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Using this document to submit your DSRIP Project Plan Applications

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

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

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

Domain 2 Projects

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

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

Project Description: This project will require an organizational structure with committed leadership, clear governance and communication channels, a clinically integrated provider network, and financial levers to incentivize and sustain interventions to holistically address the health of the attributed population and reduce avoidable hospital activity. For this project, avoidable hospital activity is defined as potentially-preventable admissions and readmissions (PPAs and PPRs) that can be addressed with the right community-based services and interventions. This project will incorporate medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system – from one that is institutionally-based to one that is community-based. This project will create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services. If successful, this project will eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes.

Each organized integrated delivery system (IDS) will be accountable for delivering accessible evidence-based, high quality care in the right setting at the right time, at the appropriate cost. By conducting this project, the PPS will commit to devising and implementing a comprehensive population health management strategy – utilizing the existing systems of participating Health Home (HH) or Accountable Care Organization (ACO) partners, as well as preparing for active engagement in New York State's payment reform efforts.

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

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

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

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

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

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

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

The NCI PPS region has an ER visit rate 32% higher than NYS rate, 69.7 vs a state rate of 46.7 and exceeds the NYS rate on every single adult prevention quality indicator (PQI) composite for avoidable hospitalizations. The Community Needs Assessment (CNA) need #1 details that one in five Medicaid Beneficiaries are living without a primary care physician and that visits to primary care is significantly below the state rate, 259.8 visits per 1,000 member months vs a state rate of 315.7 visits. Of Medicaid residents surveyed, 47.5% noted visiting an emergency department within the last year.
Health care is currently provided in separate silos with limited ability to share records or care plans. Patients with chronic and complex conditions often have multiple and contradictory care plans with little to no communication between providers in different settings. There are no agreed upon protocols for care transitions and little care management across the continuum. The Health Home has limited access to engage patients (less than 8% current engagement). There is a serious primary care workforce shortage (74 providers per 100,000 population vs 120 NYS – entire region is a federally designated Medicaid Primary Care Health Provider Shortage Area HPSA) that requires a focused cross-system effort to increase primary care capacity. Community based organizations have minimal interaction with inpatient settings. Patients need facilitated smooth transitions and communication across all care setting.

To address the system's fragmentation, the North Country Initiative (NCI) will become an Integrated Delivery System (IDS) and will include all PPS providers. The IDS will:
1) Include all medical, behavioral, post-acute, long-term care, community-based and social service providers and payers within the PPS network to support our strategy.
2) Utilize partnering Health Home and ACO population health management systems and capabilities to implement the NCI strategy to evolve into an IDS.
3) Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
4) Ensure all PPS Safety net providers are actively sharing EHR systems with the Health Information Exchange (HIE) and sharing health information among clinical partners including secure messaging and alerts by end of DY 3.
5) A key building block of the NCI IDS is the Patient Centered Medical Home or PCMH. All primary care providers in the IDS will obtain 2014 NCQA PCMH Certification, recognizing them for providing advanced primary care by end of DY 3.
6) Perform population health management by actively using EHRs and other IT platforms, including targeted patient registries for all participating providers.
7)Achieve PCMH Level 3 for all PCPs, expand access to primary care providers and meet EHR meaningful use standards by end of DY3.
8) Contract with managed care organizations (MCOs) and other payers as appropriate as an IDS and establish value based payment.
9) Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues and payment reform.
10) Re-enforce the transition to value-based payment by aligning provide compensation to patient outcomes.
11) Engage patients in IDS through outreach and navigation activities, leveraging community health workers, peers and culturally competent CBOs.
The NCI IDS will implement a comprehensive population health management strategy that will provide high quality care in the right setting at the right time, at the appropriate cost - resulting in a significant reduction in PPVs and PPAs and substantial improvement in Prevention Quality Indicators.

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

Current Assets and resources:
Community Based - There is a wide range of community based resources in the region including those that provide services to support basic life needs to fragile populations, peer run advocacy, homeless housing coalitions, strong, dedicated behavioral health organizations, two FQHCs with capacity to grow, a regional health home and a number of home-care agencies as well as specialty services such as educational services for high risk children. These organizations support, stabilize and improve the health of the regions fragile populations and will be mobilized to achieved the NCI DSRIP projects.

Health Care Provider Network - While the NCI PPS Network contains almost all Safety Net and other providers serving the region and they are fully engaged, the provider network for the NCI service region is operationally lean. There is limited excess capacity even at the hospital infrastructure level due to recent conversions to critical access hospital status. There is a substantial need to increase and expand access to quality preventive care, dental and primary care and to integrate behavioral health and primary care. The entire Tug Hill Seaway Region has been federally designated as a Low-Income Medicaid Health Professional Shortage Area (HPSA). There are significantly fewer active primary care providers (74 to 120 NYS), dentists (44 to NYS 78) and Psychiatrists (17 to 36 NYS) per 100,000 population. Disconnects exist in the current system across every sector of the care continuum with significant impact on those with the least access to resources and greatest burden of disease. There is need to expand provider's knowledge and understanding of the populations they serve.
Regional Governance Structures assets are in place as well as a strong planning organization to provide a base for DSRIP activities and achievement.
North Country Initiative, LLC - The hospitals and physicians of the region went through a planning process in 2012-2013 to form the North Country Initiative, LCC to provide a governance structure for clinical integration.
Medicare Shared Savings Program Accountable Care Organization – NCI provided the governance structure to form a second corporation, Healthcare Partners of the North Country, which was awarded the MSSP ACO. ACO governance structure is prepared to rapidly implement PPS DSRIP strategies.
Management Services Organization - A 501(e) MSO Corporation was formed to allow the hospitals to streamline non-clinical functions to provide efficiency and cost savings that will contribute to financial sustainability.
Fort Drum Regional Health Planning Organization – The FDRHPO brings the region together to plan to meet the regions needs and was the launching board for the regional governance structures in place.
The PPS strategy to develop and repurpose existing resources will increase accessibility and integration of PC and BH care, implement and expand upon existing Health Information Technology capacity and resources to standardize, measure and incentivize quality improvement, and add/augment coverage for community –based preventive services.
The NCI will grow primary care, behavioral health and dental capacity by expanding graduate medical education, placing a significant investment of dollars in recruitment strategies and by insuring that practices are resourced to practice at the top of their licensure. The FQHCs serving the region will expand service area and capacity. Five safety net hospitals and the 3 largest stand-alone behavioral health providers will co-locate services to integrate primary care and behavioral health services. One hospital will add urgent care where none exists. The NCI will cover the cost of prevention: diabetes prevention program (DPP), tobacco cessation classes, and telemedical psychiatric consults to primary care providers.

c. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project, and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges,

language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Availability and accessibility - The Tug Hill Seaway Region has been federally designated as a Low-Income Medicaid Health Professional Shortage Area (HPSA). There are significantly fewer active primary care providers (74 compared to 120 NYS), dentists (44 compared to NYS 78) and mental health professionals (Psychiatrists 17 compared to 36 NYS) per 100,000 population, practicing in the Tug Hill Seaway Region than statewide or upstate New York. The NCI PPS will focus a significant amount of DSRIP dollars on prevention service provider recruitment. A primary focus will be on expansion of FQHCs and all provider recruitment efforts will require acceptance of Medicaid
Care fragmentation – System fragmentation across the care continuum will require developing protocols to coordinate care across medical, behavioral, long term care, social and public health services. It will require multiple and regular communication channels to ensure buy-in to protocols and training on new interdisciplinary care models.
Quality - The NCI region exceeds the statewide measure on every single adult composite for avoidable hospitalizations. The fact that the region performs poorly on every prevention quality indicator (PQI) composite highlights the need to focus on quality of care initiatives such as the patient centered medical home. In addition, both Medicaid beneficiaries and the uninsured surveyed indicated the number one reason for leaving the region for care was quality. The region will implement PCMH 2014 for all PC providers and will launch interoperable HIT with Disease registry capability to incentivize quality improvement.
Also, 18 practices/clinics/agencies with 27 sites have no EMR, 60% of PCPs have either never attempted PCMH certification, or have allowed 2008 standards to lapse, only 24% have connectivity to the disease registry for population health management, and there are 45 practices/clinics/agencies at 82 sites that are not connected to the HIE for real-time data sharing (only 32% have this capability). All participating PCPs will have to re-apply to be recognized under the 2014 NCQA standards by DY3. Strategies to address this challenge are incorporated in Project 2.a.ii. Practice by practice gap analysis has been completed with budget and capital projections so that implementation can begin as soon as possible.

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

The NCI PPS is coordinating and collaborating with the neighboring Adirondack Health Institute (AHI) and Central New York Care Collaborative (CNYCC) PPS's to create a cross-PPS partnership to best serve the shared patients within our overlapping service area. The NCI will share protocols, written training materials, and evidence-based strategies with AHI and CNYCC as they are identified or developed and have shared planning of the DSRIP application. Also, we have an advantage with our neighboring PPS in Lewis County (CNYCC) in that we share the same Regional

Health Information Organization (RHIO). With patient consent, we can securely share clinical information amongst providers regardless of which PPS they are participating with. Leveraging this technological infrastructure, we will work to ensure that providers in the PPS' can work efficiently and effectively across the integrated delivery systems to provide a seamless a transition by and between systems ensuring the best patient outcomes. This will be available to all through the SHINY in the future and will allow cross connection between the PPSs. The PPS intends to integrate best practice sharing into all communications with the neighboring PPS. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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

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

The comprehensive strategy to create an Integrated Delivery Systems focused on Evidence Based Medicine/Population Health Management was selected because it is the goal upon which all other care activities rest. An Integrated Delivery System aligns incentives and brings health care focus in line with positive patient and population health outcomes. It will prepare the region for payment reform as we move from institutional-based care to community-based care. Developing the systems to coordinate care across medical, behavioral, long term care, social and public health services meets all of the criteria set by the NCI. The IDS puts in place the processes to standardize, measure and improve the quality of care for the population the IDS serves while simultaneously reducing the cost of care through incentive alignment.

The PPS Core strategies include:

- Prevention and Quality – The region performs poorly compared to NYS on every single Prevention Quality Indicator. In addition, both Medicaid and uninsured indicate quality of care as the main reason for leaving region for care. Existing providers must modify practice of care to address quality prevention through patient centered medical home (PCMH) and must place a strong focus on cardiac, diabetes, COPD, and mental illness and substance abuse prevention due to the prevalence of these diseases and their impact on avoidable admissions and emergency room visits. The NCI will monitor clinical performance, provide feedback and incentivize positive quality improvement

- Care Connections – Standardized protocols and capacity needs to be grown for care management/coordination. This includes inpatient to outpatient both from physical care floors and inpatient mental health units, inpatient to long-term-care, emergency department to primary care or outpatient behavioral health care. In addition to linkages with the hospitals, care connections needs to be established between community-based supportive services and primary care, between preventive services and primary care and between primary care and outpatient mental health and alcohol and substance abuse. This includes standardization of med record transfers. NCI will implement care coordination across the continuum including

care management at the primary care practices, care transition coordinators at the point of care transition from the acute setting, Health Home care coordination with community based resources, community navigators to engage the NU/LU and uninsured, and community health workers to work with identified high risk "hot spot" communities. The PPS will ensure that all safety net providers are actively sharing EHR systems with our local health information exchange (HealtheConnections) and through the HIE, the appropriate data will be securely shared throughout NYS via the SHIN-NY. HealtheConnections will be the standardized method for sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, and all participating providers will be connected by the end of Demonstration Year (DY) 3.
- Physician Recruitment, Primary and Preventive Care Expansion - The most significant immediate modification to meet the needs of the community is an increase in the number of primary care, psychiatry and dental providers that are in the region. We cannot connect people to primary and preventive care that does not exist. Therefore a core strategy is to increase Primary care and prevention capacity by adding additional primary care and prevention capacity across the region and in targeted settings. A Community Health Worker program will be implemented to engage high-risk communities and navigation services utilized to engage NU/LU and uninsured population in preventive care. The NCI will continue to grow primary care, behavioral health and dental capacity by expanding graduate medical education, placing a significant investment of dollars in recruitment strategies and by insuring that practices are resourced to practice at the top of their licensure. The two FQHCs serving the region will expand their service area and capacity. Five of the hospitals and the three largest stand-alone behavioral health providers will co-locate services to integrate primary care and behavioral health services so access to care for both BH and PC are provided at the patient's most common point of service. One hospital will add urgent care where none exists. The PPS will cover the cost of prevention services such as the diabetes prevention program, tobacco cessation classes, and telemedical psychiatric consults to primary care providers to ensure access to these community based services for covered Medicaid beneficiaries.
To address the system's fragmentation, NCI will become an Integrated Delivery System (IDS) and will include all PPS providers. The IDS Milestones include:
1) Inclusion of all medical, behavioral, post-acute, long-term care, community-based and social service providers and payers within the PPS network to support our strategy, as measured by provider network list.
2) Utilize partnering Health Home and ACO population health management systems and capabilities to implement the NCI strategy to evolve into an IDS, as documented by standardized care-transition/coordination process flow diagrams and by improvements in population health outcomes.
3) Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services, as measured by discharge plans of care and HIT systems reports.
4) Ensure all PPS Safety net providers are actively sharing EHR systems with the Health Information Exchange (HIE) and sharing health information among clinical partners including secure messaging and alerts by end of DY 3, as measured by data use and reciprocal service agreements.

5) A key building block of the NCI IDS is the Patient Centered Medical Home or PCMH. All primary care providers in the IDS will obtain 2014 NCQA PCMH Certification, recognizing them for providing advanced primary care by end of DY 3.
6) Perform population health management by actively using EHRs and other IT platforms, including targeted patient registries for all participating providers, as measured by disease registry and physician report cards.
7)Achieve PCMH Level 3 for all PCPs, expand access to primary care providers and meet EHR meaningful use standards by end of DY3. As measured by MU certification and DURSA certification and number of physicians recruited to IDS.
8) Contract with managed care organizations (MCOs) and other payers as appropriate as an IDS and establish value based payment, as measured by documentation of Medicaid Managed care contracts.
9) Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues and payment reform, as documented by ongoing meeting attendance lists.
10) Re-enforce the transition to value-based payment by aligning provide compensation to patient outcomes, as measured by compensation model and implementation plan.
11) Engage patients in IDS through outreach and navigation activities, leveraging community health workers, peers and culturally competent CBOs, as measured by documentation of CBO partnerships and community health worker/navigator engagement
The NCI IDS will implement a comprehensive population health management strategy that will provide high quality care in the right setting at the right time, at the appropriate cost - resulting in a significant reduction in PPVs and PPAs and substantial improvement in Prevention Quality Indicators.

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

The North Country Initiative, LLC is a hospital capitalized, physician led, Limited Liability Corporation operating with a Delegated Model of governance. The NCI has a robust history of success with implementing change, demonstrated through regional project implementation in areas like quality improvements, IT advancement, and physician engagement. The executive governance body of the NCI is a representative Board of Managers which holds accountability for all aspects of Finance, Clinical, Compliance and IT governance. Through this model, transitions in governance structure have been realized which include adding behavioral health providers and community members to the Board of Managers, expanding the committee structure to include the DSRIP Project Advisory Committee in a direct advisory capacity to the board, and adding DSRIP goals and deliverables to each of the governance committee's responsibilities.
NCI governance utilizes committees responsible for clinical, financial, information technology and data sharing and compliance governance. Reporting to the medical management committee are subcommittees focused on the achievement of specific DSRIP deliverables. These include; behavioral health integration sub-committee, population health initiative subcommittee, and a care coordination subcommittee. Reporting to the Compliance Committee is the Cultural

Competency and Health Literacy Committee which was formed to ensure that processes, policies and training are incorporated into the governance structure of the NCI. Each of these sub-committees were developed deliberately to support the projects selected as part of the application. The projects chosen directly address the community's needs identified in the community needs assessment, as well as the other fundamental requirements. All of these committees are formed and functional. Each sub-committee has created a project charter and are meeting regularly with status report outs to the committees, the PAC and/or board of managers. This structure is designed to ensure responsive, focused governance to deliver DSRIP outcomes.
This governance structure is critical to the success of the NCI PPS DSRIP deliverables as well as a recently accepted ACO under the MSSP program and the actively developing Clinically Integrated Network (CIN) program to work with commercial payer's to improve quality metrics and reduce costs. The speed and efficiency of the model of governance created by the NCI will be instrumental to DSIRP success. This governance structure will hold specific responsibilities.
- Executive - Secure active engagement of all providers in the PPS as measured by provider network lists, contractual agreements, and project milestone achievement. Receive reports from each Committee as outlined below and develop action plans to address non-compliance with objectives.
- Clinical Medical Management Committee -Tracking and monitoring achievement of PCMH Level 3 2014 for all PC providers in the Network by Q3 DY3, and of HEDIS, PQI measures and CAHPS. The North Country Initiative medical management governance committee will have the largest responsibility for regional clinical projects. In an effort to place responsibility of progress in the appropriate areas, sub-committees have been created. Strategically, these projects have been segmented into three sub committees; Care Transitions subcommittee, Behavioral Health Integration sub-committee, and Population Health subcommittee. Sub-committees will be responsible for specific outcomes for each DSRIP Project area, all contributing to the IDS.
- HIT Governance Committee – Ensure Meaningful use and utilization of the Health Information Exchange by all clinical providers participating in the IDS by DY 3, and implementing targeted Population Health Management systems in consultation with both the Clinical Medical Management Committee and the Finance and Contracting Committee. To guarantee the PPS realizes clinical outcomes and goals, a disease registry will be utilized to provide per provider quality reporting. It will receive data from electronic health records and include a comprehensive dashboard for monitoring of performance against DSRIP quality measures. Data will provide PPS physicians and partners with timely feedback of their performance and give them the information they need to deliver proactive, comprehensive, and collaborative patient.
- Finance and Contracting - Reporting and monitoring achievement of financial stability metrics for all distressed providers and monitoring other providers for potential to become distressed. Reinforce transition to value-based payment reform through alignment of provider incentives to patient outcomes. Specific incentive plans will be developed during implementation planning and throughout Q1 DY 1. These incentives will change and grow as we gain greater population health management capabilities' over the term of the DSRIP. Established meeting and plans with Managed Care organizations beginning during implementation planning, DY 1 and continuing ongoing.
- The NCI governance model has demonstrated that it is well-integrated, high functioning and prepared to implement new care delivery models and lead meaningful change on behalf of the

people we serve. The NCI will contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements. To address utilization trends, performance issues, and payment reform, the NCI will establish monthly meetings with Medicaid MCOs.
To become a fully integrated delivery system, the NCI will re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes. The PPS will engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.

3. Scale of Implementation (Total Possible Points - 20):

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

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

4. 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.

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

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

Yes	No
☒	☐

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

Capital budget funding will be required to fully implement the technology to support this project and to create the medical villages. The capital funds will be used to ensure all practices have a

certified EHR, are connected to the HIE, are sending clinical data to the regional Population Health Management (PHM) registry, and have access to telemedicine equipment to address gaps in care. A key requirement of the health care transformation is the availability of high quality primary care, and one resource of High quality care is PCMH Level 3 recognition. An electronic health record will be vital to the documentation and assessment reporting required by NCQA for the rapid transformation into a PCMH Level 3. An electronic health record or EHR will allow provider's access to evidence based tools that can be used to better treat the patient and provide improved outcomes.

Using an organized system, such as a patient registry, to observe research methods and collect data for improved patient outcomes will be a foundational piece of whole patient, high quality care. Facilitating the use of common data fields in similar health conditions will improve the opportunity to share, compare, and create linkages to provide better patient outcomes. Imbedding this use of population health management into the practices and clinics will give the providers real time insight and will allow them to identify and address care gaps within the patient population. Care management is a critical component of PHM, and while the objectives of care management can vary, they revolve around improving patient self-management, improving medication management, and reducing the cost of care. The use of data for population health management makes up an entire standard within the NCQA PCMH requirements for a Level 3 PCMH. At least annually, the practice must proactively identify patient populations and remind them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments, and evidence based guidelines.

The use of telemedicine can be used as a mode of real time communications in lieu of a traditional one-on-one, in person office visit. Studies are consistent that telemedicine saves the patient, provider, and the payer valuable time and resources when compared to traditional approaches to providing care. Additionally, providing alternative types of clinical encounters is a factor within the PCMH Patient Centered Access standard.

A fully integrated EHR will add significant value to the PPS's practices and clinics. With the use of registries, population health management, and telemedicine, providers will be able to provide more patient centered, open access, and high quality health care to our targeted population resulting in improved patient outcomes.

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

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

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

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

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

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

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

2.a.ii Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))

Project Objective: This project will transform all safety net providers in primary care practices into NCQA 2014 Level 3 Patient Centered Medical Homes (PCMHs) or Advanced Primary Care Models by the end of Demonstration Year (DY) 3.

Project Description: A key requirement of the health care transformation is the availability of high quality primary care for all Medicaid recipients and uninsured, including children and patients with higher risks. This project will address those providers who are not otherwise eligible for the necessary support or resources for practice advancement as well as those providers with multiple sites that wish to undergo a rapid transformation by achieving NCQA 2014 Level 3 Patient Centered Medical Homes (PCMHs) or Advanced Primary Care Models by the end of Demonstration Year (DY) 3. Performing Provider Systems undertaking this project, while focused on the full range of attributed Medicaid recipients and uninsured, should place special focus on ensuring children and parenting adults, and other high needs populations, to have access to high quality of care, including integration of primary, specialty, behavioral and social care services.

Project applicants should review the extensive literature available from such resources as TransforMed (https://www.transformed.com/) in the development of the response.

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. Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of Demonstration Year (DY) 3.
2. Identify a physician champion with knowledge of PCMH implementation for each primary care practice included in the project.
3. Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.
4. Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.
5. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards.
6. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
7. Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.

8. Implement preventive care screening protocols including behavioral health screenings (PHQ-9, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.
9. Implement open access scheduling in all participating primary care practices.

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.

Data obtained from the Community Needs Assessment (CNA) details that residents are living without a primary care physician, with a Medicaid beneficiary primary care visit rate 20% below the state rate, 259.8 visits per 1,000 member months vs a state rate of 315.7 visits. Of Medicaid residents surveyed, 47.5% noted visiting an emergency department within the last year. The PPS region has an ER visit rate 32% higher than NYS rate, 69.7 vs a state rate of 46.7 and exceeds the NYS rate on every single adult prevention quality indicator (PQI) composite for avoidable hospitalizations. Of the 33 primary care sites participating in the PPS, none have achieved PCMH 2014 and only 33% (13) have achieved PCMH 2011, all others either have never attempted PCMH or have allowed 2008 certification to lapse. Physician champions and care coordinators will be identified for each practice to ensure PC is center of continuum of care for assigned patients. The PPS is requiring all primary care providers within the PPS meet Meaningful Use and NCQA Level 3 PCMH by end of DY 3 to ensure that all Medicaid populations with-in the PPS have access to advanced primary care. In addition, all PCs will be required to actively share information through connection to the HIE with Direct alerts and patient look-up (currently only 18 of the 39 PC sites, less than 50%, are utilizing HIE), and to a patient registry population health management (PHM) system. Staff training on PCMH including evidenced based prevention and chronic disease management will be conducted including preventive care screening for PHQ-9 and SBIRT for all Medicaid patients with a dedicated referral process. Actively utilizing EHR's and other IT platforms, the NCI PPS will transform the delivery system to provide a high-quality, efficient and patient-centered system for our PPS.

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

The patient population to be served will be attributed Medicaid recipients and the uninsured population within the NCI service region. The PPS will place special focus on ensuring children 0-18, all adults with chronic cardiac, diabetes and respiratory chronic conditions and young adults 18-44 living with mental illness and substance use disorders gain access to PCMH level 3. The primary care site will use Population Health Management (PHM) to identify patients who are

appropriate for care management. The practice will establish a systematic process and criteria for identifying this target population including considerations for the following: Behavioral Health conditions utilizing SBIRT and PHQ9, and high cost/utilization, poorly controlled or complex conditions, social detriments of health, and referrals by outside organizations, practice staff or patient/family/caregiver.

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 PPS will work with 20 primary care practices at 39 sites and two federally qualified health centers. As part of the workforce strategy the PPS will recruit additional at least six additional PC providers to augment the capabilities of existing providers offering primary care services to the target population to provide better access to high quality health care and enable open access scheduling. The PPS will utilize currently recognized, evidence-based, practices and provide the necessary resources and support to rapidly transform practices to PCMH Level 3 2014 standards. Each primary care site will identify a Care Coordinator, who will be responsible for care connectivity, internally, as well as connectivity to care managers and other primary care practices. The PPS will need to develop and train these Care Coordinators and Care Managers to fill the gap anticipated at each primary care site. These imbedded care managers will utilize the practice site EHR systems and the regional PHM system to aid in population health management. The PPS has available to the community two PCMH-Certified Content Experts to educate and train primary care site staff in the PCMH standards and aid in them in the transformation process.

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.

During the implementation of the DSRIP projects we anticipate some challenges. These include the advanced infrastructure and technology to support the transformation of practices to a PCMH level 3. Many of the primary care sites within the PPS may be required to either obtain or upgrade their current EHR systems to meet the Meaningful Use and PCMH Level 3 standards. The PPS region has access to HIT personnel and PCMH Certified Content Experts to aid sites in these implementations and upgrades but will need to expend resources to engage them. To align with the team based care model, primary care practices will be required to define a clinical leader or physician champion with knowledge on the PCMH care model. We will be ensuring that all PPS safety net providers are actively sharing health information from their EHR systems with other collaborating providers via the local Health Information Exchange (HIE), using standardized protocols, including secure notifications and messaging. Additionally, PCMH Certified Content Expert trained staff will be assisting, monitoring and evaluating to ensure that all the primary care providers successfully complete the practice transformation process. In addition the NCI will implement PPS wide training and policy implementation for cultural competency and health literacy.

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.

The PPS plans to coordinate and collaborate with the neighboring AHI and CNY PPS's to create a cross-PPS partnership to best serve the shared patients within our overlapping service area. We have an advantage with our neighboring PPS (CNY) in that we share the same Regional Health Information Organization (RHIO). This is advantageous to both PPS's as we intend to, with patient consent, securely share clinical information amongst providers regardless of which PPS they are participating with. This helps to ensure that providers in both PPS's can work efficiently and effectively amongst each other to ensure the best patient outcomes. The PPS intends to integrate best practice sharing into all communications with the neighboring PPS. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital budget funding will be required to fully implement the technology to support this project. The capital funds will be used to ensure all practices have a certified EHR, are connected to the HIE, are sending clinical data to the regional Population Health Management (PHM) registry, and have access to telemedicine equipment to address gaps in care.
A key requirement of the health care transformation is the availability of high quality primary care, and one resource of High quality care is PCMH Level 3 recognition. An electronic health record will be vital to the documentation and assessment reporting required by NCQA for the rapid transformation into a PCMH Level 3. An electronic health record or EHR will allow provider's access to evidence based tools that can be used to better treat the patient and provide better outcomes.
Using an organized system, such as a patient registry, to observe research methods and collect data for better patient outcomes will be a foundational piece of whole patient, high quality care. Facilitating the use of common data fields in similar health conditions will improve the opportunity to share, compare, and create linkages to provide better patient outcomes. Imbedding this use of population health management into the practices and clinics will give the providers real time insight and will allow them to identify and address care gaps within the patient population. Care management is a critical component of PHM, and while the objectives of care management can vary from organization to organization, they tend to revolve around improving patient self-management, improving medication management, and reducing the cost of care. The use of data for population health management makes up an entire standard within the NCQA PCMH requirements for a Level 3 PCMH. At least annually, the practice must proactively identify patient populations and remind them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments, and evidence based guidelines.

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

Yes	No
☐	☒

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

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

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

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

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

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

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards 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.a.iv Create a Medical Village Using Existing Hospital Infrastructure

Project Objective: To reduce excess bed capacity and repurpose unneeded inpatient hospital infrastructure into "medical villages" by creating integrated outpatient service centers to provide emergency/urgent care as well as access to the range of outpatient medicine needed within the community.

Project Description: This project will convert outdated or unneeded hospital capacity into a stand-alone emergency department/urgent care center. This reconfiguration, referred to as a "medical village," will allow for the new space to be utilized as the center of a neighborhood's coordinated health network, supporting service integration and providing a platform for primary care/behavioral health integration. The proposed medical villages should be part of an "integrated delivery system" and be seen by the community as a "one-stop-shop" for health and health care.

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. Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.
2. Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.
3. Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of Demonstration Year (DY) 3.
4. Ensure that all safety net providers participating in Medical Villages 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.
5. Use EHRs and other technical platforms to track all patients engaged in the project.
6. Ensure that EHR systems used in Medical Villages must meet Meaningful Use and PCMH Level 3 standards.
7. Ensure that services that migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.

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.

According to the NCI CNA Community Need #3 there are a number of opportunities for Medical Villages with the PPS member hospitals. The Medical Village as defined by DSRIP, will convert unused hospital owned space into needed resources such as urgent care, or other uses to become the center of coordinated health care. The region served by the PPS exceeds both Upstate and NYS statewide on every single adult composite for avoidable hospitalization. As the objectives of the DSRIP are realized and these hospitalizations are in fact avoided due to increased utilization and quality of outpatient services, there is a need to consider future services and infrastructure. To this end the hospitals of the NCI PPS have recognized the need to reconfigure service structure and supporting infrastructure to meet the new care delivery model. This varies by hospital service site and will include, urgent care where none exists, on-site integration of primary care and behavioral health, expanded tele medical capacity and care management.
It needs to be noted that provider network for the NCI region is already operationally lean. There is limited excess capacity at the hospital infrastructure level due to recent conversions to critical access hospital status. However through DSRIP there is expected to be a 25% reduction in the utilization of inpatient beds for avoidable Medicaid hospitalizations with a resultant reduction based on the financial analysis of 11,469 bed days and a staffed bed reduction of 6-8 beds and a reduction of 2412 avoidable emergency department visits annually. The conversion of this internal capacity will create Medical Villages that support outpatient services to include integrated behavioral health and primary care services in Watertown, Carthage, Massena and Alexandria Bay, an urgent care center in Ogdensburg where there is a gap in urgent care and access to specialty services through the utilization of telemedicine in Star Lake.
The overwhelming community gap is primary care and integration of primary care with behavioral health services as mental illness is the single largest cause of Medicaid hospitalizations (36% with diagnosis admitted annually) and emergency department visits (56% with visit) and one community lacks access to urgent care thus there is not alternative to the ED for those without a primary care provider or where primary care providers have not implemented open access scheduling.
Samaritan Medical Center, Carthage Area Hospital and River Hospital will integrate BH and Primary care services, Claxton Medical Center will implement urgent care in Ogdensburg where none currently exists and Clifton Fine Hospital will utilize telemedicine to expand access to behavioral health care for their primary care population. Due to critical access status restrictions only Samaritan Medical Center, Massena Memorial and Claxton Hepburn can reduce beds. It is expected that the total staffed bed reduction will be less than 10 due to the already lead operational structure and the understanding that as more patients become insured and engage with the healthcare system, while avoidable hospitalizations will be reduced, there may be an initial uptick in unavoidable hospitalizations.
All Safety net providers participating in the medical village will meet PCMH 2014 level 3 if primary care and all providers will participate in health information exchange (HIE) will meet meaningful use and utilize EHR to track patients engaged in the medical village projects.

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 patient population will be attributed Medicaid patients and NU/LU and uninsured of all age groups in Jefferson and St. Lawrence Counties. In the case of the Medical Village sites implementing integration of behavioral health and primary care this population will be narrowed to those with Mental Health or substance abuse diagnosis. The only hospital in Lewis County is participating in the CNY PPS so this project will not impact Lewis County except as patients from Lewis County travel into Jefferson or St. Lawrence for care.
The target population will not only be attributed Medicaid patients in the NCI PPS, but also the hospitals across the region that will need to reconfigure service structure and supporting infrastructure to meet the new care delivery model. This reconfiguration will allow for the new space to be utilized as the center of our neighborhood's coordinated health network, supporting service integration and providing a platform for primary care/behavioral health integration. The NCI medical village will be part of an integrated delivery system and will be seen by the community as a "one-stop-shop" for health and health care. Services migrating to a different setting or location (i.e. clinics, urgent care, preventive care, behavioral health, primary care are supported by the comprehensive CNA.
The region has been designated as a Low-Income Medicaid Health Professional Shortage Area (HPSA). There are significantly fewer active primary care providers (PCPs) (NCI 74, NYS 120) and mental health professionals (Psychiatrists, NCI 17, NYS 36) per 100,000 population, practicing in the region compared to NYS. Because there is limited excess capacity even at the hospital infrastructure level due to the recent conversion to critical access hospital status, recruitment of at least 8 providers will be a target population of this project, as these professionals will be needed to support services to include integrated behavioral health and primary care.
PCPs will be a focus, as the NCI will need to ensure all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation or Advanced Primary Care Model criteria by DY3.Additionally, we will ensure all safety net providers participating in this project are actively sharing EHR systems with local HIE/RHIO/SHIN-NY and among clinical partners,including secure messaging, alerts,and patient record standards.

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.

Each of the Safety Net hospitals creating medical villages with integration of primary acre and behavioral health have article 28 primary care networks as well as Office of Mental Health (OMH) article 30 clinics currently operating in separate and distinct locations. These assets will be brought together to support this project. In the case of River Hospital and Carthage Area hospital BH integration will also explore the inclusion of Credo Community Center's addition treatment services on-site. Samaritan Medical Center will include their OASA article 31 licensed addition services. In addition the medical villages will be connected to and supported by the many other community based assets that can support their activities. Including prevention services health home care management and other supportive services.
Urgent care plays a critical role in access to care for many residents of the region. In a region that is medically underserved with shortages of primary care access for all populations and critical shortages for the Medicaid and uninsured populations, urgent care plays an

important role in the prevention of utilization of the ED for injuries and illnesses that can be treated in the outpatient setting. Preliminary research indicates that patients younger than 30 are more likely to use an urgent care than visit their PC. Thus it is important to include urgent care as part of the NCI care continuum. Access to urgent care is being appropriately met across the region with the exception of Ogdensburg. There is no urgent care facility to serve this population center along the St. Lawrence River; however, through this project, Claxton Hepburn Medical Center will create Urgent Care access.

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

The regional provider network is already operationally lean. Due to recent critical access hospital (CAH) designation at 3 NCI hospitals, there is limited capacity at the 3 hospitals. These facilities cannot undergo further bed reduction without impacting their CAH status. Additionally, three hospitals are receiving Interim Access Assurance Funds. The majority of care provided by the region's hospital system is for vulnerable populations. The inpatient payer mix is overwhelmingly federal-sponsored, covering over 68% of the region's inpatient admissions. This reimbursement structure impacts the financial sustainability of these essential providers. Development of sustainment plans with specific and defined metrics is required.
The most significant modification to meet community needs is an increase in the number of primary care, psychiatry and dental providers in the region accepting Medicaid. We cannot connect people to primary and preventive care that does not exist. There is a pipeline of 36 graduating social workers entering the NCI market over the next two years so the focus is primarily on physicians and extenders. Provider recruitment will be significantly resourced by the NCI to include incentives, sign on, loan repayment and GME expansion.
The region performs poorly compared to NYS on every Prevention Quality Indicator. Existing providers must modify care to address quality prevention through PCMH and must place a strong focus on cardiac, diabetes, COPD and mental illness and substance abuse prevention due to the prevalence of these diseases and their impact on avoidable admissions and ED visits. The NCI will implement dependable EMR systems and workflow changes to develop and sustain PCMH capacity and inform the standardization, measurement, and reporting to incentivize provider engagement and quality improvement.
Disconnects exist across every sector of the care continuum. Standardized protocols and capacity needs to be grown for care coordination including: inpatient to outpatient, ED to PC or outpatient behavioral health (BH) care. Care connections also need to be established between CBOs and PC, between preventive services and PC and between PC and outpatient MH and SA. These relationships exist but standardization to ensure regular and ongoing communication channels will require the work of care managers and care transition coordinators.

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.

The NCI PPS plans to coordinate and collaborate with the neighboring Adirondack Health Institute (AHI) and Central New York Care Collaborative (CNYCC) PPS's to create a cross-PPS

partnership to best serve the shared patients within our overlapping service area. The NCI will share protocols, written training materials, and evidence-based strategies with AHI and CNYCC as they are identified or developed. Also, we have an advantage with our neighboring PPS in Lewis County (CNYCC) in that we share the same Regional Health Information Organization (RHIO). With patient consent, we can securely share clinical information amongst providers regardless of which PPS they are participating with. Leveraging this technological infrastructure, we will work to ensure that providers in the PPS' can work efficiently and effectively across the integrated delivery systems to provide a seamless a transition by and between systems ensuring the best patient outcomes. As soon as the SHINY infrastructure is prepared this information sharing will be possible with AHI as well. The PPS intends to integrate best practice sharing into all communications with the neighboring PPS and already actively collaborating on applications. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

f. Please indicate the total number of staffed hospital beds this project intends to reduce.

Project Scale	Number of Beds Committed For Reduction
Expected Number of Staffed Beds to be Reduced	

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.

Capital funding will be need to reconfigure space for the medical villages. During the implementation planning phase engineering and architectural studies will be conducted and capital funding will be applied for to support this project. Without capital funding the space would not be suitable for medical village use.

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

Yes	No
☐	☒

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

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

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

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

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

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>completion of project requirements,</u> <u>scale of project implementation,</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.

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. 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.

As noted in the Community Needs Assessment, the top five causes of Medicaid hospitalizations (38% with admit) and emergency room visits (50% with ER visit) across the NCI region are; mental illness, cardiovascular disease, respiratory disease (COPD), diabetes and substance abuse. Mental illness and substance abuse (38% with admit) and cardiovascular disease (40% with admit) are the leading drivers of Medicaid inpatient admissions, although respiratory disease (35%) and diabetes (34%) are not far behind.
Mental illness and substance abuse (58% with visit) and respiratory disease (53% with visit) are the leading drivers of Medicaid emergency room use, although again, diabetes (42% with an ER visit) and cardiovascular (41% with an admit) are not far behind.
Also, the NCI exceeds NYS on every single adult composite for avoidable hospitalizations (Preventable Quality Indicators) including adult overall composite (PQI90), NCI 2144 admits per 100,000 compared to 1848 for NYS. Adult circulatory condition (PQI 07, 08) NCI 447 compared to NYS 422. Adult angina without procedure (PQI 13) NCI 32 compared to NYS 27. Adult diabetes composite (PQI 01, 03, 16) NCI 436 compared to NYS 372. Adult uncontrolled diabetes (PQI 14) NCI 59 compared to NYS 46. Adult respiratory conditions composite (PQI 05, 15) NCI 599 compared to NYS 500 and COPD (PQI05) NCI 1040 compared to NYS 814. All these rates also exceed Upstate averages.
Readmissions within NCI are significantly correlated with mental health discharges. A review of clinical metrics reveal existing gaps in 30-day follow-up after a mental illness hospitalization (NCI 47%, NYS 55%). In the NCI region 60% of Medicaid beneficiaries adhere to antipsychotic medications for schizophrenia; whereas NYS is at 64%.
In many instances, Medicaid patients face problems finding medical care for treatment in a timely manner, typically citing low Medicaid reimbursement as the main barrier. Administrative burdens, patient's non-medical needs (i.e. social needs), challenges with keeping appointments and adhering to treatment plans also play a significant role. The proportion of Medicaid beneficiaries coupled with the existing health care provider shortages increases access to care disparities within the region. This is illustrated by the regions ED visits per 1,000 Medicaid beneficiaries which is 32% higher (69.65) than NYS (46.7), and primary care visit rate that is significantly lower (NCI 259.88, NYS 315.73).
Community Need # 4 identifies the critical need to increase coordination between inpatient and outpatient settings using a more patient-centered approach to care and linking inpatient care management and coordination outside the clinical walls.
To fulfill this community need, it is anticipated that the NCI will not create new programs, rather leverage existing resources such as increasing referrals and utilization of the Health Home, hiring and resourcing care transition staff in the hospitals, and incorporating patient education resources such as the teach back method as part of the pre-discharge. This will ensure a warm-hand off and an understanding of discharge directions, especially for patients at high risk for readmissions.

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 will be attributed, Medicaid adults (18 years+) in Jefferson, Lewis and St. Lawrence Counties who have qualifying chronic conditions from the "major" categories of the 3M Clinical Risk Groups (CRGs) and are at moderate to high risk for readmissions. Specifically, the project will focus on mental illness, cardiovascular disease, respiratory disease (COPD), diabetes and substance abuse. These individuals will be hospitalized, need ongoing monitoring and care, and meet health home eligibility criteria based on risk stratification to include medical, behavioral and social risks.
As a result of this project, these patients will complete a standardized care transition plan within 30 days of discharge. These protocols will be defined during the early stages of the implementation phase. Based on risk stratification (low, moderate, high or extremely high resource use), or the identification of disease burden and determination of health risk status, the goal of the transition plan will vary. For example, for the low resource group, the goal is to prevent the onset of the disease. For the moderate resource group, the goal is to treat the disease and avoid serious complications. For the high risk resource group, the goal is to treat the late or final stages of the disease and minimize disability, and finally, for the extremely high resource group, the goal may range from restoring health to only providing comfort care. The degree of care management will vary depending on the level of risk, however, at all levels, the NCI will focus on medication self-management, the use of a patient-centered records to ensure the continuity of care plans across providers and settings, follow-up visits with primary care, and patient education so the patient is knowledgeable about indications that their condition is worsening and how to respond.

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.

This plan will build upon existing resources and activities including focused referral and utilization of Health Home services, expanding the use of e-discharge when patients are discharged back to long-term care or other residential facilities, development of PPS wide protocols and processes for engagement of community supportive services, and systematic care record transition. To address community needs, the NCI will also look to leverage and expand the use of electronic health records and the Population Health Management System to assure that patients with chronic diseases are receiving appropriate care and preventive care.
Providing services in the right place, at the right time and in the most cost effective way for the patient is the focus of this intervention. This project aims to address challenges related to chronic conditions and mental illness by identifying health concerns and social disparities before discharge, and providing continuity of care to enable future early intervention and reduce the likelihood of potentially preventable emergency department and/or hospital readmissions for conditions that can be managed effectively at the community care level.
To achieve project deliverables, we will facilitate the transition of care from the hospital to home or community residence, and from the home to primary care by educating and advocating for patients through the support and self-management of chronic conditions. We will utilize existing resources to hire, train (through the development of a certified care coordination curriculum in partnership with our community college, the health home and SUNY), and deploy interdisciplinary teams to provide direct, facilitated coordination for patients identified in the acute care setting.

Patients will be identified in the acute care setting and referred to the North Country Health Home based on the presence of one or more chronic condition or one single qualifying condition of either HIV/AIDS or Serious Mental Illness. By increasing awareness of and leveraging the health home and home care agencies, we will focus on both clinical and social determinants of health that are highly correlated with admissions or readmissions. Additionally, the two FQHC's, the new mobile integration team through the St. Lawrence Psychiatric Center, and the local crisis intervention program through the Children's Home of Jefferson County will be sources of support, coordination, and intervention to ensure that patients are effectively, safely, and optimally transitioning to, and remaining in outpatient care, thus reducing the incidence of hospital or ED use.
We will establish cross functional teams that span the delivery system including hospitals, long term care, the health home, hospice, and community based organizations that integrate existing social/community support services, behavioral health agencies, chemical dependency programs, and the expansion of remote monitoring services (BOSCH Health Buddy) to enhance patient support.
Established care transition protocols will be applied across the PPS beginning with assessment and risk stratification at admission, early notification of discharges for warm handoff, and health record transfer across the care continuum utilizing the RHIO, and e-discharge to ensure communication of patient records to receiving community providers.
By providing navigation, coordination and transitional care management while facilitating integration or re-integration with primary care and outpatient mental health services, the NCI will reduce the rate of hospitalization, readmission, emergency department use, and ultimately, lower the overall cost of care and improve the quality of life for impacted residents.

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 rural NCI region ranks among the most sparsely populated but geographically largest in the state with significant snowfall. The median household income in the NCI region is at least $10,000 less than the state average, (14-18% below the federal poverty level), and on average, 10% are unemployed. Also, the NCI region is a federally designated HPSA for both primary and behavioral health, thus patient's experience barriers to accessing care, the lack of an assigned provider, or the inability to receive a timely appointment. As such, patients often receive services in urgent or emergent care settings for conditions that could be managed in a primary care medical home or through outpatient behavioral health with community supportive services. The NCI will grow primary care capacity, back up providers so clinicians can operate at the top of their license, integrate primary care and behavioral health, and use telehealth to expand access. Additionally, the NCI will identify supportive services for patients prior to discharge, for the greatest challenge that impacts the ability to maintain health status are related to the socioeconomic environment that patients experience upon discharge from an inpatient facility. These challenges will be identified and addressed within the transition plan, and health home coordination with CBOs will help address the lack of housing, transportation, or the means to pay a co-pay, all which impact medication adherence. Health literacy, cultural competency, motivational interviewing and the

teach back method will be incorporated into activating optimal self-care/management, and the expansion of remote telehealth solutions will help patients feel connected to care.
Finally, facilities are providing care management, however, the approach may vary depending on the time, place or provider. To ensure the same policies and procedures are followed regardless these factors, the NCI will develop and adopt standardized protocols. The NCI's provider led initiative has engaged CBOs in a multi-level governance structure that not only facilitates buy-in, but informs the process to ensure what we say we can do can actually be done. CBOs, hospitals, the health home and physicians have been engaged from the start with project selection and are ready to develop detailed implementation plans to incorporate the strategies noted above.

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.

The NCI PPS plans to coordinate and collaborate with the neighboring Adirondack Health Institute (AHI) and Central New York Care Collaborative (CNYCC) PPS's to create a cross-PPS partnership to best serve the shared patients within our overlapping service area. The NCI will share protocols, written training materials, and evidence-based strategies with AHI and CNYCC as they are identified or developed. Also, we have an advantage with our neighboring PPS in Lewis County (CNYCC) in that we share the same Regional Health Information Organization (RHIO). With patient consent, we can securely share clinical information amongst providers regardless of which PPS they are participating with. Leveraging this technological infrastructure, we will work to ensure that providers in the PPS' can work efficiently and effectively across the integrated delivery systems to provide a seamless a transition by and between systems ensuring the best patient outcomes. The PPS intends to integrate best practice sharing into all communications with the neighboring PPS. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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.

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

Yes	No
☐	☒

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

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

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

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

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955271/
http://content.healthaffairs.org/content/32/2/223.full
http://www.hrsa.gov/publichealth/healthliteracy/
http://www.health.gov/communication/literacy/
http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program.page
http://www.hrsa.gov/culturalcompetence/index.html
http://www.nih.gov/clearcommunication/culturalcompetency.htm

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

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

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

1. Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.
2. Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.

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

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

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

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

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

According to Community Need #11 in the CNA, often the only contact that the uninsured and Medicaid non-utilizing (NU) and low utilizing (LU) populations have with the healthcare system is through the emergency department or an acute care hospitalization. Engaging these beneficiaries in the healthcare system can prevent future ED and inpatient utilization, prevent future onset of chronic disease and promote preventive care.
As per the Medicaid and uninsured populations surveyed for the CNA, more than 26% rated their health as fair or poor, and almost one third (30%) of Medicaid beneficiaries rated their mental health as fair or poor. When asked to rate the leading health issues for their community, Medicaid beneficiaries rated mental health, substance abuse and tobacco use all in the top four along with cancer followed by obesity, diabetes and heart disease. Uninsured individuals surveyed rated the leading four health issues for their community as cancer, substance abuse, obesity and tobacco followed by diabetes, heart disease and mental health.
Focusing on persons not utilizing the healthcare system, this NCI project will undertake three primary activation concepts; patient activation, financially accessible healthcare resources and partnerships with primary care and preventive care services. The NCI will contract or partner with community-based organizations to engage target populations using Patient Activation Measure (PAM) and other patient activation techniques, ensuring engagement is sufficient and appropriate. The NCI will also establish a PPS-wide training team, comprised of members with training in PAM and expertise in patient activation and engagement. We will build upon previous regional PAM experience and formally train on the PAM, regularly updating assessments of communities and individual patients to ensure we engage and provide quality healthcare to the defined target population. Last, a process for Medicaid receipts and participants to report

complaints and receive customer service will be developed, and EHRS will be used to track targeted patients.
The need to create connectivity between providers is essential, however financial accessibility of these healthcare resources must also be considered. In the NCI region, the median household income is significantly below ($45,000) the NYS average ($56,951) and more than 16% of the population lives below the poverty level (NYS 14.5%). Additionally, the rates of unemployment are greater than 10% compared to NYS (8%) and less than 20% of beneficiaries have a bachelor's degree compared to NYS (32.5%).
The most significant immediate need if the region is to be successful at engaging and connecting NU/LIU and uninsured residents to preventive care will be to grow the primary care, dental and behavioral health licensed health professional workforce. The NCI region has been federally designated a low-income Medicaid Health Professional Shortage Area (HPSA) and we cannot connect people to primary care that does not exist. By growing capacity, we will increase the volume of non-emergent care provided to UI, NU and LU persons. Additionally, we will obtain a list of PCPs assigned to this population, reconnecting beneficiaries to his/her designated PCP, focusing on establishing connectivity to resources already available to them.
Finally, it cannot be ignored that 14% of our population lacks basic prose literacy skills. The regional illiteracy rates highlight the need to improve health literacy in our community, as low health literacy is linked to poor health outcomes, higher rates of hospitalizations, and infrequent use of preventive services. Through identification of UI, NU and LU "hot spots", the NCI will contract or partner with CBOs to perform outreach with these areas. We will also train providers located within these hot spots on patient activation techniques such as shared decision making, measurements of health literacy, and cultural competency.

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 target population will be attributed adults (18 year+) in Jefferson and St. Lawrence Counties who are uninsured (UI) residents, and Medicaid beneficiaries who are classified as non-utilizing (NU) or low utilizing (LU). . In addition to the demographic and geographic definition, the target population is also defined on the basis of socioeconomic need. The project will seek to engage low socioeconomic and other individuals who fit within the UI, NU, LU classification. The overarching objective of this project is to apply Patient Activation Measures (PAM) so that UI, NU and LU populations are impacted by all relevant DSRIP PPS projects, ensuring that they too will benefit from a transformed healthcare delivery system. The NCI will work to engage and activate the target population to utilize primary and preventive services. Through our workforce strategy, we will also formally train the healthcare professionals within our PPS to use the PAM, establish baselines and regularly update assessments of communities and individual patients. Finally, this project will emphasize and focus on three primary concepts which drive the requirements for this project: patient activation, financially accessible healthcare resources, and partnerships with primary and preventive care services.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. 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.

There is great expertise within the region's community based services to connect with and assist our target population. For example, the North Country Pre-natal Perinatal Council has been successfully engaging with the Medicaid and uninsured population for many years to address prenatal health and patient navigators for facilitated enrollment. This direct hand-off to navigators who are prominently placed at hot spots, partnered CBOs, emergency departments, or community events allows them to facilitate education regarding health insurance coverage, age appropriate primary and preventive health care services and resources. Their services are reflected in noteworthy, positive health indicators in most maternal health areas.
The Urban Mission (with more than 50 member churches) on Watertown's near east side where poverty is highest, provides multiple services, are actively growing, and in addition to providing services, they also employ many from the near east side. In addition, the Mission serves critical needs for all of Jefferson County and is viewed as a positive helping hand. Throughout implementation, the Mission will be a prime site in Watertown, reaching the target population of this project.
Points North Housing Coalition brings together supportive housing providers across the region to ensure housing capacity for the homeless and near homeless. The Volunteer Transportation Center runs transport in all three counties and are valued and seen as both capable and caring. These two agencies are important, as lack of housing and transportation are social disparities often correlated with poor health outcomes such as avoidable hospitalizations (38% admits NCI region) and avoidable ED visits (50% NCI) resulting from cardiovascular disease, COPD, diabetes and substance abuse.
The NCI will leverage population health management by actively using EHRs and other IT platforms, including the use of targeted patient registries to track all patients engaged in the project.
The basic human theory must be taken into consideration as well. People want to be healthier, they want to live and be happy. This simple fact is a significant strength that can be built upon. The first recognition must be that food, clothing, shelter, and warmth have been addressed, as many of these things are services provided by the agencies above. Health is a component of safety and cannot be successfully engaged or addressed unless these others are addressed. Families and care givers are another internal strength of the NCI PPS. Many individuals that are at high risk have families and caregivers that want to help. These families and caregivers need to be engaged.
Finally, the NCI will need to grow primary care capacity, as well as train community health workers and care coordinators to serve this population within "hot spots" to ensure patient activation techniques (such as shared decision making, measurements of health literacy and cultural competency) are being effectively used and addressed. We will partner with CBOs to perform outreach within these identified hot spots. We will need to establish a PPS-wide training team, comprised of members with training in PAM and expertise in patient activation and engagement. The NCI will also obtain a list of PCPs assigned to NU and LU enrollees, reconnecting beneficiaries to his/her designated PCP, thus establishing connectivity to resources already available to the member. The NCI will also expand the use of PAM which is already being utilized

by the Fort Drum Regional Health Planning Organization and St. Lawrence Hospice and Palliative Care.

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 current system is fragmented, severely impacting the lives of those with significant burden of disease. In addition to a lack of linkages between inpatient and outpatient services, there are also disconnects between CBOs and primary care (PC), between preventive services and PC, and between PC and mental health and alcohol and substance abuse. This need to connect diverse providers is essential, however, the financial accessibility of these healthcare resources must also be considered because regionally, the median household income is below ($45,000) the NYS average ($56,951) and more than 16% of the population lives below the poverty level (NYS 14.5%). Additionally, the rates of unemployment are greater than 10% compared to NYS (8%) and less than 20% of beneficiaries have a bachelor's degree compared to NYS (32.5%).
Many individuals that are at high risk have families and caregivers that want to help, however, the system is so complex and disconnected that families cannot effectively navigate it. Community Health Workers/Navigators will be trained and deployed in hot spots to ensure patient activation, education, and connectivity to resources.
The most significant immediate need when addressing preventive care for the Medicaid and UI population will be to grow the PC, dental and behavioral health licensed health professional workforce. The NCI region has been federally designated a low-income Medicaid Health Professional Shortage Area (HPSA) and we cannot connect people to PC that does not exist. The NCI workforce strategy will recruit, train and incentivize PCPs to serve our region, specifically the Medicaid population.
Finally, it cannot be ignored that 14% of our population lacks basic literacy skills. The regional illiteracy rates coupled with the fact that NCI residents are older and have lower income levels than NYS highlight the need to improve health literacy in our region, as low literacy is linked to poor health outcomes, higher rates of hospitalizations, and infrequent use of preventive services. The NCI will formally train on the PAM and regularly update assessments of communities and individual patients to ensure we are engaging and providing quality healthcare to the population. We will also train providers located within hot spots on techniques such as shared decision making, measurements of health literacy, and cultural competency.

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.

The NCI PPS has and will continue to coordinate and collaborate with the neighboring Adirondack Health Institute (AHI) and Central New York Care Collaborative (CNYCC) PPS's to create a cross-PPS partnership to best serve the shared NU/LU and uninsured populations within our overlapping service area. The NCI will share protocols, written training materials, and evidence-based strategies with AHI and CNYCC as they are identified or developed. With patient consent, once the SHINY is available we can securely share clinical information amongst providers regardless of which PPS they are participating with. Leveraging this technological

infrastructure, we will work to ensure that providers in the PPS' can work efficiently and effectively across the integrated delivery systems to provide a seamless a transition by and between systems ensuring the best patient outcomes. The PPS intends to integrate best practice sharing into all communications with the neighboring PPS. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

2. **Scale of Implementation (Total Possible Points - 40):**
DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

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

3. **Speed of Implementation/Patient Engagement (Total Possible Points - 40):**
DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

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

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

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

Yes	No
☐	☒

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

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

The NCI Community Needs Assessment #5 identifies the need to integrate primary care and behavioral health services. Mental illness is the single highest cause of preventable inpatient admission and emergency department visit. Beneficiaries with mental illness and substance abuse were the most likely to have utilized the emergency department 58% in the past year. PCs report being unable to get their referred patients appointments for BH care and BH providers report being unable to get access to primary care for their behavioral health patients. BH health patients have high rates of co-occurring diabetes, cardiac and respiratory diseases. The suicide rate for the region is nearly twice the state rate (13.8 vs NYS 7.8), the rate binge drinking is nearly 30% higher than the NYS rate with 25% of the population indicating binge drinking in the past month and HEDIS measures for diabetes screening for those with Schizophrenia and Bi-polar are significantly below state average (70 vs NYS 79) Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. There is clear and compelling evidence that integrating PC and BH at the primary site of care for the patient is needed. To fill the need for integrated BH and MH NCI will: 1) PCMH service site - Co-locate behavioral health services at eleven rural primary care sites (Safety Net)

2) BH service site - Co-locate primary care at three of the largest volume behavioral health sites, one in each county served (Safety Net).
Each co-located PC & BH site will: Achieve 2014 NCQA level 3 patient centered medical home (PCMH) for primary care by demonstration year DY 3; develop collaborative evidence-based standards of care including medication management and care engagement; conduct preventive care screenings, including SBIRT and PHQ9, to identify unmet needs; use EHRs or other technical platforms to track all patients engaged in the project.
3) IMPACT - Implement the Improving Mood – Providing Access to Collaborative Treatment (IMPACT) model at three independent Primary Care practices with 10 providers (non-Safety net), utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care management, train an employed depression care manager meeting requirements of the IMPACT model, measure outcomes as required for IMPACT, provide "stepped care" as required by the IMPACT Model, and use EHRs or other technical platforms to track patients engaged in the project.
This multi-site approach will ensure maximum reach to meet the critical identified needs and result in measurable reduction of emergency room visits (PPV) and avoidable hospitalizations for Medicaid beneficiaries with mental illness and substance abuse disorders.

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 initiative is attributed Medicaid beneficiaries and uninsured adults (18 years+) in Jefferson, Lewis and St. Lawrence Counties who have mental illness and/or substance abuse disorders.

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

The regional behavioral health (BH) services have long worked together with a common goal to understand and serve the BH needs of soldiers and families living through more than 10 years of war and up to 6 deployments in combat zones. The Fort Drum Regional Health Planning Organization's BH Committee, existing since 2007 brings together over 25 behavioral health provider organizations. In addition, the prevention agencies have undertaken coordinated activities since their inception and local government units and community service boards have a strong history of collaboration. The strength of these assets working together will be built upon to address these needs. The North Country BH Care Network has also brought providers together to work on common goals. Three gaps were identified by the BH providers: EMR implementations, connectivity and integration with other systems; the establishment of common best practice protocols across agencies; and care transitions across provider systems including inpatient to outpatient and behavioral health to primary care.
To address these gaps, NCI participants will be connected to the Health Information Exchange (HIE) and/or utilize secure messaging to coordinate care across settings. The HIE provides a

consolidated patient record via a secure web-based portal that is available to all PPS participants with patient consent. All participating primary care practices (PCP) will have the PHQ-9 and SBIRT screenings built into their EHR and the positive screenings will prompt the provider to refer the patient to appropriate care in a timely manner, following-up to ensure a "closed-loop" referral tracking system is in place. The participating BH practices will provide primary care services through co-location at three of the largest volume behavioral health sites, the participating PCPs will provide BH services through co-location at eleven rural primary care sites. Using the Improving Mood-Providing Access to Collaborative Treatment (IMPACT) Model, patient centered medical home providers and a depression care manager and a designated, consulting psychiatrist via telemedicine will collaborate on evidence-based standards of care including medication management, care engagement processes, and the integration of depression treatment into PC to improve physical and social functioning. At IMPACT site locations where psychiatric telemedicine consults is not currently reimbursed, the NCI will utilize DSRIP funds to cover the cost of care.

Finally, as a result of NCI's care transition project, all patients who are at moderate to high risk for readmission will complete a standardized care transition plan across agencies within 30 days of discharge. Also, there are two health homes operating in the NCI region: the North Country Health Home (NCHH) is serving Jefferson, Lewis and St. Lawrence Counties and St. Joes Health Home serves only Lewis County. The NCI has included the NCHH in planning and will utilize the NCHH as a key component of the integrated delivery system.

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.

Community Need #5 identifies mental illness as the single highest cause of preventable inpatient admission and ED visits. In addition, it is clear that there is a disconnect between behavioral health (BH) and primary care (PC) services. PCs report being unable to get referred patients appointments for BH care and BH providers report being unable to get access to PC for BH patients. The NCI workforce strategy will grow PC capacity, back up providers so they can operate at the top of their license, and utilize telemedicine to increase access to care. At sites where telemedicine is not reimbursed, DSRIP funds will be used to cover the cost.

The CNA also notes that BH health patients have high rates of co-occurring diabetes, cardiac and respiratory diseases, and the suicide rate for the region is nearly twice the state rate. To address these challenges, the NCI will develop and implement standardized protocols, identifying the appropriate supportive services for the patient prior to discharge. Health literacy, cultural competency, motivational interviewing and the teach back method will be incorporated into activating self-care/management, and the expansion of remote telehealth solutions will help patients feel connected to care. A transition plan, including the secure transfer of records will be

developed and health home coordination with CBOs will help address the medical or social barriers that often times result in a preventable ED visit.
Finally, where regulations exist regarding co-location and patient transfers, waivers will be requested.

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.

The NCI PPS plans to coordinate and collaborate with the neighboring Adirondack Health Institute (AHI) and Central New York Care Collaborative (CNYCC) PPS's to create a cross-PPS partnership to best serve the shared patients within our overlapping service area. The NCI will share protocols, written training materials, and evidence-based strategies with AHI and CNYCC as they are identified or developed. Also, we have an advantage with our neighboring PPS in Lewis County (CNYCC) in that we share the same Regional Health Information Organization (RHIO). With patient consent, we can securely share clinical information amongst providers regardless of which PPS they are participating with through the SHINY infrastructure as soon as available. Leveraging this technological infrastructure, we will work to ensure that providers in the PPS' can work efficiently and effectively across the integrated delivery systems to provide a seamless a transition by and between systems ensuring the best patient outcomes. The PPS intends to integrate best practice sharing into all communications with the neighboring PPS. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

3. <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 to renovate space to accommodate Primary care at three separate Behavioral health locations one in each county – Transitional Living Services in Lewis County, Community Clinic of Jefferson County and Community Services of St. Lawrence County and to expand access to care at the new FQHC expansion site in St. Lawrence County. It will require capital as a component of Medical Village renovation/expansion for colocations at hospital owned infrastructure sites for River Hospital, Samaritan Medical Center, Carthage Area Hospital, Massena Memorial Hospital, Clifton Fine and Claxton Hepburn Medical Center and it will require capital for tele medical capacity at the Primary Care sites. In addition there are technology capital needs that have been included in IDS and PCMH but will also support integration. Without the capital this integration will not happen as space and facilities are not currently configured for this use.

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

Yes	No
☐	☒

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

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

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

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

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

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

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain

1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards 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.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only)

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

Project Description: The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of cardiovascular disease. These strategies are focused on improving practitioner population management, adherence to evidence-based clinical treatment guidelines, and the adoption of activities that will increase patient self-efficacy and confidence in self-management. Strategies from the Million Hearts Campaign (http://millionhearts.hhs.gov) are strongly recommended.

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

1. Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.
2. Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
3. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
4. Use EHRs or other technical platforms to track all patients engaged in this project.
5. Use the EHR or other technical platform to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).
6. Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.
7. Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.
8. Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.
9. Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.
10. Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.

Improve Medication Adherence:

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

Actions to Optimize Patient Reminders and Supports:

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

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

1. 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.

As indicated in the CNA, selecting evidence-based strategies for disease management for patients with cardiovascular conditions is necessary and critical. The leading cause of death and the second leading cause of premature death amongst the NCI region is heart disease. Cardiovascular disease was found to be the second leading cause of hospitalizations and preventable hospitalizations, second to mental health diseases and disorders. Furthermore, the NCI region (447) exceeds both Upstate (336) and NYS (422) adult circulatory conditions Prevention Quality Indicators composite (PQ107, 08). It is critical that our PPS has the opportunity to focus on needed changes to address the poor quality performance.

Through the Clinical Medical Management Committee (MMC), the NCI will implement a program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting (CNA need #6). The clinical governance committee has chosen Joint National Committee 8 clinical guidelines for hypertension, and American Heart Association (ACC-AHA) guidelines for cholesterol. They have also determined where appropriate clinical decision support around these guidelines will be implemented in partner EMR systems to ensure engagement. This project will include an education platform to engage patients, utilize EMR systems to track patients, interface PPS partners to the HIE and Population Health Management tool, and achieve 2014 PCMH level 3 by end of DY 3 (CNA need #2). NCI will also

implement care coordination (CNA need #4), create templates to be used around asking the 5 A's of tobacco, adhering to the nicotine dependency plan/poster program, participating in the Million Heart Campaign criteria and provide routine hypertension checks. Digital blood pressure monitors will be purchased for each participating practice to enable follow-up blood pressure checks without appointment or copay. This will include staff training to ensure standardization of blood pressure evaluation and patient engagement in obtaining routine blood pressure readings at their convenience.

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.

NCI's Clinical Medical Management Committee (MMC) has defined how the PPS will risk stratify patients, so that the region knows who to target for varying levels of intervention. MMC, has chosen to risk stratify patients, using the Risk-Stratified Care Management and Coordination template created by the American Academy of Family Physicians. With the help of this tool NCI's PPS will be able to categorize patients into 4 categories based on their disease severity, risk factors, social determinants, clinician input and others. Once categorized, the tool will assist in assigning the patients a level amongst that category, and these levels will help to determine who needs routine active engagement, care management/coordination etc. Over the course of this project, the NCI's MMC expects to actively provide care management to cardiovascular patients who have had an MI, stroke, vascular surgery, and/or those risk stratified to Level 5 and 6; however, all adult Medicaid patients with hypertension will be engaged in activities as defined.

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 first set of existing resources to be mobilized are the Primary care physicians, both safety net and non-safety net providers who see Medicaid patients with cardiovascular disease. To ensure success, NCI has determined that participating providers need to be engaged in the transformation of care. Appropriate providers and their practices/clinics will participate in improving quality metrics for cardiac patients. Specialty care providers amongst our region will collaborate with other DSRIP PPS specialists from which our beneficiaries receive care.
Diabetes is highly correlated with hypertension, therefore, additional community resources that will be mobilized include: regional nutritionists and dieticians, exercise therapists and wellness counselors (i.e. YMCA), diabetes educators (i.e. Feed the Soul Nutrition) and transportation services (i.e. the Volunteer Transportation Center).
Lastly, the lack of care coordination and provider shortages will need to be addressed through the NCI workforce strategy which will recruit, incentivize and enhance existing provider's capacity to work at the top of their licensure. Within this project it is imperative to create a team of care coordinators to work with the selected/defined patient population. There care coordinators and providers will utilize the population health management system to identify and monitor patients

in need of care management. NCI's Care Coordination Committee (project 2.b.iv) is currently working to develop a strategy to meet this need.

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.

To offset the risks of failure, the Medical Management Committee has created a list of project challenges and anticipated issues. Each of these challenges will be addressed routinely so that NCI can move at the speed needed to be successful. There are five emerging challenges: 1) Changing the behavior of Medicaid patients 2) Region wide agreement on risk stratification models 3) Adding clinical decision support into EMR systems 4) Adoption of PCMH 2014 standards 5) Existing provider gaps and the access to care issues.
The greatest challenge is providing the tools that will enable Medicaid beneficiaries to be successful at behavior change. There are significant barriers that need to be overcome to facilitate this change including lack of access to primary/specialty medical care, lack of access to prevention services, lack of knowledge, and belief in ability to change. NCI is committed to working through these challenges with initiatives that are patient centric. NCI's focus on the patient will begin with identifying subsets of patients in need of engagement whether it be through educational resources, community advocacy programs, care coordination, or other community resources such as the North Country Health Home. Also, the NCI will find ways to improve access to care through recruitment of physicians and implementing PCMH level 3 open access guidelines so that the right care at the right time is provided for our Medicaid beneficiaries.

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.

The NCI PPS plans to coordinate and collaborate with the neighboring Adirondack Health Institute (AHI) and Central New York Care Collaborative (CNYCC) PPS's to create a cross-PPS partnership to best serve the shared patients within our overlapping service area. The NCI will share protocols, written training materials, and evidence-based strategies with AHI and CNYCC as they are identified or developed. Also, we have an advantage with our neighboring PPS in Lewis County (CNYCC) in that we share the same Regional Health Information Organization (RHIO). With patient consent, we can securely share clinical information amongst providers regardless of which PPS they are participating with. Leveraging this technological infrastructure, we will work to ensure that providers in the PPS' can work efficiently and effectively across the integrated delivery systems to provide a seamless a transition by and between systems ensuring the best patient outcomes. The PPS intends to integrate best practice sharing into all communications with the neighboring PPS. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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.

In an effort to meet all the project criteria and milestones capital dollars need to be allocated. Digital blood pressure machines will be purchased to assist with access to routine unscheduled blood pressure checks within the office. The other capital needs reside in the IT budget, those capital dollars will be for capita IT to support PCMH certifications, connections to the HIE and disease registry.

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

Yes	No
☐	☒

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

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

3.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. 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.

Community Needs # 7 as identified in the CNA, provides clear evidence of the need to select a project focused on evidence based strategies for disease management for patients with diabetes to reduce avoidable hospitalization and emergency department visits for the treatable complications of diabetes. Diabetes is fourth leading cause of preventable, Medicaid hospitalizations. The NCI region (436) exceeds both Upstate (364) and NYS (372) on the adult diabetes Prevention Quality Indicators Composite (PQ101, 03, 16), and adult

uncontrolled diabetes (PQI 14), (NCI 59, Upstate 42, NYS 46). The NCI is strongly committed to changing the quality of diabetes care provided for Medicaid patients in the region.
Through the Clinical Medical Management committee (MMC), NCI will implement a program to improve diabetes management using evidence-based practices for disease prevention in ambulatory and community care settings (CNA need 7). Collectively, the MMC has chosen the ADA 2014 position statement as the evidence-based clinical guidelines to be utilized PPS wide for diabetes treatment and management. NCI will develop care coordination teams which will include diabetes educators, nursing staff, behavioral health providers, pharmacists, community health workers and health home care managers, (as appropriate to the patient risk level) to improve health literacy, patient self-efficacy, and patient self-management.
The NCI Diabetes Management Program will interface PPS partners to the HIE and disease registry, achieve 2014 PCMH level 3 recognition (CNA need #2), implement care coordination (CNA need #4), utilize "hot spotting" strategies to implement patient self-management in coordination with the Health Home in high risk neighborhoods, utilize remote monitoring (BOSCH telehealth units), and utilize diabetes educators as a component of the treatment team. In addition, the NCI will utilize DSRIP funds to pay for the Diabetes Prevention Program where it is not currently covered as a component of the diabetes management program and we will ensure coordination with the Managed Care Organizations serving the target population to prevent redundancies and isolation of other unidentified care gaps.

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.

NCI's Clinical Medical Management Committee (MMC) has defined how the PPS will risk stratify patients, so that the region knows who to target at varying levels of intervention. MMC has chosen to risk stratify patients, using the Risk-Stratified Care Management and Coordination template created by the American Academy of Family Physicians. With the help of this tool, NCI will categorize patients into 4 categories based on their disease severity, risk factors, social determinants, clinician input and others. Once categorized, the tool will assist in assigning the patients a level amongst that category and these levels will help to determine who needs routine active engagement, care management/coordination etc. The MMC has chosen within diabetic patients, to target those patients with an uncontrolled A1C above 9 and or those risk stratified to Level 5 and 6 to be part of the patient population that our PPS expects to actively engage over the course of the 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 first set of existing resources to be mobilized are the primary care physicians, both safety net and non-safety net providers who see Medicaid patients with diabetes. To ensure success, participating providers will be engaged in the transformation of care. Appropriate providers and

their practices/clinics will participate in improving quality metrics for their diabetic patients and they will be encouraged to collaborate with other PPS specialists where our beneficiaries seek care. Through clinical decision support systems in the EHR, providers will also be reminded of preventive screening requirements. Additionally, we will look to leverage the existing technological infrastructure to improve referrals and the utilization of local DPP Programs such as those at the YMCA, the St. Lawrence Health Initiative, Office for the Aging and at the local public health departments.
Additional community resources that will be mobilized include: regional nutritionists and dieticians, exercise therapists and wellness counselors (i.e. YMCA), diabetes educators (i.e. Feed the Soul Nutrition) and transportation services (i.e. the Volunteer Transportation Center).
Lastly, the lack of care coordination, provider shortages and lack of diabetes educators will need to be addressed through the NCI workforce strategy which will recruit, incentivize and enhance existing provider's capacity to work at the top of their licensure. Within this project it is imperative to create a team of care coordinators to work with the selected/defined patient population. There care coordinators and providers will utilize the population health management system to identify and monitor patients in need of care management. NCI's Care Coordination Committee (project 2.b.iv) is currently working to develop a strategy to meet this need.

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 Medical Management Committee has created a list of project challenges and anticipated issues. Each of these challenges will be addressed going forward and routinely so that NCI can move at the speed needed to be successful. There are five emerging challenges: 1) Changing the behavior of Medicaid patients 2) Region wide agreement on risk stratification models 3) Adding clinical decision support into EMR systems 4) Adoption of PCMH 2014 standards 5) Existing provider gaps and the access to care issues.
The greatest challenge is providing the tools that will enable Medicaid beneficiaries to be successful at behavior change. There are significant barriers that need to be overcome to facilitate this change including lack of access to primary/specialty medical care, lack of access to prevention services, lack of knowledge, and belief in ability to change. NCI is committed to working through these challenges with initiatives that are patient centric. NCI's focus on the patient will begin with identifying subsets of patients in need of engagement whether it be through educational resources, community advocacy programs, care coordination, or other community resources such as the North Country Health Home. Also, the NCI will find ways to improve access to care through recruitment of physicians and implementing PCMH level 3 open access guidelines so that the right care at the right time is provided for our Medicaid beneficiaries.

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.

The NCI PPS plans to coordinate and collaborate with the neighboring Adirondack Health Institute (AHI) and Central New York Care Collaborative (CNYCC) PPS's to create a cross-PPS partnership to best serve the shared patients within our overlapping service area. The NCI will share protocols, written training materials, and evidence-based strategies with AHI and CNYCC as they are identified or developed. Also, we have an advantage with our neighboring PPS in Lewis County (CNYCC) in that we share the same Regional Health Information Organization (RHIO). With patient consent, we can securely share clinical information amongst providers regardless of which PPS they are participating with. Leveraging this technological infrastructure, we will work to ensure that providers in the PPS' can work efficiently and effectively across the integrated delivery systems to provide a seamless a transition by and between systems ensuring the best patient outcomes. The PPS intends to integrate best practice sharing into all communications with the neighboring PPS. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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

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

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

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

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

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

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

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

Yes	No

☒	☐

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

Capital budget funding will be required to fully implement required technology to support this project. The capital funds will be used to ensure all practices have a certified electronic health record (EHR), are connected to the HIE, are sending clinical data to the regional Population Health Management (PHM) registry, and have access to telemedicine equipment to address gaps in care. A key requirement of the health care transformation is the availability of high quality primary care, and one resource of high quality care is PCMH Level 3 recognition. An EHR will be vital to the documentation and assessment reporting required by NCQA for the rapid transformation into a PCMH Level 3. An EHR will allow provider's access to evidence based tools that can be used to better treat the patient and improve outcomes.

Using an organized system, such as a patient registry, to observe research methods and collect data for better patient outcomes will be a foundational piece of patient-centric, high quality care. Facilitating the use of common data fields in similar health conditions will improve the opportunity to share, compare, and create linkages to provide better patient outcomes. Imbedding this use of population health management into the practices and clinics will give the providers real time insight and will allow them to identify and address care gaps within the patient population.

Additionally, care management is a critical component of PHM, as it aims to improve patient self-management, medication management, and reduce the cost of care. The use of data for PHM makes up an entire standard within the NCQA requirements for a Level 3 PCMH. At least annually, the practice must proactively identify patient populations and remind them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments, and evidence based guidelines.

The use of telemedicine can be used as a mode of real time communications saving the patient, provider, and the payer valuable time and resources when compared to traditional approaches to providing care. Additionally, providing alternative types of clinical encounters is a factor within the PCMH Patient Centered Access standard.

Finally, a fully integrated EHR will add significant value to the PPS's practices and clinics. With the use of registries, population health management and telemedicine, providers will be able to provide more patient centered, open access, and high quality health care to our targeted population resulting in improved patient outcomes.

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

Yes	No
☐	☒

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

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

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

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

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

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

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards 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.ii Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease—Primary and Secondary Prevention Projects (Adults Only)

Project Objective: Engage at-risk populations in primary and secondary disease prevention strategies to improve patient self-efficacy and self-management.

Project Description:
While Project 3.c.i is focused on diabetes care practice improvement, this project focuses on developing community resources to assist patients with primary and secondary preventive strategies to reduce risk factors for diabetes, and ameliorate the long-term consequences of diabetes and other co-occurring 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.

1. Implement Center for Disease Control (CDC)-recognized National Diabetes Prevention Programs (NDPP) and/or create partnerships with community sites to refer patients to CDC-recognized programs.
2. Use EHRs or other technical platforms to track all patients engaged in this project.
3. Identify high-risk patients (including those at risk for onset of diabetes or with pre-diabetes) and establish referral process to institutional or community NDPP delivery sites.
4. Ensure collaboration with PCPs and program sites to monitor progress and provide ongoing recommendations.
5. Establish lifestyle modification programs including diet, tobacco use, and exercise and medication compliance.
6. Ensure coordination with Medicaid Managed Care organizations and Health Homes for eligible/involved patients.

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.

According to the CNA, over 40% of Medicaid beneficiaries in the NCI region indicated diabetes as a concern. Diabetes is the fourth highest driver of inpatient admissions (34%) and ED use (42%) for the target population, and within Lewis County, diabetes emerges as a leading cause of death.

The NCI performs below state average (per 100,000) on the adult diabetes composite (NCI 436, NYS 372), and short-term complications of diabetes (NCI 157, NYS 113) and adult uncontrolled diabetes (NCI 59, NYS 46) are of particular concern for the Medicaid population. Another significant issue affecting Medicaid beneficiaries is quality of care, specifically the recommended level of care received by the population (HEDIS measure). Diabetes screenings for those with schizophrenia or bi polar disorder is lower than statewide (NCI 70, NYS 79). This data suggests that chronic disease, such as diabetes, presents a significant burden to the well-being within the region. It is clear that primary care or outpatient implementation of evidence-based strategies in the treatment of diabetes will result in less ED and inpatient utilization.
Additionally, Community Need #8 indicates that diabetes is significantly impacted by lifestyle and access to nutrition and exercise; therefore, it is critical that community-based resources be leveraged to impact choices and decisions outside the physician's office walls. Activities like the Diabetes Prevention Program and lifestyle modification programs are critical to patient success and can be life-changing, resulting in not only fewer avoidable hospitalizations and ED use to achieve DSRIP goals, but improved quality of life for both patients and families. Diabetes can be prevented if treated effectively in the outpatient setting.
NCI's Medical Management Committee will inform evidence-based strategies for diabetes management which will incorporate clinical decision support including screening into EMR systems. NCI will partner with existing DPP program providers and implement systematic referral for patients that are screened at-risk or pre-diabetic.
To fulfill this community need the NCI must; grow primary care capacity to ensure patients have access to care to be screened for referral; improve the patient and prevention focus of primary care, tracking and reporting on measures to provide feedback and undertake public health campaigns to engage the target population to embrace screening and prevention.

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 will be attributed, Medicaid adults (18 year+) in Jefferson, Lewis and St. Lawrence Counties who are at high risk for the onset of diabetes or with pre-diabetes. While NCI's project 3.c.i. is focused on diabetes care practice improvement, this project will focus on developing community resources to assist patients with primary and secondary prevention strategies to reduce risk factors for diabetes, and improve the long-term consequences of diabetes and other co-occurring chronic diseases.

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.

To achieve project requirements, the NCI will implement Center for Disease Control (CDC) recognized National Diabetes Prevention Programs (NDPP) leveraging existing partnerships with

community organizations such as the YMCA, the St. Lawrence Health Initiative, the Office for the Aging and the three public health departments within the NCI region by increasing referrals to these CDC recognized programs. Utilizing EHRs and other technical platforms such as a Population Health Management System, the NCI will track all patients engaged in this project to assure that they are receiving appropriate and preventive care. Additionally, the NCI will ensure collaboration with participating primary care practices and program sites to monitor progress and provide ongoing recommendations by leveraging the knowledge of the Medical Management Committee. The NCI will also partner with the YMCA, the Public Health Departments, regional prevention agencies such as the Seaway Valley Prevention Council, Mountain View Prevention Services and Pivot, and peer-to-peer organizations like the Mental Health Association and Step-by-Step for those with co-occuring mental illness or substance abuse disorders to establish and/or leverage lifestyle modification programs including diet, tobacco use, and exercise and medication compliance. Finally, NCI will coordinate and collaborate with the North Country Health Home and the Managed Care organizations for eligible/involved patients (presence of one or more chronic conditions or one single qualifying condition of either HIV/Aids or Serious Mental Illness), focusing referral and utilization of their services to assist with the medical, behavioral and social risk factors that are prevalent among the defined target population.

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.

Community Need #1 indicates that healthcare is currently provided in separate silos with limited ability to share records or care plans. Patients with chronic, complex conditions often have multiple and contradictory care plans with little to no communication between providers and settings. There are no agreed upon protocols for care transitions and little care management across the continuum. Due to the rural geography and transience of many high-risk patients once they leave the “teaching/engaging” moment at the hospital, the Health Home care managers are unable to find them to engage them in outpatient services and active participation in their care plans that would prevent future hospitalizations and ED use. In addition, there is a PC workforce shortage that requires a focused cross-system effort to increase capacity in order that we may serve those with chronic disease burdens. Because CBOs have little to no interaction with inpatient settings or PCPs, there is often a gap in leveraging community support services such as the NDPP. Patients need facilitated, smooth transitions and communication across all settings; an initiative that will be addressed in NCI’s care transition project (2biv) in the integrated delivery system (2ai) and as a component of PCMH (2aii).

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.

The NCI PPS plans to coordinate and collaborate with the neighboring Adirondack Health Institute (AHI) and Central New York Care Collaborative (CNYCC) PPS's to create a cross-PPS partnership to best serve the shared patients within our overlapping service area. The NCI will share protocols, written training materials, and evidence-based strategies with AHI and CNYCC as they are identified or developed. Also, we have an advantage with our neighboring PPS in Lewis County (CNYCC) in that we share the same Regional Health Information Organization (RHIO). With patient consent, we can securely share clinical information amongst providers regardless of which PPS they are participating with. Leveraging this technological infrastructure, we will work to ensure that providers in the PPS' can work efficiently and effectively across the integrated delivery systems to provide a seamless a transition by and between systems ensuring the best patient outcomes. The PPS intends to integrate best practice sharing into all communications with the neighboring PPS. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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

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

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

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

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

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

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

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

Yes	No
☐	☒

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

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

Yes	No
☐	☒

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

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

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

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

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

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

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

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards <u>completion of project requirements,</u> <u>scale of project implementation,</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 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
North Country Behavioral Healthcare Network

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.

In the CNA total population survey 78.5% identified substance abuse and 70.4% identified mental illness as the leading health problem in the region. Medicaid beneficiaries surveyed identified mental health as the number one health concern in their community. As evidenced by the CNA, mental illness is the single largest cause of Medicaid hospitalization and emergency room visits in the region and the number one cause of all avoidable hospitalizations. Both the data and the community survey respondents clearly support a more regional approach to MEB health promotion activities to reduce the prevalence of substance use and related problems including tobacco use, underage drinking, binge drinking as well as promote positive health behaviors that address anxiety, depression and other mental health disorders. Although the CNA (Community Need #9), identified gaps in MEB promotion such as a lack of consistent services across the region, further analysis needs to be taken to determine the scope of gaps within the behavioral health field across the region to inform a region-wide sustained MEB health promotion plan. The NCI DSRIP partners will bring together all regional stakeholders who are already engaged in health promotion activities but who until now have not coordinated their efforts, and measured their effectiveness in concert with each other to focus all efforts on specific measurable outcomes. This project will change that scenario by establishing a tri county MEB Health promotion consortium. Based on data recently collected in the regional health assessment, and utilizing both the SAMHSA Strategic Prevention Framework and the NYS DOH Prevention Agenda the consortium will develop and implement an evidence based regional MEB health promotion and MEB disorder prevention plan that coordinates and unifies prevention and health promotion efforts across the tug-hill seaway region. This plan will include the region-wide effort to expand "Collaborative Care" in the primary care setting as supported by the integration of primary care and behavioral health being undertaken through project 3.a.i., and a commitment to MEB cultural and linguistic training and to share data and information on MEB health promotion, prevention and treatment across the PPS.

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.*

As a population health initiative the target population for marketing and media efforts will be the residents of Jefferson, Lewis and St. Lawrence Counties in New York. This three-county has over 260,000 people spread over 5,000 square miles. Specifically the project activities will focus on school aged youth, and those geographic pockets which where poverty is correlated with high levels of mental illness and alcohol and substance abuse emergency department visits and inpatient admissions. While this may change over the course of the DY1 – DY5, at this time these pockets exist in thirteen specific census tracts where poverty is highly concentrated, with rates exceeding 20%. These census tracts are associated with five distinct communities: Near East Side of Watertown; Ogdensburg; Massena; Natural Bridge/Carthage; Port Leyden/Lyons Falls. For the over 49,000 individuals living within those census tracts, 12.6% are unemployed, 11.3% are uninsured, and only 18.6% have earned a Bachelor's Degree or higher qualification (Table 3.). Data from the New York State Department of Health indicates that potentially avoidable hospitals stays exceed 150% of the expected rates for these communities. Additionally, within these

communities, emergency department visits for non-emergent conditions exceed 100 per 1000 residents.

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.

There are currently twenty two behavioral health organizations including three OASAS licensed prevention agencies and agencies that serve multiple roles including peer support and advocacy. The agencies licensed by OASAS to provide prevention services as well as organizations specializing in health promotion and advocacy will lead the effort to identify and coordinate regional stakeholders currently providing MEB health promotion services. A comprehensive inventory of prevention related activities will be developed from among the many agencies with an aim to coordinate access and eliminate redundancy. Participating agencies will include: the OASAS prevention agencies, LGUs, Public Health Departments, Cornell Cooperative Extension, Mental Health Association, Step by Step, Independent living centers, DARE program officers, YMCA, community youth centers and schools. Resources which will also need to be coordinated and further developed include "hot spotting" tools, systematic data collection and analysis, and uniform administration of the school based Bach Harrison Prevention Needs Assessment.
The project forms a community consortium of the regional MEB health promotion providers. All three OASAS prevention providers are trained in Strategic Prevention Framework guidance as well as the national Community Anti-Drug Coalitions of America (CADCA) program. Both of these processes are nationally and state recognized strategies for community coalition building and sustainability. All three prevention providers in the tri-county region maintain community coalitions and are well prepared to offer the leadership in organizing the work being proposed.

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.

Culture change will be one of our biggest challenges. Currently the region's prevention efforts are provided in isolation of one another on a county by county basis. Services are uncoordinated and not necessarily tied to the regional health assessment data. As a result efforts are not routinely targeted to the highest priority MEB need nor are they to the geographic areas of greatest need. Tying programming to regional needs data will be a significant change for many stakeholder agencies. Likewise agencies will need to adopt evidence based practices and commit to monitoring effectiveness over time. Geography and the associated travel time for meetings may also be a barrier. Expanded use of web based meeting and video conferencing technology will be utilized. An administrative service agency will also need to be designated that can dedicate staff to implementing to project and keeping stakeholders engaged.

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.

The NCI PPS plans to coordinate and collaborate with the neighboring AHI and CNY PPS's to create a cross-PPS partnership to best serve the shared populations within our overlapping service area.

The PPS intends to integrate best practice sharing into regular communications with the neighboring PPSs and any health promotion media materials developed. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted populations.

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.

Early DY 1 and DY 2 milestones for this project will be process related to include:
1. Outreach to and engagement of key stakeholders;
2. Review known needs data and identify any additional data needed;
3. Establishing a group charter including a mission and vision statement;
4. Identify financially and geographically appropriate strategies for organizing and implementing MEB health promotion efforts;
5. Implement evidenced based culturally appropriate MEB health promotion programs and infrastructure development activities in target areas;
6. Monitor process, evaluate effectiveness, and sustain effective programs and activities.
7.Improve or replace failing efforts.

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.

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

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

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

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

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

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

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

4.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

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.

Results from the CNA (Community Need #10) indicate that health improvement related to respiratory disease (in particular COPD) and colorectal cancer will require a concentrated prevention strategy. Chronic lower respiratory diseases (including COPD) and cancer are among the top three causes of death within the NCI region. Regionally, 35% of Medicaid beneficiaries with the diagnoses had an inpatient admission due to respiratory disease, while 53% of the diagnosed beneficiaries had an ER visit due to respiratory disease. The CNA also notes that COPD is the third leading cause of hospitalization and emergency room visits for the target population and more than 20% of the region's population smokes, a rate that exceeds the statewide average (15.6%), thus helping to explain the high COPD rates.

Clearly, respiratory diseases are of concern and in particular COPD and bacterial pneumonia, often a complication of COPD. The adult respiratory composite (PQ105, 15) is 599 compared to NYS at 500. COPD composite is 1040 compared to NYS at 814, and bacterial pneumonia is 312 compared to NYS at 258. The NCI region exceeds both Upstate and NYS on every single adult composite for avoidable hospitalizations including overall adult composite (PQI90) with 2144 avoidable admits per 100,000 beneficiaries as compared to NYS (1848). Also, the Potentially Preventable ED Visit (PPV) rate is nearly double the NYS rate (NCI 62, NYS 36). Finally, regional colorectal cancer mortality rates per 1000,000 exceed NYS rates (NCI 18.8, NYS 15.7) and regional colorectal cancer screening rates are significantly lower than NYS (NCI 66.2%, NYS 69.3%).

To prevent the burden of these chronic diseases and avoid many related complications, the delivery of high-quality chronic disease prevention and management will be essential components of the NCI strategy. Many of these types of services have shown to be cost-effective and even cost-saving. However, it has been found that many Medicaid beneficiaries in the NCI region do not receive the recommended preventive care and management to prevent disease, detect health problems early, and prevent disease progression and complications. As a result, this NCI project will:

1) Enhance reimbursement and incentives to increase delivery of high-quality chronic disease prevent for respiratory disease (COPD specifically), and colorectal cancer.

2) Offer recommended clinical preventive services and connect patients to community-based preventive services resources like the Tobacco Prevention Coalition and the Cancer Services Program

3) Incorporation of Prevention Agenda goals and objectives into hospitals Community Service Plans and coordination with local health departments.

4) Adopt and use EHRs with clinical decision support and registry capability. Send reminders to patients for preventive and follow-up care and identify community resources for disease self-management
5) Adopt medical home team based models of care
6) Create linkages with and connect patients to community preventive services
7) Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement
8) Eliminate out of pocket costs for smoking cessation and prevention programs like CDSMP and DPP
The CNA clearly points to the need for a more concerted effort to advance respiratory disease prevention, incorporating smoking prevention and cessation as well as cancer prevention screenings. Both of these activities will require community engagement through media campaigns and outreach activities in addition to provider practice quality improvement and will impact total health as the region moves from a healthcare system to a system for health.

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.*

As this is a total population health initiative, the target population for colorectal cancer screenings will be all adults 50+ years of age and adults 40+ at high risk for colorectal cancer in Jefferson, Lewis and St. Lawrence Counties. The target population for respiratory disease population health prevention efforts will be current smokers, family members of current smokers and youth 12-17 living in "hot spots" for respiratory disease. The target population for respiratory disease management activities will be adults with current diagnoses of Chronic Lower Respiratory Disease (CLRD) to include Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis and asthma.

In addition to the patients, this project will also target NCI participating providers. As noted in the CNA, in the current system, care transitions from the inpatient to outpatient setting are not well coordinated. Tobacco cessation programs are not covered services and are not receiving referrals. As a result, the NCI will target participating providers by establishing or enhancing reimbursement and incentive models to increase delivery of high quality chronic disease prevention and management services. NCI will implement Patient Catered Medical Home (PCMH) for all NCI primary care providers and thus all providers will utilize National Council on Qulaity Assurance (NCQA) evidence-based guideline for screening and referrals and connect patients to community-based preventive services.

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

There is great expertise within the region's community-based services to connect with and assist targeted populations.
In April 2013, the North Country Health Compass Partners (NCHCPs), an interdisciplinary (hospitals, local health departments and other community partners), population health committee within the NCI region developed under the Fort Drum Regional Health Planning Organization (FDRHPO), assisted with the development of NCI hospital Community Service Plans. In addition, they facilitated and developed a regional Community Health Assessment and

Improvement Plan (CHIP) incorporating Prevention Agenda goals and objectives, including the following priorities: chronic disease, behavioral health, maternal and child health, and dental health. This regional CHIP was designed to be responsive to the identified community health needs, while incorporating data on available population health indicators. The plan's strategies are grounded in evidence and designed to maximize regional collaborative efforts. To facilitate implementation, which includes preventive care and disease management, the region is leveraging existing capacity for marketing, advocacy, policy development, grant support (i.e. technical assistance), and partnership building.

For the prevention of chronic disease, regional partners such as the Cancer Services Program of Jefferson, Lewis and St. Lawrence Counties, the three county OASA prevention councils and the local Public Health departments are be leveraged to increase referrals and establish a baseline screen rate. Media (patient engagement tools) targeting colorectal cancer screenings are being created and distributed. Additionally, baselines for EHR utilization (patient reminders) are being developed and technical assistance is being provided to regional providers to encourage utilization of these reminder systems. Finally, to prevent the initiation of tobacco use by youth and young adults, we are adopting an anti-tobacco marketing policy in partnership with the Tobacco Prevention Awareness Cessation Coalitions (TPACC) of the three counties Progress for CHIP initiatives is being monitored using the North Country Health Compass website (www.ncnyhealthcompass.org), a web-based source of population data and community health information for the NCI region.

It is also worth noting that while some of our practices do not have on-site spirometry, many of them do. This tool is used to diagnose COPD. Additionally, the NCI has a credentialed respiratory therapist with an extensive background and training in spirometry. His knowledge base will be instrumental in creating a standardized, systematic approach to screening and treating COPD in the region.

Lastly, certified EHRs in use within the NCI region support health maintenance by providing physicians with clinical decision support to ensure that their entire patient population is compliant with recommended health screenings including colorectal cancer screenings. In partnership with the FDRHPO North Country Health Information Partnership (N-CHIP), regional hospitals, practices, clinics and health care providers will continue to implement EHRs in medical offices region wide, connecting them to the HIE as well as a Disease Registry to improve care coordination and population-wide disease management. Combining local clinical leadership, nationally recognized technical expertise, and extensive regulatory and industry knowledge, the N-CHIP will continue to assist the NCI to leverage technological infrastructure to meet project deliverables.

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.

Currently, care transitions from the inpatient to outpatient setting are not well coordinated. Prevention programs such as tobacco cessation are not covered services and are not receiving referrals. As a result, the NCI will enhance reimbursement and incentive models to increase delivery of high quality chronic disease prevention and management services. NCI will connect patients to community-based preventive services and adopt and use certified EHRs, especially those with clinical decision supports and registry functionally to send reminders to patients for

preventive and follow-up care, including the identification of community resources to support disease self-management.
The fact that not every practice has spirometry equipment to diagnose COPD may be a potential challenge when implementing project initiatives. Because there are financial incentives (a reimbursable service) to purchasing this equipment, we will encourage providers to purchase this if able, as this will assist in ensuring a financial plan for the sustainability of spirometry screening programs.
Also, in total, 18 practices/clinics/agencies with 27 sites have no EMR, 60% of PCPs have either never attempted APC/PCMH certification, or have allowed 2008 standards to lapse. 24% have connectivity to the disease registry for population health management, and there are 45 practices/clinics/agencies at 82 sites that are not connected to the HIE for real-time data sharing (only 32% have this capability). All participating PCPs will have to re-apply to be recognized under the 2014 NCQA standards by DY3. Strategies to address this challenge will be incorporated in Project 2.a.ii.
Finally, resources are generally most available in high density population centers. While approximately 28% of the region's total population lives within these communities, almost 60% of the Medicaid population lives in more high density regions. The remaining individuals must travel long distances to access care, a situation exacerbated by the average annual snowfall of over 200 inches. To address this, the NCI will train, hire and resource care managers and CHWs to meet patients "where they are" through engagement, outreach and shared decision-making.

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.

The NCI PPS plans to coordinate and collaborate with the neighboring Adirondack Health Institute (AHI) and Central New York Care Collaborative (CNYCC) PPS's to create a cross-PPS partnership to best serve the shared patients within our overlapping service area. Specific to this project, the NCI will work together with AHI to develop a shared North Country campaign focused on prevention of respiratory disease, in particular COPD. The NCI will also share protocols, written training materials, and evidence-based strategies with AHI and CNYCC as they are identified or developed. With patient consent, we will securely share clinical information amongst providers regardless of which PPS they are participating with once the State Health Information System (SHINY) has this capability. Leveraging this technological infrastructure, we will work to ensure that providers in the PPS' can work efficiently and effectively across the integrated delivery systems to provide a seamless a transition by and between systems ensuring the best patient outcomes. The PPS intends to integrate best practice sharing into all communications with the neighboring PPS. Adopting a learning collaborative model will allow us to capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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 milestones for this project will include:
Identifying and engaging tobacco cessation programs by DY year 2nd Q 1
Developing systematic PC referral processes for tobacco cessation by 4th Q DY year 1

Eliminate out of pocket costs for cessation by 2nd Q DY Year 1 ongoing Developing a comprehensive community and patient engagement campaign respiratory by beginning of DY year 2 Developing systematic PC referral processes for colorectal cancer screening by 4th Q DY year 1 Incorporate prevention agenda goals into Hospital Community Service Plans by 3rd Q DY 1 ongoing Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement 2nd Q DY 2 - ongoing

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.

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

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