Issue 6: December 2016

Connections

Interconnecting Regional Healthcare

+ CATHERINE'S STORY:

How the IMPACT Model is Making an Impact

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Meet our two new ACO Partners!

NorthCountry Initiative

CATHERINE'S STORY:

How the IMPACT Model is Making an Impact

BY ELI ANDERSON

At age 42, Catherine Snyder feels happier and more full of life than she has in a long time.

A Vermont native and longtime resident of Lowville, Ms. Snyder has struggled with depression since she was a child. She has endured physical and sexual abuse, marriages ending in divorce and death, and other hardships along the way.

Over the years, she sought help in both medical and community environments with limited results – some programs made her feel uncomfortable talking about her personal life, others resulted in prescription drugs that she had concerns or questions about.

Then, in the familiarity of her family doctor's office, Lowville Medical Associates, she was introduced to the "IMPACT Model" and began feeling better almost immediately.

Short for "Improving Mood – Providing Access to Collaborative Treatment," this model gives Ms. Snyder plenty of one-on-one time with her doctor and an on-site Depression Care Manager, who both work closely with an off-site psychiatrist to determine an individualized treatment plan.

> "DEFINITELY REACH OUT. THERE IS HELP OUT THERE."
>
> *Catherine Snyder, Lowville IMPACT Model patient*

Ms. Snyder said her Depression Care Manager, Brenda, also checks in with her on a weekly basis, asking her to rate her mood, symptoms and other behavioral health factors from zero to three.

"She's awesome; she's very easy to talk to," Ms. Snyder said. "When she does call, not only does she ask me those questions, but she's just someone I can talk to."

"When I first started, my score was a 26, and that's pretty high," she said. "After my first week, it went down to a 20; the second week it dropped to a 12, and this week when I did it, it was a nine. I really have improved."

For Ms. Snyder, the defining factor in her mental health care was that she was able to receive it where it was most comfortable for her. She has been a patient at Lowville Medical Associates – where she regularly sees Dr. Steven Lyndaker – since the early 1990s.

"He's always just built me up, giving me encouragement," she said. "When I've tried talking about my depression in other places, I clam up – but I'm very comfortable here. It feels like you're going to a friend's house to visit. Even the secretaries go out of their way to just talk to you."

Furthermore, she said, Dr. Lyndaker and his staff always fully explain the purposes and side effects of any medications prescribed to her, and she knows that when she calls with a question or to schedule a sudden appointment, she will get the help she needs.

For Ms. Snyder, all of these factors have seemed to make a difference in her health.

"I feel so much better," she said. "I'm getting involved in the community and I'm back into liking to do things with my kids. We've been doing crafts and going on walks when we can."

Though the IMPACT Model is relatively new, Ms. Snyder said she hopes more doctors will try it and let their patients see the same benefits she has. She encourages those who are struggling with depression to reach out to a medical professional they feel comfortable talking to.

"Definitely reach out," she said. "There is help out there."

After finishing this interview at Dr. Lyndaker's office, Catherine walked down the hallway to see Brenda, her Depression Care Manager. She said she wanted to have an IMPACT Model session while she was there.

The 12 Months of DSRIP

JANUARY 2016

The PPS celebrated...

...15 health care professionals added to our region through the Provider Incentive Program.

FEBRUARY 2016

The PPS celebrated...

...a new dental provider accepting Medicaid now practicing in Lewis County.

MARCH 2016

The PPS celebrated...

...Care Transition subject matter experts awarded to our region.

APRIL 2016

The PPS celebrated...

...North Country Family Health Center receiving PCMH 2014 Level 3 certification.

MAY 2016

The PPS celebrated...

...10 new health care professionals added to our region through the Provider Incentive Program.

JUNE 2016

The PPS celebrated...

...NCI hiring medical directors for Jefferson and St. Lawrence counties.

JULY 2016

The PPS celebrated...

...3 new providers hired at Carthage Behavioral Health.

AUGUST 2016

The PPS celebrated...

...all achievement value points awarded to our region.

SEPTEMBER 2016

The PPS celebrated...

...Community Health Center of the North Country (Canton) receiving PCMH 2014 Level 3 certification.

OCTOBER 2016

The PPS celebrated...

...the launch of www.take-control.org to support NDPP, CDSMP and DSME resources in our region.

NOVEMBER 2016

The PPS celebrated...

...$160,000 awarded to our region to help grow our supply of LCSW and LCSW-R.

DECEMBER 2016

The PPS celebrated...

...$345,000 awarded to recruit and grow LCSW and Certified Diabetes Educators in our region.

Meet our New ACO Partners!

HealthCare Partners of the North Country is pleased to announce the addition of their two newest partners!

Complete Family Care and Laser Center and the North Country Family Health Center will join the ACO as of January 1, 2017.

Complete Family Care and Laser Center is an independent, family practice located in Watertown. Their team of family practice providers includes: Dr. Karen Williams, Dr. Christopher Black and Eileen Kraeger, PA-C. The practice was the first practice in the tri-county area to receive a Level 3 2014 designation under the Patient-Centered Medical Home model.

The North Country Family Health Center has locations in Watertown and Lowville. The Federally-Qualified Health Center provides medical care to infants, children and adults. Their family practice providers include: Dr. Scott Stern, Debbie Elliot, FNP, and Kit Veley, FNP.

The health center's mission, vision and values are perfectly aligned with the goals of the ACO and both entities are looking forward to a successful partnership.

The ACO works to provide high-quality, coordinated care to the Medicare population while also identifying cost reduction opportunities in our region.

Going into 2017 -- the third year for the ACO, -- Executive Director Brian Marcolini, his staff and the ACO partners will focus on strategies related to care coordination, reducing avoidable visits to hospitals and emergency departments and leveraging existing resources in the community.

NCo North Country Family Health Center

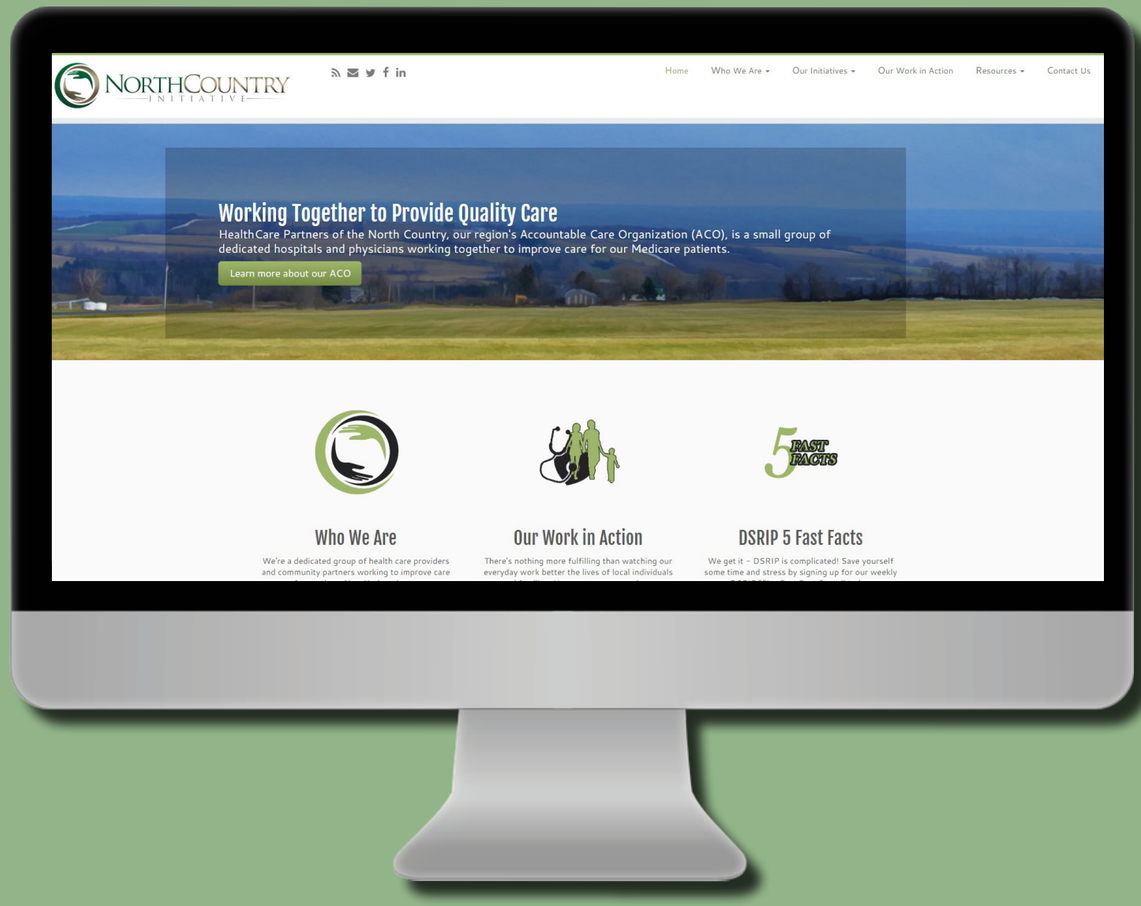
With the addition of Complete Family Care and Laser Center and the North Country Family Health Center, the ACO will have six participating hospitals, six independent practices and one Federally-Qualified Health Center spread throughout Jefferson, Lewis and St. Lawrence counties.

"Facing changes in health care as a small, independent practice is very daunting," Dr. Karen Williams said. "Medicine is migrating from a fee-for-service to a value-based payment model, with accountability for quality measures and reporting. By joining HealthCare Partners of the North Country, I can position the practice to successfully maintain autonomy and continue to provide personalized care to our patients while collaborating with other private offices and hospitals."

"It's really the best of both worlds," she said. Stay small and get big time support."

INTRODUCING...

NCI's New Website!



SAME NAME, NEW LOOK

We're confident that you will find our new website easier to use and more attractive than before. What are you waiting for? Click here to try it out!

DINNER & DISCUSSION:

"STRATEGIES FOR REDUCING READMISSIONS"

On October 5, the North Country Initiative hosted a free "Dinner and Discussion" event for its partners in Watertown, NY, featuring guest speaker Dr. Amy Boutwell, who shared strategies for reducing hospital and emergency department readmissions.

Dr. Boutwell is president of Newton, Massachusetts-based "Collaborative Healthcare Strategies," a thought-leadership and technical assistance firm that advises delivery system transformation efforts nationally. She has advised several large-scale collaborative efforts aimed at system redesign to reduce readmissions and improve care across settings, including federal initiatives funded by the Centers for Medicare and Medicaid Services (CMS) such as the Quality Improvement Organization "Care Transitions" Aim, the Partnership for Patients Hospital Engagement Networks, and the CMS Learning Systems for Accountable Care Organizations and Bundled Payments; the Massachusetts Health Policy Commission; statewide all-payer readmission reduction efforts in Massachusetts, Michigan, Washington, Maryland and Virginia; and New York Medicaid Delivery System Reform Incentive Program (DSRIP)'s "super utilizer" collaborative.

She also advises providers, provider associations, state agencies, health IT and health information exchange agencies.

Prior to founding Collaborative Healthcare Strategies, Dr. Boutwell co-designed the Institute for Healthcare Improvement's STAAR (State Action on Avoidable Readmissions) Initiative, the first state-based approach to reducing readmissions focusing on improving transitions between settings through emphasizing "cross-continuum" partnerships. Dr. Boutwell is a graduate of Stanford University, Brown University School of Medicine, and Harvard's Kennedy School of Government, where she received a Master's in Public Policy and the Robert F. Kennedy Award for Excellence in Public Service. Dr. Boutwell received her clinical training in Internal Medicine-Primary Care at Massachusetts General Hospital.

Altogher, more than 90 local health care partners and guests attended the event, discussing challenges and options for reducing readmissions and providing high-quality care to patients. Dr. Boutwell praised providers in northern New York and across the state for taking on the challenge of DSRIP:

"You should be really excited to know that you are pioneers and that you will be part of demonstrating proven projects, showing that this really can work," she said. "Remember, this is possible."

If you were unable to attend for Dr. Boutwell's remarks and would like to see her slides or a video of her presentation, please contact info@northcountryinitiative.org.

PHOTOS BY ELI ANDERSON

Above: *NCI Director Brian Marcolini gives opening remarks at the Oct. 5th event.*
Top left: *Dr. Amy Boutwell speaks to local health care professionals about strategies for reducing hospital and emergency department readmissions.*

CMS Announces Changes to Chronic Care Management Program

Since 2013, the Centers for Medicare and Medicaid Services (CMS) has been expanding Medicare payments for care management services, particularly for patients with chronic conditions. Chronic Care Management (CCM) has been shown to engage patients, improve outcomes and reduce the total cost of care. Additionally, the shift toward a value-based health system is centered around management of patient needs and extensive care management services.

On November 2, 2016, CMS announced several changes to the Chronic Care Management program, which will take effect on January 1, 2017. According to CMS, "to date, approximately 513,000 unique Medicare beneficiaries received (Chronic Care Management) services an average of four times each, totaling $93 million in total payments."

CMS anticipates the following enhancements will simplify the CCM program by eliminating redundancy and reducing the administrative burden that is often associated with billing for the service:*

- *Pay for non-face-to-face prolonged evaluation & management (E&M services)*
- *Pay for complex CCM services, with the addition of two new CPT codes*
- *Pay for care plan development*
- *Behavioral health integration*
- *Simplification of 24/7 access to care rules and beneficiary consent requirements*

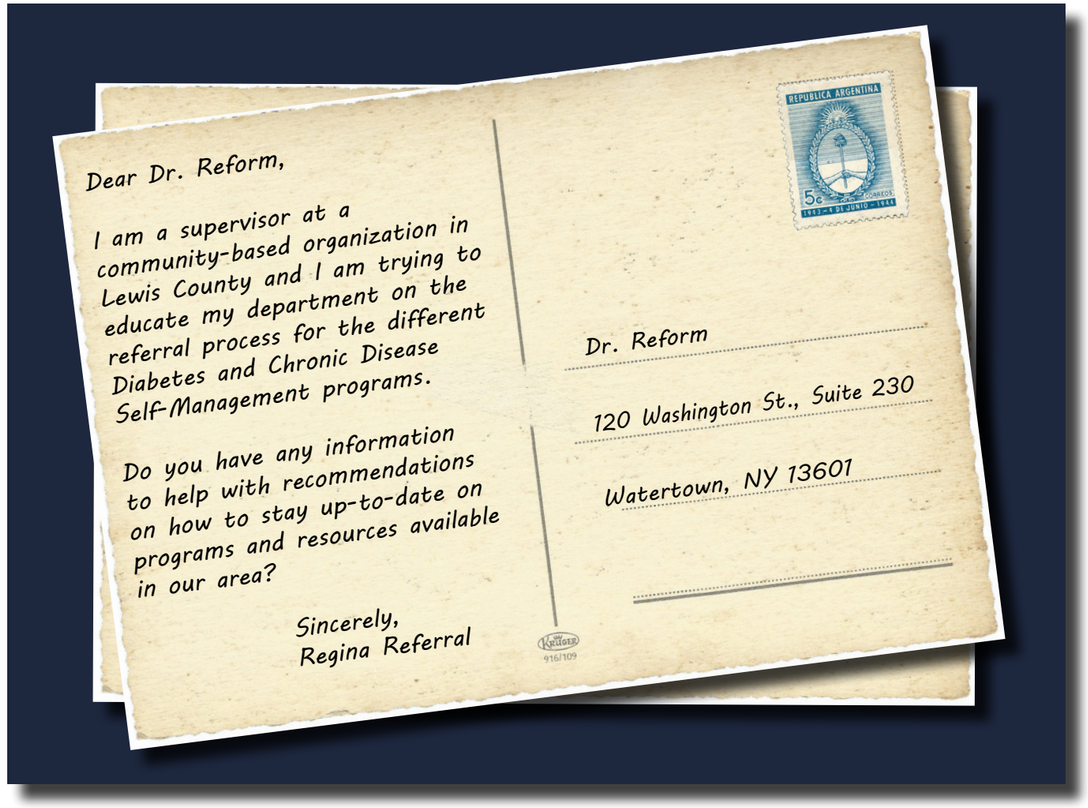
**this list is not all inclusive.*

If you have questions related to the Chronic Care Management Program, please contact Erin Shustack, ACO Project Coordinator at (315) 755-2020 ext. 32.

Click here to view the CY 2017 Medicare Physician Fee Schedule Final Rule!

NORTHCOUNTRY INITIATIVE

North Country INITIATIVE | DSRIP 5 FAST FACTS SUBSCRIBE to the weekly email update Sign Up Now



Dear Regina,

It's great to hear that your office is getting a plan in place for your team to appropriately refer people as needed to Diabetes and Chronic Disease Self-Management programs. It is so important that agencies throughout our community work hand-in-hand with the health care system to help identify, inform and refer individuals at risk so they are able to connect with a program to best help them manage their care and live a healthy life.

According to the 2016 Community Health Assessment Survey, approximately two-in-five adults in the region report that they have been diagnosed with at least one chronic condition, and the most common reported conditions were: high blood pressure (27%), obesity (11%), and diabetes (11%). Fortunately, our region has 3 programs designed to help:

1. Diabetes Prevention Program: For patients who do not have diabetes, but are at risk, this program is designed to help reduce that risk.

2. Diabetes Self-Management Program: For patients with diabetes, this program will help them take control of their condition.

3. Chronic Disease Self-Management Program: Regardless of what chronic disease a patient may have, this program will help them manage it and live a healthy life.

You can learn more about these programs, upcoming workshops and resources at NCI's affiliate website, www.take-control.org.

To your health,

Dr. Reform