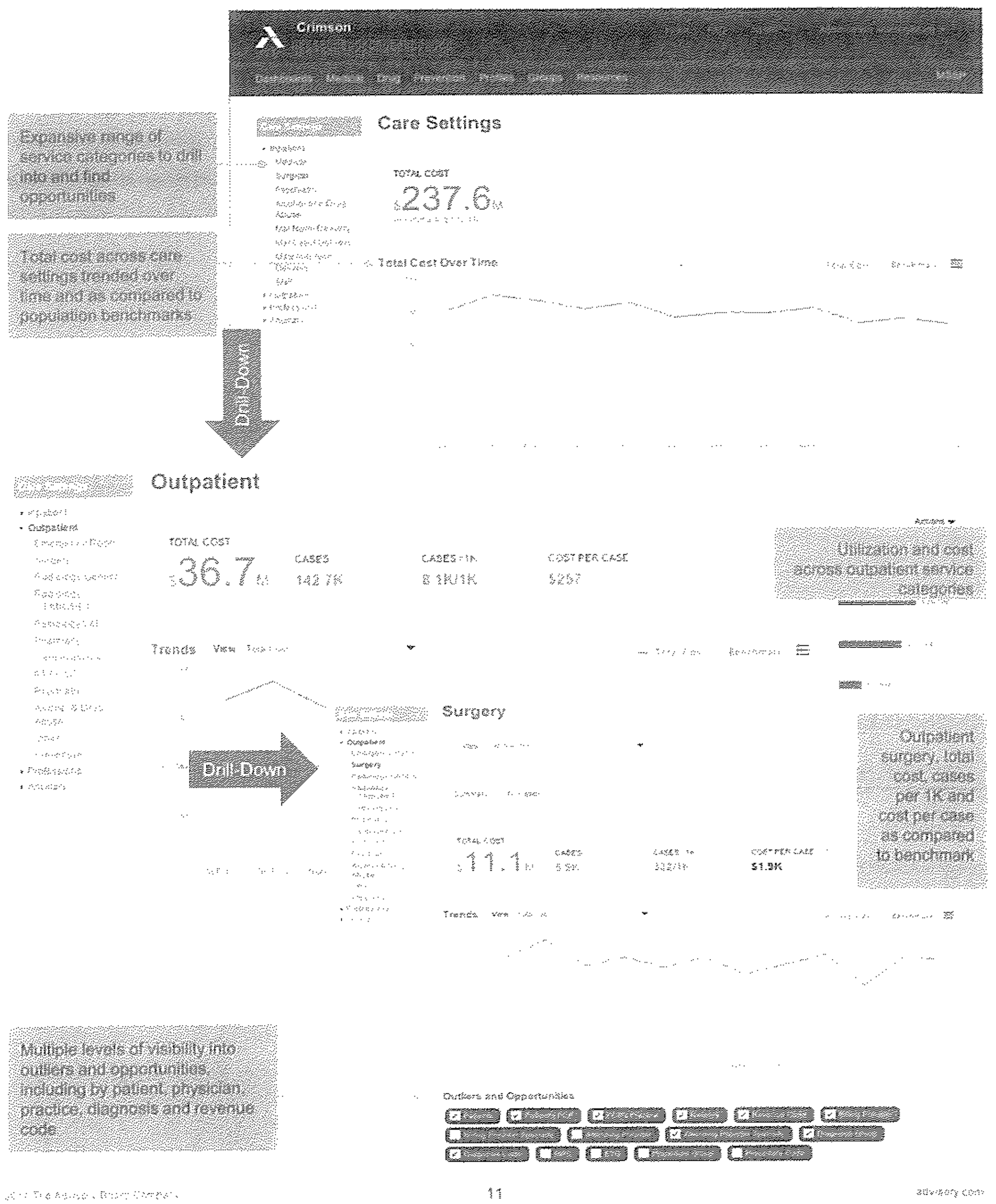
Contract Management and Care Transformation: Care Settings
Provide High-Quality Care at Lower Cost
Direct Patients to More Appropriate Care Settings and Treatments
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Care Settings
TOTAL COST
$237.6M
Total Cost Over Time
Expansive range of service categories to drill into and find opportunities
Total cost across care settings trended over time and as compared to population benchmarks
Drill-Down
Outpatient
TOTAL COST
$36.7M
CASES
142.7K
COST PER CASE
$257
Utilization and cost across outpatient service categories
Trends
Drill-Down
Surgery
TOTAL COST
$11.1M
COST PER CASE
$1.9K
Outpatient surgery, total cost, cases per 1K and cost per case as compared to benchmark
Multiple levels of visibility into outliers and opportunities, including by patient, physician, practice, diagnosis and revenue code
Outliers and Opportunities
11
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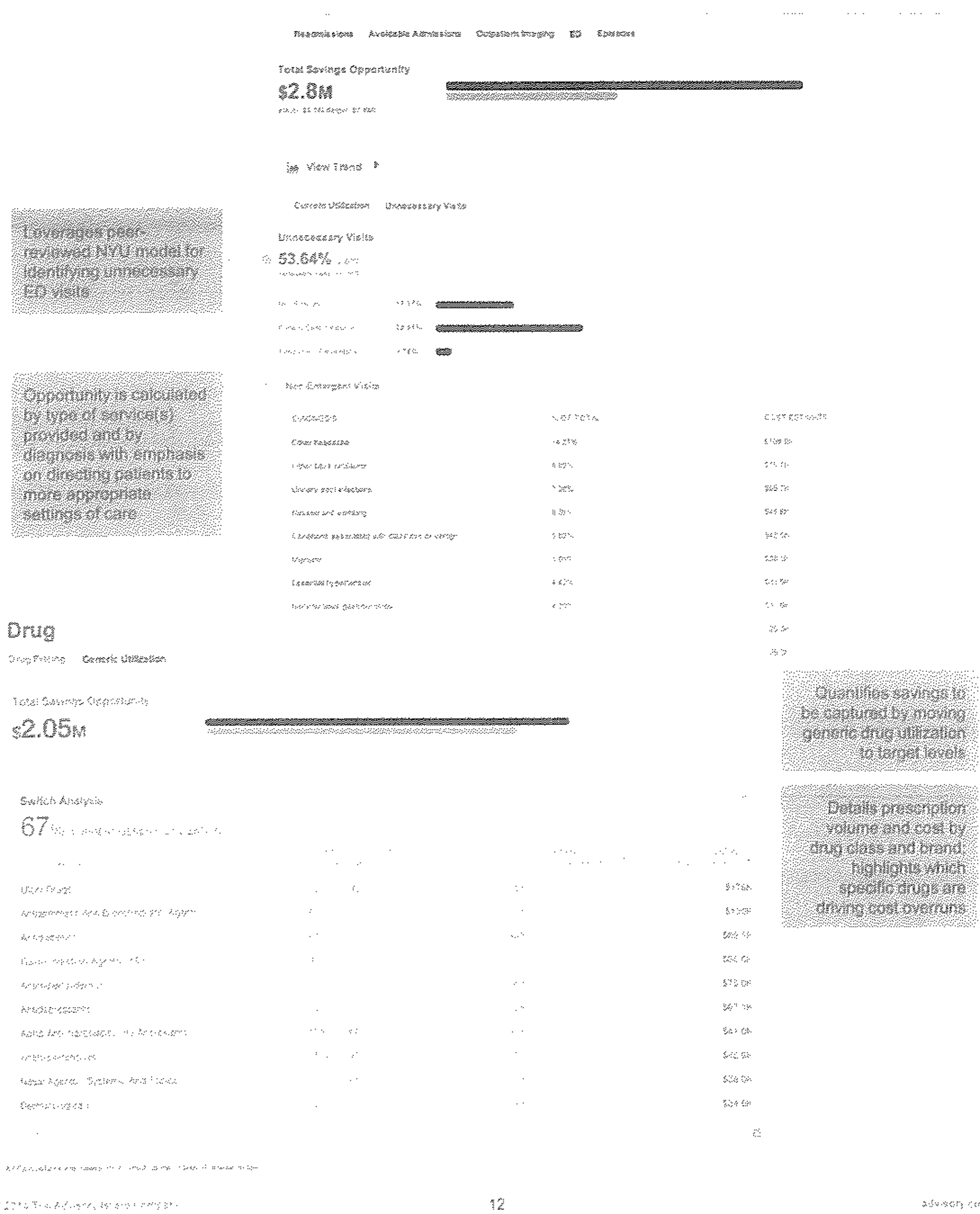
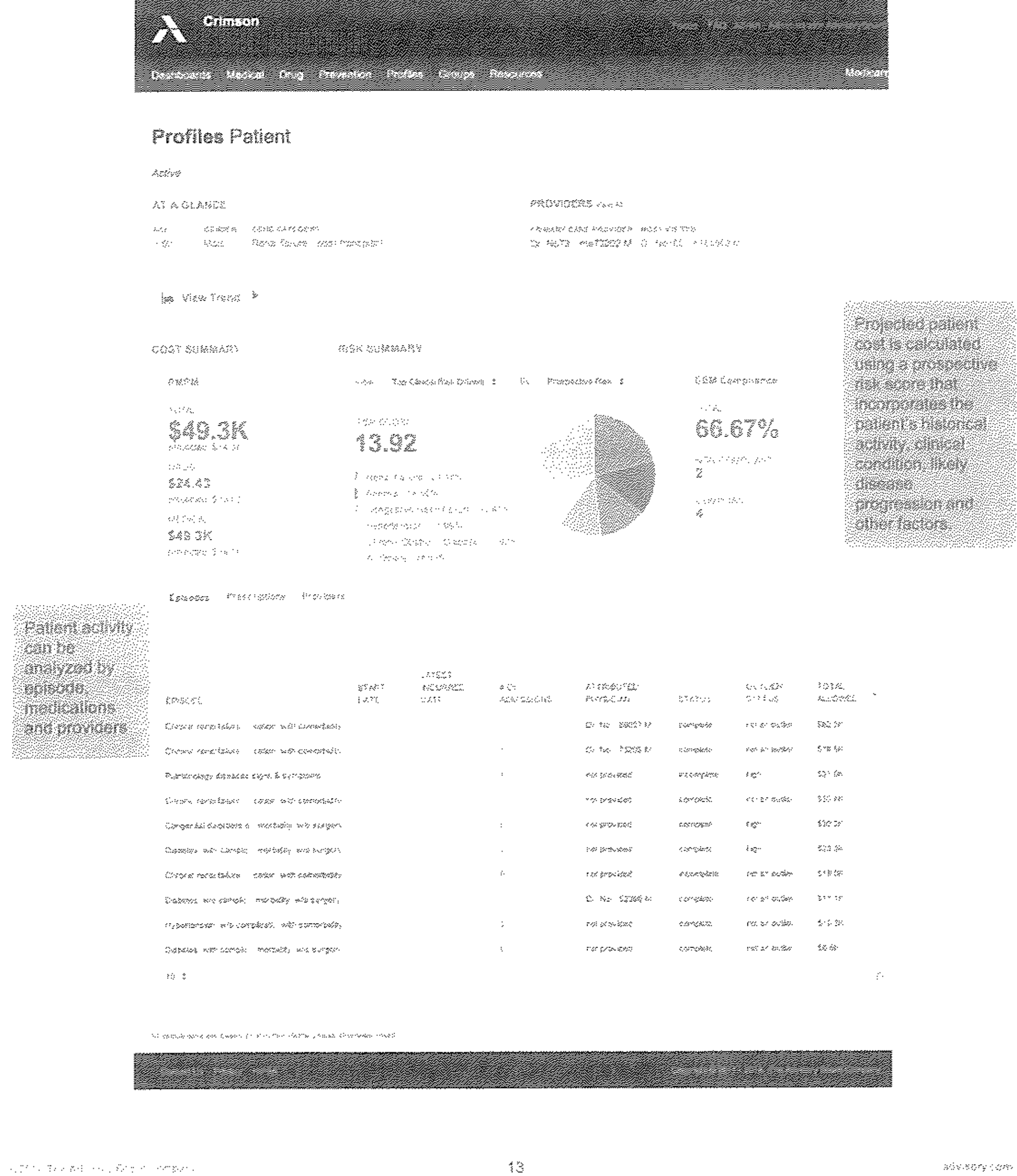

Contract Management and Care Transformation: ED Visits and Drug Costs
ED Visit Reduction and Drug Cost Drivers
Analytics Highlight Unnecessary ED Visits, Drug Alternatives to Decrease Spend
Total Savings Opportunity
$2.8M
View Trend
Unnecessary Visits
53.64%
Leverages peer-reviewed NYU model for identifying unnecessary ED visits
Opportunity is calculated by type of service(s) provided and by diagnosis with emphasis on directing patients to more appropriate settings of care
Drug
Generic Utilization
$2.05M
Switch Analysis
67
Quantifies savings to be captured by moving generic drug utilization to target levels
Details prescription volume and cost by drug class and brand; highlights which specific drugs are driving cost overruns
12

Contract Management and Care Transformation: Patient Profiles

360-Degree View of Patient Experience Across Care Continuum

Milliman Benchmarking and Claims Data Provide Insight to Patient Cost and Risk



13

Contract Management and Care Transformation: Patient and Stakeholder Engagement

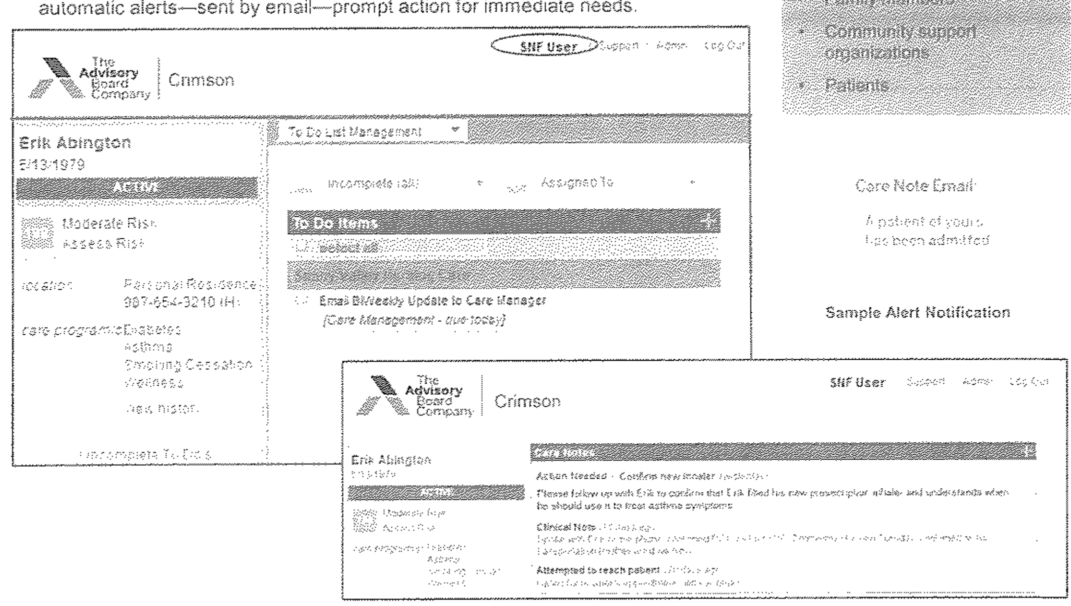
Maximize Impact by Activating Patient's Support System

Inclusive Access Empowers Extended Care Team to Change Patient Outcomes

- Collaborative approach improves outcomes and prevents avoidable cost escalation by changing patient behavior where it matters most—the home and community.
- Simple permission controls grant the right team members (clinical and non-clinical) the right amount of access to the patient's care information.
- Care team members' skills and expertise are matched to prioritize tasks, and automatic alerts—sent by email—prompt action for immediate needs.

Expanded Care Team

- Home health nurses
- Behavioral health specialists
- Health coaches
- Primary care physicians
- Family members
- Community support organizations
- Patients

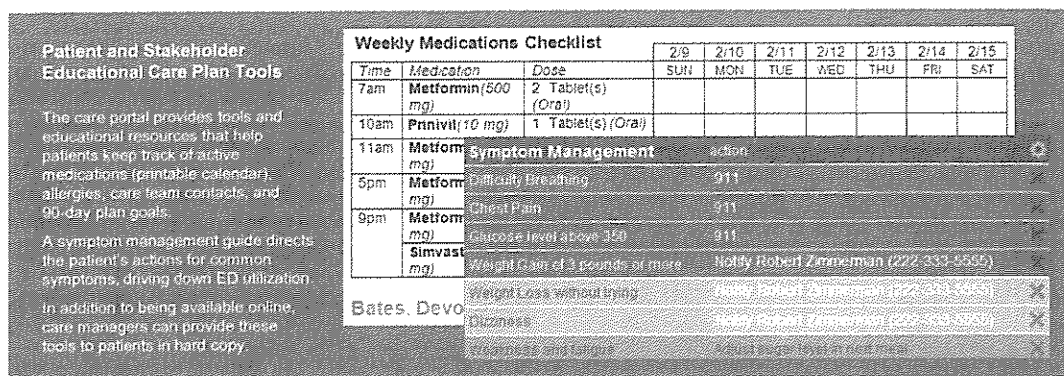


Patient and Stakeholder Educational Care Plan Tools

The care portal provides tools and educational resources that help patients keep track of active medications (printable calendar), allergies, care team contacts, and 90-day plan goals.

A symptom management guide directs the patient's actions for common symptoms, driving down ED utilization.

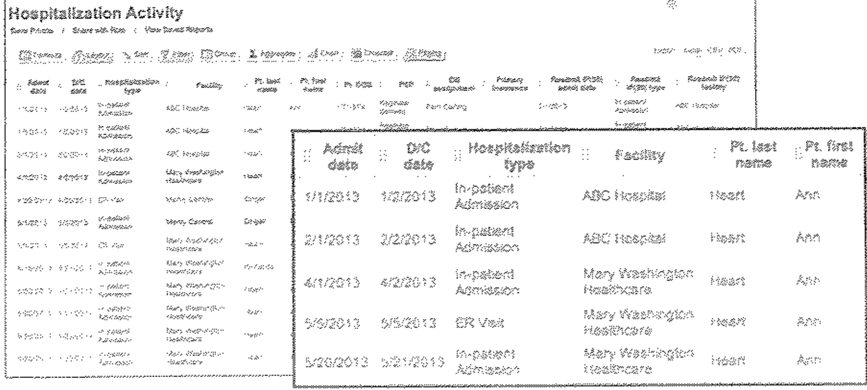
In addition to being available online, care managers can provide these tools to patients in hard copy.



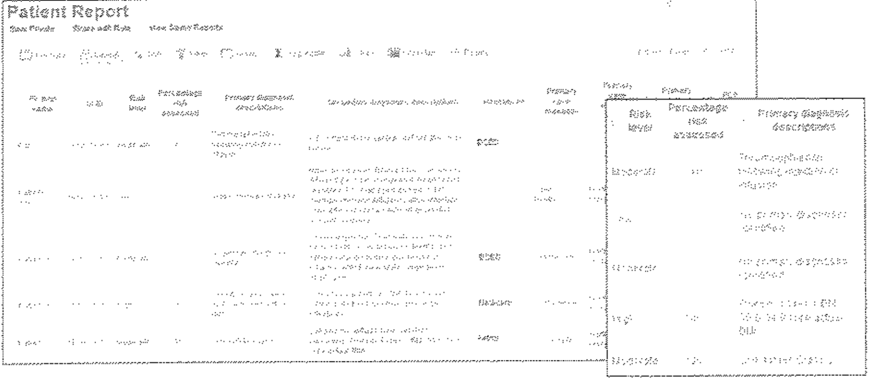
Contract Management and Care Transformation: Reporting Dashboards

Develop Strategies with Detailed Population and Trend Data

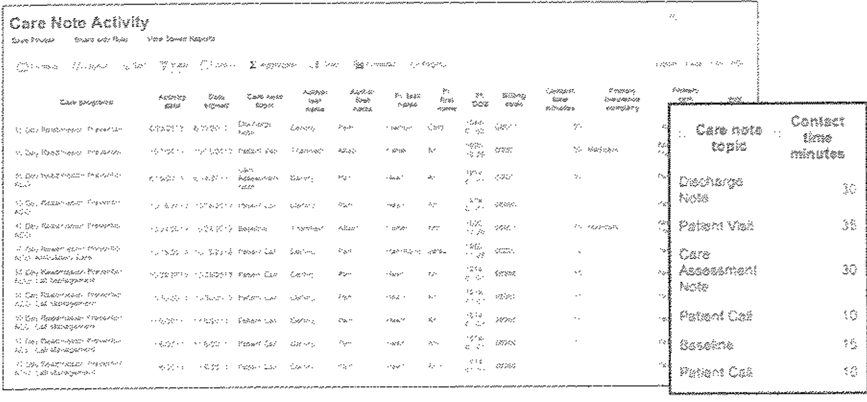
Data Capture Facilitates Performance Reporting, Drives Resource Allocation



Identification of admit and discharge allows the care team to track avoidable utilization over time; administrators are also able to estimate upcoming demand.

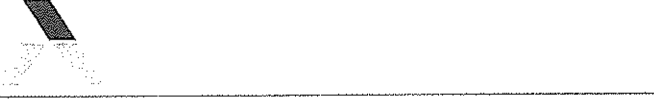


A snapshot of all patients in the system quickly orients users to the population.



Track productivity, balance caseloads, and calculate billable revenue with care manager activity reports.

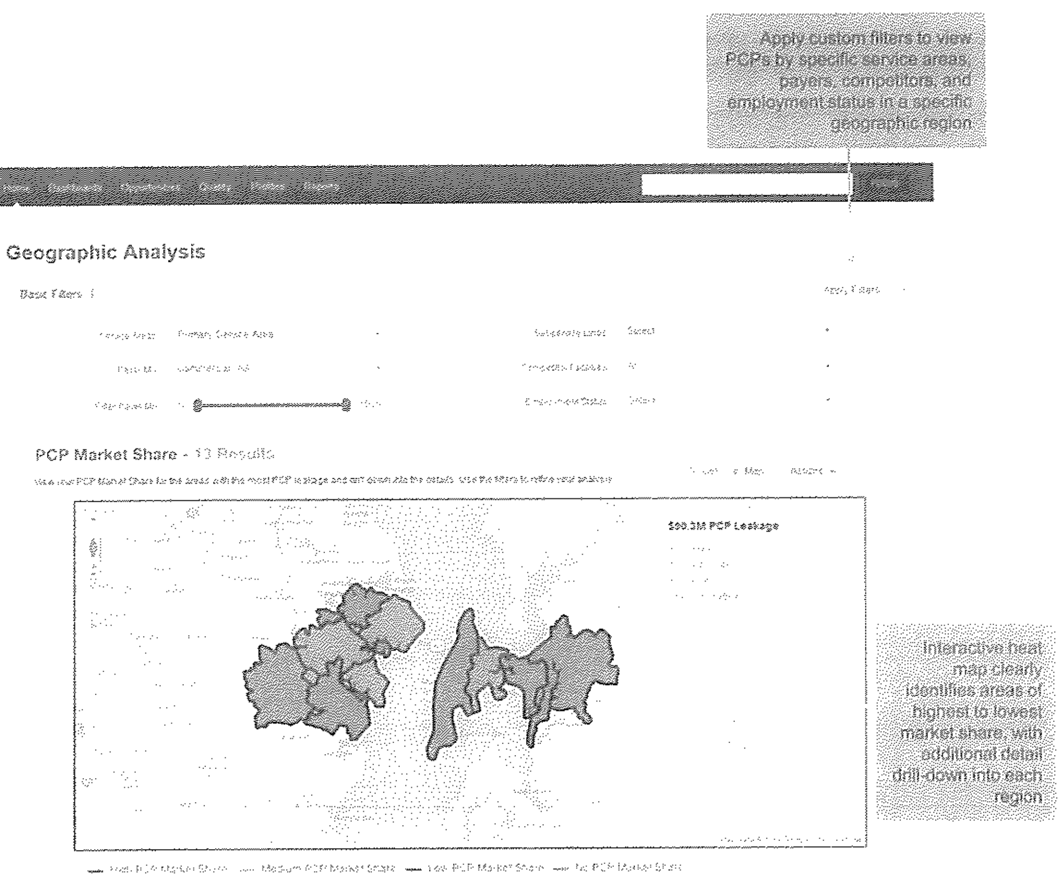
15



Network Referral Management

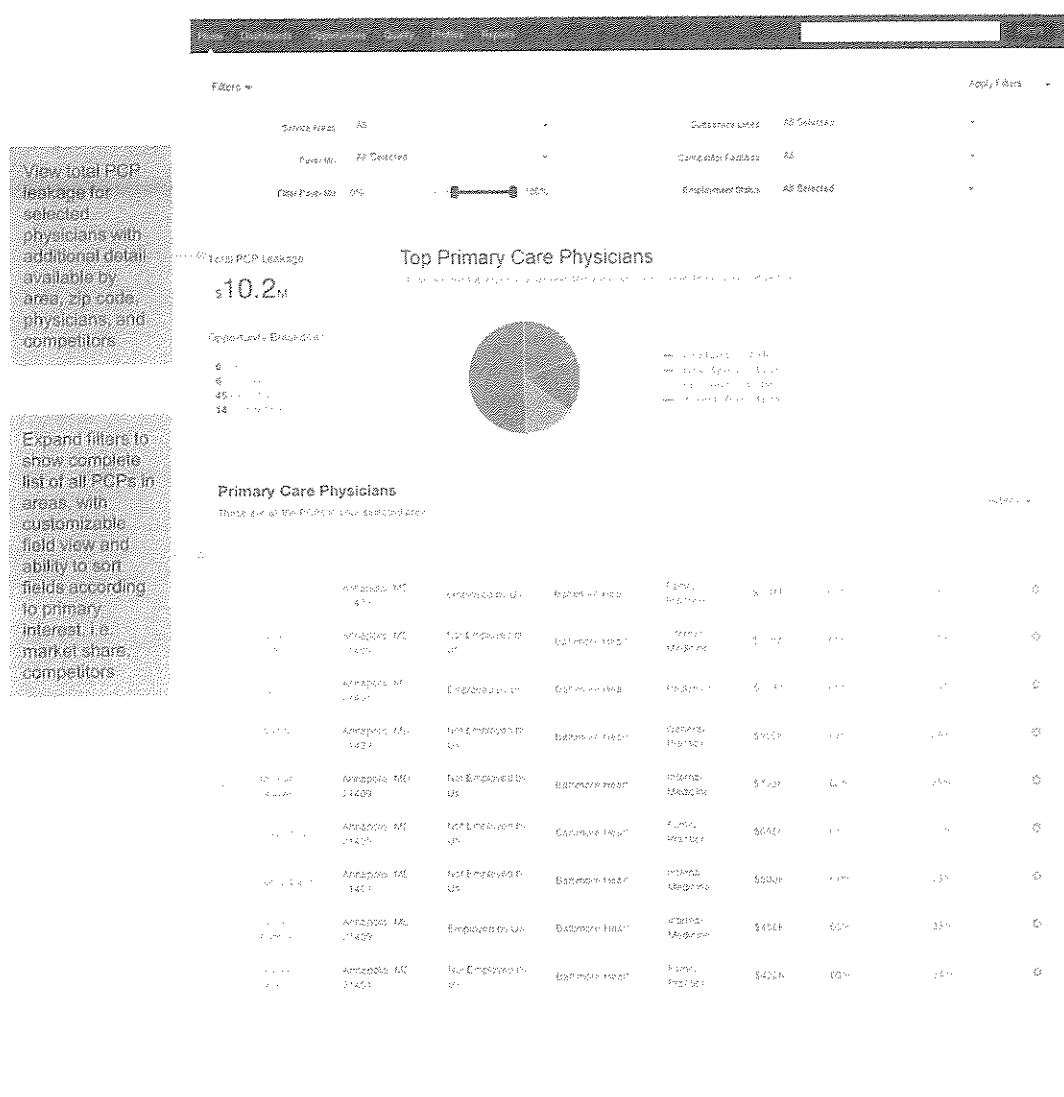
Network Referral Management: Geographic Analysis

Explore Market Analysis By Geographic Region



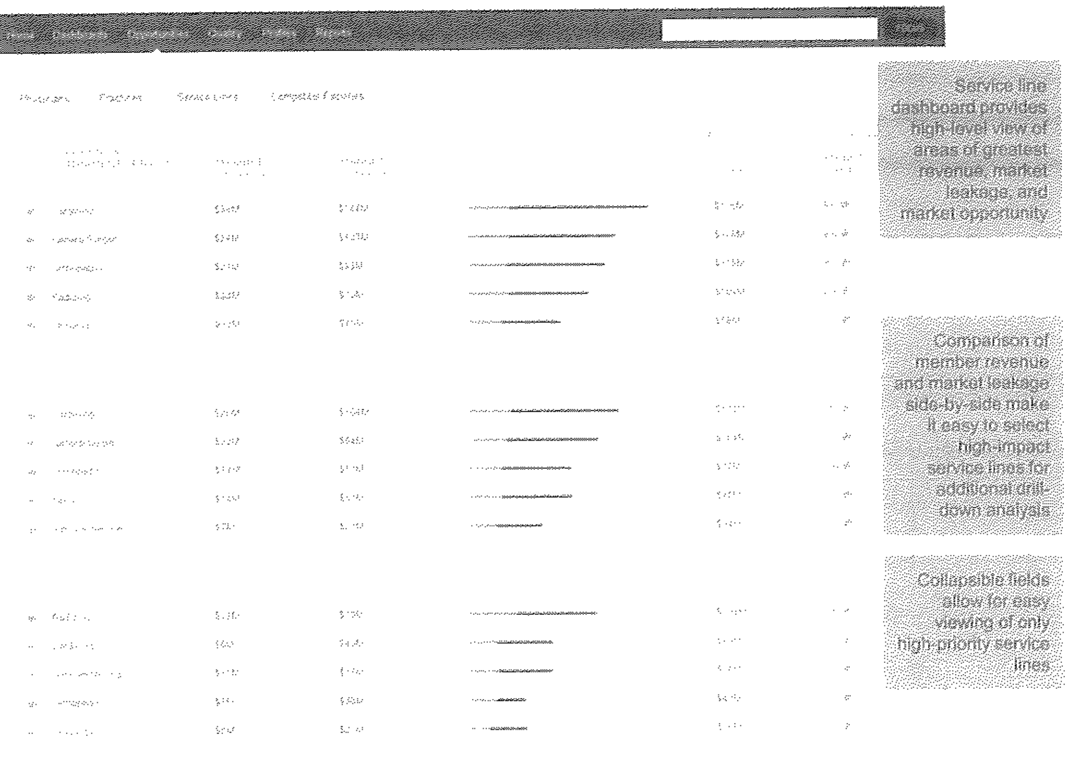
Network Referral Management: PCP Analysis

Evaluate Primary Care Physicians in Area



Network Referral Management: Service Line Overview Analysis

Service Line Dashboard Reveals Additional Opportunity



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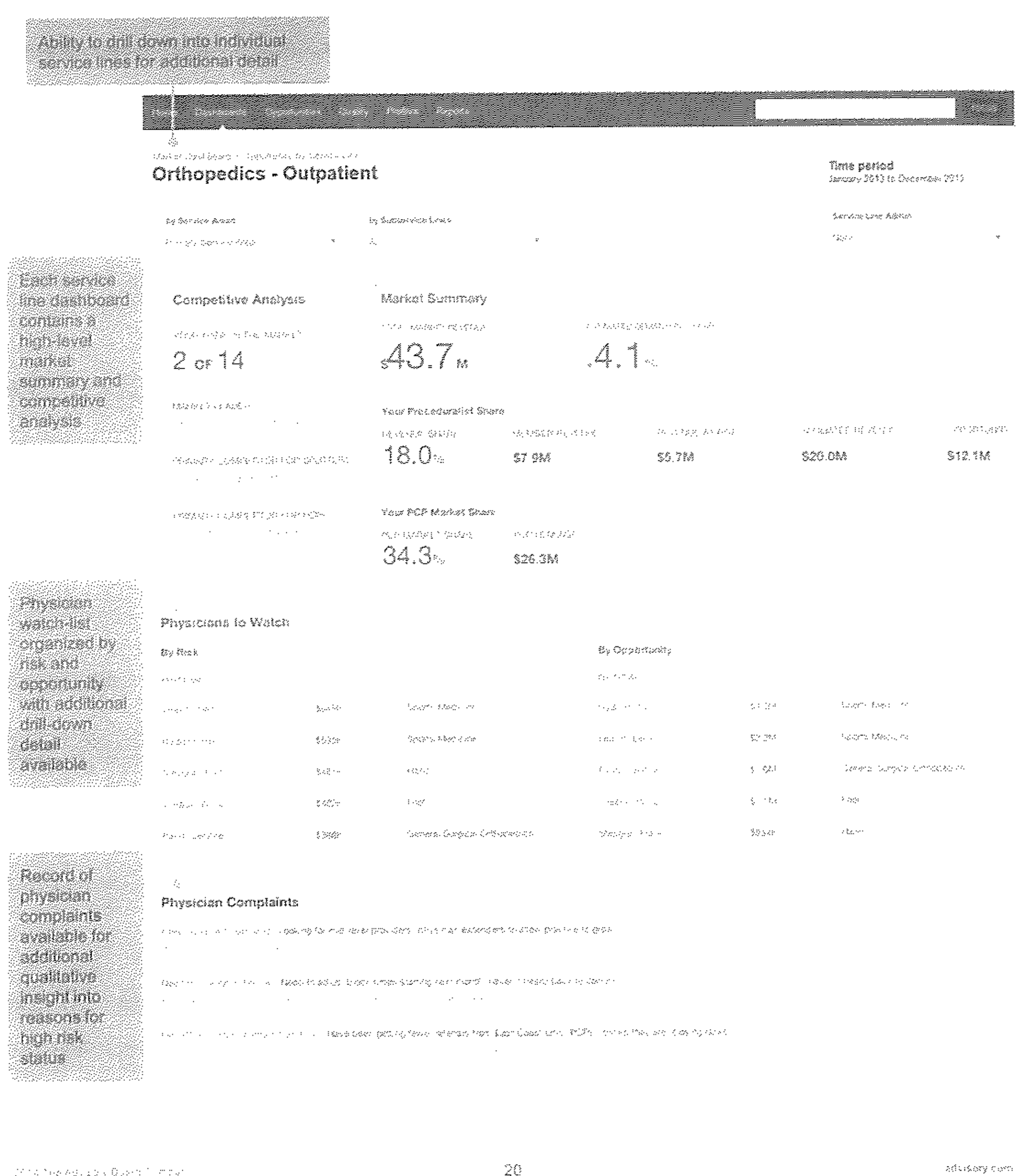
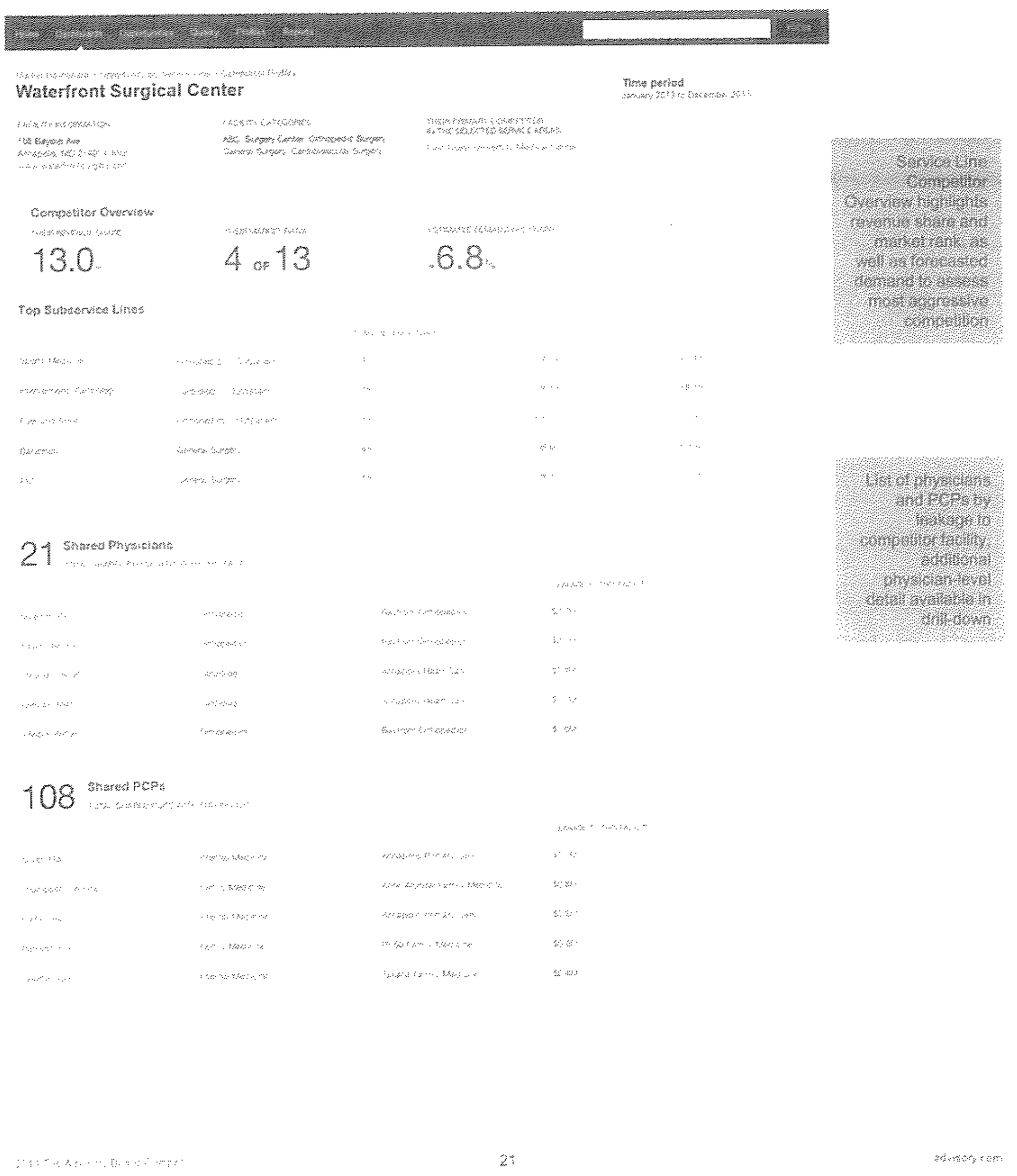


Network Referral Management: Individual Service Line Profile
Individual Service Line Opportunity
View Service Line Detail to Understand Sources of Market Revenue and Risk
Ability to drill down into individual service lines for additional detail
Orthopedics - Outpatient
Time period
Each service line dashboard contains a high-level market summary and competitive analysis
Competitive Analysis
Market Summary
2 of 14
$43.7M
4.1
Your Proceduralist Share
18.0%
$7.9M
$5.7M
$20.0M
$12.1M
Your PCP Market Share
34.3%
$26.3M
Physician watch-list organized by risk and opportunity with additional drill-down detail available
Physicians to Watch
By Risk
By Opportunity
Record of physician complaints available for additional qualitative insight into reasons for high risk status
Physician Complaints
20


Network Referral Management: Competitor Profiles
Competitor Details Available for Each Service Line
Waterfront Surgical Center
Time period
Competitor Overview
13.0
4 of 13
6.8
Top Subservice Lines
21 Shared Physicians
108 Shared PCPs
Service Line Competitor Overview highlights revenue share and market rank, as well as forecasted demand to assess most aggressive competition
List of physicians and PCPs by leakage to competitor facility, additional physician-level detail available in drill-down
21
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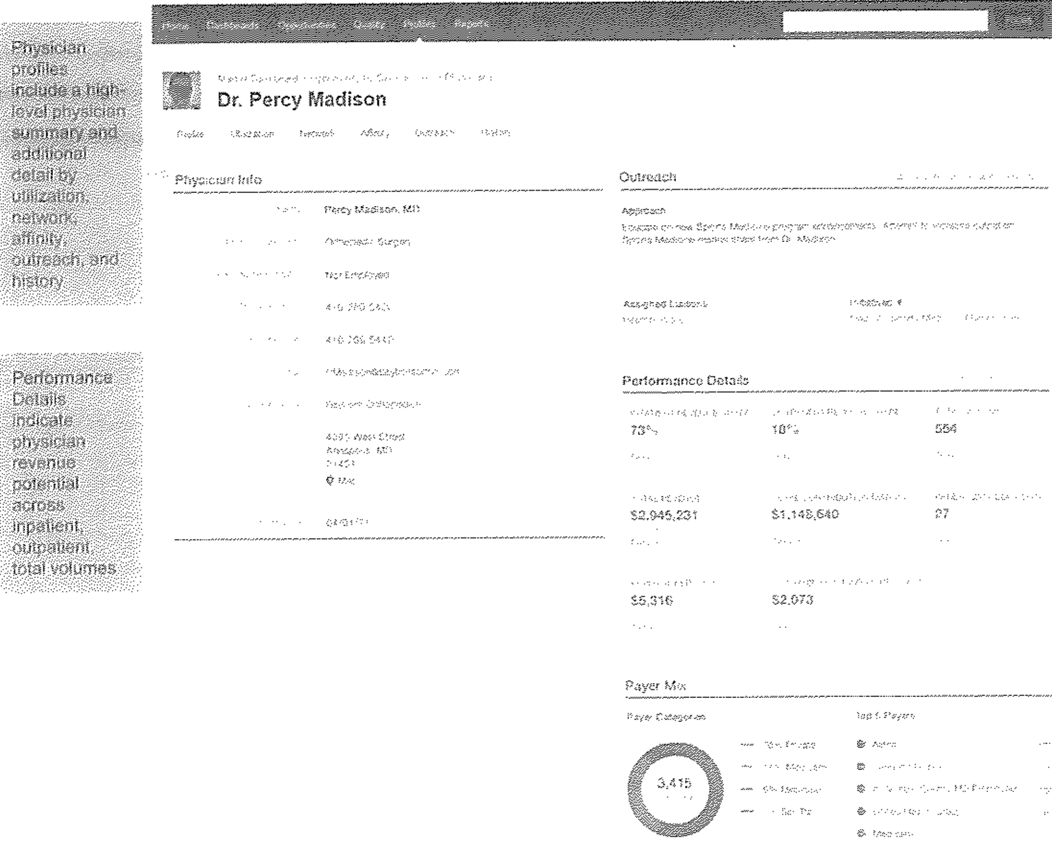
Network Referral Management: Physician Profiles

Physician Performance Details Across Activities



22

PRIORITY TARGET POPULATIONS & PLANS TO ADDRESS HEALTH DISPARITIES

Identify priority target populations and define plans for addressing their health disparities by establishing goals that reflect the state of NY Prevention Agenda

CPWNY CCHL strategy update for DY1Q4 and Population Health Milestone #1 (Identify priority target populations and define plans for addressing their health disparities by establishing goals that reflect the state of NY prevention agenda.)

A main objective of the NYSDOH's Population Health Improvement Program (PHIP) as well as the Delivery System Reform Incentive Payment (DSRIP) Program to advance and support other NYSDOH initiatives such as the Prevention Agenda. One of the priority areas within the Prevention Agenda is to prevent chronic disease.

Although 69.7% of adults age 50-75 who receive a colorectal cancer screening is at or near the NYS Prevention Agenda goal of 71.4% (57% among the lowest income group to 75% among the highest income group, with the uninsured having a screening rate of 41%), the 6 rural counties of Genesee, Wyoming Orleans, Allegany, Cattaraugus, and Chautauqua have rates as low as 51 3%. Colorectal disease is the fourth most common cancer in NYS (excluding skin cancer) and second leading cause of cancer deaths with blacks having a higher incidence and mortality than whites according to "Screening Amenable Cancers in New York State Report (2014)" **Poverty status is perhaps the most important indicator of health need.** In the Western New York region, 15% of the population lives below federal poverty level compared to 10% for the State. People at 200% of the Federal poverty level are overwhelmingly concentrated in the cities of Buffalo and Niagara Falls and widely across the Southern Tier counties of Chautauqua, Cattaraugus and Allegany in both small cities and rural areas). In June 2014 the US Census Bureau ranked the City of Buffalo as the 4th poorest city in the nation, where nearly 27% of the population lives in poverty, nearly two thirds under 200% of the federal poverty level.

In Chautauqua County, the Women's Christian Association (WCA) Hospital service area is reviewed periodically as part of the organization's Strategic Plan. The review includes market share data of services provided by zip codes along with population and demographic data. Generally, the hospital's primary service area is considered to be the zip codes from which 75% of WCA admissions originate WCA designs its community service plan around the community's needs The present plan includes cardiology, cancer treatment, general surgery, orthopedic care, women's services, behavioral health, community preventative services, primary and emergency department care. The vast geographic size of the County, coupled with the fact that almost half of its residents live in sparsely populated rural areas, creates challenges in transportation and access to healthcare. Chautauqua County includes two cities, Dunkirk and Jamestown, and is one of the poorest counties in the state: 14.5% of all county residents live below the federal poverty level (U.S Census Bureau 2007 – 2011). Hispanics are the fastest growing ethnic group in the county and in the nation, currently making up 5.9% of the county's population. Language and cultural differences can create barriers to the provision of health knowledge, health education and service delivery. Among the county's Hispanic population, 57.1% primarily speak Spanish Health care and community-based organizations play a critical role in increasing access to high-quality chronic disease preventive care and management in order to reduce the devastating impact of chronic diseases through prevention, screening, early detection, treatment, and self-management support

NYS Prevention Agenda Goal: Increase screening rates for breast, cervical and colorectal cancers, especially among the disparate population.

NYS Prevention Agenda Objectives:

1. By December 31, 2017, increase the percentage of (focus on African American women ,Erie and Niagara counties) aged 50-74 years with an income of <$25,000 who receive breast cancer screening, based on the most recent clinical guidelines (mammography within the past two years), from 76.7% (2010) to 80.5%. (Data Source: NYS BRFSS) (Health Disparities Indicator)
2. By December 31, 2017, increase the percentage of women aged 21-65 years with and income of < $25,000 who receive a cervical cancer screening, based on the most recent clinical guidelines (Pap test within the past three years) from 83.3% (2010) to 88.0%. (Data Source: NYS BRFSS) (Health Disparities Indicator)
3. By December 31, 2017, increase the percentage of adults (50-75 years) in Erie, Niagara, and Chautauqua counties who receive a colorectal cancer screening based on the most recent guidelines (blood stool test in the past year or sigmoidoscopy in the past 5 years and a blood stool test in the past year or a colonoscopy in the past 10 years):
    a. From 68.0% (2010) to 71.4% for all adults.
    b. From 59.4% to 65.4% for adults with an income < $25,000. *(Data Source: NYS BRFSS) (PA Tracking Indicator, Health Disparities Indicator)*

Strategy Blueprint for Success in Reducing Health Disparities and Outcomes

Population Health Improvement Program (PHIP) Strategies as put forth by P2 Collaborative, Buffalo , NY coinciding and collaborating with the CPWNY Delivery System Redesign Incentive Payment (DSRIP) Program Strategies and the NYS Department of Health Prevention Agenda Western New York Community

GOAL: Increase screening rates for cardiovascular disease, diabetes, and breast, cervical, and colorectal cancers, behavioral health especially among disparate populations

Desired Long Term Outcomes/Measures	Outputs: What we will use as evidence that we have succeeded
Decrease Mortality	NYS mortality rates as related to indicators, i.e. SPARCS data; CDC Wonder Page; HEDIS and QARR measures as outlined in DSRIP Measurement manual.
Increased culture of self-management	Ongoing screening- people going year after year; patient level detail from HMO and State
Reduction of avoidable hospital use	
Desired Short Term Outcomes/Measures/Interventions	Outputs: What we will use as evidence that we have succeeded
Early Cancer Screening, breast, colorectal :	
Increased early detection breast and colorectal cancer screening for health disparities populations where there is highest need. Use of a matrix to ascertain current screenings and interventions used in past that were or were not successful.	Look at high needs (risk stratification) – data currently used; Look at number of early detection screenings, specifically for breast and colorectal cancers.

Engagement of CBOs (2 way communication) to occur at this point for brainstorming and improvements as well as patient focus groups to address barriers. Training of Community Health Outreach workers on preventive screenings and where people can go to obtain.	
Population education on importance of early breast cancer and colorectal screening with emphasis on patient beliefs and values. Involvement of health homes and community outreach workers. One on One, patient navigation to improve access to primary and preventive health care Increase patient engagement in health homes	HEDIS / QARR measures
Blood Pressure Screening:	
Increased Awareness of blood pressure monitoring – providing educational self-care information related to hypertension and impact on health.	Meeting schedule template/posters/self-management tools utilized.
Increased blood pressure screening – use of self-management tools that are easy to use, reviewed by community forums and in languages prevalent in the population. Convene community stakeholders in collaborative learning sessions to identify opportunities to replicate best practices focusing on primarily on geographical areas and communities of people with the greatest need. Involvement of health homes and community outreach workers to improve access to primary care for BP monitoring. Utilize care management advisors to teach and work with practices to reduce barriers to self-care as well as community forums.	Early detection HTN and blood pressure control (HEDIS) Meeting and training templates. Increase in patient engagement in health homes thereby increasing primary care access and BP monitoring.
Behavioral Health Screening: (PHQ2,9 /SBIRT)	
Obtain understanding from diverse communities related to accessibility, resources, educational needs, stigma, and cultural competence w/r/t depression, suicide, and substance abuse. Early detection of behavioral health disorders through understanding of barriers, promotion of 2-1-1 services. Behavioral health integration with primary care.	Patient Experience surveys
Increased access to trained professionals – Care Management advisors to promote the engagement of Health Homes and PCMH offices	Increased assistance of Health Homes and social workers for linkages – DSRIP measure – Health Home assigned/ referred members in outreach or engagement.

Increase in PHQ2, 9/SBIRT screenings - Clinical Transformation specialists to work with each practice documentation system that can be queried, Meaningful Use compliance, incorporation into Clinical Integration Plan Resources (2-1-1) will be promoted by the Care Management team and Territory leads.	HEDIS measure – screening for clinical depression and follow up; 2-1-1 usage, patient engagement data
Follow up on positive screenings	HEDIS measure – screening for clinical depression and follow up

Interventions

In collaboration with P² Collaborative (WNY PHIP contractor), Community Partners and Millennium Collaborative Care (both WNY PPS) will host an educational program to inform community health partners about the basics of cancer screening as means of prevention and/or early detection and educate about associated cultural/health literacy issues regarding possible barriers to cancer screening. Participants attending this educational program will learn about the services provided through the NYS Cancer Services Program amongst other resource/referral options in order to:

1. Inform people about the range of preventive services they should receive.
2. Create linkages with and connect patients to community preventive resources.
3. Support use of alternate locations to deliver preventive services.
4. Expand public and private partnerships to implement community preventive services.
5. Support training and use of community health workers, patient navigators, social workers, care coordinators.

Educational Program for Erie County Cancer Services Program planning for May 19, 2016

Date: May 19, 2016

Time: 8:30am – 10:30am

Location: Templeton Landing, 2 Templeton Terrace, Buffalo NY 14202

Target audience: Community based organizations

DFAFT Agenda:

8:30am – 8:55am	Breakfast & Networking
8:55am – 9:00am	Welcome & introductions – Karen Hall (P2 Collaborative)
9:00am – 9:20am	Basics of Cancer Screening – Shoshone Dentice (ACS)
9:20am – 9:40am	What does Cancer Services Program do? – Michelle Wysocki (Erie County CSP)
9:40am – 9:50am	Personal Testimonials
9:50am – 10:20am	Cultural Competency/Health Literacy – May Shogun, International Institute
10:20am – 10:30am	Resources/TA available & Q&A – Karen Hall (P2 Collaborative)

Promotion:

- Promotion will begin on March 21, 2016 through the following venues:
  - P2 Collaborative via Facebook, P2 listserve, PHIP listserve
  - Community Partners of WNY
  - Millennium Collaborative
  - GBUAHN
  - Erie County CSP

Outcomes:

- Process:
  1. Number of attendees at educational seminar
  2. Number of organizations represented at educational seminar
  3. Number of organizations requesting additional training on CC/HL
  4. Number of organizations requesting an additional presenting on CSP
  5. Number of referrals to Erie County CSP after educational seminar
- Clinical:
  1. Number of screenings through the Erie County CSP
  2. Number of early stage diagnosis

Packet of information for attendees (P2 will prepare):

- Information about Cancer Services Program
- Information about services/resources provided through American Cancer Society
- Information about ACS 80% by 2018 CRC Campaign
- Where to get cancer screenings in 8 counties of WNY (P2 Collaborative)
- Change Package (P2 Collaborative)

Interventions continued:

- Have begun to download Medicaid patient data from Medent practices to ascertain level of disparities for various measures for CPWNY as an org. Targeted completion of Analysis is June 30, 2016
- Working with our CBOs to have augment training of Community health workers to assist those populations needing preventive health cancer screenings.
- Working with MEB (substance abuse anti stigma campaign), Cardiovascular (BP screening self-management tools), behavioral health (depression screening), ED triage project coordinators to ascertain self- management tools utilized that need to be evaluated by the focus groups and what needs to be improved upon
- Continue to participate in Chew and Chats that go out to the community neighborhoods to engage the population and CHW's in self-management tools and health supporting initiatives CPWNY will be sponsoring these on a quarterly basis
- Connect patients that visit the ED for conditions that could be treated to a provider office (refer to the process flow)

Primary Care Physician Assistance for ED-IP Patients with No Primary Care Physician

Patient Presents to the Emergency Department for Care

Health Home Canidate?

Yes

Health Home Community Health Workers Face-to-Face assistance with getting a Primary Care Physician

Is follow-up needed?

Telephonic outreach after the fact if the patient is missed or contact is incomplete (3 months to contact), by outreach works

No

Patient Reports PCP?

Yes

End

No

Medicaid Patient?

Yes

Patient is enrolled in the DSRIP Care Plan in C-Care Management

Patient is enrolled in the No PCP Care Plan in C-Care Management

Community Health Workers Use C-Care Management to Identify and work to get PCPs for patients

No

Report of Patients not reporting a PCP from Soarian Financials

Health Connections Team call patients to assist in getting a Primary Care Physician

Prevention agenda can be impacted on with efforts at the PCP office

In addition the review is limited to patients with ED Triage levels 4 and 5.

Determination of whether a patient has a Primary Care Physician (PCP) is based on patient self reporting.

Report from Soarian Financials is based on an entry of PtDeniesPCP or PCPDRNULL in the patients PCP field.

Connect Medicaid beneficiaries to PCP with appointment in a timely manner will assist preventive care

PATIENT CENTERED MEDICAL HOME STATUS & PRACTICE TRANSFORMATION

Plans for achieving PCMH 2014 Level 3 in relevant provider organizations, such as by using a learning collaborative for the necessary training and support

Patient Centered Medical Home Status and Practice Transformation

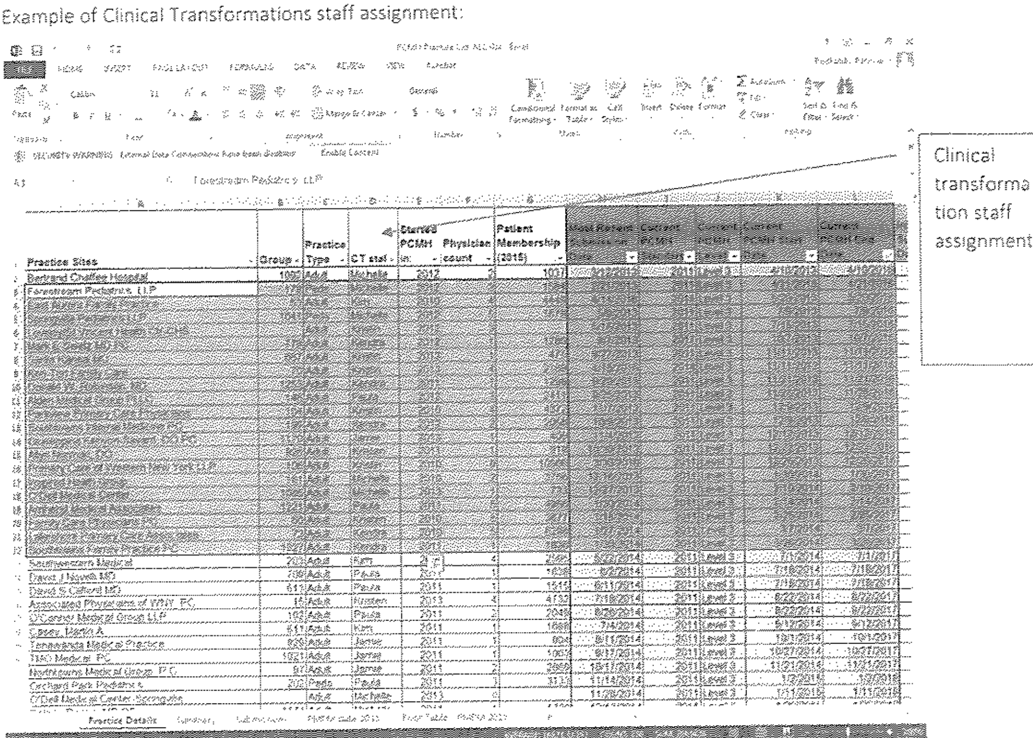
The Population Health workstream propels CPWNY focus on the attainment of Level 3 NCQA PCMH under the 2014 standards. Currently, 31.8% (98/308) of Primary Care Providers (PCP) in CPWNY have attained this status. Fifty percent (50%) -154/308) of Primary Care Providers have Level 3 NCQA PCMH under the 2011 standards and will be renewing this year and next few years. Eighteen percent (18.2, 56/308) of CPWNY providers are not in a PCMH practice. The goal is to have 100% of the CPWNY providers in a PCMH practice by DY 3 Q4.

For those practices without PCMH recognition, CMP NCQA PCMH Certified Clinical Transformation (CT) staff will continue to assess practices interest and ability to meet the NCQA 2014 standards. CPWNY and CMP are also exploring the Advanced Practice Model (NYS model under development at this time) but preference is with NCQA.

For those practices already with PCMH under 2011 standards CMP has staff assigned from both Clinical Transformation and Care Management departments- prioritizing transformation according to PCMH renewal dates. NCQA is expected to adopt a new set of standards after September 30 2017. NCQA will not accept any submission under the 2014 standards after September 30, 2017.

All practices, regardless of PCMH designation, are assisted by CMP staff (Territory Lead Physicians, Clinical Transformation Specialists and Care Management Advisors) in improvement of quality metrics through rapid cycle evaluation as appropriate. CMP will be directly accountable for transformation of practices in Niagara and Erie counties. CMP has contracted with Chautauqua County Health Network for transformation of practices in Chautauqua County with oversight by CMP Clinical Transformation Department and CPWNY PMO.

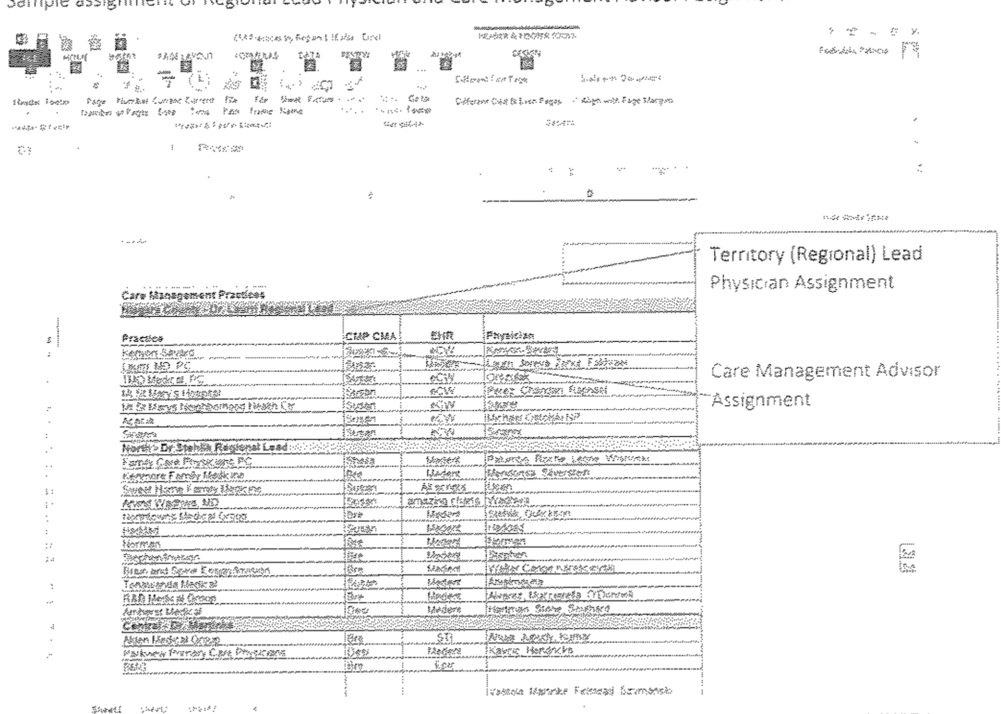
Example of Clinical Transformations staff assignment:



Practice Sites	Group	Practice Type	CT staff	Started PCMH in:	Physician count	Patient Membership (2015)	Most Recent Submission Date	Current PCMH Standard	Current PCMH Level	Current PCMH Start Date	Current PCMH End Date
Bertrand Chaffee Hospital	1005	Adult	Michelle	2012	3	1007	[illegible]	2011	Level 3	[illegible]	[illegible]
Forestream Pediatrics, LLP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Southwestern Medical	203	Adult	Kim	[illegible]	4	[illegible]	[illegible]	2011	Level 3	7/1/2014	7/1/2017
David J Novell MD	709	Adult	Paula	2011	1	1036	6/2/2014	2011	Level 3	7/18/2014	7/18/2017
David S Clifford MD	611	Adult	Paula	2011	1	1515	6/11/2014	2011	Level 3	7/18/2014	7/18/2017
Associated Physicians of WNY, PC	15	Adult	Kristen	2013	4	4132	7/18/2014	2011	Level 3	8/22/2014	8/22/2017
O'Connor Medical Group LLP	102	Adult	Paula	2011	2	2049	8/20/2014	2011	Level 3	8/22/2014	8/22/2017
Casey, Martin A	611	Adult	Kim	2011	1	1688	7/4/2014	2011	Level 3	9/12/2014	9/12/2017
Tonawanda Medical Practice	839	Adult	James	2011	1	804	8/11/2014	2011	Level 3	10/1/2014	10/1/2017
TMO Medical, PC	1021	Adult	James	2011	1	1007	9/17/2014	2011	Level 3	10/27/2014	10/27/2017
Northtowns Medical Group, P.C.	97	Adult	James	2011	2	2669	10/17/2014	2011	Level 3	11/21/2014	11/21/2017
Orchard Park Pediatrics	202	Peds	Paula	2011	3	3132	11/14/2014	2011	Level 3	1/2/2015	1/2/2018
O'Dell Medical Center-Springville		Adult	Michelle	2013	0		11/28/2014	2011	Level 3	1/11/2015	1/11/2018

Clinical transformation staff assignment

Sample assignment of Regional Lead Physician and Care Management Advisor Assignment.



Care Management Practices

Practice	CMP CMA	EHR	Physician
Niagara County - Dr. [illegible] Regional Lead			
Kenyon Savard	Susan	eCW	Kenyon-Savard
[illegible] MD, PC	Susan	Medent	[illegible]
[illegible] Medical, PC	Susan	eCW	[illegible]
Mt St Mary's Hospital	Susan	eCW	Perez, Chandan, Raphael
Mt St Marys Neighborhood Health Ctr	Susan	eCW	[illegible]
[illegible]	Susan	eCW	Michael [illegible] NP
[illegible]	Susan	eCW	[illegible]
North - Dr. Stehlik Regional Lead			
Family Care Physicians PC	Shasta	Medent	[illegible]
Kenmore Family Medicine	Bre	Medent	Mendonca, Siverstein
Sweet Home Family Medicine	Susan	Allscripts	[illegible]
Arvind Wadhwa, MD	Susan	amazing charts	Wadhwa
Northtowns Medical Group	Bre	Medent	Stehlik, [illegible]
Haddad	Susan	Medent	Haddad
Norman	Bre	Medent	Norman
Stephen/Iroquois	Bre	Medent	Stephen
Brain and Spine Rehab/[illegible]	Bre	Medent	[illegible]
Tonawanda Medical	Susan	Medent	[illegible]
R&B Medical Group	Bre	Medent	Alvarez, [illegible], O'Donnell
Amherst Medical	Desi	Medent	Hartman, [illegible]
Central - Dr. Matinke			
Aksen Medical Group	Bre	STI	[illegible]
Parkview Primary Care Physicians	Desi	Medent	Kavric, Hendricks
[illegible]	Bre	Epic	
			[illegible], Matinke, [illegible]

CPWNY Plans for Achieving PCMH 2014 Level 3

CPWNY is comprised of the following:

Current PCMH STATUS	% of total	TOTAL (practices)	CMP	NON-CMP	The work with the practices will be predicated on them having a signed agreement with the PPS.
2014 Level 3	24.5%	24	23	1	Almost 25% of our practices are have already achieved PCMH Level 3 recognition under the 2014 standards
2011	40.8%	40	32	8	Individually work with all practices on their renewal to 2014 standards; With NCQA's move to a new set of standards in 2017, they will not accept any submission under the 2014 standards after 9/30/2017. Therefore, for the 7 practices that have a recognition end date after 11/30/17 we will work with the practices to determine the best option: (1) submit their renewals to the 2014 standards (2) assess their ability to receive recognition under the new 2017 standards or (3) assess their ability to meet the requirements of APC
No PCMH	34.7%	34	26	8	Will continue to assess practices interest and ability to meet the requirements of PCMH Level 3 standards; as practices are able to meet the standards will work individually with the practice with the goal of attaining 2014 Level 3 by 11/30/2017 or meet the requirements of the new 2017 standards by 3/31/18. Will continue to assess practices interest and ability to meet the requirements of APC; as practices are able to meet the standards will work individually with the practice with the goal of attaining APC by 3/31/18. We will compare and contrast APC vs PCMH and perhaps offer another option for those practices that are not PCMH. These practices will be offered the training collaborative.
TOTAL	100%	98	81	17	

Current PCMH STATUS	% of total	TOTAL (providers)	CMP	NON-CMP	
2014 Level 3	31.8%	98	83	15	Almost 32% of our practices are have already achieved PCMH Level 3 recognition under the 2014 standards
2011	50.0%	154	94	60	Individually work with all practices on their renewal to 2014 standards; With NCQA's move to a new set of standards in 2017, they will not accept any submission under the 2014 standards after 9/30/2017. Therefore, for the 7 practices that have a recognition end date after 11/30/17 we will work with the practices to determine the best option: (1) submit their renewals to the 2014 standards (2) assess their ability to receive recognition under the new 2017 standards or (3) assess their ability to meet the requirements of APC
No PCMH	18.2%	56	38	32	Will continue to assess practices interest and ability to meet the requirements of PCMH Level 3 standards; as practices are able to meet the standards will work individually with the practice with the goal of attaining 2014 Level 3 by 11/30/2017 or meet the requirements of the new 2017 standards by 3/31/18. Will continue to assess practices interest and ability to meet the requirements of APC; as practices are able to meet the standards will work individually with the practice with the goal of attaining APC by 3/31/18. We will compare and contrast APC vs PCMH and perhaps offer another option for those practices that are not PCMH. These practitioners will be offered the training collaborative.
TOTAL	100%	308	215	107	

List of PCMH 2014 Level 3 organizations

	A	B	C	D	E	F	G	H
1	Group Name Reconcile	county	PCMH	PCMH Eligible	PCMH Standard	PCMH Level	PCMH Renewal Date	CMP
2	Bertrand Chaffee Primary Care Center	Erie	TRUE	TRUE	2011	1	4/10/2016	TRUE
3	Forestream Pediatrics, LLP	Erie	TRUE	TRUE	2011	level 3	4/21/2016	TRUE
4	East Aurora Family Practice	Erie	TRUE	TRUE	2011	level 3	5/20/2016	TRUE
5	Springville Pediatrics LLP	Erie	TRUE	TRUE	2011	level 3	7/9/2016	TRUE
6	Lovejoy St Vincent HC	Erie	TRUE	TRUE	2011	level 3	7/15/2016	TRUE
7	Westfield Family Physicians	Chautauqua	TRUE	TRUE	2011	level 3	9/1/2016	FALSE
8	Kansal, Sarita	Erie	TRUE	TRUE	2011	level 3	11/11/2016	TRUE
9	Ken-Ton Family Care	Erie	TRUE	TRUE	2011	level 3	11/11/2016	TRUE
10	Alden Medical Group	Erie	TRUE	TRUE	2011	level 3	11/25/2016	TRUE
11	Highgate Medical Group	Erie	TRUE	TRUE	2011	level 3	11/26/2016	FALSE
12	Giuseppina Kenyon-Savard, DO PC	Niagara	TRUE	TRUE	2011	level 3	12/7/2016	TRUE
13	Parkview Primary Care Physicians	Erie	TRUE	TRUE	2011	level 3	12/9/2016	TRUE
14	Southtowns Internal Medicine	Erie	TRUE	TRUE	2011	level 3	12/9/2016	TRUE
15	Limestone Primary Care Physicians	Erie	TRUE	TRUE	2011	level 3	12/15/2016	FALSE
16	Sheridan Drive Medical Group,LLP	Erie	TRUE	TRUE	2011	level 3	12/15/2016	TRUE
17	Norman, Allyn	Erie	TRUE	TRUE	2011	level 3	12/18/2016	TRUE
18	Jamestown Pediatrics	Chautauqua	TRUE	TRUE	2011	level 3	12/22/2016	FALSE
19	Primary Care of Western New York	Erie	TRUE	TRUE	2011	level 3	12/26/2016	TRUE
20	Primary Care of Western New York	Niagara	TRUE	TRUE	2011	level 3	12/26/2016	TRUE
21	Inspired Health Group, PLLC	Erie	TRUE	TRUE	2011	level 3	1/30/2017	TRUE
22	O'Dell Medical Center	Erie	TRUE	TRUE	2011	level 3	2/10/2017	TRUE
23	Amherst Medical Associates	Erie	TRUE	TRUE	2011	level 3	2/14/2017	TRUE
24	Family Care Physicians PC	Erie	TRUE	TRUE	2011	level 3	2/25/2017	TRUE
25	Lakeshore Primary Care Associates	Erie	TRUE	TRUE	2011	level 3	3/7/2017	TRUE
26	Silvercreek Pediatrics	Chautauqua	TRUE	TRUE	2011	level 3	3/7/2017	FALSE
27	Niagara Family Medicine Associates	Niagara	TRUE	TRUE	2011	level 3	3/13/2017	FALSE
28	Southtowns Family Practice PC	Erie	TRUE	TRUE	2011	level 3	3/26/2017	TRUE
29	Chaudhuri & Chaudhuri Physicians	Niagara	TRUE	TRUE	2011	level 3	4/13/2017	FALSE
30	Southwestern Medical	Erie	TRUE	TRUE	2011	level 3	7/1/2017	TRUE
31	Clifford, David	Erie	TRUE	TRUE	2011	level 3	7/18/2017	TRUE
32	Associated Physicians of WNY, PC	Erie	TRUE	TRUE	2011	level 3	8/22/2017	TRUE
33	O'Connor Medical Group	Erie	TRUE	TRUE	2011	level 3	8/22/2017	TRUE
34	Casey, Martin A.	Erie	TRUE	TRUE	2011	level 3	9/12/2017	TRUE
35	Tonawanda Medical Practice	Erie	TRUE	TRUE	2011	level 3	10/1/2017	TRUE
36	Family Health Medical Services	Chautauqua	TRUE	TRUE	2014	level 3	10/15/2017	FALSE
37	TMO Medical, PC	Niagara	TRUE	TRUE	2011	level 3	10/27/2017	TRUE
38	Northtowns Medical Group	Erie	TRUE	TRUE	2011	level 3	11/21/2017	TRUE
39	Orchard Park Pediatrics	Erie	TRUE	TRUE	2011	level 3	1/2/2018	TRUE
40	Dale L. Deahn, MD PC	Wyoming	TRUE	TRUE	2014	level 3	1/26/2018	TRUE
41	Ward, John P	Erie	TRUE	TRUE	2011	level 3	1/26/2018	TRUE
42	Allentown Pediatric & Adolescent Medicine, LLP	Erie	TRUE	TRUE	2014	level 3	2/17/2018	TRUE
43	Herman, Steven P.	Erie	TRUE	TRUE	2011	level 3	2/17/2018	TRUE
44	Lauri & Sirianni, MD, PC	Niagara	TRUE	TRUE	2014	level 3	2/20/2018	TRUE
45	Cleveland Hill Medical Group, PC	Erie	TRUE	TRUE	2011	level 3	3/2/2018	TRUE
46	Sweet Home Family Medicine	Erie	TRUE	TRUE	2011	level 3	3/11/2018	TRUE
47	Haddad, George	Erie	TRUE	TRUE	2014	level 3	3/17/2018	TRUE
48	Medicor Associates	Chautauqua	TRUE	TRUE	2011	level 3	4/8/2018	FALSE
49	Jamestown Primary Care	Chautauqua	TRUE	TRUE	2011	level 3	4/9/2018	FALSE
50	Kalmuk Primary Care	Erie	FALSE	TRUE	2011	level 3	4/9/2018	FALSE
51	Adult Medical Services	Erie	TRUE	TRUE	2014	level 3	4/13/2018	TRUE

NCQA PCMH 2014 Level 3

NCQA PCMH 2014 Level 3 practices

	A	B	C	D	E	F	G	H
5	Allentown Pediatric & Adolescent Medicine, LLP	Erie	TRUE	TRUE	2014	level 3	2/17/2018	TRUE
9	Arvind Wadhwa, MD	Niagara	TRUE	TRUE	2014	level 3	6/6/2018	TRUE
19	Burke, Amy	Erie	TRUE	TRUE	2014	level 3	9/30/2018	TRUE
21	Carrow Street Pediatrics	Erie	TRUE	TRUE	2014	level 3	12/17/2018	TRUE
31	Dale L. Deahn, MD PC	Wyoming	TRUE	TRUE	2014	level 3	1/26/2018	TRUE
33	Delaware Pediatrics	Erie	TRUE	TRUE	2014	level 3	12/2/2018	TRUE
41	Family Health Medical Services	Chautauqua	TRUE	TRUE	2014	level 3	10/15/2017	FALSE
44	Frederick J. Piwko, MD, PC	Niagara	TRUE	TRUE	2014	level 3	8/24/2018	FALSE
45	Geemson Oo, MD	Erie	TRUE	TRUE	2014	level 3	9/18/2018	TRUE
46	Genesee Transit Pediatrics	Erie	TRUE	TRUE	2014	level 3	2/21/2019	TRUE
49	Haddad, George	Erie	TRUE	TRUE	2014	level 3	3/17/2018	TRUE
63	Kenmore Family Medicine	Erie	TRUE	TRUE	2014	level 3	3/4/2019	TRUE
70	Lancaster-Depew Pediatrics	Erie	TRUE	TRUE	2014	level 3	1/16/2019	TRUE
71	Laurri & Sirianni, MD, PC	Niagara	TRUE	TRUE	2014	level 3	2/20/2018	TRUE
79	Mercy Comprehensive Care Center	Erie	TRUE	TRUE	2014	level 3	3/3/2019	TRUE
80	Mount St Marys Neighborhood Health Center	Niagara	TRUE	TRUE	2014	level 3	12/14/2018	TRUE
81	Mount St. Mary's Hospital	Niagara	TRUE	TRUE	2014	level 3	12/14/2018	TRUE
89	OLV Family Care Center	Erie	TRUE	TRUE	2014	level 3	2/10/2019	TRUE
91	Orchard Park Family Practice	Erie	TRUE	TRUE	2014	level 3	2/10/2019	TRUE
99	R&B Medical	Erie	TRUE	TRUE	2014	level 3	5/24/2018	TRUE
107	Southgate Medical Group	Erie	TRUE	TRUE	2014	level 3	3/4/2019	TRUE
115	Timothy F. Gabryel, MD, PC	Erie	TRUE	TRUE	2014	level 3	10/29/2018	TRUE
118	TriCounty Family Medicine Associates, Inc.	Chautauqua	TRUE	TRUE	2014	level 3	4/21/2018	FALSE

	A	B	C	D	E	F	G	H
52	TriCounty Family Medicine Associates, Inc.	Chautauqua	TRUE	TRUE	2014	level 3	4/21/2018	FALSE
53	R&B Medical	Erie	TRUE	TRUE	2014	level 3	5/24/2018	TRUE
54	Arvind Wadhwa, MD	Niagara	TRUE	TRUE	2014	level 3	6/6/2018	TRUE
55	Vejendla & Bals	Chautauqua	TRUE	TRUE	2011	level 1	6/28/2018	FALSE
56	Frederick J. Piwko, MD, PC	Niagara	TRUE	TRUE	2014	level 3	8/24/2018	FALSE
57	Geemson Oo, MD	Erie	TRUE	TRUE	2014	level 3	9/18/2018	TRUE
58	Burke, Amy	Erie	TRUE	TRUE	2014	level 3	9/30/2018	TRUE
59	Timothy F. Gabryel, MD, PC	Erie	TRUE	TRUE	2014	level 3	10/29/2018	TRUE
60	Delaware Pediatrics	Erie	TRUE	TRUE	2014	level 3	12/2/2018	TRUE
61	Mount St Marys Neighborhood Health Center	Niagara	TRUE	TRUE	2014	level 3	12/14/2018	TRUE
62	Mount St. Mary's Hospital	Niagara	TRUE	TRUE	2014	level 3	12/14/2018	TRUE
63	Carrow Street Pediatrics	Erie	TRUE	TRUE	2014	level 3	12/17/2018	TRUE
64	Lancaster-Depew Pediatrics	Erie	TRUE	TRUE	2014	level 3	1/16/2019	TRUE
65	OLV Family Care Center	Erie	TRUE	TRUE	2014	level 3	2/10/2019	TRUE
66	Orchard Park Family Practice	Erie	TRUE	TRUE	2014	level 3	2/10/2019	TRUE
67	Genesee Transit Pediatrics	Erie	TRUE	TRUE	2014	level 3	2/21/2019	TRUE
68	Mercy Comprehensive Care Center	Erie	TRUE	TRUE	2014	level 3	3/3/2019	TRUE
69	Kenmore Family Medicine	Erie	TRUE	TRUE	2014	level 3	3/4/2019	TRUE
70	Southgate Medical Group	Erie	TRUE	TRUE	2014	level 3	3/4/2019	TRUE
71	BOMMIREDDIPALLI SRINIVAS DR.	Chautauqua	FALSE					FALSE
72	Buffalo Emergency Associates	Erie	FALSE					TRUE
73	CCS Oncology Center	Erie	FALSE					TRUE
74	CHS	Erie	FALSE					FALSE
75	EGWAIKHIDE OHIGBAI DR.	Chautauqua	FALSE					FALSE
76	Justin Eckler MD	Erie	FALSE					FALSE
77	Mangulabnan, Melvin	Erie	FALSE					TRUE
78	MENON ZUBIN MD	Chautauqua	FALSE					FALSE
79	Mount St. Mary's Hospital	Niagara	FALSE					TRUE
80	Pragatheeshwar Thirunavukarasu MD	Erie	FALSE					FALSE
81	Roswell Park Cancer Institute	Schenectady	FALSE					FALSE
82	Swetz, Mark E.	Erie	FALSE					TRUE
83	WCA Hospital	Chautauqua	FALSE					FALSE
84	Ali, Irshad	Erie	FALSE	TRUE				TRUE
85	Andaya, Maria	Erie	FALSE	TRUE				TRUE
86	Arora, Satish	Erie	FALSE	TRUE				TRUE
87	Aurora Family Health Care	Erie	FALSE	TRUE				TRUE
88	Bojedla, Vijay	Niagara	FALSE	TRUE				TRUE
89	Botsoglou, Nikolaos	Erie	FALSE	TRUE				TRUE
90	Brain and Spine Medical Services PLLC	Erie	FALSE	TRUE				TRUE
91	Branigan, Thomas S.	Erie	FALSE	TRUE				TRUE
92	C and S Medical Building Inc	Chautauqua	FALSE					FALSE
93	Century Airport Pediatrics	Erie	FALSE	TRUE				TRUE
94	Century Medical Associates	Erie	FALSE	FALSE				TRUE
95	Cheng Shung Fu, MD, PC	Erie	FALSE	TRUE				TRUE
96	de Perio III, Jose	Erie	FALSE	TRUE				TRUE
97	DiBella, Michael D.	Erie	FALSE	FALSE				TRUE
98	Dr. Yasmin Pervez PLLC	Niagara	FALSE	TRUE				FALSE
99	Erika Connor MD	Chautauqua	FALSE					FALSE
100	Family Care Medicine PC	Erie	FALSE	TRUE				FALSE
101	Frank A. Ferraro	Niagara	FALSE	TRUE				FALSE
102	Grant W Stephenson MD	Chautauqua	FALSE	TRUE				FALSE

NCQA PCMH 2014 Level 3 Practices (cont'd)

	A	B	C	D	E	F	G	H
103	Hamburg Pediatrics, PC	Erie	FALSE	TRUE				TRUE
104	Hurley Medical Center	Erie	FALSE	TRUE				TRUE
105	J.K. Bhattacharyya MD	Erie	FALSE	TRUE				FALSE
106	Jamestown Area Medical Associates	Chautauqua	FALSE	TRUE				FALSE
107	Kalra, Tejinder	Erie	FALSE	TRUE				TRUE
108	Kids Alliance Pediatric Group	Erie	FALSE	TRUE				TRUE
109	Koleini, Jahangir	Erie	FALSE	TRUE				TRUE
110	Lakeshore Family Medicine Associates PC	Erie	FALSE	TRUE				TRUE
111	Lall, Shashi	Erie	FALSE	TRUE				TRUE
112	Les Zakrzewski MD	Erie	FALSE	TRUE				TRUE
113	Luther, Prama	Erie	FALSE	TRUE				TRUE
114	O'Gorman, Kevin	Erie	FALSE	FALSE				FALSE
115	Olean General Hospital	Cattaraugus	FALSE					FALSE
116	O'Neil, David	Erie	FALSE	TRUE				TRUE
117	Philip A Penepent Jr MD	Erie	FALSE	TRUE				FALSE
118	Pleskow, Sanford R.	Erie	FALSE	FALSE				FALSE
119	Rainbow Pediatrics of Niagara, PC	Niagara	FALSE	TRUE				TRUE
120	Rama Bojedla, MD	Niagara	FALSE	TRUE				TRUE
121	Sachar, Rajinder S.	Erie	FALSE	TRUE				TRUE
122	Shafi, Mohamad	Erie	FALSE	TRUE				TRUE
123	Sisters of Charity Hospital of Buffalo	Erie	FALSE	TRUE				TRUE
124	Southern Tier Pediatrics	Chautauqua	FALSE	TRUE				FALSE
125	Thomas Hughes MD, PC	Erie	TRUE	TRUE				FALSE
126	Vyjanthanath Rohan Gunasingham, MD	Erie	FALSE	TRUE				TRUE
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PCMH learning collaborative

Patient Centered Medical Home Learning Collaborative

The CPWNY training program will utilize the CMP Leadership Series. This series builds and assists in the clinical transformation of practices to become "high performing" practices. The program consists of review (completed at the office by the Clinical Transformation and Care Management staff) for those who previously attended classes for attainment of PCMH and it is offered to any new staff at those offices. CMP, as part of an ACO accreditation status, maintains oversight of its practices to insure that the processes in place for the high performing practice are maintained. This type of oversight will continue for partners of CPWNY

Detailed Training plan – involves practitioner champions, office managers, and designees.

Session 1.

- Focus on choosing a practice project lead
- Perspective from Primary Care practice that achieved PCMH and MU Designation
- Overview of PCMH Standards (2014) and APC
- Principles of leadership, accountability, and organizational structure
- Principles of Project Management, managing timelines and milestones, staff accountability, meeting management
- Review PCMH Standards 1- Patient Centered Access , and Standard 5 – Care Coordination and Care Transitions
- Review PDSA model (RCE) **
- Break out – begin creating quality plan/discuss progress if already started for the office; which measures are you going to select; who is going to be part of the quality team, how are you going to communicate to the practice, etc.
- Wrap up assignments : Create the quality plan for office – create a PDSA for how you want to improve 2 measures; project plan ; purchase PCMH tool

  ** The RCE method will include videos:

  https://www.youtube.com/watch?v=_-ceS9Ta820

  https://www.youtube.com/watch?v=eYoJxjmv_QI

  Teaching procedure/Instructional Events (PLAN):

  - The educator will explain that the purpose for today's session is to come up with a goal or "aim" to use for improvement in the office.
  - The educator will distribute a packet of information to representatives from the practice reflecting current measures in that practice.

- The participants will be asked to examine their data as a group.
- The participants will be asked to select one area for improvement based on the data that they have just examined. This will include demographic population and an area for improvement within that population.
- The educator will lead a group discussion where he/she will ask each group "what is your aim?"
- The educator will then ask each group what data they used to reach their aim.
- The educator will finally ask how they believe the aim will reduce unnecessary costs (could be related to inpatient stays, ER visits, etc.).
- The educator will explain that for the next time period that practice will record and examine the data in their aim.
- Revisit with intervention – office will receive follow up by Clinical Transformation team members.

Session 2:

Follow up by Clinical Transformation Specialists with designated practice staff, inclusive of practitioners, as needed to reinforce training and continue 1:1 interventions and transformation process.