NEW YORK STATE | Department of Health

DSRIP Domain 4 and the Prevention Agenda

A Reference Guide for DSRIP Domain 4 Projects Implementation Planning

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Contents

Introduction

As part of the Project Applications for the Delivery System Reform Incentive Payment (DSRIP) program, Performing Provider Systems (PPSs) selected and committed to projects that fall under various *Domains*. These include a set of projects in Domain 4 – Population-Wide Health: New York's Prevention Agenda. Herein, PPSs will find suggested milestones and activities to support the development of their project-specific implementation plans and for the continuing work for the DSRIP Domain 4 projects. This document, developed as a collaborative effort between the New York State (NYS) Department of Health (DOH) Office of Public Health (OPH) and Office of Health Insurance Programs (OHIP), is part of an ongoing series of webinars and documents intended to help guide PPSs through their project planning and implementation process.

The Delivery System Reform Incentive Payment (DSRIP) program

In April 2014, Governor Andrew M. Cuomo announced that New York had finalized terms and conditions with the federal government for a groundbreaking waiver that allows the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms.[1] $6.42 billion of this was allocated to the Delivery System Reform Incentive Payment (DSRIP) program. Year one (DY1) began April 1, 2015, and it will extend through to March 31, 2020. Over these five years, the program will promote community-level collaborations and focus on healthcare system reform. DSRIP is the foundation for "Better care, Less cost," and has the major goal to achieve a 25 percent reduction in avoidable hospital use over five years.

Within DSRIP, safety net providers have come together in what are called Performing Provider Systems (PPSs). Twenty-five (25) PPSs cover overlapping regions across the state, each made up of providers across the continuum of care. Over the course of the DSRIP program, these providers will collaborate and implement innovative projects in three domains. Below are the three domains and examples of the nature of the projects in those domains:

- Domain 2: System Transformation Projects
  - Create integrated delivery systems focused on evidence-based medicine and population health management.
  - Care transitions interventions model to reduce 30-day readmissions for chronic health conditions.
- Domain 3: Clinical Improvement Projects
  - Integration of primary care and behavioral health services.
  - Evidence-based strategies for disease management in high risk/affected populations.
- Domain 4: Population-Wide Projects
  - Strengthen mental health and substance abuse infrastructure across systems.
  - Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

In the development of DSRIP, it was important to ensure by design that DSRIP projects were aligned with other initiatives ongoing in the New York State Department of Health. One initiative in particular, the Prevention Agenda 2013-2017, had many of the same key objectives as DSRIP, but was focused on the full New York State population and not just the Medicaid population. It was decided to bring DSRIP and the Prevention Agenda visibly together in the Domain 4 projects.

While Performing Provider Systems (PPSs) do not have this entire population attributed for Domain 4, health care providers tend to treat all of their patients in the same way. As a result, changes in practice behavior that improve the health of the Medicaid population will also likely flow over to improve the health

[1] From DSRIP website: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm

of the total population. It is our expectation that this phenomenon and certain specific steps aligning the PPSs with the Prevention Agenda will result in improved health for the full population.

The NYS DOH Office of Public Health (OPH) and Office of Health Insurance Programs (OHIP) have provided in this document guidance on evidence-based project activities, milestones and metrics, and resources that they have found useful in activities related to the Prevention Agenda and which may be useful for PPSs as they develop their DSRIP implementation plans for Domain 4 projects.

Please note that the metrics that will be utilized for Domain 4 remain those listed in Attachment J of the STCs and in the DSRIP Measure Specification and Reporting Manual. No other metrics are required to be reported.

This document

This document provides considerations that PPSs may choose to incorporate into their implementation planning efforts for DSRIP projects within Domain 4. While this is not intended to be a prescriptive or exhaustive list of planning considerations, it provides guidance on evidence-based interventions and strategies that can be included in the formal implementation plans submitted to the Department of Health.

PPSs may already be engaged in some of the activities suggested in this document, or appropriate variations thereof. The regional Community Needs Assessment (CNA) that was conducted by each PPS highlighted key areas in which ongoing population health activities should be planned or underway. Many of these will, by necessity, involve important collaborations with local health departments, healthcare providers, and community partners. PPSs are encouraged to continue building these important relationships and developing their projects so as to best serve the population in their region. Concepts from this document can be incorporated, as appropriate, into this evolving planning and implementation process. When programs are already in place, the PPS can become a strong partner in addressing these projects and can be, with its partner organizations, a valuable resource to add to the collective efforts.

DSRIP Domain 4 projects

All DSRIP plans must include at least one project from Domain 4, based on the PPS's Community Needs Assessment and consistent with the Domain 3 projects in their project plan. This means that Domain 4 projects will add a new facet, but not duplicate, Domain 3 projects and will also be applicable to the full service area population. These projects are based upon the New York State Prevention Agenda, and, as such, the PPS is encouraged to work in collaboration with the community and other providers to address these statewide public health priorities.

Number of PPSs that chose Domain 4 projects

Population-wide Projects		# of PPSs
A. Promote Mental Health and Prevent Substance Abuse (MHSA)		
4.a.i	Promote mental, emotional and behavioral (MEB) well-being in communities	2
4.a.ii	Prevent substance abuse and other mental emotional behavioral disorders	1
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems	13
B. Prevent Chronic Diseases		
4.b.i	Promote tobacco use cessation, especially among low SES populations and those with poor mental health	11
4.b.ii	increase access to high quality chronic disease preventive care and management in both clinical and community settings	11
C. Prevent HIV and STDs		
4.c.i	Decrease HIV morbidity	1
4.c.ii	Increase early access to, and retention in, HIV care	7
D. Promote Healthy Women, Infants and Children		
4.d.i	Reduce premature births	2

In their DSRIP applications, PPSs were asked to identify and describe important project milestones (and associated timelines) related to the implementation of each of their Domain 4 projects. The PPS's implementation plans for these projects, then, should be consistent with these milestones. These project milestones will help guide the PPS towards achieving progress in meeting the needs of the community that had been identified in their Community Needs Assessment.

The Prevention Agenda 2013-2017

The Prevention Agenda 2013-2017 is New York State's health improvement plan developed by the New York State Public Health and Health Planning Council at the request of the Department of Health, in partnership with more than 140 organizations across the state. The Prevention Agenda calls for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities.

The Prevention Agenda supports the goals of health care reform. As our health status is largely influenced by social circumstances, environmental conditions, behavioral patterns, and access to health care, public health efforts directed at each of these factors can lower the risk of adverse health conditions. State and local spending on community-based primary and secondary prevention can improve health outcomes and yield a return on investment through savings in health care costs and Medicaid budgets.

The Prevention Agenda asks local health departments, hospitals, and other community partners to work together to identify and address local public health issues in five priority areas:

- Prevent Chronic Diseases.
- Promote a Healthy and Safe Environment.
- Promote Healthy Women, Infants and Children.
- Promote Mental Health and Prevent Substance Abuse.
- Prevent HIV/STDs, Vaccine-Preventable Disease and Healthcare-Associated Infections.

For more information on the Prevention Agenda:

On the web: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm

Email: prevention@health.ny.gov

Address: Office of Public Health Practice
943 Tower Building, ESP
Albany, New York 12237

Phone: (518) 473-4223

Project 4.a.i – Promote mental, emotional, and behavioral (MEB) well-being in communities

DSRIP Project Description

This project focuses on increasing the use of evidence-informed policies and evidence-based programs pertaining to the healthy development of children, youth, and adults.

- Increasing evidence indicates that promotion of positive aspects of mental health is an important approach to reducing Mental, Emotional, and Behavioral (MEB) disorders and related problems.
- The 2009 Institute of Medicine (IOM) report concluded that the promotion of mental health should be recognized as an important component of the mental health spectrum, rather than be merged with prevention.
- MEB health serves as a foundation for prevention and treatment of MEB disorders.
- A developmental, interdisciplinary approach to MEB health promotion will affect homes, schools, workplaces, and communities.
- Child and youth development research should be synthesized from a State MEB health well-being perspective, and assessed to identify opportunities for action.
- Research indicates that focusing on positive child and youth development policies has the potential for the greatest return on investment.

This project will help to promote MEB well-being in communities.

The Prevention Agenda

This project relates to the *Promote Mental Health and Prevent Substance Abuse (MHSA) Action Plan* (Focus Area 1) within the Prevention Agenda.

MHSA Focus Area 1: Promote mental, emotional and behavioral (MEB) well-being in communities

The 2009 Institute of Medicine report concluded there is increasing evidence that promotion of positive aspects of mental health is an important approach to reducing MEB disorders and related problems. It will serve as a foundation for both prevention and treatment of MEB disorders.[2]

Suggestions for implementation

- Invite community partners, Local Health Departments, and Local Governmental Units to take part in planning the effort and identify each organization's role in the effort.
- Support identifying and building nurturing environments.
- Build community supports and services that facilitate social connectedness including integration and access to quality preventive and treatment services.
- Implement evidence-based practices for MEB health promotion intervention that support positive development and healthy lifestyles.
- Support the mental health and parenting skills of parents.
- Practice appropriate evidence-based preventive strategies for settings such as supporting positive parenting practices.
- Support integration of evidence-based prevention and treatment interventions.

These types of activities may already be occurring in your community or region.

When programs are already in place, the PPS can become a strong partner in addressing these projects due to the number and scope of partners in the PPS itself.

[2] From the Prevention Agenda website: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/

- Advocate addressing the common protective factors, such as parent engagement and social connectedness, and risk factors for MEB well-being and disorder prevention such as poverty and exposure to violence.

Suggested milestones

- Announcement to community partners on intention to take action on this project and invitation for collaboration.
- Identification of tools that can measure community well-being in your community.
- Measure and make available local and State data on MEB well-being and MEB disorder prevention to increase transparency and quality on practice.
- Identification of opportunities to integrate social determinants of health into existing and/or new projects.
- Percent of programs that promote resiliency among participants.
- Number of participants who utilize knowledge and/or skills from a specific training.
- Number of organizations that formally implement evidence-based practices identified by the project.

Possible data sources & references

- National Research Council and Institute of Medicine (2002). Community Programs to Promote Youth Development. J. Eccles &JA Gootman (Eds) Committee on Community-Level Programs for Youth, Board on Children, Youth and Families. Washington DC. National Academy Press.
- Shea P, Shern D. Primary Prevention in Behavioral Health: Investing in our Nation's Future. National Association of State Mental Health Program Directors[3] (NASMHPD), 2011.

[3] http://www.hhs.gov/ash/oah/news/assets/sts_primary_prevention_behavioral_health.pdf

Project 4.a.ii – Prevent substance abuse and other mental emotional disorders

DSRIP Project Description

Implement strategies to prevent underage drinking, non-medical use of prescription medications, and excessive alcohol consumption by adults, prevent suicides, and reduce tobacco use among adults who report poor mental health. MEB disorders, including substance abuse, depression, and other disorders have enormous personal, family and societal costs.

This project will help to prevent substance abuse and other mental emotional disorders.

The Prevention Agenda

This project relates to the *Promote Mental Health and Prevent Substance Abuse (MHSA) Action Plan* (Focus Area 2) within the Prevention Agenda.

MHSA Focus Area 2: Prevent Substance Abuse and other Mental Emotional Behavioral Disorders

Substance abuse, depression and other MEB disorders hurt the health, public safety, welfare, education, and functioning of New York State residents. In addition to evidence substance abuse and other MEB disorders can be prevented, there is confirmation that early identification and adequate societal support can prevent and alleviate serious consequences such as death, poor functioning and chronic illness.[4]

Suggestions for implementation

- Invite community partners and Local Health Departments to take part in planning the effort.
- Promote screening and early intervention such as SBIRT[5] and Teen Intervene[6] for substance abuse, which improves the likelihood that the person will receive evaluation and treatment.
- Educate health care providers about the warning signs of substance abuse.
- Establish reporting and advertising policies that do not glamorize alcohol and substance abuse or stigmatize MEB disorders.
- Link social support, resiliency training, problem-solving skills to individuals and their networks.
- Implement evidence-based strategies to reduce underage drinking, such as those promulgated by the U.S. Surgeon General and the Centers for Disease Control and Prevention.
- Advocate for addressing common risk factors, such as poverty and exposure to violence, and promoting common protective factors, such as parent engagement and social connectedness.
- Adopt tobacco-free regulations and evidence-based smoking cessation practices in all mental health facilities.
- Assess the feasibility of expanding the Medicaid benefit for smoking cessation services such as medication for four 90-day courses of treatment annually for individuals with behavioral health disorders.

These types of activities may already be occurring in your community or region.

When programs are already in place, the PPS can become a strong partner in addressing these projects due to the number and scope of partners in the PPS itself.

[4] From the Prevention Agenda website: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/
[5] http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=222
[6] http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=287

Suggested milestones

- Identification and clarification of roles of community partners in MEB disorder, including substance abuse prevention.
- Number of individuals screened and/or engaged in early interventions.
- Number of individuals, youth, and/or organizations engaging with provided resources and support services.
- Number of facilities that adopt tobacco-free regulations and evidence-based smoking cessation practices.

Possible data sources & references

- Phyllis L. Ellickson, PhD; Joan S. Tucker, PhD; and David J. Klein, MS, Ten-Year Prospective Study of Public Health Problems Associated With Early Drinking. Pediatrics Vol. 111 No. 5 May 2003.

Project 4.a.iii – Strengthen mental health and substance abuse infrastructure across systems

DSRIP Project Description

Support collaboration among leaders, professionals, and community members working in MEB health promotion to address substance abuse and other MEB disorders, and integrate with other prevention issues such as chronic disease prevention. MEB health promotion and disorders prevention is a relatively new field, requiring a paradigm shift in approach and perspective. This project will address chronic disease prevention, treatment and recovery, and strengthen infrastructure for MEB health promotion and MEB disorder prevention. Meaningful data and information at the local level, training on quality improvement, evaluation and evidence-based approaches, and cross-disciplinary collaborations need to be strengthened.

This project will help to strengthen mental health and substance abuse infrastructure across systems.

The PPS must show implementation of three of the four sector projects in their project plan:

1. Participate in Mental, Emotional, and Behavioral (MEB) health promotion and MEB disorder prevention partnerships.
2. Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.
3. Provide cultural and linguistic training on MEB health promotion, prevention and treatment.
4. Share data and information on MEB health promotion and MEB disorder prevention and treatment.

The Prevention Agenda

This project relates to the *Promote Mental Health and Prevent Substance Abuse (MHSA) Action Plan* (Focus Area 3) within the Prevention Agenda.

MHSA Focus Area 3: Strengthen Infrastructure across Systems

Substance abuse, depression and other MEB disorders hurt the health, public safety, welfare, education, and functioning of New York State residents. In addition to evidence that substance abuse and other MEB disorders can be prevented, there is confirmation that early identification and adequate societal support can prevent and alleviate serious consequences such as death, poor functioning and chronic illness.[7]

Suggestions for implementation

1. MEB promotion/disorder prevention partnerships

- Invite and clarify roles of community partners, Local Health Departments, and Local Government Units to strengthen MEB infrastructure.
- Using data from community needs assessment and engagement with community partners, identify specific MEB issues to be addressed.
- Identify key representatives from governmental agencies, health care and community based organizations, schools, etc. to serve on an interdisciplinary team to address the specific MEB issues in the community that includes an

These types of activities may already be occurring in your community or region.

When programs are already in place, the PPS can become a strong partner in addressing these projects due to the number and scope of partners in the PPS itself.

[7] From the Prevention Agenda website: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/

approach that balances promotion, prevention, treatment and maintenance.
- Develop purpose statement that includes rationale, assets, challenges, goals, objectives, baseline data for tracking, and interventions to be implemented to address issue.
- Implement interventions, track progress, and make improvements as needed.

2. Collaborative care in primary care settings

- Using data from community needs assessment and input from community partners identify locations in community where primary care and behavioral health services can be co-located.
- Identify key representatives and organizations that can support a collaborative care model in primary care settings.
- Identify members of the collaborative care team including primary care providers, care management staff, and psychiatric consultants.
- Develop methods and data sources to track patient progress and make improvements as needed.
- Encourage effective coordination within behavioral health care, and between behavioral health care and community-based primary care providers, and other health care, recovery, and social support services. (National Behavioral Health Quality Framework goal 3 and 3a)

The intent of this project is not that the PPS becomes responsible for initiating collaborative care in settings other than those intended in its Domain 3 projects; however, the PPS will have significant experience in addressing collaborative care and can use this expertise within its community to support initiation in additional primary care sites.

3. Cultural and linguistic training on MEB health promotion, prevention and treatment

- Conduct an assessment to understand community and provider characteristics, including an understanding of MEB promotion.
- Conduct an assessment of cultural competency, including an understanding of community culture, comfort working with diverse segments, proficiency in treating community members, and participation in cultural competency training.
- Conduct training on delivering evidence-based care that is integrated with MEB promotion and disorder prevention.
- Identify and deliver curricula for children and youth to enhance their social skills, emotional competence, and conflict resolution and coping skills.
- Identify and deliver curricula to members of partnership on MEB health promotion, prevention, and treatment, using the Institute of Medicine Intervention Spectrum framework.

4. Sharing data and information on MEB health promotion and MEB disorder prevention and treatment

- Collaborate with local health departments and local government units (LGUs) to identify data sources that can be used to share information on MEB issues within the community.

In addition to the PPS, local hospitals and planning groups may have done their own targeted community needs assessment. Since the focus of the PPS has been the Medicaid population, these additional planning documents will collectively provide the more comprehensive community picture of the cultural and linguistic composition and will provide a broader understanding of how collectively community organizations will need to provide cultural and linguistic training to address MEB health promotion, prevention and treatment.

Suggested milestones

1. MEB promotion/disorder prevention partnerships

- Announcement to community partners on intention to take action on this project and invitation for collaboration.
- Identification of specific MEB issue being addressed in purpose statement.

- Number of organizations that enter into formal inter/intra organizational agreement to develop and implement interventions to support MEB efforts that balance promotion, prevention, treatment and maintenance.
- Identification of data set and baseline data for tracking implementation progress.

When projects are already ongoing in the community or region related to the Domain 4 project chosen by the PPS, the PPS will need to provide milestones in the implementation plan that are consistent with this already developed community project.

2. **Collaborative care in primary care settings**
   - Number of organizations that enter into formal inter/intra organizational agreements to integrate MEB health promotion and disorder prevention into collaborative care model.

3. **Cultural and linguistic training on MEB health promotion, prevention and treatment**
   - Use validated surveys where possible to assess cultural competency.
   - Number of organizations conducting a specific behavioral health promotion or disorder prevention cultural competency training.
   - Number of participants who completed a specific training.
   - Number of participants who utilize knowledge and/or skills from a specific training.

4. **Sharing data and information on MEB health promotion and MEB disorder prevention and treatment**
   - Assess the feasibility of incorporating and sharing data on standard measures recommended by the Institute of Medicine committee for eight social and behavioral domains:

educational attainment – financial resource strain – stress depression – physical activity social isolation – intimate partner violence (for women of reproductive age) neighborhood median-household income

Possible data sources & references

1. **MEB promotion/disorder prevention partnerships**
   - Policies and procedures of providers to capture social and behavioral measures in EHR.
   - Quarterly reports containing aggregate data on captured social and behavioral domains and measures in EHR.
   - Hawkins, J., Catalano, R., Arthur, M. and Egan, E. (2008) Testing communities that care: The rationale, design and behavioral baseline equivalence of the community development study. Prevention Science, 9, 178-190.
   - Spoth, R. & Greenberg, M. (2005) Toward a comprehensive strategy for effective practitioner-scientist partnerships and larger scale community benefits. American Journal of Community Psychology, 35, 107-126.
   - SAMHSA. (2014). Strategic Prevention Framework.[8]
   - Yang, E., Foster-Dishman, P., Collins, C. & Ahn, S. (2012) Testing a comprehensive community problem solving framework for community coalitions. Journal of community Psychology, 40(6), 681-698.

2. **Collaborative care in primary care settings**
   - Health Home Information Resource Center: The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes[9]

[8] http://www.samhsa.gov/spf
[9] http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf

- SAMHSA: National Behavioral Health Quality Framework[10]
- AHRQ: A Framework for Measuring Integration of Behavioral Health And Primary Care[11]

3. **Cultural and linguistic training on MEB health promotion, prevention and treatment**
   - Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities (2009)[12]

4. **Sharing data and information on MEB health promotion and MEB disorder prevention and treatment**
   - Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2[13]

[10] http://www.samhsa.gov/data/national-behavioral-health-quality-framework
[11] http://integrationacademy.ahrq.gov/atlas/frameworkIBHC
[12] http://www.nap.edu/catalog.php?record_id=12480
[13] http://www.iom.edu/Reports/2014/EHRdomains2.aspx

Project 4.b.i – Promote tobacco use cessation, especially among low SES populations and those with poor mental health

DSRIP Project Description

Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State (NYS). Cigarette use alone results in an estimated 28,000 deaths in NYS. There are estimated to be 570,000 New Yorkers afflicted with serious disease directly attributable to their smoking. The list of illnesses caused by tobacco use is long and contains many of the most common causes of death. These include many forms of cancer (including lung and oral); heart disease; stroke; chronic obstructive pulmonary disease and other lung diseases.

The economic costs of tobacco use in NYS are staggering. Smoking-attributable healthcare costs are $10.4 billion annually, including $3.3 billion in annual Medicaid expenditures. In addition, smoking-related illnesses result in $6 billion in lost productivity. Reducing tobacco use has the potential to save NYS taxpayers billions of dollars every year.

Although there have been substantial reductions in adult smoking in NYS, some tobacco use disparities have become more pronounced over the past decade. Smoking rates did not decline among low socioeconomic status (SES) adults and adults with poor mental health. This project targets decreasing the prevalence of cigarette smoking by adults 18 and older by health care provider adherence with U.S. Public Health Service (USPHS) clinical practice guidelines, including brief counseling, FDA-approved over-the-counter and prescription medications, and follow-up referral to cessation services such as the NYS Smokers' Quitline.

This project will promote tobacco use cessation, especially among low SES populations and those with poor mental health by focusing on health systems that serve these populations

The Prevention Agenda

This project relates to two Prevention Agenda Action Plans: the *Prevent Chronic Diseases (PCD) Action Plan* (Focus Area 2; Goal 2.2.2) and the *Promote Mental Health and Prevent Substance Abuse (MHSA) Action Plan* (Focus Area 2; Goal 2.4) within the Prevention Agenda.

PCD Focus Area 2, Goal 2.2: Promote tobacco use cessation, especially among low SES populations and those with poor mental health[14]

Objective 2.2.2: By December 31, 2017, decrease the prevalence of cigarette smoking by adults, ages 18 years and older, by 17% from 18.1% to 15.0%.

MHSA Focus Area 2, Goal 2.4: Reduce tobacco use among adults who report poor mental health[14]

Objective 2.4.1: By December 31, 2017, reduce the prevalence of cigarette smoking among adults who report poor mental health by 15% from 32.5% in 2011 to 27.6%.

- Smoking is higher among individuals reporting poor mental health than those reporting good mental health.
- Based on the Adult Tobacco Survey, from 2003-2004 to 2009-2010, smoking prevalence declined by 21 percent among those with good mental health (19.2% to 15.2%) and remained unchanged among those who report their mental health was not good. Since 2011, smoking prevalence is reported from the Behavioral Risk Factor Surveillance System (BRFSS). Smoking prevalence for

[14] From the Prevention Agenda website: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/goals_objectives.htm#2rationale

those who reported that their mental health was not good was twice that of those with good mental health (32.5% vs. 16.4%).

Suggestions for implementation

- Invite community partners to take part in planning the effort.
- Review and include community recommendations from the Community Health Needs Assessment in plans.
- Develop and adopt policies that support and enforce tobacco-free grounds throughout the PPS, including in community-based sites.
- Develop and implement a policy to ensure treatment of tobacco dependence that includes:
  - Implementation or adaptation of an existing EHR that captures and promotes screening and treatment at every encounter (outpatient and inpatient) and links to resources such as reference documents for drug interactions.
  - Implementation or adaptation of workflow to optimize delivery of tobacco use screening and treatment.
  - Instituting for all health care team members routine tobacco use treatment training that covers the 5As.
  - Provision of counseling and optimal pharmacotherapy (as appropriate) at every visit.
  - Referring patients to the NYS Smokers' Quitline (NYSSQL) as follow-up to on-site counseling and pharmacotherapy evaluation with bidirectional communication so providers receive feedback from referrals.
- Increase Medicaid cessation benefit utilization by:
  - Educating patients on their benefit.
  - Offering both counseling and pharmacotherapy during each encounter.
- Collaborate with participating health plans to identify value based methods for reimbursement for tobacco dependence treatment.
- Provide feedback reports using quality measures for screening and treatment (including CPT II codes) to providers/clinics using the EHR.

There are likely to already be activities ongoing in the community to address reduction in use of tobacco products including active medication intervention for current users. The PPS does not need to create a secondary group if such a group exists, but should consider participating in the already established group and bringing recommended activities into the clinical and community settings associated with the PPS.

Suggested milestones

These milestones will help measure the progress towards increasing provider adherence to the USPHS clinical practice guidelines.

- Announcement to community partners on intention to take action on this project and invitation for collaboration.
- Review and update a summary of current institutional policies regarding tobacco-free environment (one time).
- Incorporate provider training in tobacco dependence treatment into hospital privilege requirements and conduct biennial review of progress.
- A PPS-wide policy that ensures tobacco status is queried and documented and that decision-support for treatment is embedded in each encounter.
- Development and use of routine schedule performance measures for monitoring tobacco use screening and treatment.

Consider an annual PPS report summarizing:

- Environmental policies across all PPS members
- Review of trainings completed for providers, calendar of media campaigns, examples of consumer materials utilized
- Sample EHR template for documenting 5 A's
- Quality measure reporting template for monitoring screening, treatment (including referral to NYSSQL and feedback loop), and, if chosen, quit rates – may utilize a variety of data sources for this: PPS performance measurement system/quarterly tracking reports, EHR reports, QARR/HEDIS reports
- Quit Rates

- Dedicated staff who will provide tobacco dependence treatment as outlined by the USPHS Clinical Practice Guidelines[15] and assess the delivery of this treatment in staff performance evaluations.
- MOU with NYS DOH Bureau of Tobacco Control's[16] Health Systems for a Tobacco-Free NY contractors to receive technical assistance on system improvements related to tobacco use cessation. To find the health systems tobacco contractor in your area, contact Julie Wright at julie.wright@health.ny.gov or call the Bureau of Tobacco Control at (518) 474-1515.
- Development and dissemination of a communication strategy for patient and clinician education regarding availability of covered tobacco dependence treatment that encourages patients to use the services.
- Resources budgeted for related community service plan activities.

Possible data sources & references

- Public Health Service-sponsored Clinical Practice Guideline
- Office of Quality and Patient Safety
- NYS Smokers' Quitline

[15] http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html
[16] http://www.health.ny.gov/prevention/tobacco_control/program_components.htm

Project 4.b.ii – Increase access to high quality chronic disease preventive care and management in both clinical and community settings (Cancer)

DSRIP Project Description

The delivery of high-quality chronic disease preventive care and management can prevent much of the burden of chronic disease or avoid many related complications. Many of these services have been shown to be cost-effective or even cost-saving. However, many New Yorkers do not receive the recommended preventive care and management that include screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications. This project is targeted on increasing the numbers of New Yorkers who receive evidence based preventative care and management for chronic diseases.

This project will help to increase access to high quality chronic disease preventative care and management in both clinical and community settings for chronic diseases that are not included in Domain 3 projects, such as cancer.

This project from the Toolkit is not limited to cancer, but can be applied to any chronic disease that is not otherwise addressed in Domain 3. The PPS could implement similar but disease appropriate activities for that chronic disease.

As noted elsewhere, if there is an ongoing activity within the community related to the chosen disease, the PPS should consider joining this activity rather than initiating a separate type of activity.

The Prevention Agenda

This project relates to the *Preventing Chronic Diseases Action Plan* (Focus Area 3) within the Prevention Agenda.

Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings[17]

- *Objective 3.1.1*: By December 31, 2017, increase the percentage of women aged 50-74 years with an income of < $25,000 who receive breast cancer screening, based on the most recent clinical guidelines (mammography within the past two years), by 5% from 76.7% (2010) to 80.5%.
- *Objective 3.1.2*: By December 31, 2017, increase the percentage of women aged 21-65 years with an income of < $25,000 who receive a cervical cancer screening, based on the most recent clinical guidelines (Pap test within the past three years), by 5% from 83.8% (2010) to 88.0%.
- *Objective 3.1.3*: By December 31, 2017, increase the percentage of adults (50-75 years) who receive a colorectal cancer screening based on the most recent guidelines (blood stool test in the past year or sigmoidoscopy in the past 5 years and a blood stool test in the past years or a colonoscopy in the past 10 years): By 5% from 68.0% (2010) to 71.4% for all adults, and by 10% from 59.4% to 65.4% for adults with an income <$25,000.

[17] From the Prevention Agenda website: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/

Suggestions for implementation

- Invite community partners to take part in planning the effort. The NYS Cancer Services Program website[18] includes information about cancer screening-related programs by county.
- Establish comprehensive cancer screening policies/protocols and, where appropriate, standing orders that address the ordering, review, and follow-up of evidence-based cancer screening tests, and which makes use of the clinical care team.
- Establish system-wide approaches for ***alerting providers/care team*** on:
  - Patients due for screening.
  - Follow-up on test results.
- Establish system-wide approaches for ***reminding patients*** they are:
  - Due for screening.
  - In need of follow-up on abnormal results.
- Establish a system-wide approach to monitor and share practice screening performance results with all care team members.
- Establish a workforce to provide culturally-appropriate navigation services[19] to patient populations with low screening rates.

Suggested milestones

- Announcement to community partners on intention to take action on this project and invitation for collaboration.
- Increased provider/care team knowledge of screening protocols and clinical practice guidelines.
- Increased rates of high-quality screening (or re-screening) among defined patient populations.
- Increased adherence to timely follow-up of abnormal cancer screening results.
- Resources budgeted for related community service plan activities.

Possible data sources & references

- PPS's ongoing performance measurement system and quarterly tracking reports
- PPS Electronic Health Record(s)
- e-BRFSS and BRFSS
- QARR/HEDIS

Quantitative measures to consider:

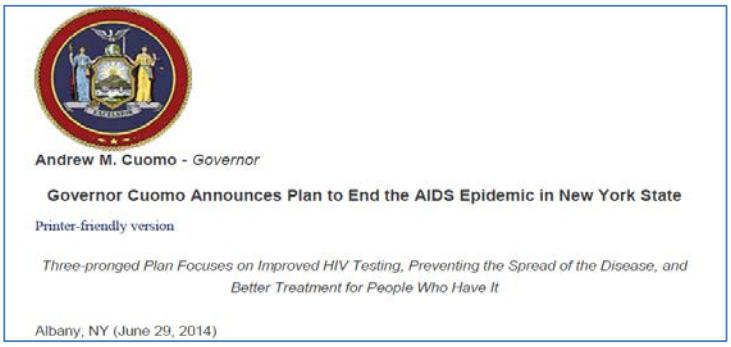
- Number of organizations with comprehensive cancer screening policies/protocols/workflows in accordance with clinical practice guidelines.
- Number of organizations/practice settings with provider/care team reminder systems in place.
- Number of organizations/practice settings with patient reminder systems in place.
- Number of organizations/practice settings with provider/care team assessment and feedback systems in place.
- Number of patients receiving culturally-appropriate navigation services.

[18] http://www.health.ny.gov/diseases/cancer/services/
[19] http://pbrn.ahrq.gov/pbrn-literature/culturally-tailored-navigator-program-colorectal-cancer-screening-community-health

Project 4.c.ii – Increase early access to, and retention in, HIV care

DSRIP Project Description

New York State (NYS) remains at the epicenter of the HIV epidemic in the country, ranking first in the number of persons living with HIV/AIDS. By the end of 2012, approximately 132,000 New Yorkers were living with HIV or AIDS, with nearly 3,300 new diagnoses of HIV infection in 2013. Prevention interventions, including those that affect underlying factors such as stigma and discrimination, are needed to address historical inequities. People of color, men who have sex with men, transgender persons continue to have much higher rates of HIV than the general population. Prevention interventions, including those that affect underlying factors such as stigma and discrimination, are needed to address historical inequities.



Andrew M. Cuomo - *Governor*

Governor Cuomo Announces Plan to End the AIDS Epidemic in New York State

Printer-friendly version

Three-pronged Plan Focuses on Improved HIV Testing, Preventing the Spread of the Disease, and Better Treatment for People Who Have It

Albany, NY (June 29, 2014)

Defining the "End of AIDS"

A 3-Point plan announced by the Governor on June 29, 2014:

1. Identify all persons with HIV who remain undiagnosed and link them to health care.
2. Link and retain those with HIV in health care, to treat them with anti-HIV therapy to maximize virus suppression so they remain healthy and prevent further transmission.
3. Provide Pre-Exposure Prophylaxis (PrEP) for high risk persons to keep them HIV negative

Reduce the number of new HIV infections to just 750 (from an estimated 3,000) by 2020.

PPS's implementing this HIV project chose a variety of initiatives such as increase early access to and retention in HIV care; peer-led interventions; educational campaigns to improve health literacy and patient participation in healthcare; HIV interventions to address homelessness, substance use, history of incarceration, and mental health; cultural competency training for providers; quality indicators for all parameters of treatment for all health plans; empowerment of people living with HIV/AIDS to help themselves and others around issues related to prevention and care; patient education to know their right to be offered HIV testing in hospital and primary care settings; interventions directed at high-risk individual patients, such as therapy for depression; group or behavioral change strategies in conjunction with HIV/STD efforts; formal partnerships between school clinics and community-based organizations to deliver health education and support teacher training programs and delivery of HIV/STD Partner Services to at risk individuals and their partners.

Prevention Agenda and Ending the Epidemic Goals

Goal #1: Decrease HIV morbidity in New York State

- Address acute HIV infection.
- Improve rates of viral suppression.
- Increase access to PrEP and nPEP.

Goal #2: Increase early access to, and retention in, HIV care in New York State

- Improve consumer linkage and retention.
- Use data to identify and assist patients lost to care or not virally suppressed.

Goal #3: Decrease STD morbidity in New York State

- Expand reimbursement for sexual and drug related health services to targeted populations.
- Promote comprehensive sexual health education.
- Remove disincentives related to possession of condoms.

Goal #4: Decrease HIV and STD disparities in New York State

- Identify and address the needs of key populations.
- Make routine HIV testing routine.
- Expand targeted HIV testing.
- Enhance services to support the non-medical needs of all persons with HIV.
- Promote the health of people who use drugs.
- Health, housing, and human rights for LGBT communities.

Quantitative measures to consider:

- Number of organizations with comprehensive HIV treatment policies/protocols in accordance with clinical practice guidelines.
- Number of visit counts of HIV prevention services such as the offer of Pre-Exposure Prophylaxis (PrEP) for high risk, uninfected persons.
- Number of organizations/practice settings with provider/care team reminder systems in place.
- Number of organizations/practice settings with patient reminder systems in place.
- Number of organizations/practice settings with provider/care team assessment and feedback systems in place.
- Number of patients trained to deliver peer services.
- Number of providers receiving cultural competency training.
- Number of patients in identified high risk populations identified and retained in treatment.

Goal #5: Increase and coordinate hepatitis C (HCV) prevention and treatment capacity in New York State

- Provide HCV testing to persons with HIV.

Suggestions for implementation

- Invite community partners to take part in a collaborative NYC wide planning effort.
- Review and include community recommendations from the Community Health Needs Assessment in plans.
- Develop and adopt policies that support identification and retention in care for HIV positive persons throughout the PPS, including in community-based sites.

Suggested milestones

- By December 31, 2017, increase the percentage of HIV-infected persons with a known diagnosis who are in care by 9% to 72% (Data Source: NYS HIV Surveillance System).
- By December 31, 2017, increase the percentage of HIV-infected persons with known diagnoses who are virally suppressed to 45%. (Data Source: NYS HIV Surveillance System).

Possible data sources & references

- PPS's ongoing performance measurement system and quarterly tracking reports.
- PPS Electronic Health Records.
- QARR/HEDIS.
- Policies and procedures to conduct provider trainings on cultural competency, including gender identity and disability issues.
- Policies and procedures for documenting data to identify vulnerable patients (e.g., collect data on health insurance status, disability, gender, and housing status).
- Policies and procedures for providers to stratify vulnerable populations for intervention, bring high-risk patients in for treatment, develop care plans, connect to community resources, and follow up across settings of care.

- Quarterly reports containing aggregate data on defined vulnerable patients receiving interventions and timely follow up of care plan implementation, e.g., connection to housing services or measuring medication adherence.

Resource

- New York State Department of Health. “2015 Blueprint. Achieving the Goal Set Forth by Governor Cuomo to End the AIDS Epidemic in New York State By the End of 2020.” April 29, 2015. Web May 28, 2015. https://health.ny.gov/EndingtheEpidemic.

Project 4.d.i – Reduce premature births

DSRIP Project Description

Preterm birth, defined as any birth before 37 weeks gestation, is the leading cause of infant death and long-term neurological disabilities in children. Babies born prematurely or at low birth weight are more likely to have or develop significant health problems, including disabling impairments, compared to children who are born at full term at a normal weight. Preterm infants are vulnerable to respiratory, gastrointestinal, immune system, central nervous system, hearing and vision problems, and often require special care in a neonatal intensive care unit after birth. Longer-term problems may include cerebral palsy, mental retardation, vision and hearing impairments, behavioral and social-emotional concerns, learning difficulties, and poor growth. More than 70% of premature babies are late preterm births, delivered between 34 and <37 weeks gestation. While these infants generally are healthier than babies born earlier, they are still three times more likely than full-term infants to die during their first year.

Prematurity can also pose significant emotional and economic burdens on families. In 2010, 11.6% of New York State births were preterm. Babies who are born preterm cost the US healthcare system more than $26 billion annually. In 2007, about 48% of preterm infant hospital stays nationally were paid by Medicaid, the largest source of health insurance for preterm infants. This project is targeted at reducing the rate of preterm births in NYS by at least 12% to 10.2% by December 31, 2017.

This project will help to reduce premature births.

The Prevention Agenda

This project relates to the *Promoting Healthy Women, Infants and Children Action Plan* (Focus Area 1; Goal 1) within the Prevention Agenda.

Focus Area 1, Goal 1: Maternal and Infant Health – Reduce premature births in New York State[20]

Improving the health of mothers and babies is an important public health priority for New York State. Key population indicators of maternal and infant health, including low birth weight, prematurity, and maternal mortality, have not improved significantly over the last decade in New York, and in some instances have worsened. Even in measures where trends are improving, such as reductions in adolescent pregnancy rates and infant mortality rates, there are significant and persistent racial, ethnic and economic disparities.

Suggestions for implementation

- Invite community-based partners to take part in planning the effort.
- Review and include community recommendations from the Community Health Needs Assessment
- Consider integrating into practice:
  - Pregnancy-specific counseling related to smoking behavior in all prenatal care visits.
  - NYS Medicaid Prenatal Care standards and other professional standards of practice such as ACOG guidelines into provision of prenatal care services.
  - Use of paraprofessionals such as community health workers to provide health information, navigation and connection to services, and social support to encourage and reinforce health promoting behaviors

These types of activities may already be occurring in your community or region.

When programs are already in place, the PPS can become a strong partner in addressing these projects due to the number and scope of partners in the PPS itself.

[20] From the Prevention Agenda website: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/wic/focus_area_1.htm

and access to needed services for high-risk pregnant women.
    - HIT system to facilitate intake, enrollment, screening, referrals, follow-up, and care coordination practices across health and human service providers.
- Consider adopting and implementing:
    - Specific innovative or evidence-based clinical care models or practices such as Centering Pregnancy, designed to improve preterm birth rates and other adverse pregnancy outcomes.
    - Specific activities to provide clinical management of preterm labor in accordance with current clinical guidelines.
    - Practices to expedite enrollment in Medicaid and Family Planning Benefit Program.
    - A referral network to refer high-risk pregnant women to home visiting services, based on eligibility criteria, identified needs, and capacity.
- Use Doulas to Improve Birth Outcomes and Decrease Costs for pregnant Medicaid patients to help achieve system transformation in maternal and child health by reducing health disparities in birth outcomes, shortening childbirth-related hospital stays, and reducing the use of costly interventions such as Cesarean section and epidural anesthesia.
- Educate and support women through pregnancy, childbirth, and the early postpartum period. Focus on:
    1. Patients experiencing challenges from social determinants of health such as poverty, food insecurity, domestic violence, and/or unstable housing;
    2. Medically high-risk patients, including those diagnosed with obesity, hypertension, gestational diabetes, Group B strep, perinatal depression, HIV/AIDS, substance abuse, and/or other medical conditions;
    3. Those considered at risk because of age, such as teenagers and women older than 35.

Suggested milestones

- Announcement to community partners on intention to take action on this project and invitation for collaboration.
- The program will educate and support women through pregnancy, childbirth, and the early postpartum period.
  Special focus will be on:
    1. Patients experiencing challenges from social determinants of health such as poverty, food insecurity, domestic violence, and/or unstable housing;
    2. Medically high-risk patients, including those diagnosed with obesity, hypertension, gestational diabetes, Group B strep, perinatal depression, HIV/AIDS, substance abuse, and/or other medical conditions
    3. Those considered at risk because of age, such as teenagers and women older than 35.
- Resources budgeted for related community service plan activities.

Possible data sources & references

- Policies and procedures of prenatal care providers to screen and counsel women for tobacco use.
- Policies and procedures of prenatal care providers related to integration of Medicaid

Quantitative measures to consider:

- Number of prenatal care providers asking all pregnant women about tobacco use.
- Number of prenatal care providers utilizing NYS Medicaid Prenatal Care standards and other professional standards such as ACOG guidelines to enhance provision of prenatal care services. Number of professional development opportunities offered.
- Number of high-risk pregnant women connected to paraprofessionals/ CHWs; number of high-risk pregnant women connected to needed health and social services by paraprofessionals/CHWs.
- Number of clinical care settings including prenatal care providers and birthing hospitals, implementing innovative or evidence-based clinical care models designed to improve pregnancy outcomes.
- Number of birthing hospitals utilizing current clinical guidelines to provide clinical management of preterm labor.
- Number of women enrolled in Medicaid in the first trimester of pregnancy. Number of women enrolled in Family Planning Benefit Program. Number of women referred to Navigators or CACs.
- Number of high-risk pregnant women in the HIT system who were screened for risks; number of referrals made; number of referrals completed; number of health and human service providers participating in the HIT system.
- Number of high-risk pregnant women referred to home visiting services meeting their needs.

Prenatal Care standards and other professional guidelines.

- Quarterly reports containing aggregate data on women receiving paraprofessional services and referrals issued by paraprofessionals to other service providers.
- Quarterly reports containing updates on implementation and progress achieved.
- Policies and procedures of providers to implement current clinical guidelines.
- Quarterly reports on aggregate data of women enrolled in Medicaid in the first trimester, and enrolled in Family Planning Benefit program.
- Completeness of data entry in required fields. Reports generated by HIT system about screenings and referrals.
- Policies and procedures for a referral system. Home visiting program reports on referrals received from the referral system.