NORTHCOUNTRY
INITIATIVE

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5 Years of High 5s

NORTHCOUNTRY INITIATIVE

A summary of successes achieved by the North Country Initiative PPS, our partners, providers and patients as part of New York State's Delivery System Reform Incentive Payment (DSRIP) program.

Dear Friends:

With the Delivery System Reform Incentive Payment (DSRIP) program coming to a close, we must reflect on what our region has accomplished. With a strong foundation in place, our clinically integrated network united over a common goal to fundamentally restructure the health care delivery system. With a history of working together and insight into our community health needs, we were able to build upon our foundation to achieve improvements in system transformation, clinical management, and population health across the care continuum.

Partners achieved incredible milestones, including the implementation of care management infrastructure, becoming Patient-Centered Medical Homes, integrating behavioral health and primary care, utilizing the health information exchange, standardizing care delivery, and much more. Together, all partners, including hospitals, primary care, behavioral health, community organizations, and EMS have improved communication and coordination, which has resulted in improved quality of care. Commitment to community members as health care consumers continues to be a driving motivator to ensure a patient-centered, collaborative system supporting each person's unique needs, whether clinical or social. Thank you to all of our DSRIP partners for your dedication to this program and for the impact you have made to patient care. We commend your achievements, all of which have contributed to a considerable reduction in avoidable hospitalizations.

I would also like to extend gratitude to the NCI Board of Managers and the staff. With the Board's dedication and direction, the network received the necessary support and buy-in required to undertake such transformation, which was then facilitated by the determined and diligent staff at NCI. We also must thank New York State for the vision and momentus opportunity that provided significant resources, allowing our region to focus on health care transformation for the benefit of our most vulnerable residents. While it is unfortunate that the DSRIP program will be ending, the Board thoughtfully engaged partners to determine what could be sustained from this great work. It is with much hope that the partnerships created among the clinically integrated network, as well as the relationships between the network and patients, will remain strong and effective in delivering whole person care as we continue to focus on improving quality and reducing health care costs.

Sincerely,

Collins F. Kellogg, Jr., MD
Chair, North Country Initiative Board of Managers

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM (DSRIP)

THE GOAL: 25 percent reduction in avoidable hospital use over DSRIP's five-year period.

On April 14, 2014, the State of New York (the State) and the Centers for Medicare and Medicaid Services (CMS) reached an agreement on a groundbreaking waiver that allowed the State to invest $8 billion of the $17.1 billion in federal savings generated by the Medicaid Redesign Team (MRT) reforms. The waiver would allow for comprehensive Medicaid delivery and payment reform primarily through a Delivery System Reform Incentive Payment (DSRIP) program.

The $6.42 billion DSRIP program provided incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low-income, uninsured individuals in their local communities by improving the quality of care, improving the health of populations and reducing costs. The DSRIP program promoted community-level collaboration and aimed to reduce avoidable hospital use by 25 percent over the five-year demonstration period.

THE PLAYERS: 25 partnership coalitions across New York State

To accomplish this, 25 Performing Provider Systems (PPS) were established statewide as partnerships between hospitals, other health care providers and community-based organizations. Each PPS chose specific projects to best meet their communities' needs. A PPS is composed of regionally collaborating providers tasked with implementing the projects spanning three domains: system transformation, clinical improvement and population health improvement (New York State's Prevention Agenda).

- Adirondack Health Institute, Inc.
- Alliance for Better Health Care, LLC
- Better Health for Northeast New York, Inc.
- Bronx Health Access
- Bronx Partners for Healthy Communities
- Care Compass Network
- Central New York Care Collaborative
- Community Care of Brooklyn
- Community Partners of Western New York
- Finger Lakes Performing Provider System, Inc.
- Leatherstocking Collaborative Health Partners
- Millennium Collaborative Care
- Montefiore Hudson Valley Collaborative
- Mount Sinai PPS, LLC
- Nassau Queens PPS
- New York-Presbyterian/Queens
- North Country Initiative
- NYU Langone Brooklyn PPS
- OneCity Health
- Refuah Community Health Collaborative
- SOMOS Community Care
- Staten Island Performing Provider System, LLC
- Suffolk Care Collaborative
- The New York and Presbyterian Hospital
- WMCHealth

North Country Initiative (NCI) is a partnership of hospitals, independent physicians and community providers working together to reform the health care system across Northern New York's Jefferson, Lewis and St. Lawrence counties. NCI works to improve the quality and efficiency of care for the rural, under-served population within its region. NCI works closely with the Fort Drum Regional Health Planning Organization (FDRHPO), sharing resources and common goals.

NCI partners encompass entities from across the health care continuum, including mental health, substance abuse, county organizations, community-based organizations, pharmacies, health homes, home health, hospitals, long-term care, hospice, housing, primary care, specialty care, Office for Persons with Developmental Disabilities (OPWDD), urgent care and emergency medical services. There are nearly 150 sites among 84 partners in our tri-county region.

DSRIP funds are allocated based on meeting milestones and metrics, including process-type milestones for infrastructure development and system redesign and outcome-based metrics for performance on nearly 50 measures, including avoidable hospitalizations, clinical care improvements, and population health improvements.

NCI BOARD OF MANAGERS

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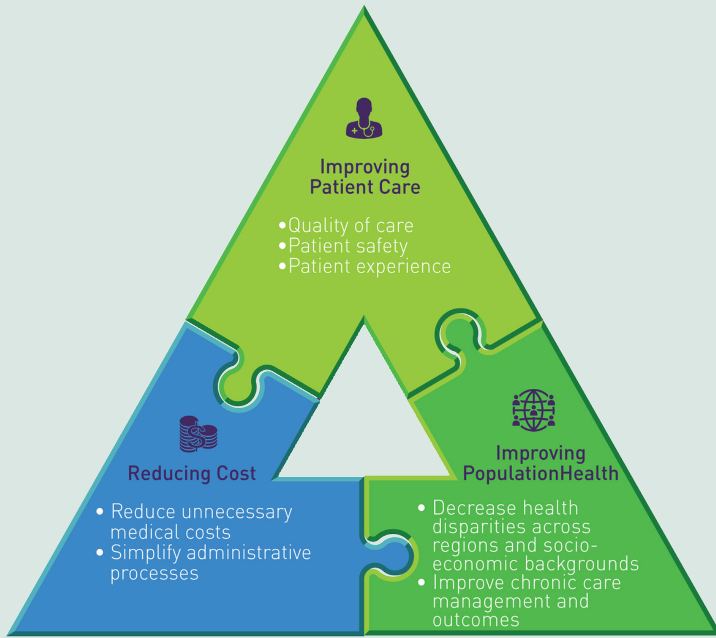


CMS Triple Aim

To improve patient care and lower overall healthcare spending, CMS instituted its "Triple Aim."

With the health care system undergoing significant change at both state and federal levels, NCI and its partners are working to align incentives, standardize clinical protocols, and develop necessary health technology infrastructure. Foundational to these strategies is the overarching goal of improving access to health care for all, while also improving the health of our community, reducing the cost of health care and improving the quality of care.

Much of NCI's work is grounded in working toward three key goals established by New York State's DSRIP initiatives and in alignment with the the Centers for Medicare and Medicaid Services (CMS) Triple Aim:

- **Improving the quality of care** for our rural, underserved population through integrated primary, specialty and behavioral health care
- **Improving population health** measures consistent with the New York State Prevention Agenda
- **Lowering healthcare costs** by reducing avoidable hospitalizations

NCI GOVERNANCE STRUCTURE

DSRIP PROJECT ADVISORY COMMITTEE (PAC) → NORTH COUNTRY INITIATIVE, LLC Board of Managers ↔ HEALTHCARE PARTNERS OF THE NORTH COUNTRY (ACO) ↔ NORTH COUNTRY INDEPENDENT PRACTICE ASSOCIATION, LLC ↔ FORT DRUM HEALTH CARE PARTNERS, INC. (MSO)

Committees under the Board of Managers:

- HEALTH INFORMATION TECHNOLOGY (HIT) COMMITTEE
- COMPLIANCE COMMITTEE
- MEDICAL MANAGEMENT (CLINICAL) COMMITTEE
  - FDRHPO BEHAVIORAL HEALTH COMMIITTEE
  - FDRHPO HEALTH COMPASS POPULATION HEALTH COMMITTEE
  - FDRHPO HEALTH LITERACY & CULTURAL COMPETENCY COMMITTEE
  - CARE CONNECTIONS (CARE COORDINATION COMMITTEE)
- VALUE-BASED PAYMENT COMMITTEE
- PAYER/FINANCE COMMITTEE
- PROFESSIONAL EDUCATION & WORKFORCE COMMITTEE
  - FDRHPO REGIONAL RECRUITMENT & EDUCATION COMMITTEE (RREC)

COMMITTEE CHAIRS

Ginger Hall/Dana McGuire
Health Compass

Kathleen Hunter
Care Connections

Steven Lyndaker, MD
Medical Management

Aileen Martin
Health Literacy/Cultural Competency

Emily Mastaler
Finance

Richard Merchant
RREC

David Rechlin, DO
Workforce

Tim Ruetten
Behavioral Health

Jack Rush, MD
Health Information Technology

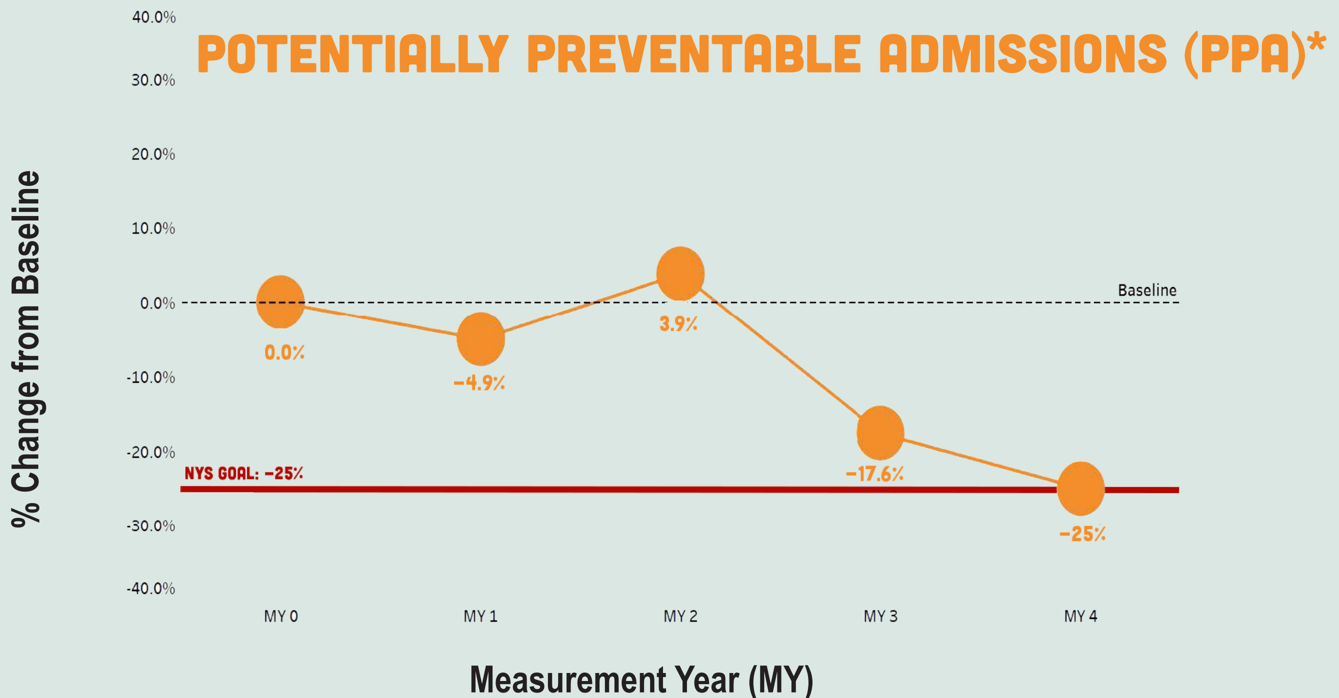
Michael Seidman, MD
Compliance

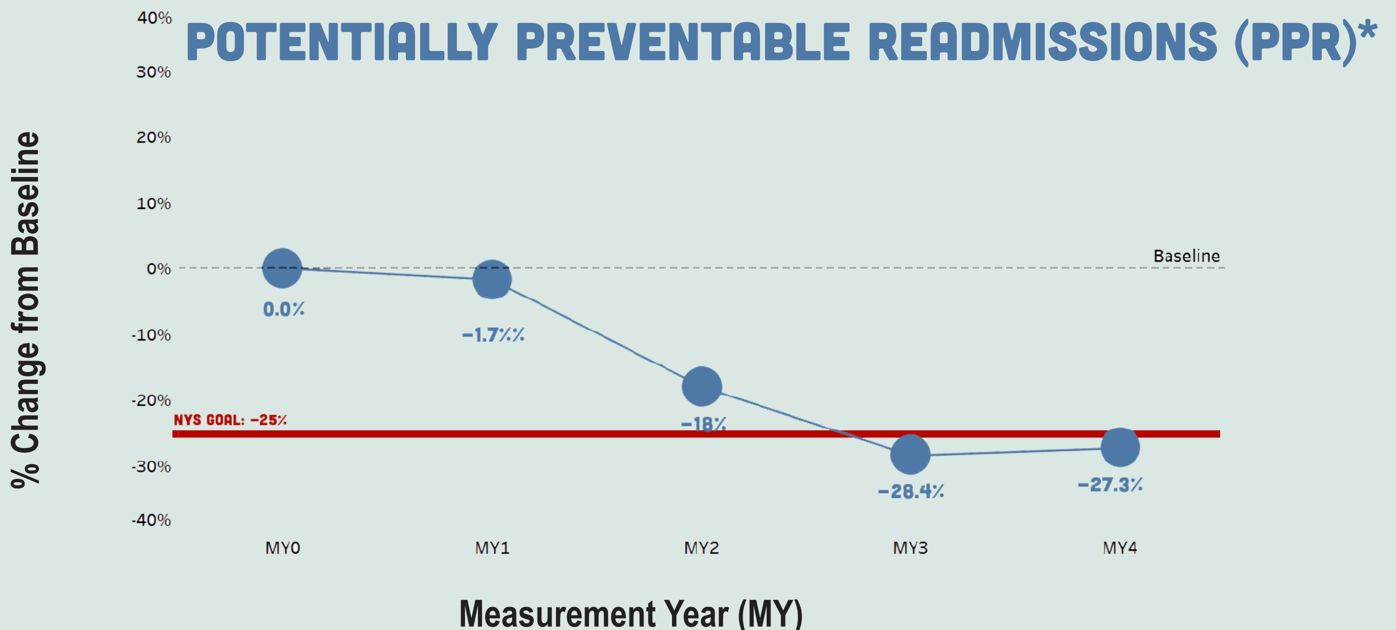
NCI PARTNERS

Advanced Asthma and Allergy of NNY
AIDS Community Resources/ACR Health
American Red Cross NNY Chapter
Black River Ambulance Squad
Bolton's Pharmacy
CanAm Youth Services (dba Rose Hill)
Cardiology Associates of NNY
Carthage Area Hospital
Cerebral Palsy Association of the North Country (Community Health Center of the North Country)
Child & Adolescent Health Associates
Children's Home of Jefferson County
Claxton-Hepburn Medical Center
Clifton-Fine Hospital
Community Action Planning Council of Jefferson County, Inc.
Complete Family Care & Laser Center
Credo Community Center
Disabled Persons Action Organization
David Ewing-Chow, MD
Family Counseling Services of NNY
Family Medicine of Carthage
Family Medicine of NNY
Nancy Girard, DO
Gouverneur Volunteer Rescue Squad
Health Services of NNY
Highland Nursing Home
Hospice of Jefferson County
Hospitality House TC
Jefferson County Community Services
Jefferson County Department of Social Services
Jefferson County Office for the Aging
Jefferson County Public Health
Jefferson Rehabilitation Center
Jeff-Lewis BOCES
L. Woerner, Inc. (dba HCR Home Care)
Lewis County Community Services
Lewis County Office for the Aging
Lewis County Public Health
Lowville Medical Associates
Massena Independent Living Center
Massena Memorial Hospital
Massena Rehabilitation and Nursing Center
Mental Health Association of Jefferson County
Howard Meny, MD
Mountain View Prevention Services
North Country Emergency Medical Consultants
North Country Family Health Center
North Country Family Medicine
North Country Freedom Homes
North Country Health Home Network
North Country Prenatal/Perinatal Council
Northern Lights Health Care Partnership
Northern Regional Center for Independent Living
Ogdensburg Family Practice
Pediatric Associates of Watertown
Phillgrey, Inc.–Seaway Valley Ambulance
Pivot
Planned Parenthood of the North Country
Pulmonary Associates of NNY
River Hospital
Samaritan Medical Center
Seaway Valley Council for Alcohol/ Substance Abuse Prevention
South Jefferson Rescue Squad
St. Joseph's Home
St. Lawrence Addiction Treatment Center
St. Lawrence County Health Initiative
St. Lawrence County Mental Health and Chemical Dependency Services
St. Lawrence New York State Association of Regional Councils
St. Lawrence Psychiatric Center
St. Lawrence Public Health
St. Lawrence-Lewis BOCES
Step by Step
The House of the Good Shepherd
Thousand Islands Emergency Rescue Squad (TIERS)
Town of Watertown Ambulance Service
Transitional Living Services of NNY
United Helpers
US Care Systems
Vision Source Original Eyewear
VNA Homecare
Volunteer Transportation Center
Watertown Family YMCA
Watertown Internists
Watertown Urban Mission
Watertown Urgent Care

As a result of the collective efforts of all NCI partners and providers, the following graphs illustrate the significant decrease achieved in DSRIP's overall measures: Potentially Preventable Admissions (PPA) and Potentially Preventable Readmissions (PPR).

How did we do it? The next several pages outline each individual DSRIP project selected by NCI and the goals and successes related to each. Our overall impact can be attributed to the individual successes of each project.





* New York State Department of Health data, October 22, 2019

NCI PROJECTS

2.a.i	Integrated Delivery System (IDS)
2.a.ii	Patient-Centered Medical Home (PCMH)
2.a.iv	Medical Village
2.b.iv	Care Transitions
2.d.i	Patient Activation Measure® (PAM)
3.a.i	Integration of Primary Care & Behavioral Health
3.b.i	Chronic Disease Management (Cardiovascular)
3.c.i	Chronic Disease Management (Diabetes)
3.c.ii	Community Prevention & Management Programs
4.a.iii	Mental Health & Substance Abuse Infrastructure
4.b.ii	Chronic Disease Prevention for All Populations

2.a.i

INTEGRATED DELIV

An Integrated Delivery System (IDS) connects clinical and community-based entities to collaborate and ensure the delivery of high-quality health care, while preventing unnecessary hospital usage, and thereby reducing health care costs. Technology, training, care coordination and alignment among all partners are key elements in creating and sustaining a strong IDS.

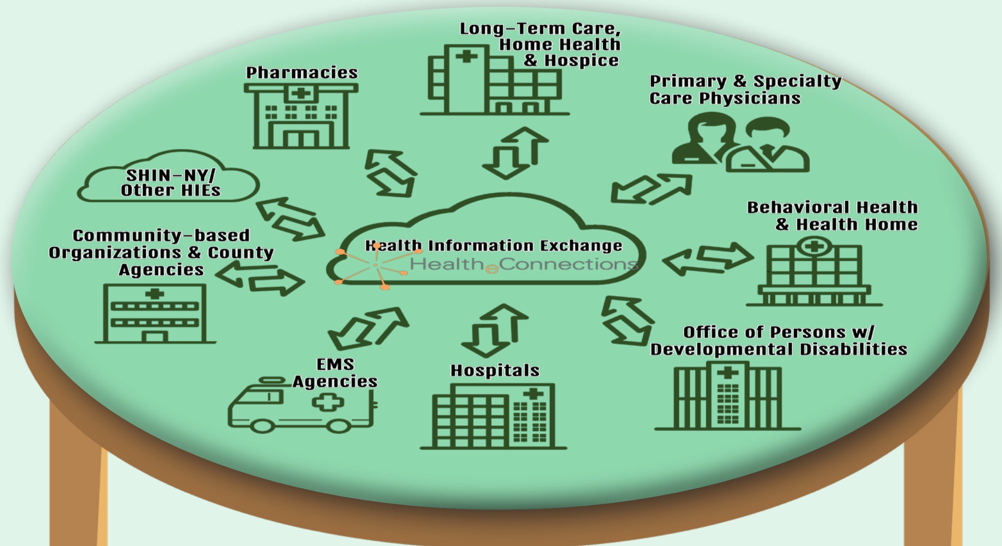
The North Country Initiative (NCI) approached network development on a larger scale, building a regional network on a foundation already in place—due, in large part, to the work of the Fort Drum Regional Health Planning Organization (FDRHPO). NCI is a clinically integrated network, whose governance and committee structures bring together representatives of the region's physicians, federally-qualified health centers (FQHCs), hospitals, behavioral health providers, community-based organizations, and other stakeholders to the table. NCI has invested DSRIP funds to support key program interventions and to support the regionwide infrastructure serving Medicaid providers and their patients. Over the past decade, NCI, its related organizations, (including FDRHPO, which provides a range of services to support NCI) and its network partners have put in place many elements of an IDS necessary for future value-based payment, including a Medicare Accountable Care Organization and Independent Practice Association. Here is how we made that happen:

PROJECT DESCRIPTION:

Create an Integrated Delivery System (IDS) focused on evidence-based medicine and population health management

PROJECT GOAL(S):

Develop the infrastructure to support the delivery of evidence-based, quality care in the right setting, at the right time, and at the appropriate cost, incorporating a full continuum of services; bring health care providers up to date with the most current standards of quality care



COLLABORATE & CONNECT

MILESTONE:

Perform population health management by actively using electronic health records (EHRs) and other information technology platforms, including use of targeted patient registries, for all participating safety net providers

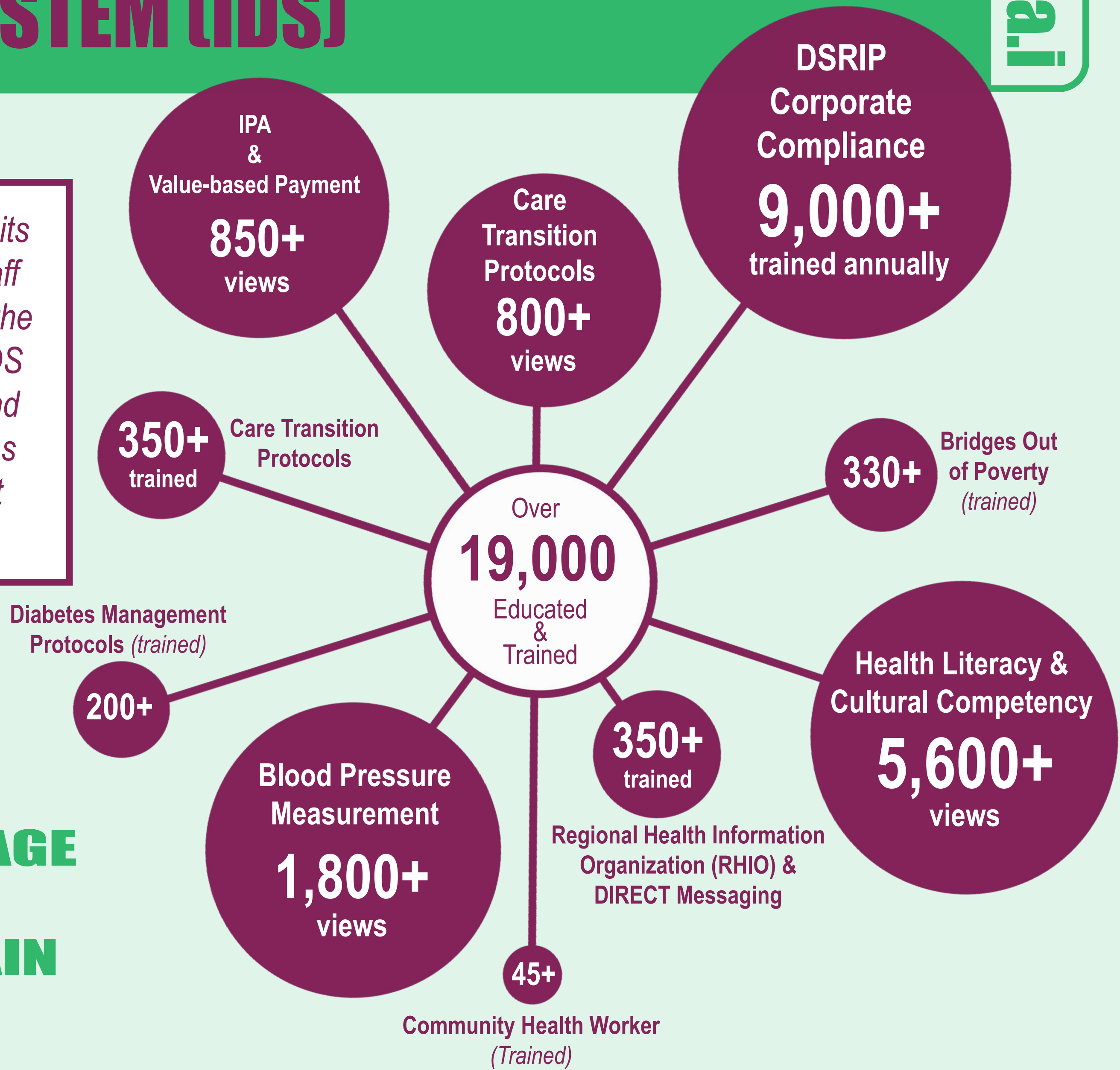
NCI ACHIEVEMENTS:

- Utilized Johns Hopkins' Adjusted Clinical Groups Risk Assessment tool to stratify patients, based on risk to allow partners to focus care management efforts on a subset of high-risk, dual-eligible patients; also enabled NCI to alert partners of hospital discharges to support care management efforts
- All participating safety-net partners connected through the health information exchange (HIE) to allow for seamless and secure HIE
- Developed in-house data application called Roster Notes to alert providers at point of care to close identified care gaps for patients
- Partners' electronic health records used to identify and close gaps in DSRIP clinical quality measures

Shouldn't MCOs and other payers be at the table, too?

Not pictured at the table with NCI's other partners are managed care organizations (MCOs). One of the milestones for this project was to contract with Medicaid MCOs and other payers, as appropriate, as an integrated system and establish value-based payment arrangements focused on cost and quality. NCI achieved this by forming an Independent Practice Association (IPA) to negotiate with MCOs in our region.

NCI trained its partners' staff throughout the region on IDS protocols and processes as each project required.



ENGAGE & TRAIN

"Real time access to a patient's complete medical record from all of their providers through HealtheConnections allows us to improve patient care, provide better assessments and avoid duplication of medical care. Overall, DSRIP has provided, through available funds, better access to the exchange for our providers and better coordination of care for our patients."

~ Dariusz Chrostowski, MD, Advanced Asthma & Allergy of NNY

MILESTONE	NCI ACHIEVEMENT	RESULT
Engage patients in the IDS through outreach and navigation activities, leveraging community health workers, peers and culturally competent community-based organizations, as appropriate	Contracts in place with two community-based organizations for community health worker and behavioral health peer support services	After engagement, hospitalizations for one patient group dropped **61%**; emergency room visits dropped **70%**; and urgent care visits dropped **48%**.

2.a.ii

PATIENT-CENTERED M

What is a Patient-Centered Medical Home (PCMH)?

For patients, PCMH means that their primary care providers' guiding philosophy ensures the right care, in the right place, at the right time. The team-based approach, which includes the patient as a member, involves working with specialists, hospitals and others to ensure the patient's health care is effectively coordinated from prevention to treatment. This means that their doctor's office has:

- Availability of same-day appointments
- Timely access to health care professionals
- Electronic access to records, results and health information
- Effective coordination of medical information among health care providers

For providers, PCMH means that their practice is recognized because they strive to meet a rigorous set of qualifications within six concept areas:

- Team-Based Care & Practice Organization
- Knowing & Managing Patients
- Patient-Centered Access & Continuity
- Care Management & Support
- Care Coordination & Care Transitions
- Performance Measurement & Quality Improvement

PROJECT DESCRIPTION:

Increase certification of primary care practitioners with Patient-Centered Medical Home (PCMH) certification and/or Advanced Primary Care models as developed under the New York State Health Innovation Plan (SHIP)

PRE-DSRIP	GOAL/MILESTONE	NCI ACHIEVEMENT
Of the primary care practice sites in the NCI: • 0% had achieved PCMH 2014 • 33% had achieved PCMH 2011 • 67% had either never attempted PCMH recognition or allowed 2008 PCMH recognition to lapse	Ensure that all participating primary care practices in the PPS meet National Committee for Quality Assurance (NCQA) 2014 Level 3 Patient-Centered Medical Home recognition and/or meet State-determined criteria for Advanced Primary Care models.	100% of partnering sites achieved 2014 Level 3 PCMH recognition by the end of DY3, and all continue to maintain their recognition.

The North Country Initiative's PCMH Team supports our partner practices as they strive to achieve and maintain the high PCMH standards. L to R: Laura Yott, ACO Project Coordinator; Ian Francis, Practice Transformation Specialist; Joanna Loomis, Director of Provider Strategy & Transformation; Tracy Hart, Behavioral Health HIT Specialist

MEDICAL HOME (PCMH)

2.a.ii

MILESTONE/SUCCESS:

Implement open-access scheduling in all participating primary care practices

A PATIENT'S PERSPECTIVE

"My 7-year-old daughter had strep throat in January of 2019. She was sent home from school early with a fever, and I was able to call Dr. Jones' office (Carthage Family Health Center) and get her a 'same day appointment' to have her seen instead of having to bring her to the Emergency Room. This saved us both time and money. We were in and out very quickly. The front desk staff assured me that '"there are always same day, sick visit appointments available for our patients.'"

~ Grateful Mom

Photo of Carthage Family Health Center staff.

NCI PRIMARY CARE PARTNER SITES

Carthage Area Hospital Philadelphia Clinic
Carthage Area Hospital Primary and Pediatric Care
Child and Adolescent Health Associates
Claxton-Hepburn Health Center – Canton
Claxton-Hepburn Health Center – Hammond
Claxton-Hepburn Health Center – Heuvelton
Claxton-Hepburn Health Center – Lisbon
Claxton-Hepburn Health Center – Madrid
Claxton-Hepburn Health Center – Ogdensburg
Claxton-Hepburn Health Center – Waddington
Claxton Medical PC – Internal Medicine
Claxton Medical PC – Pediatrics
Clifton-Fine Star Lake Clinic
Complete Family Care and Laser Center
Family Medicine of Carthage
Family Medicine of NNY
Nancy Girard, DO
Lowville Medical Associates
Massena Memorial Hospital Clinic – Kids Korner
Massena Memorial Hospital Clinic – Louisville
Massena Memorial Hospital Clinic – Medical Group
North Country Family Health Center
North Country Family Medicine
Ogdensburg Family Practice
Pediatric Associates of Watertown
River Hospital Family Health Center
St. Lawrence Internists
Samaritan Family Health Center – Adams
Samaritan Family Health Center – Cape Vincent
Samaritan Family Health Center – Clayton
Samaritan Family Health Center – GME
Samaritan Family Health Center – Lacona
Samaritan Family Health Center – LeRay
Samaritan Family Health Center – Plaza/Watertown
Samaritan Family Health Center – Sackets Harbor
Watertown Internists
Watertown Pediatrics

MILESTONE:

Identify a physician champion with knowledge of PCMH implementation for each primary care practice included in the project

NCI ACHIEVEMENT:

Appointed two physician champions, one of whom operates one of the first practices in New York State to receive 2014 Level 3 PCMH accreditation

NCI's PCMH Physician Champions

Steven Lyndaker, MD

Karen Williams, MD

2.a.iv

MEDICAL V

PROJECT DESCRIPTION:

Create Medical Villages throughout the region using existing hospital infrastructure

PROJECT GOAL(S):

Create Medical Villages throughout the region to provide patients access to multiple health care functions for outpatient care and services in one convenient location, a "one-stop shop." With today's busy lifestyle, offering more comprehensive health care services, as supported by the community needs assessment, will ensure patients are better and more appropriately served by their providers.

LIFESAVING CARE ON ONE CAMPUS

Upon receiving a new patient with little previous preventive care, River Hospital worked diligently to get the patient up to date on routine tests and screenings. When the test results revealed the patient had cancer, River Hospital took quick action.

The patient went from having no medical care in over a year to having a new cancer diagnosis and referrals to appropriate specialists within two weeks. Being a Medical Village, River Hospital could provide these services on one campus in a timely manner, helping to simplify care for a patient in a difficult situation.

Ambulatory Surgery
Behavioral Health
Cardiology
Cardiopulmonary
Convenient Care
Laboratory & Imaging
Physical Therapy
Primary Care
... and other specialties

Behavioral Health
Dermatology
Infectious Disease
Laboratory & Imaging
Nutrition & Diabetes Education
Ob/Gyn
Pediatrics
Primary Care with Integrated Behavioral Health

Behavioral Health
Cardiology
Diabetes Education
ENT
Laboratory & Imaging
Medical Oncology
Neurology
Ob/Gyn
Orthopedics
Primary Care with Integrated Behavioral Health
Sleep Lab

In addition to the creation of Medical Villages as depicted in this illustration, licensed inpatient beds in the region were reduced by 15 and replaced with additional capacity for comprehensive behavioral health services.

L VILLAGE

All six PPS hospitals are considered Medical Villages, which have all reconfigured space to support a variety of services in one location.

Massena Memorial Hospital

Cardiology
ENT
Laboratory & Imaging
Neurology
Ob/Gyn
Oncology
Pediatrics
Primary Care with Integrated Behavioral Health
Walk-in Clinic

ST. LAWRENCE COUNTY

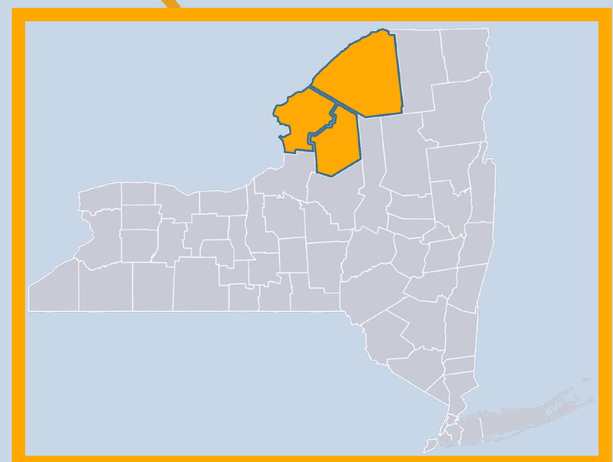
Clifton-Fine Hospital
A SAMARITAN HEALTH PARTNER
Trusted Care. Close to Home.

Laboratory & Imaging
Primary Care with Integrated Behavioral Health

COUNTY

LEWIS COUNTY

Dietary
Laboratory & Imaging
Ob/Gyn
Outpatient PT/OT
Respiratory Care
Social Work
Surgical Services



2.b.iv

CARE TRA

PROJECT DESCRIPTION:
Utilize a Care Transition Intervention Model to reduce 30-day readmissions for chronic health conditions

PROJECT GOAL(S):
The primary focus of this project was aimed at increasing the patient's awareness and understanding of follow-up care and support services once discharged from the care of a hospital.

The Care Transitions Intervention Model was the approach used to achieve success with this project's goal and associated milestones. The approach was three-fold:

1) Clinical
To address the clinical components of patient care management, standardized evidence-based protocols were developed and implemented throughout the care continuum in our region, including primary care practices, hospitals, behavioral health sites and community-based organizations. A key component includes provider notification of a patient's planned discharge to prompt a transition care manager to visit the patient while still in the hospital to develop a 30-day Care Transition Plan, including a warm hand-off, in an effort to minimize the chances of readmission.

Thanks to an extremely active and supportive Care Connections Committee, **100%** of participating NCI partners in this project adopted the 30-day Care Transition protocols.

To support these protocols, as well as patients, NCI created and funded care manager/coordinator roles at every primary care and hospital site.

2) Social
Often, when a patient thinks about their health care, they think about it in terms of doctors and hospitals. With this project, it was imperative that NCI build an infrastructure to coordinate and integrate social determinants of health into the patient's care plan.

To that end, NCI created the new community-based roles of Behavioral Health Peer Supports and Community Health Workers and supported those roles with funding. Additionally, NCI facilitated training to strengthen these individuals' skills and knowledge in their roles and provided educational opportunities around the available social services and resources in the region.

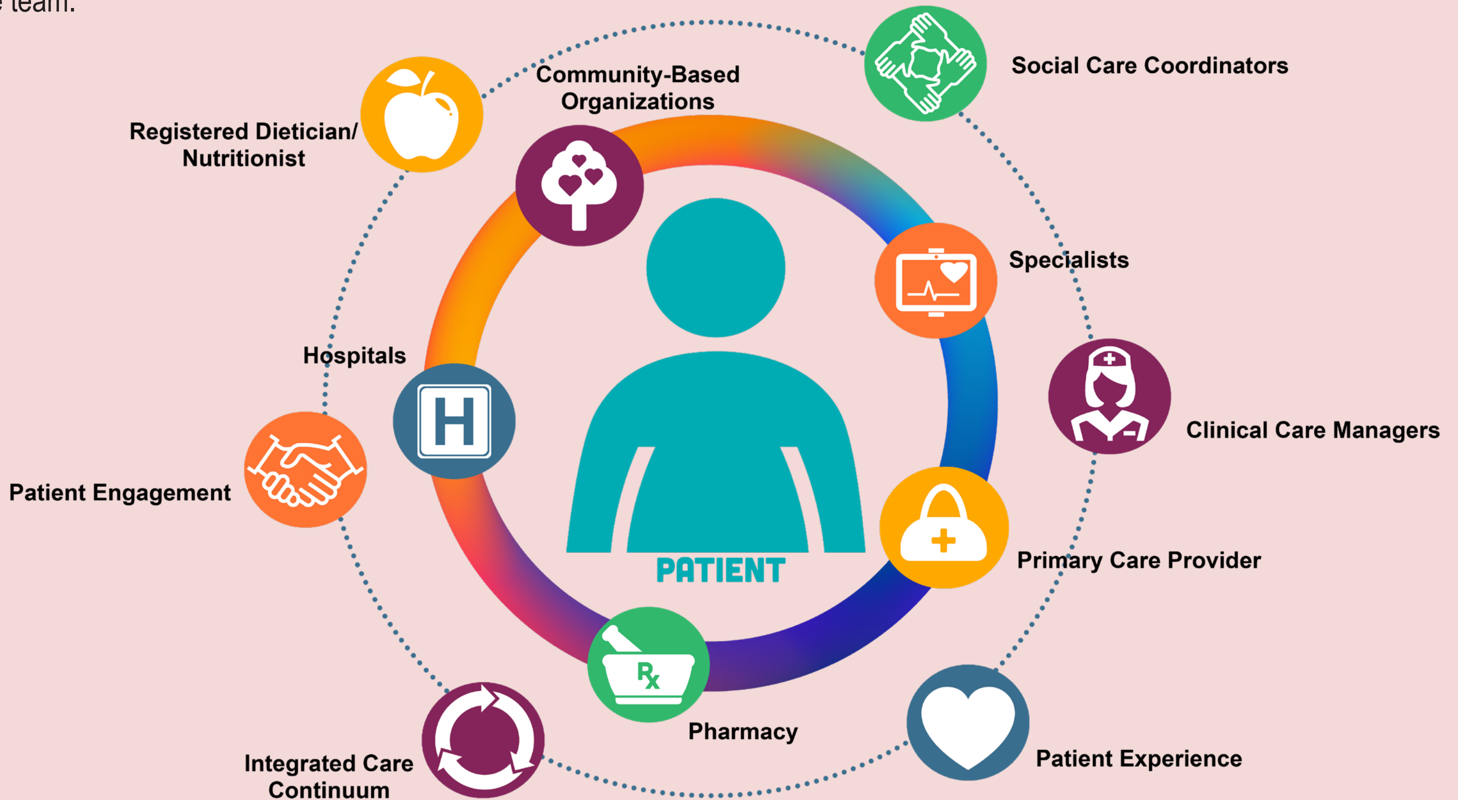
What are social determinants of health?

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The social, economic and physical conditions of each of these environments have positive or negative effects on one's ability to maintain good health. Some examples include:

- Access to …
  - … safe housing and communities
  - … local food markets
  - … educational, economic, and job opportunities
  - … health care services
  - … recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes, such as discrimination and racism
- Socioeconomic conditions, such as poverty

3) Clinical/Social Collaboration

Communication among all members of the patient's care team, whether social or clinical, must be as seamless and effective as possible. The formation of the Care Collaborative forum fostered this by bringing together all members of the care team each month to share opportunities for education, networking and case study reviews. A social service inventory was created and is still maintained and shared regularly with the network. The diagram below illustrates the integration of both the clinical and social determinants of health, with the patient always remaining at the center, as well as a critical member of their own care team.



"David is a 74-year-old homeless man with many health issues, including COPD and stage 3 renal failure, who presented at Samaritan Medical Center (SMC) Emergency Department (ED) for medical care. After treating David, the Physician Assistant (PA) asked me to meet with him. David explained to me that he was going to be homeless the next day, and he knew he had to go to the Department of Social Services (DSS) for help with temporary housing assistance; however, he had no idea how to navigate for resources in the community. So, I assisted him with calling DSS while he was still in the ED.

Upon discharge, David, his granddaughter and I went to the Watertown Urban Mission food pantry, where they gave him food to last until the end of the month. Their critical needs program also helped him with clothing. So, within 24 hours from the time I met David in the ER, he was temporarily housed in a safe, accessible room with food and clothing. I then helped David complete and submit the application for an assisted living facility in the city, linked him to a primary care physician and helped him get food stamps. He continues his connection with the Urban Mission for clothing and food, as needed. I was also able to connect David with Care Management services ito help him manage his overall care. David maintains his connections with family."

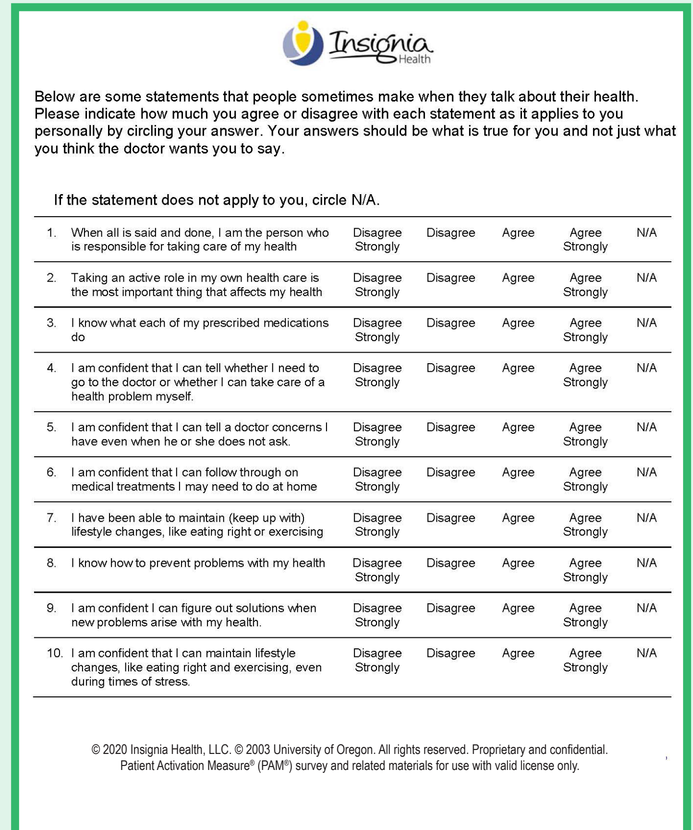
~ Community Health Worker/Behavioral Health Peer Advocate employed by Northern Regional Center for Independent Living and embedded in SMC ED

2.d.i

PATIENT ACTIVAT

What is Patient Activation?

The Patient Activation Measure® (PAM®) survey pictured to the right is completed by the patient, or with assistance from Community Health Workers and health care providers. A patient's score determines whether or not they need extra support with regard to their health. This tool assists primary care providers in proactively identifying patients who need extra support and, vice versa, assists Community Health Workers in connecting patients who need extra support to a primary care provider and other service providers.



Insignia Health

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think the doctor wants you to say.

If the statement does not apply to you, circle N/A.

1.	When all is said and done, I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2.	Taking an active role in my own health care is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3.	I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4.	I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5.	I am confident that I can tell a doctor concerns I have even when he or she does not ask.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6.	I am confident that I can follow through on medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7.	I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8.	I know how to prevent problems with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9.	I am confident I can figure out solutions when new problems arise with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10.	I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

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Patient Activation Measure® (PAM®) survey and related materials for use with valid license only.

PROJECT DESCRIPTION:

Implementation of Patient Activation to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community-based care

PROJECT GOAL(S):

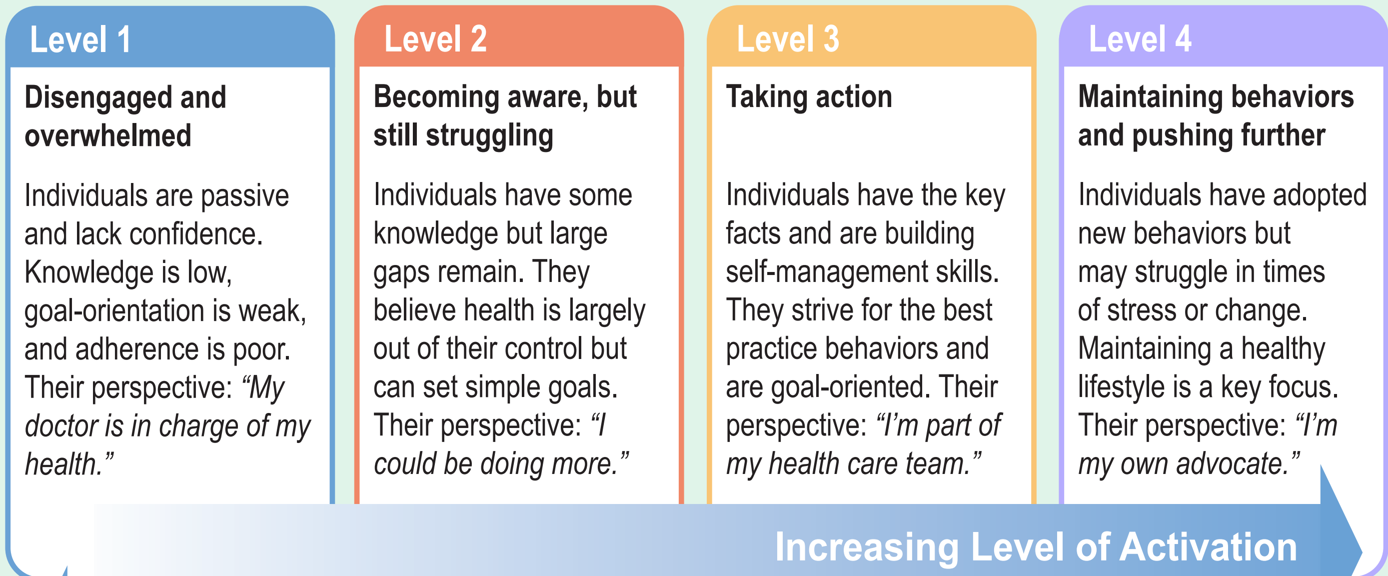
Partner with community-based organizations (CBOs) to ensure patient engagement; establish training teams; train teams and providers on patient activation techniques; promote preventative care; develop a group of community navigators, train them in patient activation techniques, and educate them about insurance options and health care resources

"The majority of surveys and patient activation activities were completed with homeless populations through our Solutions to End Homelessness Program. A significant portion of homeless individuals have a chronic health condition or disability – much of which is untreated or treated intermittently due to the fact they are often transient. Even though housing is considered a social determinant of health, we did not inquire about our clients' health insurance coverage, primary care participation, or their medical needs during the intake process. That changed when we integrated PAM®. Formerly homeless individuals now are enrolled in health insurance and established with primary or specialty care services. Additionally, we were able to assist clients with Social Security applications, which require supporting medical records and active treatment. By incorporating PAM® techniques, we ultimately are better able to assist clients in stabilizing and maintaining housing after discharge from our program, thereby reducing the chances of future episodes of homelessness."

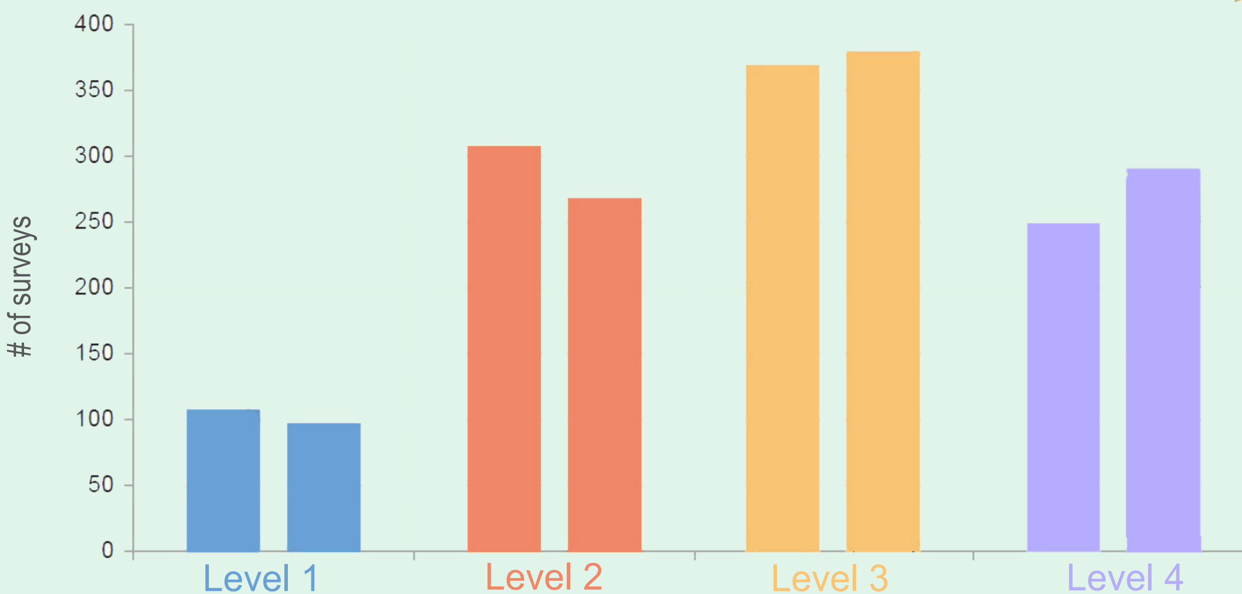
~Maximizing Independent Living Choices (MILC)

#ATION MEASURE®

2.d.i



The goal is to continuously improve PAM® scores, so that patients move from levels 1 & 2 to levels 3 & 4 over time, as illustrated in the graphic above, indicating that they are more involved, knowledgeable and confident in managing their health. Here are NCI's results:



The first bar in each level reflects initial engagement levels. Through Patient Activation efforts and subsequent surveys, patients in levels 3 & 4 increased and patients in levels 1 & 2 decreased (as indicated by the second bar in each level).

3.a.i

INTEGRATION OF PRIMARY C

PROJECT DESCRIPTION/GOAL:

Integrate behavioral health and substance abuse services with essential primary care services, ensuring coordination of care between both. Partners choose the model that best suits their practices - Model 1, Primary Care Site; Model 2, Behavioral Health Site; and Model 3, IMPACT Model.

Model 1 Co-locate Behavioral Health in an Existing Primary Care Site

# of agencies to adopt this model: 8

Agencies adopting this model developed evidence-based standards with the following principles:

- *Population-based care*
- *Systematic screening*
- *Integrated medical record*
- *Patient-Centered Medical Home (PCMH)*
- *Medication management*
- *Care coordination*
- *In-clinic suicide protocol*
- *Staff training*

These agencies conduct preventive care screenings with all patients, to include behavioral health screening tools, such as PHQ-2 or 9 (Patient Health Questionnaire) and SBIRT (Screen, Brief Intervention & Return to Treatment).

A Provider's Point of View

"Since the inception of DSRIP, we were able to integrate Behavioral Health (BH) services into our Primary Care Clinic. Services were initiated mid-2017, with the hiring of a Psychiatric Nurse Practitioner (PNP) and then adding a Licensed Certified Social Worker (LCSW-R). In 2017, 38 patients were established with behavioral health services, with a total of 107 encounters. In 2018 and 2019, the clinic had over 170 encounters each year.

Overall, the clinic has established 71 unique patients with behavioral health services. This is an incredible accomplishment for CFH's rural community. Without the commitment to the integration of behavioral health as a DSRIP incentive/deliverable, this would not have been possible."

~ Clifton-Fine Hospital

Three Thankful Moms

"Karlee has been receiving therapy here at the Pediatric Associates location for roughly three years, so she is familiar with the location and staff here. This makes it a bit easier when she has to come for appointments. It also has benefitted me as I work full time and am a single parent, so I schedule her therapy appointments and doctor appointments back to back, so we make one trip and not two."

~ Teresa C., mother of Karlee, Adams Center

"I'm a single parent of three, who all receive counseling with Shirley. It is extremely convenient to be able to come into our pediatric office for our counseling."

~ Deanne G., mother of Kayann, Mileigh & Christian, Brownville

"I am so glad that counseling is offered here at Pediatric Associates of Watertown. It has been convenient and comforting knowing we can have the offering of, not only medical care, but also of mental health and counseling. The girls feel very secure in this environment and there was no transition, as they are very familiar with the facility since coming here from birth."

~ Doreen G., mother of Annika & Aleeya, Clayton

22,367 patients with PHQs

Model 2 Co-locate Primary Care in an Existing Behavioral Health Site

# of agencies to adopt this model: 2

These agencies conduct primary care preventive services and screenings with all patients.

"The DSRIP clinic makes it easier and quicker for me to get my Chemical Dependency clients into a Primary Care Physician and to get their physical completed, so that they can continue with the process of getting established in the Chemical Dependency services. It also expedites their ability to receive Medication-Assisted Treatment (MAT) services."

~ St. Lawrence County Community Services Chemical Dependency Services (SLCCS) Staff

328 patients with preventive care services

Model 3 Implement IMPACT Model in Existing Primary Care Site

# of agencies to adopt this model: 5

What is the IMPACT Model?

Primary care sites that elect to implement this model are required to:

- Conduct preventive care screenings with all patients, to include behavioral health screening tools, such as PHQ9 (Patient Health Questionnaire 9) and SBIRT (Screen, Brief Intervention & Return to Treatment
- Employ/Appoint a trained Depression Care Manager
- Designate a psychiatrist
- Measure outcomes
- Provide "stepped care" and develop a process for ensuring the patient is referred to the appropriate care in a timely manner

In her mid-60's, MJ was dealing with a lot of family and health issues, that began to trigger her chronic depression and anxiety. She turned to her primary care doctor, who quickly recognized that MJ could benefit from some extra support to help her manage through these issues. He introduced her to the RN Care Manager who worked for the practice, Watertown Internists.

During MJ's initial screening, her depression and anxiety screening scores were quite high. After the Care Manager consulted with a psychiatrist, it was determined that MJ did not need to see a behavioral health specialist and that she could remain under the care of her doctor and Care Manager.

Over the next 11 months, MJ's treatment coupled medication management with the techniques of motivational interviewing and cognitive behavior therapy. This gave MJ the tools to cope with her depression and anxiety. She chose meditation, yoga, music and reading to redirect her negative energy and began to feel confident in her ability to successfully meet her treatment goals.

During a follow-up visit with her primary care doctor, her screening scores improved significantly, including a drop in depression screening score from 21 to 4. DSRIP has had a truly positive IMPACT on MJ's life.

1,625 patients with PHQs

The integration of primary care and behavioral health contributed to significant improvement in follow-up visits after a patient was hospitalized for a mental illness-related condition.

7-DAY FOLLOW-UP
108%
IMPROVEMENT

30-DAY FOLLOW-UP
65%
IMPROVEMENT

3.b.i

CHRONIC DISEASE MANAGEME (CARDIOVASCUL

PROJECT DESCRIPTIONS:

Develop and implement evidence-based strategies to care for patients with chronic disease - specifically, cardiovascular and diabetes - to ensure high-quality care, reflects the interests, values and needs of patients to effectively manage their care. Key factors include: clinical care goals, medication adherence goals, patient support and reminder goals.

PROJECT GOAL(S):

Develop and implement evidence-based protocols to improve the management of cardiovascular disease and diabetes in clinical and community-based settings.

100% **of NCI's participating practices adopted the evidence-based protocols and clinical practice guidelines!**

1) Developed and set forth by NCI's Medical Management Committee, these protocols and guidelines were based on recommendations from the American Heart Association, and the American College of Cardiology and the American Diabetes Association. They were reviewed annually to ensure the most current guidelines are followed.

2) To complement the standard protocols and guidelines, a care coordination team roster was created, which designated each practice with trained and certified individuals to support and assist the patient in managing his/her chronic disease outside of the office visit. The patient could take advantage of this added support as part of their treatment plan. This roster included:

- Care Coordinators
- Pharmacists
- Certified Diabetes Educators
- Community Health Workers
- Health Home Care Managers
- Behavioral Health Peer Supports
- Certified Tobacco Cessation Specialists

3) Established lifestyle modification programs, including nutrition, tobacco use, exercise and medication compliance. The care coordination team assisted with improving patient's health literacy, engagement, self-management skills and self-confidence.

"Lowville Medical Associates is working to help its patients manage and prevent cardiovascular disease using evidence-based strategies, such as smoking cessation, blood pressure management, home blood pressure monitoring and chronic care management. We are getting our patients to engage and take ownership outside of the office."

~ Steven Lyndaker, MD
Lowville Medical Associates

CARDIOVASCULAR

MEASURE & MONITOR

Cholesterol
Heart Failure
Hypertension
Smoking Cessation »»»»»

ASK
ASSESS
ADVISE
ASSIST
ARRANGE

This standard assessment tool for smoking addiction was added to the electronic medical record, prompting providers to screen every patient and treat accordingly.

11,070 patients with cardiovascular care plans

"When Maureen arrived for her annual wellness visit in early 2019, she had not needed to be on any medication and had no chronic diseases ... OR SO SHE THOUGHT.

As part of the comprehensive diabetes screening, lab results revealed that her HbA1c (a blood test that measures a patient's average blood sugar levels over the past 2-3 months) was 13.20. Normal levels are between 4-5.6. Maureen's results meant she had diabetes.

In a follow-up appointment, Maureen and her primary care provider discussed her new diagnosis and together developed a plan. That plan included chronic care management to help ease her anxiety about her new disease. She could call to discuss her diabetes with any member of the team. Maureen gained confidence in checking her blood sugar and watching what she ate.

And now, in a little less than a year, Maureen's HbA1c is now 5.80!"

~ Ogdensburg Family Practice

7,220 patients with HbA1c values taken

DIABETES

COMPREHENSIVE DIABETES SCREENINGS

HbA1c levels / eye exam / nephropathy monitor

↑45%

3.c.ii

COMMUNITY PREVENTION &

PROJECT DESCRIPTION:
Implementation of evidence-based strategies in community to address chronic disease – primary and secondary prevention projects (adults only)

PROJECT GOAL(S):
Develop community resources to assist patients with primary and secondary preventive strategies to reduce risk factors for diabetes and improve the long-term consequences of diabetes and other co-occurring chronic diseases

Patients take control of their disease in order to better care for themselves. They (and their caregivers, in many cases) take advantage of programs that NCI partners have established, including:

DPP — **Diabetes Prevention Program**
A one-year program for people with pre-diabetes or at risk of developing diabetes

DSMP — **Diabetes Self-Management Program**
A six-week program for people with type 2 diabetes and/or their caregivers

DSME — **Diabetes Self-Management Education**
One-on-one education with a nutritionist for people with diabetes

CDSMP — **Chronic Disease Self-Management Program**
A six-week program for people with chronic illness and/or their caregivers

244 patients attended at least one class

"The unwavering support from the team at NCI has been integral to our CDSMP and DPP program expansion, making the transition into a technical and assistance center possible. We are now able to serve a larger geographic region, expanding our partnerships, allowing us to exponentially reach more individuals throughout the North Country region who are greatly benefitting from these evidence-based programs."

~ St. Lawrence County Health Initiative

NCI supported this project in a variety of ways, including:

- Funding for program sites to host classes free of charge to patients
- Education of primary care providers about the benefit of these programs and facilitation of referrals
- Establishment of a secure means for community-based organizations to send and receive referrals and communicate with providers
- Development and maintainance of website (take-control.org) as a resource for patients and providers to locate programs

Take Control

HOME ABOUT PROVIDERS RESOURCES CONTACT

Providers in Your Neighborhood

Diabetes Prevention Program

Carthage Area Hospital
(in collaboration with the Watertown YMCA)
1001 West St., Carthage, NY
Contact: Michelle Graham
(315) 782-3100
ymcamgraham5@gmail.com

Claxton-Hepburn Medical Center
214 King St., Ogdensburg, NY
Contact: Michele Catlin
(315) 713-5251
mcatlin@chmed.org

Lewis County Public Health
7785 N. State St., Lowville, NY
Contact: Anna Platz
(315) 376-5453
annaplatz@lewiscounty.ny.gov

St. Lawrence County Health Initiative, Inc.
, Potsdam, NY
Cooke
ext. 239
ysic.org

y YMCA
atertown, NY
Graham
00
mail.com

Diabetes Self-Management Program/Education

Diabetes Self-Management Program (DSMP)

Claxton-Hepburn Medical Center
214 King St., Ogdensburg, NY
Contact: Michele Catlin
(315) 713-5251
mcatlin@chmed.org

Community Health Center of the North Country
(Classes offered at all health centers: Canton, Gouverneur, Ogdensburg and Malone
4 Commerce Lane, Canton, NY
Contact: Cynthia Wells
(315) 379-8107
cwells@chcnorthcountry.org

Lewis County Public Health
7785 N. State St., Lowville, NY
Contact: Anna Platz
(315) 376-5453
annaplatz@lewiscounty.ny.gov

St. Lawrence County Health Initiative, Inc.
6439 State Highway 56, Potsdam, NY
Contact: Julie Cooke
(315) 261-4760, ext. 239
julie@gethealthyslc.org

Chronic Disease Self-Management Program

Anchor Recovery Center of Northern New York
241 State St., Watertown, NY
Contact: Cynthia Getman-Hubbard
(315) 836-3460
cgetman-hubbard@anchorrecoverycenter.com

Canton-Potsdam Hospital
(in collaboration with St. Lawrence County Health Initiative)
49 Lawrence Ave., Potsdam, NY
Contact: Julie Cooke
(315) 261-4760 ext. 239
Julie@gethealthyslc.org

Claxton-Hepburn Medical Center
214 King St., Ogdensburg, NY
Contact: Michele Catlin
(315) 713-5251
mcatlin@chmed.org

Jefferson County Office of the Aging
175 Arsenal St., Watertown, NY
Contact: Sheila Kehoe
(315) 785-5081
sheilak@co.jefferson.ny.us

Lewis County Office for the Aging
(in collaboration with Lewis County Public Health)
7660 State St., Lowville, NY
Contact: Chris Baker
(315) 376-5313
chrisbaker@lewiscounty.ny.gov

take-control.org

"DSRIP initiatives have put a more intense focus on several of our preventive and disease management programs at Claxton-Hepburn Medical Center. DPP, DSME/P and CDSMP have all seen an increase in participants and coaches to deliver them. We have seen the benefits of this focus in the growth of our programs, but more importantly, in the successes of our participants.

One of our participants has really invested in the DPP and has had great success with the support of the program. He is a 68-year-old male with high risk for pre-diabetes. He initially joined the DPP in 2017. His weight was 318 pounds, he was very sedentary and did not pay attention to his diet. He reports that his energy levels at that time were very low. From 2017-2018, he regularly attended the DPP and was very diligent about following the program's guidelines.

The result was a 95-pound weight loss! He credits the program with teaching him to monitor and learn more about the foods he was eating and stay active. He enjoyed coming to classes each week because he felt supported and never judged by his fellow classmates or lifestyle coaches.

He believes so much in the program, not only did he attend multiple sessions, but in Fall of 2019, he completed training to become a DPP lifestyle coach himself. He currently volunteers his time co-teaching a group of 18 participants with the CHMC diabetes educators. He continues to lose weight and inspire those around him. His experience with the class and overcoming setbacks makes him a very effective lifestyle coach."

~ Claxton-Hepburn Medical Center

4.a.iii

MENTAL HEALTH/SUBSTANCE ABUSE INFRASTRUCTURE

PROJECT DESCRIPTION:

Strengthen mental health and substance abuse infrastructure expanded outward from Medicaid patients to the entire population

PROJECT GOAL(S):

Collaboration among leaders, professionals and community members working in mental/emotional/behavioral (MEB) health promotion to address substance abuse and other MEB disorders. Address chronic disease prevention, treatment and recovery and strengthen infrastructure for MEB health promotion.

IDENTIFY. UNDERSTAND. RESPOND.

Just as CPR helps assist an individual having a heart attack, Mental Health First Aid helps assist someone experiencing a mental health or substance use-related crisis. In the Mental Health First Aid course, participants learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help.

DEPRESSION & MOOD DISORDERS · ANXIETY DISORDERS
TRAUMA · PSYCHOSIS · SUBSTANCE USE DISORDERS

Mental Health First Aid teaches about *recovery and resiliency* – the belief that individuals experiencing these challenges can and do get better and use their strengths to stay well.

1 MILLION REACHED IN MOBILE AD CAMPAIGN

1K VIEWS OF MOVIE THEATER ANTI-STIGMA CAMPAIGN

1.5K VIEWS OF REGIONAL BILLBOARD CAMPAIGN

CHRONIC DISEASE PREVENTION FOR ALL POPULATIONS

4.b.ii

PROJECT DESCRIPTION:

Increase access to high-quality chronic disease preventive care and management in both clinical and community settings

PROJECT GOAL(S):

Delivery of high-quality chronic disease preventive care and management can prevent much of the emotional, physical and economic burden of chronic disease or avoid many related complications.

Unlike the other DSRIP projects, this project expanded outward from Medicaid patients to the entire population. NCI selected colorectal cancer and chronic obstructive pulmonary disease (COPD) as its two focus areas. These choices were based on the Community Needs Assessment and were not included in any other project.

In its efforts to implement the recommended clinical preventive services, NCI increased provider and care team knowledge of screening protocols and clinical practice guidelines in multiple ways, including incorporating clinical guidelines into communication and training plans and Patient-Centered Medical Home (PCMH) implementations, where applicable. This includes the guidelines for colorectal cancer screening and, for COPD purposes, tobacco screening. Here are some results:

COLORECTAL CANCER SCREENING

Close to

700 ***FIT Kits distributed, with a return rate of*** **53%**

Fecal Immunochemical Test (FIT) Kit for Colorectal Cancer Screening

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

with a specific focus on tobacco screening and cessation

1,527 ***Individual Counseling Referrals Made***

17 ***Tobacco Treatment Specialists Trained***

34% **have reached six months tobacco-free**

48 ***Tobacco-free Policies Enacted***

28% ***have reached 12 months tobacco-free***

HEALTH LITERACY & CULTURAL COMPETENCY

Engaging patients from all backgrounds and capabilities in the health care transformation process

To foster health literacy and cultural competency, NCI uses data to document, evaluate and assess trends and disparities related to culture, age, gender, language, education, race and ethnicity.

Since low socioeconomic status is the primary health disparity in NCI's service region, it invested time to explore research, listen to stories of those in poverty, and discover new ways of thinking as part of its Bridges Out of Poverty "Champions for Change" initiative. Through collaboration with the Watertown Urban Mission, Community Action Planning Council, the Empire State Poverty Reduction Initiative (ESPRI), and aha!Process, Inc., NCI leveraged the Bridges Out of Poverty framework to bring together people from all backgrounds and socioeconomic classes to build resources and improve outcomes.

This partnership supported an intensive three-day workshop, during which 53 local professionals earned lifetime Bridges Out of Poverty facilitator certification. Additionally, ESPRI funded "Getting Ahead in a Just-Gettin'-By World" for 12+ cohorts within the City of Watertown. The success of Getting Ahead graduates has propelled expansion of the program. Workshops are now being planned in rural communities across Jefferson and Lewis counties. Here are some post-graduate outcomes of the programs to date:

43% increased their monthly income
35% decreased their monthly debts
22% decreased their total debts
28% increased their assets
37% decreased their reliance on public benefits

Zoel Munson held several different positions at the Watertown Urban Mission before being promoted to Food Pantry Manager in 2019. She is excelling in her position, often going above and beyond in service to the low-income community. Zoel spoke at her graduation, sharing that the Getting Ahead experience helped her to find the courage to move outside her comfort zone and try new things.

WORKFORCE

Focusing on recruitment, education, training, re-training and retention of health care professionals

To keep the North Country's health workforce strong, NCI's strong partnership with the Fort Drum Regional Health Planning Organization (FDRHPO) enabled it to access a variety of established and successful approaches, starting with presentations at local middle and high schools. FDRHPO also offers career exploration programs to students, such as Medical Academy of Sciences and Health (M*A*S*H) Camp and local job shadow placements. FDRHPO has worked with institutions of higher education to develop certain degree and certificate programs, preparing students with specialized skills to fill needed health care jobs in the region. Recently, FDRHPO helped to expand its region's Rural Residency Program, which helps graduate medical students find residency programs at local sites. Finally, it has has worked to develop incentive programs and customized trainings to further support partners and health care professionals. All of these FDRHPO workforce initiatives were key in NCI's success with its DSRIP initiatives.

Below is a list of health care professionals who have either been recruited, retained or grown through NCI's efforts:

- Certified Diabetes Educators (4)
- Dentists (2)
- Family Nurse Practitioners (8)
- Licensed Clinical Social Workers (5)
- Licensed Practical Nurses (13)
- Medical Lab Technicians (9)
- Physician Assistants (5)
- Primary Care Physicians (12)
- Psychiatric Nurse Practitioners (4)
- Psychiatrists (3)
- Psychologists (3)
- Registered Nurses (24)

Dr. Yong Chang is an example of NCI's successful workforce outreach strategies — in particular, the NCI Provider Incentive Program, which helped recruit him to work in our region. Dr. Chang was recruited to practice at the North Country Family Health Center. Prior to his arrival, it had been five years since Medicaid beneficiaries had access to dental services in Lewis County.

IT PRIVACY & SECURITY

Securing the flow of patient data among health care providers in the region

Though sometimes overlooked because of their roles "behind the scenes" of everyday health care operations, health information technology (HIT) privacy and security are the cornerstones of the region's health care system. They are important safeguards that help protect and preserve a patient's confidential relationships with his/her health care provider. Recognizing this, NCI is dedicated to working with all partners to ensure they are compliant with all IT privacy and security regulations.

100% of partners have completed the six-stage process to have an active HIPAA compliance plan:

- Auditing
- Business Associate & Vendor Management & Remediation Planning
- Policy Creation/Customization
- Policy Review
- Staff Training
- Final Review

100% of applicable partners have HIPAA privacy policies in place

100% of applicable partners have security policies in place

100% of applicable partners have participated in a comprehensive review of their HIPAA privacy and security policies

"The North Country Initiative has been integral in helping Thousand Islands Emergency Rescue Service, Inc. keep up to date with the latest HIPAA privacy and security requirements. As a small 501(c)3 non-profit with limited staffing, having an ally to assist us with keeping up on the latest requirements from all regulating authorities has been invaluable."

FINANCE

Investments made to parters and system infrastructure to transform health care delivery

NCI believes in the value of community organizations participating in DSRIP, including more than 20 non-profit community-based social and human service organizations. These agencies are positioned to make a significant impact on social determinants of health and, thus increase quality of care, while reducing costs. Additionally, NCI has contracted with two of these organizations to provide peer-to-peer services and further address social determinants of health.

Through DSRIP Year 5, NCI has earned $62.1 million.

- Of total dollars earned, $4.8 million was earned for high performance
- More than $31 million was allocated for incentives and revenue loss payments to partners
- More than $5 million was distributed in support of care management infrastructure to include primary care Care Managers, hospital Care Managers, Certified Diabetes Educators, smoking cessation support, Community Health Workers, Behavioral Health Peer Supports, chronic disease program support, and psychiatrist consultations
- Over $5.7 million was invested in support of regional workforce initiatives, including incentive programs to recruit and retain physicians, nurses, social workers and other health care providers, Graduate Medical Education Program support, and workforce training
- Over $5 million was secured to support practices with transformation initiatives, including Patient-Centered Medical Home recognitions, Population Health Management implementation, HIT and data analytics, and clinical support

"DSRIP funding has provided North Country Freedom Homes, Inc. (Canton House) the ability to ensure residents are provided necessary care with the appropriate entity, when necessary. For example, in the past, a resident would have been dropped off at the emergency room or transported by ambulance when there was not enough staff to provide transportation to and from a primary care visit or after-hours. The additional funding has allowed us to provide additional staffing to ensure that the residents are treated appropriately, according to their medical needs."

Dear Friends:

As we reflect on the past five years' achievements, our first thought is one of deep gratitude.The North Country Initiative (NCI) community is arguably one of the most collaborative and selfless groups that exists. Example after example of doing the right thing for the patient population above self-interest and competition come to mind. In a region that lacks certain resources, our NCI partners make up for it in efficiencies achieved through resource sharing, de-duplication of services, and maximizing individual strengths. Please be assured, we recognize the integrity within this region; we are incredibly grateful for each of our partners; and we are certain it is because of you that we have achieved so much for our most vulnerable community members.

Erika Flint
Executive Director
FDRHPO

We would be remiss to not stop to think about how this all came to be. First, the credit must go to the leadership of New York State for giving us this unprecedented opportunity. From there, it was Denise Young, Executive Director of Fort Drum Regional Health Planning Organization (FDRHPO) at the time, whose original vision and passion secured and shaped DSRIP for the region. The evolving team at FDRHPO and NCI then set lofty goals and, along with a myriad of partners, built one of the strongest foundations that included a sophisticated and equitable governance, funds flow, and compliance/security structure and layered upon it 11 projects that were designed to transform how our patients would access and receive care. The NCI team is made up of subject matter experts, each in of themselves leaders, who not only made this work possible, but made it credible, successful, and sustainable. For all of that, we cannot thank each of you enough.

Lindsay Baldwin
NCI Deputy Director

DSRIP has impacted the way care is delivered in the region by focusing on care management, whole-person and patient-centered care, social determinants of health, patient engagement, an inclusive health care continuum, among so many other areas. Each initiative has significantly improved our health care system for the patient and community. In doing this, we took great care to ensure our investments would be sustainable long-term. For instance, examples like standardization and improvements in workflows, clinical protocols, connectivity and enhanced workforce skills demonstrate advances that will continue to have a positive impact on the region. NCI also has expanded its organizational structure to include an Independent Practice Association (IPA). This IPA will serve as a vehicle for further progression toward Value-Based Payment and our region's ability to continue to improve quality, drive down costs, and address social determinants of health, thus producing outcomes that will lead to a healthier community.

It is now formally understood that there will not be a DSRIP 2. Let us remind you that this region has a long history of working together and was, therefore, well-positioned to seize this opportunity and ensure its successes. We simply need to remain prepared and do that again. At the mid-point assessment, we ended our presentation with Martin Luther King, Jr.'s quote: "True compassion is more than flinging a coin to a beggar; it comes to see that an edifice which produces beggars needs restructuring." DSRIP gave us that opportunity to restructure, and every one of you all seized it with us. Let's continue our commitment to true compassion.

With sincerest gratitude,

Erika Flint   Lindsay Baldwin