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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.iii Health Home At-Risk Intervention Program: Proactive Management of Higher Risk Patients Not Currently Eligible for Health Homes through Access to High Quality Primary Care and Support Services

Project Objective: This project will expand access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers from Health Homes) to meet the individual needs of higher risk patients. These patients do not qualify for care management services from Health Homes under current NYS HH standards (i.e., patients with a single chronic condition but are at risk for developing another), but on a trajectory of decreasing health and increasing need that will likely make them HH eligible in the near future.

Project Description: There is a population of Medicaid members who do not meet criteria for Health Homes but who are on a trajectory that will result in them becoming Health Home super-utilizers. This project represents the level of service delivery and integration for the complex super-utilizer population who fall in between the patient-centered medical home and the Health Home general population. Some risk stratification systems refer to these patients as "the movers." Early intervention through this project shall result in stabilization reduction in health risk and avoidable service utilization.

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. Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH PCPs in care coordination within the program.
2. Ensure all participating primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH or Advanced Primary Care accreditation by Demonstration Year (DY) 3.
3. Ensure that all participating 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.
4. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards.
5. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
6. Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.
7. Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.
8. Establish partnerships between the primary care providers, in concert with the Health Home,

with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).

9. Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.

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 Community Needs Assessment (CNA) indicates that many of Staten Island's (SI) high risk Medicaid patients would benefit from expanded access to primary care and the support of integrated care teams. New York State Department of Health (DOH) statistics indicate that SI's deaths per 100,000 residents per year are 9% higher than New York City's (NYC) average rate and the highest among all five boroughs (CNA). The leading causes of death on SI are related to chronic conditions including cardiac disease, cancer, and respiratory disease. SI has approximately 1,600 PQI admissions annually, higher than the NYC and New York State (NYS) average admission rates and among the highest in the five boroughs in multiple categories (CNA). Among SI's top causes of PQI admissions are chronic diseases including COPD (or asthma in older adults), diabetes, heart failure, and hypertension. A subset of this population would benefit from early interventions through integrated care teams including care management services from SI's health homes (HH) and other care management resources, to provide connections to services that would reduce health risks and avoidable service utilization.

The ZIPcodes located in SI's North Shore (Mariner's Harbor, Port Richmond, West New Brighton, St. George, Stapleton, and Rosebank) have the highest number of Medicaid enrollee PQI discharges, as well as the highest rate of individuals living below 200% of the poverty level (CNA). Findings indicate that socioeconomic factors correlate with avoidable healthcare service utilization. Further, as indicated by HH providers within SI's Performing Provider System (SI PPS), those with low socioeconomic status are at risk of qualifying for HHs in the future and would benefit from this project.

A number of high risk patients on SI do not qualify for comprehensive care management services under current NYS HH standards but would benefit from these services to ensure they are properly and proactively managing their conditions and are connected to appropriate treatment. This project will allow the SI PPS to build upon and strengthen the current HH model on SI. One HH, Coordinated Behavioral Care (CBC), operates on SI through multiple organizations. This project will utilize existing HH infrastructure and care management models to serve additional at-risk patients. The SI PPS will also utilize and expand upon other existing care management infrastructure including North Shore-LIJ Care Solutions and the Visiting Nurse Services of New York (VNSNY), to provide comprehensive care management services as well as

Build a more coordinated service model.
According to results from the Provider Survey, the overall lack of communication between providers including primary care physicians (PCPs), coordination of care and follow-up, as well as limited access to and sharing of health data/information are reported as factors that impact efficient healthcare utilization and collaboration among providers. This project will facilitate a more coordinated referral process to the HHs and other care management resources and will strengthen and centralize the infrastructure to support referrals to care management. In addition, this model will utilize referrals, outreach techniques, and lists of potentially eligible Medicaid patients (provided by managed care organizations) to identify individuals that may require care management services under this project.

The availability of complete population wide analytics and risk stratification to proactively identify at-risk patients is a gap in the current system. As part of the SI PPS's overall approach, a care management organization (CMO) and IT platform that integrates health information will serves as a fundamental component of the SI PPS's structure to provide care coordination tools, risk stratification and predictive analytics to identify patients at risk for hospitalization, rehospitalization, or who are in need of specialized or complex 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.

This project will expand HH-like services (patient-centered care that prioritizes coordination of team-based care and communication among providers) on SI to patients with one chronic condition that are at risk of developing a second condition, or patients with other risk factors. This project's target population is a subset of the patients identified with chronic conditions including patients with a primary diagnosis of asthma (6,962), diabetes (9,566), hypertension (12,939), congestive heart failure (1,693), and chronic obstructive pulmonary disease and bronchiectasis (4,118) (these patients may be duplicates) (CNA). The SI PPS will also target the at risk subset of patients between the ages of 40 and 60 (there are approximatley 26,635 patients in this age group). SI HHs report patients in this age cohort are typically at risk for HHs. The SI PPS will further risk stratify this population to identify patients at-risk for hospitalization/rehospitalization based on these diagnosis and other factors, as well as develop referral criteria for comprehensive care management to meet Project 2.a.iii's requirements. In establishing referral criteria, the SI PPS, will consider criteria which indicates that a patient is at-risk for enrollment including criminal justice involved youth and adults, homeless/recently homeless, and those with more than one psychiatric hospitalization or emergency department (ED) visit, among others (Provider Workgroup Sessions). Further, patients living in the ZIP codes located in SI's North Shore (Mariner's Harbor, Port Richmond, West New Brighton, St. George, Stapleton and Rosebank) will be targeted for this project, as they were identified in the CNA as being at risk for avoidable hospitalization.

CBC provides care coordination to approximately 1,900 patients and conducts outreach and other services to patients that do not currently qualify for HHs. This project will target patients

that do not currently qualify for HH services but are in HH outreach programs and would benefit from the comprehensive care management.

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.

Building on CBC's HH experience and existing resources, as well as other care management resources available through the SI PPS partners, this project will expand access to community primary care services and develop integrated care teams to coordinate the target population's complex care needs. Additional care managers and patient navigators will have to be hired/trained to provide services to this population. Additional PCPs and ancillary support staff may also need to be hired to support additional patient volume.

The SI PPS will leverage CBC's ability to provide care management services to patients under its existing model and expand capacity with additional care management staff to serve more at-risk patients. The SI PPS will also leverage and expand upon the other care management services including North Shore-LIJ's Care Solutions and VNSNY. As the SI PPS significantly expands the number of individuals receiving comprehensive care management services, new staff including care managers (registered nurses and social workers) and patient navigators, will be required (as identified in Section 5-Workforce Strategy). Additionally, the SI PPS will build upon existing CMO/information technology (IT) infrastructure as well as create additional care management capacity.

Two primary care organizations within the SI PPS have achieved National Committee for Quality Assurance (NCQA) 2011 Patient-Centered Medical Home (PCMH) certification and all SI PPS members who provide primary care have committed to achieving NCQA 2014 designation by Demonstration Year (DY) 3. In order to expand access to care and facilitate convenience for patients who might otherwise elect to go to an ED, evening and weekend hours may be extended and an on-call service that schedules appointments established to triage patient/family concerns and care for those with non-urgent conditions.

As previously explained, SI North Shore communities have the highest Medicaid and uninsured populations as well as the highest quintile of chronic PQI discharges, which supports an emphasis on developing services for this part of the community (CNA). The SI PPS will expand outreach activities for at-risk patients in the North Shore, including potentially co-locating care managers in primary care offices and other community settings in this area where they are not currently available.

Individuals qualifying for the HH at-risk program will be identified and referred to the program by Richmond University Medical Center and Staten Island University Hospital's EDs, inpatient and ambulatory teams, all participating PCPs in the outpatient setting, and behavioral health and social services organizations. Onsite referral coordinators will be placed at participating PCP offices to ensure that the patient has been assigned to a care management team through referrals and ongoing follow-up.

Additional resources needed for this project include a Project Coordinator, Data Manager/Analyst as part of the Project Management Organization to support overall implementation and coordination required to ensure the implementation of the program.

Further, enhanced communication and data sharing between PCPs, care managers, and other providers will need to be developed.

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 ability to hire and train a significant number of additional care managers and patient navigators will be a challenge in implementing this project. The SI PPS will leverage existing resources that have expertise in providing care management service to take on new patients in the short term. The SI PPS will quickly need to hire and train new staff to ramp up capacity to serve the targeted population through the development of additional resources including CBC, VNSNY, and North Shore-LIJ's Care Solutions.

Two PCPs within the SI PPS have achieved NCQA 2011 Patient Centered Medical Home (PCMH) Level 3 standards, and a number of PCP providers are currently in the process of achieving this accreditation. A subset of providers will require significant effort and time to meet NCQA 2014 Level 3 PCMH Standards. This has been identified as a challenge for meeting the project's requirements. To mitigate this challenge, the SI PPS intends to provide centralized resources to support implementation of NCQA 2014 Level 3 PCMH standards, including developing an implementation plan for all facilities as well as tracking and supporting implementation.

There is also a lack of electronic connectivity between providers as most SI PPS participants are not connected to the Regional Health Information Organization (Healthix). To address this challenge, the SI PPS has begun the process of developing a high level implementation plan for integration into Healthix that will begin prior to Demonstration Year 1.

Another challenge will be ensuring that all providers collaborate and communicate in a timely manner with all care management organizations/caregivers. Collaboration and communication will also include meetings of integrated care teams including care managers to review/evaluate root causes for ED visits or hospitalizations among patients and identify solutions and improvements for care protocols. As participation in care management activities is an uncompensated expense for PCPs, the SI PPS will consider developing a model that allows for compensation of these services.

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.

Not applicable. The SI PPS is the sole PPS in the community.

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.

This project will require capital funding for the establishment of an IT infrastructure throughout the SI PPS provider network. The SI PPS strongly believes that the ability for providers to share information is central to the overall strategy for reducing hospital admissions by improving coordination and integration of the care continuum. Information sharing and health data exchange is central to the expansion of the HH model.

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
Coordinated Behavioral Care and member agencies	New York State Health Home	December 2011	Ongoing	Health Home providing care management for Medicaid beneficiaries with chronic health conditions.
Community Health Action of Staten Island HIV Case Management Program	Grant Funded	July 2010	March 2015	Case Management for HIV- positive individuals who are not Medicaid beneficiaries. Provides care coordination and support services to a majority of the undocumented HIV-positive community.
Community Health Action of Staten Island	Grant Funded	December 2008	February 2017	Medical Care coordination and education for newly diagnosed HIV+ patients and those having difficulty with medication adherence. Health promotion and education, transportation support, and support and coaching to become self-sufficient to manage medical and social needs autonomously.

Community Health Action of Staten Island	SAMHSA funded (division of the Department of Health & Human Services (DOH))	August 2013	July 2016	The Strong Steps program is a partnership with the Special Victims Bureau of the Office of the Richmond County District Attorney's office that ensures women, 18 years and older, who are survivors of domestic violence, to receive comprehensive services and support while they gain the skills and confidence to pull themselves and their families out of the crises of fear and violence. Treatment & Services Include: Individual and Group Counseling, Recovery Coaching, Case Management, Service Coordinat
Community Health Action of Staten Island	SAMHSA funded (division of the Department of Health & Human Services (DOH))	September 2013	August 2016	Return to Recovery serves men, 18 years and older, who are in prison and recently released, providing a continuum of services as they transition back into their communities and families. Treatment & Services Include: Individual and Group Counseling , Recovery Coaching, Case Management, Criminal Justice Service Coordination, Vocational Support Services and Trauma Informed Services

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.

CBC is the only designated HH in SI. CBC subcontracts with 34 care management agencies and has a network of more than 100 comprehensive medical clinics; more than 100 licensed mental health clinics; a full continuum of other mental health programs including PROS, ACT and Clubhouses; more than 60 licensed substance abuse treatment programs; more than 20 home care programs; and an estimated 20,000 shelter and supported housing beds with supportive services. CBC has submitted a non-binding, non-required letter of intent to the New York State Department of Health to express interest in pursuing designation as a HH to serve children. Other SI PPS participants (as part of the HH) provide care management to at-risk populations including Community Health Action of Staten Island, as described above.

This DSRIP project significantly expands CBC's current HH program, which is available to those with two or more chronic conditions and meet eligibility criteria for a New York State Medicaid HH. Under this project, the SI PPS will be able to significantly expand services to allow for comprehensive care management for high risk patients that do not currently qualify for HHs. This program will also expand upon the effectiveness of the current HHs by developing more coordinated services and information sharing among participating providers.

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.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

Project Objective: To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Project Description: A significant cause of avoidable readmissions is non-compliance with discharge regiments. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working one-on-one with the patient to identify the relevant factors and find solutions. The following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30-day transition period post-hospitalization.
Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/.

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. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2. Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
3. Ensure required social services participate in the project.
4. Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
6. Ensure that a 30-day transition of care period is established.
7. Use EHRs and other technical platforms to track all patients engaged in the 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 leading causes of death on Staten Island (SI) in 2011 were related to heart disease, cancer, and lower respiratory disease, with rates significantly above New York City's (NYC) aggregate rates. SI has a total of 129,096 unique Medicaid enrollees, 14,708 of which had an inpatient discharge (excluding deliveries) (CNA). Of those discharges, 9,765 had an inpatient discharge and a chronic disease diagnosis (excluding discharges related to deliveries) (CNA).

In 2013, SI's Medicaid population had 3,915 30-day readmissions (at any hopsital facility) (CNA). Of these readmissions, approximately 30% were attributed to behavioral health and substance abuse; and many of the most prevalent medical readmissions were due to chronic conditions including circulatory and respiratory disorders, diabetes, acute kidney failure, cardiac disease, infections, and cancer (CNA). Further, 28% of readmissions are attributed to the dual eligible population.

Of total readmissions at SI's two hospital Richmond University Medical Center (RUMC) and Staten Island University Hospital (SIUH), 1,171 were identified as potentially preventable readmissions (PPR) (CNA). Annually, SI has approximately 1,600 PQI admissions of which the numbers of types of PQI admissions are higher than the NYC and New York State averages. Among SI's top causes of PQI admissions are chronic diseases including COPD (or asthma in older adults), diabetes (short and long term complications and uncontrolled), heart failure, and hypertension, among others. The ZIP codes located in SI's North Shore (Mariner's Harbor, Port Richmond, West New Brighton, St. George, Stapleton and Rosebank) have the highest number of Medicaid enrollee PQI discharges, as well as the highest rate of individuals living below 200% of the poverty level (CNA). Findings indicate that socioeconomic factors correlate with avoidable healthcare service utilization. Those with low socioeconomic status are twice as likely to require an urgent emergency department (ED) visit, are four times as likely to require hospital admission, and are also more likely to have a readmission, than those with high socioeconomic status (Health Affairs; July 2013).

The current gaps identified by providers as contributing to 30-day readmissions include inadequate or delayed communication among care givers, the expense of medications, insufficient reimbursement for required services including home care, and language barriers between caregivers and patients (Provider Workgroup Sessions). Providers also report a lack of communication between providers, inadequate care transitions, failure to link patients to primary care physicians, coordination of care and follow-up, as well as sharing of health data and information as being factors impacting inappropriate healthcare utilization (Provider Survey). Additionally, providers cite the ability to perform population wide analytics and risk stratification to proactively identify patients at risk for admissions/readmissions as a gap in the current system.

As part of the overall Staten Island Performing Provider System (SI PPS) approach to address these gaps, a Care Management Organization (CMO)/Information Technology (IT) platform that integrates health information will serve as a fundamental component of the SI PPS structure to

provide care coordination tools, risk stratification and predictive analytics and identify patients most at-risk for hospitalization, re-hospitalization or in need of specialized/complex care. Further, this project will build upon existing resources including hospital discharge planners, existing home care infrastructure and care management services to build a more comprehensive and standardized care transitions program.

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.

SI's Care Transitions Intervention Model will target the reduction of 30-day readmissions from the highest risk categories of Medicaid patients discharged from RUMC and SIUH. As stated there are 4,000 total readmissions annually for SI Medicaid patients and 1,171 PPRs (avoidable readmissions) for SIUH and RUMC. The SI PPS will aim to reduce a percentage of these readmissions. As previously identified, SI's Medicaid patients most at-risk for readmission include patients with substance abuse and behavioral health disorders as well as patients with chronic diseases. The SI PPS plans to target these patients including patients with inpatient Medicaid admissions with the following primary diagnoses: chronic obstructive pulmonary disease and bronchiectasis (COPD) (228 patients), chronic kidney disease (266), heart disease (424), asthma (343), diabetes (299), behavioral health or substance abuse (2264), congestive heart failure (176), and hypertension (97) (CNA).

The SI PPS will also risk stratify the population to identify patients at risk for rehospitalization (not already identified above) and other factors. The SI PPS will align this project with project 2.d.viii: Hospital-Home Care Collaboration, where the goal is to reduce readmissions for at-risk patients discharged to home care.

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 Care Transitions Intervention Model is an evidence-based 4-week program that provides specific tools and a "transitions coach" to patients with complex care needs to assist with gaining self-management skills and to help successfully transfer patients from the hospital to the home. This model has been shown to significantly reduce 30-day readmission rates for Medicare patients. This program, not currently implemented at RUMC and SIUH, will be implemented at both hospitals through the development of a bridge program which coordinates a patient's discharge and provides support during the 30-day transition period after a hospitalization.

SIUH and RUMC, in conjunction with the overall SI PPS's CMO/IT infrastructure will risk stratify the Medicaid population to identify hospitalized patients who are at risk for readmission. To ensure early notification of planned discharges, this process will begin at the point of admission. SIUH has established similar programs for subsets of at-risk patients. The SI PPS will build upon this program, where care mangers identify Medicaid patients who are admitted and have a

primary diagnosis of a chronic disease or are identified as being at-risk due to other factors. The program will promptly connect these patients to a transitions coach who completes an assessment to develop a transition of care services plan and ensure that a discharge preparation checklist is completed (http://www.caretransitions.org/documents/checklist.pdf).

Although SIUH and RUMC have discharge planning staff and case managers, additional staff resources including transition coaches, will need be added or developed to support high risk patients (as indicated in Workforce – Section 2). The SI PPS will also require additional resources to train transition coaches to provide appropriate transition support, this includes cultural and linguistic competency training to meet the cultural needs of at-risk communities. The SI PPS will also have to expand on risk stratification capabilities to identify patients that require transition plans, as well as develop an IT infrastructure that allows for data sharing among providers.

The Transitions Coach will ensure that clinical, social work, and peer support services, which are currently available within the SI PPS, are available to the patient during the initial month of the transition. This transition team will work in conjunction and align with the overall SI PPS care management structure, and for those patients that are identified as highest risk, they will be further assessed for eligibility in the health home programs and Project 2.a.iii. The SI PPS will leverage existing services including home health visits and telehealth services to ensure these resources are available to the target population. The SI PPS plans to build upon existing home care providers' programs, best practices and infrastructure aimed at preventing unnecessary ED utilization and 30-day readmissions.

The SI PPS will also require adding staff to the Project Management Office including a Project Coordinator, and Data Manager/Analyst to support overall project goals and work with SI PPS member providers to develop standardized care transition protocols for RUMC and SIUH in partnership with home care service agencies, Medicaid MCOs, and care management resources.

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 greatest anticipated project challenges are ensuring that patients stay engaged during the transition period and that prompt outpatient medical care is available to address any clinical concerns that may arise. To address this challenge and preempt the potential loss of engagement, the transitions coach will establish a relationship with the patient and family prior to discharge from the hospital. The SI PPS will also consider the implementation of an on-call team, to be available to patients post discharge, should a need arise to prevent hospital readmission.

Another challenge facing the SI SPPS is the willingness of all providers to collaborate and communicate in a timely manner with a patient's caregiver, following discharge. To address this concern, the SI PPS will engage primary care providers (PCP) during development and implementation of the care transitions program and care management infrastructure. The SI PPS

will also consider an incentive model through bonus payments to PCPs for their active and effective participation in care teams.

There is also a lack of electronic connectivity between providers as most SI PPS participants are not connected to the Regional Health Information Organization (Healthix). To address this challenge, the SI PPS has begun the process of developing a high level implementation plan for integration into Healthix that will begin prior to Demonstration Year 1.

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.

Not applicable. The SI PPS is the sole PPS in the community.

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.

This project will require capital funding for the establishment of an IT infrastructure throughout the SI PPS provider network that will support care transitions. The SI PPS strongly believes that the care transitions intervention program is a gap in the current system, and the additional supports created by the program will have a substantial impact on overall readmissions. Additionally, the expansion of primary care may be required for high risk Medicaid patients not currently receiving primary care including non/low utilizers and the uninsured. The expansion of these services may require new space and additional capital funding.

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.

Not applicable.

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.

There are two hospitals on Staten Island (SI), Richmond University Medical Center (RUMC) and Staten Island University Hospital (SIUH), as well as 10 skilled nursing facilities (SNFs) that more than 3,000 Medicaid patients annually. The two hospitals and 10 SNFs are included within the SI Performing Provider System (SI PPS).

According to data provided by the 10 SNFs, Medicaid patients make up an estimated 1,500 transfers from SNFs to acute care facilities annually, many of which may have been avoided (Nursing Home Provider Data). SNF providers reported respiratory distress/shortness of breath, altered mental status, abnormality of gait, gastro-intestinal, cardiac (low blood pressure, heart failure or chest pain), sepsis, abnormal lab tests/vitals, pneumonia, renal failure, and cerebrovascular complications as top reasons for transfers from SNFs to acute care facilities (Nursing Home Provider Data). Further, SI's leading Medicaid PQI Hospitalizations are attributed to COPD or asthma in older adults, pneumonia, hypertension, long-term complications related to diabetes, and heart failure, among others (CNA). These findings align with the SNFs' reported reasons for transfer.

Limited communication and health data exchange between acute care facilities and SNFs due to a lack of Electronic Health Records (EHR) and Health Information Exchange (HIE) connectivity, were identified as gaps leading to continued avoidable transfers (Provider Workgroup Sessions). Providers report that they currently track reasons for transfers; however, they report inconsistencies in receiving follow-up documentation from hospitals. As a result, SNFs report difficulty performing root cause analyses for transfers. Further, data exchange is not standardized across providers. To address this gap, the SI PPS will develop standardized formats, such as Continuity of Care Documents to meet the needs of both acute care and SNF providers.

The SI PPS has elected to implement the INTERACT program, including the use of the INTERACT 3.0 toolkit across all SNFs. The INTERACT tools will assist the SI PPS in directly addressing identified gaps by establishing protocols for data exchange involving Healthix, SI's Regional Health Information Organization and other methods.

Further, the SI PPS will leverage INTERACT Communication Tools (Stop and Watch-Early Warning Tool, SBAR Communication Tool/Change in Condition Progress Note, and Hospital Communication Tools) to directly support enhanced communication and information sharing between SNFs and acute care facilities as well as among clinical providers within the SNFs.

In implementing the INTERACT Stop and Watch Tool, the goal is to prevent conditions from becoming severe enough to require hospitalization through the early identification and assessment of changes in a patient/resident's condition. The SI PPS will also leverage INTERACT decision support tools to assist in providing guidance on monitoring and managing conditions in the facility, specifically around many of the conditions previously referenced by SNF providers as reasons for transfer to acute care facilities.

The SI PPS will also leverage the INTERACT program to improve advance care planning and use of palliative care plans. The SI PPS has identified the use of palliative care and proper advance care planning as a gap within the current delivery system and will leverage INTERACT tools to provide guidance on how to communicate with residents and their families when hospice or palliative care is recommended. The SI PPS will also address this gap through Project 3.g.ii, the integration of palliative care into SNFs.

The majority of SNFs report that they are currently using some components of the INTERACT program, however each report only partial implantation. Through this project all SNFs will expand the program to full implementation.

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 target population for this project has been identified as SI Medicaid patients in SNFs including rehab patients and long term care patients, specifically the subset of patients whose transfers to acute care facilities could have been avoided. Of the total transfers currently reported by SNF providers, there are an estimated 1,500 annual transfers attributed to Medicaid patients from SNF to acute care facilities, many of which are avoidable. Research on Medicare and Medicaid enrollees in SNFs found that approximately 45% of hospital admissions among those receiving care from Medicare SNFs or Medicaid nursing facility services could have been avoided (http://innovation.cms.gov/initiatives).

The SI PPS intends to engage SNF patients from all 10 SNFs through the implementation of the INTERACT program.

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.

Many of the 10 SNFs (Clove Lakes Healthcare and Rehabilitation Center Inc., Sea View Hospital Rehabilitation Center and Home, Richmond Center for Rehabilitation and Health Care, Eger Lutheran Homes and Services, Carmel Richmond Healthcare and Rehabilitation Center, and New Vanderbilt Rehab & Care Center) have partially implemented INTERACT and are at varying levels of implementation. These SNFs report using INTERACT tools including SBAR for hospital transfers and Stop and Watch and have also developed staff training programs, facility-specific

INTERACT tools, and processes around the INTERACT program, which will serve as resources to the SI PPS to assist in further implementation of the program.

The SNFs with experience implementing INTERACT will also be utilized to assist the SI PPS in the planning process to develop and implement a centralized INTERACT training program.

SNF providers report service levels that would allow patients to remain and receive treatment on-site at the SNF provider, rather than be transferred to an acute care facility for their care to be managed in many instances, with proper patient and family education, as well as with clinician training to avoid transfer.

However the SI PPS will require the addition of new training resources to support the implementation and expansion of the INTERACT program including an INTERACT training team (as discussed in the Workforce – Section 2). The training team will be used to provide staff training at all participating SNFs.

Additionally, the SI PPS will need to develop an information technology (IT) infrastructure that allows for the sharing of relevant patient information between providers.

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 SI PPS views cultural transformation as a significant challenge in implementing the INTERACT program. Facilities that have implemented INTERACT indicate staff/care giver training on INTERACT principles and cultural transformation as the largest barriers to implementation. Cultural transformation should happen at all staff levels, including physician/clinicians. Additionally, the effort and time required to achieve full implementation is seen as a project challenge. To address this, the SI PPS will assign an INTERACT Project Clinical Lead and a Program Champion at each SNF to facilitate implementation.

The SI PPS has identified that the INTERACT program will require involvement from an interdisciplinary team and has determined that regular meetings should be held at each SNF to review goals and progress. To further address implementation challenges, the SI PPS will develop a centralized INTERACT implementation training team to provide INTERACT training and coaching and staff training. The team creates an opportunity for providers to communicate best practices and share program information across SNFs.

Rather than stagger implementation, the SI PPS plans to begin implementing the program at each SNF at the same time. Some facilities, particularly those without required infrastructure including electronic health records, may complete full implementation of INTERACT over a longer time frame than those with the required infrastructure. In order to effectively implement quality improvement tools through the INTERACT program, each participating facility must track, trend, and benchmark well-defined measures, as well as learn from root cause analyses of

events for hospital transfers. As such, the SI PPS will support the SNFs through the development of standardized processes to benchmark acute care transfers, perform comprehensive root cause analyses and identify opportunities for improvement and educational activities. In addition to staff education, education will be developed for patients and their families to mitigate hospital transfers and emphasize appropriate use of palliative care. Also, due to the lack of electronic connectivity between providers, as most providers are not connected to the Regional Health Information Organization, the SI PPS has begun developing a high level implementation plan for integration into Healthix beginning prior to DY 1.

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.

Not applicable. The SI PPS is the sole PPS in the community.

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.

This project will require capital funding for the implementation of an IT infrastructure throughout the SI PPS provider network. The ability to share health information between SNFs and hospitals and establishing connectivity to track the target patient population for rapid cycle evaluation will be critical to the project's success. Further, individual SNF providers that do not currently have electronic health records may require capital funding to support implementation.

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.

Not applicable.

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. <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.

Project 2.b.viii targets patients that would have been discharged to a skilled nursing facility (SNF) but are instead discharged to their home. These patients are typically frail, elderly seniors that may have physical, mental, social or financial limitations to accessing outpatient care, often resulting in unnecessary hospitalizations. Staten Island's (SI) 11,778 Medicaid enrollees above the age of 70 may require home care services at some point. SI has two hospitals, Richmond University Medical Center (RUMC) and Staten Island University Hospital (SIUH), 10 SNFs, and a number of home care providers, four of which serve the majority of SI's home care patients.

SI's total reported 30-day readmissions for both dual eligible and non-dual eligible patients is 3,915, with dual eligible Medicaid patients representing more than 30% of total readmissions. For the dual-eligible Medicaid population, 30-day readmissions were associated with septicemia, chronic bronchitis, respiratory illness, mood disorders, acute kidney failure, general symptoms, and anemia, among others.

Between 2013 and 2014, approximately 5,233 SI Medicaid recipients received home care services (CNA). SI Performing Provider System (SI PPS) home care agencies report an estimated 600 30-day readmissions annually for Medicaid patients discharged to home care, many of which may have been avoidable. Home care providers' top reasons for transfer to acute care facilities include other/unknown reasons, respiratory conditions (pneumonia or bronchitis), wound infection, deterioration, uncontrolled pain, and dehydration or malnutrition (Home Care Provide Data). Providers further identified that many of the readmissions may have been avoided with proper medication management, enhanced home care services, and proper connection to outpatient services (Provider Workgroups).

SI PPS home care providers identified additional reasons for patient readmissions including the status of the care giver and the socioeconomic conditions of the patient and/or care giver; education on the proper use of the emergency department (ED) for patients and their families; a lack of communication between the primary care provider (PCP) and the patient following discharge to the home; difficulty obtaining physician orders or prescriptions; and difficulty with medication reconciliation. Home care providers also pointed to transitions of care, including the standardization of transition protocols as a gap for high-risk patients, coordination or follow-up and the sharing of health data as factors impacting appropriate healthcare utilization. Another barrier identified is the shortage of home health aides on SI. SI PPS providers attribute this gap to the lack of public transportation available on SI for home health aides traveling between New York City's five boroughs, as well as adequate compensation.

In implementing Project 2.b.viii's the SI PPS will work to address the gaps identified above, incuding working to recruit home health aids. To strengthen communication and data exchange, the SI PPS will support the development of Health Information Exchange (HIE) connectivity across providers.

To address other care gaps, the SI PPS plans to implement an INTERACT-like program , including the INTERACT 3.0 toolkit, across all SI PPS home care agencies The program is proven to improve the early identification, evaluation, management, documentation, and communication of acute changes in the condition of home care patients. INTERACT principles will assist home care agencies in reducing the frequency of potentially preventable readmissions to acute care facilities, related complications, and healthcare costs. Additionally, the SI PPS's home care agencies currently employ tools and protocols that align with INTERACT principles, and may be leveraged through this project, however implementation of the INTERACT toolkit across the SI PPS will ensure the development of clear standards and tools across agencies.

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.

SI PPS home care providers report that there are an estimated 600 Medicaid 30-day readmissions associated with acute care discharges to home care annually, a percentage of which the SI PPS will aim to reduce. Patients readmitted from home care, this project's patient population, include patients at risk for readmission due to respiratory conditions (pneumonia or bronchitis), mood disorders, acute kidney failure, sepsis, wound infection, deterioration, uncontrolled pain, and dehydration or malnutrition, among others. The SI PPS will engage patients with these diagnosis and other patients discharged to homecare identified as at risk for readmission.

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 SI PPS will build upon existing resources, expertise, and standards of care available through RUMC, SIUH, and the four home care agencies. The home care agencies utilize evidence-based practices to prevent unnecessary ED utilization and 30-day readmissions including telehealth, transitions of care models, and risk stratification. The SI PPS will leverage best practices and proven strategies across the SI PPS to help inform project implementation including the INTERACT program and toolkit.

SI PPS home care agencies participating in this project utilize varying staffing models to provide services. Staffing includes interdisciplinary care teams, registered nurses (RN), specialized RNs (diabetes, certified wound care, psychiatric, etc.), rehabilitation specialists, licensed social workers, and other healthcare professionals. These staff will be leveraged to support the home care population. Although the SI PPS and home care agencies do not anticipate additional

staffing needs at this time to implement the INTERACT principles, with the exception of home health aides, additional specialized staff may be required and will be identified through ongoing root cause analysis for readmission.

The SI PPS plans to leverage new and expanded resources such as the integration of electronic health records (EHR) through SI's Regional Health Information Organization (RHIO) and the development of centralized training teams to support the implementation of INTERACT like programs across home care agencies. The SI PPS may also expand upon existing telehealth programs as well as increase existing home health aide resources.

As part of implementing this project, the SI PPS's designated hospital leads, home care agencies, and other participating providers will develop "rapid response teams" to facilitate discharges for patients identified as being at-risk. These teams, including transition coaches, will serve to facilitate transitions of care at bedside, in coordination with home care providers, complete pre-discharge interviews to identify needed services, and connect patients to a PCP and other outpatient services. The SI PPS recognizes that retraining of existing resources and the development of new resources will be required. Further, transition of care models and protocols will be developed in conjunction with Project 2.b.iv.

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 SI PPS members understand that the INTERACT like program requires a transformation in an organization's culture and processes at all staffing levels. As such, the SI PPS will develop a centralized training/coaching program and training team to be leveraged as a resource to the home care agencies. This training team will create an opportunity for providers to communicate best practices and share program information.

In order to effectively implement quality improvement tools through the INTERACT program, the SI PPS recognizes that each participating organization must track, trend, and benchmark well-defined measures, as well as learn from root cause analyses of events for hospital readmissions. The SI PPS will support participating home care agencies in this process through the development of standardized processes to benchmark readmissions, perform more comprehensive root cause analyses and identify opportunities for improvement and educational activities.

The SI PPS has identified the lack of additional home health aides on SI as an existing challenge for implementing this project. To address this issue, the SI PPS plans to strengthen infrastructure around home health aides to further support the SI PPS as part of its workforce strategy. The SI PPS will also dedicate resources for recruiting home health aides.

Another challenge identified by providers is that protocols around discharge and transitions of care differ by home care provider and hospital provider. To address this, the SI PPS will develop

suggested standardized transition of care elements for patient to home discharge.

To address implementation, the SI PPS will assign a Project Lead and develop a Program Champion at each of the home care agencies to provide the requisite skills to implement and support a successful program.

There is also a lack of electronic connectivity between providers as most SI PPS participants are not connected to the Regional Health Information Organization. To address this challenge, the SI PPS has begun the process of developing a high level implementation plan for integration into Healthix that will begin prior to Demonstration Year 1.

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.

Not applicable. The SI PPS is the sole PPS in the community.

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 will be required for health information technology integration to share clinical information between participating providers. The ability to share information between providers has been identified as a critical component of the success of the SI PPS. Additional capital would be required to implement an enhanced telehealth program. Although telehealth programs exist, these programs have chosen to be an effective and cost effective way to manage at risk patients and may be expanded as part of project implementation.

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
Visiting Nurse Association of Staten Island	Medicaid Waiver Program	March 2009	Ongoing	Nursing Home Transition and Diversion Program (NHTD): Provides long term services to members of the community who are at nursing home level of care. Program provides coordination of services, oversight and supervision, and access to housing subsidy.
Visiting Nurse Association of Staten Island	Medicaid Waiver Program	1982	Ongoing	Lombardi (Long Term Care) Program: Provides long term skilled services to members of the community with a medical need for home care. Member must require 3 skilled services to be eligible for this program.
Visiting Nurse Association of Staten Island	Medicaid covered under Lombardi/NHTD Program	July 1988	Ongoing	Health Watch Lifeline: Personal Emergency Response Service which provides immediate emergency response to patients in emergent situations.
Visiting Nurse Association of Staten Island	Medicaid Waiver Program	March 2009	Ongoing	Traumatic Brain Injury (TBI): Provides long term services to members of the community who are at nursing home level of care. Program provides coordination of services, oversight and supervision, and access to housing subsidy.

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 Nursing Home Transition and Diversion Program, Lombardi Program, Health Watch Lifeline, and Traumatic Brain Injury programs are focused on providing services for patients with medical needs for home care, as well as patients who are at nursing levels of care including coordination of services, oversight, as well as skilled services to keep them in the home setting. These programs are in line with the goals of this project. Services and best practices can be leveraged through the implementation of this project however will need to be significantly expanded as they are only addressing a limited number of at risk patients.

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. <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. The project description should consider three primary activation concepts: *patient activation*, *financially accessible health care resources*, and *partnerships with primary and preventive care services.*

The Staten Island Performing Provider System (SI PPS) selected Project 2.d.i in an effort to better serve the uninsured and low/non-utilizing Medicaid population which makes up approximately 15% of SI's total population. Specifically the State estimates there are 53,428 uninsured patients on SI (11% of the population), 8,240 non-utilizing Medicaid enrollees, and approximately 11,000 low-utilizer Medicaid enrollees (CNA). The SI PPS will develop a comprehensive program to engage the uninsured and low/non-utilizing Medicaid population including engaging those that do not properly utilize Staten Island's (SI) primary and preventative care services through the implementation of Patient Activation Measures (PAM).

SI is comprised of an ethnically diverse population, presenting linguistic and cultural barriers for Medicaid enrollees and the uninsured attempting to self-manage care and access and navigate SI's healthcare provider system. Approximately 30% of SI's population speaks a language other than English at home, higher than the New York State (NYS) average (CNA). The Asian/Pacific Island populations maintain the lowest levels of English proficiency, followed by the Indo-European and Spanish speaking population. The CNA further revealed that across all non-English speaking populations, the aging population, those 65 or older, have the lowest English proficiency levels.

Over the course of 3 years, SI has added 3,891 people to its population count, of which 3,718 (95.6%) were classified as being international immigrants (CNA). The CNA identified that SI's

highest number of Medicaid enrollees is attributed to its White population (37.6%) followed by its Hispanic (26.5%), African American (15.7%) and Asian/Pacific Islander population (8.7%). Further, SI's African American, Non-Hispanic and Hispanic populations have the highest percentage of uninsured individuals (28.0% and 27.2%, respectively) (CNA). Additionally, SI's population has a lower percentage of residents with high school degrees compared to the NYS average, and SI's estimated poverty level is measured at 13.7%. Per capita income is reported to be on average, lower than the per capita income reported as the NYS average (CNA).

The CNA also identified SI's North Shore Medicaid population as having hospitalization rates higher than the NYS average, with the North Shore population representing the majority (59.0%) of SI's Medicaid population (zip codes in the northern most part of SI are commonly referred to as the North Shore). The highest composite PQI admission rates also occur from these ZIP codes. In selecting Project 2.d.i, the SI PPS will aim to address the linguistic, cultural, educational, and financial barriers that exist on SI by leveraging PAM, building a robust neighborhood-specific community outreach program and connecting patients to primary and preventive care services and financially accessible healthcare resources.

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.

The SI PPS's patient population for Project 2.d.i is comprised of SI's uninsured population (under the age of 65) of approximately 53,428 individuals; SI's non-utilizing population, defined as Medicaid enrollees who were continuously enrolled for 12 months and did not utilize care (no claims generated during 12 month period), approximately 8,240 individuals; and SI's low- utilizing population, defined as members enrolled in Medicaid that utilize three or fewer services per year and have little to no connectivity to their primary care provider, approximately 11,000 individuals (CNA). Although the approximate number of SI's undocumented immigrant population is not available (as a percentage of the total uninsured), this project will also target their care needs.

SI's uninsured population accounts for a total of 1,964 self-pay hospital discharges with patients ages 18-44 having the highest number of hospital discharges (CNA). Based on the reported uninsured hospital discharges, the communities with the five highest discharge rates are located on the North Shore and Mid-Island (New Springville and New Dorp) (CNA). These areas, specifically those in the North Shore, are the poorest areas on SI with predominantly Asian/Pacific Islander and Hispanic populations who are not proficient in English. The North Shore and Mid-Island areas have been identified as community hot spots for reaching this project's patient population.

The Medicaid non/low-utilizing population is largely White, Hispanic, African American, and Asian/Pacific Islander (CNA). Similar to SI's uninsured population, the SI's Medicaid North Shore communities have higher rate of hospitalizations than the NYS average (CNA).

Through dedicated outreach teams, community based organizations (CBO), and provider resources, the SI PPS will reach a percentage of this project's patient population of uninsured or non/low utilizing patients for engagement in PAM. The SI PPS will target hot spot communities referenced, specifically the North Shore.

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.

This project will focus on engaging patients not currently utilizing the healthcare system or primarily seeking care in the ED by connecting them to primary and preventive services and financially accessible healthcare resources. As identified in the Provider Survey and in Provider Workgroups throughout the DSRIP planning process, a cohesive sense of community and collaboration among providers and CBOs are factors that may be leveraged to achieve project goals. Further, due to geography, SI is considerably isolated from other communities. As such, many providers in the SI PPS have existing relationships with CBOs that may be leveraged and expanded upon to implement the goals of this project.

The SI PPS currently has financially accessible healthcare resources; including services for the uninsured, through its two hospitals, Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC), as well as two Federally Qualified Health Centers (FQHC). Patients however may not be aware of or connected to appropriate services. As the SI PPS connects more uninsured patients to care, specialty care and other services for the uninsured will need to be expanded through this project. When possible, facilitated enrollment staff will identify and help procure insurance coverage for individuals who may be eligible.

A number of participating providers currently have community outreach programs and infrastructure as well as programs to engage this project's target population including SI's FQHCs (Beacon Christian Community Center and Community Health Center of Richmond), Community Health Action of Staten Island, and Visiting Nurse Services of New York, as well as SI's two acute care hospitals, SIUH and RUMC, among others. These existing programs provide mobile health outreach and engagement, and harm reduction outreach, among other services. There are also SI PPS providers currently utilizing PAM or PAM-like approaches. Further, CBO's and providers have existing relationships developed within community organizations as well as community and religious leaders that may be leveraged to access, engage, educate and ultimately serve the uninsured and low/non-utilizing populations on SI.

As part of its implementation strategy the SI PPS will expand existing resources as well as potentially contract with and/or develop partnerships with CBOs to perform outreach and activation activities. The SI PPS will target its efforts in the community hot spots described in previous sections. Activities will include engaging the population in PAM, promoting self-management and health coaching, and developing care plans based on beneficiaries' level of engagement and need. Through this process, patients will be linked to services including

reconnecting patients to existing primary care providers or other community resources including patient centered medical homes, FQHCs, hospital ambulatory clinics, as well as mental health, social services, and housing support.

Both of the SI hospitals and FQHCs would serve as resources that can be expanded upon to serve additional patients. Specialized care, mental health and substance abuse, and other services will also need to be expanded, to serve additional patients.

The newly engaged Medicaid and uninsured population will require various levels of care including preventive and primary care services, as well as high acuity specialty care. For patients requiring care management and diabetes management services, etc., their impact is being considered in other projects including Project 2.a.iii.and Project 3.c.i.

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.

A significant project challenge will be the impact that engaging this population will have on the current healthcare system's staffing and infrastructure capacity. To address this, the SI PPS will plan to expand overall capacity to meet the needs of this project as well as the others that will have similar (yet less substantial) impacts on the system. The SI PPS also plans to significantly expand its capacity including developing a SI PPS-wide training team comprised of members with PAM training. The SI PPS will utilize a faceted strategy for engagement including community health workers, patient navigators, social workers, and health coaches, among others.

Currently there are 13 individuals trained in PAM within the SI PPS, as well as others trained in PAM-like approaches. To train 250 individuals in PAM by DY 4, the SI PPS will need to allocate resources and funding to train and add staff. To address this challenge, as part of the training team described above, the SI PPS will utilize the existing trained individuals as well as train current SI PPS providers through the SI PPS's Workforce Strategy.

An additional challenge the SI PPS faces are the language, cultural, financial, and education barriers facing the patient population. The project's success relies on the success of engaging and educating a population with cultural, language, and financial barriers. The SI PPS intends to include a Diversity and Inclusion Committee to address health literacy and cultural competency as part the overall governance structure for this project and others, which will include a comprehensive training program.

The SI PPS will also need to collaborate with pharmacies as they make routine calls for medications when they are not picked up, specifically with chronic respiratory and diabetes medications.

There is also a lack of electronic connectivity between providers as most SI PPS participants are

not connected to the RHIO. To address this challenge, the SI PPS has begun the process of developing a high level implementation plan for integration into Healthix that will begin prior to Demonstration Year 1. The SI PPS will also need to develop interactive information technology (IT) infrastructure to provide reminders for medication and appointment compliance and connect patients to resources.

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.

Not applicable. The SI PPS is the sole PPS in the community.

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.

This project will require capital funding for the establishment of an Information Technology (IT) infrastructure throughout the SI PPS provider network. The SI PPS strongly believes that the ability for providers to share information is central to the overall strategy for reducing hospital admissions by improving coordination and integration of the care continuum. Additionally the SI PPS may require capital funding to expand primary care capacity, and other service capacity in existing settings and new settings to serve additional Medicaid beneficiaries as well as the uninsured that will be engaged through this project. This project may also require capital funding for mobile vehicles.

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
Visiting Nurse Services of New York (VNSNY)	NYS DOH Social Services Block Grant	September 2013	September 2015	Rockaway Wellness Partnership provides care and assistance to victims of Hurricane Sandy. The team facilitates access to primary care and uses evidence based health coaching to promote wellness and better self-management.

Name of Entity	Medicaid/ Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Staten Island Mental Health (SIMH) and Community Health Action of Staten Island (CHASI)	SOMH/FE MA	January 2014	September 2015	Sandy Mobile Integrated Health Team (MIHT) - SIMHS as the lead agency, has partnered with CHASI to meet the medical and behavioral health needs of children, adults and families severely affected by Hurricane Sandy. The MIHT provides in-home services and services on our mobile van including emotional health assessments and treatment, health assessments, and case management services.
Community Health Center of Richmond, Inc.	NYSOH	August 2013	September 2018	Navigator Program (Insurance Market Enrollment)
Community Health Center of Richmond, Inc.	NYSOH	October 2013	September 2018	Maternal and Infant Community Health Collaborative
Community Health Center of Richmond, Inc.	CMS	July 2013	July 2015	Connecting Kids Program (Insurance Enrollment for Kids)

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 SI PPS will leverage and expand upon the existing programs aimed at meeting the goals of this project as indicated above. Many of the models that exist throughout the SI PPS have shown to be effective and the SI PPS will leverage programs that have been successful in the SI communities specifically, that are also based on best practice/evidence based models. However, the targets for this project will require a much more expansive effort including the development of new models and the addition of new resources and capacity.

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 <u>scale of project implementation, completion of project requirements</u> and <u>patient engagement progress</u> 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):

2. <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.

Staten Island's (SI) Medicaid population had 28,868 behavioral health diagnoses that utilized at least one type of healthcare service (CNA). SI has a large volume of Medicaid mental health admissions and Emergency Department (ED) visits with 10,640 Medicaid mental health hospital admissions and 14,108 mental health ED visits in 2012. SI also had 6,826 substance abuse admissions and 6,172 substance abuse-related ED visits (CNA). The rate of substance abuse and mental health ED visits were higher for patients with North Shore ZIP codes (Mariner's Harbor, Port Richmond, West New Brighton, St. George, Stapleton, and Rosebank) (CNA). Additionally, in 2013, SI's Medicaid enrollee population had 3,915 30-day readmissions . Of these readmissions, approximately 30% were attributed to behavioral health and substance abuse disorders, and a significant percentage were related to medical readmissions due to chronic conditions including circulatory and respiratory disorders, diabetes, acute kidney failure, and cardiac disease (CNA). Results from the Community Survey found that mental health and depression were the leading health conditions reported.

Of the Medicaid/dual eligible hospitalizations during 2013, SI had a total of 2,080 admissions

where the patient had both a behavioral health and chronic condition diagnosis (CNA). Depressive disorders are typically more common among persons with chronic conditions (obesity, cardiovascular disease, diabetes, asthma, arthritis, and cancer) and among those with unhealthy behaviors (smoking and physical inactivity) (www.cdc.gov). These statistics support the need for enhanced services to further support patients with behavioral health/substance abuse diagnoses and chronic medical conditions.

SI PPS behavioral health/substance abuse providers indicated that either all or a large percentage of their patients would benefit from access to primary care/medical services (Provider Workgroup Sessions). Providers indicated, that although they may provide referrals to a primary care provider (PCP) and encourage follow-up, most patients have no or inconsistent medical follow-up and have difficulty with medical compliance. SI PPS PCPs indicated that the co-location of behavioral health/substance abuse and primary care services would ensure better coordination of care among providers, would help to identify behavioral health diagnoses in PCP patients, and ensure that treatment is quickly provided without the stigmas associated with referral to a behavioral health/substance abuse provider.

The SI behavioral health, substance abuse, and primary care providers felt strongly that a comprehensive program which co-locates primary care and behavioral health services (or the opportunity for rapid consults) should include services at both locations, e.g. behavioral health/substance abuse services at patient centered medical home (PCMH) locations and primary care services at behavioral health/substance abuse sites. In applying this approach, the SI PPS believes that the project will meet the needs of the targeted patient population.

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.

SI PPS providers from primary care/clinics and behavioral health/substance abuse providers agreed that Project 3.a.i should target existing behavioral health patients that require PCP services via co-location at Article 31/32 clinics; as well as existing patients at PCPs including the two federally qualified health centers (FQHC), hospital ambulatory clinics at Staten Island University Hospital and Richmond University Medical Center, and other participating PCPs. Providers reported that approximately 9,500 Medicaid patients being served annually would benefit from either behavioral health/substance abuse services or PCP services at participating provider sites (Provider Data).

The SI PPS PCPs estimate 15% of their patients will likely have a behavioral health/substance abuse diagnosis based on overall population estimates. To address this need, the SI PPS will develop a screening process to identify PCP patients that are in need of behavioral health services based on indicators including expressed need and non-compliance. The project will target PCPs and behavioral health/substance abuse providers located in communities across SI, including providers on the North Shore, where patients are at a higher risk for behavioral

Health/substance abuse admissions.
In addition to patients currently identified as benefiting from co-location, the SI PPS believes based on the goals of Project 2.d.i; additional patients will be identified as requiring services not currently being served. The SI PPS plans to include the non/low low-utilizing population and the uninsured within this project's patient population that are likley to have a behavioral

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 SI PPS has identified existing programs within the SI community that currently integrate PCP and behavioral health services, a number of which are pilot programs or are limited in scale. SIUH has a pilot program that provides primary care services to behavioral health patients. The program is staffed with residents and psychiatrists, among others, that devote time each week to the program. RUMC has a partnership with the Substance Abuse and Mental Health Association's Northeast Addiction Transfer Technology Center (ATTC). This program is focused on developing co-occurring treatment capabilities (behavioral health/substance abuse). The second phase will focus on the integration of co-occurring treatment with primary care. RUMC has also developed a program with the Staten Island Mental Health Society to screen and treat patients under a new initiative. Additionally, both of SI's FQHCs have some degree of co-location including partnerships with a SI behavioral health/substance abuse providers where social workers and other staff perform screenings, counseling and referrals. The SI PPS also plans to leverage South Beach Psychiatric Center's program model, to provide primary care services at BH sites in Staten Island.

The SI PPS will build upon models that have been piloted or are currently being piloted at locations where infrastructure is available to quickly expand services in Demonstration Year (DY) 1 and utilize the models developed during pilot phases to expand services throughout provider sites over time.

Integration of behavioral health/substance abuse into PCMH:
Additional staffing will be needed to support integration (psychiatrists, nurse practitioners, licensed clinical social workers, and care managers, among others). SI's participating providers, in conjunction with the Staten Island Performing Provider System, LLC Clinical Governance, will develop evidence-based standards of care for medication management, care management, and screenings as well as treatment protocols. The SI PPS will utilize a model that utilizes multidisciplinary care teams that are accountable for coordinating a full range of medical, behavioral, and supports services including connecting patients with care managers.

Integration of primary care into behavioral health/substance abuse:
In order to integrate PCPs into behavioral health programs, the SI PPS will require additional PCPs and other clinical/non-clinical staff. The integrated model will utilize multidisciplinary care teams and case managers to support high risk patients.

Additionally, the SI PPS will need to develop real-time information sharing across systems through the integration of information technology. This project will require the expansion or development of facilities to support the co-location of behavioral health/substance abuse in PCMH locations and primary care into behavioral health/substance abuse providers including costs for building or renovating existing space into medical exam rooms or space to provide behavioral health assessments, counseling/treatment. Additionally the SI PPS may require funding for the purchase of mobile vans to provide co-located services.

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.

Among SI PPS partners, there are currently two PCPs that have achieved NCQA 2011 PCMH Level 3 standards and a number of PCP providers that are currently in the process of achieving this accreditation. A subset of providers will require significant effort and time to meet NCQA 2014 Level 3 PCMH standards, creating a challenge to meeting project's requirements. To respond to this challenge, the SI PPS intends to provide centralized resources to support and track implementation of NCQA 2014 Level 3 PCMH standards.

There is a lack of electronic connectivity between providers as most SI PPS participants are not connected to the Regional Health Information Organization. To address this challenge, the SI PPS has begun the process of developing an implementation plan for Healthix integration beginning prior to DY 1.

The SI PPS also anticipates the need for additional staffing resources that may prove to be a significant barrier to the project's success as it is difficult to recruit PCPs and psychiatrists. To address this, the SI PPS will provide recruitment support associated with this and other projects for the hiring of additional staff as part of the SI PPS Workforce Strategy.

In order for co-location to successfully occur, waivers will need to be granted to provide regulatory relief to allow for the provision of medical services at Article 31/32 providers, as well as the provision of behavioral health/substance abuse services in Article 28 clinics.

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.

Not applicable. SI PPS is the sole PPS in the community.

3. 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.

This project will require the expansion or development of facilities to support the co-location of behavioral health/substance abuse in PCMH locations and primary care into behavioral health/substance abuse providers including costs for building or renovating existing space into medical exam rooms or space to provide behavioral health assessments and counseling. This project will require capital funding for the establishment of an information technology (IT) infrastructure throughout the SI PPS provider network. The SI PPS strongly believes that the ability for providers to share information is central to the overall strategy for reducing hospital admissions by improving coordination and integration of the care continuum.

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
Richmond University Medical Center (RUMC) and SAMHSA Northeast Addiction Transfer Technology Center (ATTC)	Other	July 2014	July 2016	RUMC is engage d with Dr. Stan Sacks, Director of SAMHS A Northeast ATTC, in a multiyear educational and system change to improve the co-o ccurring treatment capability of all the RUMC outpatient services, provide training for staff and consultation by the ATTC on systemic and programmatic changes . The initial focus is to develop co- occurring treatment capabilities and the second phase is to integrate co- occurring treatment with primary care.

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.

This project will build upon, and significantly expand pilot and new efforts the SI PPS providers are currently pursuing around the integration of primary care and behavioral health services. As mentioned above, SIUH has an existing pilot program that provides primary care services to behavioral health patients. RUMC has a partnership with the Substance Abuse and Mental Health Association's Northeast Addiction Transfer Technology Center (ATTC). However, this program is very limited in scope and is in early or pilot phases. Project 3.a.i will allow for the necessary and significant expansion required to serve the projects patient population. The SI PPS plans to leverage existing programs as models to inform staffing and SI PPS protocols to rapidly expand services during implementation.

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.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs

Project Objective: To develop withdrawal management services for substance use disorders (SUD) (ambulatory detoxification) within community-based addiction treatment programs that provide medical supervision and allow simultaneous or rapid transfer of stabilized patients into the associated SUD services, and to provide/link with care management services that will assist the stabilizing patient to address the life disruption related to the prior substance use.

Project Description: The majority of patients seeking inpatient detoxification services do not require the intensive monitoring and medication management available in the inpatient setting. These patients can be monitored in an outpatient program until stability is assured and, then, rapidly integrated into a co-located outpatient SUD program with PCP integrated team. Additionally, patients will be provided with care management services that will assist the stabilizing patient to organize medical, educational, legal, financial, social, family and childcare services in support of abstinence and improved function within the community. Care management can be provided as part of the SUD program or through a Health Home strongly linked to the SUD program if qualified for Health Home services. Such programs can address alcohol, sedative and opioid dependency as well as provide access to ongoing medication management treatment.

Project 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. Develop community-based addiction treatment programs focusing on withdrawal management that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.
2. Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.
3. Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.
4. Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.
5. Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.
6. Develop care management services within the SUD treatment program.
7. Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.

8. 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.

Of the Medicaid population, there are 28,868 Staten Island (SI) Medicaid recipients with a mental health or substance abuse diagnosis, as defined by the New York State Office of Mental Health (OMH), and utilized at least one healthcare service in the past year. This subset of the Medicaid population represents approximately 6% of SI's overall population (CNA). Additionally, SI has a high volume of Medicaid substance abuse-related admissions at its two acute care hospitals, Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC), 6,826 substance abuse admissions and 6,172 substance abuse-related Emergency Department (ED) visits (CNA). Of SI's 3,915 30-day readmissions approximately 1,133 admissions (30%) were attributed to substance abuse or psychiatric disorders. Also, the rate of substance abuse and mental health ED visits are higher among patients living in SI's North Shore (Mariner's Harbor, Port Richmond, West New Brighton, St. George, Stapleton and Rosebank).

The SI PPS Community Survey distributed to community members, found that more than 20% of respondents identified substance abuse/alcohol addiction as a primary health condition. Further supporting this finding, in 2012, the SI rate of deaths per 100,000 from drug overdoses was 20.1, far exceeding the Bronx at 16.5 and all of the five boroughs. Further, SI's overdose mortality rate has increased by 8 percentage points from 12.0 per 100,000 in 2010 to 20.1 per 100,000 in 2012. Many factors are contributing to the substance abuse rates including the availability of prescription pain killers. The rate and amount of prescriptions for opioid analgesics is dispensed at double or triple the rate of other boroughs for drugs including Oxycodone and Hydrocodone (CNA).

In responding to the care needs described above, participating SI PPS providers consistently reported a lack of appropriate ambulatory detoxification capacity and regulatory restrictions for adolescent detoxification services as a significant deficit in the current delivery system. SI has 8 ambulatory providers currently providing comprehensive substance abuse treatment in addition to RUMC and SIUH ambulatory substance abuse treatment programs. The Staten Island Performing Provider System (SI PPS) will focus on implementing this project at these existing providers. Substance abuse providers on SI are providing only limited ambulatory detox services (including medication management). Providers also reported through workgroups, weak coordination of care and services between inpatient detox and outpatient treatment programs, poor referral networks, and difficulty sharing health information. These findings were further

reflected in results from the Provider Survey where an overall lack of communication between providers, coordination of care and follow-up, and limited access to and sharing of health data were reported as factors impacting appropriate healthcare utilization.

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 SI PPS recognizes that most patients seeking substance abuse disorder services do not require intense monitoring and medication management services in inpatient settings. As identified, SI has the highest rate of heroin and opioid overdose among NYC's boroughs. The SI PPS will initially focus efforts on developing ambulatory detoxification for patients with an opioid addiction to address SI's high opioid use. Overtime, the SI PPS may be able to extend services to patients with other addictions.

SI had 653 Medicaid recipients with an inpatient discharge and a substance abuse diagnosis in 2013-2014 (CNA). SIUH is the only SI hospital providing inpatient detox services. For these admissions, opioids were the primary substance for which patients sought treatment (65%) or an estimated 424 patients, followed by alcohol and benzodiazepines. Project Hospitality, an SI PPS provider, provides crisis services for medically monitored withdrawal and treatment to approximately 200 patients with opioid addictions. The SI PPS will target patients that use ambulatory detox services, as well as patients that may benefit from services but are not currently seeking treatment. These patients will be monitored in an outpatient program until stability is assured and, as appropriate, be referred to the most appropriate level of ongoing care.

Opioid use and substance abuse is a borough wide issue; therefore the SI PPS will not focus efforts on one geographic area, rather will extend ambulatory detoxification services to multiple substance abuse providers across SI.

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.

SI PPS plans to leverage the 8 outpatient substance abuse/Article 32 providers currently providing comprehensive substance abuse treatment in addition to RUMC and SIUH's ambulatory substance abuse treatment programs. Substance abuse and withdrawal services currently being provided include drug and alcohol outpatient treatment, outpatient intensive treatment, outpatient day rehab with alternative schooling, medication assisted treatment, opioid treatment program, residential treatment, harm reduction (syringe exchange), inpatient detox, and inpatient rehab.

In addition to these services, the SI PPS Article 32 providers and dual-licensed SIUH and RUMC

will develop or enhance ambulatory detox capacity at their organizations following OASAS guidelines.

The development of ambulatory detox capacity will require expansion of existing resources, as well as new resources, including identifying a Project Medical Director (board certified in addiction medicine, psychiatrists, registered nurses/nurse practitioners, licensed clinical social workers, Credentialed Alcoholism and Substance Abuse Counselors (CASAC), and other staff to expand ambulatory detox capacity.

As the SI PPS expands capacity across multiple provider sites, the Project Medical Director, in conjunction with Staten Island Performing Provider System, LLC's Clinical Governance and participating providers, will develop guidelines for evidence-based case management programs for withdrawal management.

The SI PPS recognizes that an important component of this project will be providing care management services for patients utilizing ambulatory detox services to assist in stabilizing the patient and connecting them with support services. As such, the SI PPS intends to develop a coordinated care management infrastructure that combines information technology for the sharing of integrated health information to support this and other projects. Care management may be provided by additional resources at the participating substance abuse provider sites, or by health homes on SI. The SI PPS will need to expand care management capacity as part of this and other projects for high risk patients.

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 SI PPS anticipates that additional staffing will be needed to expand ambulatory detox/withdrawal management services across the SI PPS. Staffing will include recruiting additional psychiatrists and physicians who are certified to dispense Suboxone and other drugs used for withdrawal management. The SI PPS providers report that it may take up to one year or more to recruit psychiatrists with the expertise necessary to support this project. To address this challenge, the SI PPS infrastructure will support recruitment efforts, for this and other projects, to address challenges/barriers for project implementation.

In addition to staffing challenges, the SI PPS has indicated the need to work with the managed care companies to review and modify current guidelines around reauthorization of Suboxone prescriptions.

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.

Not Applicable

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.

This project will require the expansion or development of facilities to support the development of ambulatory detox/withdrawal management at existing sites. Capital needs will include the cost for building or renovating existing space and adding new buildings to expand capacity. This project will require capital funding for the establishment of an IT infrastructure throughout the SI PPS provider network. The SI PPS strongly believes that the ability for providers to share information is central to the overall strategy for reducing hospital admissions by improving coordination and integration of the care continuum.

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.

Not applicable.

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.c.i Evidence based strategies for disease management in high risk/affected populations. (Adult only)

Project Objective: Support implementation of evidence-based best practices for disease management in medical practice related to diabetes.

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 diabetes. Specifically, this includes improving practitioner population management, increasing patient self-efficacy and confidence in self-management, and implementing diabetes management evidence based guidelines.

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.

1. Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.
2. Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.
3. Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.
4. Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.
5. Ensure coordination with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other technical platforms to track all patients engaged in this project.
7. Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3 for EHR systems used by participating safety net providers.

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.

Findings indicate that heart disease and Type II Diabetes (diabetes) are commonly linked conditions and that heart disease is the leading cause of death in the U.S. (National Vital Statistics). Similarly, heart disease is the leading cause of death on Staten Island (SI) and SI's death rate for heart disease is higher than the average rate across New York City (CNA). These findings apply to Project 3.c.i, as adults with diabetes are two to four times more likely to have heart disease than those without diabetes (American Heart Association). This high rate can in part be explained by poor lifestyle habits, reflected in SI's smoking and obesity rates (CNA). These lifestyle habits, amenable to public health interventions, also lead to the development of adult onset diabetes.

SI has 14,025 Medicaid recipients with a diabetes diagnosis (any level), which accounts for approximately 10% of SI's Medicaid population (CNA). The CNA also indicates that 353 or 20% of the 1,639 Medicaid PQI hospitalizations on SI were due to diabetes-related complications. In 2013 there were 428 discharged with a primary diagnosis of diabetes and 4,185 admissions with a secondary diagnosis of diabetes.

An analysis of admissions by ZIP codes reveals that low-income Medicaid population in SI's North Shore have a greater incidence of diabetes than other higher income communities (CNA). Although this project will span all participating primary care providers (PCP) on SI, the PPS plans to specifically target patients living in SI's North Shore communities where there are significant opportunities to improve lifestyle habits, health status and longevity and expand upon existing diabetes self-management and prevention programs.

A chronic shortage of endocrinologists places a great burden on PCPs to provide diabetes care to their patients. The SI PPS will work with RUMC and SIUH affiliated endocrinologists to develop CME programs to support PCPs treating diabetes patients. The SI PPS will also work with the PCPs to identify which patients should be referred for endocrinologist consults and care.

The existing diabetes self-management and prevention programs on SI will support this project. Limited reimbursement for diabetes education has restricted access of these programs. Providers report there may also be cultural barriers that inhibit patients with diabetes or at risk for diabetes from managing their own health. For the programs that currently exist, in addition to the above, sustaining and expanding services due to program costs is reported as a barrier, as well as the availability of Certified Diabetes Educators. The SI PPS will support the expansion of self-management programs through this initiative.

Further, the SI PPS will work to connect non/low-utilizing patients with diabetes to prevention and diabetes management, as well as implement evidence based standards of care across participating PCPs.

The SI PPS will also need to expand upon Information Technology (IT)/Care Management Organization (CMO) infrastructure to risk stratify the population and identify and connect patients with, or at risk for diabetes to prevention and diabetes management services.

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.

As part of Project 3.c.i's goals, the SI PPS aims to target SI Medicaid enrollees with a diabetes diagnosis in addition to those at risk for developing diabetes (CNA). The SI PPS includes multiple primary care providers, that have committed to implementing diabetes management within their practices. The participating PCPs estimate that of their current Medicaid patients, approximately 4,500 have diabetes or are at-risk for developing diabetes (Provider Data).

The SI PPS will begin to target the identified population by first enhancing the standard of care and evidence-based disease management practices in participating PCP practices, to ensure that needs are being met for the patients being served. These standards will be developed collaboratively with PCPs and endocrinologists. The SI PPS will also seek to identify those patients that have diabetes but are not diagnosed or not currently receiving appropriate prevention and disease management services, including the non/low-utilizing Medicaid population. The SI PPS estimates that 15% of the non/low utilizing Medicaid population has diabetes or is at risk for diabetes. These patients will also be targeted through this project.

Although this project will target patients being served by PCP's across SI, the SI PPS will focus on expanding prevention, management and self management program in the hot spot areas of the North Shore of SI.

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 SI PPS will leverage the Stanford Model for Chronic Diseases as a resource for establishing a framework for self-management training and provide trainings in hot spot areas on SI's North Shore in community settings (e.g. churches, libraries, and community centers) accessible to patients in those communities. As identified in the provider survey and during provider workgroup sessions, many of the SI PPS providers have existing relationships with Community Based Organizations (CBO) that can be leveraged for facilitating self-management trainings at CBO locations.

Additionally, the SI PPS has identified existing diabetes self-management and prevention programs within the community as well as in participating PCP offices and clinics which will be leveraged to achieve Project 3.c.i's goals. Existing programs include Community Health Action of Staten Island's Chronic Disease Self-Management Program and the Certified Diabetes Prevention Program provided by the YMCA. Further, the SI PPS will leverage CDEs currently supporting SIUH's ambulatory clinic and Victory Internal Medicine's physician practices. In leveraging the existing programs as well as trained staff to further expand the programs, and as represented by the Stanford Model, the SI PPS anticipates significant improvements in exercise, cognitive symptom management, communication with physicians, and self-reported general

health, health distress, fatigue, and disability among this project's target population.

The SI PPS will work with PCPs to create proper referral mechanisms for chronic disease and diabetes self-management programs as well as diabetes prevention programs. Further, the SI PPS will work with SI PPS members to coordinate and expand upon current infrastructure to support PCPs, including expanding upon care coordination teams with diabetes educators, care managers, and nutritionists, among others, to provide evidence-based best practices, improve health literacy, and guide patients towards becoming more effective in diabetes self-management. The SI PPS will also work closely with aligned pharmacies to provide support and follow-up to patients who must adhere to complex medication regimens.

The SI PPS will work with the existing Managed Care Organizations (MCO) and in conjunction with the overall SI PPS MCO/IT infrastructure will risk stratify the Medicaid population to identify patients that are diagnosed with or at risk for developing diabetes, that are not receiving proper disease management or are not connected to a PCP. In leveraging this infrastructure, which the SI PPS plans to further expand, the identified patients will be recommended for care management at participating provider sites (PCPs, emergency departments, hospitals, and behavioral health and social service providers) and connected to care management, care coordination teams and diabetes self-management programs.

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 Community and Provider Surveys indicated challenges within the SI healthcare delivery system that may impact the ability of the SI PPS to implement this project including limited evening and weekend hours at PCP offices, limited transportation, waiting lists and high costs for services, language barriers, and education.

The SI PPS will work with endocrinologists and PCPs to enhance their capacity to provide diabetes care by hiring and training mid-level providers and CDEs to support care delivery. The SI PPS will develop public education and community outreach strategies to encourage self-management education programs. Additionally, the SI PPS will promote diabetes screening and self-management programs to hot spot areas to mitigate transportation issues. In effort to support providers and address cultural/ethnic barriers, the SI PPS will hire bilingual staff and/or leverage a SI PPS wide language line.

There is a lack of electronic connectivity between providers as most SI PPS participants are not connected to the RHIO (Healthix). The SI PPS has begun the process of developing a high level implementation plan for integration into Healthix that will begin prior to DY 1.

Finally, two PCP organizations currently meet NCQA 2011 PCMH standards and a number of providers are in the process of achieving this accreditation. However, a subset of providers will

require significant effort and time to meet NCQA 2014, Level 3 Standards. To mitigate this challenge, the SI PPS intends to provide centralized resources to support and track implementation of PCMH 2014 NCQA standards.

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.

Not applicable. The SI PPS is the sole PPS in the community.

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.

This project will require capital funding for the establishment of information technology (IT) infrastructure throughout the SI PPS provider network. The SI PPS strongly believes that the ability for providers to share information is central to the overall strategy for reducing hospital admissions by improving coordination and integration of the care continuum. Additionally the SI PPS may require capital funding to expand facilities to provide diabetes treatment and self-management 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

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.

Not applicable.

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.g.ii Integration of Palliative Care into Nursing Homes

Project Objective: To increase access to palliative care programs in Nursing Homes.

Project Description: Per the Center to Advance Palliative Care, "Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment." (http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc)

Increasing access to palliative care programs for persons with serious illnesses and those at end of life can help ensure care and end of life planning needs are understood, addressed and met prior to decisions to seek further aggressive care or enter hospice. This can assist with ensuring pain and other comfort issues are managed and further health changes can be planned for.

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.

1. Integrate Palliative Care into practice model of participating Nursing Homes.
2. Contract or develop partnerships with community and provider resources, including Hospice, to bring the palliative care supports and services into the nursing home.
3. Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.
4. Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.
5. Engage with Medicaid Managed Care to address coverage of services.
6. Use EHRs or other IT 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.

The Staten Island Performing Provider System (SI PPS) has selected Project 3.g.ii in an effort to integrate palliative care programs into its 10 skilled nursing facilities (SNFs) to address care needs for Medicaid patients at any age and stage of caring for a serious illness. Staten Island's

(SI) Medicaid population which would largely benefit from palliative care can be described as ethnically diverse and facing cultural and language barriers to care. SI also has the highest overall mortality rates of New York City's (NYC) five boroughs, with heart disease and cancer being SI's leading causes of deaths. SI's heart disease and cancer rates are also above the NYC averages. In addition to high mortality rates, SI's Medicaid Per-Member-Per-Month (PMPM) costs are the highest among SI's population above the age of 80 (80+), PMPMs for 80+ females are also higher than those for 80+ males. This information is particularly relevant to the goals of Project 3.g.ii, evidencing that there are high Medicaid expenditures for end-of-life care in hospitals that could otherwise be lowered through the provision of palliative care programs (Morrison RS, Cassel JB, Caust-Ellenbogen M, Spragens L, Meier D. Substantial Cost Savings Associated with Hospital-Based Palliative Care Programs. Journal of the American Geriatrics Society.2007;44:S7).

There are also high instances of cancer occurring within specific SI communities, Princes Bay (colorectal and breast (female) cancer), Eltingville (breast (female) cancer), Mariners Harbor (prostate and lung cancer), Port Richmond (lung cancer), Rosebank (lung cancer), New Dorp (lung cancer), and Tottenville (lung cancer) (CNA). These communities are located throughout SI and are not concentrated in one area. As previously identified, cancer is the second highest leading cause of death on SI and those diagnosed with cancer, as well as other serious illnesses could benefit from palliative care, including Congestive Heart Failure (CHF) and COPD. Among PQI admissions on SI, COPD in older adults and heart failure are among the top reasons for hospital admissions (CNA).

During provider workgroup sessions and in the provider survey, the need to change perceptions around the way palliative care is viewed by patients and families was identified. Providers indicated that there is a perception among families that electing palliative care over a rehabilitation facility or hospital means that the patient/family member is foregoing treatment. This perception is further compounded by cultural impacts and a lack of English proficiency, particularly in the aging Medicaid population on SI, when describing palliative care options to patients and their families. To address this care gap, the SI PPS plans to provide education and training for clinical and other nursing home staff around palliative care options, with consideration of cultural competency and health literacy to engage patients and their families. Although this project focuses on implementing palliative care into SNFs, the SI PPS's approach will more broadly focus on educating patients as well as healthcare providers to address misconceptions around palliative care across SI.

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 SI PPS's target population for Project 3.g.ii is comprised of patients with serious illnesses that would benefit from receiving palliative care services at participating SNFs. Approximately 283 SI Medicaid recipients received nursing home care for palliative-related diagnoses (e.g. cancer, liver disease, dementia, congestive heart failure, etc.) during the 2010-2012 time period (CNA). SI PPS SNF providers reported that approximately 90 Medicaid recipients are currently receiving palliative care services at the 10 SNFs. Patients elligible for pallitatve care at all 10 SI based SNFs wil be targeted fro this project.

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 SI PPS will build upon existing resources to increase access to palliative care services in SNFs. The Center to Advance Palliative Care identified four different models to approach palliative care in SNFs. The SI PPS will use a combination of models to further integrate palliative care into the practice model of participating SNFs including utilizing existing hospice staff and infrastructure to provide and expand palliative care services.

An assessment completed by the Center for Advanced Palliative Care indicates that while some components of palliative care are delivered in most SNFs, few SNFs have formal palliative care programs and SNF leaders' perception of the quality of care being delivered is often at odds with residents' reported experiences.

Currently, a number of participating SNFs offer palliative care services in their facilities; however providers report that there is an opportunity to significantly expand palliative care services. The SI PPS will leverage and develop partnerships with hospice providers and the PPS SNFs to bring comprehensive interdisciplinary end-of-life/hospice care to SNF patients that are eligible and elect for the hospice benefit.

The SI PPS will develop clinical guidelines agreed to by all participating providers defining the scope of palliative care services to be offered and patient. Additionally the SI PPS will develop resources to be utilized to train SNF staff and other clinical and community providers in palliative care skills and protocols, including Nurse Educators.

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.

SI PPS providers identified reimbursement for palliative care as a challenge to project implementation. The SI PPS will work with Managed Care Organizations to restructure reimbursement models to provide enhanced coverage for palliative care. The Provider Survey

cites staffing and training as a challenge. Palliative care is being provided to a limited percentage of SNF patients, and the expansion of services may require additional leadership staff including NPs with expertise in palliative medicine. Providers indicated that practitioners will be difficult to hire. The SI PPS plans to address this through the development of centralized training teams, supporting recruitment and building upon existing resources form the PPS hospice providers.

There is a lack of electronic connectivity between providers as most SI PPS participants are not connected to the SI Regional Health Information Organization. To address this, the SI PPS has begun the process of developing a high level implementation plan for Healthix integration beginning prior to DY 1.

There is also a need to educate/change perception of palliative care among patients and their families as well as SNF staff and community providers. To address this gap as well as the cultural and language gaps within SI's diverse population, the SI PPS will educate SNF staff and providers across the care continuum, on palliative care options as well as cultural competency and health literacy to fully engage patients and their families.

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.

Not applicable. The SI PPS is the sole PPS in the community.

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. 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.

This project will require capital funding for the establishment of an IT infrastructure throughout the SI PPS provider network. The ability to share health information between SNFs and hospitals, or connectivity to track patients involved in this project for rapid cycle evaluation will be critical to the overall project success.

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.

Not applicable.

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 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.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)

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

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

Project Requirements: The PPS must show implementation of three of the four sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, specific potential interventions are identified on the Preventive Agenda website under "Interventions to Promote Mental Health and Prevent Substance Abuse" (http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/interventions.htm).

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

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
Achdiocese Drug and Alcohol Prevention Program; Fund for Publich Health New York; Jewish Community Center, Parent to Parent; New York City Prevention Resource Center; Office of Alcholism and Substance Abuse Services; Developmental Disabilities Services Council; Prevention Resource Center; Staten Island Child and Adolescent Mental Health Committee; The Staten Island Foundation; New York City Department of Education; Families on the Move;

New York City Housing Authority; and NAMI-Staten Island

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 SI PPS plans to implement Project 4.a.iii to align with and expand upon the goals of other selected Domain 3 projects (Project 3.a.i and 3.a.iv). As demonstrated by the SI PPS's CNA there is a clear indication that mental health and substance abuse infrastructure needs to be strengthened across SI. Further, mental and emotional well-being is essential to an individual's overall health. Thus the SI PPS has placed an emphasis on expanding the availability of services to address mental, emotional and behavioral (MEB) issues to mitigate their impact on high psychosocial and economic costs later in life (New York State Prevention Agenda).

Approximately 21% of SI's Medicaid population has a mental health or substance abuse diagnosis (CNA). Results from a Community Survey, distributed to SI community members found that mental illness, depression, and drug and substance abuse were among the top five reported health conditions leading individuals to seek healthcare treatment. SI also had a significant volume of Medicaid mental health and substance abuse related hospital admissions and ED visits in 2012 including 10,640 mental health hospital admissions, 14,108 mental health ED visits, 6,826 substance abuse admissions and 6,172 substance abuse related ED visits (CNA). Additionally, in 2013, SI's Medicaid enrollee population had 3,915 30-day readmissions. Of these readmissions, approximately 30% were attributed to behavioral health or substance abuse issues. The high hospital utilization indicates mental health and substance abuse are significant drivers of inappropriate utilization of care and the capacity to serve these patients outside of the inpatient setting should be expanded or strengthened so patients are connected to appropriate treatment and services.

Substance abuse on SI has been a well-documented and significant and ongoing community need. In 2012, the SI rate of deaths per 100,000 from drug overdoses was 20.1, far exceeding the Bronx at 16.5 and all of the five boroughs. Further, SI's overdose mortality rate has increased by 8 percentage points from 12.0 per 100,000 in 2010 to 20.1 per 100,000 in 2012. Many factors are contributing to the substance abuse rates including the availability of prescription pain killers. The rate and amount of prescriptions for opioid analgesics is dispensed at double or triple the rate of other boroughs for drugs including Oxycodone and Hydrocodone. In 2011, Staten Island residents had the highest median day supply (25 days) of high dose opioid analgesic prescriptions, compared with 15 days among residents of the Bronx, Brooklyn and Queens, and 10 days among Manhattan residents (CNA). High dosage rates of pain killers can lead to dependence on these drugs. Further, there is increasing evidence that the rate of use of heroin is directly related to the illicit use of prescription drugs. Further, SI has the highest rate of youth substance use of any City borough for opioid analgesics and other prescription drugs

(CNA).

Overall, CNA findings indicate that the rate of substance abuse/mental health ED visits were higher for ZIP codes located in SI's North Shore communities, which tend to have the highest socioeconomic challenges, highest care needs, and are where the majority of the Medicaid population resides. However the substance abuse epidemic on SI knows no geographic, ethnic or economic boundaries and is a borough wide issue, with the highest rate of heroin overdoses occurring in Roseback (Southbeach) and on the south shore of SI, Tottenville.

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 SI PPS will aim to target residents of SI with mental health and substance abuse diagnosis, including Medicaid and uninsured residents, as well as develop a population wide strategy aimed at promoting the mental health and reducing epidemic substance abuse rates across SI.

SIs North Shore is a hot spot area with higher rates of mental health and substance abuse related admissions and ED visits. As previously identified, the North Shore communities typically have the highest poverty levels, and low levels of English proficiency.

However, although the SI PPS plans to provide focused efforts targeted towards SI's North Shore, the substance abuse epidemic on SI is a borough wide and is not limited to a specific geographic region or ethnicity. As previously mentioned, in 2012 Tottenville (a south shore community) was among the top five City neighborhoods with the highest rate of heroin related overdose in the city. Therefore the PPS's efforts including outreach, engagement, and education for health promotion, prevention and treatment will be a borough wide effort.

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.

Through Project 4.a.iii, the SI PPS will expand upon existing SI resources including behavioral health and substance abuse providers, primary care providers (PCP), the two SI hospitals, and community based organizations (CBO), among others. Additionally, SI PPS will provide project management and staff to support the development of common goals and ensure that milestones are identified, managed and met.

Both hospitals on SI offer a wide range of drug prevention programs working with community based providers as well as comprehensive behavioral health services to leverage in this project. In addition to existing behavioral health/substance abuse provider resources, SI PPS plans to leverage the SI Partnership for Community Wellness' program, Tackling Youth Substance Abuse (TYSA) Collective Impact in Action initiative. This program is aimed at driving major improvements in youth SA. TYSA aligns with current efforts among cross-sector partners to fill necessary service gaps and create a strong infrastructure around SA prevention and treatment.

The SI PPS partners will work together to develop and expand clinical services, including

ambulatory detoxification, as well as educate clinicians and pharmacists on the dangers of overprescribing opioid analgesics. Further, the SI PPS will expand upon outreach and education related to the dangers of substance use in community settings, schools, and faith based organizations.

SI PPS selected the following three sector projects:

1. Participate in MEB health promotion/ MEB disorder prevention partnerships.

SI PPS has demonstrated ongoing partnership-building efforts during the DSRIP application phase. Behavioral health/substance abuse providers, CBOs, health home providers, among others, have participated in provider workgroup meetings aimed at collaboration to reach common goals.

To implement this project, a Project Committee (PC) comprised of representatives from various stakeholders will oversee project activities, including the development of an implementation plan using the evidence based collective impact model. The PC will be responsible for building the common agenda, and working with PPS providers and clinical governance to develop/implement evidence based approaches. The PC and SI PPS will develop training and education for both providers and the patient community around MEB health promotion. The PPS plans to add trainers/nurse educators and community health workers to accomplish these goals.

2. Expand efforts to implement Collaborative Care in primary care settings.

In implementing Project 3.a.i, the SI PPS will expand collaborative care in primary care settings (including the co-location of services). Throughout the planning process, SI PPS providers reported that patients have co-occurring behavioral health/substance abuse conditions in addition to primary care needs. Also in line with Project 3.a.i goals, the SI PPS will develop pilot programs and evidence-based best practice models to share expertise around the placement of primary care providers (PCP) into behavioral health settings and behavioral providers into PCP programs.

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

The North Shore communities have the highest mental health and substance abuse admissions, highest poverty levels, and lowest levels of English proficiency which present cultural barriers for accessing proper healthcare prevention/treatment. SI PPS will leverage and expand on SIUH's cultural literacy program in terms of literature, training, and ongoing programs. The PPS is also including a Diversity and Inclusion Committee in the overall Governance Structure to support and facilitate the development of programs (including PPS wide training) to improve and reinforce patient health literacy, develop a culturally responsible system of care, identify cultural competency challenges and engage front line workers to improve patient outcomes.

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 Staten Island Performing Provider System (SI PPS) faces a significant challenge implementing this project and achieving the project goals due to the language, cultural, financial, and education barriers facing the patient population. The behavioral health/substance abuse population has additional inherent difficulties with compliance to treatment protocols and medication management for both medical and behavioral health/substance abuse diagnosis (Provider Workgroups); a significant challenge to meeting the goals of this project.

As previously mentioned, there are high rates of prescriptions for opioid analgesic in SI, as compared to other boroughs. A comprehensive approach to addressing SI's community need will require the buy-in from the physician/ pharmacists on SI including education around the dangers in overprescribing, and compliance with practices that help to limit the overall availability of prescription drugs on SI.

PPS providers identified there is a growing population of patients that have a behavioral health, substance abuse, and medical needs, requiring clinical providers to develop expertise in the treatment of complex patients with co-occurring conditions. This is a challenge identified that will need to be addressed through comprehensive training programs.

The SI PPS behavioral health/substance abuse providers identified data collection and information sharing as a barrier for project implementation (Provider Workgroups). This is due to a lack of electronic connectivity between providers as most SI PPS participants are not connected to the RHIO. To address this challenge, the SI PPS has begun the process of developing a high level implementation plan for integration into Healthix that will begin prior to DY 1. The SI PPS will also facilitate and develop infrastructure for the identification, collection, and sharing of appropriate data to help in inform and manage community need. The SI PPS will build upon existing partnerships with the State Office of Mental Health and Office of Alcoholism and Substance Abuse Services to further identify project data needs and develop an infrastructure for data collection and reporting.

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.

Not applicable. SI PPS is the sole PPS in the community.

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.

This project requires an interdisciplinary implementation team to prioritize project needs related to data, training, and evidence-based practices. Below is an anticipated timeline with important milestones.

July 2015: Identify and form an interdisciplinary implementation team and partnerships. October 2015: Develop common agenda, goals, and implementation plan. January 2016: Establish workgroups to develop strategies in each focus area including collaborative care for MEB disorders, substance abuse prevention, and training and education related to MEB health promotion, prevention and treatment. Identify opportunities meet data needs. April 2016: Begin implementation of chosen initiatives including the outreach, education and training on MEB health promotion, prevention, and treatment.

2. <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 may require capital for the purchase of mobile vans to provide BH/SA services or other supports in the community. Mobile outreach has been shown on SI to be an effective means of engaging high risk non/underutilizing patients, specifically patients with BH/SA challenges. This project will require capital funding for the establishment of an Information Technology (IT) infrastructure throughout the Staten Island Performing Provider System (SI PPS) provider network. The SI PPS strongly believes that the ability for providers to share information is central to the overall strategy for reducing hospital admissions by improving coordination and integration of the care continuum.

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
Tackling Youth Substance Abuse	Grant Funded	2011	Ongoing	A cross-sector coalition to address youth substance abuse.

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.

As referenced above, the Staten Island Partnership for Community Wellness' Tackling Youth Substance Abuse (TYSA) project focuses specifically on driving major improvements in youth substance abuse on Staten Island. SI PPS plans to expand upon TYSA's model and infrastructure to build a comprehensive approach to address components of this project. This will enable the project to actively engage an even broader population with more expansive care needs.

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.b.ii Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings (Focus Area 3) (This project targets chronic diseases that are not included in Domain 3, such as cancer)

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

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

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. The implementation must address a specific need identified in the community assessment and address the full service area population.

1. Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services.
2. Offer recommended clinical preventive services and connect patients to community-based preventive service resources.
3. Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and other community partners.
4. Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management.
5. Adopt medical home or team-based care models.
6. Create linkages with and connect patients to community preventive resources.
7. Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts.
8. Reduce or eliminate out-of-pocket costs for clinical and community preventive services.

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
The Fund for Public Health - New York; Jewish Community Center; New York City Prevention Resource Center; The Staten Island Foundation; New York City Department of Education; Department of Education Representatives; The College of Staten Island; and Wagner College

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

1. **Project Justification, Assets, Challenges, and Needed Resources (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.

There is strong evidence of the need for a chronic disease prevention and management program given the severe risk factors for chronic and preventable diseases on Staten Island (SI), in comparison to the average rate across New York State (NYS) as well as New York City (NYC).

There are significant disparities in access to care across SI, with residents in the North Shore communities lacking adequate access.

SI's North Shore has the highest number of Medicaid enrollee PQI discharges. In addition to high discharge rates, the North Shore also has the highest rate of individuals living below 200% of the poverty level with the highest minority population (CNA). The North Shore also has the highest rate of COPD discharges among NYC and NYS averages. The communities in the highest quintiles are Port Richmond, St. George, and Stapleton. Among SI's leading causes of PQI hospitalizations are admissions related to COPD or asthma (453 or 28% of the population) and hypertension (128 or 8% of the population) (CNA). The North Shore and Mid-Island areas of SI have the highest rate of hypertension discharges among the entire borough.

The NYS Cancer Registry provides data on individuals living in SI who developed colorectal, female breast, prostate, or lung cancer. Based on expected incidence rates compared to observed, SI residents are largely within the 14.9% or less range. However certain hot spots, including Mariners Harbor for lung and prostate cancer, present rates 15.0% - 49.9% greater than expected (CNA).

SI has high household income yet continues to be the borough with the highest mortality rate (679.8 compared to a citywide aggregate of 622.7 per 100,000) (CNA).

The leading causes of death are cardiac disease and cancer. The need for enhanced access to prevention, education and disease screening is demonstrated by the abovementioned aggregate mortality rate, and other negative public health indicators in the CNA , despite SI's relative economic affluence.

Additionally SI's death rates due to both cancer, and chronic lower respiratory diseases (COPD), exceed city wide rates (CNA). Across SI's ethnic groups and in specific communities, the disparities are even more significant. Approximately 70% of non-Hispanic blacks are identified as being likely to die prematurely (before the age of 75) compared to SI's white population at 40%. Similarly, 60% of deaths among SI's Hispanic population are considered premature. SI's high death rates are likely related to the population's high rate of preventable risk factors (CNA).
Obesity has emerged as an important risk factor for respiratory diseases and cancers, and in many instances weight loss is associated with important systematic improvement in respiratory diseases (National Cancer Institute). 36.2% of SI residents between the ages of 45 and 64 years are considered obese as well as 34.8% of residents between the ages of 25 and 44.
Additionally, SI is identified as the borough with the highest percentage of current smokers, 16.5% (estimates may be lower than actual smoking status due to low sampling sizes) (CNA). Smoking is considered a risk factor for both COPD and cancer.
The SI PPS will leverage this project to prioritize new and expanded chronic disease preventative and management services to target Medicaid recipients with COPD, cancer, and hypertension (chronic diseases not included in Domain 3 Projects) across the Staten Island Performing Provider System (SI PPS), with a focus on residents in hot spot communities including the North Shore. Given SI's clearly identified targets for chronic disease intervention; this project presents a significant opportunity to improve the health status for the diseases not addressed in other SI PPS projects.

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 SI PPS plans to target a subset of SI residents with chronic diseases including those with COPD, cancer, and hypertension as well as residents who are at-risk for developing these chronic diseases including smokers and obese patients (CNA).

As identified by the CNA, the North Shore communities are described as hot spots and will serve as the focus areas for clinical and community-based chronic disease outreach, wellness promotion, prevention and screening. The North Shore population has the highest risk of developing chronic disease and has the greatest challenges in accessing care, as well as the highest rate of PQI admissions. The North Shore communities are also more ethnically diverse and lower income than the other communities on SI.

Additionally, there are other communities on SI that have been identified as hot spots for patients with cancer (e.g. Prince's Bay, Eltingville, Mariner's Harbor, and Great Kills) that will be targeted for prevention and management efforts.

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.

SI currently has multiple programs centered on chronic disease preventive care and management in both clinical and community settings. However, the SI PPS has identified that these programs will need to be expanded upon and reimbursement models for these programs will need to be established. For example, Tobacco Treatment Specialists (CTTS) are currently providing services but are not able to bill for reimbursement of services. Additionally, Staten Island University Hospital (SIUH) has a smoking intervention program that targets patients admitted to the emergency department (ED). SI residents do not have the benefit of public health initiatives that are funded through New York City Health and Hospital Corporation's acute care facilities.
A community education program that includes media/social media, as well as leverages the SI educational institutions, including the College of Staten Island and Wagner College will be employed as part of the SI PPS strategy. This will include educating residents on how to access preventive resources available through community and clinical settings.
In order to deliver services to patients in SI's North Shore hot spot communities, the SI PPS is considering expanding mobile vehicle preventive care centers that are currently being utilized (the use of mobile vans will also assist the SI PPS in meeting Project 2.d.i goals) and other models that bring preventive care to patients in community settings, including non-medical settings. Additional services will include fit test kits, flu shots, and preventive screenings in faith-based organizations and community organizations.
Additionally the SI PPS will work towards increasing primary care utilization for non/low utilizing Medicaid beneficiaries and the uninsured. This may be accomplished through expanded hours as well as expanded primary care capacity through the Federally Qualified Health Centers and ambulatory settings. In both the primary care offices and in the mobile preventive care centers, Medicaid patients will be offered the wellness and health management services that are considered evidence based standards of care with an emphasis on reducing risk and complications for those with COPD, hypertension, and cancer.

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.

At the implementation level, the SI PPS views staffing and staff training as a project challenge. The SI PPS anticipates that as the program develops over time and continues to grow, there will be a need for more resources to staff the program. Dedicated primary care clinical leadership and clinical support staff will be needed to support project activities. The SI PPS will support participating providers with recruitment strategies.

An additional challenge the SI PPS faces in implementing this project and achieving project requirements are the language, cultural, financial, and education barriers facing the patient population. The CNA revealed that SI's uninsured population is predominantly located in SI's poorest areas, specifically the North Shore whose population is predominantly Asian/Pacific Islander and Hispanic populations who are not proficient in English and are between the ages of 18-44. SI's Medicaid population is predominantly White, Hispanic, Black and Asian/Pacific Islander, between the ages of 0-39 years, and residing in the North Shore Communities which have the highest poverty levels on SI and lowest levels of English proficiency (CNA). The findings

of the CNA present a challenge in implementing this project, because the project's success relies on the success of engaging and educating residents with cultural, language, and financial barriers to access and navigate the healthcare system for preventive services. Currently, residents tend to utilize the ED as a "one stop shop" for all their medical needs, resulting in never establishing a consistent relationship with a primary care provider. The SI PPS plans to address this challenge by leveraging the existing community outreach programs as well as the relationships developed with other providers, community based organizations (CBO), neighborhoods and indigenous community/cultural leaders. Due to the inherent sense of community and collaboration on SI, the preexisting community outreach programs and provider relationships/integration within neighborhoods and cultural communities serve as a way for the SI PPS to access, engage and educate residents on SI in preventive care and management.

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.

Not applicable. The SI PPS is the sole PPS in the community.

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.

Project infrastructure requires an interdisciplinary implementation team to prioritize data needs, training, technical assistance, and evidence-based practices. The team will develop prevention partnerships; training, prevention, and treatment; and data sharing systems/protocols.

June 2015: Develop project team and chronic disease prevention and management approach including recommended clinical preventive services.

Jan–Apr 2015: Implement clinical preventive services, connecting patients to community-based preventive resources: develop community-based outreach program; develop mobile outreach teams; expand and implement smoking intervention program; implement primary care training and prevention activities; and identify and expand referral program for chronic disease self-management.

2. <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.

This project will require capital funding for the establishment of an information technology (IT) infrastructure throughout the SI PPS provider network. The SI PPS strongly believes that the

ability for providers to share information is central to the overall strategy for reducing hospital admissions by improving coordination and integration of the care continuum. Additionally the SI PPS may require capital funding to expand PCP capacity in existing settings and new settings to serve additional Medicaid beneficiaries. This project may also require capital funding for mobile vehicles.

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
☐	☒

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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.

Not applicable.

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