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Using this document to submit your DSRIP Project Plan Applications

Please complete all relevant text boxes for the DSRIP Projects that you have selected.

The Scale and Speed of Implementation sections for each of the Domain 2 and 3 projects have been removed from this document (highlighted in yellow) and are provided in a separate Excel document. You must use this separate document to complete these sections for each of your selected projects.

Once you have done this, please upload the completed documents to the relevant section of the MAPP online application portal.

Domain 2 Projects

2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management

Project Objective: Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management.

Project Description: This project 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 population and reduce avoidable hospital activity. For this project, avoidable hospital activity is defined as potentially-preventable admissions and readmissions (PPAs and PPRs) that can be addressed with the right community-based services and interventions. This project will incorporate 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 is community-based. This project will create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services. If successful, this project will eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes.

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. By conducting this project, the PPS will commit to devising and implementing a comprehensive population health management strategy – utilizing the existing systems of participating Health Home (HH) or Accountable Care Organization (ACO) partners, as well as preparing for active engagement in New York State's payment reform efforts.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.
2. Utilize partnering HH and ACO population health management systems and capabilities to implement the strategy towards evolving into an IDS.
3. Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
4. Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners,

including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.

5. Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
6. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
7. Achieve 2014 Level 3 PCMH primary care certification for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of Demonstration Year (DY) 3.
8. Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.
9. Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
10. Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
11. Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

CNA findings strongly indicate a need for delivery system integration across the spectrum of care to reduce avoidable utilization and improve public health. Annually, the region's Medicaid population experiences over 140,000 potentially preventable ED visits, nearly 4,000 avoidable adult admissions, and over 2,000 avoidable readmissions. Pediatric Prevention Quality Indicators for the region ranked near the bottom against other Upstate regions for asthma, gastroenteritis, and short-term complications of childhood diabetes. Our PPS surveys indicated that both patients and providers view healthcare delivery in WNY to be highly fragmented with little care coordination. Patients want better follow-up care and more responsive staff.

System gaps identified in the CNA include:

(a) Excess bed capacity: MCC hospitals have an occupancy rate of 71% that translates into 511 beds not in use, and the NYSDOH projected (2016) 499 excess beds for residential healthcare facilities in WNY.

(b) Gaps in RHIO interoperability: Care management information sharing does not exist and interoperability with hospitals and pharmacies needs to be enhanced. There is a lack of universal protocols across settings, and care coordination is missing. We lack interoperable HIE to make vital healthcare information accessible in real time.

(c) Gaps in primary care infrastructure: (i) PCMH/APCM status is low within MCC, with only 36% (85) out of 235 primary care locations currently NCQA recognized as PCMH facilities and (ii) shortages exist in large portions of the region that are designated as Health Professional Shortage Areas.

(d) Lack of behavioral health/primary care integration: There is little meaningful integration of behavioral health with primary care.

(e) Gaps in care coordination and patient navigation: There is little navigation built into hospital discharge planning that is capable of preventing readmissions. ED workflow that is capable of reducing preventable ED visits is virtually nonexistent. Navigation in community crisis settings does not connect to the delivery system. There are few, if any, PCP staff devoted to care management of the high-risk complex population.

(f) Other workforce gaps: Severe shortage of psychiatrists and psychologists, 50% of State's full-time equivalent per capita; few dentists accept Medicaid; primary care settings lack mid-levels (only 22% of PCPs are PAs or NPs) and lack behavioral health providers (LMHC or LMSW).

To address these system gaps, MCC aims to accomplish the following:

(a) Resolve excess bed capacity in hospital and SNF facilities through fact-finding and sound planning

(b) Activate a continuum of IDS providers through service agreements that pinpoint needs and how to address them

(c) Achieve care coordination across the continuum through the use of Care Transition Coordinators, ED Care Coordinators, and a standardized care coordination system

(d) Achieve clinically interoperable care management through the use uniform risk stratification software

(e) Achieve PCMH/APCM standards and meaningful use by deploying PCMH Coordinators to safety net locations

(f) Improve care coordination infrastructure across the region by enhancing EHR connectivity to RHIO's HIE by providing IT Support Liaisons to safety net PCPs

(g) Achieve healthcare information technology integrated population health management through leadership by MCC's Chief Medical Officer, Population Health Manager, and the resources of HIE Analysts

(h) Establish contracts with Medicaid managed care organizations (MMCOs) that feature value-based payments that pay for performance

(i) Engage patients in the IDS at all levels through use of patient activation methods and effective cultural competency and health literacy programs

(j) Achieve service integration with Health Home care managers by educating all partners on their vital role

(k) Address shortages and access gaps for PCPs and specialists by working with experts on effective recruitment strategies

b. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Current assets and resources mobilized: Through collaborative partnerships, the PPS will maximize the use of current healthcare resources, including 10 hospitals, 12 EDs, 41 nursing homes, 7 FQHC locations, 235 primary care locations (30% are safety net), 521 behavioral health outpatient locations, 48 home care agency locations, 8 Community Action Organizations, facilitated enrollers from 4 MMCOs, 6 Health Home agencies, 120 nonprofit community-based organizations (CBOs), 437 food and basic needs service agencies, 370 housing/shelter basic need organizations, 42 crisis intervention agencies, 32 individual and family support service groups, 96 education and literacy support programs, 184 local social services programs, and 128 information referral service locations, as well as a full array of specialty providers from medical, behavioral, and community settings.

The WNY region currently has community health worker programs and visiting home nursing services that focus on very high-need zip codes in Buffalo and Niagara Falls. These existing resources will be utilized and repurposed to advance the objectives of our project to improve maternal and infant care and to reduce premature births. A sampling of these programs includes Maternal and Infant Community Health Collaborative; Healthy Families New York; Women, Infant, and Children program; Medicaid Obstetric Maternal Services; Healthy Mom–Healthy Baby Prenatal and Postpartum Home Visiting; The Priscilla Project; Project ACT; The "Healthy Start for All" Coalition; Healthy Babies are Worth the Weight; Centering Pregnancy; Nurse Family Partnership; and Baby and Me Tobacco Free.

We are also tapping the assets of HEALTHeLINK, the RHIO's HIE, which is working to make clinical data available through the exchange, provide patient event notifications, and connect practices with EMRs for electronic results delivery.

New resources needed:

(a) A MMC administrative structure that will support all components of an IDS and will include an Executive Director, Compliance Officer, Finance Director, Administrative Director, and Chief Reporting Officer

(b) Leadership at the PPS level to drive clinical integration, including a Clinical Integration Officer and Clinical Manager

(c) Unwavering PPS commitment to quality and population health management that will be led by the MCC's Chief Medical Officer and Population Health Manager

(d) A unified plan for continuing education led by a Continuing Education Manager at the PPS level

(e) Major investments in training to assure the success of MCC's selected projects including training on evidence-based models (e.g., Coleman, INTERACT, patient activation, primary care and behavioral health

integration, Million Hearts strategies to reduce hypertension, best practices to reduce premature births, evidence-based cultural competency and health literacy practices)

(f) Program managers and support personnel to lead and carry out each of the 11 selected projects

(g) Workforce development services to support retraining and redeployment

(h) Care Transition Coordinators and ED Care Coordinators to connect patients to the right care at the right place

(i) Community Health Workers to connect the uninsured as well as low-utilizers and non-utilizers to medical homes and to serve at-risk moms and their children

(j) PCMH Coordinators to meet 2014 NCQA/Advanced Primary Care standards and to provide instruction on the use of registries and other tools to improve patient management

(k) IT Support Liaisons and HIE Analysts who will be deployed to assist safety net providers meet meaningful use standards, connect to the RHIO, and achieve EHR connectivity

(l) Unified software systems for care coordination and risk stratification that can be use across the region at all key service points

m) Public education and intervention strategies to improve mental, emotional, and behavioral well-being and promote heart health

c. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project, and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

System change for care integration across medical, behavioral, and community care involves new HIE functionality, new protocols, buy-in for adoption, massive workflow changes, and workforce retraining. Just 46% of WNY's total population has signed consent forms authorizing release of their medical information through HEALTHeLINK; more participation in such information sharing needs to be secured. These are the most complex challenges facing the PPS in the early years. We will explore mechanisms for integration by overcoming structural barriers (regulatory, confidentiality, lack of interoperability, lack of cross-training) and mandating use of EMRs and the RHIO. We will enhance interoperability to support care coordination for high-risk patients in transition, emergency care changes to prevent improper use, SNF innovations to prevent readmissions, improved home care connections, integration of crisis stabilization services, and interoperability with behavioral health and community supports. PPS partners will encourage their patients/clients to sign HEALTHeLINK consent.

We will train key personnel across the system to participate in the new care delivery model and develop standard training protocols for new roles. When possible, excess staff from reductions will fill new positions.

Excess bed capacity is a complex issue that is unique to each facility. Through effective strategic planning we will work collaboratively with facilities to resolve each situation in terms of reuse, repurpose, liquidation, renovation, or other options.

Primary care infrastructure challenges pertain to practice transformation, healthcare professional shortages, and pediatric and adolescent care. (a) PCMH Coordinators will drive necessary buy-in and change needed to rapidly reach level 3 PCMH/APCM and MU. (b) Primary care shortages throughout the region include insufficient physicians and mid-levels (PA, NP) working in primary care settings, a need for more primary care locations, and a lack of safety net primary care locations. We will invest in addressing safety net workforce gaps, work with AHEC partners to influence primary care career choices, and work with health professional schools. (c) School-based health services will be expanded in high-need areas such as Buffalo, Niagara Falls, and Jamestown to increase primary care access for pediatric and adolescent patients.

d. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

As a result of working together on the CNA, the two main PPSs serving WNY (MCC and Catholic Medical Partners) have formed strong communication links and are engaged in cooperative efforts that will benefit all Medicaid beneficiaries in the region. Through a collective assessment of community needs, the two PPSs selected six core projects in common because they recognized that widespread health system integration issues need to be resolved to assure effectiveness of the selected projects. The two PPSs are also jointly sponsoring and co-funding project 4.a.i. (Improve Mental, Emotional, and Behavioral Well-Being) in an effort to dramatically change patterns of behavior that have led to high rates of substance abuse and widespread mental health issues in our region.

The ability of MCC to reach out and work cooperatively with other entities was clearly demonstrated when it facilitated the merger of the Niagara-Orleans emerging PPS and the Upper Alleghany Health System with its PPS organization. These mergers assure the efficient use of resources and infrastructure not only during the five years of DSRIP programming but beyond.

Ongoing collaboration among MCC and its bordering PPSs (Catholic Medical Partners and Finger Lakes PPS) will be essential. We plan to organize and hold periodic meetings with the other PPSs to promote exchange of information; provide progress reports; share lessons learned; and identify opportunities for joint training, joint protocol development, and common reporting. Equally important, we will jointly investigate ways to leverage existing resources and engage in joint purchasing to reduce PPS administrative costs. Progress reports and information exchange will be the subject of periodic meetings among the PPS organizations.

We will continue to coordinate with the other PPS organizations in an effort to educate all hospitals and systems in regards to common transition protocols, RHIO interoperability, and shared community resources. MCC partners will continue to interact with all hospital systems within the eight counties of WNY simply because that is what our patients do. This underscores the need for cooperative PPS

approaches to track and coordinate care to patients who utilize multiple services offered by more than one PPS as a means for preventing re-hospitalization and avoiding inappropriate ED use.

2. <u>System Transformation Vision and Governance</u> (Total Possible Points – 20)

a. Please describe the comprehensive strategy and action plan for reducing the number of unnecessary acute care or long-term care beds in parallel with developing community-based healthcare services, such as ambulatory, primary care, behavioral health and long term care (e.g. reduction to hospital beds, recruitment of specialty providers, recruitment of additional primary care physicians, hiring of case managers, etc.). The response must include specific IDS strategy milestones indicating the commitment to achieving an integrated, collaborative, and accountable service delivery structure.

The PPS will use a comprehensive strategy to achieve delivery system integration across the spectrum of care to reduce avoidable utilization and to improve public health by addressing: excess bed capacity, gaps in interoperability for care integration, gaps in primary care safety net infrastructure, lack of behavioral health and primary care integration, and workforce safety net gaps, while engaging patients at every level. We will achieve this strategy by implementing six interrelated action plans with specific milestones. Strict timelines and scheduled activities will guide the process. All strategies and action plans will be overseen by MCC's Board of Managers. It should be noted that the milestone dates below are based on the speed and scale documents submitted with this application and are subject to change should the assumptions in those documents change.

Action plan 1: Resolve excess bed capacity in hospital and SNF facilities. An action plan to evaluate both acute care and long-term care capacity and related needs/issues will be conducted. We will assemble a task force comprised of PPS, hospital, SNF, and community representatives to help drive this effort. This action plan will be developed in two structured phases. Phase one will offer a fact-based data collection process pertaining to the following issues:

(a) Staffed beds versus licensed hospital beds

(b) Current utilization of need for licensed long-term care beds

(c) Service delivery profiles, including specialty resources and unique services

(d) Assessments of physical plants

(e) Examination of financial performance and financial forecast profiles

(f) Forecasts on how improved population health will impact acute care and nursing home bed capacity

(g) Impact of other current and possible future trends on hospital and nursing home operations

(h) New projects and programs that are underway and that serve as alternatives to hospital and nursing care

(i) Opportunities for additional development of community-based healthcare services

Phase two will involve analysis of information and conclude with a detailed set of recommendations. During this phase, the task force will be responsible for formulating recommendations for:

(a) Achieving reductions in hospital and SNF bed capacity

(b) Repurposing the use of such facilities

(c) Developing a regional service delivery plan that optimizes delivery of service by all partners in the PPS

Project milestones for the excess bed component of the action plan include:

Milestone 1.1: Initiate phase one excess bed review: DY1-Q2

Milestone 1.2: Complete phase one bed review and release findings: DY1-Q4

Milestone 1.3: Initiate development of phase two recommendations: DY2-Q1

Milestone 1.4: Release and begin implementation of phase two recommendations: DY2-Q2

Action plan 2: Achieve interoperable integrated healthcare care and social care across settings

Work plan 2 establishes the framework for achieving care coordination across medical, behavioral and community settings, embedding care management in PCMH functions and integrating Health Home care management functions at all critical service points. The milestones for these activities will be a series of emerging agreements with six types of essential providers initially: safety net primary care, Health Homes (HH), behavioral health, hospital inpatient services, ED, and CBO. The agreement for provider type will be specific to the setting and the care provided. Each setting-specific agreement will detail the following: (a) care coordination/care management scope; (b) integration gaps; (c) essential data sharing (both ways); (d) care team interface protocol (both ways); (e) HIE gap; (f) care team change needs; and (g) workflow change requirements.

Milestone 2.1: Initial memoranda of understanding on scope of integration executed by DY1-Q1

Milestone 2.2: Action plan agreements for Care Transition Coordinators, ED Care Coordinators, INTERACT champions, Health Home care managers, PCMH care managers and other staff, behavioral health integration personnel, home care staff, crisis stabilization teams, and Community Health Workers executed by DY1-Q2

Milestone 2.3: Implementation contracts (with needed resources awarded) executed by DY1-Q2

Action plan 3: Primary care safety net infrastructure

Work plan 3 seeks to fortify the primary care safety net infrastructure by providing the support and technical assistance practices need to meet PCMH/APCM standards, adhere to meaningful use requirements, and achieve EHR connectivity to the RHIO's health information exchange. Another element of this work plan concerns implementation of population health management best practices, including data collection, population stratification and monitoring, and team-based interventions.

Milestone 3.1: Meaningful use certification complete by DY1-Q3/Q4

Milestone 3.2: PCMH/APCM level 3 certification complete by DY2-Q3/Q4

Milestone 3.3: EHR connectivity to RHIO's HIE complete by DY1-Q3/Q4

Milestone 3.4: High-risk population registries complete by DY1-Q3/Q4

Action plan 4: Transition to value-based compensation. Work plan 4 will establish contracts with Medicaid MCOs featuring payment strategies that link financial incentives to providers' performance on a defined set of measures. This strategy, which is central to attaining DSRIP program goals, will achieve better value by driving improvements in quality. This work plan component will support MCC's continued transition to a value-based compensation model that will mature over time.

Milestone 4.1: Regular meetings with Medicaid MCOs started by DY0-Q4

Milestone 4.2: First round of executed contracts with Medicaid MCOs complete by DY1-Q1/Q2

Milestone 4.3: Action plan agreements for compensation model complete by DY1-Q3/Q4

Milestone 4.4: Executed provider compensation model contracts complete by DY2-Q1/Q2

Action plan 5: Patient engagement at all levels. Work plan 5 will provide for the adoption of measures to engage patients in their care. This all-important goal will be attained by improving the knowledge, skills, ability, and willingness of patients to manage their own and family members' health and care. The action plan will also set forth steps to assure active collaboration between patients and providers.

Milestone 5.1: Action plan for patient engagement in all core components approved by DY1-Q1/Q2

Milestone 5.2: Implementation of active patient engagement process launched by DY1-Q3/Q4

Action plan 6: Address shortages and assess gap in high-need areas. Work plan 6 will address shortages and assess gaps for primary care and specialty services in high-need areas. Recruitment of various types of healthcare professionals will be a crucial element of filling identified service gaps. This action plan will involve numerous community partners, including Area Health Education Center (AHEC), numerous colleges and universities in the Buffalo area, and existing physician and dental groups that can assist in recruitment efforts.

Milestone 6.1: Recruitment of safety net providers (MD, DO, PA, NP, LMSW, LMHC) in high-need areas completed by DY1-Q3/Q4

Milestone 6.2: Recruitment of safety net psychiatrists and clinical psychologists in high-need areas completed by DY2-Q1/Q2

Milestone 6.3: Recruitment of safety net dentists in high-need areas completed by DY2-Q1/Q2

b. Please describe how this project's governance strategy will evolve participants into an integrated healthcare delivery system. The response must include specific governance strategy milestones indicating the commitment to achieving true system integration (e.g., metrics to exhibit changes in aligning provider compensation and performance systems, increasing clinical interoperability, etc.).

The MCC governance strategy for evolving participants into an IDS will be based on open engagement, transparency, shared visioning, mutually established core principles, and alignment of Board of Managers Standing Committees with the action plans to assure appropriate oversight. The MCC governance structure rests on meaningful participation across all providers and facilities and meaningful participation by Medicaid consumers. Our governance strategy provides incentives to reward collaboration and improve quality of care.

The MCC PPS was founded on the policy of open engagement and transparency. Going forward we will use three strategies: (1) shared visioning, (2) mutually established core principles, and (3) alignment of Board of Managers Standing Committees with specific action plans for oversight, according to defined governance milestones.

Strategy 1: Launch shared visioning with all Board of Managers Standing Committees

Milestone 1: Establish shared vision that is reviewed annually by DY1-Q1

Strategy 2: Establish core principles for all Board of Managers Standing Committees

Milestone 2: Establish core principles that are reviewed annually by DY1-Q1. One example of a core principle concerns achieving delivery system integration across the spectrum of care to reduce avoidable utilization and to improve public health. Other core principles involve:

(a) Person-centered care: Services should reflect an individual's goals and emphasize shared decision-making approaches that empower patients, provide choice, and minimize stigma. Services should be designed to optimally treat illness and should emphasize wellness, attention to an individual's overall well-being, and full community inclusion.

(b) Recovery-oriented: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, vocational, and social skills that are offered in home- and community-based settings to promote hope and encourage each person to establish an individual path towards recovery.

(c) Integrated: Services should address both physical and behavioral health needs of individuals. Care coordination activities should be the foundation for care plans, along with efforts to foster individual responsibility for health awareness.

(d) Data-driven: Providers should use data to define outcomes, monitor performance, and promote health and well-being. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

(e) Evidence-based: Services should utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote the use of best practices.

(f) Trauma-informed: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization.

All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA, 2014).

(g) Peer-supported: Peers will play an integral role in the delivery of services and the promotion of recovery principles.

(h) Culturally competent: Culturally competent services that contain a wide range of expertise in treating and assisting people with serious mental illness and substance use disorder in a manner responsive to cultural diversity.

(i) Flexible and mobile: Services should adapt to the specific and changing needs of each individual, using mobile service delivery approaches along with therapeutic methods and recovery approaches which best suit each person.

(j) Inclusive of social network: The person, and when appropriate, family members and other key members of the person's social network are always invited to initial meetings or any necessary meetings thereafter to mobilize support.

(k) Coordination and collaboration: These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family, and other key natural supports and service providers.

Strategy 3: Align Board of Managers Standing Committees with the action plans for oversight

Action plan 1: Resolve excess bed capacity in hospital and SNF facilities.

Milestone 3.1: Align with Finance Committee and advisory councils by DY0-Q4

Action plan 2: Achieve interoperable integrated care across medical, behavioral health, and community settings

Milestone 3.2 Align with Finance Committee, Clinical/Quality Committee, IT Data Committee, Project Advisory Committee, Physician Steering Committee, and advisory councils by DY0-Q4

Action Plan 3: Advance primary care safety net infrastructure

Milestone 3.3 Align with Finance Committee, Clinical/Quality Committee, IT Data Committee, Project Advisory Committee, Physician Steering Committee, and advisory councils by DY0-Q4

Action plan 4: Transition to value-based compensation

Milestone 3.4.1: Align Medicaid MCO agreements with Finance Committee by DY0-Q4

Milestone 3.4.2: Align provider compensation model with Finance Committee, Clinical/Quality Committee, Project Advisory Committee, Physician Steering Committee, and advisory councils by DY1-Q3/Q4

Action plan 5: Achieve patient engagement at all levels

Milestone 3.5: Align with all Board of Managers Standing Committees by DY0-Q4

Action plan 6: Address shortages and access gap in high-need areas Milestone 3.6: Align with Finance Committee, Clinical/Quality Committee, Project Advisory Committee, Physician Steering Committee, and geographic councils by DY0-Q4

3. <u>Scale of Implementation</u> (Total Possible Points - 20):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

5. <u>Project Resource Needs and Other Initiatives</u> (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Capital funding is necessary for various projects to be successful. Capital support will be required to reduce avoidable ED visits by establishing primary care centers with extended hours within the immediate vicinity of EDs. Capital investments will permit necessary renovations to existing primary care and behavioral health treatment sites to accommodate integrated treatment. Capital funding will address other needs, including, but not limited to:

- EHR systems for nursing homes participating in the INTERACT project

- Additional safety net primary care sites in high-need areas

- Expansion of facilities that provide 24x7 addiction treatment services

- Infrastructure to support implementation of the hospital/home care collaboration project

Capital funding will also help secure and expand the future of a vital safety net provider, the Women and Children's Hospital of Buffalo (WCHOB). WCHOB is relocating inpatient and outpatient services from its current location at 219 Bryant Street to the Buffalo Niagara Medical Campus. WCHOB serves as the Regional Perinatal Center for Western New York and is the regional center for specialty inpatient and outpatient pediatric care. The relocation to the Buffalo Niagara Medical Campus will allow WCHOB to expand the capacity of critical maternal and pediatric outpatient services for WNY by increasing the outpatient and ambulatory footprint in response to the shift from inpatient services to outpatient services.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

a. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

6. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards the

implementation of the IDS strategy and action plan, governance, completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics.** Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

2.b.iii ED Care Triage for At-Risk Populations

Project 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). Objective is also to improve provider-to-provider communication and provide supportive assistance to transitioning members to the least restrictive environment.

Project Description: 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. This project will impact avoidable emergency room use, emphasizing the availability of the patient's primary care physician/practitioner. This will be accomplished by making open access scheduling and extending hours, EHR, as well as making patient navigators available. The key to this project's success will be to connect frequent ED users with the PCMH providers available to them.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Establish ED care triage program for at-risk populations.
2. Participating EDs will establish partnerships with community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.
    a. All participating PCPs Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of Demonstration Year (DY) 3.
    b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.
    c. Ensure real time notification to a Health Home care manager as applicable.
3. For patients presenting with minor illnesses who do not have a primary care provider:
    a. Patient navigators will assist the presenting patient to receive a timely appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.
    b. Patient navigator will assist the patient with identifying and accessing needed community support resources.
    c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).
4. Establish protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)
5. Use EHRs and other technical platforms to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

There are over 140,000 Medicaid potentially preventable ED visits per year in WNY. WNY has an 8% higher observed rate of Medicaid potentially preventable ED visits compared to NYS. The current rate is 37.6/100; the goal rate for a 25% reduction would be 28.2/100. Medicaid non-English Speaking ED visitors in Erie County (mostly from the west side of Buffalo) speak over 40 languages. Potentially Preventable Visits (PPV) rates in Allegany (48.4/100), Cattaraugus (49.5/100), and Niagara (35.5/100) Counties are far above the State rate. Patients with the highest rates of multiple ED visits in WNY tend to have diagnoses relating to alcohol abuse (19.5%), asthma (13.9%), and anxiety (13.1%).

Low health literacy, language issues in Erie County, and lack of engagement with the community healthcare system-- particularly a lack of primary care connection and access--have been identified as important factors confirmed by the CNA. WNY has a 28% lower PCP visit rate and a lower proportion of beneficiaries with a PCP visit (60%) compared to NYS (64%). This suggests that Medicaid patients in the region rely on the ED for non-emergent care instead of using primary care. One challenge to address is ensuring beneficiaries have access to PCPs with conveniently locations and extended hours.

Most EDs have no triage function for dealing with non-emergent care needs, and most have little follow-up with PCP to prevent repeat ED visits.

To address the gaps identified in the CNA, this initiative, “Project Connect,” uses evidence-based approaches that have been recognized by CMS for delivering appropriate care in the most appropriate settings (CMS Bulletin, January 16, 2014). Our project seeks to reduce inappropriate ED utilization by engaging 12 EDs in four target counties identified in the CNA: Allegany, Cattaraugus, Erie, and Niagara.

Project Connect is designed to prevent future ED visits, focus on the needs of ED patients with behavioral health issues and those who have recorded multiple ED visits, expand access to primary care services, and avoid inappropriate use of ambulance trips.

During a non-emergent ED visit, ED staff will connect targeted patients to ED Care Coordinators who will be based in the ED seven days a week and provide coverage during prime ED activity hours. ED Care Coordinators will educate Medicaid patients on alternatives to the ED, complete a brief social/environmental assessment with the patient to identify barriers to accessing primary care and required resources, provide real-time referrals to PCPs (and Health Homes if eligible), and connect patients to community-based organizations (CBOs) for social and economic support services.

Primary care practices which are certified as PCMHs or committed to NCQA accreditation will be included in the network tied to Project Connect. Open access is critical to adhering to the NCQA 2014 standards. Participating practices will be required to operate evening and weekend hours and agree to promote and adhere to the PCMH 2014 access-to-care policy.

Currently, two of our hospital EDs have a successful program for connecting patients who present to the ED for non-emergent situations to a primary care clinic. In these programs, the patient receives a medical screening exam, and if it is determined that he or she has a non-emergency condition, they may be transferred to a primary care clinic. We will evaluate the PPS's ability and desire to expand on this model.

The MCC will continue to engage the first responder community in strategic discussions about options for transport of patients with non-emergent needs to PCMHs and other alternate care sites. Working cooperatively with first responders, there are opportunities to provide more telephone-based assessment and advice to patients with non-urgent conditions, embed triage functions in traditional emergency services, and identify other ways to provide at-the-scene advice to by-pass the ED and directly connect patients to primary care.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The Medicaid beneficiaries to be served by this project are those who utilize the ED for primary care or outpatient behavioral health treatable conditions. ED "super-utilizers" who are more likely to have fragile support networks, poor access to PCPs, and be dissatisfied with their care are, overall, more frequently ill and often suffer from multiple comorbid conditions. Though many are homeless, this population typically resides in zip codes near hospital EDs in urban centers such as Buffalo and Niagara Falls, which our CNA shows fare worse than average on PPVs to the ED. Since this project proposes to close the gap between PCP access and the ED, the target population will consist, broadly, of two subsets of this population: Medicaid beneficiaries lacking PCPs and those who have recorded more than one visit within the previous six months.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

A variety of current assets will be mobilized for this project in Allegany, Cattaraugus, Erie, and Niagara Counties. This includes 12 EDs, 5 Health Homes, 235 primary care locations including 69 safety net primary care practices, 428 outpatient behavioral health service locations, 126 substance abuse treatment sites, 340 agencies providing food/basic need services, 280 housing/shelter basic need organizations, 26 individual and family support services, 118 public assistance programs, and 29 crisis intervention programs. Many of these existing resources will be integrated with Project Connect to meet project objectives.

(a) Primary care practices participating in the project will expand their operating hours to include evenings and weekends and establish appointment scheduling procedures to provide timely care to referred ED patients. These practices will reconfigure staff duties to prepare for and obtain NCQA 2014 level 3 PCMH or APCM certification by the end of DY3.

(b) ED staff will change workflows to make appropriate hand-offs of non-emergent patients to ED Care Coordinators.

(c) Behavioral health agencies (working collaboratively with Health Home agencies) will develop procedures for scheduling immediate appointments for referred ED clients and for exchanging information with ED Care Coordinators on whether a referred patient connects to care.

(d) Scores of CBOs which provide food, housing, support service and public assistance will establish methods for information exchange with ED Care Coordinators and expand their service capacity to meet increased demands.

New resources will be invested in the project. These include:

(a) The creation of 34 full-time equivalent ED Care Coordinators who will be required to have a bachelor's degree in a relevant field. EDs will provide dedicated space for private patient consultations. Software to link coordinators to PCP patient scheduling systems will be installed, permitting appointments to be made while patients are still in the ED. EHR/care coordination platforms will be acquired to permit coordinators to record patient assessments, interventions, referrals, and plans of care, in order to track a patient's progress and monitor actual connections to primary care and support services.

(b) Funding for "just–in-time" transportation services to transport patients with same-day urgent needs to referred services by bus or cab will also be required. Most Medicaid-funded transportation requires advance notice.

(c) Patient advocates for specific non-English speaking or cultural groups identified as high utilizers of the ED. These patient advocates will be on call to assist ED Care Coordinators in situations involving language or cultural barriers. The number and type of patient advocates will depend on level of need in specific ED settings.

(c) PCMH Coordinators to provide NCQA training and coaching to primary care staff to ensure that primary care practices meet NCQA 2014 level 3 standards, especially standard #1: patient-centered access.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Target population resistance to change: Medicaid patients with a pattern of high ED usage may be uncooperative at first. To change attitudes and behaviors, the project will adopt many of the protocols

that have been used by the Greater Detroit Area Health Council and shown to effectively reduce avoidable ED visits. Understandable and culturally sensitive materials will be used to educate patients on proper use of the ED; these materials will be reviewed with patients as part of their ED discharge instructions.

Language and cultural barriers: Tied to population resistance in certain ED settings will be major language and cultural barriers. Patient advocates will be recruited from those settings to coach ED Care Coordinators in approach and to potentially be on call to assist with high-need cases.

ED transformation challenges: Sustaining ED buy-in is challenging due to shift rotations of ED staff. Having consistent ED Care Coordinator presence in the ED will help bridge communication gaps and provide opportunities to train ED staff on workflow changes to connect patients to coordinators before they are discharged.

PCMH transformation challenges: It will be a major lift to achieve the open access and PCMH readiness to respond to ED Care Coordinator referrals. PCMH Coordinators will coach this process, and specific clusters of PCMHs will be aligned with specific Project Connect EDs. Each cluster will meet regularly to expedite transformation in both PCMH and ED settings.

Health Home integration challenges: Health Home agencies are relatively new and do not yet have expansive working relationships with EDs and PCMHs. To assure that Health Home agencies engage with their enrollees while they are still in the ED, the project will use electronic alert systems to immediately notify Health Homes when an enrollee visits the ED. This system will promote teamwork between ED Care Coordinators and Health Home care managers.

Integration challenges with community resources: Keeping an array of stakeholders—CBOs, behavioral health agencies, and ED staff—linked to Project Connect will be challenging. The project will bring together stakeholders from across service areas to address issues through multidisciplinary case reviews, creation of working committees, and frequent information exchange (e.g. electronic newsletters) on outcomes and results.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

As a result of the joint CNA, this project was selected by both MCC and Catholic Medical Partners (CMP). It was recognized that a coordinated approach was necessary to be effective with the high-ED utilizing Medicaid target population. Close coordination with CMP and the Finger Lakes PPS will be assured by encouraging use of standardized referral protocols, utilizing uniform tracking and reporting systems, adopting universal alert messaging via the RHIO, maintaining common messaging to educate patients about the appropriate use of EDs, and sharing lessons learned. Progress reports and information exchange on the project will be the subject of periodic meetings among the PPS organizations.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Capital funding will be required to establish primary care clinics with extended operating hours within the immediate vicinity of busy EDs as a way to reduce avoidable ED visits.

a. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Niagara Falls Memorial Medical Center	Vital Access Provider-Phase One grant	3/1/13	2/28/16	Used to assist in the implementation of inpatient and ED behavioral health reforms

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that

exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

The VAP One program deals serves the behavioral health population using strategies and models that are different that those to be used by the ED Care Triage project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

2.b.vii Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)

Project Objective: Skilled nursing facilities (SNFs) 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).

Project Description: INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program focusing on the management of changes in a resident's condition, with the goal of stabilizing the patient and avoiding transfer to an acute care facility. The program includes clinical and educational tools and strategies for use in everyday practice within 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) and supported by the Commonwealth Fund. This DSRIP project will further increase the impact of INTERACT by integrating INTERACT 3.0 tools into SNF health information technology through a standalone or integrated clinical decision support system.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.
2. Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.
3. Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.
4. Educate all staff on care pathways and INTERACT principles.
5. Implement 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.
6. Create coaching program to facilitate and support implementation.
7. Educate patient and family/caretakers, to facilitate participation in planning of care.
8. Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.
9. Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.
10. Use EHRs and other technical platforms to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The CNA provides important insights into hospital use by SNF residents. Over half of the counties in WNY have SNF to hospital admission rates higher than the State's 14.81/1,000 rate for SNF beneficiaries. Many SNF patients are transferred to hospitals for conditions that could have been identified early and preempted before emerging to acute problems. In 2012, 3,817 SNF residents in WNY recorded 5,313 hospital admissions, resulting in an average hospitalization rate of 1.39 per resident. The diagnoses most commonly associated with the hospitalization of nursing home residents in WNY are sepsis, bacterial pneumonia, congestive heart failure (CHF), and urinary tract infection (UTI). In fact, 78% of hospital readmissions are attributed to sepsis, respiratory issues/bacterial pneumonia, CHF, UTI, and dehydration. There are also system gaps in many SNF settings in terms of structure and workflow for the early detection and management of these conditions, and there is little enhanced communication between SNFs and acute care facilities once these admissions occur.

These needs will be addressed by implementing the INTERACT project at two system levels: a central INTERACT support team and local SNF INTERACT implementation teams.

The central INTERACT support team will be responsible for the following:

(a) The core INTERACT program will be developed and implemented for the INTERACT model (3.0 toolkit) at every committed partnering SNF, permitting practitioners to practice at the highest level of their scope. The PPS will train and provide guidance to SNFs on how their staffs, from Certified Nursing Assistants to RNs, can use INTERACT's tools and strategies to improve early identification and assessment of changes in the status of nursing home residents.

(b) Protocols, pathways, and best practices will be developed and shared among partnering SNFs to raise the level of care provided by all facilities. Nursing home RNs and LPNs will be provided with and trained in the model's care pathways and other clinical tools to address common conditions such as dehydration and CHF and avoid hospital transfers. At present, most SNFs do not have in-house capability to perform PICC line care or IV medications, causing unnecessary hospital transfers. These services can be added to appropriate facilities, expanding and strengthening the level of care provided.

(c) Advance care planning tools: INTERACT support team will provide important instruction and training to nursing home staff on how to appropriately engage in end-of-life discussions with residents and their families.

(d) A coaching program will facilitate and support implementation.

(e) Enhanced communication will be established for information exchange between the SNF and acute care hospitals, preferably via EHR and HIE connectivity.

(f) Outcome measurement will be conducted for quality improvement outcome monitoring (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.

The Local SNF INTERACT Teams will be responsible for the following:

(a) Facility leadership: a champion will be identified who will engage other staff, serve as a coach, and lead the local INTERACT team

(b) Implementation of the INTERACT 3.0 toolkit and other resources, provided by the central INTERACT support team

(c) Cyclical education with audit and feedback, conducted with all SNF staff on care pathways and INTERACT principles with active facilitation from the PPS project team

(d) Patient/family engagement via the SNF team, to educate patient and family/caretakers and facilitate their participation in care planning

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The patient population expected to be engaged are Medicaid members residing in SNFs who meet INTERACT criteria (at risk for potentially avoidable inpatient transfer). INTERACT protocols will first be applied to patients with or at risk for the conditions most commonly associated with the hospitalization of nursing home residents: are sepsis, respiratory issues/bacterial pneumonia, CHF, UTI, and dehydration. The patient population of each facility will be stratified to prioritize application of the model to a certain percentage of high-risk patients. This portion of targeted individuals will increase year over year until INTERACT is used for all eligible residents. As nurses and doctors become more comfortable with the INTERACT protocols, tools, and accompanying workflow changes, these protocols will be applied across all patients who are decompensating (regardless of diagnosis).

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Current assets and resources mobilized:

(a) Skilled nursing facilities: 41 SNFs are in the MCC PPS, of which 8 are currently using INTERACT in their facilities. These SNFs will lend their INTERACT expertise and provide first-hand experience and lessons learned. The contributions of this SNF staff will serve as valuable assets for supporting facilities just starting down the INTERACT road. We will leverage this invaluable expertise through regular meetings, communications, and learning collaboratives to support the new INTERACT facilities.

(b) Hospitals: There are 22 acute care hospitals in WNY, 10 of which are in MCC. SNF INTERACT partners will utilize all hospital systems within the eight counties of WNY. It will be essential that patients are reviewed closely prior to return from inpatient to SNF to help prevent re-hospitalization. All hospitals within all local PPSs will be asked to be involved in an effort to educate all hospitals and systems in regards to the INTERACT project. ECMC's successful "Conversation Project," which encourages patients, caregivers, and families to discuss end-of-life choices, will be leveraged and expanded to educate and support all partners in the PPS on palliative care and advanced care planning.

New resources needed:

(a) A central INTERACT support team composed of an INTERACT Project Director (one full-time equivalent), INTERACT Coaches (two FTEs), and an INTERACT Continuing Educator (one FTE). INTERACT Coaches will be retained to oversee and support the project. The Coaches will assist with the development of the program and will provide education and outreach to ensure the project's success.

(b) Local SNF INTERACT teams: Champions (10 FTEs). At some nursing homes, the staff required for the INTERACT project will be existing personnel who are retrained or redeployed. At other facilities, new staff will need to be hired to perform INTERACT functions. Every partnering facility needs to identify an INTERACT Champion who will facilitate the model's use in their own facility. The Champion could be a repurposed RN position filled by an existing staff member.

(c) Consultant services: The creator of INTERACT, Joseph G. Ouslander, MD, will be traveling to WNY with his I-Team to provide education to INTERACT Champions and INTERACT Coaches during the early developmental phases of the project.

(d) IT solutions to establish information exchange between the SNF and acute care hospitals, preferably with EHR and HIE connectivity. IT resources will also be needed to conduct quality improvement outcome monitoring (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

The primary challenge will be health information exchange. SNFs within MCC PPS show great variability in IT capabilities. Every facility will need to use INTERACT tools and protocols. Depending on the SNF's level of technical sophistication, these tools will have to take different forms. INTERACT materials will need to be developed and modified for use by all facilities from paper charts all the way to EHR systems with electronically integrated INTERACT tools. SNFs currently lacking EHR systems will receive support for EHR implementation and use from the PPS's team of IT Support Liaisons. According to the SNF survey conducted by MCC, 37% of SNFs use paper and less than 30% of facilities have telemedicine capabilities.

The most important contributor to current service fragmentation and gaps in the inability to electronically share residents' clinical records between nursing homes and hospitals. Currently, SNFs

routinely receive only hard-copy hospital discharge summaries upon a resident's return, and these may be incomplete or omit minor facts that can become significant in a SNF environment. The planned EHR installations and RHIO connections will allow access to timely and accurate health information. INTERACT can be used on paper, but over five years the goals will be connectivity.

While electronic information exchange is crucial to the INTERACT project, there is also a need to establish and improve communication between nursing home and hospital personnel via phone, email, and even in-person visits. Our project will provide education to hospital teams about INTERACT. We believe this process will help build the dialogue between staffs that is essential for timely information sharing.

Moreover, due to wide variations in the staffing models used by partnering facilities, the role of an INTERACT Champion does not correspond directly to any standard job title. For example, the Director of Nursing is not always the most appropriate choice for an INTERACT Champion. One of the tasks to be addressed in the readiness phase of this project is to assist participating facilities in identifying the best candidate from a facility's existing staff, or to hire a Champion if a qualified individual does not exist within the SNF's ranks, case by case, individually, in each facility.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

MCC will coordinate with the two bordering PPSs, Catholic Medical Partners (CMP) and Finger Lakes PPS, in an effort to educate all hospitals and systems in regards to the INTERACT project. SNF INTERACT partners will utilize all hospital systems across the eight counties of WNY. As a result, it is essential that patients are reviewed closely prior to admission to SNFs to help prevent re-hospitalization. Coordination with specialists in each PPS will also help strengthen the INTERACT project via telemedicine and onsite access within SNFs.
Close coordination with CMP and Finger Lakes PPS will be assured by encouraging the use of standardized referral protocols, utilizing uniform tracking and reporting systems, adopting universal alert messaging via the RHIO, maintaining common messaging to educate patients about patient activation, and sharing lessons learned. Progress reports and information exchange on the project will be the subject of periodic meetings among the PPS organizations.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. <u>Project Resource Needs and Other Initiatives</u> (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Additional funds will be necessary to help designated SNFs meet the needs of the INTERACT project as well as to design and develop specialized long-term care units. Capital will also be required to address current shortcomings in HIE and EHR capabilities.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

2.b.viii Hospital-Home Care Collaboration Solutions

Project Objective Implementation of INTERACT-like program in the home care setting to reduce risk of re-hospitalizations for high risk patients.

Project Description: Many patients who previously were transferred to skilled nursing facilities (SNFs) are now being discharged to less restrictive alternative locations, primarily home-based. Aside from the many benefits of returning to a known and personal setting, there are the risks of potential non-compliance to 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 these risks by matching services with transition care management. Services are expected to last more than 30 days.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.
2. Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.
3. Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.
4. Educate all staff on care pathways and INTERACT-like principles.
5. Develop 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.
6. Create coaching program to facilitate and support implementation.
7. Educate patient and family/caretakers, to facilitate participation in planning of care.
8. Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.
9. Utilize telehealth/telemedicine to enhance hospital-home care collaborations.
10. Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.
11. Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.
12. Use EHRs and other technical platforms to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The CNA reveals that Medicaid readmissions for inpatient services represent additional utilization and increased healthcare expenditures. There are over 2,000 Medicaid potentially avoidable readmissions per year in WNY. The current rate is 5.8/100, and the goal rate for a 25% reduction would be 4.4/100. Lack of care coordination during transitions, low health literacy, language issues, and lack of engagement with the community healthcare system have been identified as important factors. Transition supports such as home care services are not well deployed. Currently, many patients with chronic conditions are readmitted within 30 days because home care was not evaluated and arranged under supervision of the PCP.

These needs will be addressed by implementing the hospital/home care project at two system levels: the Central Home Care Support Team level and the Local Rapid Response Team level.

The Central Home Care Support Team will be responsible for the following:

(a) The Core Home Care Program will be developed and implemented using INTERACT-like principles at every committed partnering hospital, with procedures and protocols for discharge planning, discharge facilitation, and confirmation of home care services. The PPS will train and provide guidance to hospitals on how their staffs can form Local Rapid Response Teams using INTERACT-like tools and the AHRQ Toolbox for Reducing Medicaid Readmissions to facilitate patient discharge to home and assure needed home care services are in place, including hospice when appropriate.

(b) Care pathways: Protocols, pathways, and best practices will be adopted from the AHRQ Toolbox and shared among partnering hospitals to raise the level of post-discharge care to prevent readmission. Hospital-based Local Rapid Response Teams will be provided with and trained in the model's care pathways and other clinical tools to address common risk factors for readmissions.

(c) Advance care planning tools: The Central Home Care Support Team will provide important instruction and training to Local Rapid Response Teams on how to appropriately engage in end-of-life discussions with patients and their families.

(d) A coaching program will facilitate and support implementation.

(e) An interoperable EHR will be established for information exchange between the hospital, PCP, and home care provider to avoid medication errors and prevent duplicative services.

(f) Telehealth/telemedicine will be used to enhance hospital/home care collaborations.

(g) Outcome measurement will be conducted for quality improvement outcome monitoring (including quality assessment/root cause analysis of transfer) in order to identify additional interventions. The evidence-based AHRQ Toolbox for Reducing Medicaid Readmissions that will used for this project includes tools for readmission risk assessment, whole-person assessment, discharge checklist, and forming cross-continuum teams.

Local Rapid Response Teams will be hospital-based cross-continuum teams comprised of hospital discharge staff (pharmacy as needed), home care providers, and PCPs (Health Home as needed). Local Rapid Response Teams will be responsible for the following:

(a) Team leadership: A Response Team Leader will be identified who will engage other staff and serve as a champion/coach and leader of the local team.

(b) Implementation of the AHRQ Toolbox and other resources provided by the Central Home Care Support Team.

(c) Cyclical education with audit and feedback will be conducted with all Local Rapid Response Team staff on care pathways and INTERACT principles, with active facilitation from the PPS.

(d) Patient/family engagement via the Local Rapid Response Team, to educate patient and family/caretakers and facilitate their participation in care planning.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

Patients to be engaged in this project will be all Medicaid population being discharged from participating PPS hospitals in WNY. Those identified as high-risk by the AHRQ Readmission Risk Assessment tool will be offered the project services of the Local Rapid Response Teams.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Current assets and resources mobilized:

Through its collaborative partnerships, MCC PPS will maximize the use of current healthcare resources, including 10 hospital, 48 home care locations, 235 primary care locations (30% are safety net), 6 Health Homes, 120 nonprofit CBOs, 437 food and basic needs service agencies, 370 housing/shelter basic need organizations, 42 crisis intervention agencies, 32 individual and family support service groups, 96 education and literacy support programs, 184 local social services programs, and 128 information referral service locations, as well as a full array of specialty providers form medical, behavioral, and community care settings. ECMC's successful "Conversation Project," which encourages patients, caregivers, and families to discuss end-of-life choices, will be leveraged and expanded to educate and support all partners in the PPS on palliative care and advanced care planning.

New resources needed:

(a) Central Support Team: A Project Director (one full-time equivalent), Coaches (two FTEs), and a Continuing Educator (one FTE). Coaches will be retained to oversee and support the project. The Coaches will assist with the development of the program and will provide education and outreach to ensure the project's success.

(b) Local Rapid Response Teams: RN Team Leaders (10 FTEs). At some hospitals, the staff required for the project will be existing personnel who are retrained or redeployed. At other facilities, new staff will need to be hired to perform Response Team functions. Every partnering facility needs to identify a Response Team Leader who will facilitate the model's use in their own facility and community partners. The Leader could be a repurposed RN position filled by an existing staff member.

(c) Interoperable EHR solutions will be leveraged to establish information exchange between the hospital, PCP, and home care provider to avoid medication errors, prevent duplicative services, and conduct quality improvement outcome monitoring (including quality assessment/root cause analysis of transfer) to identify additional interventions.

(d) Telehealth/telemedicine solutions will be leveraged to enhance hospital/home care collaboration.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Creating cross-continuum Response Teams: Forming hospital-based cross-setting teams comprised of hospital discharge staff, pharmacy, home care providers, PCPs, Health Homes, behavioral health, and other community resources will be very challenging. We will use INTERACT-like principles and training to facilitate the team-building process. We will work with each partner to set goals, achieve administrative buy-in, allocate resources, foster a team approach, and educate with audit and feedback on a regular basis.

Interoperability of EMRs: Our project will be challenged by current limitations of EMR systems which lack the capacity to easily move patient information between providers. This project will accelerate the pace at which changes in IT are taking place.

Training for staff: Providing staff in hospital, home care, primary care, and behavioral health settings with training in this new model of care will also be a challenge. Fortunately, there are many evidence-based models for the reduction of Medicaid readmissions. Training in these models is readily available, and this project will provide the necessary resources to train all involved staff.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

MCC PPS will coordinate its strategies with those of the neighboring PPS, Catholic Medical Partners (CMP). CMP already has a system in place to reduce hospitalization. We will coordinate training, identify patients in CMP's system that fit our criteria, and leverage their expertise and lessons learned. We also have planned to coordinate our efforts with the other neighboring PPS, Finger Lakes PPS, and have agreed to regular meetings between our respective PPSs to develop consistent strategies.
Close coordination with CMP and Finger Lakes PPS will be assured by encouraging the use of standardized referral protocols, utilizing uniform tracking and reporting systems, adopting universal alert messaging via the RHIO, maintaining common messaging to educate patients about patient activation, and sharing lessons learned. Progress reports and information exchange on the project will be the subject of periodic meetings among the PPS organizations.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. <u>Project Resource Needs and Other Initiatives</u> (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Capital funding is needed to support infrastructure development for the hospital/home care project.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

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

In order to be eligible for this project, a PPS must already be pursuing 10 projects, demonstrate its network capacity to handle an 11th project, and evaluate that the network is in a position to serve uninsured (UI), non-utilizing (NU), and low utilizing (LU) populations. Any public hospital in a specified region has first right of refusal for implementing this 11th project. Only the uninsured, non-utilizing, low-utilizing Medicaid member populations will be attributed to this project. Finally, in order to participate in pay-for-reporting outcome metrics in Demonstration Years (DY) 4 and 5, the PPS will submit data as specified.

Project Objective: The objective of this 11th project is to address Patient Activation Measures® (PAM®) so that UI, NU, and LU populations are impacted by DSRIP PPS' projects. Feedback from the public comment period resulted in the state to include UI members in DSRIP, so that this population benefits from a transformed healthcare delivery system. Please refer to the body of literature found below on patient activation and engagement, health literacy, and practices to reduce health care disparities:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955271/
http://content.healthaffairs.org/content/32/2/223.full
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
http://www.hrsa.gov/culturalcompetence/index.html
http://www.nih.gov/clearcommunication/culturalcompetency.htm

Project Description: This project is focused on persons not utilizing the health care system and works to engage and activate those individuals to utilize primary and preventive care services. The PPS will be required to formally train on PAM®, along with base lining and regularly updating assessments of communities and individual patients. This project encapsulates three primary concepts, which drive the requirements for this project:

- Patient activation
- Financially accessible health care resources
- Partnerships with primary and preventive care services

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.

2. Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.
3. Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.
4. Survey the targeted population about healthcare needs in the PPS' region.
5. Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.
6. Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).
   - This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.
   - Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.
7. Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM® during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.
8. Include beneficiaries in development team to promote preventive care.
9. Measure PAM® components, including:
   - Screen patient status (UI, NU and LU) and collect contact information when he/she visits the 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, assess patient using PAM® survey and designate a PAM® score.
     - Individual member score must be averaged to calculate a baseline measure for that year's cohort.
     - The cohort must be followed for the entirety of the DSRIP program.
   - On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation.
   - If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.
     - The PPS will NOT be responsible for assessing the patient via PAM® survey.
     - PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.
   - Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.
10. Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.

11. Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage community health care resources (including for primary and preventive services) and patient education.
12. Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.
13. Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.
14. Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive health care services and resources.
15. Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.
16. Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.
17. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. The project description should consider three primary activation concepts: *patient activation*, *financially accessible health care resources*, and *partnerships with primary and preventive care services.*

CNA findings indicate that rural and inner city minority areas have uninsured (UI) rates higher than the State (13% vs 11%). While WNY Medicaid patients are slightly less likely to be non-utilizers (NU) or low-utilizers (LU) of outpatient, inpatient, and ED services than the State; despite their poor health, they are less likely to see a PCP (35% no PCP compared to NYS 31%).

Multiple interrelated factors contribute to this:

(a) Entrenched poverty: Nearly a half million individuals in the region (478,765) live in or near poverty, with incomes under 200% of the federal poverty level

(b) Poor distribution and shortage of primary care, especially safety net locations

(c) Limited access to reliable transportation: One out of eight households across WNY do not have a vehicle, higher than in any other region of the state outside of NYC

(d) Low health literacy and lack of engagement

This "11th Project"—the MCC Activation Project—addresses these gaps by fostering patient activation, connection to financially accessible healthcare resources, and linkage of UI and LU/NU Medicaid beneficiaries to a safety net PCMH. This will be accomplished at three levels: (1) Central Project Integration; (2) Community-Based Activation Teams; and (3) Safety Net PCMH Network.

Central Project Integration: Using ongoing CNAs with involvement of patient advocates, MCC will identify UI, NU, and LU "hot spots" that will be the focus of this project. They will establish Community-Based Activation Teams in each hot spot target area by means of an RFP process. MCC will ensure that PPS partner organizations that encounter the UI and LU/NU Medicaid population in these areas will directly refer cases to the Activation Team. MCC will establish a PPS-wide train-the-trainer team comprised of members with Patient Activation Measure (PAM®) and patient activation expertise. The team will train Community Health Workers (CHWs)/Navigators in patient activation, education, and use of the PAM, and will educate them about insurance options and healthcare resources available to UI, NU, and LU populations. MCC will also perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the MCC Activation Project. The central project office will also develop a process for Medicaid recipients and project participants to report complaints and receive customer service.

Community-Based Activation Teams: Each hot spot target area with high UI and LU/NU Medicaid concentrations will have a Community-Based Activation Team. Designation of target areas will also consider linguistic and cultural characteristics so the Activation Team can be appropriately matched to the area. Each Activation Team will have a team manager and at least five CHWs/Navigators to connect target populations to healthcare coverage, primary care, and community resources. Each team will engage target populations using PAM with PPS oversight. They will complete all PAM components, assessing each beneficiary cohort using PAM at baseline and at set intervals.

Safety Net PCMH Network: MCC will establish a network of 69 safety net primary care (PCMH) locations and 12 ED locations to be aligned with Activation Teams. Care managers in the PCMH and ED network will be trained on patient activation techniques such as shared decision-making and cultural competency. Each year, every PCMH location will obtain a list from their managed care organizations (MCOs) of Medicaid NU and LU enrollees who are assigned to them but not seen. With the assistance of the project's CHWs/Navigators (who will interface with Health Home care managers), the PCMH will reconnect beneficiaries. With Activation Team help, the PCMH network will increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population. Note: Only the uninsured, non-utilizing, low-utilizing Medicaid member populations will be attributed to this project.

Based on information provided by NYSDOH, the UI population residing in all eight counties of WNY is over 113,000. The project estimates that there are over 98,000 LU/NU Medicaid beneficiaries in WNY. The combined UI/LU/NU population target is over 211,000. Based on evidence associated with the PAM tool, it is estimated that approximately 55% of the target population will be engaged, based on best practices. Therefore, the patient population expected to be engaged through the implementation of the MCC Activation Project is estimated to be about 116,000 (55% of 211,000).

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. Please demonstrate that the PPS has network capacity to handle an 11th project and how the PPS is in a position to serve these UI, NU and LU populations. In addition, identify any needed community resources to be developed or repurposed.

Current assets and resources mobilized:

Given Erie County Medical Center Corporation's (ECMCC's) role as the sole provider of trauma care and largest safety net facility in WNY, it has strong affiliations with a vast number of community-based organizations (CBOs) and safety net providers throughout the region. It has current assets to lead the Central Project Office to accomplish project requirements with strong local CBO partners.

Current assets that will be leveraged in connection with the MCC Activation Project include staff at 12 EDs in WNY, 69 primary care safety net locations, 8 Community Action Organizations, facilitated enrollers from 4 Medicaid MCOs, 6 Health Home agencies, 120 nonprofit CBOs, 437 food and basic needs service agencies, 42 crisis intervention agencies, 32 individual and family support service groups, 96 education and literacy support programs, 184 local social services programs, and 128 information referral service locations.

The new resources to be invested in the project include:

(a) An MCC Activation Project Manager (one full-time equivalent)

(b) A Train-the-Trainer Team (three FTEs)

(c) Community-Based Activation Teams in each designated hot spot target area. The number of teams will be determined during the implementation phase, following further assessment and patient involvement. Each team will minimally have an Activation Team Leader (one FTE) and at least five FTE CHWs/Navigators.

MCC Activation Project operational resources are expected to include: (a) the cost of the PAM tool components; (b) training-related costs; (c) educational materials and supplies; (d) transportation costs relating to leasing and operating vans to transport individuals; and (e) an IT platform integrated with PAM software to facilitate real-time updates from CHWs/Navigators who will use mobile devices in the field to report on new patient activations.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Project coordination: The target population's size and geographic distribution over a relatively large region presents major logistical challenges. Our strategy for optimizing project logistics is to designate hot spot areas with lots of local input to minimize logistical problems and to use a robust RFP process to

select local CBOs as the Community-Based Activation Team with the best cultural competency fit with the hot spot to be served.

Language and cultural barriers: The region's UI and LU/NU population is incredibly diverse, including marginalized inner-city African-American and Latino individuals, resettled refugees with limited English proficiency, Native American communities, the working poor, and migrant farm workers. Health literacy among target area residents and cultural competency among CBO partners will likely be issues. Our strategy for these challenges is to designate hot spot target areas based on language and cultural characteristics, use a robust RFP process to select local CBOs with the best cultural and competency fit with the hot spot to be served, and provide Activation Team staff with training and project material that addresses cultural competency and health literacy.

Covering the uninsured: Still another challenge involves financing the care that is delivered to the UI. Specifically, there is concern that participating PCMHs may not have the financial resources to absorb free care. The MCC Activation Project will address this by training CHWs/Navigators in facilitating enrollment in the New York State of Health insurance marketplace or Medicaid, depending on eligibility. CHWs/Navigators will also partner with MCO-facilitated enrollers to achieve this. The PCMH Safety Net Network includes eight FQHC locations that are large practices with capacity for handling uninsured patients.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

MCC PPS is working with Catholic Medical Partners (CMP) PPS (four overlapping counties) and the Finger Lake PPS (four overlapping counties) to coordinate logistics regarding the Activation Project. In cases when a member of the UI/LU/NU population already has a PCP in another PPS, there will be common protocols for activating the reconnection of the member to sources of care outside the PPS. Close coordination with CMP and Finger Lakes PPS will be assured by encouraging the use of standardized referral protocols, utilizing uniform tracking and reporting systems, adopting universal alert messaging via the RHIO, maintaining common messaging to educate patients about patient activation, and sharing lessons learned. Progress reports and information exchange on the project will be the subject of periodic meetings among the PPS organizations.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. <u>Project Resource Needs and Other Initiatives</u> (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

The PPS will invest DSRIP capital funds for the development of PCMH Level 3 clinics in identified PCP shortage areas.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards scale of project implementation, completion of project requirements and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

Domain 3 Projects

3.a.i Integration of Primary Care and Behavioral Health Services

Project Objective: Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.

Project Description: 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 delivered under one roof by known healthcare providers is the goal of this project.

The project goal can 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).

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones & Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

There are three project areas outlined in the list below. Performing Provider Systems (PPSs) may implement one, two, or all three of the initiatives if they are supported by the Community Needs Assessment.
Any PPS undertaking one of these projects is recommended to review the resources available at http://www.integration.samhsa.gov/integrated-care-models.

A. *PCMH Service Site:*
   1. Co-locate behavioral health services at primary care practice sites. All participating primary care providers must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by Demonstration Year (DY) 3.
   2. Develop collaborative evidence-based standards of care including medication management and care engagement process.
   3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
   4. Use EHRs or other technical platforms to track all patients engaged in this project.

B. Behavioral Health Service Site:

1. Co-locate primary care services at behavioral health sites.
2. Develop collaborative evidence-based standards of care including medication management and care engagement process.
3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
4. Use EHRs or other technical platforms to track all patients engaged in this project.

C. IMPACT: This is an integration project based on the Improving Mood - Providing Access to Collaborative Treatment (IMPACT) model. IMPACT Model requirements include:

1. Implement IMPACT Model at Primary Care Sites.
2. Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.
3. Employ a trained Depression Care Manager meeting requirements of the IMPACT model.
4. Designate a Psychiatrist meeting requirements of the IMPACT Model.
5. Measure outcomes as required in the IMPACT Model.
6. Provide "stepped care" as required by the IMPACT Model.
7. Use EHRs or other technical platforms to track all patients engaged in this project.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

CNA findings indicate that behavioral health conditions have a profound effect on medical management of chronic complex disease. Mental disorder is among the top ten causes of hospitalization in WNY for the general population, moreso for African-Americans. Admission rate for depression is high (45.5/100,000 beneficiaries with depression), exceeding the NYS rate (40.6). Readmissions due to mental health issues are a problem in WNY (28% with multiple admissions). There are many indicators of poor quality associated with lack of behavioral health and primary care integration: (a) Antidepressant medication management for the effective acute phase of treatment is done 48% of the time (b) Antidepressant medication management for the effective continuation phase of treatment is done less than 38% of the time (c) Diabetes monitoring for people with schizophrenia is done 70% of the time

(d) Diabetes screening for people with schizophrenia/(BPD using antipsychotic medication is done 68% of the time
(e) Follow-up care for children prescribed ADHD medication is done 54% of the time
(f) Follow-up after hospitalization for mental illness is done 59% of the time
(g) Adherence to antipsychotic medication with schizophrenia occurs 57% of the time
(h) Low health literacy
System gaps include: structural barriers between the medical system and behavioral health system hamper integration (regulatory, confidentiality, lack of interoperability, lack of cross-training); WNY has half the number of psychiatrists and psychologists per beneficiary as the State; shortage of primary locations, especially safety net PCMH settings, capable of dealing with behavioral health complexity; lack of care management across settings; and Health Homes just started and are not yet well integrated with primary care, especially in rural counties.
To address these gaps, this project, Behavioral Health Connect, will implement three strategies:
(1) Integrate across settings: Overcome structural barriers (regulatory, confidentiality, lack of interoperability, lack of cross-training); improve HIE coordination among partners through mandated use of EMRs and RHIO while enhancing RHIO interoperability; accelerate integration of emerging Health Home agencies into the infrastructure; work with Area Health Education Center partners to recruit behavioral health specialists into shortage areas.
(2) Enhance behavioral health settings: In serious mental illness (SMI) high-need locations, co-locate full-scope primary care services using mid-levels (NPs or PAs); train all providers (behavioral health and PCPs) in Collaborative Care model; conduct preventive medical and behavioral health screenings (PCMH standard screening, PHQ-9, SBIRT); share EHR systems with local HIE/RHIO, share health information among all Behavioral Health Connect partners.
(3) Enhance primary care safety net settings: In safety net locations, co-locate behavioral health services (LMHC or LMSW); rapidly transform to PCMH 2014 Level 3 and EHR MU; use Collaborative Care model; conduct preventive behavioral health screenings (PHQ-9, SBIRT); share EHR systems with local HIE/RHIO, share health information among Behavioral Health Connect partners.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The patient population to be engaged in Behavioral Health Connect are Medicaid (all ages) in WNY that have a behavioral health diagnosis. The following standard CMS condition categories will be engaged:
(a) Depression, type I major depression, and type II depressive disorders
(b) Alcohol use disorders and complications
(c) Substance-related disorders
(d) Anxiety disorders
(e) ADHD, conduct, and impulse disorders

(f) Personality disorders
(g) Post-traumatic stress disorders (PTSD)
(h) SMI: BPD, schizophrenia and other psychotic disorders

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Current assets and resources mobilized:
Region-wide current assets are: 512 behavioral health service locations (122 that serve high-need SMI and 8 that have co-located primary care), 69 safety net primary care locations, 23 peer mental health advocacy organizations, 12 EDs, 6 Health Homes, 437 agencies providing food/basic need services, 370 housing/shelter basic need organizations, 184 public assistance programs, and 29 crisis intervention programs. Many of these existing resources will be integrated with Behavioral Health Connect to meet project objectives.
(a) Primary care safety net practices participating in the project will obtain NCQA 2014 Level 3 PCMH/APCM and MU certification by end of DY3. PCMH transformation design will embed the Collaborative Care model, preventive behavioral health screenings (PHQ-9, SBIRT), and full interoperability with the RHIO.
(b) Behavioral health agencies (collaboratively with Health Homes) will train their providers in the Collaborative Care model. They will conduct preventive medical screenings in targeted locations and will share EHR systems with the RHIO.
(c) Scores of community-based organizations (CBOs) which provide food, housing, support service and public assistance will establish methods for information exchange with Behavioral Health Connect partners and expand their service capacity to meet increased service demands.
New resources needed:
(a) A Behavioral Health Connect Project Director (one full-time equivalent)
(b) New PCPs for behavioral health settings: 12 FTEs of mid-level primary care (NP or PA) and 25 RN FTEs will be co-located in SMI high-need behavioral health locations. Participating behavioral health locations will hire new personnel with PPS cost-share support during ramp-up years. Billable services and value-based reimbursement will eventually sustain new services.
(c) New behavioral health providers for primary care safety net settings: 25 FTEs of co-located behavioral health providers (licensed mental health counselors or licensed clinical social workers) will be co-located in PCMH safety net locations. Participating PCMH locations will hire new personnel with PPS cost-share support during ramp-up years. Billable services and value-based reimbursement will eventually sustain new services.
(c) Peer advocates for specific non-English speaking or cultural groups identified as behavioral health high-risk. They will be on call to assist Behavioral Health Connect partners in situations involving language or cultural barriers.
(d) PCMH Coordinators to provide NCQA training and coaching to primary care staff to ensure that primary care practices meet NCQA 2014 Level 3 and MU standards related to behavioral health integration.

(e) New psychiatrists and/or clinical psychologists in unserved areas: PPS will support recruitment and ramp-up costs; billable services and value-based reimbursement will eventually sustain.
(f) Office space and equipment: Participating primary care and behavioral health sites will require office space and equipment for new services.
(g) Training for both primary care and behavioral health practitioners involved in the project will be necessary for success.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Stigma: The stigma attached to behavioral health disorders often interferes with patients consistently engaging in primary care services. By screening all patients for behavioral health problems and utilizing behavioral specialists in primary care practices, this project normalizes behavioral health concerns.
Shortage of behavioral health professionals: By treating more behavioral health disorders within primary care practices, this project will reduce the demand for psychiatrists and psychiatric nurse practitioners. This project will co-locate behavioral health providers in primary care safety net locations. The project will also support the recruitment and startup of psychiatrists and/or clinical psychologists in unserved areas.
Interoperability of EMRs: Our project will also be challenged by current limitations of EMR systems which lack the capacity to easily move patient information between providers. This project will accelerate the pace at which changes in IT are taking place.
Training for staff: Providing staff at primary care and behavioral health sites with training in this new model of care will also be a challenge. Fortunately, there are many evidence-based models for integration of primary care and behavioral health. Training in these models is readily available, and this project will provide the necessary resources to train all involved staff.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

As a result of the joint CNA, this project was selected by both MCC and Catholic Medical Partners (CMP). It was recognized that a coordinated approach is necessary to effectively address the high-risk behavioral health population. Close coordination with bordering PPSs (CMP and Finger Lakes PPS) will be assured by encouraging the use of standardized referral protocols, utilizing uniform

tracking and reporting systems, adopting universal alert messaging via the RHIO, maintaining common messaging to educate patients about behavioral health/PCP services, and sharing lessons learned. Progress reports and information exchange on the project will be the subject of periodic meetings among the PPS organizations.

2. Scale of Implementation (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? *(Please mark the appropriate box below)*

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Capital budget funding is required for:

Renovating existing primary care and behavioral health facilities to fully staff, equip, and train multidisciplinary staff for integrated treatment

Building new integrated treatment sites (both primary care and behavioral health provider-driven) to ensure physical access to community-based treatments in areas where such facilities do not exist (e.g., east side of Buffalo, South Buffalo/Lackawanna, Niagara Falls)

Upgrading health information technology EHR systems to accommodate additional staff, services, facilities, and effectively coordinate care among them

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. **Domain 1 DSRIP Project Requirements Milestones & Metrics:**

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

c. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

d. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

3.a.ii Behavioral Health Community Crisis Stabilization Services

Project 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.

Project Description: 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. This project entails providing 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. 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 Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones & Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.
2. Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.
3. Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.
4. Develop written treatment protocols with consensus from participating providers and facilities.
5. Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.
6. Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).
7. Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.
8. Ensure that all PPS safety net providers are actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
9. Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.
10. Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.
11. Use EHRs or other technical platforms to track all patients engaged in this project.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

CNA data demonstrate that behavioral health-related repeat ED revisits comprise a significant share of the ED revisits recorded by hospitals in Western New York. The three mental health diagnoses whose rates of ED revisits exceed state rates are as follows: anxiety (WNY 13% vs NY 11%); adjustment reaction (WNY 7% vs NY 4%); and drug withdrawal (WNY 13% vs NY 9%). System gaps consist of limited integration in crisis intervention community settings that serve the low- and non-utilizing Medicaid populations. Most crisis services have limited coordination across the region and there is virtually no interoperability with the RHIO. Currently many patients with behavioral health problems end up in the ED or acute care for extended periods of time because they lack support and assistance in the community at times of crisis. Much of this utilization can be diverted if we offer more viable service alternatives. In response to these needs, behavioral health providers in WNY have come together to develop the WNY Crisis Stabilization Services Network, a comprehensive plan to fill gaps that will feature the following design:

(a) Regional network: They will implement or enhance crisis intervention programs with outreach, mobile crisis team(s), and intensive crisis services in the eight counties of WNY, using evidence-based protocols. The plan is not a “one size fits all” approach. Rather, it addresses crisis stabilization service needs at the county level and offers solutions that best fit localized needs while assuring proper integration and oversight at the PPS level. The programs will be based on a recovery model of empowerment and social inclusion. At the PPS level, programming will be conducted to ensure that crisis stabilization services are linked to Health Homes, EDs, and hospital services. Agreements will be established with Medicaid Managed Care Organizations (MMCOs) to reimburse for crisis stabilization services.

(b) Central triage service: A central triage service will be established with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers. A uniform triage tool, modeled after the C.A.R.E.S. initiative in Australia, will be implemented to provide a common mental health triage rating scale, assess the level of crisis, and determine the urgency of referral and appropriate provider level of care.

(c) Network infrastructure: (i) the Comprehensive Psychiatric Emergency Program (CPEP) and expanded access to specialty psychiatric and crisis-oriented services; (ii) expanded access to observation unit(s) within hospital outpatient or at an off-campus crisis residence for stabilization monitoring services (up

to 48 hours); (iii) ensure that all safety net providers are able to actively share connected EHR systems with the local RHIO accessible by clinical partners, including direct exchange (secure messaging), alerts, patient record lookup, and secure notifications/messaging; and (iv) a quality committee will have oversight and surveillance of compliance with protocols.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The patient population expected to be engaged by this project is the adult (18+) Medicaid population in the eight counties of WNY who experience an acute behavioral and/or chemical dependency crisis severe enough that they are at risk for ED visits. Individuals do not need to have a diagnosed mental illness and may be experiencing suicidal or homicidal thoughts, panic attacks, situational crises, severe depressive symptoms, and/or psychotic symptoms.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Current assets and resources mobilized:

Region-wide current assets are: 29 crisis intervention programs, Erie County Medical Center's CPEP serving WNY with 12,000 visits per year and nearly 4,000 admissions annually, 512 behavioral health service locations (122 that serve high-need SMI and 8 that have co-located primary care), 23 peer mental health advocacy organizations, 24 EDs (12 in MCC), and 6 Health Homes.

Needed expansion and enhancement:

(a) Improve existing crisis services hotlines in Erie, Niagara, and Chautauqua Counties. This will enhance phone assessment and intervention and ensure that immediate responses are provided.

(b) Increase mobile crisis response capacity in Erie and Niagara Counties.

(c) Enhance drop-in center services in Erie and Niagara Counties.

(d) Train area law enforcement agencies to respond appropriately to individuals in crisis.

(e) Expand medically supervised and medically monitored addiction treatment services provided by Horizon Health at its facility on 90 Elm Street in Buffalo; expand this 24x7 service to include Niagara County.

(f) Add after-hours mobile crisis services in Cattaraugus County where such service currently does not exist.

(g) In partnership with the New York State Psychiatric Center located on Buffalo's west side, two other programs will be implemented: (i) the Living Room program which will provide

individuals in crisis with a place to stay and stabilize for 24-72 hours; and (ii) the Rose House model on the Psychiatric Center's campus. Persons served by this crisis service model will receive respite services up to seven days, giving clients time to talk through their issues and develop plans to deal with them. These services will offer individuals in crisis an alternative to obtaining services at an ED.

(h) New PPS investments are required to build and properly operate the network including: 1 FTE Program Director; 1 FTE Respite Center Director; 0.2 FTE Respite Center Advisor; 4.2 FTE Peers; and 2 FTE Crisis Outreach Workers. Additionally, funding is required for training, RHIO interoperability, and various operating expenses.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Qualified staffing: Hiring and maintaining qualified staff to perform 24x7 crisis stabilization service work is a challenge. The demand for behavioral health workers trained in mental health and addiction treatment is on the rise in the Buffalo area. The PPS will work with area colleges and universities to inform them of these new job demands and work with schools to accelerate programming to facilitate recruitment of these individuals.

24x7 treatment options: Continuation of 24x7 addiction treatment services at the 90 Elm Street facility in Buffalo and expansion of such services to Niagara County will require capital investments. This challenge will be met by seeking DSRIP capital funding to assist in purchasing the 90 Elm Street building in Buffalo, making renovations to the Buffalo facility, and renovating an existing facility in Niagara County.

Crisis stabilization education: The healthcare community and clients themselves have little understanding of the role of crisis stabilization services. The PPS will educate the community about the value of crisis stabilization services to help facilitate referrals. This education will squarely address any concerns relating to liability when a client uses a service as an alternative to the ED.

Health literacy and cultural competency: Equally important, education will be client-directed, and messaging will meet health literacy and cultural competency standards. This education will be provided to ensure that consumers feel comfortable using crisis stabilization services as an ED service alternative.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

Close coordination with bordering PPSs (Catholic Medical Partners and Finger Lakes PPS) will be assured by encouraging the use of standardized referral protocols, adopting universal alert messaging via the RHIO, maintaining common messaging to educate all health systems about the WNY Crisis Stabilization Services Network, and sharing lessons learned. The success

of the project requires cooperation of all EDs--even those located at hospitals that are affiliated with other PPSs. Ongoing education, project updates, and the exchange of information among the PPSs on the project will help assure that project objectives are met.

2. Scale of Implementation (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Capital funding is required to purchase and renovate the 90 Elm Street building in Buffalo to enable that facility to continue providing 24x7 addiction treatment services that can be leveraged by the WNY Crisis Stabilization Services Network. To expand such services to Niagara County, an existing facility in Niagara County will need to be renovated.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics.

Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only)

Project Objective: To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions. (Adults Only).

Project Description: 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.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones & Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.
2. Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
3. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
4. Use EHRs or other technical platforms to track all patients engaged in this project.
5. Use the EHR or other technical platform to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).
6. Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.
7. 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.
8. Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.
9. Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.
10. 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.

Improve Medication Adherence:

11. Prescribe once-daily regimens or fixed-dose combination pills when appropriate.

Actions to Optimize Patient Reminders and Supports:

12. Document patient driven self-management goals in the medical record and review with patients at each visit.
13. Follow up with referrals to community based programs to document participation and behavioral and health status changes
14. Develop and implement protocols for home blood pressure monitoring with follow up support.
15. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.
16. Facilitate referrals to NYS Smoker's Quitline.
17. Perform additional actions including "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.
18. Adopt strategies from the Million Lives Campaign.
19. Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.
20. Engage a majority (at least 80%) of primary care providers in this project.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The CNA shows that in this region and all eight counties of WNY cardiovascular disease (CVD)/heart-related conditions are the leading causes of death, premature death, hospitalization, and preventable hospitalization for the general population and moreso for African-Americans. WNY exceeds the State for CVD-related Ambulatory Care Sensitive conditions such as Heart Failure (389/100,000 vs 272) and Angina without Procedure (24/100,000 vs 20). Compared to the State, the region and all counties have a higher prevalence of CVD-related diseases: High Blood Pressure (33% vs 278%), Cardiovascular (9.1% vs 7.7%), and Coronary Heart (8% vs 6%).

Risk factors for CVD-related conditions are also high relative to State Prevention Agenda goals:

Obese adults: goal is 23%; WNY rate is 30%

Cigarette-smoking adults: goal is 15%; WNY rate is 21%

Age-adjusted heart attack hospitalization: goal is 14%; WNY rate is 18%

The identified factors confirmed by the CNA are low health literacy, lack of engagement with community supports, and lack of primary care access. There are also gaps in interoperability and communication; meanwhile, care management data-sharing among PCPs, specialists, mental health, Health Homes, and community-based organizations is lacking.

To address these gaps, the Million Hearts Project will implement CDC guidelines for the "ABCs" (aspirin use, blood pressure control, cholesterol control, and smoking cessation support) at 235 MCC primary care locations in eight counties, focused mostly in Allegany, Cattaraugus, Erie, and Niagara Counties with the highest CNA need. Presently 85 (36%) of the 235 PCP locations are PCMH-recognized. Of the MCC PCP locations, 69 are safety net. MCC will use project 2.a.i. (Integrated Delivery System) to ensure that all PCPs actively share EHR systems with the RHIO and with clinical partners, certify at PCMH 2014 Level 3, and meet EHR MU standards. The Million Hearts Project is designed to translate national guidelines to educate, screen, and treat.

(1) Educate: PCMHs will use CDC's Million Heart campaign materials to educate and link patients to healthy eating, exercise, and smoking cessation programs provided by CBOs. These materials will be available for non-English speaking or cultural groups that are identified as high-risk for CVD. The PPS will invest in an evidence-based social marketing campaign to raise awareness about hypertension—"the silent killer"—especially targeted at African-Americans.

(2) Screen: All adults in PCMH settings will be screened for cholesterol and smoking according to guidelines. The PCMH care team's workflow will be modified to achieve this as a component of meeting 2014 PCMH NCQA standards.

(3) Treat: The protocols of the national Million Hearts campaign will be adopted by PCMHs engaged in the Million Hearts project: patients with vascular disease will be monitored for use of aspirin; patients with hypertension will be managed to goal for blood pressure control; all adults identified with high LDL will be treated to goal; and all adults identified as tobacco users will receive cessation intervention and treatment according to guidelines.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The Million Hearts Project will focus on the Medicaid population age 18+ according to CDC Million Hearts criteria. We will educate and screen the entire adult target population for cholesterol and smoking status. Within the target group, those identified as smokers or as having high LDL, vascular disease, or hypertension will be treated to goal according to guidelines. Moreover, the target population will also include uninsured adults connected to PCMHs through the 11th Project (MCC Activation Project) and who fall into Million Hearts target groups noted above.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Current assets and resources mobilized:

Care teams at 235 primary care locations will apply guideline-based services to the target population. Patient education and referral services will be provided by 12 EDs, 521 behavioral health agency locations, 26 smoking cessation services, 21 religious service organizations, 120 community outreach organizations, 96 education and literacy support services, and 128 information referral service locations.

(a) Primary care practices participating in the project will modify their workflow to address Million Hearts population health management objectives. These practices will reconfigure staff duties to prepare for and obtain NCQA 2014 Level 3 Medical Home or Advanced Primary Care Model certification by the end of DY3.

(b) Behavioral health agencies (working collaboratively with Health Home agencies) will develop procedures for scheduling immediate appointments for referred PCMH clients and exchanging information with PCMH care managers on whether a referred patient connects to care.

(c) Scores of CBOs which provide patient self-management supports will establish methods for information exchange with PCMH care managers and expand their service capacity to meet increased service demands.

(d) Content experts: (1) The Global Vascular Institute (GVI), staffed by professionals ranging from cardiologists to nutritionists, will support the project. GVI experts will provide guidance to a Million Hearts collaborative learning group made up of the PCMH teams. The GVI will also provide outpatient evaluation, management, and treatment services for complex Medicaid patients referred by the PCMH groups. A feasibility analysis will be conducted to assess opening a satellite GVI site in Cattaraugus County to make specialty services available in the Southern Tier region. (2) The SUNY-DOH Collaborative for Medication Management (based at the University at Buffalo School of Pharmacy) will provide academic detailing to the PCMH locations. PCMH providers will be connected to web-based modules featuring best pharmaceutical practices for treatment of hypertension and heart disease.

New resources will be invested in the project. These include:

(a) A Million Hearts Project Manager (one full-time equivalent)

(b) Million Hearts Practice Facilitators (three FTEs): Provide NCQA training and coaching to primary care staff to ensure they meet NCQA 2014 Level 3 standards with regard to Million Hearts guidelines; also responsible for orchestrating IDS interoperability initiatives with this project

(c) Patient advocates for specific non-English speaking or cultural groups identified as high-risk will be on call to assist PCMH care managers in situations involving language or cultural barriers. The number and type of advocates will depend on level of need in specific PCMH settings.

(d) MCC will invest in an evidence-based social marketing campaign to raise aware about Million Hearts patient activation themes. It will be designed to address non-English speaking groups and cultural barriers.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Target population resistance to change: Medicaid patients who are high-risk for CVD may be uncooperative at first. To change attitudes and behaviors, the project will adopt many of the CDC's Million Hearts educational materials for conducting a public awareness campaign. As this progresses and engagement increases, it is expected more patients will be activated.

Language and cultural barriers: Tied to population resistance, in certain PCMH settings there will be major language and cultural barriers. Patient advocates will be recruited from those settings to coach PCMH care managers in approach and to potentially be on call to assist with high-need cases.

PCMH transformation challenges: RHIO interoperability of PCMHs to specialists and other settings will be addressed by the IDS project. Rapid PCMH certification will be challenging to reach full readiness to respond to the Million Hearts workflow changes. PCMH Coordinators will orchestrate this process.

Health Home integration challenges: Health Home agencies are relatively new. To assure that Health Homes engage with their enrollees while they are at the PCMH office, the project will use electronic alert systems to immediately notify Health Homes when one of their enrollees visits the PCMH with behavioral health or other self-management issues.

Integration challenges with community resources: Keeping array of stakeholders linked to Million Hearts will be challenging. The project will bring together stakeholders from across service areas to address issues through the creation of working committees and RHIO interoperability.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

As a result of the joint CNA, this project was selected by both MCC and Catholic Medical Partners (CMP). It was recognized that a coordinated approach was necessary to be effective with addressing the CVD Medicaid target population. Close coordination with both bordering PPSs (CMP and Finger Lakes PPS) will be assured by encouraging the use of standardized referral protocols, utilizing uniform tracking and reporting systems, adopting universal alert messaging via the RHIO, maintaining common messaging to educate patients about appropriate Million Heart risk factors, and sharing lessons learned. Progress reports and information exchange on the project will be the subject of periodic meetings among the PPS organizations.

2. Scale of Implementation (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☐	☒

If yes: Please describe why capital funding is necessary for the Project to be successful.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards scale of project implementation, completion of project requirements and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

3.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies)

Project Objective: To reduce avoidable poor pregnancy outcomes and subsequent hospitalization as well as improve maternal and child health through the first two years of the child's life.

Project Description: 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's life.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones and Metrics,** which will be used to evaluate whether the PPS has successfully achieved the project requirements.

For performing partner systems where the community assessment identifies significant high risk obstetrical/parenting cases, there are **three models** for intervention that may be utilized for this project. Systems should choose one primary project but may also choose requirements from the other two projects to add as part of their project.

Model 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.

1. Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high-risk mothers including high-risk first time mothers.
2. Develop a referral system for early identification of women who are or may be at high risk.
3. Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.
4. Use EHRs or other technical platforms to track all patients engaged in this project.

Model 2: Establish a care/referral community network based upon a regional center of excellence for high risk pregnancies and infants.

1. 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).
2. 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.
3. Develop service MOUs between the multidisciplinary team and OB/GYN providers.
4. Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.

5. Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
6. Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
7. Use EHRs or other IT platforms to track all patients engaged in this project.

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

1. Develop 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.
2. Employ a Community Health Worker Coordinator responsible for supervision of 4 – 6 community health workers. Duties and qualifications are per NYS DOH criteria.
3. Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.
4. Establish protocols for deployment of CHW.
5. Coordinate with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other IT platforms to track all patients engaged in this project.

Project Selection
For this project, one of the following three project models can be selected. Please indicate which of the three will be chosen:

- ☐ Model 1: Implementation of Nurse-Family Partnership program model for pregnant high risk first time mothers.
- ☐ Model 2: Establish a care/referral network based upon a regional center of excellence for high risk pregnancies and infants.
- ☒ Model 3: Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaborative (MICHC) program.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

CNA findings demonstrate many women and their children on Medicaid do not consistently receive adequate prenatal or well child care. This area's rate of preterm births is 12.1%, above the NYS Prevention Agenda goal of 10.2. The maternal mortality rate is 26.8/100,000 births, above the Prevention Agenda goal of 21/100,000. WNY's 69.5% of children who have had the recommended number of well child visits in government-sponsored programs is below the State goal of 76.9%. Medicaid well care visits in the first 15 months are done only 87% of the time. Medicaid low-weight births (<2,500 grams) happen 9.6% of the time. Inadequate prenatal care for Medicaid women occurs 22% of the time. High-risk pregnancies occur for Medicaid mothers 11% of the time. The percent of unintended pregnancy among live births is 33.2%, well above the 23.8 Prevention Agenda goal. Complications of pregnancy or childbirth is the second leading cause of hospitalization in WNY.

System gaps include: (a) structural barriers between the medical system and community resources for maternal and child health services hamper integration (lack of interoperability, lack of cross-training); (b) shortage of primary care locations, especially safety net PCMH settings capable of addressing maternal and child health complexity; (c) care management across settings is not functional; (d) low health literacy; and (e) lack of engagement of the high-risk population by the community healthcare system, particularly a lack of primary care connection and access.

To address these gaps, we will implement Model 3: the Community Health Worker (CHW) program. This approach is considered the most effective model for MCC due to the region's wide variation in population mix and diversity between the urban and rural settings. CHWs are a proven way to improve health outcomes while reducing costs by addressing the social determinants of health such as poverty, education, and housing. CHWs build capacity in the healthcare system by providing outreach, health education, home visiting, translation/interpretation services, and care coordination. This initiative will assess and build upon existing federal and state funded programs such as Maternal and Infant Community Health Collaborative (MICHC) and the NYSDOH-funded CHW training program.

We will establish CHW teams in highest need areas. The number of teams will be based on further CNA assessment with patient input. Each team will consist of a Coordinator responsible for four to six CHWs with duties and qualifications per NYSDOH criteria. Teams will be sponsored by CBOs selected by RFP process that matches cultural competency and CHW capabilities of the CBO to unique gaps in each area. CHWs on each team will be assigned to participating PCMH safety net locations in their target area to facilitate connection to primary care and engagement in the health system. The project will coordinate with MMCOs and Women & Children's Hospital of Buffalo (WCHOB, WNY's maternal and child tertiary care center) to target high-risk pregnancies and high-risk children. All partners will actively share EHR systems with the RHIO and will share health information among clinical partners.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The project will target Medicaid women of child-bearing age (14–44 years), infants, and children (0–18 years). It will focus on those who are homeless, abusing drugs or alcohol, experiencing domestic violence, and/or lacking a regular healthcare provider. The population to be served includes racial, ethnic, and linguistic minorities; refuges; teenagers; and individuals and families experiencing multiple social and/or economic stressors.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Current assets and resources mobilized:

The project will utilize the expertise and services of an array of existing CHW programs and visiting home nursing services in WNY that focus on specific high-need zip codes. These programs include MICHC; Healthy Families New York; Women, Infant, and Children program; Medicaid Obstetric Maternal Services; Healthy Mom–Healthy Baby Prenatal and Postpartum Home Visiting; The Priscilla Project; Project ACT; The "Healthy Start for All" Coalition; Healthy Babies are Worth the Weight; Centering Pregnancy; Nurse Family Partnership; and the Regional Perinatal Center.

In addition to the existing CHW programs that will be mobilized, there are 169 primary care locations serving maternal and child population (family medicine, pediatrics, or OB/GYN) that will interface with the CHW program. Of these, there are 56 safety net primary care locations that will be actively linked to the new CHW program. The project will also mobilize existing resource of the four MMCOs and WCHOB to target high-risk pregnancies and high-risk children.

New resources needed:

(a) A CHW Program Manager (one full-time equivalent)

(b) Community-Based CHW Teams established in each designated high-need area. The number of teams will be determined during the implementation phase, following further assessment and patient involvement. Each team will minimally have one full-time CHW Team Leader and four to six CHWs.

(c) CHW project resource costs are expected to include: CHW training programs (well-established CHW training programs in WNY will be used), transportation such as leasing and operating a van to transport individuals within each team, and an IT platform with integrated software to facilitate real-time updates from CHWs who will use mobile devices in the field to actively share EHR systems with the RHIO and share health information among clinical partners.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Sustainment of new CHW services: Home visiting services provided by CHWs are not reimbursable. Moreover, many nursing related-maternal home visits are not eligible for reimbursement. To address the reimbursement challenge, MCC will work with NYS Medicaid, MMCOs, and local payers to ensure that these services are reimbursed through government-funded health insurance plans. Otherwise, value-based reimbursement should sustain a CHW service that reduces avoidable complications and prolonged hospitalizations.

Expanding the CHW workforce: Implementation of this project and expansion of existing CHW programs will require significant expansion of the workforce. MCC will work collaboratively with agencies such as the Community Health Worker Network of Western New York to ensure that an adequate workforce is available and trained to implement this project.

CHW program interoperability: One of the project requirements is to track all patients engaged in this project through EHR or other IT platforms and to actively share EHR systems with the RHIO and share health information among clinical partners. This capability is not currently consistent across existing programs. Some programs do employ tracking software, but generally these are isolated implementations that do not connect to other service agencies or healthcare providers. CHWs will be given access to IT resources that are interconnected. Since CHWs often work in areas with inconsistent internet access, this program will issue each CHW a tablet (or other mobile device) that can be used to maximize communication and efficiency.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

Both MCC and Catholic Medical Partners (CMP) chose project 3.f.i., but selected different models. Cooperation between the two PPSs, in the form of mutual referrals, will result in comprehensive support across the whole region. CMP is implementing a Nurse/Family Partnership program model, so MCC providers will refer their patients for whom that program would be appropriate. Meanwhile, CMP providers will refer their patients to MCC's CHW programs as appropriate. This coordination will ensure that patients are matched up with the type of support programs that are most likely to be appropriate (and thus more effective) for them.

MCC will work collaboratively with bordering PPSs (CMP and Finger Lakes PPS) to expand the scope of the Regional Perinatal Center and the Regional Perinatal Outreach grant to include a center that will serve the entire WNY region. The center will provide free information, referral, technical assistance, and support to families, professionals, and community agencies concerned with prenatal care similar to the Early Childhood Direction Center (ECDC) model for all of WNY. Like ECDC, this center will work with community stakeholders to coordinate referrals to community programs, educate providers on services available, and increase collaboration among all stakeholders in the communities. This regional center will support all of WNY, including the initiatives of other PPSs.

2. Scale of Implementation (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☐	☒

If yes: Please describe why capital funding is necessary for the Project to be successful.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Baby & Me Tobacco Free			Ongoing	Smoking cessation program in Chautauqua County created to reduce the burden of tobacco use on the pregnant and post-partum population
Baby & Me Tobacco Free			Ongoing	Smoking cessation program in Erie County created to reduce the burden of tobacco use on the pregnant and post-partum population
Centering Pregnancy			Ongoing	Group healthcare model which incorporates three major components: assessment, education, and support. Patients meet with their care provider and other group participants for 90–120 minutes, at regularly scheduled visits. Promotes greater patient engagement, personal empowerment, and community building. Starts around the beginning of the second trimester through delivery.
Community Health Worker Network of Buffalo			Ongoing	Trains CHWs to assist individuals, families, and communities to be active participants in their personal and community level health and well-being
Healthy Babies are Worth the Wait		November 2014	Ongoing	Provides education for pregnant women, perinatal providers, and

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				the greater community on preterm birth, risk factors, and strategies for reducing risk
Healthy Families Niagara @ Family & Children's Services of Niagara			Ongoing	Provides parenting education from prenatal to 5 years; currently serves 95 families with capacity for 105 families
Healthy Families NY @ BPPN			Ongoing	Locates families in the City of Buffalo during pregnancy up to 3 months of age. Provides case management and education in the home. Screens for depression, drinking, and developmental delays. Encourages women to complete school, get job training, find employment, and navigate the system on their own.
Healthy Start Community Health Worker Program-BPPN			Ongoing	Uses a communitywide systems approach in the City of Buffalo to target African-American and Hispanic women before, during, between, and after pregnancy, to reduce racial disparities in infant mortality and adverse perinatal outcomes. Goes door-to-door looking for pregnant women as early as possible in pregnancy.
Maternal Infant Community Health Collaborative (MICHC)			Ongoing	Refers and provides direct 1:1 assistance to help clients in Erie County obtain and consistently utilize health insurance, primary care and/or prenatal care, family planning, and other needed community services. Provides social support to promote and reinforce health-promoting behaviors; helps clients utilize

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				services and be able to communicate their needs. Provides case management during pregnancy and after birth up to 1 year.
Maternal Infant Community Health Collaborative (MICHC)			Ongoing	Refers and provides direct 1:1 assistance to help clients in Chautauqua County obtain and consistently utilize health insurance, primary care and/or prenatal care, family planning, and other needed community services. Provides social support to promote and reinforce health-promoting behaviors; helps clients utilize services and be able to communicate their needs. Provides case management during pregnancy and after birth up to 1 year.
Neighborhood Health Center			Ongoing	Embeds CHWs in Health Center OB/GYN department
Nurse Family Partnership			Ongoing	CMP is leading this project
Parenting and Pregnancy Assistance Program			Ongoing	Strives to create greater awareness of resources available to support pregnant and parenting students and their families
Priscilla Project			Ongoing	Fosters healthy births for culturally and linguistically isolated refugee women
Project Act			Ongoing	Serves pregnant and parenting teens in Buffalo Public Schools

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

The DSRIP project described here will greatly expand the population served by the above programs. Currently the programs above are limited by geography and limited funds; therefore they are not reaching the entire high-risk population for the counties of WNY. With DSRIP support, these existing programs that have already been proven effective in WNY can reach a broader target population.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well

as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

Domain 4 Projects

4.a.i Promote mental, emotional, and behavioral (MEB) well-being in communities (Focus Area 1)

Project Objective: This project will help to promote mental, emotional, and behavioral (MEB) well-being in communities.

Project Description: The best opportunity to improve the public's mental health and prevent its development from manifesting is the delivery of preemptive interventions. This project focuses on increasing the use of evidence-informed policies and evidence-based programs pertaining to the healthy development of children, youth, and adults.

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

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Identify and implement evidence-based practices and environmental strategies that promote MEB health. A menu of interventions is found on the Prevention Agenda website accessible via the following:
    - Website:(http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/interventions.htm)
    - Section: Promote Mental Health and Prevent Substance Abuse Action Plan, Interventions for Goal 1: To promote mental, emotional and behavioral (MEB) well-being in communities
2. Support and facilitate quality improvement of evidence-based practices and environmental strategies that promote MEB health.

Partnering with Entities Outside of the PPS for this Project
Please provide the name of any partners included for this project outside of the PPS providers. This may include an entity or organization with a proven track record in addressing the goals of this project.

Entity Name
Catholic Medical Partners/Catholic Health System Finger Lakes PPS

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 100)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The CNA contains information on select health prevention metrics, identifying gaps in behavioral and mental health services. The promotion of community well-being is fragmented at the local level and is not well orchestrated at the regional level. The binge drinking rate in WNY (18.9%) is higher than the state rate of 17.4%. The suicide rate in the region is a staggering 11.4/100,000, which is 20% higher than the state rate. The rate of poor mental health days (+14 days in last month) is 11.7% in WNY, higher than the state goal of 11.8%. The percentage of cigarette smoking among adults in the region is 20.3% compared to a state rate of 17.3% and a State Prevention Agenda goal of 15%. Mental disorder is among the top five leading causes of hospitalization for the general population in the region and the third leading cause of hospitalization for African-Americans. Further, the community needs survey completed by over 7,000 area residents shows that mental health issues rank as the number two concern among Medicaid beneficiaries.

To address these needs, various evidenced-based SAMHSA-approved programs will be deployed: Mental Health First Aid; Too Good for Violence; Ripple Effects; Compeer; Wellness Recovery Action Plan (WRAP); elementary and middle school social skills programs (Too Good For Violence, An Apple A Day, Building Skills, and SPORT); college programming (Challenging College Alcohol Abuse); coalition/community programming (Project Northland); a high school intervention for those experimenting with alcohol and other drugs (Teen Intervene); an intervention targeting women of childbearing age (Project CHOICES); a SAMHSA-approved wellness in the workplace model program (Wellness Outreach at Work); and a government-recognized evidence-based practice (Switch What You Do, View, and Chew) that focuses on healthy eating, increasing physical activity, and decreasing “screen time” for youth.

Our project will support and facilitate quality improvement of evidence-based practices and environmental strategies that promote MEB health. Our evidence-based prevention activities will be delivered to community groups as well as to elementary, middle, high school, and college students and will include outreach and advocacy programs. Our goals are to deliver evidence-

based prevention programs to increase knowledge and positive decision-making among participants and to improve mental health and reduce substance abuse in the community through education or intervention in high-risk populations with low access to preventive services. Specifically, the program aims to reduce binge drinking and drinking-related ER visits by college students; increase awareness of the symptoms of depression; increase referrals to Roswell Park Cancer Center's smoking cessation program and reduce the rate of sexually-transmitted diseases in the Buffalo Public School system. We will also monitor the rates of ED visits for self-harm events and/or ideation, as well as for substance abuse.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population *must be specific and could be based on geography, disease type, demographics, social need or other criteria.*

The population that is expected to be engaged in this project will be anyone four years of age (pre-K) and older in the general population. The population to be served by this initiative will be wide-ranging:
(a) The pre-K to 8th grade population will receive evidence-based classroom programing
(b) High school-aged students (9th to 12th grade) will receive intervention assistance (e.g. immediate counseling and information and referral) if they exhibit signs of drug abuse
(c) Adults age 18 and over will interface with the project through a media campaign, the Mental Health First Aid project, and other community-based services

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Both MCC and Catholic Medical Partners (the other PPS in WNY) have engaged the Mental Health Association (MHA) of Erie County and the Erie County Council for the Prevention of Alcohol and Substance Abuse (ECCPASA) to be lead partners on this project. MHA and ECCPASA are the two lead organizations for promoting MEB across the eight-county region and, together with a large group of collaborators, are well positioned to deliver high-quality and evidence-based programs to the population. This partnership brings together experts in two different disciplines—mental health and substance abuse prevention—to wage a comprehensive program for improving MEB well-being across the eight-county region.
The comprehensive group of collaborators includes approximately 30 agencies throughout the eight-county region. Some of the major collaborators are Native American Community Services, WNY United, Compeer of Greater Buffalo, WNY Independent Living Center, Jewish Family Services, Chautauqua County Council, Cattaraugus County Council, Niagara County Council, and MHAs and substance abuse councils in all eight WNY counties.
Given the multitude of factors that have to be addressed in an effective MEB well-being project, there is no single strategy that can meet project objectives. Our project addresses this reality by incorporating and integrating several evidence-based strategies in our programming. MHA and its vendors have established programs that are SAMHSA-approved.

ECCPASA has experience administering many evidence-based programs targeting youth, college students, and adults. The following SAMHSA-approved programs that ECCPASA and their partners provide include elementary and middle school social skills programs (Too Good For Violence, An Apple A Day, Building Skills and SPORT); college programming (Challenging College Alcohol Abuse); coalition/community programming (Project Northland); a high school intervention for those experimenting with alcohol and other drugs (Teen Intervene); and an intervention targeting women of childbearing age (Project CHOICES).
The selected MEB interventions were based upon geography, demographics, and high-risk clinical conditions that have the greatest potential for successful intervention, behavior change, and cost avoidance/cost reduction. The clinical conditions targeted include nicotine use, prescription drug abuse, binge drinking, obesity, sexually transmitted diseases, child and adolescent depression, adolescent/adult substance abuse, adult depression, and adolescent/adult suicide prevention.
Our interventions will target each of the eight counties in WNY with a specific focus on urban, first-ring suburban, and rural areas. The main target areas will include the ones identified in the CNA as high-risk. The targeted population addresses the changing demographic mix in our region and includes specific Spanish and Arabic language programs.
With new resource support from MCC and CMP, MHA and ECCPASA will expand existing programs in the geographic areas currently served and to new geographic areas. For example, Teen Intervene will be expanded into Niagara County and The Early Childhood program to Niagara, Chautauqua, and Cattaraugus Counties.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Stigma: A primary challenge faced by the collaboration is to effectively overcome the stigma—and related inaction and attendant costs—associated with substance abuse, addiction, and mental illness. To address the subjects objectively and with a clear focus on improving knowledge and changing the targeted behaviors, the partners will engage a professional public relations and media consultant to develop a region-wide awareness campaign to raise awareness, address stigma, and generate positive, measurable change.
Competing demands in school districts: Another challenge is gaining access to various school systems with demanding schedules and mandated state education requirements. School districts have been faced with increasing curriculum requirements and standards. In order to ensure engagement with the schools and mitigate this problem, the partners will align initiatives with school curricula and the State Education Department. In addition, programs will be succinct so that schools will allow implementation time.
Magnitude of MEB health problems underestimated: Another challenge is that communities, leaders, and organizations all fail to fully appreciate the magnitude of MEB health problems and neglect to see their role in effectively solving them. We will face this challenge by actively engaging these leaders to give them a better understanding of their responsibility for bringing

knowledge and evidence-based prevention to their communities to promote positive outcomes such as healthy decision-making and positive behavior changes.
Cultural and language barriers: The final barrier identified in our CNA includes cultural and language barriers associated with the changing demographic mix in the eight-country area as a result of immigration. Our project partners have broad experience working with culturally and ethnically diverse communities. This experience, combined with the solid working relationships they have established with community leaders, will help them overcome any cultural barriers.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

This project is a joint initiative of MCC and CMP. Both PPSs will contribute funding to the project at a percentage rate that is equivalent to their respective shares of attributed lives in WNY. Representatives of both PPSs will oversee project implementation and operations. Reporting of outcomes, project milestones, progress reports, etc., will be standardized for both PPS organizations.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.

The important project milestones relative to the implementation of this project are as follows:
Milestone 1: Finalize roles and responsibilities of project partners by DY0-Q3/Q4
Milestone 2: Determine which project initiatives will be implemented in specific geographic areas of WNY by DY0-Q3/Q4
Milestone 3: Complete a plan for detailed, periodic reporting of project outcomes by DY0-Q3/Q4
Milestone 4: Finalize estimates and establish final targets on population to be served by project by DY0-Q3/Q4
Milestone 5: Launch preparations for media campaign by DY1-Q1/Q2
Milestone 6: Begin phase-in of project implementation in all target settings by DY1-Q1/Q2

2. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☐	☒

If yes: Please describe why capital funding is necessary for the Project to be successful.

b. Are any of the providers within the PPS and included in the Project Plan PPS currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

3. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due by March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

4.d.i Reduce premature births (Focus Area 1; Goal 1)

Project Objective: This project will help to reduce premature births.

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

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

Project Requirements: The 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.

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, healthcare 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.

Partnering with Entities Outside of the PPS for this Project
Please provide the name of any partners included for this project outside of the PPS providers. This may include an entity or organization with a proven track record in addressing the goals of this project.

Entity Name
Catholic Medical Partners/Catholic Health System
Finger Lakes PPS

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 100)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

CNA findings indicate that in the general population in WNY there is inadequate prenatal care, risk reduction, and management of high-risk pregnancy, all necessary to reduce premature birth rates. Within the Medicaid population, low-weight births (<2,500 grams) happen 9.6% of the time; inadequate prenatal care occurs 22.2% of the time; and high-risk pregnancies occur 10.9% of the time. In the WNY general population, 12.1% of births are preterm, above the NYS Prevention Agenda goal of 10.2% (minority disparity between non-minority rates is slightly above State targets); the maternal mortality rate is 26.8/100,000 births, above the Prevention Agenda goal of 21/100,000; 33.2% of live births are unintended pregnancies, well above the Prevention Agenda goal of 23.8% (the minority disparity between non-minority rates is slightly above the State targets); and 21.4% of live births occur within 24 months of a previous pregnancy (above the Prevention Agenda goal of 17%). Low health literacy, language issues in Erie County, and lack of engagement with the community healthcare system--particularly a lack of primary care connection and access--have been identified as other important factors confirmed by the CNA.

The PPS will work to collaborate and coordinate with key stakeholders in WNY to improve maternal and infant health outcomes for high-need women and families who reside in targeted high-risk areas. This is being done by implementing broad population based interventions that will enhance, promote, and improve the perinatal healthcare system. To address these CNA gaps, the PPS will specifically use three system enhancement strategies targeting: (1) prenatal care; (2) community supports for risk reduction; and (3) management of high-risk pregnancy.

(1) Enhanced prenatal care services will include: (a) a network of 101 OB and family medicine primary care locations that will provide timely, continuous, and comprehensive prenatal care services using NYS prenatal standards and American Congress of Obstetricians and Gynecologists guidelines; (b) at every visit, they will ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for smokers; (c) we will use the innovative Centering Pregnancy model to improve preterm birth rates; (d) we will use 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; (e) we will connect to community support for expedited Medicaid enrollment; (f) we will refer high-risk patients to home visiting programs; and (g) we will provide prenatal education at all points of care.
(2) Enhanced community supports for risk reduction will include linking to: (a) community supports for smoking cessation; (b) peer counselors, lay health advisors, and community health workers (linguistically and culturally matched) to reinforce health education, healthcare service utilization, and enhance social support; and (c) expedited enrollment of low-income women in Medicaid, including presumptive eligibility for prenatal care and family planning coverage.
(3) Enhanced management of high-risk pregnancy will include: (a) clinical management of preterm labor in accordance with guidelines; (b) referral of high-risk patients to home visiting services; and (c) use of Community Health Workers (CHWs)/Navigators to enhance social support for high-risk pregnant women.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population *must be specific and could be based on geography, disease type, demographics, social need or other criteria.*

The project will target all women of child-bearing age (14–44 years), infants, and children (0–18 years). It will focus on those who are homeless, abusing drugs or alcohol, experiencing domestic violence, and/or lacking a regular healthcare provider. The population to be served includes racial, ethnic, and linguistic minorities; refuges; teenagers; and individuals and families experiencing multiple social and/or economic stressors.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

The project will utilize the expertise and services of an array of existing resources. The WNY region currently has community health worker programs and visiting home nursing services that focus on specific high-need zip codes. These programs include Maternal and Infant Community Health Collaborative (MICHC); Healthy Families New York; Women, Infant, and Children (WIC) program; Medicaid Obstetric Maternal Services (MOMS); Healthy Mom–Healthy Baby Prenatal and Postpartum Home Visiting; The Priscilla Project; Project ACT; The “Healthy Start for All” Coalition; Healthy Babies are Worth the Weight; Centering Pregnancy; Nurse Family Partnership; and Baby and Me Tobacco Free. The programs operate within organizations such as Buffalo Prenatal/Perinatal Network, Chautauqua County Health Department, Cattaraugus County Health Department, Buffalo Public Schools, Catholic Charities, Community Health Center of Buffalo, Community Health Worker Network of Buffalo, EPIC – Every Person Influences Children, Erie 1 BOCES, Erie County Department of Health, Erie-Niagara Tobacco Free Coalition, Family Help Center, Jericho Road Ministries, Kaleida Health, Catholic Health System, Niagara Falls Memorial Medical Center, March of Dimes, Neighborhood Health Center, P2 Collaborative, UB Family Medicine, UB Gynecologists and Obstetricians, United Way of Buffalo and Erie County, UBMD Pediatrics, and Upper Allegheny Health System.

In addition to the existing community programs that will be mobilized, there are 101 primary care (OB and family medicine) locations that will interface with the project. Of these PCP sites, there are 30 safety net primary care locations that we be actively linked to the new project resources. The project will also mobilize existing resources of the four Medicaid managed care organizations and the Women & Children's Hospital of Buffalo (WNY's maternal and child tertiary care center) to target high-risk pregnancies and high-risk children.
New resources needed:
This project will fund enhancement to existing smoking cessation programs (such as the provision of gift cards or other incentives) and gap support for startup of community risk reduction services in high-need areas lacking such services.
This project will also invest new resources including: (a) training-related expense: (b) 2 full-time Program Directors and 6 Program Supervisors; (c) 4 FTE high-risk coordinators and 5 FTE care coordinators; (d) 33 FTE community-based CHWs to work in designated high-need areas. The number of areas will be determined during the implementation phase, following further assessment and patient involvement.
Resources from project 2.a.i. (Integrated Delivery System) that will be leveraged for this project include RHIO interoperability enhancements and PCMH Coordinators to translate guidelines into PCMH care team practice.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Resistance to smoking cessation: It is extremely difficult to get pregnant women to stop smoking. Use of incentives has proven to be an effective strategy for smoking cessation. This project will enhance existing program by supporting such incentives.
Prenatal appointment no-shows: The challenge of getting pregnant women to attend prenatal care appointments is compounded by the lack of reliable public transportation in many areas of WNY. CHWs/Navigators will fill in the transportation gap by providing expectant moms rides to prenatal appointments. Moreover, pregnant women will be reminded of appointments through use of reminders sent through text messages.
Translating prenatal guidelines into practice: Primary care offices, especially safety net locations, have many competing demands, making it difficult to institute new prenatal guidelines and the workflow changes they involve. Under the IDS project, the PPS will adequately address this challenge for this project.
Lack of interoperability: There is not sufficient health information exchange of prenatal-related information to adequately manage high-risk pregnancies across settings. This challenge will be addressed by interoperability enhancements that are part of the IDS project.
Integration of community support with primary care: The extensive array of community supports involved in this project are not well connected to the primary care network. These organizations have little or no connection to the RHIO and there is no alert messaging capability.

This challenge will also be addressed by interoperability enhancements that are part of the IDS project.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

Both MCC and Catholic Medical Partners (CMP) are working jointly on a related project, 3.f.i. (Support for Maternal and Child Health). Cooperation between the two PPSs for this and the 3.f.i. will be in the form of mutual referrals, resulting in comprehensive support across the whole region. CMP is implementing a Nurse–Family Partnership program model, so MCC providers will refer their patients for whom that program would be appropriate. MCC is expanding its existing CHW programs, and CMP providers will refer their patients to these programs as appropriate. This coordination will ensure that patients are matched up with the type of support programs that are most likely to be appropriate (and thus more effective) for them.

MCC PPS will work collaboratively with both bordering PPSs (CMP and Finger Lakes PPS) to expand the scope of the Regional Perinatal Center and the Regional Perinatal Outreach grant to include a center that will serve the entire WNY region. The center will provide free information, referral, technical assistance, and support to families, professionals, and community agencies concerned with prenatal care similar to the Early Childhood Direction Center (ECDC) model for all of WNY. Like ECDC, this center will work with community stakeholders to coordinate referrals to community programs, educate providers on services available, and increase collaboration among all stakeholders in the communities. This regional center will support all of WNY, including the initiatives of other PPSs.

Close coordination with CMP and Finger Lakes PPS will be assured by encouraging the use of standardized referral protocols, utilizing uniform tracking and reporting systems, adopting universal alert messaging via the RHIO, maintaining common messaging to educate patients about patient activation, and sharing lessons learned. Progress reports and information exchange on the project will be the subject of periodic meetings among the PPS organizations.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.

Because of significant overlap in terms of efforts and staffing between this project and 3.f.i. (Maternal and Child Health), the milestones in this project are aligned with the schedule defined for project 3.f.i. The important project milestones relative to the implementation of this project are as follows:

Milestone 1: Finalize roles and responsibilities of project partners by DY0

Milestone 2: Enroll 25% of eligible participants by DY1

Milestone 3: Enroll 75% of eligible participants by DY2

Milestone 4: All eligible participants are enrolled by DY3 and DY4

2. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☐	☒

If yes: Please describe why capital funding is necessary for the Project to be successful.

b. Are any of the providers within the PPS and included in the Project Plan PPS currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Baby & Me Tobacco Free			Ongoing	Smoking cessation program in Chautauqua County created to reduce the burden of tobacco use on the pregnant and post-partum population
Baby & Me Tobacco Free			Ongoing	Smoking cessation program in Erie County created to reduce the burden of tobacco use on the pregnant and post-partum population
Centering Pregnancy			Ongoing	Group healthcare model which incorporates three major components: assessment, education, and support. Patients meet with their care provider and

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				other group participants for 90–120 minutes, at regularly scheduled visits. Promotes greater patient engagement, personal empowerment, and community building. Starts around the beginning of the second trimester through delivery.
Community Health Worker Network of Buffalo			Ongoing	Trains CHWs to assist individuals, families, and communities to be active participants in their personal and community level health and well-being
Healthy Babies are Worth the Wait		November 2014	Ongoing	Provides education for pregnant women, perinatal providers, and the greater community on preterm birth, risk factors, and strategies for reducing risk
Healthy Families Niagara @ Family & Children's Services of Niagara			Ongoing	Provides parenting education from prenatal to 5 years; currently serves 95 families with capacity for 105 families
Healthy Families NY @ BPPN			Ongoing	Locates families in the City of Buffalo during pregnancy up to 3 months of age. Provides case management and education in the home. Screens for depression, drinking, and developmental delays. Encourages women to complete school, get job training, find employment, and navigate the system on their own.
Healthy Start Community Health Worker Program-BPPN			Ongoing	Uses a communitywide systems approach in the City of Buffalo to target African-American and Hispanic women before, during,

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				between, and after pregnancy, to reduce racial disparities in infant mortality and adverse perinatal outcomes. Goes door-to-door looking for pregnant women as early as possible in pregnancy.
Maternal Infant Community Health Collaborative (MICHC)			Ongoing	Refers and provides direct 1:1 assistance to help clients in Erie County obtain and consistently utilize health insurance, primary care and/or prenatal care, family planning, and other needed community services. Provides social support to promote and reinforce health-promoting behaviors; helps clients utilize services and be able to communicate their needs. Provides case management during pregnancy and after birth up to 1 year.
Maternal Infant Community Health Collaborative (MICHC)			Ongoing	Refers and provides direct 1:1 assistance to help clients in Chautauqua County obtain and consistently utilize health insurance, primary care and/or prenatal care, family planning, and other needed community services. Provides social support to promote and reinforce health-promoting behaviors; helps clients utilize services and be able to communicate their needs. Provides case management during pregnancy and after birth up to 1 year.
Neighborhood Health Center			Ongoing	Embeds CHWs in Health Center OB/GYN department

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Parenting and Pregnancy Assistance Program at Erie Community College			Ongoing	Strives to create greater awareness of resources available to support pregnant and parenting students and their families
Priscilla Project			Ongoing	Fosters healthy births for culturally and linguistically isolated refugee women
Project Act			Ongoing	Serves pregnant and parenting teens in Buffalo Public Schools

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

The DSRIP project described here will greatly expand the population served by the above programs. Currently the programs above are limited by geography and limited budgets; therefore they are not able to reach the entire high-risk population for the counties of WNY. With DSRIP support, these existing programs that have already been proven effective in WNY can reach a broader target population.

3. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due by March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both

the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. Quarterly reports to the Independent Assessor will

c. include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.