

New York State Delivery System Reform Incentive Payment Program Project Toolkit

Overview

The following strategies and projects were chosen by New York State and approved by CMS for use by Performing Provider Systems to develop DSRIP Project Plans. The overall goal of DSRIP is to reduce avoidable hospital use by 25% through transforming the New York State health care system into a financially viable, high performing system. To transform the system, DSRIP will focus on the provision of high quality, integrated primary, specialty and behavioral health care in the community setting with hospitals used primarily for emergent and tertiary level of services. The Performing Provider Systems submitting an application for DSRIP must include at least 5 but no more than 11 projects chosen from the following three domains:

Domain 2: System Transformation Projects

All DSRIP plans must include at least two projects from this domain based on their community needs assessment. At least one of those projects must be from strategy sub-list A and one from either sub-list B or C. Performing Provider Systems can submit up to 4 projects from Domain 2 for valuation and scoring purposes unless the PPS is also qualified to add project 2.d.i, which would be the fifth project. It is the expectation that all primary care practices in the Performing Provider System will meet 2014 NCQA Level 3 standards by the end of DSRIP Year 3. The 2014 NCQA Level 3 standards are aligned with Stage 2 Meaningful Use (MU) standards which are included in the metrics for Domain 2. In some of the projects, PCMH status is specifically noted and, in some, the requirement to meet these standards must be met by DSRIP Year 2.

It is important in the development of PPSs to ensure involvement of a wide variety of health care, behavioral health, long term care (community based and facility based) and community providers to ensure success in system transformation projects. Implementation of system transformation projects should be done with a fresh view of how these multiple providers can be connected and utilized for their expertise to meet the goals of Domain 2.

Domain 3: Clinical Improvement Projects

All DSRIP plans must include at least two projects from this domain, based on their community needs assessment. At least one of those projects must be a behavioral health strategy from sub-list A. Performing Provider Systems can submit up to 4 projects from Domain 3 for valuation and scoring purposes

Domain 4: Population-wide Projects

All DSRIP plans must include at least one project from this domain, based on their community needs assessment and consistent with the Domain 3 projects included in their project plan. Consistent means that it will add a new facet, but not be a duplicate, to the Domain 3 projects and be applicable to the full service area population. Performing Provider Systems can submit up to 2 projects from Domain 4 for valuation and scoring purposes. The Domain 4 projects are based upon the New York State Prevention Agenda. While details of the allowed projects will be included in this Toolkit, additional details and supporting resources will be available on the Prevention Agenda website. Performing provider systems will need to review these details of the Prevention Agenda on the NYS DOH website:

http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm

Section 1: a. DSRIP Projects List

Project Number	DESCRIPTION
Domain 2: System Transformation Projects	
A.	Create Integrated Delivery Systems
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.ii	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))
2.a.iii	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.a.iv	Create a medical village using existing hospital infrastructure
2.a.v	Create a medical village/alternative housing using existing nursing home infrastructure
B.	Implementation of Care Coordination and Transitional Care Programs
2.b.i	Ambulatory Intensive Care Units (ICUs)
2.b.ii	Development of co-located primary care services in the emergency department (ED)
2.b.iii	ED care triage for at-risk populations
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.v	Care transitions intervention for skilled nursing facility (SNF) residents
2.b.vi	Transitional supportive housing services
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.viii	Hospital-Home Care Collaboration Solutions
2.b.ix	Implementation of observational programs in hospitals
C.	Connecting Settings
2.c.i	Development of community-based health navigation services
2.c.ii	Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services
D.	Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations
2.d.i	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
Domain 3: Clinical Improvement Projects	
A.	Behavioral Health
3.a.i	Integration of primary care and behavioral health services
3.a.ii	Behavioral health community crisis stabilization services

3.a.iii	Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance
3.a.iv	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
3.a.v	Behavioral Interventions Paradigm (BIP) in Nursing Homes
B.	Cardiovascular Health—Implementation of Million Hearts Campaign
3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.b.ii	Implementation of evidence-based strategies in the community to address chronic disease – primary and secondary prevention projects (adult only)
C	Diabetes Care
3.c.i	Evidence-based strategies for disease management in high risk/affected populations (adults only)
3.c.ii	Implementation of evidence-based strategies to address chronic disease – primary and secondary prevention projects (adults only)
D.	Asthma
3.d.i	Development of evidence-based medication adherence programs (MAP) in community settings– asthma medication
3.d.ii	Expansion of asthma home-based self-management program
3.d.iii	Implementation of evidence-based medicine guidelines for asthma management
E.	HIV/AIDS
3.e.i	Comprehensive Strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for Management of HIV/AIDS
F.	Perinatal Care
3.f.i	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)
G.	Palliative Care
3.g.i	Integration of palliative care into the PCMH Model
3.g.ii	Integration of palliative care into nursing homes
H.	Renal Care
3.h.i	Specialized Medical Home for Chronic Renal Failure
Domain 4: Population wide Projects: New York's Prevention Agenda	
A.	Promote Mental Health and Prevent Substance Abuse (MHSA)
4.a.i	Promote mental, emotional and behavioral (MEB) well-being in communities
4.a.ii	Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
B.	Prevent Chronic Diseases
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.
4.b.ii	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)
C.	Prevent HIV and STDs
4.c.i	Decrease HIV morbidity
4.c.ii	Increase early access to, and retention in, HIV care
4.c.iii	Decrease STD morbidity

4.c.iv	Decrease HIV and STD disparities
D.	Promote Healthy Women, Infants and Children
4.d.i	Reduce premature births

Section 1. b. DSRIP Project Descriptions

Project Domain	System Transformation Projects (Domain 2) <i>A. Create Integrated Delivery Systems</i>
Project ID	2.a.i
Project Title	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine/ Population Health Management
Objective	
<p>Create an integrated, collaborative and accountable service delivery structure that incorporates the full continuum of care, eliminating service fragmentation while increasing the opportunity to align provider incentives. This project will facilitate the creation of this structure by incorporating the medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system from one that is institutionally-based to one that centers around community-based care. Each organized integrated delivery system (IDS) will be accountable for delivering accessible evidence-based, high quality care in the right setting, at the right time, at the appropriate cost. These organized IDSs will commit to devising and implementing comprehensive population health management strategies and be prepared for active engagement in New York State’s payment reform efforts.</p>	
Rationale and Relationship to Other Projects	
<p>Reducing avoidable hospital activity requires a new vision, with the formation of an integrated delivery system that is community-oriented and incorporates the full continuum of patient care needs including medical, behavioral, long term care, post-acute and social. In this system, avoidable hospital activity will be defined by potentially preventable admissions and readmissions (PPAs and PPRs) that can be addressed early with the right community-based services and interventions. This new vision will require an organizational structure with committed leadership, clear governance and communication channels, a clinically integrated provider network, and financial levers to incentivize and sustain interventions to holistically address the health of the attributed populations. Integrated delivery systems are encouraged to use one of several organizing structures including single governance or joint governance (binding contracts or memoranda of understanding). Regardless of the structure, the IDS will need to demonstrate how it will function as a “coordinated network” and not as configuration of independent organizations. It is also anticipated that, over time, the organizational structure will evolve and the relationships between providers will deepen. An integrated delivery system will expand access to high quality primary care, participate in payment reform, rebalance/restructure health delivery (including hospital and nursing home bed reduction), enhance community based services (especially behavioral health services), and be driven by a comprehensive community needs assessment and an internal emphasis on quality improvement. Increased structural accountability for quality and a more aligned set of service incentives should be key focus areas in this project.</p>	
Project Index Score	
56	
Core Components	
<p>Each performing provider system will complete the following general steps :</p> <ul style="list-style-type: none"> • Develop a clearly articulated governance model for the IDS, with appropriate supporting legal structures. The model of governance should incorporate participating providers and include meaningful consumer and patient representation. The governance model should also promote increased collective accountability for quality of care improvements and key 	

governance partners should work to develop shared incentive structures that reward collaboration and reduce fragmentation.

- Health Homes (HH) and Accountable Care Organizations (ACOs) are encouraged to consider evolving into IDSs, in concert with other providers. In their current status, HH and ACOs have features of the integrated delivery system envisioned in this strategy; however, they will need to engage a broader group of providers to qualify as an IDS. True integration requires a broader governance structure, broader health information sharing capabilities, real service integration and more in depth vision incorporating a population management strategy than the populations eligible for Health Home or ACO services in their current system.
- Re-balance the health care delivery system in ways that are consistent with the health care needs of the community served by the IDS. Each IDS will need to complete, and continuously update, a comprehensive community-based health needs assessment, that should build on Internal Revenue Service 501 (c)(3) and relevant state requirements. Based upon the assessment, the system will develop and implement a comprehensive strategy and action plan for development of ambulatory/community based health care services, acute care bed reduction, and development of key community partnerships including primary care services, behavioral health services, long term care, pharmacy, school systems (e.g., school based health clinics), social services including social support services, housing, and Health Homes, public safety/criminal justice and local governmental units (health department, SPOA, social services).
- Ensure that patients requiring care coordination receive appropriate health care, including integrated medical and behavioral health care, post-acute care, long term care, social and public health services. These activities should be done in concert with relevant Health Homes and Medicaid Managed Care Plans. It is expected that each IDS will have/develop an ability to share relevant patient information in a timely manner through use of HIT technology so as to ensure that patient needs are met and care is provided efficiently and effectively. Any patients admitted to any hospital in the IDS should have access to well-coordinated discharge planning, including care coordination services. IDS should also employ systems for tracking care outside of hospitals, to ensure that all critical follow up services are in place and recommendations are followed.
- Support EHR linkage by actively participating in the local health information exchange/RHIO/SHIN-NY including supporting notifications/secure messaging. By DSRIP Year 3, all eligible participating providers in the Performing Provider System's integrated delivery system will need to be connected to the local RHIO/SHIN-NY and be actively sharing information across all key clinical partners.
- Expand access to high quality primary care based upon the findings of the community needs assessment. This expansion will require both an increase in primary care capacity as well as a commitment to meeting [2014 Level 3 PCMH](#) [2014 Level 3 Recognition or most current PCMH Recognition Program](#) standards and/or the standards established by the state for the Advanced Primary Care Model by Year 3 of DSRIP. Since [2014 Level-3 PCMH](#) standards align with EHR meaningful use (MU), all provider practices eligible for EHR meaningful use (MU) also must meet that standard by Year 3. As noted above, practices should also collaborate with regional health information exchanges

(RHIOs) wherever possible and utilize the established health information exchange (HIE).

- Contract with Medicaid Managed Care and other payers as a single system and be paid using a value-driven payment system. Systems will need to prepare to take on performance risk and possibly insurance risk as part of their drive toward payment reform.
- Establish monthly meetings with Medicaid managed care plans to discuss utilization trends, performance issues and payment reform.
- Evolve the provider compensation and performance management systems to reward providers for improved patient outcomes through the provision of high quality, coordinated care. PPSs adopting early implementation of these systems will be awarded additional points.
- Develop process improvement capabilities and strategies such as Lean to ensure efficiency and effectiveness within the delivery system.
- Utilize, where appropriate, community health workers, Peers and culturally competent community-based organizations to assist with patient outreach and navigation.
- Demonstrate a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation, including addressing issues of health disparities. This engagement may take place through community needs assessment activities and other demonstrated stakeholder outreach.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) <i>A. Create Integrated Delivery Systems</i>
Project ID	2.a.ii
Project Title	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))
Objective	
To transform <u>all</u> safety net providers in primary care practices into NCQA 2014 Level Three (or most current recognition program) Patient Centered Medical Homes (PCMHs) or Advanced Primary Care Models.	
Rationale and Relationship to Other Projects	
<p>A key component of the health care transformation is the provision of high quality primary care for all Medicaid recipients, and uninsured, including children and high needs patients. The PCMH and Advanced Primary Care models are transformative, with strong focus on evidence based practice, population management, coordination of care, HIT integration, and practice efficiency. Such practices will be imperative as the health care system transforms to a focus on community based services. This project will address those providers who were not otherwise eligible for support in this practice advancement as well as those programs with multiple sites that wish to undergo a rapid transformation. Performing provider systems undertaking this project, while focused on the full range of attributed Medicaid recipients and uninsured, should place special focus on ensuring children and their parenting adults, and other high needs populations have access to the high quality of care inherent in this model, including integration of primary, specialty, behavioral and social care services. The end result of this project must be that all primary care providers within the performing provider system must meet PCMH 2014 Level 3 Recognition or most current PCMH Recognition Program NCQA 2014 Level Three PCMH accreditation and/or meet state- determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3, and successfully sustain that practice model with improvement in monitored quality improvement metrics through the end of DSRIP.</p>	
Project Index Score	
37	
Core Components	

Provider organizations who wish to include this project should review the extensive literature available from such resources as TransformMed (<https://www.transformed.com/>). Practices will be expected to meet NCQA 2014 Level 3 Medical Home [or most current PCMH Recognition Program](#) standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3 (http://www.health.ny.gov/technology/innovation_plan_initiative/). They must also effectively sustain the model and show continuous improvement in monitored practice metrics.

The following components must be included in this project:

- Identification of a physician champion with knowledge of PCMH implementation who can assist with meeting all components of the NCQA requirements including skills of population management through EHR and process improvement methods.
- Gap analysis of practice sites within the PPS system.
- Identification of care coordinators at each primary care site who are responsible for care connectivity and engagement of other staff in PCMH process as well connectivity to other care managers who provide care coordination for higher risk patients (e.g., health home

care managers)

- Implementation of necessary HIT functionality including EHRs that meets meaningful use standards (MU), HIE connectivity, e-prescribing, instant messaging, ER alerts; active participation in local RHIOs/SHIN-NY will also be required by all eligible participating providers in the Performing Provider System.
- Staff training on care model including evidence based preventive and chronic disease management
- Preventive care screenings including behavioral health screenings (PHQ-9, SBIRT) will be implemented for all patients to identify unmet needs. A process must be developed for assuring referral to appropriate care, if not provided in the practice, in a timely manner, including a “warm hand-off” where possible.
- Implementation of open access scheduling
- Development of quality management program to monitor process and outcome metrics and to implement improvement strategies including rapid cycle improvements to ensure fidelity with PCMH standards and practice quality improvement. The program should include reporting to staff and patients.
- Monitoring of financial status
- Demonstration of a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation, including addressing issues of health disparities.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) <i>A. Create Integrated Delivery Systems</i>
Project ID	2.a.iii
Project Title	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
Objective	
To expand access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers from Health Homes) to meet the individual needs of higher risk patients who do not qualify for care management services from Health Homes under current NYS HH standards (i.e., patients with a single chronic condition but at risk for developing another), but who appear on a trajectory of decreasing health and increasing need that will likely make them HH eligible in the near future.	
Rationale and Relationship to Other Projects	
This project represents the level of service delivery and integration falling in between the patient-centered medical home for the general population and the Health Home for the complex super-utilizer population. There is a population of Medicaid members who do not meet criteria for Health Homes but who are on a trajectory that will result in them becoming Health Home super-utilizers. Some risk stratification systems refer to these as “the movers”. These are often persons who have a single chronic disease and are at risk of one or more additional chronic diseases. Their needs are greater than can be met in a standard patient centered medial home, but they do not qualify for care management through a Health Home under current NYS standards (but these patients do qualify under current federal HH standards if they have risk for a second chronic condition). Early preemptive intervention could result in stabilization and reduction in health risk and avoidable service utilization. It is expected that Patient Centered Medical Homes will partner with their local Health Home(s) to implement this project.	
Project Index Score	
46	
Core Components	
<p>All primary care providers in the Performing Provider System (PPS) who are participating in this project must already be an NCQA (2011) accredited Patient Centered Medical Home, level 3, and commit to achieving NCQA 2014 Level 3 PCMH 2014 Level 3 Recognition or most current PCMH Recognition Program or becoming an Advanced Primary Care practice in the first two years of DSRIP. These standards are aligned with requirements for an EHR that meets meaningful use (MU) standards.</p> <ul style="list-style-type: none"> • Performing Provider Systems will do a community needs assessment to identify service area sectors of higher risk patients with insufficient access to/use of primary care services. • Using EHR registries and other community data, at risk patients will be identified who do not already have access to care management services nor are engaged with the care management team. The team will work with the member to develop a comprehensive care management plan to engage him/her in care and to reduce patient’s risk factors • Performing Provider Systems will develop primary care capacity in identified shortage areas based upon the community needs assessment. This may include not only community based services, but also focused services in congregate living sites such as assisted living facilities. • This primary care provider will establish linkages with the local Health Home for care 	

management services.

- The primary care provider with the Health Home will provide linkages with needed services to include behavioral health providers, pharmacists, nurse educators, care managers as well as social services that are necessary to meet patient needs in that community. It is expected the provider will work with local government units such as SPOAs and public health departments where appropriate.
- Evidence based practice guidelines will be implemented to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening/etc.) as well as to ensure appropriate management of chronic diseases (Diabetes/Cardiovascular Disease/Asthma). Assessment of social service needs will be integral to these activities. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population.
- Instant messaging and alerts programs will be implemented to ensure timely sharing of critical patient information across key clinical members of the PPS.
- A dashboard of outcome metrics will be established to monitor the care provision and ensure rapid cycle improvements can be made. A formal quality committee will regularly monitor the outcome metrics and implement improvements using standard process improvement methodology.
- The program will demonstrate a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation, including addressing issues of health disparities.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) <i>A. Create Integrated Delivery Systems</i>
Project ID	2.a.iv
Project Title	Create a medical village using existing hospital infrastructure
Objective	
To reduce excess bed capacity and repurpose unneeded inpatient hospital infrastructure into “medical villages,” integrated outpatient service centers providing emergency/urgent care as well as access to the range of outpatient medicine needed within that community.	
Rationale and Relationship to Other Projects	
<p>With advances in medical technology and methods of delivery, health care systems face the central issue of how and where to provide effective and efficient care. The role of the hospital is evolving in the health care system. With an emphasis on outpatient diagnosis and treatment as well as alternatives to long-term hospital care with reduction in bed utilization, hospital inpatient services cannot provide all of the health care that a community needs, but rather, should be a part of a highly effective, integrated health delivery system. With this understanding, access to high quality primary care and community-based specialty care is a critical component of an effective system of care. To achieve this state, hospitals must continue to undergo delivery and service reconfiguration to promote clinical integration and reduce reliance on inpatient revenue. As more services are delivered in outpatient settings, the state envisions DSRIP as a way to allow hospitals to reduce their inpatient bed capacity, while expanding other services in the continuum of care that meet the needs of the community they serve. These new services can be offered by the hospital itself or in partnership with other providers in the performing provider system. Services can also be offered at alternative locations if it is in the best interest of the community.</p> <p>To achieve this transition, an outdated/unneeded hospital (or portion of a hospital) must be converted into a stand-alone emergency department/urgent care center and/or spaces occupied by local service organizations and primary care/specialized/behavioral health clinics with extended hours and staffing. This reconfiguration, referred to as a “medical village,” allows for the space to be utilized as the center of a neighborhood’s coordinated health network, supporting service integration and providing a platform for primary care/behavioral health integration as envisioned in DSRIP behavioral health projects. The structure of the medical village will be driven by the outcome of the community needs assessment. These new integrated centers will result in a health system that includes organizations with fully integrated provider networks responsible for community health outcomes, a primary focus on quality and service outcomes, enhancement of primary and preventative health care services as well as easier integration of and more incentive to utilize health information technology resources.</p> <p>In order to be successful, a medical village must be part of the broader health care delivery system. To the maximum degree possible it should be part of an “integrated delivery system” and be seen by the community as a one stop shop for health and health care. This is especially true for providers in low income communities with high government payer mix. In order to ensure long run sustainability, medical villages must be a part of larger delivery systems that have an ability to provide high quality care long into the future.</p>	
Project Index Score	
54	
Core Components	

The transformation of hospital infrastructure capacity will be required to be undertaken with current understanding of its catchment area health care needs, capacity issues, currently available services and gaps based upon the community needs assessment. Financial viability analysis of the transformed system will need to be provided. The required components of this project are:

- A clear strategy document that includes current assessment of community and facility service capabilities, expertise and gaps, and community health care needs, and addresses avoidable hospital use. This document must include evidence of community involvement in the development and the specific activities that will be undertaken during the project term.
- A detailed time line documenting the specifics of bed reduction and rationale. Bed reduction must include active or “staffed” beds. A time line will need to include strategies to support staff retraining and redeployment. Providers will be expected to develop a comprehensive workforce plan in concert with their employees and their relevant unions. Included with the time line must be a detailed work plan from which process metrics for Domain 1 will be developed.
- The community-based service delivery capacity that will be built to meet community needs as part of the bed closure process must be specified. Primary care practices developed in this community-based service delivery system must meet [PCMH 2014 Level 3 Recognition or most current PCMH Recognition Program 2014 NCOA Level 3 PCMH](#) standards by end of Year 3 of DSRIP. This includes implementation of an EHR, consistent with the PCMH standards and meeting meaningful use standards. All medical villages must also be connected to the local RHIO/SHIN-NY and actively be sharing information by end of DSRIP Year 3.
- A clear strategy for how the medical village will be integrated into a broader health care delivery system that is capable of participation in broader payment reform.
- Any services that migrate to a different setting or location (clinic, hospitals, etc.) must be supported by the comprehensive community needs assessment.
- Financial section must be included with a detailed operating budget by cost category including personnel costs, FTE data, OTPS and additional capital costs. The applicant must show that the medical village will be financially sustainable well into the future.
- Demonstration of a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation including addressing issues of health disparities.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) <i>A. Create Integrated Delivery Systems</i>
Project ID	2.a.v
Project Title	Create a medical village/alternative housing using existing nursing home infrastructure
Objective	
To transform current nursing home infrastructure into a service infrastructure consistent with the long term care programs developing in the state to help ensure that the comprehensive care needs of this community are better met.	
Rationale and Relationship to Other Projects	
<p>Over the past decade, while there have been increases in persons having long term care needs, there has been a shift in the care delivery system with increasing emphasis on home and community based services, including the recognition of Naturally Occurring Retirement Communities (NORCs). This shift in care delivery site has lead and will continue to lead to reductions in the numbers of needed skilled nursing home (SNF) beds. New York is committed to providing home and community based services that promote independence and self-directed care, safety and dignity. New payment strategies that include Medicare such as Institutional Special Needs Plans and Fully Integrated Dual Eligibles as well as Medicaid Managed Long Term Care are changing payment systems. Hence, nursing homes must undergo a delivery and service reconfiguration to deliver the most meaningful services to its patient population in this changed environment. As more services are delivered in the community, New York State envisions the SNF Medical Village Project as a way to allow nursing homes to reduce their bed capacity, while creating other services in the continuum of care that meet the needs of the community they serve, such as respite services (Scheduled Short Term Admissions), NYS certified adult home, a certified Enriched Housing Program, licensed assisted living residence (Basic, Enhanced, Special Needs), and transitional supportive housing (as defined in DSRIP Glossary). This hub model of care may include providing primary and geriatric care providers as well as specialty clinics in a reconfigured site. This should also address improved care coordination for patients who may move through the various service types (e.g., home care) in the PPS based upon medical and behavioral health stability with the goal that the patient is the locus of the coordination of care and has a single medical record that is available to the care providers no matter the specific site of care. This may include increased reliance on technology to support patient independence. The array of new/modified services must be developed based upon the community needs assessment and must take into account the presence of NORCs and their unique service needs.</p> <p>This program is also an opportunity for nursing homes, in collaboration with hospitals and other providers, to move more urgent care services (e.g., IV fluids/antibiotics) and sub-acute services (step down acute care services) into the nursing home, reducing avoidable hospital use and reserving hospital services for truly acute care. Additionally, facilities with high rates of avoidable hospitalizations would be encouraged to apply, so as to reduce the capacity of poorer-performing nursing homes and realign those resources to provide, more effective and efficient out-patient and long term care services.</p> <p>Regardless of which model is implemented each facility will be expected to be part of an integrated delivery system that is dedicated to better patient care. Providers will need to demonstrate that all the services provided are part of a broader continuum of care and there is a clear commitment to pursuing payment reform in the near future.</p>	

Project Index Score
42
Core Components
<p>Providers undertaking this project will be required to undertake an assessment of the current and future anticipated health care needs for the aging and disabled population in their region, in alignment with care in the least restrictive environment. The following key components must be defined within a clear project plan with identified milestones that will become the process metrics for this project:</p> <ul style="list-style-type: none"> • Clear statement of how the infrastructure transformation program will promote better service and outcomes (service volume, occupancy statistics, etc.) for the community based upon the community needs assessment including evaluation of specific planning needs for any NORCs occurring within the PPS. • Financial section with a detailed operating budget by cost category including personnel costs, FTE data, OTPS and additional capital costs must be included. This should include financial projections for the planned infrastructure changes. • A defined timeline for accomplishing the project’s activities/goals that will be used for Domain 1 milestones. • A clear description of how this re-configured facility will fit into a broader integrated delivery system that is committed to high quality care and willing/able to participate in payment reform. • Documentation that any and all housing plans are consistent with the Olmstead Decision and any other federal requirements. • A workforce plan which outlines how workers will be retrained in order to provide services in the new system. This plan should be developed in concert with current employees and their unions. • The provision of non-long term care services at these reconfigured facilities is encouraged. Services that are offered should be driven by the comprehensive needs assessment and be designed to reduce avoidable hospital use. • Any Closure Plan should outline how this will be accomplished with a clear timeline for implementing closure and the effect on employees (including severance and other closure costs not covered by other assets of funds, costs related to job relocation, retraining efforts, transitioning of staff to alternate service areas in facility, etc.). • Additional points will be given to any project involving the closure or downsizing of capacity in poorly performing nursing homes (assuming the community needs assessment supports the downsizing). • Specific community-based services that will be developed in lieu of these beds based upon the community need. If primary care practices are implemented in this project, they are required to meet PCMH 2014 Level 3 Recognition or most current PCMH Recognition Program 2014-NCQA Level 3-PCMH standards end of DSRIP Year 3 and have implemented an EHR that meets meaningful use (MU) standards. • Demonstration of a clear cultural competence and willingness to engage Medicaid members in the design and implementation of this system transformation including addressing issues of health disparities.
Outcome Metrics
Domain 2 Metrics

Project	System Transformation Projects (Domain 2)
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Domain	B. Implementation of Care Coordination and Transitional Care Programs
Project ID	2.b.i
Project Title	Ambulatory Intensive Care Units (ICUs)
Objective	
Create ambulatory ICUs for patients with multiple co-morbidities including non-physician interventions for stabilized patients with chronic care needs.	
Rationale and Relationship to Other Projects	
An ambulatory ICU, the term for multi-provider team based visits for patients with complex medical, behavioral, and social morbidities, and for community based non-physician care for stable patients in need of chronic disease monitoring, allows efficient provision of complex services by allocating levels of service only as needed. This model is based upon the Nuka team based care program (http://www.cmgc.com/media/handouts/29IH01/M22_NukaModel_Eby.pdf) endorsed by the Institute for Healthcare Improvement. Nuka is an Alaskan Native word that means a strong, living, and large structure.	
Project Index Score	
36	
Core Components	
<p>The following components must be included in this program:</p> <ul style="list-style-type: none"> • Identification of need for complex specialty services in a community including input by community providers and social agencies • Development of specialty services network to include medical, behavioral health, nutritional, rehabilitation and other necessary provider specialties to participate in the ambulatory ICU • Identification of and integration into model of primary care physicians/practitioners interested in the ambulatory ICU program • Identification of eligible population of patients through EHR patient registries and community and Health Home referrals • Co-locating care managers, including from Health Homes for all HH eligible members, and social support services on site in ambulatory ICU clinic. • Development of an EHR meeting meaningful use standards, having HIE connectivity, having the ability to provide notifications and secure messaging to ensure complete access to all patient medical information, and having a patient portal to support communication and self-management skills. • Team based review of care planning. • A process for connectivity to the assigned health plan Primary Care Provider (PCP) and real time notification to the Health Home care manager as applicable should be developed as part of this project. • Quality program monitoring the ambulatory ICU and outcome metrics and implementing appropriate identified actions. Rapid cycle improvement methodology should be part of the quality program. • Demonstration of a clear cultural competence and willingness to engage Medicaid members in 	

the design and implementation of system transformation including addressing issues of health disparities.
Outcome Metrics
Domain 2 Metrics

Project	System Transformation Projects (Domain 2)
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Domain	B. Implementation of Care Coordination and Transitional Care Programs
Project ID	2.b.ii
Project Title	Development of co-located primary care services in the emergency department (ED)
Objective	
To improve access to primary care services with a PCMH model co-located/adjacent to community emergency services	
Rationale and Relationship to Other Projects	
<p>Patients in certain communities are accustomed to and comfortable with seeking their health care services in the hospital setting, frequently leading to over use of emergency room services for minor conditions while missing preventive health care services. This model allows a facility to have a co-located primary care PCMH adjacent to the ED. The PCMH practice, consistent with the model, will have extended hours and open access scheduling. This will allow patients presenting to the ED who, after triage, are found not to need emergency services to be redirected to the PCMH, beginning the process of engaging patients in comprehensive primary care.</p> <p>Medical villages with free standing emergency rooms would be particularly valuable sites to have such a co-located PCMH practice.</p>	
Project Index Score	
40	
Core Components	
<p>Performing provider systems planning to implement this project will need to provide justification for this service structure utilizing its community assessment. The basic components of this project are as follows:</p> <ul style="list-style-type: none"> • Based upon a community assessment of need for primary care services, analysis of service type provided by community ED, and zip code analysis of ED patients seeking non-acute services to ensure appropriate location of the co-located primary care, a performing provider system can seek to recruit or relocate a PCMH into the same facility as the community ED. These relocated PCMH practices are expected to meet NCQA 2014 Level 3 PCMH/PCMH 2014 Level 3 Recognition or most current PCMH Recognition Program standards within 2 years after relocation. Because these standards are aligned with NCQA 2014 Level 3 PCMH/PCMH, these practices are also expected to have an EHR that meets meaningful use (MU) standards. • If a new practice is started at this site, it will be required to meet NCQA 2014 Level 2 PCMH standards by end of Year 2, and Level 3 or most current PCMH Recognition Program or Advanced Primary Care Practice by end of Year 3. Minimally at start up, the practice will need to have open access scheduling and extended hours and have EHR capability that is interoperable with the ED. • Practitioners in the ED and the PCMH will develop care management protocols for triage and referral to ensure compliance with EMTALA standards. • EHR with HIE connectivity including secure messaging and alerts will be needed to ensure rapid communication of service updates and sharing of medical records between the two services. 	

- As part of the PCMH model, a care coordinator will assist patients in understanding use of the health system, increasing confidence in self-management of common conditions, and increasing knowledge on appropriate care for common conditions based upon evidence based medicine guidelines.
- Payment and billing strategy will need to be addressed in the project plan. The PCMH may only bill usual primary care billing codes and not emergency billing codes.
- A process for connectivity to the assigned health plan Primary Care Provider (PCP) and real time notification to the Health Home care manager as applicable should be developed as part of this project. The care coordinator should ensure that the patient who has an assigned PCP is assisted in seeking care at that site or, only if the patient wishes, is assisted in transferring primary care services to the collocated PCMH.
- Utilizing culturally competent community based organizations to raise community awareness of alternatives to the emergency room including using home visiting in target neighborhoods with excess avoidable emergency department use.
- The involved practices will need to demonstrate a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation including addressing issues of health disparities.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) B. Implementation of Care Coordination and Transitional Care Programs
Project ID	2.b.iii
Project Title	ED care triage for at-risk populations
Objective	
To develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health condition(s), improve provider to provider communication, and provide supportive assistance to transitioning members to the least restrictive environment.	
Rationale and Relationship to Other Projects	
Emergency rooms are often used by patients to receive non-urgent services for many reasons including convenience, lack of primary care physician, perceived lack of availability of primary care physician, perception of rapid care, perception of higher quality care and familiarity. To impact avoidable emergency room use, these reasons need to be addressed and the value of having an available source of primary care emphasized. Open access scheduling, EHRs and extended hours in PCMH as well as patient navigators can all be part of the solution. The key will be to connect frequent ED users with the PCMH providers available to them.	
Project Index Score	
43	
Core Components	
<p>The following components are included in this project:</p> <ul style="list-style-type: none"> • The participating emergency departments (ED) will establish linkages to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. All practices participating in this project are expected to meet NCQA 2014 Level 3 or most current PCMH Recognition Program standards which include having an EHR that meets meaningful use (MU) by end of Year 3 of DSRIP. A process for connectivity between the emergency department and community primary care providers, e.g., the assigned health plan Primary Care Provider (PCP) for a patient accessing the ED, and real time notification to a Health Home care manager as applicable must be developed as part of this project. • For patients presenting with minor illnesses who do not have a primary care provider, once required medical screening examination is performed validating a non-emergency need, patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider with whom they can establish a care relationship. In addition, they may assist the patient with identifying and accessing needed community support resources. For patients with a primary care provider, the patient navigator will assist the member in receiving a timely appointment with that provider’s office. It is expected that the triage information for the patient in either scenario will be timely transmitted to the provider’s office. • In a collaborative model between an ED and first responders working with established protocols and under supervision of the ED practitioners, patients calling for ambulance services for non-acute disorders could be transported to alternate care sites including the PCMH to receive more 	

appropriate level of care. (This component is optional.)

- Service providers must demonstrate a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation including addressing issues of health disparities. This should include educational activities, appropriate to the community, providing information about how and where to access health care services including the role of the primary care provider, urgent care and the emergency room. This education, done in collaboration with community-based organizations, should include information about community resources including phone numbers, hours of service, etc. and should be available in literacy and language levels appropriate to the community.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) B. Implementation of Care Coordination and Transitional Care Programs
Project ID	2.b.iv
Project Title	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
Objective	
To provide a 30 day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly those with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.	
Rationale and Relationship to Other Projects	
A significant cause of avoidable readmissions is non-compliance with discharge regimens. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. These can be addressed by a transition case manager working 1 on 1 with the patient to identify the relevant factors and find solutions. Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/ .	
Project Index Score	
43	
Core Components	
Systems undertaking this project will be required to complete the following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30 day transition period post hospitalization to ensure patient understanding of self-care and receipt of follow-up care: <ul style="list-style-type: none"> • The community assessment will be utilized to identify the key causes of readmissions at the partner hospitals, including diagnoses, identifiable social concerns including housing, dietary resources, transportation and health literacy barriers, and medically related concerns such as lack of engagement with a primary care provider, medication access and medication reconciliation. • These hospitals, partnering with a home care service or other appropriate community agency, will develop standardized protocols to assist patients in the development of solutions for the identified issues. • The PPS will engage with the Medicaid Managed Care Plans and Health Homes, as applicable, associated with their identified population to develop transition of care protocols that will ensure coordination of care will be supported, covered services including DME will be readily available and that there is a payment strategy for the transition of care services. The PPS will have a protocol for patients identified as eligible for Health Home services to ensure linkage with those services as required under the ACA. • The PPS will ensure required social services are included in their network. These may include unique services such as medically tailored home food services. • Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient in the hospital to develop the transition of care services. • Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider. 	

- A 30 day transition of care period will be utilized for this program.
- The PPS will demonstrate a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation including addressing issues of health disparities.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) B. Implementation of Care Coordination and Transitional Care Programs
Project ID	2.b.v
Project Title	Care transitions intervention for skilled nursing facility (SNF) residents
Objective	
Utilizing a similar model as 2.b.iv, this will provide a supported transition period after a hospitalization to ensure discharge directions are understood and implemented for skilled nursing home patients at high risk of readmission, particularly those with cardiac, renal, diabetes, respiratory and/or psychiatric disorders.	
Rationale and Relationship to Other Projects	
<p>Nursing home patients with recent hospital discharges are at risk of early re-hospitalizations even though they are in a controlled medical environment. This is often due to inadequate care coordination between the SNF staff and the hospital staff. For example, discharge summaries may not be complete nor include minor facts that can become significant in the SNF environment. Additionally, information about treated precursors to pressure ulcers or increased risk for healthcare associated infections may not be fully transferred, preventing what should be continuous surveillance measures.</p> <p>Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/.</p>	
Project Index Score	
41	
Core Components	
<p>Systems undertaking this project will be required to complete the following components to meet the two main objectives of this project, 1) SNF staff access to hospital patient record and hospital staff prior to patient discharge and 2) timely care record transition to SNF and receiving practitioner:</p> <ul style="list-style-type: none"> • The community assessment will be utilized to identify the key causes of SNF readmissions at the partner hospitals, including diagnoses, identifiable social concerns, and medical issues such as lack of engagement with a primary care physician, medication access and medication reconciliation. • These hospitals will partner with associated SNFs to develop a standardized protocol to assist with resolution of the identified issues. This may include development of a standard medical record transfer form to follow the patient during any care site transfer. • The PPS will engage with the Medicaid Managed Care and Managed Long Term Care or FIDA Plans associated with their identified population to develop transition of care protocols that will ensure coordination of care will be supported, covered services including DME will be readily available and that there is a payment strategy for the transition of care services. • Transition of care protocols will include as early as possible notification of planned discharges and the ability of the SNF staff to visit the patient and staff in the hospital to develop the transition of care services. SNF staff will be allowed access to review the hospital medical record. Additionally, SNF staff will be able to discuss patient care issues with the staff caring for the patient prior to discharge and additional access to staff post-discharge/re-admission to the SNF. • Protocols will include standardized care record transitions to the SNF staff and medical personnel. • Hospitals and SNFs will be expected to have shared EHR system capability and RHIO HIE access for 	

electronic transition of medical records by the end of DSRIP Year 3.

- Both hospital and SNF will demonstrate a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation including addressing issues of health disparities.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) <i>B. Implementation of Care Coordination and Transitional Care Programs</i>
Project ID	2.b.vi
Project Title	Transitional supportive housing services
Objective	
Participating hospitals will partner with community housing providers and, if appropriate, home care services to develop transitional housing for high risk patients who, due to their medical or behavioral health condition, have difficulty transitioning safely from a hospital into the community.	
Rationale and Relationship to Other Projects	
Access to safe supportive housing (as defined in the DSRIP glossary) has been shown to be a key determinant in stabilizing chronically ill super-utilizers of the health care system. The availability of safe supportive housing and home care services including unique services such as medically tailored home food services could allow the transitioning patient to stabilize in the outpatient, community setting instead of “ping-ponging” back to the hospital due to social and housing uncertainties. Such housing would provide short term care management to allow transition to a longer term care management program or a PCMH, and would allow additional time to support rehabilitation and recovery, stabilization of medical and/or behavioral health condition, and patient confidence in self-management.	
Project Index Score	
47	
Core Components	
<p>Performing provider system hospitals participating in this project will partner with supportive housing services, home care services and other social supportive services in the community to perform the following activities:</p> <ul style="list-style-type: none"> • Perform a community needs assessment that identifies availability of appropriate housing including supportive housing and transitional housing to document the gap between available and needed as part of a community development strategy. • Develop protocols for identifying chronically ill super-utilizers who qualify for this service and develop a priority list for access to housing. Priority should be given to Medicaid members who are Health Home eligible and are at high risk of returning to the hospital. • Develop MOUs that allow the supportive housing staff and home care services to meet with patients in the hospital and plan the transition from inpatient to supportive housing. • Develop coordination of care strategies with Medicaid Managed Care plans to ensure needed services at discharge are covered and in place at the supportive housing site. • Develop transition of care protocols that address medical, behavioral health and social needs of patients. • Ensure medical records and care plans are transmitted timely to patient’s primary care provider and frequently used specialists. • If the member is already in a Health Home, engage with the Medicaid patient’s Health Home care manager to develop safe transition plans; if the member is not in a Health Home, provide a “warm” referral for assessment and enrollment in a Health Home with assignment of a care manager. 	

- Monitor quality of program and success in engaging member in community care, establishing long term safe housing and social stability and reducing avoidable hospitalizations.
- Demonstrate a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation including addressing issues of health disparities.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) <i>B. Implementation of Care Coordination and Transitional Care Programs</i>
Project ID	2.b.vii
Project Title	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
Objective	
The skilled nursing facilities (SNF) will implement the evidence-based INTERACT program developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a contract from the Centers for Medicare and Medicaid Services (CMS).	
Rationale and Relationship to Other Projects	
<p>INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute changes in a resident’s condition in order to stabilize the patient and avoid transfer to an acute care facility. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities. The current version of the INTERACT Program was developed by the INTERACT interdisciplinary team under the leadership of Dr. Ouslander, MD with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) supported by the Commonwealth Fund. There is significant potential to further increase the impact of INTERACT by integrating INTERACT II tools into the SNF health information technology through a standalone or integrated clinical decision support system.</p>	
Project Index Score	
41	
Core Components	
<p>The SNF(s) in the PPS will need to undertake the following activities:</p> <ul style="list-style-type: none"> • Engagement and education of leadership in the INTERACT principles • Identification of a facility champion who can act to engage other staff and serve as a coach. • Development of care pathways and other clinical tools for the monitoring of chronically ill patients with the goal to early identify potential instability and allow intervention to avoid hospital transfer. Education of all staff on care pathways and INTERACT principles • Development of Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care. • Coaching program to facilitate and support implementation • Education of patient and family on the initiative and empowering them to participate in planning of care. • Establishment of enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity. • Measurement of outcomes including quality assessment/root cause analysis of transfer to identify interventions. • Use of INTERACT 3.0 toolkit and other resources available at http://www.pathway-interact.com/http://interact2.net • Demonstration of a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation including addressing issues of health disparities. 	
Outcome Metrics	

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) <i>B. Implementation of Care Coordination and Transitional Care Programs</i>
Project ID	2.b.viii
Project Title	Hospital-Home Care Collaboration Solutions
Objective	
Implementation of INTERACT-like program in the home care setting to reduce risk of re-hospitalizations for high risk patients.	
Rationale and Relationship to Other Projects	
<p>Many patients who previously were transferred to skilled nursing facilities are now being discharged to lesser restrictive alternatives, primarily their own home. With the many benefits of returning to a known and personal setting, there are the risks of potential non-compliance with discharge regimens, missed provider appointments and less frequent observation of an at-risk person by medical staff. This project will put services in place to address this problem. It may be paired with transition care management but the service would be expected to last more than 30 days.</p>	
Project Index Score	
45	
Core Components	
<p>This program should be implemented based upon the evaluation of the community assessment evaluation for causes of avoidable admissions and readmissions. The following are core components of this program that will need to be established by the PPS through coordination with participating hospitals including emergency rooms and pharmacy services, home care services, primary care physicians and specialty services:</p> <ul style="list-style-type: none"> • Rapid Response Teams (hospital/home care) to facilitate patients’ discharges to home including assuring needed home care services are in place. • Home care staff with knowledge and skills to identify and respond to patient risks for readmission and to support evidence based medicine chronic care management. • Development of care pathways and other clinical tools for the monitoring of chronically ill patients with the goal to identify early potential instability and allow intervention to avoid hospital transfer. Education of all staff on care pathways and INTERACT principles • Development of Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care. • Coaching program to facilitate and support implementation • Education of patient and family/caretakers on the initiative and empowering them to participate in planning of care. This should include support of the family/caretakers as well as potential for respite services. • Integration of primary care, behavioral health, pharmacy and other services into the model to enhance coordination of care and medication management. • Utilization of telehealth/telemedicine. • Utilization of interoperable EHR to enhance communication, avoid medication errors and duplicative services. • Measurement of outcomes including quality assessment/root cause analysis of transfer to 	

identify interventions.

- Demonstration of clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation including addressing issues of health disparities.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) <i>B. Implementation of Care Coordination and Transitional Care Programs</i>
Project ID	2.b.ix
Project Title	Implementation of observational programs in hospitals
Objective	
To reduce inpatient admissions by creation of dedicated observation units for patients presenting to ED whose need for inpatient services is not clearly defined or who need limited extended services for stabilization and discharge.	
Rationale and Relationship to Other Projects	
While observation beds are not new in hospitals, the goal of this initiative is to bring care coordination services to the unit to ensure continuity of care with community services. Short stay hospitalizations can be related to ambulatory sensitive diagnoses. These admissions would be avoided by improved access to primary care and behavioral health services as well as compliance by the practitioner and patient with evidence based clinical guidelines. Health literacy, community values and language may be barriers to integration of the patient with necessary health care services. Appropriate communication may assist with removing these barriers.	
Project Index Score	
36	
Core Components	
<p>Performing provider systems who undertake this project must justify the need for this intervention based upon the community assessment showing a higher than expected rate of short stay hospital admissions for ambulatory sensitive diagnosis and that this project is planned to specifically address this problem. Applicants cannot use this project to support an already in place observation program unless significantly new wrap around services are put into place and the community assessment supports the need to address additional ambulatory sensitive diagnoses.</p> <ul style="list-style-type: none"> • Providers will create a clinical and financial model supporting the need for the unit to include number of beds, staffing requirements, services definition, and admission, discharge, and inpatient transfer protocols. • Appropriately sized and staffed units will be established in close proximity to ED services unless the services required by the patient are better provided in another specific section of the facility. When the latter occurs, care coordination must still be provided. • Care coordination services will be established to ensure safe discharge either to the community or a step down level of service such as behavioral health or assisted living/SNF. These services will provide the same level of 30 days services as standard transition of care coordination programs but will need to be planned to fit a short stay situation. • EHRs with HIE/RHIO connectivity and ability to send alerts/secure messaging will be required to ensure community providers are aware of short stay patients and will receive sufficient information to accept transfer back to the community and ensure connectivity/continuity with required community services including Health Home services. • A quality assurance program will be established to ensure unit is meeting service and quality outcome goals. This will include a rapid cycle evaluation process that will include representation from community providers and service organizations. • The program will demonstrate a clear cultural competence and willingness to engage 	

Medicaid members in the design and implementation of system transformation including addressing issues of health disparities.
Outcome Metrics
Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) <i>C. Connecting Settings</i>
Project ID	2.c.i
Project Title	Development of community-based health navigation services
Objective	
To develop a community based health navigation service to assist patients to access health care services efficiently.	
Rationale and Relationship to Other Projects	
<p>Health literacy, community values, language barriers, and lack of engagement with community health care services can result in avoidable use of hospital services. People who do not understand how to access and use the health care system cannot be expected to use it effectively. This community resource is not necessarily a licensed health care provider, but a person who has been trained and resourced to understand the community care system and how to access that system including, e.g., assisting patients with appointments and obtaining community services. They may be available face to face, telephonically or through on line services and will have access to language services as well as low literacy educational materials. This service may be developed as an extension project to an existing Health Home program to assist with outreach, engagement and retention in Health Home services. Community navigators may follow a patient longitudinally to ensure the patient is able to access health care and other needed services and is gaining self-confidence in managing his/her health. (Note: While this project and Project 2.d.i both utilize community-based health navigators, the focus of the two projects is very different. Project 2.d.i is focused on persons not utilizing the health care system and working to engage and activate them to utilize the system to see primary and preventive care services. This project is focused on persons utilizing the system but doing it ineffectively or inappropriately. The navigation service here assists these person to access the system effectively and appropriately by providing bridge support until the patient has the self-confidence to manage his/her own health.)</p>	
Project Index Score	
37	
Core Components	
<p>The performing provider system will undertake the following components of this program:</p> <ul style="list-style-type: none"> • The need for this program will be identified through a regional or service area needs assessment. Need may be based on identified language, cultural or health literacy barriers to understanding the health care delivery system, particularly as it transforms and old patterns of care are expected to change. Hot spots of service need may be identified. • Where need is identified, a collaborating program oversight group of medical and behavioral health practitioners and providers and community nursing and social support services will develop a community care resource guide to assist the community resource person and to ensure compliance with protocols. Training protocols will need to be developed and implemented. (Training for community health workers may serve as guidance, despite a different community role.) • Recruitment for the community navigators would ideally be done from the residents in the targeted area to ensure community familiarity. In addition, PPSs should not attempt to “recreate the wheel” 	

- Resourcing for the community navigators will need to be established and could include placement in an ED waiting area, community health center, community meeting center, etc. Telephonic and IT resources including a chat line will need additional resourcing to increase community access to the service.
- Community navigators will need access to non-clinical resources such as transportation and housing services to remove patient barriers to accessing medical and behavioral health care.
- For community navigators who are following patients longitudinally, case loads and discharge processes will need to be established to ensure efficiency in the system.
- Wide marketing of the resource in the community will be done.
- Utilization measures that will be based on the community assessment will need to be developed, collected and reported on to the program oversight committee to understand the effectiveness of the program and changes that are needed.
- Consistent with the need in the community, the program must demonstrate a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation including addressing issues of health disparities.

Outcome Metrics

Domain 2 Metrics

Project Domain	System Transformation Projects (Domain 2) <i>C. Connecting Settings</i>
Project ID	2.c.ii
Project Title	Expand Usage of Telemedicine in underserved areas to provide access to otherwise scarce services
Objective	
Create access to services otherwise not accessible due to patient characteristics, travel distance or specialty scarcity through the use of telecommunication.	
Rationale and Relationship to Other Projects	
<p>Patients may not have access to needed health care services due to patient characteristics (e.g., home bound status), travel distance (particularly in rural New York), and/or specialty scarcity (e.g., child psychiatry services). With the emphasis that NYS has placed on EHR and HIE connectivity as well as other advances in telehealth, these services can be made available to the public where access is otherwise missing. Services can be supplied in the patient home for patient to MD/practitioner management or in the primary care office for enhanced specialty access. This electronic communication encompasses the use of interactive telecommunications equipment that includes, at a minimum, audio and, preferably also, video equipment, and supports direct active communication that is not delayed or stored.</p> <p>Telemedicine projects could address the patient issues such home based telemedicine for chronic disease management and/or specialty scarcity such as telemedicine specialty services for AIDS/HIV, Adult Psychiatry or Child Psychiatry.</p> <p>This service is intended to meet an unmet service need and is not intended to be a convenience service for the member or provider where access is otherwise available.</p> <p>Telemedicine capabilities have also been used to increase primary care provider and other medical personnel’s expertise through programs such as Project Echo (echo.unm.edu/). Modeling of Project Echo is encouraged where appropriate.</p>	
Project Index Score	
31	
Core Components	
<p>Performing provider systems planning to engage in this project will be required to demonstrate from their community assessment that this will have significant impact upon the Medicaid population in their service area. The following components are included in this project:</p> <ul style="list-style-type: none"> • Explanation of how telemedicine services will reduce avoidable hospital use by increasing patient access to services not otherwise available and/or increase specialty expertise of primary care providers and their staff to increase availability of specialty services otherwise not easily available. • Definition of telemedicine service to be supplied (such as access to HIV specialty services) and the rationale for choice, • Equipment specifications and rationale for equipment choice including cost of acquisition, maintenance and sustainability of service. • Definition of service area for implementation including providers that will be participating with clear delineation between telemedicine hub sites versus spoke sites. • Service agreements in place for provision of the telemedicine service such as specialty service, participating primary care networks and nurse triage monitoring. • Standard protocols for the service (such as patient eligibility, appointment availability, medical 	

<p>record protocols, educational standards and continuing education credits) as well as to address consent and confidentiality standards meeting all federal and state requirements.</p> <ul style="list-style-type: none"> • Coordination with Medicaid Managed Care companies to develop and ensure service authorization and payment strategies are in place to support sustainability of patient care uses. • Quality review process to ensure adequate use of services, appropriateness of services and quality of clinical outcomes related to use of services. • Demonstration of a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation including addressing issues of health disparities.
Outcome Metrics
Domain 2 Metrics

Project	System Transformation Projects (Domain 2)
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Domain	D. Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations
Project ID	2.d.i
Project Title	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
Objective	
<p>This project will be focused on increasing patient activation related to health care paired with increased resources that can help the uninsured (UI) as well as non-utilizing (NU) and low utilizing (LU) populations gain access to and utilize the benefits associated with DSRIP PPS projects, particularly primary and preventative services.</p> <p>(Note: While this project and Project 2.c.i both utilize community-based health navigators, the focus of the two projects is very different. This project is focused on persons not utilizing the health care system and working to engage and activate them to utilize the system to see primary and preventive care services. Project 2.c.i is focused on persons utilizing the system but doing it ineffectively or inappropriately. The navigation service in this case assists these person to access the system effectively and appropriately by providing bridge support until the patient has the self-confidence to manage his/her own health.)</p>	
Rationale and Relationship to Other Projects	
<p>People have many reasons they do not interact with the health care system, including lack of knowledge of health issues, language, literacy and health literacy, lack of insurance or understanding coverage, cultural and religious barriers, embarrassment, fear and other life priorities, to name a few. Without targeted activities to address these issues, it will be difficult to engage these persons in managing their health and integrating them into the reformed health care system.</p> <p>Significant efforts have been undertaken to increase access to health insurance and other financial resources to cover the cost of health care; however, without addressing the other aforementioned issues, there will still be a population that remains disenfranchised from the system until a serious/catastrophic event is sufficient to force them to seek care. Engagement with this population will not only require understanding their barriers, but also creating opportunities for this population to gain confidence in their ability to understand their health and how to manage it as well as how to understand and manage their interactions with the health care system.</p> <p>There is a body of literature on patient activation and engagement, health literacy, and practices to reduce health care disparities that can all be used to develop a project that increases access to, and use of, the health care system by the UI, NU and LU populations. These resources include:</p> <p>http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955271/ http://content.healthaffairs.org/content/32/2/223.full https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/index.html http://www.hrsa.gov/publichealth/healthliteracy/ http://www.health.gov/communication/literacy/ http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program.page?</p>	

<http://www.hrsa.gov/culturalcompetence/index.html>

<http://www.nih.gov/clearcommunication/culturalcompetency.htm>

Additionally, when individuals do not have health insurance, they face significant barriers not only accessing the services they need, but also in receiving those services in a timely manner. Cost becomes a significant barrier for those seeking the primary and preventive care they need. Self-pay costs, in most instances, are generally significantly higher than the discounted rates that the government and other insurers can negotiate. Personal barriers noted above may keep persons from self-negotiating for reduced fees or becoming aware of the availability of financial assistance or new options for coverage. The lack of connectivity to primary care and preventive services results in reliance on emergency departments for both minor urgent care and well as true emergent care that was potentially avoidable. Furthermore, health care facility providers are put in a precarious position when providing care to the uninsured, because, by law, providers must service this population when they seek emergency services, while knowing that they may not receive adequate financial compensation for services rendered.

Furthermore, in addition to the state’s uninsured population, there are also Medicaid members with very low to no PCP connectivity to the program. Currently, there are over one million Medicaid members that are enrolled in the program, but not using any services in a given year. Moreover, there is another group of Medicaid members that have minimal service utilization and little to no connectivity with their PCP or care manager. While these may represent generally healthy persons with limited needs for episodic health care, their lack of connectivity with primary and preventive services insures they will not have an adequate entry portal should they have urgent/emergent needs. This continues the cycle of being forced to use urgent/emergency services.

As part of the public comment period on the waiver and attachments, advocates strongly encouraged the state to include uninsured members in DSRIP, so that this population could utilize the benefits of a transformed health care system also. Also, concerns were raised about the NU and LU populations and the ability of PPS to affect their health. This project will focus on these three populations and will require the PPS:

- to develop activities that promote community and patient activation and engagement with the above resources as a starting point,
- to provide community bridges that allow access to health coverage resources, and
- to build linkages to community based primary and preventive services and create community based health education to sustain and grow the community and patient activation in the region they serve.

The PPS will be required to undertake training to perform the Patient Activation Measure and will be required to assess their communities and individual patients on this measure before and at regular intervals during this project. This will provide the quality outcome metrics for this project.

In order to be eligible for this project, a PPS must already be pursuing 10 projects and must demonstrate in its Project Plan application its network capacity to handle an 11th project and how the network is in a position to serve the UI, NU and LU populations. Any public hospital PPS in a specified region would have the first right of refusal in taking on this additional project and having the specified populations in their region attributed to their PPS. Only the uninsured as well as non-utilizing and low-utilizing Medicaid member populations will be attributed to this project.

Project Index Score
56
Core Components

PPSs undertaking this project will be required to complete the following activities which are grouped in three primary activities: patient activation, financially accessible health care resources, and engagement and linkage to primary and preventive care services.

1. Patient Engagement

- Establish a team of appropriate staff who are formally trained in the Patient Activation Measure® (PAM®) and have expertise in developing patient activation and engagement activities to serve as “trainers” for the PPS. DSRIP applications that choose the 11th project must identify the relevant staff that will be designated for this team as part of its proposal.
- Identify “hot spot” areas for UI, NU and LU within the PPS partner network (e.g., emergency rooms), while also working with partnering CBOs who are familiar with, and trusted by the community, to perform outreach in identified hot spots within the service region’s community.
- Work with PPS partners to develop activities, including community forums, surveying the targeted population about health care in the PPS’ region.
- PPS Providers located in “hot spot” areas should be trained by the above trainers in patient activation techniques, including shared decision making, measurements of health literacy, and cultural competency.
- PPS is expected to partner with CBOs to assist in engagement efforts to the project’s targeted populations. PPSs must provide oversight and ensure that engagement is sufficient and appropriate.
- To ensure continuity of care and the importance of an assigned PCP, MCOs will provide PPS with the PCPs assigned to NU and LU enrollees. The PPS must work with the member's MCO and assigned PCP to help reconnect that beneficiary to their designated PCP (see outcome measurements below). This patient activation project is not to be used as a mechanism to inappropriately move members to different health plans and PCPs; but rather, shall be focused on establishing connectivity to resources already available to the member.
 - The PPS will work with the managed care plan and PCP to assure that there is proactive outreach to the beneficiary and that the beneficiary is provided information about insurance coverage, language resources and availability of primary and preventive services. The state must review and approve educational materials provided to beneficiaries that managed care plans or providers develop as part of this effort. Materials should comply with state marketing guidelines and federal regulations at 42 CFR §438.104.
- PPS baselines will be set, by cohort (cohort assignment is based on the MY within which individual received their first PAM survey) and will be used to determine AV award amounts when compared to that cohort’s progress in performance years (subsequent years) during P4P years. The mean of each cohort will serve as the cohorts year end score. PPS base line for each beneficiary cohort (a method will be developed by the state to appropriately identify this cohort) will be measured during first year of the project and at set intervals utilizing the PAM®. A baseline must be set for each cohort and intervals towards improvement must be set at the beginning of each performance period. The PPS will establish the intervals towards improvement that must be achieved at the beginning of each performance period.

- PPS will include beneficiaries as part of a development team to promote preventative care
- Measurement of PAM®
 - PPS will be responsible for screening patient status (UI, NU, LU) and for collecting the most recent contact information for the patient when they visit PPS designated facility or “hot spot” area for health service.

- If the beneficiary is UI, does not have a registered PCP or is attributed to a PCP in the PPS' network, the PPS will be responsible for assessing patient, through PAM survey and designating a PAM score for baseline measure. Individual member score will then be averaged to calculate a baseline measure for that year's cohort. The cohort will be followed for the remainder of DSRIP.
- On an annual basis, the PPS will be responsible for assessing individual member and the overall cohort's level of engagement, with the goal of moving the beneficiary to a higher level of activation.
- If the beneficiary is deemed to be LU & NU, but has a designated PCP that is not part of the PPS' network, the PPS will be responsible for counseling the beneficiary on how to better utilize their existing health care benefits, while also encouraging the beneficiary to reconnect with their designated PCP. The PPS will NOT be responsible for assessing the patient through PAM survey.
 - PPS will also be responsible for providing the most current contact information to the beneficiary's MCO, so that MCO may help the assigned PCP reach out to the member.
- PPS should provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis and to DOH on a quarterly basis so that the state can track engagement and outreach efforts associated with the project.

2. Linkage to Financially Accessible Health Care Resources

- Through engagement PPS will increase the volume of non-emergency (primary, behavioral, dental) care provided to uninsured persons and low utilizing Medicaid beneficiaries through its partner providers.

3. Linkage to Health Care Systems and PPSs

- In collaboration with CBO, the PPS will develop a group of community Navigators who are trained in linkages to health care coverage, community health care resources including for primary and preventive services, and patient education. The PPS must keep record and report to the state, the number of Navigators that it employs. PPS must have a means for Medicaid recipients and project participants to report complaints and receive customer service.
- Community Navigators will receive training in patient activation and education including use of the PAM® so they can appropriately assist project beneficiaries.
- Navigators will be prominently available to the community at PPS "hot spots," PPS partner CBOs, Emergency Departments and community events to ensure there is the ability to have direct hand-offs to the Navigator to educate on health insurance coverage (if applicable), educate on age-appropriate primary and preventive health care services, and to connect with primary and preventative care resources.
- PPS will proactively inform and educate navigators about insurance options and health care resources available to populations in this project.
- PPS will proactively ensure when Navigators call for primary and preventive services for a community member there is appropriate and timely access available.

Outcome Metrics*

Non- and Low Utilizer Medicaid Members

1. Interval change in PAM®— The mean of each cohort will be determined by including each eligible member’s year end score (the last administered PAM survey of each MY). Means in performance years will be compared to means in baseline years. PPS will be awarded AVs depending on the growth of each cohort’s mean PAM score (0.01-0.99 = 25% of AV; 1.00-1.99 = 50% of AV; 2.00-2.99 = 75% of AV; > 3.00 = 100% of AV). The sum of each cohorts AV will be weighted against that cohorts size to determine the entire project AV.
~~Interval change in PAM®—Percent of members measured at Level 3 or Level 4 on the PAM®— Using no less than the 13 item version of PAM® and specific health related behaviors such as self-management behaviors including follow a low fat diet, manage stress in a healthy way and know recommended weight, ask about medication side effects when taking a new prescription; disease specific self-management behaviors including hypertension, arthritis and diabetes; and other variables related to health related quality of life, a measure of depression and a measure of social desirability.~~
2. Use of primary and preventive care services-- Percent of attributed Medicaid members with no claims history for primary care and preventive services in measurement year compared to same in baseline year.

Uninsured Population

1. Interval change in PAM®— The mean of each cohort will be determined by including each eligible member’s year end score (the last administered PAM survey of each MY). Means in performance years will be compared to means in baseline years. PPS will be awarded AVs depending on the growth of each cohort’s mean PAM score (0.01-0.99 = 25% of AV; 1.00-1.99 = 50% of AV; 2.00-2.99 = 75% of AV; > 3.00 = 100% of AV). The sum of each cohorts AV will be weighted against that cohorts size to determine the entire project AV.
- ~~1.—Interval change in PAM®—Percent of members measured at Level 4 on the PAM®— Using no less than the 13 item version of PAM® and specific health related behaviors such as self-management behaviors including follow a low fat diet, manage stress in a healthy way and know recommended weight, ask about medication side effects when taking a new prescription; disease specific self-management behaviors including hypertension, arthritis and diabetes; and other variables related to health related quality of life, a measure of depression and a measure of social desirability.~~
2. Emergency department use by uninsured persons as measured by percent of Emergency Medicaid emergency department claims compared to same in baseline year
3. CG-CAHPS done by the PPS documenting the uninsured experience within the PPS

*Revisions to Project 2.d.i Outcome Metrics were final with the CMS approval of amended STC Attachment I, January 19, 2016

Project Domain	Clinical Improvement Projects (Domain 3) <i>A. Behavioral Health</i>
Project ID	3.a.i

Project Title	Integration of primary care and behavioral health services
Objective	Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.
Rationale and Relationship to Other Projects	<p>Integration of behavioral health and primary care services can serve 1) to identify behavioral health diagnoses early, allowing rapid treatment, 2) to ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects, and 3) to de-stigmatize treatment for behavioral health diagnoses. Care for all conditions is delivered under one roof by known health care providers.</p> <p>This may be achieved by 1) integration of behavioral health specialists into primary care clinics using the collaborative care model and supporting the PCMH model, or 2) integration of primary care services into established behavioral health sites such as clinics and Crisis Centers. When onsite coordination is not possible, then in model 3) behavioral health specialists can be incorporated into primary care coordination teams (see project IMPACT described below).</p> <p>These three projects are outlined in this section. Performing Provider System (PPS) should identify which one of these is most impactful on their population based upon the community assessment data.</p> <p>Any PPS undertaking one of these projects is recommended to review the resources available at http://www.integration.samhsa.gov/integrated-care-models.</p>
Project Index Score	
	39
Core Components	<p>1. PCMH Service Site: Performing provider systems undertaking this project will develop behavioral health services onsite at their 2014 NCQA level 3 PCMH or most current PCMH Recognition Program or Advance Primary Care Model practices. Practices that are not at this level should anticipate meeting it by the beginning of Year 3 of DSRIP. This level of integrated and collaborative care will be required to successfully implement this project. The following components must be met:</p> <ul style="list-style-type: none"> • Provider will work with community, facility and Local Governmental Unit (LGU) Single Point of Access (SPOA) resources to identify behavioral health providers in the community with an interest in developing the collaborative care model with PCMH. This will include a community assessment of most efficient care delivery plan. • With interested community and facility providers, provider will develop structure for integration including governance, MOUs, financial feasibility, and meeting regulatory requirements. • PCMH and behavioral health providers will collaborate on evidence based standards of care including medication management and care engagement process. • Preventive care screenings including behavioral health screenings (PHQ-9, SBIRT) will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service. • A shared EHR/clinical record must be implemented to ensure coordination of care planning. • A quality process and outcome program will be implemented to ensure integration is efficient

and appropriate outcome metrics are met.

2. Behavioral Health Service Site: It is anticipated that the components of this project will mirror those of “1” above with the exception that primary care services will be placed within behavioral health clinics. There are additional specific aspects in the first bullet point that need to be addressed:

- Performing provider systems will identify appropriate behavioral health sites where there can be an efficient integration of primary care services. Provider will work with community, facility and LGU (SPOA) resources to identify behavioral health providers in the community and interest in developing collaborative care model at that behavioral health site. This will include a community assessment of most efficient care delivery plan. Licensure issues for co-located clinics must be addressed.
- With interested community and facility providers, provider will develop structure for integration including governance, MOUs, and financial feasibility.
- PCHM and behavioral health providers will collaborate on evidence based standards of care including medication management and care engagement process.
- Preventive care screenings including behavioral health screenings (PHQ-9, SBIRT) will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.
- A shared EHR/clinical record should be implemented to ensure coordination of care planning.
- A quality process and outcome program will be implemented to ensure integration is efficient and appropriate outcome metrics are met.

3. IMPACT: This is an integration project based on the Improving Mood – Providing Access to Collaborative Treatment (IMPACT) model. The IMPACT model, which originates from the University of Washington in Seattle, integrates depression treatment into primary care and improves physical and social functioning, while cutting the overall cost of providing care. Several community-based primary care providers in New York have experience implementing the IMPACT model. In this model, the behavioral health providers do not necessarily physically integrate into the primary care site.

From <http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/http://impact-uw.org>, the following are the key components of the program that will be expected to be present in this project:

1. Collaborative care is the cornerstone of the IMPACT model and functions in two main ways:

- The patient's primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy)
- Care manager and primary care provider consult with psychiatrist to change treatment plans if patients do not improve

2. Depression Care Manager:

This may be a nurse, social worker or psychologist and may be supported by a medical assistant or other paraprofessional. The care manager:

- Educates the patient about depression
- Supports antidepressant therapy prescribed by the patient's primary care provider if appropriate

<ul style="list-style-type: none"> • Coaches patients in behavioral activation and pleasant events scheduling • Offer a brief (six-eight session) course of counseling, such as Problem-Solving Treatment in Primary Care • Monitors depression symptoms for treatment response • Completes a relapse prevention plan with each patient who has improved <p>3. Designated Psychiatrist:</p> <ul style="list-style-type: none"> • Consults to the care manager and primary care physician on the care of patients who do not respond to treatments as expected <p>4. Outcome measurement:</p> <ul style="list-style-type: none"> • IMPACT care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter. We recommend the PHQ-9 as an effective measurement tool, however, there are other effective tools. <p>5. Stepped care:</p> <ul style="list-style-type: none"> • Treatment is adjusted based on clinical outcomes and according to an evidence-based algorithm • The aim is for a 50 percent reduction in symptoms within 10-12 weeks • If patient is not significantly improved at 10-12 weeks after the start of a treatment plan, the treatment plan is modified. The change can be an increase in medication dosage, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatments suggested by the team psychiatrist. <p>A quality process and outcome program will be implemented to ensure integration is efficient and appropriate outcome metrics are met.</p>
Outcome Metrics
Domain 3. A. Behavioral Health (do not include SNF based metrics)

Project Domain	Clinical Improvement Projects (Domain 3) <i>A. Behavioral Health</i>
Project ID	3.a.ii

Project Title	Behavioral health community crisis stabilization services
Objective	
To provide readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis.	
Rationale and Relationship to Other Projects	
Routine emergency departments and community behavioral health providers are often unable to readily find resources for the acutely psychotic or otherwise unstable behavioral health patient. The Behavioral Health Crisis Stabilization Service provides a single source of specialty expert care management for these complex patients for observation monitoring in a safe location and ready access to inpatient psychiatric stabilization if short term monitoring does not resolve the crisis. A mobile crisis team extension of this service will assist with moving patients safely from the community to the services and do community follow-up after stabilization to ensure continued wellness.	
Project Index Score	
37	
Core Components	
<p>Performing provider systems undertaking this project must first assure that the need is supported by the community assessment process and that service development is feasible within their community. The following components must be included:</p> <ul style="list-style-type: none"> • A crisis intervention program that, at a minimum, includes outreach, mobile crisis and intensive crisis services as described above. • Close linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services • Agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project. • Development of community and facility consensus on treatment protocols. • Access to a hospital with specialty psychiatric services and crisis oriented psychiatric services • An observation unit within a hospital outpatient facility or at an off campus crisis residence for up to 48 hours of monitoring to attempt stabilization • Development of mobile crisis team with appropriate management skills utilizing evidence based protocols developed by medical and behavioral health staff • EHR and HIE connectivity to allow alerts and secure messaging and to obtain current medical records for the patient. • Concurrence of community of psychiatrists and behavioral health providers to support central triage service based upon community assessment of need • Quality committee for oversight and surveillance of compliance with protocols and quality of care. 	
Outcome Metrics:	
Domain 3. A. Behavioral Health (do not include SNF based metrics)	
Project Domain	Clinical Improvement Projects (Domain 3) <i>A. Behavioral Health</i>
Project ID	3.a.iii

Project Title	Implementation of evidence-based medication adherence program in community based sites for behavioral health medication compliance
Objective	
To assist patients who have difficulty with medication adherence to improve compliance with medical regimens	
Rationale and Relationship to Other Projects	
Medication adherence is particularly important for persons with psychiatric conditions to maintain health and function. This program is based upon shared decision-making and behavior modification to effect sustained change. Tools in the New York City Department of Health and Mental Hygiene’s and the Fund for Public Health NY’s Medication Adherence Project, while not originally focused on behavioral health, would be useful to form the basis of this intervention. Other evidence based tools and educational materials may be used. Various factors influence what we call “non-compliance” including health literacy, cultural values, language, and side effects of treatment. The goal of this program is to assist patients identify these issues and resolve them with motivational interviewing and structured conversations around medication compliance.	
Project Index Score	
29	
Core Components	
<p>Performing provider systems will identify the appropriateness of this program for behavioral health based upon the community assessment process. The following components are required:</p> <ul style="list-style-type: none"> • Identification and engagement of care teams including practitioners, care managers including Health Home care managers, social workers and pharmacists who are engaged with the behavioral health population. It is expected that this project will include a significant number of primary care and other practitioners working with patients with behavioral health issues in order to support its effectiveness. • <u>Understanding of the methods discussed in the toolkit and training guide available through the Fund for Public Health in New York:</u> http://medadherenceresources.com/upload/resources/Education-Tools/MARC%20-%20Medication%20Adherence%20Project%20Toolkit%20and%20Training%20Guide.pdf http://fphny.org/programs/medication-adherence-project-and-the-NYCDHMH/ http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-map-tools-manual.pdf. • https://www1.nyc.gov/site/doh/providers/resources/public-health-action-kits-medication-adherence.page NYC DOHMH • Providers are encouraged to access other supportive educational tools such as provided by NYS OMH and OASAS, and may use other evidence based interventions they have identified. • Quality committee for oversight and surveillance of compliance with protocols and quality of care. • Projects should work closely with Medicaid Managed Care Plans to assure appropriate coordination. 	
Outcome Metrics	
Domain 3. A. Behavioral Health (do not include SNF based metrics)	

Project Domain	Clinical Improvement Projects (Domain 3) <i>A. Behavioral Health</i>
Project ID	3.a.iv

Project Title	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
Objective	
To develop withdrawal management services for substance use disorders (SUD) (ambulatory detoxification) within community-based addiction treatment programs that provide medical supervision and allow simultaneous or rapid transfer of stabilized patients into the associated SUD services, and to provide/link with care management services that will assist the stabilizing patient to address the life disruption related to the prior substance use.	
Rationale and Relationship to Other Projects	
The majority of patients seeking inpatient detoxification services do not require the intensive monitoring and medication management available in the inpatient setting. These patients can be monitored in an outpatient program until stability is assured and, then, rapidly integrated into a co-located outpatient SUD program with PCP integrated team. Additionally, patients will be provided with care management services that will assist the stabilizing patient to organize medical, educational, legal, financial, social, family and childcare services in support of abstinence and improved function within the community. Care management can be provided as part of the SUD program or through a Health Home strongly linked to the SUD program if qualified for Health Home services. Such programs can address alcohol, sedative and opioid dependency as well as provide access to ongoing medication management treatment.	
Project Index Score	
36	
Core Components	
<p>Steps to establish a program includes:</p> <ul style="list-style-type: none"> • Assessment of community need for this service to ensure location and services are coincident. • Establishing referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols. • Addressing licensure/certification status of withdrawal management services based upon service category, i.e., ambulatory detoxification or ancillary withdrawal service. • Identification/recruitment of a medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/Naltrexone as well as familiarity with other withdrawal management agents • Identification of community providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics. • Development of community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training approved by the OASAS medical director, if provided in an OASAS setting. • Development of care management services within the SUD treatment program. For patients who qualify for Health Home services, development of a referral/shared care relationship with appropriate Health Homes. Care management will be expected to continue for the period the patient is in the treatment program. Care management may be enhanced by peer supports. • Agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project. 	

Outcome Metrics
Domain 3. A. Behavioral Health (do not include SNF based metrics)

Project Domain	Clinical Improvement Projects (Domain 3) <i>A. Behavioral Health</i>
Project ID	3.a.v

Project Title	Behavioral Interventions Paradigm (BIP) in Nursing Homes
Objective	
To reduce transfer of patients from a SNF facility to an acute care hospital by early intervention strategies to stabilize patients with behavioral health issues before crisis levels occur.	
Rationale and Relationship to Other Projects	
<p>Many patients in long term care have behavioral health issues as a primary disease or as the result of other ongoing chronic diseases. Despite the prevalence of such problems within the SNF, staff may have inadequate formal training to manage these problems or rely on medication to manage these patients. These patients are a significant cause of avoidable admissions and readmissions to hospitals from SNF. This program provides a pathway to avoid these transfers and to ensure better care for the SNF patient with these diagnosis. Interventions that rely on increased training of the usual care staff to identify and address behavioral health concerns have been found to be effective management tools.</p> <p>Resources from other evidence based SNF initiatives to reduce avoidable hospital admissions, e.g., INTERACT (http://www.pathway-interact.com/http://interact2.net/index.aspx) may be integrated into this program.</p>	
Project Index Score	
40	
Core Components	
<p>The BIP in Nursing Homes model uses SNF skilled nurse practitioners (NP) and psychiatric social workers to provide early assessment, reassessment, intervention, and care coordination for at risk residents to reduce the risk of crisis requiring transfer to higher level of care. Model requires:</p> <ul style="list-style-type: none"> • Augmenting the skills of the clinical professionals in behavioral health issues. • Enabling the non-clinical staff to effectively interact with a behavioral population • Assigning a NP with Behavioral Health Training as a coordinator of care • Implementing a Behavior Management Interdisciplinary Team Approach to care • Implementing a medication reduction and reconciliation program • Increasing the availability of psychiatric and psychological services via telehealth and urgently available providers. • Holistic psychological Interventions • Providing enhanced recreational services • Developing Crisis Intervention Strategies via development of an algorithm for staff intervention and utilizing sitter services • Improving documentation and communication re: patient status • Modifying the facility environment • Agreements with the Medicaid Managed Care organizations (including MLTC and FIDA plans) serving the affected population to provide coverage for the service array under this project. 	
Outcome Metrics	
Domain 3. A. SNF Behavioral Health Metrics	
Project Domain	Clinical Improvement Projects (Domain 3) B. Cardiovascular Health-- Implementation of Million Hearts Campaign
Project ID	3.b.i

Project Title	Evidence-based strategies for disease management in high risk/affected populations. (adult only)
Objective	
To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions	
Rationale and Relationship to Other Projects	
<p>The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of cardiovascular disease. These strategies are focused on improving practitioner population management, adherence to evidence-based clinical treatment guidelines, and the adoption of activities that will increase patient self-efficacy and confidence in self-management. Strategies from the Million Hearts Campaign (http://millionhearts.hhs.gov) are strongly recommended.</p>	
Project Index Score	
30	
Core Components	
<p>Participating provider systems undertaking this project will be required to engage a majority (at least 80%) of their primary care practices in this activity. It is expected that the community assessment will identify key sites that will provide the greatest benefit to the system’s community. The following are key components that need to be included in this project (see Millions Hearts – Hypertension Control – Action Guide for Clinicians: https://millionhearts.hhs.gov/tools-protocols/action-guides.htmlhttp://millionhearts.hhs.gov/Docs/MH-HTN-Clinician-Guide.PDF):</p> <ul style="list-style-type: none"> • Actions to Improve Delivery System Design such as: <ul style="list-style-type: none"> ○ Practices/clinics will build on the current DOH strategies focused on EHR implementation and PCMHs to enhance use of patient registries including recall strategies and implement patient stratification models. It is expected that these practices will be exchange information over the local health information exchange. ○ Practices will adopt and follow standardized treatment protocols for hypertension and elevated cholesterol. ○ Practices will develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management. For patients who are in a Health Home, this should include the Health Home care manager. Practices will provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment. ○ Practices will assure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment. ○ Practices will identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit. ○ Practices will use the EHR to prompt providers to complete the 5 A’s of tobacco control (Ask, Assess, Advise, Assist, and Arrange) • Actions to Improve Medication Adherence, such as: <ul style="list-style-type: none"> ○ Provide once-daily regimens or fixed-dose combination pills when appropriate. • Actions to Optimize Patient Reminders and Supports: <ul style="list-style-type: none"> ○ Document patient driven self-management goals in the medical record and review with 	

<p>patients at each visit.</p> <ul style="list-style-type: none"> ○ Evidence based disease management will be implemented in a culturally appropriate format to encourage patient compliance. ○ Practices will follow up with referrals to community based programs to document participation and behavioral and health status changes. ○ Develop and implement protocols for home blood pressure monitoring with follow up support. ○ Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit. ○ Facilitate referrals to NYS Smoker’s Quitline. <ul style="list-style-type: none"> ● Additional actions may include “hot spotting” strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases. Particular attention should be paid to addressing health care disparities related to this condition. ● Providers should review the Million Lives Campaign and adopt appropriate strategies for their community. These should be identified in the provider’s plan. ● Agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.
Outcome Metrics
Domain 3. B. Cardiovascular Metrics

Project Domain	Clinical Improvement Projects (Domain 3) B. <i>Cardiovascular Health--Implementation of Million Hearts Campaign</i>
Project ID	3.b.ii

Project Title	Implementation of evidence-based strategies in the community to address chronic disease--primary and secondary prevention projects. (adult only)
Objective	
These projects are focused on improving patient self-efficacy and confidence in self-management, and engagement of the at-risk population in primary and secondary disease prevention strategies related to cardiovascular health.	
Rationale and Relationship to Other Projects	
While Project 3.b.i is focused on practice improvement in the management of cardiovascular health, this project focuses on developing community resources that will work collaboratively with community practitioners to assist patients with primary and secondary preventive strategies to reduce their risk factors and ameliorate the long term consequences of cardiovascular diseases and other associated chronic diseases.	
Project Index Score	
26	
Core Components	
<p>Performing provider systems undertaking this project will need to complete the following key components:</p> <ul style="list-style-type: none"> • Providers will develop or partner with community resources to expand the availability of evidence-based self-management programs such as the Stanford Chronic Disease Self-Management Program (CDSMP). • Providers will develop protocols to refer patients with HTN or at high risk for onset of hypertension to community-based self-management programs. • Providers will collaborate with community-based self-management programs to monitor progress of referred patients and make ongoing recommendations. • Performing provider systems that serve food to employees, patients and/or the public will improve the nutritional quality of foods served, including reducing sodium, by adopting comprehensive nutrition standards. • A quality committee will be established including providers and staff from the “wellness center” to monitor the outcomes of the project and implement improvements when indicated. • A protocol should be developed that includes referral to a Health Home when it is evident that that level of care management may be indicated for the patient. When a patient is already part of a Health Home, the program should include the care manager in all communications and collaborate with that person as needed. 	
Outcome Metrics	
Domain 3. B. Cardiovascular Metrics	

Project Domain	Clinical Improvement Projects (Domain 3) <i>C. Diabetes Care</i>
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Project ID	3.c.i
Project Title	Evidence-based strategies for disease management in high risk/affected populations. (adult only)
Objective	
To support implementation of evidence-based best practices for disease management in medical practice.	
Rationale and Relationship to Other Projects	
The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of diabetes. These projects are focused on improving practitioner population management, including consistent implementation of evidence based guidelines for the management of diabetes, and implementation of activities that will increase patient self-efficacy and confidence in self-management.	
Project Index Score	
30	
Core Components	
<p>Participating provider systems undertaking this project will be required to engage a majority (at least 80%) of their primary care practices in this activity. It is expected that the community assessment will identify key sites that will provide the greatest benefit to the system’s community. The following are key components that need to be included in this project:</p> <ul style="list-style-type: none"> • Practices/clinics will build on the current DOH strategies focused on EHR implementation and PCMHs to enhance use of patient registries including recall strategies and implement patient stratification models. It is expected that these practices will be exchange information over the local health information exchange. • Practices will develop care coordination teams including use of diabetes educators, nursing staff, behavioral health providers, pharmacy, and community health workers to address health literacy issues, and patient self-efficacy and confidence in self-management. Where appropriate Health Home care managers can be deployed to assist. • Evidence based disease management will be implemented in a culturally appropriate format to encourage patient compliance. • Additional actions may include “hot spotting” strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases. • Providers should review evidence based strategies and adopt appropriate strategies for their community. These should be identified in the PPS Project Plan. • Coordination with the Medicaid Managed Care organizations serving the affected population. 	
Outcome Metrics	
Domain 3. C. Diabetes Care Metrics	

Project Domain	Clinical Improvement Projects (Domain 3) <i>C. Diabetes Care</i>
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Project ID	3.c.ii
Project Title	Implementation of evidence-based strategies in the community to address chronic disease--primary and secondary prevention projects. (adult only)
Objective	
These projects are focused on improving patient self-efficacy and confidence in self-management, and engagement of the at-risk population in primary and secondary disease prevention strategies.	
Rationale and Relationship to Other Projects	
While Project 3.c.i is focused on practice improvement focused on diabetes care, this project focuses on developing community resources that will work collaboratively with community practitioners to assist patients with primary and secondary preventive strategies to reduce their risk factors for diabetes and ameliorate the long term consequences of diabetes and other co-occurring chronic diseases.	
Project Index Score	
26	
Core Components	
<p>Performing provider systems undertaking this project will need to complete the following key components:</p> <ul style="list-style-type: none"> • Providers will implement CDC-recognized National Diabetes Prevention Programs (NDPP) and/or create linkages with community program delivery sites to refer patients to CDC – recognized programs in the community such as the National Diabetes Prevention Program (NDPP), Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Education (DSME). • Providers will identify patients at high risk for onset of diabetes or with pre-diabetes and refer them to institutional or community NDPP delivery sites. • Providers will collaborate with these sites to monitor progress and make ongoing recommendations. • Focus will be on life style modification including diet, tobacco use, and exercise and medication compliance and will provide recommendations consistent with community resources. • A quality committee will be established including providers and NDPP staff to monitor the outcomes of the project and implement improvements when indicated. • Coordination with the Medicaid Managed Care organizations serving the affected population as well as Health Homes for eligible/involved patients. 	
Outcome Metrics	
Domain 3. C. Diabetes Care	

Project Domain	Clinical Improvement Projects (Domain 3) <i>D. Asthma</i>
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Project ID	3.d.i
Project Title	Development of evidence-based medication adherence programs (MAP) in community settings – asthma medication
Objective	
To assist patients who have difficulty with medication adherence to improve compliance with medical regimens by integrating evidence-based solutions into the provider system	
Rationale and Relationship to Other Projects	
Program is based upon shared decision-making and behavior modification to effect sustained change. This program is conceptually based upon the NYC Department of Health and Mental Hygiene’s and the Fund for Public Health NY’s Medication Adherence Project. Other evidence based training and tools may also be used. Various factors influence what we call non-compliance including health literacy, cultural values, language, and side effects of treatment. The goal of this program is to assist patients identify these issues and resolve them with motivational interviewing and structured conversations around medication compliance.	
Project Index Score	
29	
Core Components Score	
<p>Performing provider systems will identify the appropriateness of this program for asthma management based upon the community assessment process. The following components are required:</p> <ul style="list-style-type: none"> • Identification and engagement of care teams including primary care and specialist practitioners, care managers including Health Home care managers, social workers and pharmacists as indicated for the community population of persons with asthma. It is expected that this project will include a significant number of practitioners working with patients with asthma health issues in order to support its effectiveness. • Understanding and implementing the methodology outlined in the toolkit and training guide available through the Fund for Public Health in New York: http://medadherenceresources.com/upload/resources/Education-Tools/MARC%20-%20Medication%20Adherence%20Project%20Toolkit%20and%20Training%20Guide.pdf; http://fphny.org/programs/medication-adherence-project-and-the-NYCDHMH-medication-adherence-program; http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-map-tools-manual.pdf. Other evidence based tools may also be used. Quality committee for oversight and surveillance of compliance with protocols and quality of care. • Coordination with the Medicaid Managed Care organizations serving the affected population. 	
Outcome Metrics	
Domain 3. D. Asthma Metrics	

Project Domain	Clinical Improvement Projects (Domain 3) D. Asthma
Project ID	3.d.ii
Project Title	Expansion of asthma home-based self-management program
Objective	
To ensure implementation of asthma self-management skills including home environmental trigger reduction, self-monitoring, medication use and medical follow-up to reduce avoidable ED and hospital care. Special focus will be on children where asthma is a major driver of avoidable hospital use.	
Rationale and Relationship to Other Projects	
It is generally thought that emergency department visits and hospitalizations for exacerbations should be considered avoidable events with good asthma management. Often, despite the best efforts of practitioners to implement evidence based practices, patients continue to have difficulty controlling their symptoms. Home-based services can address the factors that contribute to these exacerbations.	
Project Index Score	
31	
Core Components	
<p>Providers will partner with home care or other community based programs to develop a home-based self-management program that will address:</p> <ul style="list-style-type: none"> • Assessment of the home environment and education about the home environment’s role in asthma control • Changing the indoor environment to reduce exposure to asthma triggers such as pests, mold, second hand smoke by providing, coordinating, or linking the client to resources for evidence based trigger reduction interventions e.g. integrated pest management, mold remediation, smoking cessation counseling.” • Training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans. • Coordinated care for the individual with asthma, to include social services and support <ul style="list-style-type: none"> ▪ Periodic follow-up particularly after ED or hospital visit occurs to assist family with root cause analysis of what happened and how to avoid future events. <p>Programs will be built from recommendations of evidence based guidelines for management of asthma.</p> <p>Services will ensure communication and coordination with Medicaid Managed Care plans, Health Home care managers, primary care providers and specialty providers to ensure continuity and coordination of care.</p>	
Outcome Metrics	
Domain 3. D. Asthma Metrics	

Project Domain	Clinical Improvement Projects (Domain 3) <i>D. Asthma</i>
Project ID	3.d.iii
Project Title	Implementation of evidence-based medicine guidelines for asthma management
Objective	
To ensure access for all patients with asthma to care consistent with evidence-based medicine guidelines for asthma management.	
Rationale and Relationship to Other Projects	
This project addresses asthma management issues related to compliance with clinical asthma practice guidelines and to lack of access to pulmonary and allergy specialists in areas of New York State. Asthma action plans and patient self-management are key cornerstones in asthma management. Unfortunately, not all patients are using these tools. In addition, those with difficult to manage asthma may not have ready access to asthma specialists that would be needed for better control.	
Project Index Score	
31	
Core Components	
<p>Where asthma has been identified as a critical cause of avoidable use of hospital services based upon the community assessment plan, the performing provider system will be responsible for implementing the following activities:</p> <ul style="list-style-type: none"> • Establishing collaborations between primary care practitioners, specialists and community based asthma programs (e.g., NYS Regional Asthma Coalitions) to support a regional population based approach to asthma management. • Establishing agreement to adhere to national guidelines for asthma management and protocols for access to asthma specialists. Protocols may include using EHR-HIE connectivity and telemedicine. • Providing educational activities addressing asthma management for primary care providers • Developing a quality committee to assess outcomes including medical record audit to ensure guideline compliance. • Coordination with the Medicaid Managed Care organizations serving the affected population. Coordination should also include Health Homes for involved patients. 	
Outcome Metrics	
Domain 3. D. Asthma Metrics	

Project Domain	Clinical Improvement Projects (Domain 3) E. HIV/AIDS
Project ID	3.e.i
Project Title	Comprehensive Strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations—development of Center of Excellence for management of HIV/AIDS
Objective	
Governor Cuomo has committed the state to end the AIDS epidemic by the end of the decade. This project is part of that overall effort. To reduce transmission of HIV and end the epidemic will require improving identification of those currently infected with HIV, improving access to effective viral suppressive therapy and implementing evidence based prevention and disease management strategies. The ultimate goal of both this project and the “End of AIDS” is consistent long-term viral load suppression (VRL) in as many patients as possible. Linkage to care, retention in care and adherence to medication are all core elements of this process and key to the success of this project.	
Rationale and Relationship to Other Projects	
There are effective strategies to manage viral loads of HIV, slow progression of the disease and reduce transmission. These strategies need to be available to all persons currently infected with HIV and all persons at risk for HIV infection. HCV infection can also be addressed in this scenario.	
Project Index Score	
28	
Core Components	
<p>A performing provider system that has identified HIV/AIDS as a significant issue within their community may choose from two interlocking projects to promote evidence based management of HIV/AIDS:</p> <p>Model 1: Early Access to and Retention in HIV and HCV Care –Scatter Model</p> <p>The performing provider system will be required to implement the following steps:</p> <ul style="list-style-type: none"> • Develop a consulting/referral/educational relation with a center of excellence for management of HIV/AIDS; ensure medical and behavioral health consultation expertise are available. • Identify primary care providers who have significant case loads of patients infected with HIV • Implement training for primary care providers which will include consultation resources from the center of excellence. A recommended training model is Project Echo (echo.unm.edu/), an evidence-based tele-educational program with a proven record of increasing disease specific expertise in primary care providers and their staff. • Develop coordination of care services with behavioral health and social services within or linking with the primary care providers’ offices. Services may include access to unique services such as home based meal delivery for debilitated patients and syringe exchange programs. Linkages should include with Health Home care managers for those patients enrolled in a Health Home and referral process for those eligible for Health Homes but not yet enrolled. • Ensure systems are in place that address patient linkage to care, ensure follow-up and retention in care, and promote adherence to medication management, monitoring and other components of evidence based practice for management of this infection. • Institute a system to monitor quality of care with educational services where gaps are 	

identified.

Model 2: Center of Excellence Management for HIV/AIDS (including HCV)

The performing provide system will be required to implement the following steps:

- Identify site location which would provide access to the population infected with HIV (and/or HCV). Site could be in a hospital or medical village, for example.
- Co-locate at this site services generally needed for this population including primary care, specialty care, dental care, behavioral health services, dietary services, high risk prenatal care and buprenorphine maintenance treatment. Prevention services such as PREP for high risk, uninfected persons should be available. The goal is to have all services on site for “one stop shopping” so medical visits/treatments are efficiently provided and reduce the time persons need to spend addressing this issue.
- Care management services including Health Home care managers for those eligible for Health Homes should additionally be co-located at this site. A referral process and connectivity for referrals should be developed for those persons who qualify for but are not yet in a Health Home.
- Ensure understanding and compliance with evidence based guidelines for management of HIV/AIDS (and HCV).
- Ensure coordination of care between all available services preferably through a single electronic health/medical/care management record. The record should address linkage to care, ensure follow-up and retention in care, and promote adherence to medication management, monitoring and other components of evidence based practice for management of this infection.
- Establish quality of care committee to ensure guideline compliance, review complex cases and review service provision.
- Seek designation as center of excellence from New York State Department of Health.

Outcome Metrics

Domain 3. E. HIV/AIDS Metrics

Project Domain	Clinical Improvement Projects (Domain 3) <i>F. Perinatal Care</i>
Project ID	3.f.i
Project Title	Increase support programs for maternal and child health (including high risk pregnancies) (Example: Nurse-Family Partnership)
Objective	
To reduce avoidable poor pregnancy outcomes and subsequent hospitalization as well as improve maternal and child health through the two years of the child’s life.	
Rationale and Relationship to Other Projects	
High risk pregnancies do not end with the birth of the child, but can continue with high risk parenting situations. Women with high risk pregnancies due to age, social situation or concurrent medical or behavioral health conditions may need significant support beyond obstetrical care to grow a healthy child. Nuclear families and single mothers may not have access to functional parenting skill advice to assist them in the crucial first two years of a child’ life.	
Project Index Score	
32	
Core Components	
<p>For performing partner systems where the community assessment identifies significant high risk obstetrical/parenting cases, there are three options for intervention that may be utilized for this project. Systems should choose one primary project but may also chose components of the other two projects to add as part of their project. They will need to supply justification for the project structure.</p> <p>1. Implementation of an evidence based home visiting model for pregnant high risk mothers including high risk first time mothers. Potential programs include Nurse Family Partnership (http://www.nursefamilypartnership.org/) and Healthy Families New York. If a program is currently in place in the PPS service area, it can only be included in the DSRIP project plan if there is an expansion of the program in some valid manner. The PPS should be partnering with the local department(s) of health for this project.</p> <ul style="list-style-type: none"> • Implement the home visiting model in its standard format—project plan will need to provide time line. • Develop a referral system for early identification of woman who are or may be at high risk. • Establish a quality oversight committee of ob/gyn and primary care providers to monitor quality outcomes and implement new/changes activities as appropriate. A community recipient must be included in the committee. <p>2. Establish a care/referral community network based upon a regional center of excellence for high risk pregnancies and infants. (NB: This is a community based service and does not change any service requirements related to the New York State Regional Perinatal Centers and system of regionalized perinatal services for hospitals.)</p> <ul style="list-style-type: none"> • Identify and engage a regional medical center with expertise in management of high risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center) • Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high risk mother and infant with local community obstetricians and pediatric providers. Service availability will be pregnancy through at least the first year of life. 	

- Develop service MOUs between the multidisciplinary team and ob/gyn providers.
- Utilize best evidence care guidelines for management of high risk pregnancies and newborns.
- Ensure EHR and HIE/RHIO connectivity are in place to ensure real time data sharing, analytic capabilities, and implementation of uniform clinical protocols based upon evidence based guidelines.
- Establish Clinical Quality Committee composed of community practitioners and regional medical center experts to oversee quality of program.

3. Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program.

- Access NYSDOH-funded CHW training program.
- Employ a Community Health Worker Coordinator responsible for supervision of 4 – 6 community health workers. Duties and qualifications are per NYS DOH criteria.
- Identify appropriate candidates for Community Health Worker who meet the following criteria:
 - Indigenous community resident of the targeted area;
 - Writing ability sufficient to provide adequate documentation in the family record, referral forms and other service coordination forms, and reading ability to the level necessary to comprehend training materials and assist others to fill out forms;
 - Bilingual skills, depending on the community and families being served;
 - Knowledge of the community, community organizations, and community leaders;
 - Ability to work flexible hours, including evening and weekend hours.
- Establish protocols for deployment of CHW.
- Monitor outcomes of program.
- Coordination with the Medicaid Managed Care organizations serving the target population is required.

Outcome Metrics

Domain 3. F. Perinatal Care Metrics

Project Domain	Clinical Improvement Projects (Domain 3) G. Palliative Care
Project ID	3.g.i
Project Title	Integration of palliative care into the PCMH model
Objective	
To increase access to palliative care programs	
Rationale and Relationship to Other Projects	
<p>Per the Center to Advance Palliative care, “Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.”</p> <p>(https://www.capc.org/topics/hospital/http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc)</p> <p>Increasing access to palliative care programs for persons with serious illnesses and those at end of life can help ensure care and end of life planning needs are understood, addressed and met prior to decisions to seek further aggressive care or enter hospice. This can assist with ensuring pain and other comfort issues are managed and further health changes can be planned for.</p>	
Project Index Score	
22	
Core Components	
<p>Performing provider systems that have identified a need for palliative care services may choose one of the three palliative care programs as a primary service. They may chose components of the other two programs to facilitate their program. This project develops palliative care services within primary care settings.</p> <p>Performing provider systems will be required to do the following steps:</p> <ul style="list-style-type: none"> • Identify appropriate primary care practices, preferably already using the PCMH model, who are willing to integrate Palliative Care into their practice model. If practices are not in the PCMH model, they will be expected to achieve at least Level 1 of the 2014 standards or most current PCMH Recognition Program standards within the first two years of the project. Provider systems may consider this as a service in a Medical Village in association with the primary care practice. • Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice. • Develop/adopt clinical guidelines agreed to by all partners including services and eligibility. This should include implementation, where appropriate, of the IPOS Staff, IPOS Patient, or IPOS Dem surveys. This should include implementation, where appropriate, of the DOH-5003-MOLST form, the only authorized form in NY for documenting both nonhospital Do Not Resuscitate and Do Not Intubate orders. Engage staff in trainings to increase role-appropriate competence in palliative care skills. • Engage with Medicaid Managed Care to address coverage of services. • Develop a quality committee to monitor and address quality. 	

Outcome Metrics
Domain 3. G. Palliative Care Metrics

Project Domain	Clinical Improvement Projects (Domain 3) G. Palliative Care
Project ID	3.g.ii
Project Title	Integration of palliative care into nursing homes
Objective	
To increase access to palliative care programs	
Rationale and Relationship to Other Projects	
<p>Per the Center to Advance Palliative care, “Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.”</p> <p>(https://www.capc.org/topics/hospital/http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc)</p> <p>Increasing access to palliative care programs for persons with serious illnesses and those at end of life can help ensure care and end of life planning needs are understood, addressed and met prior to decisions to seek further aggressive care or enter hospice. This can assist with ensuring pain and other comfort issues are managed and further health changes can be planned for.</p>	
Project Index Score	
25	
Core Components	
<p>Performing provider systems that have identified a need for palliative care services may choose one of the three palliative care programs as a primary service. They may chose components of the other two programs to facilitate their program. This project develops palliative care services within the skilled nursing home setting, providing on-site management of pain and symptoms and supporting the end of life goals of residents with advanced, life-limiting conditions.</p> <p>-</p> <p>Performing provider systems will be required to do the following steps:</p> <ul style="list-style-type: none"> • Identify appropriate nursing homes willing to integrate Palliative Care into their practice model. • Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the nursing home. • Develop/adopt clinical guidelines agreed to by all partners including services and eligibility. This should include implementation, where appropriate, of the IPOS Staff, IPOS Patient, or IPOS Dem surveys. This should include implementation, where appropriate, of the DOH-5003-MOLST form, the only authorized form in NY for documenting both nonhospital Do Not Resuscitate and Do Not Intubate orders. Engage staff in trainings to increase role-appropriate competence in palliative care skills. • Engage with Medicaid Managed Care to address coverage of services. • Develop a quality committee to monitor and address quality. 	
Outcome Metrics	
Domain 3. G. Palliative Care Metrics	

Project Domain	Clinical Improvement Projects (Domain 3) <i>H. Renal Care</i>
Project ID	3.h.i
Project Title	Specialized Medical Home for Chronic Renal Failure
Objective	
To develop a comprehensive “one stop shopping” practice to manage chronic renal failure	
Rationale and Relationship to Other Projects	
The prevention and management of renal failure requires early identification and implementation of evidence based care, close monitoring, anticipatory guidance and education for the patient, and proactive interventions for ports in anticipation of need for dialysis. A medical home for chronic renal failure would ensure primary care, specialty care including behavioral health, nursing, dialysis, nutritional education services and social supports would be coordinated to optimally manage declining renal function and support improved quality of life for these patients.	
Project Index Score	
29	
Core Components	
<p>Performing provider systems will need to identify that chronic renal failure is a significant medical issue in their service area based upon their community assessment.</p> <p>Program development requires:</p> <ul style="list-style-type: none"> • Identification of nephrologist champion supportive of the new model of care • Identification of primary care physicians/practitioners interested in shared care of their complex renal patients • Identification of support services including behavioral health, social services and dialysis co-located at clinic site for efficiency • Adoption of evidence based practice guidelines and protocols for patient management. • Development of EHR with care planning enhancements for team based records of clinic visits; HIE connectivity for collection of laboratory and other clinical testing; patient portal for self-management and communication with care team • Coordination with the Medicaid Managed Care organizations serving the affected population. 	
Outcome Metrics	
Domain 3. H. I Renal Metrics	

Domain 4: Population-wide Projects: New York’s Prevention Agenda

(https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm ~~2017/index.htm~~)

The following health care delivery sector projects represent priorities in the State’s Prevention Agenda that are intended to influence population-wide health. Performing Provider Systems will select one or more projects from at least one of the four priority areas to include in the final project plan. The selected project should be relevant to the system transformation goals of the Performing Provider System and be consistent with but not duplicative of the projects chosen from Domain 3. The Performing Provider Systems should use the county health assessment data in determining which priority areas are of particular need for the project. Each Prevention Agenda Focus Area has different sets of actions that are relevant to different sectors of the community such as public health, employers, etc. For DSRIP, we are listing the Healthcare Delivery System Sector Projects from the Prevention Agenda website. Each Performing Provider Plan should review the sector projects for their chosen Domain 4 project and review the detailed information that is available on the Prevention Agenda website. The projects are from the Prevention Agenda and further information on these areas and the Prevention Agenda as a whole is available through its website.

Project Domain	Population-wide Projects: New York’s Prevention Agenda (Domain 4) <i>A. Promote Mental Health and Prevent Substance Abuse (MHSA)</i>
Project ID	4.a.i
Project Title	Promote mental, emotional and behavioral (MEB) well-being in communities. (Focus Area 1)
Objective	
The best opportunities to improve the public’s mental health are interventions delivered before a disorder manifests itself in order to prevent its development. This project focuses on increasing the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults.	
Rationale and Relationship to Other Projects	
<ul style="list-style-type: none"> Increasing evidence indicates that promotion of positive aspects of mental health is an important approach to reducing MEB disorders and related problems. The 2009 IOM report concluded that mental health promotion 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 	
Project Index Score	
20	
Core Components	
<p>Healthcare Delivery System Sector Projects: PPS must show implementation of both sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population.</p> <ol style="list-style-type: none"> Identify and implement evidence- based practices and environmental strategies that promote MEB health. A menu of interventions is found on the Prevention Agenda website section, Promote Mental Health and Prevent Substance Abuse Action Plan, under Interventions for Goal 1: To promote mental, emotional and behavioral (MEB) well-being in communities (https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/focus1_by_sector.htm(http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/interventions.htm). Support and facilitate quality improvement of evidence-based practices and environmental strategies that promote MEB health. 	
Outcome Metrics	
Domain 4	

Project Domain	Population-wide Projects: New York’s Prevention Agenda (Domain 4) <i>A. Promote Mental Health and Prevent Substance Abuse (MHSA)</i>
Project ID	4.a.ii
Project Title	Prevent Substance Abuse and other Mental Emotional Behavioral Disorders (Focus Area 2)
Objective	
Implement strategies to prevent underage drinking, non-medical use of prescription medications, and excessive alcohol consumption by adults and reduce tobacco use among adults who report poor mental health.	
Rationale and Relationship to Other Projects	
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.	
Project Index Score	
20	
Core Components	
<p>Healthcare Delivery System Sector Projects: PPS must show implementation of two of the three sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, there is a list of potential interventions that the PPS can use to develop its project. These interventions are found on the Prevention Agenda website under “Interventions to Promote Mental Health and Prevent Substance Abuse”</p> <p>https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/focus2_by_sector.htm 2017/plan/mhsa/interventions.htm</p> <ol style="list-style-type: none"> 1. Identify and implement evidence-based practices and environmental strategies to prevent underage drinking, substance abuse and other MEB disorders. 2. Consider 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. 3. Increase understanding of evidence-based practices for smoking cessation among individuals with mental illness and/or substance abuse disorder. 	
Outcome Metrics	
Domain 4	

Project Domain	Population-wide Projects: New York’s Prevention Agenda (Domain 4) <i>A. Promote Mental Health and Prevent Substance Abuse (MHSA)</i>
Project ID	4.a.iii
Project Title	Strengthen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)
Objective	
Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery and strengthen infrastructure for MEB health promotion and MEB disorder prevention	
Rationale and Relationship to Other Projects	
MEB health promotion and disorders prevention is a relatively new field, requiring a paradigm shift in approach and perspective. 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.	
Project Index Score	
20	
Core Components	
<p>Healthcare Delivery System Sector Projects: PPS must show implementation of three of the four sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, specific potential interventions are identified on the Preventive Agenda website under “Interventions to Promote Mental Health And Prevent Substance Abuse”</p> <p>(https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/focus3_by_sector.htm 2017/plan/mhsa/interventions.htm)</p> <ol style="list-style-type: none"> 1. Participate in 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. 	
Outcome Metrics	
Domain 4	

Project Domain	Population-wide Projects: New York’s Prevention Agenda (Domain 4) B. Prevent Chronic Diseases
Project ID	4.b.i
Project Title	Promote tobacco use cessation, especially among low SES populations and those with poor mental health. (Focus Area 2; Goal #2.2)
Objective	
To decrease the prevalence of cigarette smoking by adults 18 and older; Increase use of tobacco cessation services including NYS Smokers’ Quitline and nicotine replacement products.	
Rationale and Relationship to Other Projects	
<p>Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State (NYS). Cigarette use, alone, results in an estimated 25,000 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.</p> <p>The economic costs of tobacco use in NYS are staggering. Smoking-attributable health care costs are \$8.2 billion annually, including \$3.3 billion in annual Medicaid expenditures. In addition, smoking-related illnesses result in \$6 billion in lost productivity.¹⁸ Reducing tobacco use has the potential to save NYS taxpayers billions of dollars every year.</p> <p>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 adults and adults with poor mental health.</p>	
Project Index Score	
23	
Core Components	
<p>Healthcare Delivery System Sector Projects: PPS must show implementation of all sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population.</p> <ol style="list-style-type: none"> 1. Adopt tobacco-free outdoor policies. 2. Implement the US Public Health Services Guidelines for Treating Tobacco Use. 3. Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange). 4. Facilitate referrals to the NYS Smokers' Quitline. 5. Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications. 6. Promote smoking cessation benefits among Medicaid providers. 7. Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications. 8. Promote cessation counseling among all smokers, including people with disabilities 	
Outcome Metrics	
Domain 4	

Project Domain	Population-wide Projects: New York’s Prevention Agenda (Domain 4) B. Prevent Chronic Diseases
Project ID	4.b.ii
Project Title	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Focus Area 3) (This project targets chronic diseases that are not included in Domain 3., such as cancer.)
Objective	
To increase the numbers of New Yorkers who receive evidence based preventive care and management for chronic diseases.	
Rationale and Relationship to Other Projects	
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.	
Project Index Score	
17	
Core Components	
<p>Healthcare Delivery System Sector Projects: PPS must undertake actions that address all sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population.</p> <ol style="list-style-type: none"> 1. Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services. 2. Offer recommended clinical preventive services and connect patients to community-based preventive service resources. 3. Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and other community partners. 4. Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management. 5. Adopt medical home or team-based care models. 6. Create linkages with and connect patients to community preventive resources. 7. Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts. 8. Reduce or eliminate out-of-pocket costs for clinical and community preventive services. 	
Outcome Metrics	
Domain 4	

Project Domain	Population-wide Projects: New York’s Prevention Agenda (Domain 4) C. Prevent HIV and STDs
Project ID	4.c.i
Project Title	Decrease HIV morbidity (Focus Area 1; Goal #1)
Objective	
By December 31, 2017, reduce the newly diagnosed HIV case rate in New York by 25% to no more than 14.7 new diagnoses per 100,000. (Data Source: NYS HIV Surveillance System)	
Rationale and Relationship to Other Projects	
HIV/AIDS, sexually transmitted diseases (STDs) and hepatitis C (HCV) are significant public health concerns. 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 2010, approximately 129,000 New Yorkers were living with HIV or AIDS, with nearly 3,950 new diagnoses of HIV infection in 2010. ¹ Furthermore, 123,122 New Yorkers had STDs, representing 70 percent of all communicable diseases reported Statewide in 2010. ² The number of people with chronic or resolved cases of HCV in NYS exceeded 175,000 between 2001 and 2009. However, many of those with chronic HCV do not know they are infected, and recently it has been noted that more New Yorkers are dying from HCV than from HIV.	
Project Index Score	
19	
Core Components	
Healthcare Delivery System Sector Projects: Each of the four HIV/STD Projects contain the same 13 sector projects. PPS implementing this project will need to review these projects and chose at least 7 or more that are impactful upon their population, state why the sector projects were chosen, and then develop their Domain 4 project using those sector projects. The PPS at any time may add additional sector projects if it is determined these will add to the impact of their project.	
<ol style="list-style-type: none"> 1. Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care. 2. Increase peer-led interventions around HIV care navigation, testing and other services. 3. Launch educational campaigns to improve health literacy and patient participation in health care, especially among high-need populations, including Hispanics, and lesbian, gay, bisexual and transgender (LGBT) groups. 4. Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration and mental health. 5. Assure cultural competency training for providers, including gender identity and disability issues. 6. Implement quality indicators for all parameters of treatment for all health plans operating in New York State. An example would be raising the percentage of HIV-positive patients seen in HIV primary care settings who are screened for STDs per clinical guidelines. 7. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care. 	

8. Educate patients to know their right to be offered HIV testing in hospital and primary care settings.
9. Promote interventions directed at high-risk individual patient, such as therapy for depression.
10. Promote group or behavioral change strategies in conjunction with HIV/STD efforts.
11. Assure that consent issues for minors are not a barrier to HPV vaccination.
12. Establish formal partnerships between schools and/or school clinics, and community-based organizations to deliver health education and support teacher training programs.
13. Promote delivery of HIV/STD Partner Services to at risk individuals and their partners.

Outcome Metrics

Domain 4

Project Domain	Population-wide Projects: New York’s Prevention Agenda (Domain 4) C. Prevent HIV and STDs
Project ID	4.c.ii
Project Title	Increase early access to, and retention in, HIV care (Focus Area 1; Goal #2)
Objective	
<p>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)</p> <p>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)</p>	
Rationale and Relationship to Other Projects	
Project Index Score	
19	
Core Components	
<p>Healthcare Delivery System Sector Projects: Each of the four HIV/STD Projects contain the same 13 sector projects. PPS implementing this project will need to review these projects and chose at least 7 or more that are impactful upon their population, state why the sector projects were chosen, and then develop their Domain 4 project using those sector projects. The PPS at any time may add additional sector projects if it is determined these will add to the impact of their project.</p> <ol style="list-style-type: none"> 1. Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care. 2. Increase peer-led interventions around HIV care navigation, testing and other services. 3. Launch educational campaigns to improve health literacy and patient participation in health care, especially among high-need populations, including Hispanics, and lesbian, gay, bisexual and transgender (LGBT) groups. 4. Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration and mental health. 5. Assure cultural competency training for providers, including gender identity and disability issues. 6. Implement quality indicators for all parameters of treatment for all health plans operating in New York State. An example would be raising the percentage of HIV-positive patients seen in HIV primary care settings who are screened for STDs per clinical guidelines. 7. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care. 8. Educate patients to know their right to be offered HIV testing in hospital and primary care settings. 9. Promote interventions directed at high-risk individual patient, such as therapy for depression. 10. Promote group or behavioral change strategies in conjunction with HIV/STD efforts. 	

11. Assure that consent issues for minors are not a barrier to HPV vaccination.
12. Establish formal partnerships between schools and/or school clinics, and community-based organizations to deliver health education and support teacher training programs.
13. Promote delivery of HIV/STD Partner Services to at risk individuals and their partners.

Outcome Metrics

Domain 4

Project Domain	Population-wide Projects: New York’s Prevention Agenda (Domain 4) C. Prevent HIV and STDs
Project ID	4.c.iii
Project Title	Decrease STD morbidity (Focus Area 1; Goal # 3)
Objective	
To reduce the rates of Gonorrhea, Chlamydia, and primary and secondary Syphilis by 10% in New York State. To reduce the rates of congenital Syphilis by 10%.	
Rationale and Relationship to Other Projects	
The same behaviors and community characteristics associated with HIV also place individuals and communities at risk for STDs and viral hepatitis. STDs increase the likelihood of HIV transmission and acquisition. Epidemiological data increasingly point to HIV, STDs and HCV as "syndemics", or infections which occur in similar groups of people with the same behavioral risk factors. Notably, in the United States in 2010, the leading cause of death among people with HIV was liver disease from co-infection with HCV. ³	
Project Index Score	
15	
Core Components	
<p>Healthcare Delivery System Sector Projects: Each of the four HIV/STD Projects contain the same 13 sector projects. PPS implementing this project will need to review these projects and chose at least 7 or more that are impactful upon their population, state why the sector projects were chosen, and then develop their Domain 4 project using those sector projects. The PPS at any time may add additional sector projects if it is determined these will add to the impact of their project.</p> <ol style="list-style-type: none"> 1. Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care. 2. Increase peer-led interventions around HIV care navigation, testing and other services. 3. Launch educational campaigns to improve health literacy and patient participation in health care, especially among high-need populations, including Hispanics, and lesbian, gay, bisexual and transgender (LGBT) groups. 4. Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration and mental health. 5. Assure cultural competency training for providers, including gender identity and disability issues. 6. Implement quality indicators for all parameters of treatment for all health plans operating in New York State. An example would be raising the percentage of HIV-positive patients seen in HIV primary care settings who are screened for STDs per clinical guidelines. 7. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care. 8. Educate patients to know their right to be offered HIV testing in hospital and primary care settings. 9. Promote interventions directed at high-risk individual patient, such as therapy for 	

<p>depression.</p> <ol style="list-style-type: none"> 10. Promote group or behavioral change strategies in conjunction with HIV/STD efforts. 11. Assure that consent issues for minors are not a barrier to HPV vaccination. 12. Establish formal partnerships between schools and/or school clinics, and community-based organizations to deliver health education and support teacher training programs. 13. Promote delivery of HIV/STD Partner Services to at risk individuals and their partners.
Outcome Metrics
Domain 4

Project	Population-wide Projects: New York’s Prevention Agenda (Domain 4)
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Domain	<i>C. Prevent HIV and STDs</i>
Project ID	4.c.iv
Project Title	Decrease HIV and STD disparities (Focus Area 1; Goal # 4)
Objective	
<p>By December 31, 2017, decrease the gap in rates of new HIV diagnoses by 25% between Whites and Blacks to 45.7 per 100,000 population, and between Whites and Hispanics to 22.3 per 100,000. (Data Source: NYS HIV Surveillance System)</p> <p>By December 31, 2017, meet the National HIV/AIDS Strategy benchmarks for viral suppression among non-white racial and ethnic groups and men who have sex with men (MSM). (Data Source: NYS HIV Surveillance System)</p>	
Rationale and Relationship to Other Projects	
<p>The impact of HIV, STDs and HCV is greater in some population groups. For instance, non-Whites have rates of infection that are several times higher than Whites. Prevention interventions, including those that affect underlying factors such as stigma and discrimination, are needed to address these historical inequities. People of color account for more than 75 percent of new HIV diagnoses and, for persons living with HIV, the racial/ethnic distribution is 21 percent White, 43 percent Black, 32 percent Hispanic, 1.2 percent Asian/Pacific Islander, 0.1 percent Native American and 2.8 percent more than one racial group. Data on race and ethnicity of people with STDs and HCV suggest significant disparities exist as well. Men who have sex with men, transgender persons and women of color continue to have much higher rates of these diseases than the general population. Though HIV among injection drug users has decreased steadily (due in large part to expanded access to sterile syringes), HCV among drug injectors is prevalent.</p>	
Project Index Score	
18	
Core Components	
<p>Healthcare Delivery System Sector Projects: Each of the four HIV/STD Projects contain the same 13 sector projects. PPS implementing this project will need to review these projects and chose at least 7 or more that are impactful upon their population, state why the sector projects were chosen, and then develop their Domain 4 project using those sector projects. The PPS at any time may add additional sector projects if it is determined these will add to the impact of their project.</p> <ol style="list-style-type: none"> 1. Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care. 2. Increase peer-led interventions around HIV care navigation, testing and other services. 3. Launch educational campaigns to improve health literacy and patient participation in health care, especially among high-need populations, including Hispanics, and lesbian, gay, bisexual and transgender (LGBT) groups. 4. Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration and mental health. 	

5. Assure cultural competency training for providers, including gender identity and disability issues.
6. Implement quality indicators for all parameters of treatment for all health plans operating in New York State. An example would be raising the percentage of HIV-positive patients seen in HIV primary care settings who are screened for STDs per clinical guidelines.
7. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care.
8. Educate patients to know their right to be offered HIV testing in hospital and primary care settings.
9. Promote interventions directed at high-risk individual patient, such as therapy for depression.
10. Promote group or behavioral change strategies in conjunction with HIV/STD efforts.
11. Assure that consent issues for minors are not a barrier to HPV vaccination.
12. Establish formal partnerships between schools and/or school clinics, and community-based organizations to deliver health education and support teacher training programs.

Promote delivery of HIV/STD Partner Services to at risk individuals and their partners.

Outcome Metrics

Domain 4

Project Domain	Population-wide Projects: New York’s Prevention Agenda (Domain 4) D. Promote Health Women, Infants and Children
Project ID	4.d.i
Project Title	Reduce premature births (Focus Area 1; Goal 1)
Objective	
By December 31, 2017, reduce the rate of preterm birth in NYS by at least 12% to 10.2%.	
Rationale and Relationship to Other Projects	
<p>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 percent 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.</p> <p>Prematurity can also pose significant emotional and economic burdens on families. In 2010, 11.6 percent of New York State births were preterm. Babies who are born preterm cost the US health care system more than \$26 billion annually. In 2007, about 48 percent of preterm infant hospital stays nationally were paid by Medicaid, the largest source of health insurance for preterm infants.</p>	
Project Index Score	
24	
Core Components	
<p>Healthcare Delivery System Sector Projects: PPS must undertake actions that address all sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population.</p> <ol style="list-style-type: none"> 1. Ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for smokers. 2. Provide timely, continuous and comprehensive prenatal care services to pregnant women in accordance with NYS Medicaid prenatal care standards and other professional guidelines. 3. Work with paraprofessionals, including peer counselors, lay health advisors, and community health workers to reinforce health education and health care service utilization and enhance social support to high-risk pregnant women. 4. Implement innovative models of prenatal care, such as Centering Pregnancy, demonstrated to improve preterm birth rates and other adverse pregnancy outcomes. 5. Provide clinical management of preterm labor in accordance with current clinical guidelines. 6. Implement practices to expedite enrollment of low-income women in Medicaid, including presumptive eligibility for prenatal care and family planning coverage. 7. Utilize health information technology to facilitate more robust intake/enrollment, 	

screening/risk assessment, referral, follow up and care coordination practices across health and human service providers including Health Homes where applicable. 8. Refer high-risk pregnant women to home visiting services in the community.
Outcome Metrics
Domain 4