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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.

Our PPS region spans 4,800 square miles and includes urban centers, suburban bedroom communities and remote rural communities, and is home to 2.3 million residents and nearly 544,000 Medicaid beneficiaries. In many ways, it is a microcosm of the State's Medicaid population. As our CNA demonstrates, the region is home to an all-ages Medicaid population that has experienced marked growth over the past 10 years, especially among minority populations.

There are significant health care workforce shortages in our region, including primary care providers (PCPs) (in some areas the rate of active PCPs per 100,000 population is 90.8 compared to 120 in New York State (NYS)), psychiatrists (in some areas as low as 15.7 compared to 36 in NYS) and other professionals who care for vulnerable populations and the homeless. As a result, many Medicaid and uninsured patients in our region face significant challenges accessing primary, specialty, and other care, and the broader behavioral and social needs of many of these vulnerable residents go unmet. Access to community-based services varies widely by county and community. Limited access is due in large part to fragmentation in the health care system, which results in beneficiaries with unmanaged chronic health conditions, preventable readmissions following inpatient care, inappropriate utilization of high cost services, and under-treated behavioral health comorbidities.

Our CNA revealed specific geographic areas – zip code level "hot spots" - of chronic condition

prevalence region-wide that necessitate reducing fragmentation and integrating care. Geographically, areas of high need correlate with high levels of poverty, including Newburgh, Poughkeepsie, New Rochelle, Yonkers, and Kingston. Diabetes, congestive heart failure, coronary atherosclerosis, hypertension, asthma, chronic obstructive pulmonary disease, HIV, bipolar disorder, depression, schizophrenia, chronic alcohol abuse, and opioid abuse are all conditions that occur at increased rates.

To meet the need for a truly integrated delivery system (IDS), our PPS will build an organized, coordinated and collaborative network that links health care, behavioral health and social services in a community-based system that delivers accessible evidence-based, quality care in the right setting at the right time. Medicaid patients in our communities will be supported by providers with access to systems to manage and improve clinical outcomes and the health status of the population.

Eight elements will provide the foundation for the IDS: (1) robust data analytics, including ongoing hot spotting, outcome evaluation, and the integration of non-clinical data that address the broader determinants of health; (2) "supporting excellence," wherein evidence-based protocols are disseminated throughout the network, and adherence is tracked and facilitated through the use of rapid cycle evaluation mechanisms; (3) quality oversight and clinical governance, including standing committees, project-specific work groups and region-wide multi-PPS collaborations/councils; (4) achieving National Committee for Quality Assurance (NCQA) patient centered medical home (PCMH) Level 3 certification among eligible providers in the PPS; (5) creating medical neighborhoods comprised of diverse networks of medical, behavioral health, Health Homes, and community-based organizations; (6) linking appropriate care management to delivery of care; (7) developing value-based payment models and incentives; and (8) data sharing, leveraging health information exchange (HIE), shared care plans, and technologies that enable actionable information to providers and their patients.

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.

Our PPS includes the two largest providers of inpatient and emergency services for Medicaid patients in our region - Westchester Medical Center (WMC) and Good Samaritan Hospital of Suffern. WMC, an academic medical center, is the region's only public hospital, the only Level 1 Trauma provider between NYC and Albany, and has the highest patient acuity case mix in the country. Our PPS also includes inpatient psychiatric services with specialized units for children, adults, and behavioral health, and the region's largest practice association of behavioral health service providers as well as county Departments of Mental Health.

Many of our PPS Participants have begun care integration initiatives which we plan to build upon. Our PPS includes three Health Homes whose operations will be expanded through our Health Home At-Risk Intervention Program, enabling the expansion of best practices and key infrastructure and processes. Several of our participants have formed accountable care organizations (ACOs), participate in CMS Shared Savings Programs and have accordingly begun coordinating patient care across conditions, providers, and settings, shifting their models from fee-for-service (FFS) to value-based and risk bearing models. Several primary care practices and FQHCs in our network are Level 3 PCMHs; several participate in the CMS Comprehensive

Primary Care initiative, and virtually all of these organizations have launched initiatives to improve the quality of care for patients with chronic conditions. Others have implemented innovative approaches such as co-location to integrate primary and behavioral health care services.

Health information technology (IT), which is key to our IDS strategy, has been deployed to various degrees across the PPS. Many practices are advanced users of EHRs, whereas others are in the early stages of technology adoption. Data sharing through the local regional health information organization (RHIO) has been challenging, however the Taconic Health Information Network and Community (THINC) RHIO is currently joining with Southern Tier HealthLink (STHL) to create HealthLinkNY. This partnership will bring to bear robust technical and operational capabilities that we will leverage to connect PPS Participants to the RHIO and Statewide Health Information Network for New York (SHIN-NY), and foster technology adoption throughout the region. PPS Participants will be called upon to share data through Direct connections, or by accessing a RHIO-based provider portal.

Our IDS will use a Hub governance approach (described more fully below) to implement quality improvement efforts across the large number of attributed patients in our region. While strategy can be centrally determined, actual care delivery is ultimately local and smaller networks can be more nimble and sensitive to local needs, concerns, and cultures. Accordingly, PPS Participants will be enlisted to lead and staff several geographically-based Hubs, enabling stakeholders to represent and address an area's unique needs, mobilize providers, and build relationships that underpin medical neighborhoods and other IDS components.

We will also look beyond our current PPS network of over 275 community-based and provider organizations to engage new partners including medical equipment suppliers, local charities, and others. Workforce development, in partnership with local unions and professional associations, will be a priority as the IDS creates and modifies health care jobs and skills required over the course of the program.

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.

Connectivity to the RHIO will be complicated by various levels of readiness – technical and operational – among providers, and the rate at which the RHIO can establish connections. Interim solutions using Direct connections and provider portals will be facilitated, as will associated workflows. A robust plan to obtain patient consent to share data is as important as the technical connections themselves and a comprehensive plan to seek (and manage) patient consent will be implemented. Role-based access to patient data will be strictly managed and information shared only on a need to know basis.

Existing Health Home infrastructure is challenged by inadequate connections to medical care. Hospitals have built some care management capacity but it is not typically connected to either primary care or Health Homes. Among primary care practices, care management capacity is limited. Expanding and integrating appropriate care management support for patients will require linking these siloed resources. A plan for care management is detailed in Project 2.a.iii, "Health Home At-Risk Intervention Program."

Changing the health care payment model will require providers to look at their performance using cost and clinical outcomes data and many will need technical assistance to do so. Training and change management techniques will facilitate adjustment to a value-based model and engage clinical champions to anticipate and respond to frustration among providers whose services are newly evaluated for cost and quality. By tying financial incentives and aligning provider compensation to DSRIP milestones and clinical quality outcomes early in the project, our PPS will lay the groundwork for value-based contracting.

Integration of the health care delivery system will impact the workforce, as new jobs are created and staff retrained or redeployed. Our PPS, in partnership with local unions including 1199SEIU, New York State Nurses Association (NYSNA), and the Civil Service Employees Association (CSEA), is developing a strategy to address these changes as part of a dedicated workforce initiative; this strategy is detailed in the Workforce Section of our PPS' Organizational Application.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and New York State. The three PPSs in our region led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council that supports the development of a regional system of efficient and effective care, patient safety, and continuous quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project plans and implementation plans and make recommendations to align overlapping project approaches. Region-wide coordination, common requirements, and similar expectations will minimize providers' implementation burdens and create consistent, high quality experiences for patients. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating proven and promising clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and its payers.

Continuing the cooperation that resulted in the creation of a common Community Needs Assessment, the PPSs in our region have embraced cross-PPS collaboration throughout the selection, design, and development phases of their respective DSRIP projects. To date, the PPSs have committed to coordinate implementation in three critical areas: behavioral health crisis intervention and coordination with local County Departments of Health and Mental Health; protocols for patient consent and physician connectivity to HealthlinkNY (RHIO); and a tobacco cessation public health campaign.

2. System Transformation Vision and Governance (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.

IDSs should be easy for patients to navigate and include access to a quality-driven network of service providers as close to where patients reside as possible. Redesigning the safety net in our region to build a system of care that puts the patient at the center and ensures the patient receives the "right care at the right place at the right time" will require a paradigm shift. The end result of this framework will be a right-sizing of acute care beds and an increase in access to primary and behavioral health care and preventive services. We recognize that key to the creation of an IDS is paying special attention to patients with behavioral health needs. These individuals experience higher than average admission and emergency department (ED) visit rates, challenges adhering to complex psychoactive medication protocols, and an overall lack of connection to primary care. Our health service interventions will be tailored to take into account the special needs of behavioral health patients across all areas of DSRIP – delivery system transformation, chronic disease management, and preventive care.

Our IDS strategy is to create a diverse network of community partners committed to and accountable for key principles including: (1) timely access to appropriate medical, behavioral health and social services resources; (2) clear accountability and responsibility for patient care across care transitions, including the sharing of patient information; (3) optimization of patient self-care, through patient activation, engagement, education and peer supports; (4) data-driven quality improvement, including transparency, performance feedback, and accountability; (5) service utilization that is based on value and defined by cost and quality as measured by patient outcomes; and (6) a culture of supporting excellence.

The action plan to realize this strategy entails several concurrent areas of focus. One focus area is supporting our PPS network of providers to improve their processes. To ensure provider capability to operate in the IDS, we will: (1) actively engage and expand the network of quality-driven providers across the continuum of care who collaborate to deliver evidence-based care, improve quality and efficiency, and coordinate care; (2) identify metrics and set performance targets to achieve meaningful clinical practice improvement across the continuum of care; (3) advance technology-enabled performance improvement through the deployment of health IT tools including certified EHRs, registries, and clinical decision support; (4) ensure that PPS providers connect to HealthlinkNY RHIO by the end of DY 3 via certified EHRs, Direct connections, or a web-based provider portal; (5) ensure that eligible providers in the IDS achieve PCMH Level 3 accreditation (including adoption of Meaningful Use certified EHRs) by the end of DY 3; and (5) ensure the IDS develops tools and resources to help Medicaid beneficiaries play a more active role in managing their care.

A second focus area for the IDS is right-sizing acute care beds while building primary care and behavioral health capacity. These are addressed through the PPS's project 2.a.iv, "Create a

Medical Village Using Existing Hospital Infrastructure" wherein the PPS PAC Executive Committee will be responsible for overseeing the closure of 125 inpatient beds, the creation of six observation beds, the creation of a new health center, and the expansion of current outpatient services. For expanded use of behavioral health services, our PPA will implement Project 3.a.i, "Behavioral Health/Primary Care Integration," and we will physically integrate medical and behavioral health services at 22 sites.

A third area of focus for the IDS is to lay the ground work for value-based contracting. We have created a Sustainability Taskforce to partner with local Medicaid Managed Care Organization (MCO) stakeholders charged with identifying, testing, and evolving sustainability strategies for the PPS. The Taskforce may address such alternative payment arrangements as pay-for-reporting, pay-for-performance, shared savings, and capitation, and evaluate successful models within the region and nationally.

It may not be desirable or feasible for our PPS to pursue a single contracting strategy. Our governance will evolve and likely vary based on different geographies. We anticipate our PPS will support the evolution to value-based purchasing in four primary ways: (1) providing centralized services to advance the IDS' capabilities to manage population health; (2) creating a value-based contracting vehicle for the IDS; (3) providing the infrastructure to help other PPSs in the region develop value-based contracting platforms; and (4) providing the infrastructure to help ACOs and other provider-driven accountable care collaborations in the region enter into risk-based Medicaid contracts.

The fourth area of focus is the development of a centralized PPS organization responsible for the execution of the DSRIP initiatives and, ultimately, ensuring that the IDS that can successfully enter into value-based contracts. Our PPS has established a broad stakeholder governance model that centers on clinical governance, financial governance and IT governance to lay the foundation for value-based contracting. The Center for Regional Healthcare Innovation (CRHI) at WMC is the centralized services and project management organization for our PPS and is developing a capability to support practice transformation, to achieve DSRIP's technical and functional goals, to recruit and manage the network, and to collaborate with Medicaid MCOs in the region to test and advance payment reform strategies.

Milestones for these IDS efforts include: (1) the creation of a technology plan that supports data sharing, RHIO connections, analytics, relevant PCMH Level 3 metrics, Meaningful Use Stage 2 EHRs, shared care plans, and other enabling technology procurement(s); (2) integration of the Medical Village Project into our PPS' regional approach; (3) integration of PPS required quality and outcomes measures across the region; and (4) development of a strategy to support value-based contracting, including integrating information on cost and outcomes to determine value, incentive payments, upside and downside risk, and a campaign to educate providers about the value-based model.

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.).

Our PPS has established a strong and effective organizational and governance structure that will enable the PPS to evolve into an integrated and high-functioning provider network. WMC has made a significant investment to support the startup of our PPS through the establishment and staffing of CHRI which will provide clinical supervision services by hiring, contracting with and/or leasing clinical staff who will collaborate with care coordinators and health care professionals working with Participants throughout the PPS. CRHI will supply necessary IT services to support our PPS, providing or arranging for the provision of staffing necessary for the operation of the PPS, training Participant staff as necessary to support achievement of PPS goals, data analytics necessary to support PPS operations, and back office and administrative services necessary to ensure a high-functioning, high-performing DSRIP operation.

Our model allows for clear delineation of responsibilities and individual performance goals through detailed schedules and accountability for incentive payments and any supplemental payments for services rendered. It is a cooperative agreement as the IDS will be a learning system and both the centralized services organization and individual Participants will benefit from the flexibility and rapid course correction our Collaborative Contracting model affords. Relatedly, a central pillar of our PPS care transformation framework is to develop a learning organization. Our PPS will continually monitor performance and identify opportunities for improvement and transformation – including the effectiveness of our governance approach – regardless of DSRIP year. We adopted a Hub model precisely because it drives accountability to the point of care and fosters the development of true medical neighborhoods with local clinical leaders, serving the needs of our region's residents. Our Hub governance structure will be in regular communication with the PPS Executive Committee and vice versa. We will learn from our successes and failures and share best practices through both formal and informal information sharing platforms. Our financial model includes funds for training and peer-to-peer networking and education.

PPS governance is built around an inclusive, transparent committee structure that includes representation from a broad range of Participants. The structure features both centralized and localized governance, with the aim of maximizing Participant engagement, and balancing the need for centralized structure with the necessity of meeting local needs and areas of focus. The PPS will be organized into four Hubs, which will be comprised of Participants located within a defined geographic area.

Goals for DYs 1-3 will focus on providing oversight of DSRIP milestones, enforcing Participant obligations, evaluating/tracking PPS and Participant performance relative to established metrics, and developing the foundational capabilities and competencies for clinical and financial integration. The associated milestones include the creation and convening of approved formal committees, advisory committees, workgroups, and regional councils. These will be evidenced by: (1) charters and meeting minutes; (2) the formalization of the Hubs, including membership, board composition, operating plans and budgets, as well as meeting schedules and minutes; (3) the establishment of contracts between WMC, CRHI and PPS Participants, including payment and reimbursement terms, as well as business associate and data use and sharing agreements; (4) finalization of the IT and clinical governance structures; and (5) DSRIP implementation plans, specifying program and project-level activities and deliverables, and the roles and responsibilities of Participants.

We envision a transition to value-based contracting before DY5, based on our experience in DYs 1-3, with the goal of ensuring sustainable transformation. Our PPS recognizes its governance and

organizational structure will need to change as DSRIP objectives and goals evolve toward sustainability and value-based contracting. As our PPS evolves from program management to a true IDS with the supporting processes and infrastructure to measure quality and outcomes, a newly formed entity/entities will likely be established as a vehicle/vehicles for value-based contracting. In addition, our PPS plans to support local ACOs as well as other PPSs in the region to access the data and analytics capabilities necessary to successfully pursue alternative Medicaid contracting models.

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.

The WMC-led PPS will seek capital funds to develop a shared health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry/registries; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of Participant's EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and

coordination among our PPS partner organizations and will facilitate the development of an integrated and accountable care delivery structure. This capability will be shared across all 11 DSRIP projects.
To facilitate effective and efficient patient triage, specialty and community-based servies referrals, appointment tracking, and care management, our PPS will seek capital funding to establish a call center and expand space to train PPS staff.
Our PPS will also require capital funds to support: (1) the expansion of facilities for the co-location of behavioral health and primary care services, and (2) the renovation of inpatient facilities and the acquisition of additional capital equipment to accommodate expanded outpatient services that will be part of our two Medical Village projects.

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
Dominican Sisters Family Health Service, Inc.	Community-based Care Transitions Program	2013	2017	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Park Manor Acquisition II LLC dba Middletown Park Rehabilitation Center	Community-based Care Transitions Program	2012	2016	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
The Greater Hudson Valley Family Health Center, Inc.	Partnerships for Care HIV grant (CDC & HRSA)	9/1/14	8/31/15	The Partnerships for Care HIV grant supports the identification of undiagnosed HIV infection, establishes new access points for HIV care and treatment, and improves HIV outcomes along the continuum of care for people living with HIV (PLWH). The grant helps to support required staffing and equipment.
The Greater Hudson Valley Family Health Center, Inc.	Supplemental Funding for Expanded Services (HRSA)	9/1/14	8/31/15	Expanded Services Supplemental Funding supports increased access to preventive and primary health care services, including oral health, behavioral health, pharmacy, and/or vision services at existing Health Center Program grantee sites for underserved populations in the service area. Specifically, funding supports a pediatrician and internist staff and provides a Mobile Health Van for sheltered homeless patients.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Mental Health Association in Orange Co., Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Open Door Family Medical Center, Inc.	Hospital Medical Home Demonstration Program	2012	2014	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Park Manor Acquisition II LLC dba Middletown Park Rehabilitation Center	Hospital Medical Home Demonstration Program	2012	2016	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
The Institute for Family Health	Hospital Medical Home Demonstration Program	2012	2014	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Visiting Nurse Service of New York	Health Workforce Retraining Initiative	2014	2015	The Health Workforce Retraining Initiative supports organizations that train or retrain health care workers to obtain the necessary qualifications for new or changing positions. Funding supports the training of Population Care Coordinators and certified home health aides through the Partners in Care Program.
The Children's Village	Bridges 2 Health	2009	NA	Bridges 2 Health addresses the complex needs of children in foster care and their families, reducing the need for hospitalization and other out-of- home care. Funding supports in home services for foster children who have emotional problems, developmental disabilities or are medically fragile.
Cerebral Palsy of Westchester	OPWDD People First Waiver	2014	2019	New York's Developmental Disabilities Individual Support and Care Coordination Organization (DISCO) program provides enhanced care coordination to developmentally disabled Medicaid populations through qualified managed care plans.

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.

Our PPS will build upon current efforts ongoing in our region in pursuit of an integrated delivery system by expanding services offered by the entities listed above beyond those above currently targeted to limited patient groups to our PPS's larger Medicaid and attributed population. This project will not supplant or replace current funding, but rather will look to these providers as experts in providing care to underserved populations and leveraging the skill and experience these entities have garnered through their services to ensure our project is successful.

For example, The Community-based Care Transitions program targets Medicare patients. Our PPS will build on Participants' experiences and expertise to establish standard care transitions models across the region and expand the model to support Medicaid patients. The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, and will serve a larger group of Medicaid patients who are not currently eligible for Health Home services in New York State, specifically Medicaid beneficiaries who have a chronic condition requiring ongoing management, are at risk for deteriorating health status, and/or are likely to be hospitalized or use the emergency department (ED). Our PPS will work closely with Open Door, for example, to leverage the organization's expertise gained from this demonstration as we seek to expand care coordination, care teams and team communication, and smooth care transitions. This DSRIP project will expand these services to a much larger population, including to our Participant hospitals and many other Participant sites. Further, this funding is ending and therefore will not be supplanted or duplicated through DSRIP. This DSRIP project will work alongside the Bridges to Health program, but DSRIP funding will not be provided to Bridges to Health participating providers if doing so would supplant or duplicate other federal or State funding. DISCO service providers and enrollees are likely to participate in this project. This DSRIP project, however, is being implemented at the Participant/provider, not plan level, and is distinct from and will supplement DISCO services. In addition, this project will extend to all of our actively engaged population, not just those enrolled in DISCO plans.

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

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

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

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

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

government units (such as SPOAs and public health departments).

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

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

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

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

New York State (NYS) Health Homes currently provide critical care management services to Medicaid beneficiaries with multiple chronic conditions and complex medical and behavioral health needs. However, there are many other Medicaid beneficiaries who, while they do not meet NYS Health Home eligibility criteria, stand to benefit from care management services or may otherwise suffer from worsening and unattended health issues.

We analyzed a sample (n=119,212) of Medicaid managed care enrollees to estimate the population in our region who would be eligible for expanded Health Home services if services were expanded to beneficiaries with a single dominant chronic disease. Beneficiaries with this clinical status accounted for 28% of the sample population and 31% of total costs, representing a cost index of 1.1 (compared to 1.0 for entire population). These beneficiaries also experienced 94 hospital admissions annually per 1,000, and 327 ED visits annually per 1,000, compared overall population averages of 93 and 290, respectively. Within this population, 33% of inpatient stays were for behavioral health conditions compared to 24% for the population as a whole and several studies suggest behavioral health issues are markedly underdiagnosed as a comorbidity in patient with chronic diseases.

Geographically, we identified several hot spots of increased clinical risk including nine zip codes in communities (e.g. Kingston, Yonkers, Middletown) where close to 10% of the dual and non-dual Medicaid population had a behavioral health diagnosis in 2012.

To meet the needs of the described at-risk Medicaid population, we will develop new resources and adapt existing ones. Principally, our initiative will expand the current Health Home infrastructure to include the at-risk population, as well as work closely with primary care providers (PCPs) and behavioral health providers. We will create short-term care management services that emphasize patient activation, closing gaps in care, and mitigating risk factors for decreased health status, in an effort to avoid a patient's conversion to "full" Health Home status. Although the existing NYS Health Home program is not expanding per se as part of this initiative, the three Health Homes in our region will be called upon to expand their capacity to:

(a) provide care management services to a new population, the Health Home at-risk group, and

(b) develop a new set of short-term care management services supported by care teams that include medical, behavioral health, care managers, health educators, community health workers, and pharmacy professionals.

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

This project will target Medicaid patients attributed to our PPS who have one or more chronic diseases and who are not known to be enrolled in a NYS Health Home. Identified beneficiaries will also be assessed relative to their Area Deprivation Index (ADI), a well-accepted measure of neighborhood socioeconomic disadvantage, which links a patient's zip code to an index of the broader social and environmental risk factors and inform patient care decisions.

The Health Home at-risk initiative will be implemented through primary care and behavioral health providers in our region, starting with PCMHs affiliated with our PPS. Based on our CNA findings, we expect there will be concentrations of increased clinical risk in several areas with high levels of poverty. Our PPS will establish a registry to track identified eligible beneficiaries and notify PCPs and behavioral health providers to arrange for assessments of their at-risk patient population. After a beneficiary completes an initial assessment, a Health Home care coordinator will create a comprehensive care management plan to be shared with the patient and their provider(s).

The precise components of the comprehensive care management plan will be collaboratively developed by our PPS Quality Committee, but are expected to include: notation of patient strengths and personal goals, an assessment of patient activation such as the 13-question Patient Activation Measure (PAM), an estimate of social needs based on the ADI, need for medication reconciliation, and status of applicable quality metrics. The plans will also describe processes to address each identified beneficiary need, detailing the role of a beneficiary's PCP, behavioral health provider(s), Health Homes, local health departments (Local Government Unit/Single Point of Access), and others as needed. Patients with low activation scores on the PAM will be referred for tailored health coaching, and those with high ADI scores (i.e. patients who live in zip codes with an index above their resident county's mean index) will be referred to appropriate social services. Through this approach, our PPS will bring needed community-based and social service support into primary care practices leveraging Health Homes' existing networks and, ultimately, expand services to the target population.

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 existing NYS Health Home and PCMH infrastructure in our region provides a strong foundation to improve the connection between Health Homes and primary care practices and target Medicaid beneficiaries at risk for declining health status. Seventeen practice sites in our PPS, including FQHCs, are accredited NCQA PCMHs, and they will be co-developers of the Health Home At-Risk Intervention Program. This project will begin with PCMH recognized primary care practices and FQHCs located within or near hot spots, and then spread to include all primary care practices. These organizations, through their familiarity with patient-centered care, cultural competence and health literacy, rapid cycle evaluation, and other quality improvement work, are well-positioned to pilot the Health Home at-risk intervention program. Importantly, all three

Medicaid Health Homes in our region (Hudson Valley Care Coalition, Community Health Care Collaborative, and the Institute for Family Health) are part of our PPS network and are affiliated with PCMH-accredited FQHCs.

Our PPS will need to work closely with our provider partners to develop supportive workflows to enable practices to assess at-risk patients and refer them for short-term Health Home care management services. At the same time, our PPS will work closely with our region's Health Homes to increase their capacity to accept and manage this additional population. New communication protocols and procedures, data collection, and reporting capabilities will need to be developed and implemented. Existing PCMH-accredited primary care practices will be mobilized both to pilot the at-risk intervention program and serve as subject matter experts on outreach, care team formation and communication, and other elements of effective care coordination.

Health Homes in our region are currently able to share patients' care plans via a shared platform, called InsightPlus, which is used by over 40 local care management agencies and hundreds of individual users. InsightPlus is expected to establish import/export capabilities with our local RHIO, HealthlinkNY, in 2015. Our PPS will leverage HealthlinkNY's functionality – expanding it beyond Health Homes where feasible – to facilitate data sharing among providers for any population, including and with an initial focus on the Health Home at-risk population. This project will also build on existing health information technology (IT) and exchange (HIE) infrastructure to facilitate the sharing of care summaries and secure messages between PCPs, hospitals and other providers. By DY 3, all affiliated PCPs will meet PCMH Level 3 and Meaningful Use requirements and will be connected to HealthlinkNY and the SHIN-NY. Other Health Home care team members, including behavioral health providers and community-based organizations, will be called upon to connect to HealthlinkNY through their EHRs or via a provider portal. Direct connections will also be expanded to facilitate the communication of clinical information for specific patient care purposes.

A comprehensive care management plan for at-risk patients remains to be developed and will be a focus of the cross-PPS Regional Clinical Council. A comprehensive care management plan will be created for each patient to engage him/her in their care, promote self-management behaviors, and reduce identified social and environmental risk factors. The comprehensive care management plan will also serve to alert providers to their patients' strengths and personal goals and to key medical issues that may be overlooked, particularly for patients with severe or chronic behavioral health conditions.

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.

Successful identification, screening, and follow up for Health Home at-risk patients will require workflow changes for both Health Homes and providers. Even with additional resources, the logistics of a new workflow and increased focus on a target population can be challenging. Our PPS will utilize Plan-Do-Study-Act evaluation cycles to rapidly test alternative workflows and evaluate options for administering the PAM, ADI, and other assessments via tablets, computers, and other mobile technologies. In accordance with our imperative to develop culturally

appropriate tools and materials, our PPS will make available assessments in English and Spanish at the 3rd grade reading level.

While InsightPlus provides significant functionality for sharing care plans among care team members and tracking members enrolled in Health Homes, its functionality will need to be customized for the Health Home at-risk population, whose care management requirements will vary from that of Health Home patients. Technology development cycles can be lengthy; it could take several months for new functionality to be tested and made widely available. However, we are actively creating functional requirements as part of the program development process and expect the vendor to begin development concurrent with our workflow, training, and other implementation efforts. The new functionality will be tested and refined before a system-wide rollout.

The identification of patients and their providers must rely on valid data and data insufficiencies/quality will be a barrier to implementation. Using disparate data sources and complex algorithms to find at-risk patients will be challenging, especially as available information may be incomplete or out of date. We recognize that refining our PPS's population-level analyses will be iterative and that accuracy will improve over time as we bring more EHR data online and refine logic based on feedback from outreach efforts. In the interim, we will work closely with NYS, Health Homes, PCPs and behavioral health providers to use available data sources and collaboratively define assumptions to inform Health Home and provider workflow and interactions with patients.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and state. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council that supports the development of a regional system of efficient and effective care, patient safety, and continuous quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping project approaches. Region-wide coordination, common requirements, and similar expectations will minimize providers' implementation burdens and create consistent, high quality experiences for patients. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating proven and promising clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and its payers.

Continuing the cooperation that resulted in the creation of a common Community Needs Assessment, the PPSs in our region have embraced cross-PPS collaboration throughout the selection, design, and development phases of their respective DSRIP projects. To date, the PPSs have committed to coordinate implementation in three critical areas: behavioral health crisis intervention and coordination with local county departments of health and mental health;

protocols for patient consent and physician connectivity to HealthlinkNY (RHIO); and a tobacco cessation public health campaign.

This project requires a significant degree of coordination. All three area Health Homes are participating in all the region's PPS, and several FQHC PCMH and behavioral providers are participating in more than one PPS with similar projects. We do not anticipate that all PPSs will design and implement the project in the same manner, but the Regional Clinical Council will provide a forum for vetting implementation issues of concern with all providers participating with more than one PPS.

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 order to contact and engage a target population beyond the Health Home program's current patient base, capital funds are needed to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations. This capability will be shared across all 11 DSRIP projects and is central to our IDS development.

Capital funding will also be needed for the acquisition of new hardware, including tablets and computers that facilitate administering the PAM survey tool in providers' waiting rooms.

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
Cedar Manor Nursing & Rehabilitation Center	Health Homes for Medicaid Enrollees and Chronic Conditions	2015	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Family of Woodstock, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	2014	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mental Health Association in Orange Co., Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Hudson River Healthcare	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Ulster-Greene ARC	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Westchester Jewish Community Services (WJCS)	Health Homes for Medicaid Enrollees and Chronic Conditions	2014	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Dominican Sisters Family Health Service, Inc.	Community-based Care Transitions Program	2013	2017	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

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.

Our PPS's Health Home at Risk Intervention project will focus on individuals how are not currently eligible for Health Homes to connect them with needed care and community support services. The experience and capacity of our participating Health Homes and downstream care management agencies is a strong foundation for many of our DSRIP projects, and especially this one. This project will build on this work, but will serve a larger group of Medicaid patients, particularly those who are not currently eligible for Health Home services, and specifically Medicaid beneficiaries who have a chronic condition requiring ongoing management, are at risk for deteriorating health status, and/or are likely to be hospitalized or use the emergency department (ED). The proposed project will develop comprehensive care plans for eligible patients and connect patients to necessary referrals and resources. The Community based Care Transitions program targets Medicare patients. Our PPS will build on Participants' experiences and expertise to establish a health home at-risk program for Medicaid patients. The proposed project will develop comprehensive care plans for eligible patients and connect patients to necessary referrals and resources, but will be focusing on a different population.

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

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

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

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

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. 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.

In order to create more effective and efficient care models, Bon Secours Community Hospital (BSCH) in Orange County and HealthAlliance Hospitals in Ulster County will create Medical Villages that consolidate and reconfigure in-patient infrastructure to enhance primary and ambulatory care service capacity. Both BSCH's and HealthAlliance's transformations are supported by data on inpatient occupancy rates and Prevention Quality Indicators (PQI) that suggest an increased need for ambulatory services that provide the right care at the right time and place.

Despite significant progress on restructuring our region's inpatient infrastructure, excess bed capacity remains. Recent studies show a 62% hospital licensed bed occupancy rate for the region, which is below the New York average of 65.3%. The region also has a higher rate of hospital beds per 100,000 people than the State average (297 versus 289 beds). With respect to access to ambulatory care, 78.3% of the population in Orange and 79.6% in Ulster have a regular healthcare provider, rates that are lower than the State average.

In western Orange County, the current healthcare delivery system is acute-care centric. At BSCH, occupancy is 47% on its 55 staffed beds. As a safety-net hospital, BSCH is grappling with sustaining service provision to the large number of medically underserved in a service area that is rural, geographically remote, and has a population-wide burden of ambulatory-sensitive and chronic conditions. In Port Jervis, overall PQIs are 134%; acute conditions are 117% with pneumonia at 131% and dehydration at 203%; and respiratory is 216% with COPD at 362%.

To provide timely, effective, and comprehensive care, BSCH's Port Jervis Medical Village strategy is threefold: (1) reduce staffed beds by 25 (from 55 beds to 30) over 5 years, (2) create a six bed observation unit, and (3) develop two primary care centers, including an FQHC and a primary care/urgent care office. In addition to the FQHC partnership, BSCH will recruit primary care physicians and work to certify practices to NCQA PCMH Level 3 accreditation.

In Ulster County, HealthAlliance is a safety-net provider for an at-risk population who depend upon essential services such as obstetrics (OB), substance abuse, and psychiatry: 70% of HealthAlliance's OB admissions are Medicaid beneficiaries from the city of Kingston, and HealthAlliance represents nearly 80% market share of substance abuse and psychiatry services. Kingston also represents a "hotspot" with respect to ambulatory sensitive conditions: in 2012, overall PQIs were 133%. Acute conditions were 140% with pneumonia at 148% and dehydration at 146%; respiratory was 151% with COPD at 157%.

In recent years, HealthAlliance has seen consistent decline in patient volumes. From 2007 to 2012, discharges decreased by 10%, patient days by 21%, ED visits by 7%, and surgeries by 27%. Volume and occupancy rates have steadily decreased, and HealthAlliance now operates at close to 60% occupancy for 300 beds across its Mary's Avenue and Broadway campuses. Based on declining volumes and a shifting emphasis to primary and preventive care, HealthAlliance has

developed a plan to consolidate services into a single facility (the Mary's Avenue campus), reduce licensed beds from 300 to 200, and use the vacated facility (the Broadway campus) to create a Medical Village. Redevelopment plans for the Broadway Campus (which include the Institute for Family Health, an FQHC), will expand primary care, behavioral health, and crisis stabilization services. HealthAlliance will explore relocation of the outpatient behavioral health services into the Medical Village, educational and workforce redevelopment opportunities including simulation laboratories and seminar space, and development of population health and care coordination resources.

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

Our PPS will target attributed patients who utilize services offered at the BSCH and HealthAlliance Medical Village sites. As noted below, BSCH and HealthAlliance serve different geographic regions and have differing strategies for the development of their Medical Villages.

Located in western Orange County, BSCH's Port Jervis "hot spot" patient population is 14,600. Five percent of the Port Jervis population are foreign born, of which 88% entered the US before 2010. Of those less than 5 years old, 10% spoke a language other than English at home. Of those speaking a language other than English at home, 48% spoke Spanish and 52% spoke some other language; 21% reported that they did not speak English "very well." Among the civilian, non-institutionalized population, 12% had no insurance. Fourteen percent of the population is estimated to be in poverty, with 19% of children and 11% of people over 65 years old below the poverty level. Among the non-institutionalized population, 17% reported a disability. BSCH's Medicaid unduplicated member count is 4,133 for acute care and 482 for behavioral health. Based on the patient population characteristics, BSCH's Medical Village will focus on the following conditions: (1) all chronic conditions with emphasis on respiratory and diabetes; (2) heart disease; (3) mental and behavioral health; and (4) cancer.

Located in Ulster County, HealthAlliance serves the Kingston community, which has a population of 35,000. Nine percent of Kingston population are foreign born, of which 98% entered the US before 2010. Of those less than 5 years old, 57% speak Spanish, 34% speak other European languages, and 7% speak Asian languages. Among the civilian, non-institutionalized population, 12% had no insurance. Fifteen percent of the population is estimated to be in poverty, with 24% of children and 8% of people over 65 years old below the poverty level. Among the non-institutionalized population, 17% reported a disability. Based on the patient population characteristics and disease prevalence in the Kingston "hot spot," HealthAlliance's Medical Village will focus on the following conditions: (1) diabetes; (2) cardiac conditions; (3) respiratory conditions; and mental and behavioral health.

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.

In alignment with our PPS's Medical Village project, BSCH and HealthAlliance will consolidate and convert inpatient capacity into space for primary care and preventive services.

Based on a comprehensive planning process involving 217 stakeholder interactions, BSCH proposes to realign its certified bed capacity to reflect historical utilization and anticipated reductions in unnecessary admissions due to enhanced access to and usage of primary care services. BSCH will reduce 25 staffed beds and will decertify 36 licensed beds, including six intensive care unit beds and 30 medical/surgical beds.

BSCH will create a six-bed observation unit to provide post-stabilization for short-term treatments, assessment, and a determination concerning admission, discharge or transfer that can reasonably be expected within 48 hours. BSCH will develop a FQHC partnership and develop a walk-in urgent/primary care center to provide timely, comprehensive care for non-emergent and primary care services including peer-supported wellness and education space and co-location of space for services agencies.

BSCH has developed a comprehensive Community Asset Map identifying resources that will be provided in the Medical Village for various services (e.g., smoking cessation, diabetes and nutrition education, local pharmacy, FQHC, home visit programs, a fitness center). BSCH will develop an evidence-based care coordination/transitional care program that links patients with community-based primary care providers, improves patient competence and confidence in self-management of health conditions, enhances provider-to-provider communication, and provides supportive assistance to transition individuals to the least restrictive environment for care. BSCH will also recruit additional primary care physicians.

HealthAlliance has held frequent community meetings to discuss the provision of a high quality, more accessible, lower cost, financially sustainable care delivery system. In September 2011, HealthAlliance announced its intent to move clinical care from its Broadway campus into its Mary's Avenue campus, continuing to provide all behavioral health and other essential services to the community. To advance its planning efforts, HealthAlliance held numerous public information sessions, engaged a design-build firm to quantify projected expenses, and hired Gordian-Dynamis Solutions for consulting guidance. To date, HealthAlliance has determined the appropriate mix of patient services to meet anticipated demand for primary and ambulatory care. Because HealthAlliance is currently reviewing proposals from parties interested in the proposed Medical Village location, specific details are still evolving. Potential options under consideration include expansion of primary care and behavioral health services, colocation with a FQHC, the addition of crisis stabilization services, the creation of simulation labs and seminar space for educational and workforce redevelopment programs with local colleges, and the development of a population health, care coordination infrastructure to be used by the DSRIP PPS and HealthAlliance Physician Network. With respect to PCMH in HealthAlliance's Medical Village, the Institute for Family Health has achieved Level 3 2011 PCMH recognition and will submit to meet 2014 standards in 2015. The majority of the Institute's providers have already met or are prepared to meet Meaningful Use.

Across both HealthAlliance's and BSCH's Medical Villages, we will provide central services to assist participating safety net providers meet PCMH certification, meaningfully use EHRs, and share information with the local RHIO, HealthlinkNY. We have begun discussion with

HealthlinkNY to expand connectivity to and utilization of its automated admissions, discharge, and transfer alert functionality. We will also establish an analytics platform to incorporate data from EHRs to track patients and support program measurement and evaluation.

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.

Both BSCH and HealthAlliance face conversion costs and funding challenges, potential disruptions in care delivery during the transition period, and workforce training and redeployment considerations.

To contain costs, BSCH will contract locally for the following: ED contracts for urgent care; contracts for outpatient psychiatric services; and rehabilitation, laboratory, radiology and surgical contracts for outpatient services. In exchange for space, local organizations will provide specific services including smoking cessation and diabetes education, a local pharmacy, nutrition program, and fitness programs.

To fund infrastructure development, BSCH and HealthAlliance will apply for the Capital Restructuring Financing Program, new market tax credits, foundation funding for capital and VAP funding for operating losses. Both Medical Villages will also attempt to offset losses through expansion of outpatient services—including laboratory, diagnostic radiology, and ambulatory surgery.

Medical Village development requires facility changes, closures, and creation of new services that shift patterns of care. ED patients, out of habit, may arrive at the wrong campus location. To mitigate potential disruptions in care delivery, BSCH and HealthAlliance are conducting comprehensive community engagement and planning to identify needs, assets, health behavior and utilization patterns and perceptions. BSCH and HealthAlliance will continue efforts to increase awareness of and promote access to the new services. Dedicated outreach programs will focus on identified health needs of the community and include comprehensive marketing and communication efforts.

Rebalancing health delivery to focus on primary and ambulatory care will result in staffing growth in certain job categories (e.g., outpatient, care management, community health workers) and staffing reductions in some inpatient units. Our PPS is committed to retaining/retraining/redeploying impacted staff to meet the skill-mix required to maintain employment or gain skills for new positions. This includes working with our labor organizations to access retraining resources for both new positions and for at-risk workers. To aid the development of an effective workforce strategy, BSCH and HealthAlliance will create a detailed timeline documenting the specifics of bed reduction and rationale.

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.

Under DSRIP, patients may receive care from any provider, some participating in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and State. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council to support development of a regional system of efficient and effective care, patient safety, and quality improvement.

The Council will review DSRIP project and implementation plans and make recommendations to align overlapping approaches. Region-wide coordination, requirements, and expectations will minimize providers' implementation burdens and create consistent, high quality patient experiences. The Council will identify region-wide care improvement goals and serve as a forum to share and evaluate clinical strategies and practices.

Continuing the cooperation that resulted in the creation of a one region-wide CNA, the PPSs in our region have embraced collaboration throughout the selection, design, and development phases of their respective DSRIP projects. To address potential barriers or disruptions due to market overlaps or consolidation, BSCH will hold reoccurring meetings with representatives from the Refuah-led PPS to coordinate regional implementation, share and spread successful innovations, maximize synergies, and collaboratively problem-solve. In Ulster and Dutchess Counties, the RCC will hold reoccurring meetings with representatives from the Montefiore-led PPS to develop coordinated efforts to address any potential disruptions in services due to consolidation.

Question 1f below states "Please indicate the total number of staffed hospital beds this project intends to reduce." Our PPS Number of Beds Committed for Reduction is: 125 beds. (There is an error in the application tool that prevents us from entering data in the table below and we have been directed by DOH and KPMG to answer question 1f at the end of our entry for question 1e).

a. 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.

Our two Medical Villages will require capital funds to consolidate and reconfigure in-patient infrastructure to enhance primary and ambulatory care service capacity.

BSCH needs capital funding to create a six-bed observation unit and to convert space and acquire new equipment to support two primary care centers (a FQHC and a primary care/urgent care office).

HealthAlliance needs capital funding to execute its construction and renovation plans for consolidation of inpatient hospital services into a single facility (on the Mary's Avenue campus) and then the conversion of the Broadway campus into a Medical Village for outpatient services. Redevelopment plans for the Broadway Campus include expansion of primary care and behavioral health and crisis stabilization services, as well as the acquisition of new equipment for such uses as redeveloping existing facilities into simulation laboratories and seminar space.

The Westchester-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations. This capability will be shared across all 11 DSRIP projects and is central to our IDS development.

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. <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, 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.

In our broader region, overall rates of adult and child hospital admissions that might have been avoided with appropriate ambulatory care were better than the NYS average (2011-2012). However, there were significant "hot spots" that indicate opportunities for improvement. Ulster, Orange and Dutchess counties had higher than average rates of avoidable hospital admissions for adult respiratory disease; rates were above average for hypertension in Orange County and for diabetes in Ulster and Westchester counties.

Congruent with our hot spot analysis, patients discharged from some hospitals within our PPS demonstrated a higher rate of Potentially Preventable Readmissions (PPRs) than was reported statewide in 2012, including some of the highest and lowest risk adjusted PPR rates in NYS: Blythedale Children's Hospital, 32.39; Ellenville Regional Hospital, 18.3; WMC, 6.98; Northern Westchester Hospital, 4.48; Northern Dutchess Hospital, 1.09.

In addition to geographic and socioeconomic disparities, research conducted as part of our CNA indicated patient with certain diagnoses or co-morbidities were more likely to experience potentially preventable admissions or readmissions. Medicaid beneficiaries with behavioral health (BH) diagnoses (e.g. mental health, substance abuse) experience PPRs over 3.5 times more frequently than beneficiaries without BH diagnoses. The rate for follow up after hospitalization for mental illness within 7 days and within 30 days is lower compared to overall regional and statewide rates. In Rockland, rates are 28.9% and 41% respectively compared to 38.5 and 54.4 for NYS; rates are also lower for 7 day follow up in Orange and Dutchess.

Our CNA convened meetings and conducted interviews with partners involved in care coordination and reducing admissions. Identified gaps to best practice care transitions included inconsistent discharge protocols and processes; the lack of coordinated medication reconciliation, information technology, and care plan exchange constraints; and shortages in community based resources.

To achieve the ambitious statewide DSRIP goal of reducing avoidable admissions across the Medicaid population by 25%, it will be necessary to not only reduce variation by addressing outlier performance, but to broadly reduce all avoidable admissions, including readmissions and ambulatory sensitive admissions to best-in-class levels. To advance this goal, our PPS will convene a Quality Committee to compare and standardize discharge transition protocols among participating hospitals and primary care organizations. We will involve MCOs, Health Homes, and participating home care agencies to ensure protocols are feasible and will bring early implementation results back to the committee so protocols can be adjusted based on what works. Our PPS will establish an analytics platform to incorporate data from participating partner EHRs to track patients and to support evaluation. Our project will specifically address factors that may contribute to excess hospitalization of patients with severe or chronic BH conditions who often lack connection with a primary care professional (PCP) and will assess engagement with PCPs as a component of discharge planning and ensure participating hospitals send complete and timely care transition records to PCPs and other outpatient providers. After discharge, patient confusion about medications is a frequent cause of medical error. Our project will have a strong component of pharmacist assisted Medication Reconciliation, which may be particularly needed for patients whose BH medications may impact their physical health. To support all of these efforts, we will enhance and/or develop four region-wide capabilities, discussed in greater detail below: (1) care coordination and analytics platforms,
(2) risk stratification tools, (3) a centralized inventory of social service organizations, and (4) health information exchange capabilities.

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

The target population for this project will be attributed patients discharged from hospitals in our PPS who receive ambulatory care from affiliated PCPs. The project will focus on adult patients with discharge diagnoses related to diabetes, heart or respiratory disease, or a mental and/or behavioral health disorder. To be sustainable, an intervention at transition of care must tailor the intensity of the intervention to the patient risk of readmission. One of the first tasks of the project will be to review and compare risk stratification tools and to reach consensus with project partners.

Our CNA process identified the importance of discharge disposition (particularly to rehabilitation, home, or home with home care services), assessing patient engagement using the Patient Activation Measure (PAM) or similar instrument, and assessing the social determinants of health when evaluating risk for readmission. We will use the Area Deprivation Index (ADI), a well-accepted measure of neighborhood socioeconomic disadvantage. The ADI is a factor-based index that uses 17 U.S. census poverty, education, housing, and employment indicators and has been linked to hospitalizations and readmission rates. We will be able to link our patients' zip codes to an index which will provide our PPS with a snapshot of the broader risk factors challenging our beneficiaries and inform patient care decisions.

Those identified at increased risk of readmission will receive the care coordination appropriate to their level of risk and post-discharge setting. A 30-day transition period will be defined with appropriately scaled intensity of follow-up established for all discharged patients. Those at highest risk will receive a home visit. Others may be followed by phone or attendance at scheduled appointments will be monitored. Particular attention will be paid to connecting eligible patients with Health Home services and with advanced primary care offered by our PCMHs. We recognize that to impact PPRs, patients with behavioral health needs will be of particular concern. Our project will ensure that admission, discharge, and care transition protocols reflect the needs of this special population and will be coordinated with our work to integrate BH and primary care services in our project 3.a.i and the establishment of BH crisis intervention supports in our project 3.a.ii.

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.

Across the region, our PPS Participants deploy a range of post-discharge strategies, processes , and tools. WMC developed a sophisticated algorithm to predict readmission risk from information available to the hospital at the time of discharge. St. Luke's Cornwall Hospital implemented the Coleman model to follow patients post discharge and rolled out its effective "Taking it to the Streets" discharge program. Bon Secours Community Hospital and WMC participated in Project Red, a national project to reduce admissions. They found a successful

transition care plan rests on the ability of the ambulatory care team to manage the patient in the community. HealthAlliance addressed patient hand–offs to ambulatory providers in their Ulster County Care Transition Coalition that includes their community partners.

Among outpatient providers, initiatives are underway to notify PCPs of ED visits, admissions, and/or discharges. Crystal Run Healthcare (CRHC), a large multi-specialty group partner, has established a post-discharge home visiting program. Discharged patients at higher risk of readmission receive a home visit from a CRHC Nurse Practitioner (NP) within two days of discharge. In 41% of cases, the NP has intervened to make some an adjustment to treatment. As a result of this program, CRHC readmission rates have decreased from 20% to 12%.

Home care agency partner Dominican Sisters won a CMMI innovation award to test the effectiveness of home visits in preventing readmissions in another region of NYS and will bring the benefit of their learnings to our PPS.

Enhancing these assets, our PPS will utilize an analytics platform to enable identification and tracking of beneficiaries in the project and evaluation of process and outcome measures. We are currently evaluating systems that draw data from multiple source including hospitals, community based providers, ancillary providers, state immunization registry and other databases. We will also expand care management capacity, particularly linked to primary care. Whereas care management has often been located in hospitals and behavioral health agencies, we believe that primary care providers' ability to manage and coordinate care is critical to successfully preventing readmissions. The protocols, training, and tools needed to achieve will be developed as part of this project.

Our PPS includes the regions three Health Homes. Health Home care teams are currently able to share care plans via a common care coordination management platform, InsightPlus, which is used by over 40 agencies and hundreds of individual users. InsightPlus is expected to establish connectivity capabilities with HealthlinkNY in 2015, which we will leverage to share care plans among providers who coordinate post discharge care.

In order to calibrate the intensity of the post-discharge intervention appropriately, we will deploy a risk stratification tool. As noted above, several risk stratification tools are currently in use, and we will work with our PPS Quality Committee to determine standard elements, methodologies, and weights and support broader adoption.

Our PPS formation process has also resulted in the creation of a robust network of over 275 community-based organizations in a WMC Community Resource Database, which serve a wide spectrum of social service needs. To facilitate referrals to and connections with vital community-based assets that are critical in minimizing readmissions, we will enable this database to be patient facing, linking it to a searchable tool that can assist patients and families to locate needed services.

While the Hudson Valley's Regional Health Information Organization, HealthlinkNY, can provide automated admission, discharge, and transfer (ADT) alerts to providers and care teams, the functionality is not widespread. We have begun discussion with HealthlinkNY on strategies to expand connectivity to and utilization of its automated ADT alert functionality.

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.

One project objective is to have a transition care manager visit the patient in the hospital prior to discharge. It is desirable to involve members of the care team from the ambulatory side prior to discharge, and we will implement when feasible. However, this requirement underscores the complexity of expanding care management. Care managers may be affiliated with MCOs, Health Homes, hospitals, or primary care. Coordinating the coordinators will be a challenge. NYS has invested heavily in Health Homes precisely to address this need, however, most Health Home care managers are currently affiliated with BH care and have only tenuous relations with primary or other clinical care providers. Few Health Home care managers have nursing or medical backgrounds and may not be qualified to evaluate deteriorating medical conditions post-discharge. While it is desirable to have a single, consistent care manager working with a patient, it will be necessary at times to have a hospital-based RN care manager or primary care affiliated care navigator work in tandem with their Health Home colleagues until a transition is complete.

A second challenge is access to timely data. Our PPS needs data from many sources, and providers must be able to participate in health information exchange to support sharing of transitional care plans, to perform medication reconciliation, and to link patients with community services. As discussed above, our approach is two-folded: we will foster connections to the community-level record through HealthlinkNY and encourage data sharing between providers through IT and standard policies.

A final challenge relates to scale. The goal of achieving a significant reduction in avoidable admissions across the Medicaid population will require that the project include patients who receive care from hospitals and/or PCPs not affiliated with the PPS. This will be accomplished through cross-PPS collaboration and alignment.

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.

Under DSRIP, patients may receive care from any provider, some participating in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and State. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council to support development of a regional system of efficient and effective care, patient safety, and quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping approaches. Region-wide coordination, requirements, and expectations will minimize providers' implementation burdens and create consistent, high quality patient experiences. The Council will identify region-wide care improvement goals and serve as a forum to share and evaluate clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and payers.

Continuing the cooperation that resulted in the creation of a common CNA, the PPSs in our region have embraced collaboration throughout the selection, design, and development phases

of their respective DSRIP projects. While the other PPSs in our region may not have expressly selected project 2.b.iv, common protocols and shared best practices for transitions in care will be a critical foundational component of many DSRIP projects. Our PPS Quality Committee and associated workgroups focused on the 30-day readmission reduction project will communicate the standardized discharge transition protocols to the other PPS via the Council to inform their own policies and procedures as appropriate.

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.

1. **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.

The WMC-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE

capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations and will enable providers and patients to improve post-discharge activities. The capability will be shared across all 11 DSRIP projects.

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
Cedar Manor Nursing & Rehabilitation Center	Community-based Care Transitions Program	2013	2014	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
Dominican Sisters Health Service, Inc.	Community-based Care Transitions Program	2013	2017	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
The Greater Hudson Valley Family Health, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Open Door Family Medical Center, Inc.	Hospital Medical Home Demonstration Program	2012	2014	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Park Manor Acquisition II LLC dba Middletown Park Rehabilitation Center	Hospital Medical Home Demonstration Program	2012	2016	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
The Institute for Family Health	Hospital Medical Home Demonstration Program	2012	2014	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Visiting Nurse Service of New York	Health Workforce Retraining Initiative	2014	2015	The Health Workforce Retraining Initiative supports organizations that train or retrain health care workers to obtain the necessary qualifications for new or changing positions. Funding supports the training of Population Care Coordinators and certified home health aides through the Partners in Care Program.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
United Hebrew Geriatric Center	Institutional Special Needs Plans Program	2014	ongoing	Institutional Special Needs Plans assess early change in the health status of Medicare beneficiaries to avoid unnecessary hospitalization.

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

The work of the Participants listed above closely aligns with the project our PPS plans to implement to decrease hospital readmissions.

We plan to build on what is existing in our area to expand the scope and reach a larger population. For example, The Community based Care Transitions program targets Medicare patients. Our PPS will build on the Participants' experience and expertise of these Participants to establish a customized standard care transitions models across the region and expand the model to support Medicaid patients. Our PPS will also work closely with Open Door to leverage the organization's expertise gained from this demonstration as we seek to expand care coordination, care teams and care team communication, and smooth care transitions. This DSRIP project will expand these services to a much larger population, including to our Participant hospitals and many other Participant sites. Further, this funding is ending and therefore will not be supplanted or duplicated through DSRIP.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects and the experience Health Homes hold in care management will help inform this project. However this project will not replace this but rather build on this work, and serve a larger group of Medicaid patients, including those who are not currently eligible for Health Home services, expanding the reach of the care management knowledge, techniques and experiences to populations not served by Health Homes.

ISNP are useful tools in addressing unnecessary hospitalization among Medicare beneficiaries. This DSRIP project, however, is being implemented at the Participant/provider, not plan level, and is distinct from and will supplement INSP services. And, as noted above, this project will extend to all of our actively engaged population, not just those enrolled in ISNPs.

4. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

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

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

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

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

preventive services) and patient education.

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

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

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

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

Our Patient Activation Project will address the need to engage and activate the uninsured (UI) and Low Utilizing (LU) and Non-Utilizing (NU) Medicaid populations and increase access to and effective utilization of healthcare resources. Though the rate of uninsured in the broader region (11.7%) is lower relative to the State (12.6%), rates vary significantly by county from 9.4% in Putnam County to 13.9% in Sullivan County.

The distribution of uninsured varies by race and age. In Sullivan for example, approximately 13% of White and 13% of Black residents lack some form of health insurance. Within the 18-24 year-old population roughly 38% of White and 32% of Black young adults are uninsured. Among individuals of Hispanic/Latino origins the percentage of uninsured is much higher, 42.5% overall. There is also a significant increase within this group once an individual turns 18 years old, with 9.1% uninsured between the ages of 6-17 and that rises to a 87.3% uninsured within the 18-24 year age group.

As part of our CNA, we distributed a consumer survey and received 4,777 responses. Among the Medicaid and uninsured respondents, who represented 31% and 10% respectively of our respondents, Medicaid beneficiaries were almost twice as likely and uninsured individuals were 1.2 times as likely to have been to the ED in the past 12 months for care compared to commercially insured respondents. Among reasons indicated for the visit, almost 13% of uninsured respondents indicated that there was "no other place to go."

Among those surveyed, areas of lowest utilization of key prevention services were found in Orange County, where 83.1% of adults had a regular health care provider, and 86.7% of adults

have had a routine check-up in the past two years.

With respect to knowledge and utilization of the health system, focus groups of Medicaid, uninsured and insured consumers revealed that most patients do not have a case worker, social worker, or advocate helping them navigate the system. Participants indicated that an accessible, understandable, and centralized resource was not available, or if there was one, none of the participants were aware of it.

To improve patient activation, our PPS will hire field managers for each of four geographic Hubs in our region: Westchester/Putnam, Dutchess/eastern Ulster, western Ulster/Sullivan/Delaware, and Rockland/Orange. We will recruit candidates with demonstrated bilingual and cultural competence skills and experience working with local community-based organizations (CBOs). Field managers will comprise a PPS-wide training team to provide ongoing oversight and supervision to the local CBOs around project objectives and deliverables. Field managers will oversee recruitment and training of community navigators. CBOs will be selected for participation based on location near or within "hot spots" where UI/NU/LU populations seek services.

To ensure that community members access a system that has "no wrong door," we will create a virtual "Outreach Cooperative" within each Hub that provides: training to existing community outreach workers on patient activation using the 13 question Patient Activation Measure (PAM), shared decision making, health literacy, and cultural competency.

Community members will be able to receive patient activation coaching; learn about appropriate use of healthcare services and affordable community healthcare options; receive assistance making appointments for primary, behavioral health and dental care; and be connected with their health plan and PCP if they have one, or referred to a Marketplace Facilitated Enroller for help with insurance options.

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.

Our PPS will focus on the UI, LU and NU Medicaid populations and work to engage and activate individuals to utilize primary and preventive care services. To improve patient activation, we will pursue a two pronged strategy: (1) leverage the resources of organizations that work with LU and NU Medicaid members and the UI, and (2) develop a core capability to coordinate, train, and conduct patient activation activities across the region.

To better understand where community challenges are most prevalent, we utilized hot spotting techniques developed by Dr. Brenner of the Camden Coalition. We identified "hot spots" zip codes with higher disease prevalence and/or under representation on key prevention measures. We identified the top 9 high-density zip codes in our region: Mt. Vernon (10550), Yonkers (10701 and 10705), Kingston (12401), Newburgh (12550), Middletown (10940), Poughkeepsie (12601), New Rochelle (10801), and Spring Valley (10977). Survey respondents from the hot spot zip codes represent 25% of our consumer survey respondents. Respondents in hot spots

were more likely to have visited the ED in the past year for care due to access issues. These communities also present with higher rates of asthma and smoking and lower rates of cancer screenings. We will target the patient population within the identified hot spots and recruit CBOs within each area.

In our region, the LU, NU and UI currently engage the health system at multiple points, including FQHCs, EDs, Medicaid MCOs, and organizations that facilitate insurance enrollment. FQHC staff will be trained on use of the PAM. Our PPS will work with FQHCs to ensure patients screened with PAM are entered into the PPS registry to track the PAM scores at baseline and for each year's cohort of patients per the method to be established by NY State. As providers of primary care services, FQHCs will be well positioned to deliver patient activation coaching to patients who initially screen low with a goal of identifying and closing gaps in care and moving the patient to a higher level of activation. We will also work with our 14 hospitals to incorporate patient activation information and surveys in EDs.

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.

Our PPS formation included the creation of a robust network of over 275 CBOs in our Community Resource Database that serve a wide spectrum of social service needs. We will enable this database to be patient facing and link it to a searchable tool that assists patients and families locate needed services. The relationships that we have initiated through the CNA process with housing activists, food banks and regional perinatal networks will form the basis our outreach to the UI, NU, and LU populations.

Our PPS also includes one of the largest NY State of Health Insurance Navigator Agencies in our region, the Maternal Infant Services Network (MISN), which has eight Marketplace Facilitated Enrollers and three subcontracted agencies. We will work with MISN and other organizations' Facilitated Enrollers to incorporate patient activation programs into their existing enrollment outreach efforts.

For the uninsured, MCOs also serve as potential points of engagement. In our region, the three largest MCOs (Affinity, Fidelis, and MVP) have representatives who assist uninsured individuals obtain coverage. The health plans' field representatives, formerly called Certified Application Counselors, often encounter people who are not eligible for insurance. We will work with MCOs to augment their enrollment efforts to include strategies and pathways to improve the UI's patient activation. We will also work closely with MCOs to identify and engage the LU and NU Medicaid beneficiaries. We will obtain lists of PCPs assigned to NU and LU enrollees from MCOs to help them reconnect with their designated PCP. In concert with MCOs and PCPs (and with approval from NYS), we will develop material for outreach to LU and NU Medicaid beneficiaries to encourage them to connect or re-connect with their PCPs. Outreach materials will include language on how to file a complaint and receive customer service. To increase the likelihood that prevention strategies are adopted by the target populations, we will Include representatives from the UI, NU, and LU populations in the team that develops and promotes preventive care.

Staff at participating FQHCs, PCPs, and EDs will be trained to collect updated contact information during PAM screening, and we will notify MCOs on a monthly basis of

any formerly NU and LU members who are engaged through this project. All three project cohorts (UI, NU, LU) will be surveyed using PAM® during the first year of the project and at annual intervals throughout the project.

We will 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. If the patient is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, we assess the patient using PAM® survey and designate a PAM® score. We will track the UI cohort over the entirety of the DSRIP program.

In support of partner organizations in the Hubs, our PPS is developing a centralized service infrastructure that will: (1) maintain a core competency on patient activation techniques; (2) facilitate region-wide coordination; (3) develop and deploy standardized training modules, patient assessment tools, and best practices and strategies to improve patients' activation levels; (4) identify and track patients and program progress through a centralized electronic system that includes (within the limits of confidentiality laws) a master index of contacted individuals; (5) perform population health management by actively using EHRs and other IT platforms; (6) support the increased provision of non-emergent care; and (7) establish and maintain a capacity to take complaints and provide customer service.

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.

We anticipate challenges (1) locating patients, (2) cost-effectively implementing surveys, (3) improving patient activation scores and utilization of primary and prevention services, and (4) obtaining informed consent.

Locating the target population, most of whom lack consistent contact with clinical settings, represents a significant challenge. To meet patients "where they are," we will conduct outreach at multiple points including CBOs, FQHCs, EDs, and organizations that facilitate insurance enrollment to ensure direct and timely hand-offs to navigators who facilitate age-appropriate primary and preventive healthcare services and resources. We will collect centrally and rapidly diffuse lessons learned, engagement best practices, and up-to-date information on insurance options and healthcare resources.

Administering patient activation surveys represents a new and significant responsibility for our PPS partners. We will use Plan-Do-Study-Act cycles to help incorporate PAM screening into our partners' workflows. We will provide payment incentives to organizations based on the number of survey instruments completed. To increase the likelihood of patients' completion of activation assessments, we may offer a free mobile phone application that links patients with local clinical and social services.

Locating and assessing the target population represent important first steps, but will not guarantee improved activation scores and health outcomes. Consistent and sustained engagement with the health system results from a foundation of patient understanding and

trust. To establish trust and rapport, we will partner with CBOs and others to recruit community members to serve as peer and community navigators to promote connectivity with the healthcare system and assist with patient activation and education. Our patient activation outreach and engagement strategies will include provisions for culturally competent community navigators who are trained in patient activation techniques and education for the target age ranges. Once engaged, we will link patients to services that support the full range of clinical and social service needs. Tracking PAM scores for individuals who are encountered in a CBO location may require an Institutional Review Board process and elaborate consent that could be an obstacle to wide engagement. We will work with NYS to address this concern.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across the region and New York State. The three PPSs serving the region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council that supports the development of a regional system of efficient and effective care, patient safety, and continuous quality improvement.

The Council, including input from providers, payers, government agencies, and others, will review DSRIP project plans and implementation and make recommendations to align overlapping project approaches. Region-wide coordination, common requirements, and similar expectations will minimize providers' implementation burdens and create consistent, high quality experiences for patients. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating proven and promising clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and its payers.

Although the other two PPSs in our region are not implementing project 2.d.i., we will work with them to facilitate the identification of the uninsured population, provide updates on engagement and enrollment progress, and share best practices on patient activation efforts.

Beyond our region, we will share best practices and lessons learned with the other PPSs that are implementing project 2.d.i. statewide.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Our PPS will need capital funds to provide meeting space to train staff to use the PAM survey instrument. Electronic tools, such as computers and tablets, will be critical tools to help the PPS effectively screening patients using the PAM survey, collect patient information, and record PAM scores. Capital funds will also be used to pay for licenses for educational software and online modules to advance patient health literacy.

The Westchester-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations for patient outreach, engagement, and activation activities. The capability will be shared across all 11 DSRIP projects and are central to our IDS development.

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
Family Service Society of Yonkers	NYS DOH Senior Supportive Housing Services Program	2014	2016	The Senior Supportive Housing Services Program combines capital assistance and supportive services within existing senior housing communities to serve low-income, Medicaid eligible seniors who are homeless or reside in the community and who are at risk of nursing home placement and seniors transitioning out of nursing homes into community living who require long term care services.
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
The Greater Hudson Valley Family Health Center, Inc.	Partnerships for Care HIV grant (CDC & HRSA)	9/1/14	8/31/17	The Partnerships for Care HIV grant supports the identification of undiagnosed HIV infection, establishes new access points for HIV care and treatment, and improves HIV outcomes along the continuum of care for people living with HIV (PLWH). Funding supports required staffing and equipment.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
The Greater Hudson Valley Family Health Center, Inc.	Outreach and Enrollment (HRSA)	6/1/13	ongoing	Supports navigation assistance to patients using New York's Marketplace, New York State of Health.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

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

This project will seek to connect low utilizing, non-utilizing Medicaid members, as well as the uninsured, to heath care services. It will not supplant funds currently supporting existing services but rather will use the relationships set in place through these programs to reach uninsured members of the target population. For example, through the foundation set in place by the Senior Supportive Housing Services Program, our PPS will aim to reach uninsured seniors and, to the extent applicable, other uninsured members of the target population. The project will expand the impact of this program and the services of health centers, by connecting the target population identified through these programs with a full range of social supports and medical services. Further, the project will expand, not supplant, outreach and enrollment assistance funding to reach greater numbers of uninsured New Yorkers eligible for marketplace or Medicaid coverage.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a larger group of low/non-utilizing Medicaid patients who are not currently eligible for Health Home services, and will expand the reach of the care management knowledge, techniques and experiences to populations not served by Health Homes.

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

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

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

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of

driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

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

Domain 3 Projects

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

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

Project Description: Integration of behavioral health and primary care services can serve 1) to identify behavioral health diagnoses early, allowing rapid treatment, 2) to ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects, and 3) to de-stigmatize treatment for behavioral health diagnoses. Care for all conditions delivered under one roof by known healthcare providers is the goal of this project.

The project goal can be achieved by 1) integration of behavioral health specialists into primary care clinics using the collaborative care model and supporting the PCMH model, or 2) integration of primary care services into established behavioral health sites such as clinics and Crisis Centers. When onsite coordination is not possible, then in model 3) behavioral health specialists can be incorporated into primary care coordination teams (see project IMPACT described below).

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

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

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

B. Behavioral Health Service Site:

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

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

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

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

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

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

Ambulatory behavioral health (BH) treatment (e.g. mental health, substance use and alcohol abuse services) may not be reaching the right people at the right time in our region. An analysis of data from the NY Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) for our CNA found, for example, nearly 350,000 Westchester County residents had a history of a BH disorder, yet only 27% had a BH-related ambulatory visit last year. The age adjusted suicide rate in the County is 7 per 100,000 and, 18% of adults engaged in binge drinking in the past month; both of these numbers could decline with timely care.

Our region-wide resident survey indicates that 22%-30% of respondents do not know where to go for BH services, though close to 80%-90% of respondents reported having a healthcare provider and seeing a doctor for a check-up in the last year. This suggests that BH services co-located with primary care could improve access to those who need BH services.

In addition, many Medicaid beneficiaries may not be diagnosed with or receiving treatment for the most common BH disorders, including depression which produces a greater decline in health

than angina, arthritis, asthma or diabetes. In our region, over 30% of those with depression had one or more medical or BH inpatient admissions, and 45% had one or more emergency department (ED) visits.

Medicaid beneficiaries with serious BH disorders may not be receiving adequate primary care. In our region, 23% of adults with BH disorders discharged from community hospitals had one or more chronic medical conditions. Our CNA focus group participants said integrated care with a single, integrated treatment plan would help facilitate better coordination of care and reduce patient barriers to accessing BH services.

This project is designed to reach a broad population of Medicaid beneficiaries with a wide range of unmet BH and primary care needs. Eight PPS Participants across 22 sites will implement the PCMH-integrated model to provide on-site BH screening, assessment and integrated services, including medication management and other evidence-based care coordination services. Integrated care sites will be aligned with our PPS' BH providers, BH Crisis Systems as defined in Project 3.a.ii, and hospitals to provide the right care at the right time.

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

This project will target all attributed Medicaid beneficiaries ages 12 and older who receive primary care services and have a visit during the year at one of the 22 project sites. The primary care provider (PCP) will ask target patients to complete both the PHQ 9 (screen for depression) and SBIRT (screen for alcohol and/or drug use). One participating FQHC that has implemented routine depression screening with the PHQ-9 reports a screening rate of 50%. Using this as a benchmark, it is reasonable to expect that completion rates will be lower when both PHQ-9 and SBIRT are required instruments.

Our PPS will seek to engage the highest need populations in integrated care as identified within certain high need areas of our regions and by our BH Crisis Stabilization project. This project will work in tandem with Projects 2.a.iii, “Health Home At-Risk Intervention Program” and 2.b.iv, “Create a Medical Village Using Existing Hospital Infrastructure” to target outreach to beneficiaries with serious BH conditions (e.g., bipolar disorder, depression, schizophrenia, other psychoses, chronic alcohol abuse, opioid abuse, heroin and/or cocaine abuse), HIV, developmental disabilities (DD) and/or those who are homeless and living in high need areas with significant African American and Hispanic populations. These areas include Mount Vernon, Yonkers, New Rochelle, Poughkeepsie, Newburgh, Middletown, Port Jervis and Kingston, many of which are also medically underserved areas.

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.

Our PPS will implement the PCMH Service Site model and will provide planning, workforce training, capacity building and implementation support to project Participants.

Eight Participants in our PPS, representing over 22 project sites will participate in this project. This includes three hospitals (Bon Secours, Phelps Memorial, WMC), four FQHCs (Greater Hudson Valley Family Health Center, The Institute for Family Health, Open Door Medical Center, Mount Vernon Neighborhood Medical Center), and one Diagnostic and Treatment Center (DTC) (United Cerebral Palsy Association of Putnam and Southern Dutchess Counties). Most sites are in high need counties with cultural competencies for diverse populations. One site primarily serves people with DD, and another site serves people with HIV. A number of the Participants' sites will offer urgent care.

The participating FQHCs currently offer some on-site BH screening and services and will develop/expand BH screening and/or on-site service capacity to meet the project requirements. Depending on regulatory flexibility and funding availability, BH clinics can affiliate with PCMH integrated care sites to (1) provide BH clinicians for on-site services; (2) participate in the delivery of team-based care when specialty care is needed and in alignment with protocols set by our PPS; and/or (3) connect BH clients with primary care at integrated care sites. To ensure that patients receive appropriate services, our PPS will identify Medicaid beneficiaries engaged in BH care who have not received primary care and will work with BH providers to assess these patients using the 13-question Patient Activation Measure, offer subsequent coaching when indicated and address common service gaps (e.g. flu shots, immunizations, basic medical assessments, smoking status) to improve overall health status.

About half of the 22 project sites have achieved 2011 NCQA PCMH accreditation. Our PPS will provide all sites with assistance to achieve 2014 Level 3 PCMH recognition by the end of DY 3, including adoption of electronic health records (EHRs) or other systems to enable the PPS to effectively track patients and project outcomes. WMC is currently developing telepsychiatry capabilities that may be used to provide psychiatric consultations to integrated care sites which will significantly enhance their capability to diagnose and treat more complex BH disorders.

Care coordination and social service programs are also critical to improving outcomes for Medicaid beneficiaries with social and economic challenges that can trigger or worsen depression, anxiety and substance abuse. Our region's three Health Homes collectively serve 7,446 unique Medicaid members with BH and/or other conditions. The integrated care sites will help facilitate enrollment of additional eligible beneficiaries. Our PPS can offer concrete, essential help with social services: shelters, food pantries, supportive housing, entitlement assistance, and the soon-to-be available the HARP 1915i benefit services such as employment and peer support. These services will target beneficiaries in neighborhoods with high measures of socioeconomic disadvantage.

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.

Our PPS anticipates several challenges in implementing this project. Currently, there are limitations on providing BH services in Article-28 licensed sites, which could pose a challenge to co-locating services. If regulatory waivers are not granted, Participants may pursue licensure from the Office of Mental Health (OMH) and/or Office of Alcoholism and Substance Abuse Services (OASAS) at primary care sites serving sizable BH populations. Our PPS will request waivers for these barriers as needed.

We also anticipate financial challenges. Today, FQHCs can only bill for one daily service, which will impede the financial sustainability of this project; as such, our PPS has requested that the NYS DOH address this issue. On the provider side, some PCPs may be reluctant to screen for BH disorders due to past difficulties connecting with BH providers and/or a lack of experience with BH disorders. To combat this concern, the project will add BH staff to clinic sites and develop PCP training and an Implementation Toolkit to facilitate cultural/age competent use of PHQ 9 and SBIRT so that PCPs are comfortable screening for BH disorders. Our region's RHIO and tools to be centrally developed by our PPS will support electronic documentation of clinical assessments, tracking of patients, project implementation and outcomes. Our PPS will also develop and implement a process to obtain patient consent for information sharing among providers.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and state. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council to support development of a regional system of efficient and effective care, patient safety, and quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping approaches. Region-wide coordination, requirements, and expectations will minimize providers' implementation burdens and create consistent, high quality patient experiences. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and payers.

Continuing the cooperation that resulted in the creation of a common CNA, the PPSs in our region have embraced collaboration throughout the selection, design, and development phases of their respective DSRIP projects. The PPSs have committed to coordination with local County Departments of Health and Mental Health to support the expansion of integrated BH and primary care in our region.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Our PPS will require capital funds for the renovation and expansion of clinics to support physical co-location of behavioral health services into primary care sites. Funding will support new construction, repairs, and renovation of fixed assets, equipment costs, and other asset acquisitions to expand existing and create new co-located sites as well as providing the appropriate tools for performing PHQ-9 /SBIRT screening.

The WMC-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations for enhanced behavioral health and primary care activities. The capability will be shared across all 11 DSRIP projects and is central to our IDS development.

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
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
Orange County Department of Mental Health	Port Jervis Connections Project - "Court Connection Program"	10/1/13	9/31/14 NCE to mid2015	The Court Connection Program targets individuals in the criminal justice system and provides medical services to individuals court system exhibiting signs of mental illness to improve public safety, reduce corrections costs, and improve quality of life for participants.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	HRSA Behavioral Health Integration (BHI)	2014	ongoing	HRSA Behavioral Health Integration grants support health centers to improve behavioral health services and capacity, and to employ integrated models of primary and behavioral health care.

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

This project will require coordination and cooperation between and among providers. The services provided in our region will serve as instrumental in this project. However DSRIP funds will not supplant or replace current funding as this project will build on what has already been done to expand the reach of the project to the attributed population. For example, our PPS will build on the experiences that come out of the Court Connection Program to apply treatment and intervention strategies to the target Medicaid population.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a larger group of Medicaid patients, including those who are not currently eligible for Health Home services, and will expand the reach of the care management knowledge, techniques and experiences to populations not served by Health Homes.

Our PPS will build on the experience of the Institute for Family Health which has already begun work to improve behavioral health care under HRSA Behavioral Health Integration grants. However, this DSRIP project will extend to many additional mental health/behavioral health and primary care settings, allow us to reach a broader population than is currently being targeted. DSRIP funding will not be provided to HRSA BHI participating providers if doing so would supplant or duplicate funding.

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.a.ii Behavioral Health Community Crisis Stabilization Services

Project Objective: To provide readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis.

Project Description: Routine emergency departments and community behavioral health providers are often unable to readily find resources for the acutely psychotic or otherwise unstable behavioral health patient. This project entails providing readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis. The Behavioral Health Crisis Stabilization Service provides a single source of specialty expert care management for these complex patients for observation monitoring in a safe location and ready access to inpatient psychiatric stabilization if short term monitoring does not resolve the crisis. A mobile crisis team extension of this service will assist with moving patients safely from the community to the services and do community follow-up after stabilization to ensure continued wellness.

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

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

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

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

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

Addressing behavioral health (BH) crisis stabilization services is a critical issue in our region. Our CNA conducted six focus groups, three with service providers and three with peers with BH disorders, during which a participant noted "To someone who has mental illness and a medical issue and no housing and...they're running out of meds, it's a crisis every day." During our planning process, our PPS held 12 fact finding and planning meetings on BH crisis stabilization services with broad participation by BH and Developmental Disabilities (DD) service providers, Medicaid MCOs and County Health/Mental Health Departments. Results from these meetings indicated that our region has too few alternatives when individuals' usual care and support systems prove inadequate for their needs. The region lacks a NYS Office of Mental Health Comprehensive Psychiatric Emergency Program, which provides a systematic response to psychiatric emergencies with crisis outreach/intervention, community crisis beds and hospital-based observation beds. There is also very limited access to alternative crisis respite, such as "Living Rooms" where a person can be in a safe, low stress environment with professional and peer staffing for several days until they can return home.

Our CNA documented high ED use among Medicaid beneficiaries with serious BH conditions. Experts consulted during the CNA noted that ED visits can increase patient agitation, treatment in the ED is short-term and usually there is no post-discharge follow-up. Participants agreed our region needs alternative crisis care and that the best way to address a BH crisis is to prevent it. There was consensus that BH crisis stabilization begins with a whole person approach to outpatient care that encompasses mental health, substance abuse, medical and social needs.

Among adults in our region with serious BH disorders, 40%-66% are estimated to experience serious functional impairment based on co-occurrence of multiple BH disorders. Almost 1 in 4 adults with general hospital inpatient stays in 2013 (48,971 people) had BH disorders including a major mental illness, alcohol and/or substance abuse issue. Over a third of these adults were Medicaid patients and 83.5% had one or more chronic medical diagnoses.

In consultation with an advisory workgroup comprised of providers, peers, local government agencies and Medicaid MCOs, our PPS will "knit" together existing crisis services and fill identified gaps (e.g. lack of integrated ambulatory care) to create a seamless comprehensive BH response that offers the right services at the right time through integrated primary and BH care, BH "urgent care," mobile crisis team(s), expanded and intensive crisis services,

existing/repurposed crisis/respite and observation beds, development of a region-wide crisis line to centralize triage services, and outreach/support including peer workers who will deliver culturally appropriate assistance. Our PPS will also work closely with Participants to ensure all providers are using EHRs or other systems to enable information sharing and ongoing tracking of the target population.

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

This project will work in tandem with our Projects 3.a.i , 2.a.iii and 2.b.iv to address the needs of Medicaid beneficiaries 12 years and older with serious BH diagnoses (including bipolar disorder, depression, schizophrenia, other psychoses, chronic alcohol abuse, opioid abuse, heroin and/or cocaine abuse) living in high need areas, including those with significant African American and Hispanic minority populations. These areas include Mount Vernon, Yonkers, New Rochelle, Poughkeepsie, Newburgh, Middletown, Port Jervis and Kingston. These urban areas have large numbers of Medicaid beneficiaries with serious BH disorders and are BH hospitalization "hot spots;" many are also medically underserved areas. Those who are homeless, have developmental disabilities (DD) and/or criminal justice involvement will also receive targeted outreach to ensure access to expanded services because they are high users of ED and inpatient care, with generally poor access to ambulatory services.

An educational campaign will inform providers, community-based organizations, beneficiaries and their families, local government agencies, and others about available BH crisis services and early warning signs of new onset and deteriorating BH conditions. This will enable patients and providers to know where to find the right level of service to prevent escalation when it is possible and the most appropriate setting for care when it is not. With PPS practice-based support, providers will have additional resources to do targeted outreach to at-risk beneficiaries.

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.

Our PPS will form seven Crisis Systems in collaboration with the counties, Medicaid MCOs and other PPSs in our region. These Systems will be in the seven Hudson Valley counties; Delaware County (a primarily rural region) will be supported by the System in closest geographic proximity, principally out of Ulster County. Our PPS will support local planning and implementation, develop treatment protocols, and provide funding to fill gaps and bolster existing programs. Our PPS Quality Committee will continuously monitor quality improvement activities, including compliance with treatment protocols.

In collaboration with Participants, our PPS will: (1) add a Central Triage Service (CTS)/crisis line

capable of tracking patients, follow-up and reporting; (2) fill gaps for crisis services (e.g. mobile teams, crisis beds with 48 hour observation capacity); (3) help launch telepsychiatry services to provide 24/7 psychiatric consultations to participating providers; (4) conduct outreach around community-based crisis services; and (5) facilitate information sharing via EHRs and the RHIO. The project will build on and link current resources in our region as outlined below.

Crisis stabilization services will position PPS hospitals as alternatives to ED/inpatient care. WMC has the largest BH inpatient capacity in the region with 106 adult, 20 adolescent and 15 children psychiatric beds, plus 10 adult detoxification beds and 50 adult substance abuse beds on two campuses. Our PPS will build on WMC's partnership with Dutchess County's crisis team and St. Luke's Cornwall Hospital's partnership with Occupations, Inc. to offer ED/inpatient diversion mobile crisis services.

Mobile BH services are currently available region-wide, but are not reaching a broad population and lack other critical components (e.g., adequate hours, staffing). Mental health crisis beds are also available but are not adequate to meet the region's needs and/or are not connected to a comprehensive system. Our PPS will ensure there are adequate system components for mobile BH services and that 48 hour observation bed capacity is available in participating hospitals or the greater community as the PPS develops its implementation plan. Detox and other crisis needs are largely met through OASAS-licensed inpatient and residential programs. Our PPS will identify effective early intervention and ambulatory services to address substance abuse.

State and county programs are building blocks of our project plan. The Rockland Psychiatric Center has hospital-based and ambulatory clinic care, transitional residences and more in the service area. The New York Systemic Therapeutic Assessment, Respite and Treatment (NY START) program offers community-based crisis prevention/ intervention services to individuals with DD and co-occurring BH needs.

This project will work closely with the 22 integrated care sites participating in Project 3.a.i which will offer urgent care through the Crisis Systems. The Systems will leverage the multiple information, referral, education and supportive peer and family services already offered by counties and community providers to facilitate access and optimize resource

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.

Crisis stabilization services are expensive and reimbursement will be challenging. Our PPS will work with Medicaid MCOs to establish agreements that cover these services and ensure their viability. Additionally, current NYS DOH requirements do not allow Article 28 hospitals to operate and be reimbursed by Medicaid for BH health observation beds. WMC will request waivers to address this issue.

Coordination with other PPSs in our region will be critical to ensure patients in need of BH crisis services have a seamless experience and can access services regardless of their location or provider. This project will enable all three PPSs in our region to achieve efficiencies through the Central Triage Service and the Regional Clinical Council (below).

Capturing and tracking patients and their services in a centralized way to allow all PPSs in our region to accurately report the required project metrics will be challenging as most BH crisis providers are not reimbursed through Medicaid and many BH and community PPS Participants do not have EHRs. We will work with the other PPSs to develop a region-wide encounter system to capture patient services attributed to this project. The PPS will work with participating providers to ensure they are actively using EHRs and are connected to the RHIO to support secure messaging/notifications by DY 3.

Changing behavior is both a challenge and a key to success. Our PPS will implement outreach to encourage people with BH disorders, community service providers and family members to seek project services to prevent potential crises.

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.

Under DSRIP, patients may receive care from any provider, some participating in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and State. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center and WMC, will establish a provider-led Regional Clinical Council to support development of a regional system of efficient and effective care, patient safety and quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping approaches. Region-wide coordination, requirements and expectations will minimize providers' implementation burdens, and create consistent, high quality patient experiences. The Council will identify region-wide care improvement goals and serve as a forum to share and evaluate clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols, as well as evidence-based practices across the region and payers.

Continuing the cooperation that resulted in the creation of a common CNA, the PPSs in our region embraced collaboration throughout the selection, design and development phases of their respective DSRIP projects. The Council prioritized crisis stabilization as a primary area of focus and is aligned on core project elements. We will conduct a joint needs assessment across the region, working jointly with local Commissioners.

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital funding is required for the creation of observation units in community setting and/or on hospital campuses, as the service area does not have any Comprehensive Psychiatric Emergency Programs (CPEP) with such beds. These beds will be created by either repurposing inpatient beds or OMH-licensed community residence/OMH-designated crisis beds. Capital funds will also support the physical rehabilitation and equipping of community-based crisis residences and service sites.

The WMC-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of

partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations for enhanced crisis stabilization services. The capability will be shared across all 11 DSRIP projects and is central to our IDS development.

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
Mental Health Association of Putnam County	Community Crisis Stabilization	2015	2019	New York's Health and Recovery Plans (HARPs) will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
NAMI-FAMILYA of Rockland County Inc.	Medicaid Managed Care HCBS 1915i Medicaid "Like" Service	2011	2019	New York's HARPs will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Occupations, Inc.	Enriched Crisis and Transitional Housing (ECTH) Pilot	2015	NA	Enriched Crisis and Transitional Housing (ECTH) Pilot is a onetime capital funding and operation for housing services for persons with serious mental illness. Funding supports the creation or reconfiguration of existing residential space to develop three crisis housing units for persons with serious mental illness.
Orange County Department of Mental Health	Port Jervis Connections Project - "Court Connection Program"	10/1/13	9/30/14 NCE to mid2015	The Court Connection Program targets individuals in the criminal justice system and provides medical services to individuals in the court system exhibiting signs of mental illness to improve public safety, reduce corrections costs, and improve quality of life for participants.
The Institute for Family Health	HRSA Behavioral Health Integration (BHI)	2014	ongoing	HRSA Behavioral Health Integration grants support health centers to improve behavioral health services and capacity, and to employ integrated models of primary and behavioral health care.

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

This project will differ from the current Medicaid initiatives because it aims to build bridges and knit together the existing services into a region-wide crisis stabilization system. Our PPS will build on the experiences that come out of the Court Connection Program to apply treatment and intervention strategies to the target Medicaid population. HARP service providers and behavioral health enrollees are likely to participate in this project. This DSRIP project, however, is being implemented at the Participant/provider, not plan level, and is distinct from and will supplement HARP services. In addition, this project will extend to all of our actively engaged population, not just those enrolled in HARP plans. Participants in ECTH will likely also participate in this DSRIP project. However DSRIP funds will not be used to supplant or replace ECTH funding.

Our PPS will build on the experience of the Institute for Family Health which has already begun work to improve behavioral health care under HRSA Behavioral Health Integration grants. However, this DSRIP project will extend to many additional mental health/behavioral health and primary care settings, allow us to reach a broader population than is currently being targeted. DSRIP funding will not be provided to HRSA BHI participating providers if doing so would supplant or duplicate funding.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

Project Description: The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of diabetes. Specifically, this includes improving practitioner population management, increasing patient self-efficacy and confidence in self-management, and implementing diabetes management evidence based guidelines.

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

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

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

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

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

Diabetes is a prevalent diagnosis and comorbidity among Medicaid beneficiaries in our region. Hospitalization rates for short-term diabetes complications per 10,000 are higher than the regional rate (4.3) in Delaware (4.9), Orange (5.9) and Sullivan (6.2). Large numbers of Medicaid beneficiaries with diabetes are found in areas of population density served by our PPS associated with higher levels of poverty, including Yonkers, Mount Vernon, New Rochelle and Peekskill in Westchester County; Spring Valley and Monsey in Rockland County; Newburgh and Middletown/Port Jervis in Orange County; Poughkeepsie in Duchess County; the Kingston area in Ulster County; and Liberty and Monticello in Sullivan County.

In a survey of our region's residents conducted as part of our CNA development, 43% of Medicaid respondents considered diabetes to be one of the top five health issues in their community; more than 50% of these same respondents had not had a diabetes test in the past 12 months and close to 25% did not know where to go within their county of residence to access diabetes testing, nutrition education or weight loss programs.

High prevalence, noted prioritization among surveyed residents, and the failure to meet quality standards make diabetes an important target for PPS intervention. Our PPS will implement four strategies to improve outcomes: (1) promote systematic incorporation of evidence-based treatment guidelines for diabetes management into primary care; (2) establish a PPS-wide registry to track diabetes patients; (3) coordinate efforts to close gaps in care by care teams including Health Homes, pharmacists, behavioral health providers, primary care based care coordinators; and (4) promote patient self-efficacy and expand the availability of evidence-based, self-management training for patients in the community setting.

Our PPS Quality Committee will review performance measures associated with the project and consult with participating primary care providers (PCPs) to focus on overcoming barriers to better performance. Our PPS is evaluating analytics and population health management platforms; in DSRIP DY1, we will implement a system to identify and track patients with diabetes. The PPS will expand care coordination resources region-wide, working with existing Health Homes to the extent possible to train care coordinators which will be integrated into primary care sites to support DSRIP project goals. Our PPS will share information with PCPs about existing community based self-management and education resources and work with community-based organizations offering self-management to develop cost effective expansion of such programs. We are also evaluating patient-facing tools that connect patients with community-based resources critical to self-management (such as support groups, food banks, nutrition counseling, etc.) and that allow patients to report their experience with services received.

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

This project will target attributed adult Medicaid beneficiaries who have Type 1 or Type 2

diabetes as identified either by the beneficiary's PCP, by medical claims or by EHR data available to our PPS. Our PPS will establish a central registry to track beneficiaries with diabetes and will engage with Medicaid MCOs to coordinate diabetes outreach to beneficiaries and their PCPs. We will also identify patients with pre-diabetes or are at risk for diabetes based on increased BMI index consistent with overweight status or obesity and/or hemoglobin A1C blood test that is above normal but below the threshold for diabetes. Patients with pre-diabetes will be tracked separately and offered access to programs such as the Diabetes Prevention Program, which is available in the community from many of the same groups offering the Stanford Chronic Disease Self-Management Program.

The PPS will initially work with PCPs who have achieved NCQA PCMH Level 3 accreditation to put in place the four strategies. During DY 1-3 the PPS will ensure all affiliated PCPs achieve PCMH accreditation and implement a Meaningful Use-certified EHR. As part of our efforts to support PCMH accreditation, we will work with practices to extend the diabetes management project to 80%-100% of PCPs who treat adult patients.

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.

For over a decade, diabetes care has been a focus for quality improvement in our region. The New York Diabetes Coalition (NYDC), founded in Westchester County in 1999, has involved a broad group of stakeholders including health professional societies, health plans, patient advocacy groups and State, city and county departments of health and continues to be a State-wide source for diabetes management tools. Though still below goal, scores on diabetes quality of care measures have improved across the region. Our PPS will adopt appropriate NYDC tools, help to standardize, streamline and centralize patient outreach and build on existing collaborations to help primary care practices more consistently deliver excellent diabetes care.

Our region has existing resources for patient self-management training. Several PPS Participants offer the Stanford Chronic Disease Self-Management Program - The Greater Hudson Valley Family Health Center, Open Door Family Medical Centers, and Visiting Nurse Association of Hudson Valley offer the Stanford program for diabetes. Web-based cross-training is available from Stanford that will allow PPS partners who current use the Stanford model for other chronic diseases to develop diabetes-focused offerings.

HealthAlliance of the Hudson Valley's Diabetes Education Center offers a Support Group, financial and insurance assistance, and training to children and adults with Type 1, Type 2, Gestational, and pre-diabetes. The Institute for Family Health and Mount Vernon Neighborhood Health Center offer diabetes education programs. The Rockland County Department of Health implemented an electronic diabetes registry in partnership with NYDC and Steps program and offers a Diabetes Prevention Program to individuals at risk for Type 2 diabetes. A proposal from the Primary Care Development Corporation, Hudson Information Technology for Community Health (HITCH), and FQHCs participating in our PPS was selected as one of four finalists in a State-sponsored pay-for-success project that, if selected, will administer the National Diabetes

Prevention Program to approximately 3,570 patients over five years. The National Diabetes Prevention Program is led by the Centers for Disease Control and takes an evidence-based approach to lifestyle change and prevention of Type 2 diabetes. (This work would complement, not duplicate, our PPS program efforts.)

Our PPS will work with the three regional Health Homes to identify additional "hot spots" where diabetes self-management programs are needed or are under-resourced. We will provide training to Health Home care coordinators on closing "gaps in care" for management of diabetes and other medical conditions and will provide training to affiliated PCPs on how better to link patients with Health Home resources and community based self-management training.

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.

We will primarily concentrate our strategies for regional diabetes care improvement in the delivery of services to patients with diabetes through our enhanced primary care model network (comprised of PCMH Level 3-accredited practices). It will be challenging to deliver these enhanced services to beneficiaries attributed to our PPS who receive their primary care outside our PPS. Our cross-PPS Regional Clinical Council will be charged with addressing this and other region-wide issues. The Council will adopt a consolidated set of DSRIP performance metrics that will include best practices for diabetes.

Our PPS anticipates providers and patients may not be aware of diabetes self-management programs, patients may be reluctant to attend, and the time or the location may be inconvenient. In an effort to engage patients, the PPS will coordinate with Health Homes, care coordinators, and peers to elevate awareness and ensure services and materials are widely available and in patients' native languages. All PPS providers will participate in annual cultural competency training throughout the life of the DSRIP initiative.

Young adults (ages 18 – 21) with diabetes may receive care from pediatric specialists who are less familiar with adult measures of diabetes care. Our PPS will use data to identify young adults with diabetes and consult with pediatricians and pediatric endocrinologists to modify the program to meet the particular needs of these 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.

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region

and state. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council to support development of a regional system of efficient and effective care, patient safety, and quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping approaches. Region-wide coordination, common requirements, and expectations will minimize providers' implementation burdens and create consistent, high quality patient experiences. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and payers.

Continuing the cooperation that resulted in the creation of a common CNA, the PPSs in our region have committed to coordinate in critical areas and will consider a comprehensive set of quality performance standards including evidence-based practices for diabetes and pre-diabetes across the region and its payers.

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.

The WMC-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations for improved asthma management. The capability will be shared across all 11 DSRIP projects and are central to our IDS development.

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
Dominican Sisters Family Health Service, Inc.	Community- based Care Transitions Program	2013	2017	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

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

This project will seek to equip patients with the right tools to effectively manage their diabetes. The care management experiences of the Medicaid initiatives identified above will be valuable in informing this process. However this project differs from these initiatives because it expands the population targeted. For example, The Community based Care Transitions program targets Medicare patients. Our PPS will build on the experience of these Participants to establish a customized standard care transitions models across the region and will expand the model to support to a broader population of Medicaid patients. The PPS will also expand health center services for the attributed population.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a larger group of Medicaid patients, including those who are not currently eligible for Health Home services, and will expand the reach of the care management knowledge, techniques and experiences to populations not served by Health Homes.

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, 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.

3.d.iii Implementation of Evidence Based Medicine Guidelines for Asthma Management

Project Objective: Implement evidence based medicine guidelines for asthma management to ensure consistent care.

Project Description: The goal of this project is to implement asthma management practice guidelines, develop asthma action plans, and increase access to pulmonary and allergy specialists in areas of New York State.

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 asthma management guidelines between primary care practitioners, specialists, and community based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population-based approach to asthma management.
2. Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.
3. Deliver educational activities addressing asthma management to participating primary care providers.
4. Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.
5. Use EHRs or other technical platforms to track all patients engaged in this project.

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

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

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

The feeling of being unable to breathe is understandably frightening. Accordingly, an exacerbation of respiratory disease, particularly asthma, often results in visits to the emergency department (ED). In a survey of residents in our region conducted as part of our PPS CNA development, 17.4% of respondents considered asthma to be one of the top five health issues in their community. Asthma clusters appear in Middletown, Newburgh, Poughkeepsie, Haverstraw, and southern Westchester. According to data analyzed for Medicaid beneficiaries in our region, there were over 13,000 total inpatient admissions and more than 39,000 total ED visits in 2012.

Respiratory illnesses, including asthma, chronic obstructive pulmonary disease (COPD), and

bronchiectasis are found among Medicaid beneficiaries in our region in areas associated with higher levels of poverty, including Yonkers, Peekskill, Spring Valley, Newburgh, and Monticello. Our PPS CNA found hot spots of elevated risk for asthma hospitalization around Middletown, Newburgh, Poughkeepsie, Haverstraw, and southern Westchester. People with behavioral health conditions have a high rate of asthma; according to the Medicaid Institute, 24% of Medicaid mental health beneficiaries have asthma/COPD (at least 30% higher than among non-mental health beneficiaries), and 26% of substance abuse beneficiaries have asthma/COPD (at least 50% higher than non-substance abuse beneficiaries). Furthermore, because some asthma medicines cause patients' heart rates to increase, they can trigger anxiety attacks, leading to ED visits.

Our PPS will utilize four strategies to engage and address attributed Medicaid patients with asthma: (1) specialists in our PPS will review and adopt national and state evidence-based guidelines for asthma management, including protocols for appropriate spirometry, a common office test used to assess how a patient's lungs work, specialty referrals, and an Asthma Action Plan; (2) we will establish a PPS-wide registry to track asthma patients informed by work the PPS is doing now to evaluate analytics and population health management platforms (during DY 1 we will implement a system to identify and track patients with chronic disease, including asthma, and monitor patient and provider adherence to treatment guidelines); (3) we will implement health information exchange (HIE) protocols for creating, updating and sharing patient-centered asthma action plans among treating providers, Health Homes, patients and their families (to do so, a region-wide, all-PPS asthma workgroup will engage with HealthlinkNY, the local RHIO, to facilitate HIE); and (4) we will expand training for primary care providers (PCPs) on asthma management and use of spirometry and expand the availability of evidence-based asthma education for patients and parents of patients who are minors.

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.

Our PPS will target attributed Medicaid beneficiaries aged 5 and older who have persistent asthma identified either by the beneficiary's PCP, medical claims, or EHR data available to the PPS. We will also incorporate the Area Deprivation Index (ADI) as we identify and stratify patients according to risk. The ADI is a well-accepted measure of neighborhood socioeconomic disadvantage which links a patient's zip code to an index of broader social and environmental risk factors to inform patient care decisions. Asthma is often exacerbated by environmental triggers, such as living conditions, that are reflected in the ADI. Patients with higher ADI scores may be stratified to a higher level of risk.

The PPS will engage Medicaid MCOs and Health Homes to coordinate asthma outreach to attributed Medicaid beneficiaries and their PCPs. The PPS will initially work with PCPs who have achieved PCMH accreditation to put in place the four strategies referenced above. As more affiliated PCPs connect to the RHIO, the asthma project will be extended broadly among the PPS

primary care network. We estimate that a minority of patients in our region currently have an Asthma Action Plan, and our goal is to raise the proportion of patients with an Asthma Action Plan to 75% of asthma patients treated within our PPS.

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 Hudson Valley Asthma Coalition, a major asset to our PPS, is currently assisting organizations in two of the identified high need areas in our region, Yonkers and Newburgh. The Coalition assists health care providers to incorporate national evidence-based guidelines from the National Heart Lung and Blood Institute into their EHRs to prompt guideline-compliant asthma care and track asthmatic patients and their outcomes. Our PPS will work closely with the Coalition in supporting and expanding the reach of its programs across the region.

HealthlinkNY, a RHIO formed recently from the merger of Taconic Health Information Network and Community (THINC) and Southern Tier HealthLink (STHL), will span 11 counties across the Hudson Valley, Catskills, and Southern Tier, offering secure electronic access to statewide health information for both providers and patients in our region as well as information and tools to aid in health transformation. HealthlinkNY will maintain and consolidate patients' health information from participating health care organizations and provider practices across the region. Access to patient health information through HealthlinkNY's single, central, secure platform will allow a health care provider to view a patient's complete medical record. This expanded network will enable more efficient care coordination, reduce duplication of medical testing, and substantially cut health care costs.

The PPS will work with the Hudson Valley Asthma Coalition and HealthlinkNY to establish a regional asthma guidelines workgroup including PCPs, asthma specialists, asthma educators and representatives of all PPSs in the region working on asthma to standardize elements of an AAP that can be created, updated and shared among providers and with patients and families using the HealthlinkNY platform.

WMC, our PPS lead organization, is in the process of expanding its telemedicine capabilities that may support specialty asthma consultations across the region. The PPS will use rapid-cycle evaluation techniques to evaluate the efficacy of telemedicine to improve asthma care by making specialty asthma consultations more widely available and accessible to our attributed Medicaid patients.

Our PPS also has exceptional educational assets that we will build upon. We will leverage the experience of a local asthma specialist in our PPS who offers two highly regarded physician training programs: (1) a curriculum designed to train PCPs who currently do not perform spirometry to achieve proficiency; and (2) a program for PCPs to shadow an experienced pediatric pulmonologist to boost PCPs' comfort with asthma management. Our PPS will make these training programs more widely available to PPS Participants.

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 time needed to achieve agreement on standard Asthma Action Plan components will be a challenge. In addition, it may be difficult to engage some patient populations to follow their Action Plan. Asthma medications can cause feelings similar to an anxiety attack, which is a barrier to use for patients dually diagnosed with asthma and behavioral health conditions. An especially promising approach may be to involve trusted Health Home care coordinators in educating behavioral health patients on Action Plans, medications, and other treatment protocols.

Patients treated in the ED also present particular challenges. ED physicians are trained to treat acute problems and refer patients back to their usual source of care. However, because many patients do not actually follow up with their PCP after an ED visit, a meaningful plan for long term maintenance or self-management remains neglected. Training ED physicians to prescribe medicine to control inflammation and incorporating guidelines into EHRs may improve both prescribing and patient compliance rates because patients (and parents) in the ED are very attuned to the severity of their (or their child's) illness and particularly receptive to strategies for avoiding future attacks. We expect that other PPS projects, specifically 3.a.i "Integration of Primary and Behavioral Health Care" and 2.a.i. "Create an Integrated Delivery System" will also contribute to a streamlined, comprehensive approach to asthma management.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieve DSRIP goals across. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council to support development of a regional system of efficient and effective care, patient safety, and quality improvement.

The Council will review DSRIP project and implementation plans and make recommendations to align overlapping projects. Region-wide coordination, common requirements, and expectations will minimize providers' implementation burdens and create consistent, high quality patient experiences. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and payers.

The PPSs in our region have embraced collaboration throughout the selection, design, and development phases of their respective DSRIP projects. To date, the PPSs have committed to coordinate implementation in three critical areas: behavioral health crisis intervention and coordination with local County Departments of Health and Mental Health; protocols for patient consent and physician connectivity to HealthlinkNY; and a tobacco cessation public health campaign.

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.

The WMC-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network

management. Collectively, these tools support critical communication and coordination among our PPS partner organizations for improved asthma management. The capability will be shared across all 11 DSRIP projects and are central to our IDS development.

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
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
Haverstraw Pediatrics	Health Homes for Medicaid Enrollees with chronic conditions	2011	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees with chronic conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees with chronic conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees with chronic conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

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

This project will seek to ensure patients are adequately informed of their asthma plan to minimize potential negative health outcomes from an asthma related event. The care management experiences of the Medicaid initiatives identified above will be valuable in informing this process. However this project differs from these initiatives because it expands the population targeted. For example, the Community based Care Transitions program targets Medicare patients. Our PPS will build on the experience of these Participants to establish a customized standard care transitions models across the region and will expand the model to support to a broader population of Medicaid patients. The PPS will also expand health center services for the attributed population.

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, 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.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)

Project Objective: This project will promote tobacco use cessation, especially among low SES populations and those with poor mental health.

Project Description: Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State (NYS). Cigarette use alone results in an estimated 25,000 deaths in NYS. There are estimated to be 570,000 New Yorkers afflicted with serious disease directly attributable to their smoking. The list of illnesses caused by tobacco use is long and contains many of the most common causes of death. These include many forms of cancer (including lung and oral); heart disease; stroke; chronic obstructive pulmonary disease and other lung diseases.

The economic costs of tobacco use in NYS are staggering. Smoking-attributable healthcare costs are $8.2 billion annually, including $3.3 billion in annual Medicaid expenditures. In addition, smoking-related illnesses result in $6 billion in lost productivity. Reducing tobacco use has the potential to save NYS taxpayers billions of dollars every year.

Although there have been substantial reductions in adult smoking in NYS, some tobacco use disparities have become more pronounced over the past decade. Smoking rates did not decline among low-socioeconomic status adults and adults with poor mental health. This project is targets decreasing the prevalence of cigarette smoking by adults 18 and older by increasing the use of tobacco cessation services, including NYS Smokers' Quitline and nicotine replacement products.

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. Adopt tobacco-free outdoor policies.
2. Implement the US Public Health Services Guidelines for Treating Tobacco Use.
3. Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).
4. Facilitate referrals to the NYS Smokers' Quitline.
5. Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.
6. Promote smoking cessation benefits among Medicaid providers.
7. Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.
8. Promote cessation counseling among all smokers, including people with disabilities.

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
Center for a Tobacco Free Hudson Valley (an affiliate of the American Lung Association)
Tobacco Free Action Communities in Ulster, Dutchess, and Sullivan Counties
Westchester Institute for Human Development (WIHD)

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

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

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

Smoking is the leading preventable cause of death in the United States. In our region, the highest rates of smoking, which exceed the NYS Prevention Agenda objective of 15%, are seen in Sullivan (24.5%), Delaware (22.9%), Ulster (21.1%), Dutchess (16.1%) and Orange (15.7%) Counties. Our CNA revealed that populations of lower socioeconomic status experience higher rates of smoking than higher income groups. Tobacco use is also a concern among adults with behavioral health conditions whose smoking rates average 32%, exceeding the 24% prevalence goal set by the NYS Prevention Agenda. In Sullivan County, 48% of adults with a behavioral health condition smoke; in Delaware, Dutchess, and Ulster Counties 37-39% of adults with a behavioral health condition smoke.

It is not surprising that health conditions related to tobacco use, including respiratory cancer, chronic obstructive pulmonary disease (COPD), and bronchiectasis, are prevalent throughout our region. When COPD and bronchiectasis are examined by volume of Medicaid beneficiaries, the neighborhoods with the highest counts of beneficiaries relative to the rest of the region are in populous regions, such as southern and northwestern Westchester County (Yonkers/New Rochelle and Peekskill areas), central and eastern Rockland County (Spring Valley and Haverstraw areas), eastern Orange County (Newburgh), western Dutchess County (Poughkeepsie), and to a lesser degree central Sullivan County (Monticello/Harris area). Respiratory cancer hospitalization rates evidenced a hot spot centered in Kingston, a cluster in southern Westchester, and a geographically small cluster around Somers.

Our PPS will work to reduce overall smoking prevalence in the region with special attention to Medicaid beneficiaries living with the added stress of socioeconomic disadvantages, chronic behavioral health conditions or developmental disabilities (DD). All three PPSs in our region have agreed to work with local County Health Departments and advocacy groups, specifically the Center for a Tobacco Free Hudson Valley (an affiliate of the American Lung Association) and

Tobacco Free Action Communities, to develop a region-wide tobacco cessation campaign based on U.S. Preventive Services Task Force (USPSTF) guidelines for treating tobacco use. The campaign will align messaging and each PPS will implement the campaign among participating providers. The PPSs will also collaborate to share best practices on tobacco free outdoor policies (i.e., templates for policies and strategies for overcoming barriers); work with Medicaid MCOs to expand coverage for tobacco cessation counseling and for prescription and over-the-counter medications; and develop strategies to educate Medicaid providers about increased coverage and promote smoking cessation benefits.

A special focus of the our PPS campaign will be to enable health information technology to promote smoking cessation counseling. Wherever feasible, our PPS will assist all types of providers to build EHR templates to prompt providers to complete the "5 A's" of effective smoking cessation counseling – ask, advise, asses, assist, arrange – and refer smokers to the NYS Smokers' Quitline.

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.*

Our target population is all smokers in our region receiving health care services from PPS providers or community-based organizations. Under the umbrella of the Regional Clinical Council, comprised of representatives of all three PPSs in our broader region, we will convene a tobacco cessation campaign committee to develop messaging for a region-wide public health campaign. We anticipate the committee will include representatives from local County Health Departments and tobacco cessation advocates such as the Center for a Tobacco Free Hudson Valley and Tobacco Free Action Communities.

Our PPS will also develop outreach materials for use by medical, dental, behavioral health and DD providers that encourage patients to ask their providers about smoking cessation and to educate and remind providers how to provide and bill for tobacco cessation services. Patient-facing outreach materials will be tailored to appeal to special populations, such as those with behavioral health conditions. Provider-facing materials will address concerns from the provider's point of view; for example, how to appropriately dose smoking cessation aids for patients taking anti-depressants or anti-psychotic medications. In some cases, patients with behavioral health conditions may be using tobacco to mask symptoms or medication side effects. Some patients might be more affected by nicotine withdrawal than others; patients prone to panic attacks may have a harder time quitting because the symptoms of withdrawal — such as increased heart rate — can trigger a panic attack or they find the effects of nicotine beneficial. Research has shown that nicotine can improve attention and concentration, an appealing benefit for some behavioral health patients.

Our tobacco cessation campaign materials will encourage referrals to the NYS Smokers' Quitline, and the PPS will assess our campaign's impact by monitoring the Quitline's county specific engagement rates that are published monthly. Medicaid MCOs will be invited to participate in the campaign committee and asked to monitor rates of prescription and over-the counter-smoking cessation aids, as well as smoking cessation counseling for their enrollees in the our

region. Our goal is to see an increase in smoking cessation activity broadly across the region and for the Medicaid population in particular.

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 several community-based organizations in the region that are currently working toward our PPS' project goals and have strong relationships with PPS providers including the Center for a Tobacco Free Hudson Valley, an affiliate of the American Lung Association, and the Tobacco Free Action Communities in Ulster, Dutchess, and Sullivan counties. For example, the Center for a Tobacco Free Hudson Valley has strong relationships with FQHCs in seven of our PPS' counties and works with providers to develop and implement tobacco dependence treatment policies that follow national Public Health Service (PHS) guidelines and to integrate these policies into providers' screening systems and workflow. Crystal Run Healthcare (CRHC), a multispecialty group practice with over 300 physicians, is another asset as a PPS Participant. CRHC has already adopted a tobacco-free outdoor policy at its locations, follows the PHS guidelines for treating tobacco use, uses EHRs to remind providers to complete the 5 A's including appropriate and electronic referrals to the NYS Smokers' Quitline, and promotes tobacco cessation counseling among all smokers, including people with disabilities.

To promote tobacco cessation among Medicaid beneficiaries, our PPS will develop targeted outreach materials for the populations served by physicians, dentists, pharmacists, behavioral health and DD providers. Materials will be modeled on a very successful tool a PPS Participant developed to assist physicians and patients with discussions of obesity and will serve the dual purpose of encouraging patients to discuss smoking with their provider while educating providers about USPSTF and PHS guidelines for tobacco cessation counseling. Materials will be distributed through our tobacco cessation campaign with the goal of encouraging Medicaid providers to engage in tobacco cessation counseling; materials will include payer-specific instructions on how to bill for services for all provider types.

As noted in our CNA, tobacco use is high among adults with behavioral health conditions, making this group a critical population to reach with this project. However tobacco cessation can be particularly difficult for patients who are heavily dependent on nicotine and find the routine of smoking to be soothing. The PPS will leverage the Center for a Tobacco Free Hudson Valley's model to integrate tobacco screening and cessation counseling into provider and community-based organizations' workflows. This model has been successfully implemented by providers in our region, such as Putnam Family and Community Services which provides behavioral health services. There, tobacco screening has been integrated with intake procedures and cessation activities and follow up activities have been incorporated into the permanent job description of an on staff nurse. The Regional Clinical Council will provide a forum for identifying and sharing best practices like Putnam Family and Community Services' approach across PPSs.

Another resource the PPS can employ is the mobile dental van run by the Westchester Institute for Human Development (WIHD). WIHD provides a range of medical services for children and adults with disabilities. The mobile van travels throughout our region and can serve as conduit

to dental care services, as well as tobacco use cessation services. Utilizing a mobile van will be particularly useful in reaching populations with disabilities and in the areas identified by our CNA as Health Professional Shortage Areas, specifically Yonkers, Mt. Vernon, Monsey/New Square, Newburgh, and Middletown.

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 address time constraints and competing priorities for providers, our PPS will expand the use of EHR prompts for tobacco use screening and counseling, especially the 5 A's, and automate patients referrals to the NYS Smokers' Quitline. We will work with PPS Participants to implement the most automated solution feasible for their unique circumstances. When automation is not feasible or is in progress, waiting room flyers will encourage patients to discuss tobacco cessation and serve as regular reminders to providers.

Quitting smoking is more difficult for patients with behavioral health issues. Our PPS will distribute provider-facing guidelines for this population on dosing of smoking cessation aids and adjusting psychotropic medications.

Dental, behavioral health and DD providers may be unaware of Medicaid coverage for smoking cessation and billing requirements that vary by payer. To encourage additional tobacco screening and counseling, we will educate all eligible provider types on evidence-based treatment guidelines and work with Medicaid MCOs to clarify billing and reimbursement policies as needed. The Regional Clinical Council will also work collaboratively to pursue expanded Medicaid and health plan coverage of tobacco dependence treatment counseling and medications as gaps in coverage are identified.

Achieving consensus on a region-wide tobacco cessation campaign through the Regional Clinical Council will be time intensive, especially due to the need to refine messaging for target subpopulations. To mitigate the potential impact of delays, our PPS will work in parallel on other needed campaign content so that materials can be produced quickly and efficiently when the Regional Clinical Council reaches agreement on campaign tactics messaging.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and New York State. The three PPSs serving the Hudson Valley and Delaware County, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council that supports the development of a regional system of efficient and effective care, patient safety, and continuous quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping project approaches. Region-wide coordination, common requirements, and similar expectations will minimize providers' implementation burdens and create consistent, high quality experiences for patients. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating proven and promising clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and its payers.

Continuing the cooperation that resulted in the creation of a common Community Needs Assessment, the PPSs in our region have embraced cross-PPS collaboration throughout the selection, design, and development phases of their respective DSRIP projects. To date, the PPSs have committed to coordinate implementation in three critical areas: behavioral health crisis intervention and coordination with local County Departments of Health and Mental Health; protocols for patient consent and physician connectivity to HealthlinkNY (RHIO); and a tobacco cessation public health campaign.

The PPSs will also collaborate to share best practices on establishing tobacco free outdoor policies (templates for policies, strategies for overcoming barriers) and to work with Medicaid MCOs to develop consistent language around expanded coverage for tobacco cessation counseling and for prescription and over-the-counter medications.

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.

Our PPS will: (1) initially survey PPS Participants about their outdoor policies, share best practices, and re-survey Participants by DY2 to assess progress in implementing tobacco-free outdoor policies; (2) convene a region-wide tobacco cessation campaign committee by DY1; (3) engage Medicaid MCOs around coverage and payment by the end of DY1; (4) survey PPS Participants about USPSTF and PHS guidelines, use of EHRs to facilitate 5 A's, and referrals to the NYS Smokers' Quitline by mid DY1, and subsequently promulgate best practices by DY2; (5) launch a campaign to promote tobacco cessation among all eligible providers by late DY1; and (6) develop targeted outreach materials for special populations (dental, behavioral health, and DD patients) by DY2.

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

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

Yes	No
☐	☒

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

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.

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.

Our PPS will build on work done by the Greater Hudson Valley Family Health Center when reaching out to the target population. This project will significantly expand on this work by extending services to the attributed population.

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

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

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

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

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

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. Quarterly reports to the Independent Assessor will 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
Cancer Services Program of the Hudson Valley (operated by Hudson Information Technology for Community Health (HITCH))
Cancer Services Program of Delaware Otsego and Schoharie Counties
Cancer Services Program of Orange County

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

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

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

Despite widely accepted guidelines on cancer prevention from the U.S. Preventive Services Task Force (USPSTF) and other bodies, there are areas in our region with low cancer screening rates among specific groups of Medicaid beneficiaries within target gender and age groups for respective screenings. Breast cancer screening rates are generally low (<50%) in the northern PPS region (Sullivan, Dutchess, and Ulster Counties). Cervical cancer screening rates are low (<50%) in much of Dutchess and Ulster Counties, as well as specific zip codes in each of the remaining counties. Colorectal cancer screening rates are generally low (<50%) in all PPS counties, with particularly low rates (<40%) dominating Dutchess, Ulster, and Sullivan Counties.

The CNA revealed racial and ethnic disparities in outcomes related to these cancers which are also found statewide (NYS Minority Health Surveillance Report 2012). In our region, White non- Hispanic women have a higher rate of breast cancer (140 per 100,000) compared to Black non- Hispanic women (116), but the mortality rate for Black non-Hispanic women is higher than that of White non-Hispanic (28.3 compared to 22.6). Cervical cancer incident and mortality rates are twice as high among Black non-Hispanic and Hispanic women compared to White non-Hispanic women. Likewise, Black non-Hispanic adults in the region also have higher incident and mortality rates for colorectal cancer.

Combined, these findings indicate a deficit of both screening and follow up. Obstacles to cancer screening and follow up include geographic isolation, limited health literacy or self-efficacy, a lack of patient understanding regarding the benefits of screenings, language barriers, and a lack of provider coordination. The experience of our safety net providers indicates that even the need for a mammogram or colonoscopy order can be a barrier to service, as can the need for a patient to make a separate appointment to obtain the screening or follow up service.

Our project aims to increase access to cancer prevention care in clinical and community settings. Cancer screening is one of the "gaps in care" for which many providers do currently assess patients to ensure they are getting timely access to high quality care. However, new resources need to be developed to support more providers to reach a higher proportion of patients, especially in those communities with particularly low screening rates. We will work directly with primary care providers (PCPs), building on the model of the New York State (NYS) Cancer Services Program (CSP), a statewide, comprehensive cancer screening program that provides breast, cervical, and colorectal cancer screening services to uninsured and underinsured individuals. Among the benefits of the CSP model is that in addition to connecting patients to local cancer screening services, it coordinates follow up for diagnostic testing if necessary. The CSPs also work with provider networks to train them on and reinforce screening guidelines, collaborate with community-based organizations to promote the importance of cancer screening and the availability of CSP services, and participate in awareness-raising and screening events. Our plan is to leverage CSPs' best practices to improve outcomes in the target Medicaid population.

Our PPS, under the umbrella of the Regional Clinical Council, comprised of representatives of all three PPSs in our region, will coordinate region-wide project implementation with local health departments and other community partners. The Council will also work with hospitals across the region to incorporate Prevention Agenda goals and objectives into hospital community service plans and with Medicaid MCOs and health plans to seek enhanced reimbursement for cancer screening and prevention services.

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

The target population will be adult Medicaid patients of our PPS Participants in the eight county region we serve. We will target people for screening based on USPTF guidelines, specifically: for cervical cancer, women aged 21 to 64 years will be screened with cytology (pap smear) every 3 years; for breast cancer, women aged 50 to 64 will be screened by mammogram every other year; for colorectal cancer, adults aged 50 to 64 years will be screened using fecal occult blood test or colonoscopy, depending on the patient's profile. Note that the age criteria and timeframes will be modified in cases where patients are at increased risk, including patients who show symptoms or have a family or personal history of cancer, are being actively treated for cancer, or who are otherwise ineligible for clinical reasons.

Patients who are eligible and due for screenings according to the USPTF guidelines outlined above will be identified via medical record data in the office setting, or via health assessments conducted by Health Homes or in other clinical settings. All primary care practices in our PPS will be called upon to identify and address cancer screening gaps among their patient populations, and to track their patients in an EHR-linked cancer screening registry. Providers without an EHR will be provided with a basic computer-based tool for tracking their patients. The registry will enable providers to identify patients in need of services, flag patients for referrals at upcoming visits, and send patient reminders.

Secondarily, we will assist the subpopulation of patients whose screening results indicate the

need for follow up diagnostic testing. These patients will be provided with care management assistance to facilitate referrals to appropriate specialists, follow up primary care visits, and other services as needed.

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 NYS CSP is a valuable model and resource for our PPS to efficiently establish best practices in cancer screening and follow up. The CSP of the Hudson Valley, operated by Hudson Information Technology for Community Health (HITCH), is a PPS Participant and serves Dutchess, Putnam, Rockland, Ulster, and Westchester Counties; we will also partner with the CSP of Delaware Otsego and Schoharie Counties and the CSP of Orange County. The CSP model that empowers culturally-competent care coordinators to assist patients with follow up care can be applied to this project's target population targeted. The CSPs can assist our PPS with workflows, data collection strategies, talking points, and lessons learned, so that we may establish a comprehensive cancer screening function.

There is some care management capacity in our PPS, but it is limited. Existing care management programs are primarily focused on post-discharge transitions of care, or are Health Home-based and concerned with managing multiple chronic conditions and/or behavioral health comorbidities. Accordingly, we will need to establish more extensive care management capabilities in our region, ultimately aiming to adopt medical home and team-based care models among all PPS Participants by the end of DY3. We will work through the established Hubs to develop detailed cancer screening project implementation plans that take into consideration staffing needs, community resources, and social and environmental factors.

In addition to the CSPs, our region includes other cancer screening capabilities that can be expanded or modeled. For example, Memorial Sloan Kettering (MSK) Cancer Center is a PPS Participant that provides high-risk cancer screening services in West Harrison. Open Door Family Medical Centers and the Institute for Family Health are under contract with the CSP of the Hudson Valley to provide cancer screening services within their Health Homes as part of the model to be expanded as described above. WMC and Good Samaritan Regional Medical Center offer special screening events in adult outpatient clinics in addition to regular screening services. We propose to build on these and other PPS Participants' capabilities, for example, by establishing venues for walk-in mammograms at dates and times convenient to patients, so that in one stop a patient can obtain an order, be tested, and be referred back to her PCP.

Existing health information technology (IT) tools can be mobilized to achieve improved screening and follow up. PCPs using certified EHRs are able to track and report on screening activity as well as use clinical decision support features for alerts and reminders. As part of the initiative, we will expand enabling technologies to connect providers to Healthlink NY, the local RHIO, and the SHIN-NY, allowing providers to see a community patient record including cancer screening and other services, as well as engage in data sharing and electronic referrals either through the RHIO or Direct connections. Providers without an EHR will be provided with a basic computer-based tool for tracking their patients, enabling providers to identify patients in need of services, flag patients for referrals at upcoming visits, and send patient reminders. We will ensure that all PPS Participants are connected to the Healthlink NY RHIO by the end of DY 3 via certified EHRs, Direct connections, or a web-based provider portal.

We will establish a PPS-wide cancer registry to track patients eligible for cancer screening services. The PPS is evaluating analytics and population health management platforms and during DY 1 will implement a system to identify and track patients, and monitor patient and provider adherence to treatment guidelines. The platform will draw from claims data, EHRs, care management systems, and other data sources to enable identification and outreach to patients.

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

The adaptation of the NYS CSP to our PPS will be challenging, but we believe it will provide a strong foundation for the project. Because the program serves the uninsured, it includes specific eligibility criteria, intake processes, and data collection and reporting systems outside of the Medicaid system; these will need to be revised for the Medicaid population. Coordination with the CSP will also be a challenge and an imperative because we expect that a proportion of underserved patients cycle between Medicaid and uninsured status, and that coordination will be key to providing comprehensive care. Our PPS will work closely with the local CSPs to design the implementation plan for our cancer screening project, identifying additional resources, systems, and other requirements to ensure the project's success. We will convene a working committee that meets regularly to ensure an integrated approach.

Another challenge we anticipate is that of competing priorities for both providers and patients. Providers, while they recognize the importance of cancer screening, may be compelled to postpone discussion or ordering of cancer screening services if their patients have more urgent needs (e.g., acute health condition, or behavioral health crisis) at the time of a visit. Patients may be overwhelmed by other health issues or social and environmental factors that prevent them from addressing preventive care (e.g., job instability, transportation concerns, or lack of child care). We believe that our approach of reinforcing screening guidelines, providing supportive technical and human resources, and implementing a system of both provider and patient-facing alerts and reminders will enable us to mitigate this challenge.

Our PPS will also tie PPS Participant bonus payments to performance relative to the delivery of cancer screening and prevention services to the target population. The PPS Quality Committee will establish clinical benchmarks tied to Participant reimbursement and monitor Participant and individual provider performance. We will publish process and outcome metrics and provide feedback to Participants who fall below expectations.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and New York State. The three PPSs serving the Hudson Valley and Delaware County, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council that supports the development of a regional system of efficient and effective care, patient safety, and continuous quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping project approaches. Region-wide coordination, common requirements, and similar expectations will minimize providers' implementation burdens and create consistent, high quality experiences for patients. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating proven and promising clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence- based practices across the region and its payers.

Continuing the cooperation that resulted in the creation of a common Community Needs Assessment, the PPSs in our region have embraced cross-PPS collaboration throughout the selection, design, and development phases of their respective DSRIP projects. To date, the PPSs have committed to coordinate implementation in three critical areas: behavioral health crisis intervention and coordination with local County Departments of Health and Mental Health; protocols for patient consent and physician connectivity to HealthlinkNY (RHIO); and a tobacco cessation public health campaign.

The Council may also collaborate on processes for cancer screening as both Montefiore and the WMC-led PPSs are planning to implement this project though specific target populations may vary.

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.

Key milestones for the cancer screening project in DY1 are: (1) development of a comprehensive implementation plan, (2) an analysis of CSP best practices and lessons learned, (3) development of a technology-enablement plan to embed cancer screening guidelines, alerts and reminders in EHRs; (4) identification of functional requirements for the cancer screening registry; and (5) piloting rapid cycle evaluation of our PPS' care management function. In DY2, milestones include: (1) selection of an analytics platform to support patient identification; (2) roll-out of a one-stop screening pilot; and (3) wider roll-out of CSP-adapted protocols and preliminary evaluation of results. By the end of DY3 the PPS will ensure all providers have developed or adopted PCMH or team-based care models.

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

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

Yes	No
☒	☐

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

The WMC-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations for enhanced cancer prevention and management efforts. The capability will be shared across all 11 DSRIP projects and is central to our IDS development.

Additional capital funding will support transportation services to cancer screening clinics, as well as vehicles for mobile screenings.

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
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
The Greater Hudson Valley Family Health Center, Inc.	Supplemental Funding for Expanded Services (HRSA)	9/1/14	8/31/15	Expanded Services Supplemental Funding supports increased access to preventive and primary health care services, including oral health, behavioral health, pharmacy, and/or vision services at
Open Door Family Medical Center, Inc.	CSP of the Hudson Valley, operated by Hudson Information Technology for Community	2011	NA	The NYS Cancer Services Program (CSP) provides breast, cervical, and colorectal cancer screenings at no cost to women and men who are uninsured or whose insurance does not cover the cost of screenings and meet other eligibility requirements.
The Institute for Family Health	CSP of the Hudson Valley, operated by Hudson Information Technology for Community Health (HITCH)	2011	NA	The NYS Cancer Services Program (CSP) provides breast, cervical, and colorectal cancer screenings at no cost to women and men who are uninsured or whose insurance does not cover the cost of screenings and meet other eligibility requirements.

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.

Our PPS's DSRIP project differs from the existing New York State Cancer Services Program (CSP) because it will expand cancer screening and prevention services to the Medicaid population; today the CSP only serves the uninsured population. The proposed project will also increase the scope of CSPs to include respiratory/lung cancer screening. The PPS plans to work with the local CSPs to hire required staff and augment resources as needed to support this expansion to the Medicaid population and enhanced scope of services. The PPS will also expand health center services for the attributed population and will look to providers participating in the Expanding Services initiative as experts in providing care to underserved populations, but will not supplant or replace this project as it will expand access to care to the broader Medicaid population.

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

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

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

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

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