CARE COMPASS NETWORK

Cohort Management Program:
Approved Networks

Table of Contents

Network Summary

VLC	General Description of Cohort Population
Addiction Center of Broome County, Inc	Adult women with substance use disorder & trauma
CASA-Trinity	Substance use disorder/Mental health + High Emergency department usage
Catholic Charities of Chenango County	Behavioral health with 1 or more Emergency department visit
Cayuga Medical Center at Ithaca (1)	High Emergency department usage
Cayuga Medical Center at Ithaca (2)	Behavioral health inpatient
Cayuga Medical Center at Ithaca (3)	Opioid use disorder and homeless
Children's Home of Wyoming Conference	Childhood obesity
Family Counseling Services	Childhood trauma
Family Health Network of Central NY	Obesity and Diabetes
Family Planning for South Central New York	Women of reproductive age who have not had an annual exam and 4 or more ED visits
Gerould's Professional Pharmacy	COPD/Asthma adults
Guthrie Corning Hospital	Adult Diabetes
Guthrie Cortland Medical Center	Congestive heart failure/heart disease
Our Lady of Lourdes Memorial Hospital (1)	Opioid use disorder adults
Our Lady of Lourdes Memorial Hospital (2)	High Emergency Department - Community Health Worker
Schuyler Hospital, Inc	High Emergency Department
Springbrook NY Inc	OPWDD avoidable Emergency Department
Visiting Nurse Service of Ithaca and Tompkins County	Low income housing authority residents with chronic conditions

Network Detail

	Addiction Center of Broome County
General Description of Cohort Population	Adult women with SUD & trauma
Counties Served	Broome County
Goals	• Increase 'show' rate of those in MAT appointments • Increase retention rate of those in substance use-related treatment • Decrease PCL-C score from baseline • Successfully place or arrange housing for cohort members • Cohort members will be referred to health home services for proactive care management • 50% of members will establish care with a physician, nurse practitioner, or physician assistant (non-SUD care)
SDoH Interventions	• Childcare assistance • Financial assistance • Rx assistance • Housing assistance • Nutrition assistance • Transportation assistance • Environment-Substandard • Home care support • Adult vaccination • Provider cultural competency • Patient self-management skills • Access to primary care • Criminal justice services • Family/community support services • Trauma services
DSRIP High Performance Metrics	• Adult Access to Preventive Care • Antidepressant Med Management - Effective Acute Phase • Antidepressant Med Management - Effective Continuation Phase • Antipsychotic Medication Adherence – Schizophrenia • Cardiovascular Disease (CVD) Test - CVD and Schizophrenia • Diabetes Mellitus (DM) Test - Schizophrenia and DM • Diabetes Mellitus (DM) Test - Schizophrenia, Bipolar, Antipsychotic Rx • Non-Use of Primary Care Services • Potentially Preventable ER Visits • Potentially Preventable Readmissions • PQI 90 - Adult Composite (Avoidable Hospitalizations)
Network Name	ACBC Cohort
Network Partners	• Addictions Center of Broome County • Crime Victims Assistance Recovery Services • Fairview Recovery Services • YWCA of Binghamton and Broome County

	CASA-Trinity
General Description of Cohort Population	Substance use disorder or mental health dx with a quality flag indication of "High Utilization – Inpatient/ER"
Counties Served	Chemung and Steuben Counties
Goals	• Connect our cohort members who are admitted to ER/Inpatient to outpatient follow up appointments • Cohort members in Substance Use or Mental Health treatment will remain engaged • Each member of the Cohort will have a primary care physician of record and have at least one PC visit by the end of the program • Reduction in the percentage of patients who have a PSYCKES Quality Flag Indicator of "two or more Inpatient/ER admissions in the past 12 months"
SDoH Interventions	• Childcare assistance • Housing assistance • Transportation assistance • Access to primary care • Family/community support services • Employment/ educational training
DSRIP High Performance Metrics	• Adult Access to Preventive Care • Follow-up after Mental Health Hospitalization – 30 Days • Follow-up after Mental Health Hospitalization – 7 Days • Non-Use of Primary Care Services • Potentially Preventable ER Visits • Potentially Preventable Readmissions
Network Name	CASA-SUD
Network Partners	• Capabilities • CASA-Trinity • Family Service of Chemung County • Guthrie Corning Hospital • iMatter Foundation • YWCA

Catholic Charities of Chenango County	
General Description of Cohort Population	Medicaid members with a behavioral diagnosis and one or more potentially preventable ER visits
Counties Served	Chenango County
Goals	• Increase members connectivity to services, providers, and primary care doctors • Increase treatment adherence • Decrease the amount of avoidable emergency room visits
SDoH Interventions	• Access to primary care • Family/community support services • Patient self-management skills • Criminal justice services • Patient health literacy skills
DSRIP High Performance Metrics	• Adult Access to Preventive Care • Antidepressant Med Management – Effective Acute Phase • Antidepressant Med Management – Effective Continuation Phase • Antipsychotic Medication Adherence – Schizophrenia • Follow-up after Mental Health Hospitalization – 30 Days • Follow-up after Mental Health Hospitalization – 7 Days • Non-Use of Primary Care Services • Potentially Preventable ER Visits • Potentially Preventable Readmissions
Network Name	Chenango County Cohort
Network Partners	• Catholic Charities of Chenango County • Chenango County Behavioral Health Services • Chenango Health Network • Norwich Police Department

Cayuga Medical Center at Ithaca (1)	
General Description of Cohort Population	Medicaid patients with 3 or more ED or urgent care visits in a 6-month timeframe.
Counties Served	Tompkins County
Goals	• Engage patients in follow-up care, enhancing their primary care relationship • Increase patient self-management in the outpatient setting
SDoH Interventions	• Childcare assistance • Rx assistance • Housing assistance • Transportation assistance • Medical directives • Patient self-management skills • Patient health literacy skills • Access to primary care • Family/community support services
DSRIP High Performance Metrics	• Adult Access to Preventive Care • Non-Use of Primary Care Services • Potentially Preventable ER Visits
Network Name	Cayuga Medical Center – Emergency Department (ED) Utilization
Network Partners	• Cayuga Area Preferred • Cayuga Medical Associates • Cayuga Medical Center at Ithaca • Human Services Coalition of Tompkins County

Cayuga Medical Center at Ithaca (2)	
General Description of Cohort Population	Medicaid patients experiencing a discharge from inpatient behavioral services unit at Cayuga Medical Center.
Counties Served	Tompkins County
Goals	• Engage patients in outpatient follow-up care at Tompkins County Mental Health after discharge from Behavioral Services Unit. • Increase patient behavioral health self-management in the outpatient setting.
SDoH Interventions	• Childcare assistance • Rx assistance • Transportation assistance • Medical directives • Patient self-management skills • Patient health literacy skills • Access to primary care • Family/community support services • Patient stigma support • Provider stigma training • Trauma services
DSRIP High Performance Metrics	• Antidepressant Med Management - Effective Acute Phase • Antidepressant Med Management - Effective Continuation Phase • Antipsychotic Medication Adherence - Schizophrenia • Follow Up after MH Hospitalization – 30 Days • Follow Up after MH Hospitalization – 7 Days
Network Name	CMC Behavioral Health Cohort – Tompkins County Mental Health Post-Discharge Follow Up
Network Partners	• Cayuga Area Preferred • Cayuga Medical Center at Ithaca • Suicide Prevention & Crisis Service • Tompkins County Mental Health

Cayuga Medical Center at Ithaca (3)	
General Description of Cohort Population	Medicaid patients who have experienced an ED visit related to overdose or those who have a history of opioid use and are not engaged in primary care.
Counties Served	Tompkins, Cortland, and Schuyler Counties
Goals	• Increase engagement in primary care • Maximize the number of patients who have stable housing • Increase patient self-management
SDoH Interventions	• Financial assistance • Rx assistance • Housing assistance • Nutrition assistance • Transportation assistance • Home remediation • Environment-Structural • Environment-Substandard • Medical directives • Patient self-management skills • Patient health literacy skills • Access to primary care • Family/community support services • Patient stigma support • Provider stigma training • Trauma services
DSRIP High Performance Metrics	• Adult Access to Preventive Care • Potentially Preventable ER Visits • Potentially Preventable Readmissions
Network Name	Cayuga Medical Center – Opioid Use Disorder
Network Partners	• Cayuga Area Preferred • Cayuga Medical Center at Ithaca • Alcohol and Drug Council • REACH Medical • Tompkins Community Action

Children's Home of Wyoming Conference

General Description of Cohort Population	Children between the ages of 5 and 18 with diagnosis of obese or overweight enrolled in a Children's Home program
Counties Served	Broome and Chenango Counties
Goals	• The youth will lose weight either dropping below a 25 BMI or losing 10% body weight • Increase exercise • Increase healthy eating • Increase youth recognition of disorder and increased desire to change.
SDoH Interventions	• Patient self-management skills • Patient health literacy skills • Nutrition assistance
DSRIP High Performance Metrics	• Children's Access to Primary Care • PDI 90 – Children's Composite (Avoidable Hospitalizations)
Network Name	Childhood Obesity Project
Network Partners	• Broome County Council of Churches • Children's Home of Wyoming Conference • Synergy Athletics • United Way of Broome County • VINES (Volunteers Improving Neighborhood Environments)

	Family Counseling Services
General Description of Cohort Population	Medicaid members, including children and their adult caregivers, with positive trauma screen (such as Adverse Childhood Experiences--ACE) and/or impacted by unmet Social Determinants of Health needs
Counties Served	Cortland County
Goals	• Cohort members build protective factors and resilience and reduce risk factors • Cohort members engage in behavioral health services to address identified needs • Cohort members engage in primary care services to address identified needs • Cohort members access quality childcare and afterschool care that supports the development and needs of both child and caregiver • Build community resilience through a variety of training strategies including: ▪ Community members (general public) are educated about ACEs, resilience, toxic stress, and trauma-informed care ▪ Healthcare providers, educators, law enforcement, first responders, and other professionals receive training on ACEs, toxic stress, trauma-informed care and Emotionally Disturbed Person Response Team (EDPRT) intervention techniques
SDoH Interventions	▪ Patient health literacy skills ▪ Access to primary care ▪ Family/ community support services ▪ Provider cultural competency ▪ Childcare assistance ▪ Criminal justice services ▪ Trauma services ▪ Patient stigma support ▪ Provider stigma training
DSRIP High Performance Metrics	▪ Children's Access to Primary Care ▪ Follow Up Care for Children with ADHD Rx – Initiation ▪ Follow Up Care for Children with ADHD Rx – Continuation ▪ Non-Use of Primary Care Services
Network Name	The Resilience Project
Network Partners	▪ Cortland County Community Action Program ▪ Family Counseling Services ▪ United Way for Cortland County ▪ YWCA of Cortland County

Family Health Network of Central NY

General Description of Cohort Population	Adults ages 18-60 with a BMI>30 or a diagnosis of impaired fasting glucose, pre-diabetes, or type 2 diabetes without complications/A1c<8
Counties Served	Cortland County
Goals	▪ By March 31, 2020 members of cohort will have increased knowledge of weight management to help manage or prevent disease ▪ By March 31, 2020 members of cohort will have a better understanding and awareness of pre-diabetes and diabetes and lifestyle factors to manage this disease ▪ Increase education surrounding healthy eating, preparing, and planning of healthy meals by March 31, 2020
SDoH Interventions	▪ Patient health literacy skills ▪ Patient self-management skills ▪ Nutrition assistance ▪ Transportation assistance
DSRIP High Performance Metrics	▪ Adult Access to Preventive Care ▪ Diabetes Mellitus (DM) Test – Schizophrenia and DM ▪ Diabetes Mellitus (DM) Test – Schizophrenia, Bipolar, Antipsychotic Rx ▪ Potentially Preventable ER Visits ▪ Potentially Preventable Readmissions
Network Name	Family Health Network
Network Partners	▪ Catholic Charities of Cortland County ▪ Cortland County Family WMCA ▪ Family Health Network of Central NY ▪ Seven Valleys Health Coalition

Family Planning of South Central New York	
General Description of Cohort Population	Women, ages 18-45 years old, who have not had an annual examination and have had 4 or more ED visits in the last 12 months
Counties Served	Broome, Chenango, and Delaware Counties
Goals	▪ Increase annual exams ▪ Educate patients about current Primary Care Provider, and changing to a PCP of their choice if desired ▪ Increase the number of primary care visits ▪ Increase cohort member interaction with community-based organizations and resources ▪ Increase cohort member education on preventive medical services available to them during the annual exam, and with Network Partners ▪ Decrease preventable ED visits for women who are established patient with Family Planning or a PCP
SDoH Interventions	▪ Patient health literacy skills ▪ Patient self-management skills ▪ Nutrition assistance ▪ Transportation assistance ▪ Access to primary care ▪ Family/ community support services ▪ Provider cultural competency ▪ Childcare assistance ▪ Housing assistance ▪ Financial assistance ▪ ESL/ literacy support ▪ GED/ education support
DSRIP High Performance Metrics	▪ Adult Access to Preventive Care ▪ Non-Use of Primary Care Services ▪ Potentially Preventable ER Visits ▪ Potentially Preventable Readmissions ▪ PQI 90 – Adult Composite (Avoidable Hospitalizations)
Network Name	Family Planning Cohort
Network Partners	▪ American Civic Association ▪ Chenango Health Network ▪ Family Enrichment Network ▪ Family Planning for South Central New York ▪ Mothers and Babies Perinatal Network ▪ YWCA of Binghamton and Broome County

Gerould's Professional Pharmacy

General Description of Cohort Population	Adults 18+ with a Chronic Respiratory Condition
Counties Served	Schuyler, Chemung, Steuben, and Tioga Counties
Goals	▪ Overall Reduction in 30 day readmissions by 25% ▪ Reduction in overall admissions by 10% ▪ Reduction in ED visits ▪ Use of Spirometry in the diagnosis and management of disease response and stages ▪ Smoking Cessation ▪ Completion of Pulmonary Rehab Program (facility or home based) ▪ Improvement in SDoH for those with identified disparities ▪ Improved PCP Engagement ▪ Referral to Palliative Care
SDoH Interventions	▪ Patient health literacy skills ▪ Patient self-management skills ▪ Nutrition assistance ▪ Transportation assistance ▪ Access to primary care ▪ Family/ community support services ▪ Provider cultural competency ▪ Rx assistance ▪ Medical directives ▪ Home care support
DSRIP High Performance Metrics	▪ Adult Access to Preventive Care ▪ Antidepressant Med Management – Effective Acute Phase ▪ Antidepressant Med Management – Effective Continuation Phase ▪ Heart Failure Hospitalization Rate (PQI-8) ▪ Non-Use of Primary Care Services ▪ Potentially Preventable ER Visits ▪ Potentially Preventable Readmissions ▪ PQI 90 – Adult Composite (Avoidable Hospitalizations)
Network Name	Adult Chronic Respiratory Cohort
Network Partners	▪ Arnot Health ▪ CareFirst Hospice ▪ Clinical Associates of the Southern Tier ▪ Gerould's Professional Pharmacy ▪ Guthrie Corning Hospital ▪ Human Services Development (S2AY) ▪ Rural Health Network SCNY

Guthrie Corning Hospital	
General Description of Cohort Population	Adults 18+ with diagnosis of Diabetes and/or Diabetes in the problem list
Counties Served	Chemung, Steuben, and Tioga Counties
Goals	▪ Reduce ED Visits ▪ Improve Diabetes Composite Score ▪ Increase engagement in patient self-management of Diabetes
SDoH Interventions	▪ Patient health literacy skills ▪ Patient self-management skills ▪ Nutrition assistance ▪ Transportation assistance ▪ Access to primary care ▪ Family/ community support services ▪ Rx assistance ▪ Medical directives
DSRIP High Performance Metrics	▪ Adult Access to Preventive Care ▪ Non-Use of Primary Care Services ▪ Potentially Preventable ER Visits ▪ Potentially Preventable Readmissions ▪ PQI 90 – Adult Composite (Avoidable Hospitalizations)
Network Name	Guthrie Diabetes Cohort Network
Network Partners	▪ CareFirst Hospice ▪ Gerould's Professional Pharmacy ▪ Guthrie Corning Hospital ▪ Guthrie Medical Group ▪ Guthrie Robert Packer Hospital ▪ Human Services Development (S2AY) ▪ Rural Health Network SCNY

Guthrie Cortland Medical Center

General Description of Cohort Population	Adults 21-64 with heart disease and/or congestive heart failure
Counties Served	Cortland County
Goals	▪ Increase member adoption rate of established services by 15% ▪ Reduce potentially preventable ED visits ▪ Reduce potentially preventable admissions ▪ Establish a strong network that includes; timely sharing of member information to manage outcomes ▪ Increase the percent of Medicaid members who had an ambulatory or preventive care visit during the measurement year by 5%.
SDoH Interventions	▪ Patient self-management skills ▪ Patient health literacy skills ▪ Nutrition assistance ▪ Access to primary care ▪ Family/ community support services ▪ Transportation assistance ▪ Rx assistance ▪ Medical directives ▪ Home care support ▪ Provider cultural competency
DSRIP High Performance Metrics	▪ Adult Access to Preventive Care ▪ Heart Failure Hospitalization Rate (PQI-8) ▪ Potentially Preventable ER Visits ▪ Potentially Preventable Readmissions
Network Name	Cortland Value Based Network (CVBN)
Network Partners	▪ Catholic Charities of Cortland County ▪ Cortland County Health Department ▪ Family Counseling Services ▪ Family Health Network of Central NY ▪ Guthrie Cortland Medical Center ▪ Regional Medical Practice, PCP ▪ Seven Valleys Health Coalition

Our Lady of Lourdes Memorial Hospital, Inc (1)

General Description of Cohort Population	Adults with opioid use disorder, high ED utilization, and gaps in primary care
Counties Served	Broome County
Goals	▪ Lower the number of ED visits for the identified population by 10% from the baseline ▪ Increase patient engagement with primary care provider and available resources by 10 % from the baseline ▪ Increase patient engagement with community health worker and available resources ▪ Lower the number of hospitalizations by 10% from the baseline ▪ Increase provider and community education regarding how to best engage the target population ▪ Creating acceptance and remove the stigma associated with OUD patients ▪ Increase the number of providers who are waiver trained and have DEA X license
SDoH Interventions	▪ Patient self-management skills ▪ Patient health literacy skills ▪ Nutrition assistance ▪ Transportation assistance ▪ Access to primary care ▪ Family/ community support services ▪ Rx assistance ▪ Provider cultural competency ▪ Home care support ▪ Childcare assistance ▪ Housing assistance ▪ Financial assistance ▪ Criminal justice services ▪ Trauma services ▪ Patient stigma support ▪ Provider stigma training
DSRIP High Performance Metrics	▪ Adult Access to Preventive Care ▪ Non-Use of Primary Care Services ▪ Potentially Preventable ER Visits ▪ Potentially Preventable Readmissions
Network Name	Lourdes Opioid Use Disorder (OUD) Cohort
Network Partners	▪ Addictions Center of Broome County ▪ Our Lady of Lourdes Memorial Hospital, Inc ▪ REACH Medical ▪ Rural Health Network SCNY ▪ Southern Tier AIDS Program ▪ Truth Pharm

Our Lady of Lourdes Memorial Hospital, Inc (2)	
General Description of Cohort Population	Adults 18+ attributed to Lourdes Center for Family Health with chronic disease and/or high ED utilizers
Counties Served	Broome County
Goals	▪ Lower the number of preventable ED visits for the identified population by at least 10% from the baseline ▪ Increase this populations engagement with primary care provider and available community resources by at least 10 % from the baseline ▪ Increase patient engagement with community health worker and available community resources Lower the number of hospital readmissions by 10% from the baseline ▪ Increase clinical and non-clinical provider education regarding how to best engage the target population's SDoH
SDoH Interventions	▪ Patient self-management skills ▪ Patient health literacy skills ▪ Nutrition assistance ▪ Transportation assistance ▪ Access to primary care ▪ Family/ community support services ▪ Rx assistance ▪ Provider cultural competency ▪ Home care support ▪ Childcare assistance ▪ Housing assistance ▪ Financial assistance ▪ Criminal justice services ▪ Trauma services ▪ ESL/ literacy support ▪ GED/ education support ▪ Environment-Substandard ▪ Adult vaccination ▪ Home remediation ▪ Environment-Structural
DSRIP High Performance Metrics	▪ Adult Access to Preventive Care ▪ Non-Use of Primary Care Services ▪ Potentially Preventable ER Visits ▪ Potentially Preventable Readmissions ▪ PQI 90 – Adult Composite (Avoidable Hospitalizations)
Network Name	Lourdes Community Health Worker at 303 Main Street Cohort
Network Partners	▪ American Civic Association ▪ Broome County Health Department ▪ Catholic Charities of Broome County ▪ Our Lady of Lourdes Memorial Hospital, Inc ▪ Rural Health Network SCNY

	Schuyler Hospital, Inc
General Description of Cohort Population	Adults 18-100 with 2 or more ED visits in a 6-month timeframe
Counties Served	Schuyler County
Goals	▪ Engage patients in follow-up care, enhancing the primary care relationship ▪ Increase patient self-management in the outpatient setting ▪ Improve cohort members participation in relevant preventative health practices by 5% ▪ Begin to track and trend referrals made to community resources
SDoH Interventions	▪ Patient self-management skills ▪ Patient health literacy skills ▪ Transportation assistance ▪ Access to primary care ▪ Family/ community support services ▪ Rx assistance ▪ Housing assistance ▪ Environment-Substandard ▪ Home remediation ▪ Environment-Structural
DSRIP High Performance Metrics	▪ Adult Access to Preventive Care ▪ Non-Use of Primary Care Services ▪ Potentially Preventable ER Visits
Network Name	Schuyler Community Wellness Network
Network Partners	▪ Cayuga Area Preferred ▪ Schuyler Hospital, Inc ▪ Schuyler Housing Opportunity Council ▪ Transportation Link-Line

	Springbrook NY, Inc
General Description of Cohort Population	Individuals 18+ with diagnosis of developmental disabilities, who are non-utilizers of primary care
Counties Served	Broome, Chenango, and Delaware Counties
Goals	▪ Increase occurrence of PCP visit to improve prevention and screenings, reduce hospitalization, and improve health coordination ▪ Decrease preventable ER usage ▪ Decrease preventable hospitalization
SDoH Interventions	▪ Patient self-management skills ▪ Patient health literacy skills ▪ Transportation assistance ▪ Access to primary care ▪ Family/ community support services ▪ Rx assistance ▪ Provider cultural competency ▪ Home care support ▪ ESL/ literacy support ▪ Adult vaccination ▪ Patient stigma support
DSRIP High Performance Metrics	▪ Adult Access to Preventive Care ▪ Non-Use of Primary Care Services ▪ Potentially Preventable ER Visits ▪ PQI 90 – Adult Composite (Avoidable Hospitalizations)
Network Name	Springbrook Primary Care Project
Network Partners	▪ Basset Health System, Norwich Primary Care Practice ▪ Rural Health Network SCNY ▪ Southern Tier Connect ▪ Springbrook NY, Inc

	Visiting Nurse Services of Ithaca and Tompkins County
General Description of Cohort Population	Low income housing authority residents with chronic conditions
Counties Served	Broome, Cortland, and Tompkins Counties
Goals	▪ Decrease hospitalization ▪ Decrease ER utilization ▪ Increase medication compliance ▪ Increase understanding of self-care protocols ▪ Increase understanding/follow through of discharge orders ▪ Increase utilization of use of personal health record ▪ Increase # of pts that attend follow up apt. with PCP within 7 days of ER or hospital visit
SDoH Interventions	▪ Patient self-management skills ▪ Patient health literacy skills ▪ Transportation assistance ▪ Access to primary care ▪ Family/ community support services ▪ Rx assistance ▪ Home care support ▪ ESL/ literacy support ▪ Housing assistance ▪ Nutrition assistance ▪ Medical directives
DSRIP High Performance Metrics	▪ Adult Access to Preventive Care ▪ Diabetes Mellitus (DM) Test – Schizophrenia, Bipolar, Antipsychotic Rx ▪ Heart Failure Hospitalization Rate (PQI-8) ▪ Non-Use of Primary Care Services ▪ Potentially Preventable ER Visits ▪ Potentially Preventable Readmissions ▪ PQI 90 – Adult Composite (Avoidable Hospitalizations)
Network Name	Housing Authority Cohort
Network Partners	▪ Binghamton Housing Authority ▪ Community Health and Home Care ▪ Cortland Housing Authority ▪ Ithaca Housing Authority, Titus Towers ▪ Metro Plaza ▪ SEPP Management ▪ Visiting Nurse Service of Ithaca and Tompkins