DSRIP Support Team

The prototype DSRIP application:

a companion guide

November 2014

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0 How to use this guide

This guide is designed to help you to develop a robust, effective DSRIP application by providing you with:

- Some of the lessons we learned in creating our prototype application;
- An explanation of the rationale behind what we wrote in that prototype; and
- Insight into how the Independent Assessor viewed our prototype and where we could have improved our response or our score.

Our Prototype Application is not intended to be a perfect answer. The Prototype Scoring Document (the Independent Assessor's 'Reviewer Responses') sets out what score the Independent Assessor gave to each of our responses. Reading the Prototype Scoring Document side-by-side with the Prototype Application, therefore, will allow you to see what level of detail and what depth of supporting analysis the Independent Assessor is looking for in each section and sub-section. It will also allow you to make your own assessment of what makes for a strong response to a given question.

The rest of this document takes each section of the application in turn and explains some of the lessons we learned in creating our prototype application, the rationale behind what we wrote and any areas where we could have provided a stronger response.

We have also included in this Companion Guide a glossary of some of the terms used in the application that are potentially ambiguous, or where further clarification will help you in writing your response. In addition, we have listed a number of useful resources that you might want to draw upon, either in the drafting of your application, or in the design of your DSRIP projects.

More detailed support and guidance, particularly on some of the more technical aspects of this application, is available through a series of webinars hosted on the DSRIP website. The webinar topics include but will not be limited to the following:

Webinar	Available
Governance	On the DSRIP website
Funds Flow	On the DSRIP website
Population Health Management	11/17
Population Health Management – the supporting IT infrastructure	11/18
Workforce Strategy	11/19
Data sharing & IT governance	*Expected* 11/21
Behavioral Health / Primary Care Integration	*Expected* 11/24
Payment reform	*Expected* 11/24
Performance management / RCE	*Expected* 11/24

How the prototype compares to the final application tool

Our prototype application was written as a response to the 29th September version of the application document (i.e. the version that was available for public comment). The revised version, published 13th November, includes some additional bullet points. Our prototype makes it clear where there are new bullet points that we have not responded to.

One notable difference between the 29th September version of the application and the final application tool will be that the final application tool will have separate text boxes and separate word limits for each of the bullet points in each sub-section. You will see that our prototype reflects this division. The 'redline' version of the application, published on 14th November, does not reflect this new structure.

Word counts will not be transferrable between text boxes sections and the Independent Assessor will score each text box separately. If one bullet point is not applicable to your PPS, you will not be able to transfer the word count of that text box to another. The word limits for each of the bullet-point text boxes will be as follows:

Section	Word limit
1. Executive Summary	
Description	
Succinctly explain identified goals…	**275**
Explain how the PPS has been formulated…	**150**
Provide the vision of what the delivery system…	**150**
2. Governance	
Governance Organizational Structure	
Outline the organizational structure…	**500**
Specify how the selected governance structure…	**500**
Specify how the selected clinical governance…	**250**
When applicable, organizational structure will evolve…	**250**
Governance Members and Processes	
Please outline the members of the governing body, along with roles…	**150**
Provide a description of the process implemented to select the governing body…	**500**
Explain how the members included provide sufficient representation…	**125**
Outline where coalition partners have been included, as well as…	**125**
Describe the decision making/ voting process of the governing team…	**225**
Explain how conflicts and issues will be resolved…	**125**
Describe how the governing body will ensure a transparent process…	**125**
Describe how the governing body will engage stakeholders…	**125**
Project Advisory Committee	
Describe how the PAC was formed…	**300**
Outline the role the PAC will serve…	**125**
Outline the role of the PAC in the development of the PPS's organizational…	**125**
Explain how the PAC members provide sufficient representation of…	**125**

Compliance	
Identify the compliance official, and describe the individual's relationship to …	**125**
Describe the mechanisms for addressing compliance problems…	**150**
Describe the compliance training for all PPS members and coalition partners…	**150**
Describe how community members, Medicaid beneficiaries, and the uninsured…	**150**
PPS Financial Organizational Structure	
Describe the processes to support the financial success of the PPS…	**150**
Describe the key finance functions within the PPS…	**150**
Identify the planned use of internal and/or external auditors…	**150**
Describe the PPS's plan to establish a compliance program…	**150**
Oversight & Member Removal	
Describe the process in which the PPS will monitor performance…	**150**
Outline how the PPS will address lower performing members…	**150**
Describe the process for removing a poor performing member from the PPS…	**300**
Indicate how Medicaid beneficiaries can provide feedback to inform…	**150**
Describe how Medicaid beneficiaries are notified when providers are removed…	**150**

3. CNA Analysis

Oversight of the Completion of the CNA	
Describe the process in which the CNA was completed…	**250**
Outline the information and data sources leveraged to conduct the CNA…	**250**
Healthcare Provider Infrastructure	
Describe on an aggregate level the existing healthcare infrastructure available…	**400**
Outline how the composition of the providers needs to be modified …	**400**
Community Resources	
Describe on an aggregate level the existing community resources available…	**400**
Outline how the composition of community resources needs to be modified…	**400**
Community Demographics	
Provide detailed demographic information on a full array of factors…	**1000**
Community Population Health	
Identify leading causes of death and premature death…	**150**
Identify leading causes of hospitalization and preventable hospitalization…	**150**
Identify rates of ambulatory care sensitive conditions and risk factors…	**150**
Identify disease prevalence such as diabetes, asthma…	**400**
Identify the state maternal and child health outcomes…	**150**
Identify health risk factors such as obesity, smoking, drinking…	**150**
Resources Identified Gaps	
Identify the health and behavioral health service gaps and/or excess capacity…	**400**
Include data supporting the causes for the identified gaps…	**300**
Identify the strategy to sufficiently address the identified gaps in order to…	**300**
Stakeholder and Community Engagement	
Describe the stakeholder and community engagement process undertaken…	**300**
Describe the number and types of focus groups that have been conducted…	**150**

Summarize the key findings that were identified through the stakeholder…	**150**

4. The DSRIP projects

Project 2.a.i

Project Description and Justification	
Address the gaps identified in the CNA that this project will fill…	**500**
Provide a summary of the current assets that can be mobilized to achieve…	**300**
Describe anticipated challenges the PPS will encounter, and how to address…	**500**
Outline how the PPS plans to coordinate on the DSRIP project with other PPSs…	***300***
System Transformation Vision	
Describe the comprehensive strategy for reducing the number of acute care beds…	**1000**
Describe how this project's governance strategy will evolve participants into…	**750**
Project Needs and Other Initiatives	
If the project requires capital funding, describe why capital funding is necessary…	**375**
If there are other related Medicaid initiatives, describe how this proposed project differs from or expands upon the initiatives…	**375**

All Other Domain 2 Projects

Project Description and Justification	
Address the gaps identified in the CNA that this project will fill…	**500**
Define the patient population expected to be engaged in this project…	**300**
Provide a summary of the current assets that can be mobilized to achieve…	**500**
Describe anticipated challenges the PPS will encounter, and how to address...	**300**
Outline how the PPS plans to coordinate on the DSRIP project with other PPSs…	**300**
Indicate the staffed hospital beds to reduce…	**100**
Project Needs and Other Initiatives	
If the project requires capital funding, describe why capital funding is necessary…	**375**
If there are other related Medicaid initiatives, describe how this proposed project differs from or expands upon the initiatives…	**375**

All Domain 3 Projects

Project Description and Justification	
Address the gaps identified in the CNA that this project will fill…	**400**
Define the patient population expected to be engaged in this project…	**200**
Provide a summary of the current assets that can be mobilized to achieve…	**400**
Describe anticipated challenges the PPS will encounter, and how to address them…	**200**
Outline how the PPS plans to coordinate on the DSRIP project with other PPSs…	**200**
Project Needs and Other Initiatives	
If the project requires capital funding, describe why capital funding is necessary…	**375**
If there are other related Medicaid initiatives, describe how this proposed project differs from or expands upon the initiatives…	**375**

All Domain 4 Projects

Project Description and Justification	
Address the gaps identified in the CNA that this project will fill…	**500**
Define the patient population expected to be engaged in this project…	**300**
Provide a summary of the current assets that can be mobilized to achieve…	**500**
Describe anticipated challenges the PPS will encounter, and how to address them…	**300**
Outline how the PPS plans to coordinate on the DSRIP project with other PPSs…	**300**
Identify and describe the important project milestones relative to the implementation..	**100**
Project Needs and Other Initiatives	
If the project requires capital funding, describe why capital funding is necessary…	**375**
If there are other related Medicaid initiatives, describe how this proposed project differs from or expands upon the initiatives…	**375**

5. Workforce Strategy

Detailed Workforce Strategy	
Summarize how existing workers will be impacted, as well as potential reductions…	**600**
Demonstrate the impact to the workforce by identifying specific workforce categories..	**250**
Describe the approach to minimize the negative impact to the workforce…	**250**
Describe any workforce shortages that exist and the impact on the PPS's ability…	**250**
Workforce Impact: Retraining Staff	
Describe the process by which employees will be retrained…	**450**
Indicate whether retraining will be voluntary…	**300**
Describe the impact of this approach, particularly the impact to compensation…	**150**
Articulate the ramifications of existing employees' refusal…	**100**
Describe the role of labor representatives in this retraining plan…	**150**
Workforce Impact: Redeployment	
Describe the process by which employees will be redeployed…	**600**
Describe the impact of this approach, particularly the impact to compensation…	**150**
Articulate the ramifications of existing employees' refusal…	**100**
Describe the role of labor representatives in this redeployment plan…	**150**
Workforce Impact: New Hires	
Describe the new jobs that will be created as a result of DSRIP…	**500**
State Program Collaboration Efforts	
Describe any plans to utilize existing state programs in the implementation of…	**250**
Stakeholder & Worker Engagement…	
Outline the stakeholder engagement process undertaken in developing…	**125**
Identify consulted labor groups…	**150**
Outline how the PPS will engage frontline workers in the system change…	**150**
Describe the steps planned to continue stakeholder engagement…	**125**

6. Data-Sharing, Confidentiality & RCE	
Data-Sharing & Confidentiality	
Provide a description of the plan for appropriate data sharing amongst partner…	**125**
Explain the strategy describing how all partners will act in unison to ensure…	**125**
Describe how the PPS will have/ develop an ability to share relevant…	**250**
Rapid Cycle Evaluation	
Identify the organizational unit accountable for reporting results and…	**150**
Outline how the PPS will use collected patient data…	**125**
Describe the oversight of the interpretation and application of …	**125**
Explain how the Rapid Cycle Evaluation will assist the development of …	**125**
7. Cultural Competency & Health Literacy	
Approach to Achieving Cultural Competence	
Describe the known cultural competency challenges which the PPS must address…	**250**
Describe the strategic plan the PPS will implement to develop a cultural…	**250**
Describe how the PPS will contract with community-based organizations to…	**250**
Approach to Improving Health Literacy	
Describe the PPS plan to improve and reinforce health literacy of patients served…	**250**
Indicate the initiatives that will be pursued by the PPS to promote health literacy…	**250**
Describe how the PPS will contract with community-based organizations to achieve...	**250**
8. DSRIP Budget & Flow of Funds	
Description	
Describe the plan in which the PPS plans on distributing DSRIP funds…	**125**
Describe how the PPS plans to distribute funds among the clinical specialties…	**125**
Outline how the distribution of funds is consistent with the governance structure…	**125**
Describe how the proposed approach will best allow the PPS to achieve…	**200**
9. Financial Sustainability Plan	
Assessment of PPS Financial Landscape	
Describe the assessment the PPS has performed to identify the PPS partners…	**250**
Identify the expected financial impact DSRIP projects will have on financially fragile…	**500**
Path to PPS Financial Sustainability	
Describe the plan outlining the PPS's path to financial sustainability…	**300**
Describe how the PPS will ensure fragile safety net providers will achieve…	**150**
Describe how the PPS will sustain the DSRIP outcomes after…	**150**
Strategy to Pursue Payment Transformation	
Articulate the PPS's vision for transforming to value-based reimbursement…	**200**
Outline how payment transformation will assist the PPS to achieve…	**300**

Note: this table does not include the new bullet points included in the application following the public comment period. We will confirm word counts for these text boxes shortly.

1 Executive Summary

The basics:

- The Executive Summary does not need to identify or explain all of the subsequent sections (there is not enough space in the word limit for that), but it should identify the PPS's goals, explain how the PPS is capable of meeting the health needs of the community, and describe in brief your vision of what care will look like in the PPS in 5 years
- Be sure to follow the requirements specifically, without additions or missing portions.
- You will need to indicate whether or not your PPS requires sign-off to receive a Certificate of Public Advantage, become an Accountable Care Organization, or to apply for Regulatory Relief. Each requires a brief response, and is easy to miss.

2 Governance

The Governance section will be crucial in satisfying the Independent Assessor that you have designed organizational structures, oversight function and compliance procedures that are robust and that support your PPS's transition to being a high-performing health system.

The Independent Assessor will expect to see links with your Budget & Flow of Funds section and with your Data Sharing & Confidentiality section, as well as alignment with the governance you describe for your chosen projects.

As well as reading this Companion Guide, the Independent Assessor's comments in the prototype scoring document will give you some insight into their priorities and concerns in this section. A Governance 'How To' guide and a webinar are also useful tools that can be found on the DSRIP website.

The basics:

- This should be a detailed description of how the PPS will be governed and how it will develop from being a group of affiliated providers to being a high-performing integrated delivery system, including concrete implementation steps and details of how the PPS will address lower performing members of the network
- Your PPS's finance group will be closely involved in decisions around governance
- Your application will need to describe a governance structure and processes that are robust and representative of your entire network and the entire continuum of care. You will need to demonstrate how that governance structure will support you in becoming a high performing, integrated delivery system.

Lessons learned from writing the prototype:

- We chose a delegated governance model for Forestland PPS, in part because of "the large number (180) of FHPP partners". However, having a small number of partners does not preclude the use of the Delegated Model. The Delegated Model is a useful structure for managing complexity. It could be used in a rural setting where the PPS has to manage a number of different local cultures and delivery systems. In addition, the Delegated Model is particularly useful when a PPS does not feel that a single Lead Applicant does justice to the composition of the PPS. Through the Delegated Model, organizations can share ownership through any combination (e.g. 50:50 or 50:25:25) they may seem fit. Each PPS should use legal counsel when deciding what areas of authority to retain or delegate by the Lead Entity and/or the other Governing Partners.
- You will see that our decisions about 'Governance Members and Governing Process' were based on the characteristics of our network and our service area. Rural environments and single-PPS environments will have different issues to contend with. The reference list at the end of the Governance "How To" Guide may provide some additional helpful information about how the environment influence governance structure. However, whatever the geographic and demographic characteristics of your service area are, you will need to articulate how your governance structures and processes have been designed in response to them.

- Forestland PPS chose to establish its Project Management Office (PMO) as an LLC in order to manage vendor relationships more efficiently and effectively. Each PPS should seek the advice of counsel when selecting an organizational structure such as an LLC, 501c(3) or LLP.
- Decisions about your governance structure will have a significant impact on your plans for designing and implementing your DSRIP projects. The reverse is also true – that your project selection will have an impact on the kind of governance model(s) you use. Developing these two elements of your application in tandem will help to ensure you have thought through the dependencies.
- You will see that Forestland PPS chose to design its committee structure around the projects it had selected. There is no specific requirement to create a committee structure based on the CNA or the particular projects you have selected. However, it is essential that each project has proper oversight at some point in the governance structure. Many of the projects are inter-connected – both in terms of their delivery and in terms of the impact they will have on the health of your population. It is important, therefore, that your governance structure allows you to maintain coordinated oversight of your projects.
- Our prototype describes a very open, public process. The formation of the PAC, for example, was advertised "in all major publications, was the subject of an extensive Public Service Announcement, and was posted on the FHC web site." Public disclosure is not a requirement for the formation of the PPS or the PAC. An alternative PAC formation or governance process may be equally adequate but should always reflect the nature of your network and the environment in which your PPS operates. Because DSRIP is about engaging communities and reaching out to the most vulnerable populations, being open and inclusive in your communications and – as far as possible – decision making will be an important building block of future success.
- PPSs should take steps to ensure that their compliance program is as objective as possible. Hiring a compliance officer with no past ties to the PPS partners is one step that can be taken.
- Your governance structure will need to ensure adequate representation and participation for your partner organizations from throughout the care continuum, including behavioral health providers and primary care. A more representative structure will support more effective management of your DSRIP projects and the transition towards an integrated delivery system.

3 Community Needs Assessment

The text of this section of the application seems to focus on asking you to summarize aspects of your CNA findings but summarizing isn't enough. You need to use this section of your application to describe *your interpretation of the implications* of the CNA findings and, crucially, how the CNA has informed the development of your PPS, your project selection and your plans for implementing those projects.

As well as the guidance below, the Independent Assessor's scoring commentary will give you insight into the level of detail that the Independent Assessor is looking for in terms of your assessment of existing resources – your excess inpatient capacity, for example.

The basics:

- At the core, this should be a comprehensive assessment of the demographics and health needs of the population you serve, the resources available to meet these needs and how those resources need to be developed in order to do so.
- Crucially, this section needs to be the basis of your justification for your choices and decisions explained elsewhere in the application – particularly in the project applications.
- Wherever possible, you should err on the side of concrete details, rather than generalizations. The Independent Assessor will be looking for you to quote the evidence base to back up your analysis of the trends and issues that you describe in this section.

Lessons learned from writing the prototype:

- The narrative in your CNA analysis section will need to form the basis of the justification for your project selections and your project design. It will also need to inform your workforce strategy, your governance structures and your approach to cultural competency. As you can imagine, therefore, writing this section in isolation will make it much harder to put together a consistent and compelling DSRIP application. This is a two-way dependency though – the narratives in those other sections of the application will have a significant impact on what key themes and data points you pull out of your CNA to include in this section.
- A lack of clear alignment between the CNA and your project choices will damage your scoring for each project. The 'Summary of CNA Findings' table will be an important tool that the Independent Assessor will use to monitor this alignment. This summary table is also responsible for 20% of the total score of this section, so it is important that this table is comprehensive. Your response here should articulate clearly how the most important findings in the CNA have influenced your project selections and your project design.
- The 'Summary of CNA Findings' table is not only designed to justify your project choices, however. It is also an opportunity for you to explain projects that you have ***not*** selected. There may be instances in which you have decided ***not*** to pursue a particular project that aligns closely with one of the major findings of your CNA. There could be legitimate reasons for this (for example, an existing improvement project in your service area that has exactly the same remit). If this is the case, use the 'Summary of CNA Findings' table to explain this.

- It is also important to point out that this is not just a rubber stamp. Selectively picking data from the CNA to underscore a project selection you had already made, for example, will not receive high scores.
- The Independent Assessor will be looking for you to quote the evidence base to back up your analysis of the trends and issues that you describe in this section. Drawing on a broad range of sources of evidence (including ‘soft’ evidence from stakeholder engagement activities) will improve the strength of this section of your application.

4 The DSRIP project applications

This is one of the most important – and challenging – sections of the whole DSRIP application. For each of your project applications, you will need to:

- Justify the project selection with explicit and detailed reference to your CNA;
- Identify and describe the disease and demographic groups you will be impacting through this project;
- Describe the resources that you currently have at your disposal for delivering this project and those you will need to develop or improve;
- Explain how you will mitigate the project risks you have identified; and
- Set out clear plans for coordinating with other PPSs that overlap on your service area.

…and through all of this you will need to provide a clear narrative for your approach to delivering each project, whilst taking account of the interplay between projects that will be highly interconnected.

The basics:

- The individual project applications are far from stand-alone sections. There needs to be close alignment (and explicit cross-referencing) between projects that have similar goals, target populations or initiatives.
- Similarly, the alignment between your project plans and the organizational section of your application needs to be clear and explicit. Your response to Project 2.a.i., for example, will need to explain how the governance structures and processes for that project will fit into your PPS's governance structure.
- The bullet points for the project applications are very tightly defined and quite prescriptive. The Independent Assessor will be looking for precise responses to these bullet points, so keep in mind the exact questions that the application document is asking you to answer.
- Each of these bullet points also has its own word limit (which is a change from the 29th September version of the application. This presented a challenge in terms of drafting a coherent narrative for our proposed approach to each project. It will require you to think through your approach to each project in detail, in order to be able to describe succinctly your target population, the resources you will leverage etc.

Lessons learned from writing the prototype:

The 'Project Justification, Assets, Challenges, and Needed Resources' sub-section breaks down into a similar set of bullet points for the majority of the projects across all of Domains 2, 3 and 4. We have summarized below some of the lessons we learned in responding to these bullet points.

'Identifying the gaps (via the CNA) that this project will address'

- The Independent Assessor is looking for very strong links to the evidence base created by the CNA. Relying on only subjective knowledge of gaps in the delivery system in your service area is unlikely to be sufficient and will undermine your score in this section.

- Conceptually there is a lot of crossover between this bullet point and the subsequent bullet point, which requires you to define the patient population you expect to engage through this project. However, the word limit for this first bullet point is considerably larger, so you have room here to describe the high level challenges across your service area and network – both in terms of patterns of health and lifestyle, and in terms of gaps in resources or poor access – before narrowing your focus in the next bullet onto the specific groups of individuals you intend to impact through this project.

'Defining the patient population you expect to engage through the implementation of this project'

- The Independent Assessor is looking for a tight definition here (what subgroups, out of all possible patients/beneficiaries, will you seek to engage), closely and explicitly linked to the CNA.
- The Independent Assessor is also looking for evidence that you have considered multiple factors in targeting a particular group. Defining the patient population you intend to engage with reference only to their age, for example, or their disease profile, is not likely to be enough. Our prototype responses would have benefited from more detail in Domain 3 in particular, where the Independent Assessor was looking for our response to have considered "social needs, demographics and other identifying factors". Our response to Project 3.c.i., conversely, scored highly in this regard because we included "clear neighborhood designations: Medicaid patients with diabetes in Hazelcrest and Birchview" and because we explained our "use of C.N.A. and focus groups to arrive at this conclusion."

'Summarizing the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project'

- The Independent Assessor is looking for a high degree of detail in responses to this bullet point and not just a summary. You will need to make close reference to your CNA and, where relevant, to the staffing gaps described in your workforce strategy.
- Our responses tended towards using this bullet point to explain our approach to the project and how we would utilize existing or future resources to achieve the goals of the project, at a relatively high level. However, the priority in this section needs to be providing a detailed description of assets and resources that will be deployed or developed in order to achieve the project requirements. Where this means retraining staff, or creating a cadre of people in a particular role (the creation of teams of health navigators, for example), you will need to describe how many individuals you plan to develop or retrain in this way. As with the Workforce Strategy section of the application, the Independent Assessor is looking for evidence that you have robust plans for the resources required per project (including staff) but these calculations can be revised in the implementation plan based on further analysis or more detailed project planning.
- You will need to consider not only the assets and resources within your PPS network but also, where relevant, the community assets and the community-based organizations that you can leverage for each project.

'Describing anticipated project challenges'

- The description of anticipated project challenges needs to be specific to the initiatives or interventions planned for each particular projects, rather than describing more generic challenges.
- Once again, the Independent Assessor is looking for evidence that at least some of these project challenges are supported by the CNA findings – for example, cultural or language barriers, or income levels and demographics inhibiting access.

- The mitigating strategies that you identify to address your risks will need to be specific and detailed. For example, simply pointing to 'patient outreach programs' would not be specific enough to describe a strategy to mitigate the risk of low levels of patient engagement with preventive services.
- Many of the implementation challenges faced by Forestland PPS were a result of the highly urban, relatively deprived setting of its service area. Conversely, more rural PPSs are likely to face challenges of longer travel times for patients, challenges in finding key staff, or isolation for many elderly patients for example.

Project Scoring Explanation

For the majority of DSRIP projects, 'Scale of Implementation' and 'Speed of Implementation' make up 80% of the points for each project. It is therefore important to understand how these are calculated, what they mean in practical terms and what the trade-offs are that you need to make as you calculate your speed and scale of implementation.

"Scale of Implementation"

For most projects, the definition of 'Scale of Implementation' can be broken down into two parts: project scale, and patient scale

- Project scale is the number of sites for new services and the number of providers committed to the project – particularly safety net providers
- Patient scale is the number of patients that you expect to be able to "actively engage" by DY4
- The definition of "actively engaged" is different for each project and it is defined for you in the application document

You have the flexibility in the 'Project Justification, Assets, Challenges, and Needed Resources' section to identify your target population (i.e., 'all patients with diabetes' in Project 3.c.i). However, the Scale of Implementation section is not asking you about the size of that target population. It is asking you how many of those individuals you think you will be able to 'actively engage' by DY 4, according strictly to the definition prescribed in the application document (i.e. for Project 3.c.i. it would be 'the number of participating patients with at least one hemoglobin A1c test within previous Demonstration Year (DY)'.)

It is therefore absolutely crucial that you understand the definition of 'actively engaged' for each project that you undertake and that you can accurately estimate the number of people who will meet this definition by DY 4 as a result of your project.

Scale of Implementation – scoring

As each of the three following factors increase, so too will the project score:

- The number of providers/sites/entities committed to the project
- The providers committed to the project that are 'safety net providers' as a percentage of all 'safety net providers' in the service area (not just in the PPS's network)
- The total number of patients that are expected to be actively engaged by the end of DY4 as a percentage of the total attributed population

"Speed of Implementation"

For most projects, the definition of 'Speed of Implementation' can be broken down into two parts: project speed, and patient engagement speed

- Project speed is how fast all Domain 1 project requirements for all committed sites/ providers are met
- Patient engagement speed is how quickly you can "actively engage" 100% of those patients identified in the preceding patient scale component

Speed of Implementation – scoring

As each of the two following factors decrease, the project score will increase:

- The time required to complete all Domain 1 project requirements
- The time required to have 100% of the patients identified in patient scale become *actively engaged*

What to consider when filling out these components:

- The scoring structure for scale and speed of implementation is designed to incentivize you to be ambitious but realistic. You need to make an explicit trade-off between your ambitions for the scale of your project and your ambitions for how quickly you will deliver it.
- Underestimating either component will result in a lower score and thus lower funding
- Also, low ambitions on either component will make it harder to 'move the needle' on your overall outcome measures
- Overestimating either component will result in an initially higher score but risks setting you up to fail to meet these goals, which would result in lower-than-expected funding in future

5 Workforce strategy

The Workforce Strategy section of the application is highly dependent upon other sections – in particular, the project applications. In order to put together a strong Workforce Strategy section, you will need a detailed, robust understanding of the number and type of staff who will need to be redeployed, retrained or hired as a result of each of your projects.

As well as *quantifying* the staffing changes that result from your projects, this section requires you to have considered all of these retraining, redeployment and recruiting needs collectively and put together a detailed approach for delivering them. You will need to:

- Understand your current state across your network – including any geographic variations in availability or level of training of staff;
- Compare that to what is needed to deliver your DSRIP program; and
- Describe your approach for delivering this future state.

The Workforce Strategy webinar (to be released shortly) will provide detailed guidance about how to develop your plans for workforce change in a way that is robust and meets the needs of the application.

In addition, the Prototype Scoring Document will give you more insight into the level of detail required for each of the questions in this section.

The basics:

- The focus of this section is on: (a) anticipating and quantifying the recruitment, retraining and redeployment that will need to occur as a result of your DSRIP program; and (b) setting out robust, detailed plans for delivering this workforce transformation
- The Independent Assessor will be looking for evidence that you have engaged with stakeholders in order to develop your strategy – including but not limited to labor representatives
- Your Workforce Strategy will need to reflect your Community Needs Assessment – consider the skill shortages described in your CNA, the cultural and language barriers and the assessment of where the biggest gaps are along the continuum of care.
- The Independent Assessor will be looking for an approach that prioritizes retraining and redeployment and seeks to mitigate the risk of letting staff go. Whilst the transformation of your delivery system will be significant, it is expected that your workforce strategy will aim to adapt your workforce by moving people out of an acute setting and equipping them with the skills and training to operate in a preventive, community-based system.
- All of this will need to be done in collaboration with your workforce and a broad range of other stakeholders, including labor representatives. The Independent Assessor will be looking for evidence that this has already happened, as well as concrete plans for it continuing in future.

Lessons learned from writing the prototype:

- Throughout this section of our prototype we assumed that Forestland PPS had developed a comprehensive workforce future state model – 'Forestland Health Future' – outlining in detail the strategic objectives of Forestland and linking them to the supply and demand for staff over the coming 5 years, broken out by role, skill, location, etc. and a detailed gap analysis. In this section of your application, the Independent Assessor will be looking for you to quantify the number of individuals you will need to retrain, redeploy and recruit in order to deliver on your strategy. Some PPSs have expressed concern that this is a premature point in the process to put a specific number on their recruitment and redeployment plans. However, PPSs will be able to revise these numbers in advance of the implementation plan deadline, based on the further analysis and planning that they will do between now and then. The forthcoming Workforce Strategy webinar will give you insight into how to create a robust Workforce Strategy.
- The Workforce Strategy section of the application includes strong incentives to describe ambitious plans for recruitment, retraining and redeployment. However, failing to meet these ambitions will have a negative impact in future years of the DSRIP program through missed deliverables and missed incentives, so you should ensure that the plans you describe are achievable and reflect the challenges described in your CNA. These kinds of local challenges might include:
  - How quickly you will be able to hire new staff – have some providers in your network traditionally had difficulty attracting new talent, for example, or are there particular roles for which resources are scarce across your whole service area?
  - How easy it will be for staff to move from one location within your service area to another – are there major disparities in the cost of living between different areas, for example, or are long commutes often a barrier to staff relocating?
- In our prototype application, Forestland PPS adopted an approach that we called 'Rapid Workforce Adjustment' (RWA). The objective of this approach was to give Forestland PPS the flexibility to shift capacity quickly from an acute setting into the community. We saw this kind of flexibility – and the pan-network approach driven by our workforce steering committee – as important factors in our need to balance supply and demand of available staff across multiple organizations and care settings.
- When considering how existing workforce programs might align with your DSRIP Workforce Strategy, you should bear in mind the timing of the solicitations associated with most of these programs. RFAs for some (including the PCSC and DANY), for example, are expected in the next quarter but other programs might be harder for you to take advantage of.
- In the prototype, we assumed that the WFSC was a subcommittee of the Forestland DSRIP Steering Committee and that, going forward into implementation, the WFSC would develop sub-structures, including multiple working groups, to manage the workforce transformation across the PPS network and the DSRIP projects. Working groups like this provide an opportunity for staff engagement in workforce transformation.
- The Independent Assessor will not only be looking for details of the stakeholder engagement that you have carried out so far but also for your plans for continued involvement of staff in this workforce redesign process as your PPS evolves and as you implement your DSRIP projects.
- Your plans for stakeholder and staff engagement should consider all of your network partners throughout the continuum of care, as well as community based organizations, local government and the public. The Independent Assessor will be looking for concrete actions that you have and plan to take to keep these communities engaged and informed. The diversity, demographic, geographic, cultural, and language differences of your area will determine the complexity of achieving meaningful engagement.
- There are bonus points available for PPSs that demonstrate they have worked with a proven workforce strategy vendor. It is important to note that these bonus points are tied to the overall

DSRIP program goal of "minimizing the negative impact to the workforce to the greatest extent possible" and not just the use of an independent contractor. You will need to explain clearly why your chosen vendor has the appropriate experience to help you design and manage this workforce change program. The Independent Assessor will be looking for evidence of a proven track record in a similar restructuring program.

6 Data sharing & confidentiality and rapid cycle evaluation (RCE)

The Data Sharing, Confidentiality, and Rapid Cycle Evaluation (RCE) section includes two sub-sections that are linked but which do require separate thinking. In order to write a strong Data Sharing, Confidentiality and RCE section, you will need to understand how the two sections depend on each other to support the PPS's successful evolution throughout the DSRIP program, as well as how each is fundamentally linked to the PPS's governance structure and processes.

There are ***two forthcoming webinars*** that will cover the subjects of Data Sharing & Confidentiality and Performance Measurement respectively. Also, the two Population Health Management webinars (one of which has already been published on the DSRIP website) will touch upon performance management and the data you will receive from the DOH to facilitate that task.

The basics:

- This section is where your PPS must determine what protocols, procedures and safeguards and IT infrastructure will be needed for effective data sharing and performance monitoring.
- In this section you need to be able to articulate clearly how you will strike a balance between maintaining the safety and security of the data of each PPS member (and Medicaid beneficiary), while also enabling the quick and seamless transfer of data between members to support more integrated, preventive care and a shift towards population health management across your PPS network.
- In the RCE subsection, PPSs should propose a performance management approach that merges the appropriate organizational structures and processes with the appropriate technology (including metrics) to ensure that the PPS is maximally 'in control' of its outcomes and achieving the DSRIP goals.
- A strong PPS application will describe how its performance management approach will be used to drive a continuous learning cycle whereby data are used to adjust both policies and clinical practices as conditions change.
- The DOH will provide a strong foundation for your performance management approach by providing, through the MAPP portal, a PPS-specific data source for most DSRIP metrics, including drill-down abilities, possibilities to stratify subpopulations, and so forth, optimally utilizing available claims and encounter data. The above-mentioned webinars will provide more details on what you can expect, and in what timeframe.

Lessons learned from writing the prototype:

- The Independent Assessor will be looking for evidence that you have assessed the various levels of maturity and infrastructure of the providers throughout your network – for example, their ability to transmit data electronically – and that you have developed robust plans to mitigate these risks.
- This section is interdependent with the IT governance topic within the Governance section, since a data-sharing strategy is not a one-time event, but an ongoing process.
- In the RCE / performance management section, you will need to consider how you monitor and stay in control of the metrics that demonstrate the impact of your PPS and your projects. Again, this will

vary greatly between PPSs, depending on the level of IT infrastructure they have, as well as the quality governance processes that are in place at providers throughout their network

- The RCE section will therefore need to be closely aligned with the Governance Section, as well as the payment reform sub-section of the Financial Sustainability section
- Continuous performance improvement will require more than technical capacity. Strong PPS applications will provide a thoughtful and realistic plan for ensuring meaningful representation and participation of service providers, partners, and stakeholders at the various levels of governance.
- A key component of the RCE response is to demonstrate that the PPS is capable of being 'in control' of its performance in order to meet its metrics. The assessor should believe that a PPS can monitor and change its behaviour throughout the network in order to improve its outcomes/ performance to meet future metrics.
- RCE & Data-sharing are intentionally placed within the same section of the application – performance management depends on having sufficient data-sharing capabilities between providers to allow for performance monitoring, analysis, and action to take place. Ensure that the two subsections make reference to each other in the response
- One of the key goals of the DSRIP program is to move towards a 90% Value-based Payment system within the PPS by the end of the program. RCE is a vital tool in achieving this goal, by measuring the quality of outcomes produced by the PPS. It could help to make reference to RCE's importance in the PPS's commitment to meeting the 90% Value-based Payment goal in order to demonstrate commitment to the program.

7 Cultural competency and health literacy

This section requires you to demonstrate to the Independent Assessor that your plans for the evolution of your PPS and, crucially, for the implementation of your chosen projects meets the cultural and social needs of your population.

This section is very closely linked to the Community Needs Assessment and you will need to reference concrete evidence from your CNA of the cultural and social barriers that exist in your service area.

The basics:

- You will need to demonstrate a deep understanding of the communities you will serve, describing not only health outcome statistics but also the social determinants of health and the cultural barriers and challenges you expect to encounter in implementing DSRIP projects.
- Your strategic plan for developing culturally competent organizations needs to look beyond the whole population level and address how you will improve cultural competency in frontline workers, as well as executive management.

Lessons learned from writing the prototype:

- This is about more than just providing multi-lingual services. You need to think about what the differences are between different communities in your region, in terms of the lifestyle and behavioral choices that lead to certain conditions (e.g. diet), or the cultural / moral beliefs that may affect their approach to healthcare-seeking behavior.
- Many other sections within the application are implicitly evaluated for how well they take account of cultural competency and health literacy integration. For example:
  - Patient engagement & activation in your workforce strategy and in Project 2.d.i.
  - Improving patient access to the delivery system in a broad range of DSRIP projects, including 2.a.i. and the many projects targeting emergency care.
- This sub-section is an opportunity for you to explain the unique social and cultural barriers that affect individuals (and specific groups of patients) in your service area. You will need to develop a plan to address those barriers, including targeted outreach, engagement, communication and education and training for staff at all levels. However, it will be a challenge to explain the full details of your plan in what is a relatively small section.

8 DSRIP budget and flow of funds

In the DSRIP Budget & Flow of Funds section the Independent Assessor is looking for you to describe your plan to manage the DSRIP funds received from DOH.

This section is essential to assure the Independent Assessor that the PPS has developed a funds flow budget model and a distribution plan that is consistent with the governance process and that will support the PPS's efforts to achieve its DSRIP goals. The Independent Assessor will expect to see an indication in the description of the plan that you have adequate and appropriate provisions for implementation costs, impacts to revenue streams, incentives to achieve DSRIP goals, and consideration for financially challenged providers. The Assessor will also expect to see strong links to the governance structure and process in the actual definition and administration of the funds flow plan.

The Funds Flow Webinar, published on the DSRIP website on 14th November, will be a useful tool to support you in completing a strong application.

The basics:

- This section should provide a concise description of your funds flow plan. Despite a tight word limit, this description will need to convey to the Independent Assessor that a thoughtful and effective plan has been developed, that it will support the achievement of the DSRIP project goals, and that it is strongly tied to the Governance structure and process.
- As you write the narrative responses, consider the conceptual design of the plan and the guiding principles for your flow of funds. This will include high level descriptions of:
  - Categories of costs and bonus pool payments to be allocated in accordance with the plan;
  - Initial thought on the distribution of funds into each category stated as a percentage and how this might change over time;
  - Although the budget allocation is stated as a percentage of the total DSRIP funds, analysis of each budget category should be conducted to support these percentages
  - Your consideration of the providers / provider types who will participate in receiving funds directly and how the plan provides for the distribution to them.
- This is not a submission of the final plan in detail but a description of the plan as it is presently approved by the PPS and expected to be administered.
- At this point, the PPS Governance structure should be defined and have an active, if not fully implemented, finance function with oversight of all finance related functions.
- The model or guide for the process for managing DSRIP funds can leverage, but be separate from, the PPS Lead's current structure for finance related functions, including:
  - Banking and related structure and processes for receiving funds
  - Payables process for distributing funds
  - Financial reporting and analysis for preparing and submitting reports to DOH

Lessons learned from writing the prototype:

- Funds flow is very challenging – especially to describe sufficiently within the parameters and limitations for this section of the application. Be comfortable in describing the plan at a high level – but in a manner that conveys that a more detailed plan has been developed. It is important for the

Independent Assessor to know that you have a plan and that you understand the fundamentals of funds flow and the priorities but the Independent Assessor does not need to see your entire plan.

  - The plan should include overall expectations for the areas where your PPS will budget and distribute funds.
  - The plan should include conceptual design of funds flow to provider types such as hospitals, SNFs, FQHCs, physicians, etc.

- Your responses should describe a funds flow process that is robust and that has been thought through and structured in a way that supports the PPS in achieving its goals by properly providing for costs to implement the projects, that incentivizes appropriate behavior and services, and that helps ensure sustainability.
- Developing your funds flow plan is likely to be an iterative process, starting with gathering the information needed to prepare an initial draft and working with that model.
- In drafting our prototype, we assumed that Forestland PPS's governance structure began to consider the entire funds management issue early, following the establishment of the finance committee. Our funds flow plan was designed to address the unique needs of Forestland PPS's participating providers, including those that require some level of financial support.

9 Financial sustainability

In this section the Independent Assessor is looking for a clear indication that the PPS has made a robust assessment of the overall financial health of the PPS, has identified any providers who are financially fragile and has established robust financial controls and practices that will support the financial sustainability of the PPS. The Independent Assessor will also need to see a clear indication that the PPS understands how the DSRIP projects will impact all of the providers – but especially those who are financially challenged or whose participation in the DSRIP projects might impact their financial stability.

This section needs to convey that the PPS has a plan for ensuring these providers, whose services are essential to the DSRIP goals, are able to sustain services throughout the DSRIP project period and beyond. The plan must also convey that the financial stability of the safety net providers is understood and considered in the overall plan.

The information that you gather to inform this part of your application, concerning the financial health of the PPS providers, will also inform your funds flow plan.

The basics:

- PPS Leads might consider using a survey or a financial model to gather the information required from its partners to assess the financial stability of those partner organizations and to develop the financial sustainability plan.
- As a starting point, you should have a basic knowledge of the financial challenges of providers in the PPS – particularly the providers whose absence would most significantly disrupt access to services for the attributed members or that would negatively impact the PPS's ability to achieve its DSRIP project goals. These providers, and any others as deemed appropriate by the PPS, should be the initial focus of the financial sustainability review.
- The PPS Lead will need to evaluate a significant amount of financial information in completing this assessment. An established, reliable finance function will be required in order to complete this analysis and any follow up steps – including the development of a DSRIP business office.
- The PPS and PPS Lead should also develop a knowledge of the various project dependencies including the process and costs for transformation redesign and overall implementation for the participating providers.
- The PPS Lead will not be expected to provide financial support to financially fragile participants in its PPS, however there is an expectation that the Lead will be able to provide oversight of the development and implementation of any restructuring plans that a fragile member will need to undertake in order to become financially viable.
- Within 5 years, 90% of all payments from MCO's to providers will have to be value-based. The State will submit a roadmap to CMS on how to achieve this before April 1st, 2015, which will build upon the foundation already created by the MRT Payment Reform & Quality Measurement Work Group. A webinar will be distributed by DOH which will outline some of the first ideas for this roadmap as soon as possible. Although it is important to take the insights from that webinar into consideration for your application, you are not expected to make definite statements at this moment about how you would apply some of these ideas and what value-based payment options you would choose.

Lessons learned from writing the prototype:

- It is important to be clear on the objective of this section, otherwise it can seem impossible to cover all of the ground in what is a relatively small section. This section does not specifically require that you assess the financial health of all of the individual providers within your network. Instead, you need to understand the overall financial health of the PPS, with a focus on ensuring the sustainability of the whole PPS and ensuring continued access to services for your attributed population.
- In order to do this, you will need an understanding of which providers' services are essential to one or more of the DSRIP project goals and of the extent to which the projects have dependencies on single providers versus a provider type that is broadly represented across the PPS.
- As with other sections, it is important for the Independent Assessor to see strong links to the governance process throughout this narrative. This would include links to the project functions and committees – including a Finance Committee – that are driving the DSRIP projects. It is important that this section demonstrates that you understand how each of the DSRIP projects will affect the providers in your network.
- Forestland PPS's plan included provisions for providers that were under a PPS approved Financial Stability Plan.
- This section of the application requires you to think beyond the 5 years of the DSRIP program also required FHPP to consider how the PPS would collaborate with the other providers to initiate development of a strategy to sustain the gains of the projects beyond the 5 year period.
- PPS may have had limited conversations with payers related to the future of value-based payments (VBP) and DSRIP. It's important to indicate in the application that PPSs understand transforming the payment system will be a meaningful method of building sustainability beyond the 5 year DSRIP period, and illustrates some initial thinking around areas the PPS thinks are most ripe to move into VBP.
- Consider areas where your PPS, providers, and payers have experimented with value based payment concepts. Have they been successful? Where there any important lessons learned you might want to incorporate in your VBP vision for the future of the PPS? Are there certain types of care, for example PCMHs or Advanced Primary Care models that you think are particularly well suited for value based contracting in the future?
- The text in the section on Financial Sustainability in the Prototype Application is illustrative of the path towards payment reform that will be further discussed in the forthcoming webinar.

10 References and further research suggested by key stakeholders

A number of key stakeholders have contributed ideas to this companion guide. As well as their input on specific sections of the application, many have provided suggestions of further sources of information for PPSs undertaking particular projects. We have listed these suggestions below as a potential resource. We have not sought to investigate any of these sources or verify them independently.

The following organizations have been invaluable in providing this kind of support and advice (in alphabetical order):

- HRHCARE
- NYAPRS
- NYCDOHMH
- OASAS
- OMH
- OPH

Project 2.a.i – Create an Integrated Delivery System

- Suggested literature references/ materials to use
  - https://ny.getcare.com/programs.php - lists county by county NY Connects programs (states federally recognized aging and disability resource centers (ADRCs)
  - https://ceacw.org/health-and-wellness-programs - searchable database (by zip code) of Stanford CDSMP and DSMP programs.
  - http://www.aging.ny.gov/nysofa/localoffices.cfm - county by county listing of offices for the aging, providing non-medical community-based LTSS and post-acute services

Project 2.b.ii – Development of co-located primary care services in the ED

- Suggestions of best practice:
  - SBIRT is an important element for any primary care or emergency department setting. This model – when used in its entirety and not just the screening element – has been shown to reduce substance abuse and prevent or delay the need for treatment.

Project 2.b.iv Care Transitions Intervention

- Suggestions of best practice:
  - PPSs choosing to implement care transitions programs for behavioral health discharges should consult with NYS OMH, OASAS, and county local governmental units regarding hospital peer bridge programs available in the region.

Project 2.b.vi Transitional Housing Supportive Services

- Key literature references/ materials to use
  - HEARTH Act Purposes – Sec. 1002(b), cited in "Understanding the HEARTH Act" presentation by Norman Suchar for the National Alliance to End Homelessness' Center for Capacity Building.
  - "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness – 2010", United States Interagency Council on Homelessness.

- Best practices for PPSs to examine or follow:
  - So that they can become ready for permanent housing. It consists of housing specifically dedicated to this purpose, sometimes using a scattered-site approach but often using a facility-based approach. It is often limited to a fixed number of housing units.
  - HUD and other national housing advocates have decisively rejected the traditional model of Transitional Housing (specialized time-limited housing that people go to in order to "get fixed") in favor of Housing First models whereby people move rapidly into permanent housing and there are provided with the services they need to retain the housing.

Project 2.d.i – Implementation of Patient Activation Activities for the Uninsured and Non/Low Utilizers of Medicaid

- Key literature references/ materials to use
  - Center for Practice Innovations at Columbia University/New York State Psychiatric Institute: http://www.practiceinnovations.org

Project 3.a.i – Integrated of Primary Care and Behavioral Health

- Key literature references/ materials to use
  - SAMHSA offers a thorough toolkit for BH/PCP integration that addresses current strategies, best practices, and research that offers recommendations per the effectiveness of certain approaches: http://www.integration.samhsa.gov/integrated-care-models
  - The University of Washington provides resources for implementation of the IMPACT model: http://impact-uw.org/implementation/.
  - Nineteen NYS academic medical centers participated in the NYS Collaborative Care Initiative in 2013 – 2014 (see: Sederer LI: JAMA Psychiatry 2014 May; 71(5):485-6, PMID: 24590239).
  - Collaboration of care:
    - Atlantis, E., Fahey, P. & Foster, J. (2014). Collaborative care for comorbid depression and diabetes: a systematic review and meta analysis, British Medical Journal Open, 4:e004706. Doi:10.1136/bmjopen-2013-004706.
    - Bower, A.J. (2012). Collaborative care for depression and anxiety problems (Review). Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD006525.

    - Community Preventive Services Task Force. (2012. Recommendation for the Community Preventative Services Task Force for Collaborative Care for the Management of Depressive Disorders. American Journal of Preventive Medicine , 42(5), 521-524.
  - Integration of Care:
    - Alfano, E. (2005). Integration of primary care and behavioral health: report on a roundtable discussion of strategies for private health insurance. Bazelon Center for Mental Health Law, 1-25. http://www.bazelon.org
    - Carey, T.S., Crotty, K.A., Morrissey, J.P., Jonas, D.E., Thaker, S., Ellis, A.R., Woodell, C., Wines, R.C. & Viswanathan, M. (2013). Future research needs for evaluating the integration of mental health and substance abuse treatment with primary care. Journal of Psychiatric Practice, 19(5), 345-359.
    - Institute for Clinical Systems Improvement: Health Care Guideline: Adult Depression in Primary Care. Matcham F. Prevalence of depression in R: systematic review and meta-analysis. Rheumatology. Dec. 2013; 52(12):2136-2148.
    - Patel, V.,Belkin G.S., Chockalingham, A., Cooper, J., Saxena, S., & Unutzer, J. (2013). Grand challenges: Integrating mental health services in priority health care platforms. PLoS Med 10(5). 1-6. DOI: 10.1371/journal.pmed.1001448
  - Chronic disease as a risk factor for depression:
    - Katon, W.J. (2011). Epidemiology and treatment of depression in patients with chronic medical illness. dialogues. Clinical Neuroscience, 13(1): 7-23.
    - Kessler, R.C. (2012). The costs of depression. The Psychiatric Clinics of North America, 35(1):1-14.
    - Voinov, B, Richie, W.D. & Bailey, R.K. (2013). Depression and chronic disease: It is time for a synergistic mental health and primary care approach. Primary Care Companion for CNS Disorders, 15(2). pii: PCC.12r01468. doi: 10.4088/PCC.12r01468. Epub 2013 Apr 4.
  - Surgeon General's Report- 50 Years of Progress http://www.surgeongeneral.gov/library/reports/index.html
  - Treating Tobacco Use and Dependence Clinical Practice Guideline: 2008 Update http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf Chapter 7- Specific populations
  - Smoking Among Adults with Mental Illness: http://www.cdc.gov/features/vitalsigns/smokingandmentalillness/

Project 3.a.ii – Behavioral Health Community Crisis Stabilization Services

- Key literature references/ materials to use:
  - http://nyculturalcompetence.org/
  - http://www.integration.samhsa.gov/images/res/PDF,%20PSWRC.pdf
  - http://ncmhr.org/peer-run-respite.htm
- Best practices for PPSs to examine or follow:
  - There are many examples of how peer-run crisis respites and crisis intervention team planning have been successful. In NY, the Rose House model is the longest standing and has significant research and best practice protocols, as well as a thorough manual for providers and community groups interested in establishing the model. Learn more and contact Director Steve Miccio here: http://projectstoempower.org/

NYC has invested in a crisis respite model spanning four boroughs, in collaboration with DOHMH, which was built off of the Rose House model. More information can be found here: http://www.nyc.gov/html/doh/html/mental/parachute-respite.shtml
Learn more about the 'Living Room' model, one of the most reputed models for community respite, here: http://www.gjcpp.org/en/article.php?issue=15&article=74

- Parachute NYC
- First Episode/Early Intervention training and treatment models: Coordinated Specialty Care (CSC) Treatment Model, such as the OnTrackNY program, and EIS (Early Intervention Services).

Project 3.b.i – Cardiovascular Disease Management

- Key literature references/ materials to use
  - Million Hearts® clinical protocol template to achieve HTN control: http://millionhearts.hhs.gov/Docs/Hypertension-Protocol.pdf
  - The American Medical Group Foundation and American Medical Group Association (AMGA) have produced a toolkit to help provider practices improve hypertension control: http://www.measureuppressuredown.com/HCProf/Find/provToolkit_find.asp
  - Million Hearts Hypertension Control an Action Guide for Providers: http://millionhearts.hhs.gov/Docs/MH_HTN_Clinician_Guide.PDF
  - The American Heart Association's home blood pressure monitoring resources: http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/SymptomsDiagnosisMonitoringofHighBloodPressure/Home-Blood-Pressure-Monitoring_UCM_301874_Article.jsp
  - NYS Quality and Technical Assistance Center offers training for the Chronic Disease Self-Management Education (CDSME), National Diabetes Prevention Program in New York State and Walk With Ease Programs. Visit the site to see the full menu of offerings. http://ceacw.org/qtac/q-training
  - NY State Obesity Prevention Program: http://www.health.ny.gov/prevention/obesity/
  - Tobacco Free NY State, technical assistance can be obtained by contacting your local Tobacco Control Community Partnership: http://www.tobaccofreenys.org/Contacts-NY.html
  - NY State's Food Standards to Reduce Sodium in Hospitals and Workplaces: http://www.health.ny.gov/diseases/cardiovascular/heart_disease/programs_and_tools.htm
  - To find public health contractors in your county that can support local Prevention Agenda efforts: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/contractor_map.htm

- Best practices for PPSs to examine or follow:
  - The American Medical Group Foundation and American Medical Group Association (AMGA) have produced a toolkit to help provider practices improve hypertension control: http://www.measureuppressuredown.com/HCProf/Find/provToolkit_find.asp
  - Kaiser Permanente Colorado Receives Recognition from Health and Human Services Secretary for Excellence in Hypertension Care – http://share.kaiserpermanente.org/article/kaiser-permanente-colorado-receives-recognition-from-health-and-human-services-secretary-for-excellence-in-hypertension-care/#sthash.mpdUvdMb.dpuf
  - New York Develops Clinical Pathway to Identify and Manage Adult Hypertension
    through the ASTHO Million Hearts State Learning Collaborative, one local clinic in New York is working with the New York State Department of Health (NYSDOH) and other state and local partners to develop and implement a standardized clinical pathway to identify and manage patients

with uncontrolled and undiagnosed hypertension. http://www.astho.org/Prevention/NY-Develops-Clinical-Pathway/

- Million Hearts Case Study: New York Cardiac Population Health Initiative
  The New York Cardiac Population Health Initiative (NY CPHI) is a collaboration between the New York State Department of Health (NYSDOH), IPRO (New York's designated quality improvement organization, or QIO), volunteering practices, and organizations throughout the state. NY CPHI is designed to achieve system-wide practice change and healthcare improvement by providing technical assistance and practice support statewide to improve performance and health outcomes around Million Hearts metrics, including the ABCS of heart health.
  http://www.astho.org/prevention/chronic-disease/million-hearts/case-study-ny-expanded/

Project 3.c.i – Diabetes Disease Management

- Key literature references/ materials to use
  - Adherence to NYS Guidelines for Adult Diabetes Care: http://professional.diabetes.org/cpr_search.aspx
  - Participation in Diabetes Self- Management Education (DSME) programs:
    - Improve self-efficacy resulting in better glycemic control; leading to fewer hospital visits for diabetes-related complications.
    - Only 40% of adults with diabetes participate in Diabetes Self-Management Programs
    - In NY, adults with diabetes who participated in DSME programs were more likely to monitor their blood glucose levels daily (75.2%) than those who did not (54.1%)
    - http://professional.diabetes.org/erp_zip_search.aspx
  - National Diabetes Prevention Program: http://www.cdc.gov/diabetes/prevention/prediabetes.html
  - Redesigning the Healthcare Team: Diabetes Prevention and Lifelong Management: http://ndep.nih.gov/media/NDEP37_RedesignTeamCare_4c_508.pdf?redirect=true
  - NYS Quality and Technical Assistance Center (QTAC): offers the Stanford Diabetes Self-Management Program and the CDC National Diabetes Prevention Program in New York State. Visit the site to see the full menu of offerings. http://ceacw.org/qtac/q-training

- Best practices for PPSs to examine or follow
  - ADA/AADE –recognized DSME programs http://professional.diabetes.org/erp_zip_search.aspx
  - Stanford Diabetes Self-Management Program (DSMP): http://patienteducation.stanford.edu/programs/diabeteseng.html

Project 4.a.iii – Strengthening Mental Health

- Key literature references/ materials to use
  - http://acestoohigh.com for research and best practices on coping with community trauma, preventative tools for children and families, and assessment strategies.
- Best practice examples:
  - Community in-reach by people with lived experiences—often in teams encompassing other para/professionals—can overcome systemic barriers to access. Linguistic competence in

engagement is not enough to understand the cultural nuances acting as barriers within a community, and persons with lived experience of a given ethnic, age, gender, or geographic background can provide fundamental support to engaging people in treatment. PPS' can find projects and associated research from the NYC Center for Excellence for Cultural Competence.

- Reducing underage and excessive alcohol use in communities
- Reducing the prevalence of tobacco use among populations with serious mental illness (and other groups with high prevalence of smoking).
- Promoting successful early child development through policies/programs that promote parent coaching and interventions to identify and reduce maternal depression
- US Public Health Services Guidelines for Treating Tobacco Use
  - Use electronic medical records to prompt providers to complete "5 As" (Ask, Advise, Assist, Assess, and Arrange).
  - Use motivational counselling intervention utilizing the "5 Rs" (Risk, Rewards, Relevance, Roadblocks, Repetition)
  - Promote Medicaid's smoking cessation benefits among enrollees.
  - Integrate guideline-concordant tobacco dependence treatment such that every smoker receives evidence-based treatment at every visit.

Project 4.b.ii – Increase Access to Chronic Disease Preventative Care Programs

- Key literature references/ materials to use
  - Agency for Healthcare Research and Quality (AHRQ) Delivery System Redesign resources at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/
  - AHRQ Care Coordination evidence base and resources at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html
  - AHRQ Community-Clinical Linkages evidence base and resources at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

11 Glossary

Central triage

Context: in project 3.a.ii, the term "central triage" is ambiguous because it can be interpreted as a clinical term (to prioritize according to acuity) or as a general term (to guide patients to their appropriate service provider).

Definition: In a broad sense, it is used as a general term, but the clinical aspect can come into play. What is meant by this is that "central triage" for project 3.a.ii means having a central hub to guide patients at risk of crisis to the services appropriate to them. However, in the case where a patient is experiencing an acute crisis, "clinical" triage should also take place to prioritize patient service based on acuity.

Co-location

Context: project 2.b.ii specifically focuses on the "co-location" of ED and primary care services

Definition: co-location involves reasonable accessibility such that a patient presenting to an ED can easily access the PCP without barriers. Co-locating will be required to the extent necessary to achieve this. It is expected that over time the hours of co-location will increase as the patient base expands.

"Expected # of Actively Engaged Patients"

Context: All DSRIP projects in Section 4, excluding Domain 4 projects, ask for both the scale of actively engaged patients, as well as the speed at which patients will become actively engaged

Definition: The total expected number of patients the PPS intends to 'actively engage' throughout this project. Each project has its own definition of what 'actively engaged' means, as determined by the Independent Assessor, based on the project's content.

Immediate

Context: in project 2.b.iii, it is suggested that after a patient has been triaged in the ED, they should be seen by a PCP "immediately."

Definition: providing service to a patient in an "immediate" manner means within the same timeframe that they would be serviced if they had waited in the ED. Generally this is between 4 to 6 hours. The idea behind this definition is that a patient triaged to a PCP will suffer a delay in the time before they are served because of the co-located of primary and emergency services.

Note: This also applies to "timely."

Patient **scale**

Context: All DSRIP projects in Section 4, excluding Domain 4 projects, ask for the "patient scale" of the project

Definition: The total number of patients that are expected to be actively engaged by the end of Demonstration year 4

Project scale

Context: All DSRIP projects in Section 4, excluding Domain 4 projects, ask for the "project scale" of the project

Definition: The total number of sites for new services or the number of participating networks providers or entities committed to the project

Patient engagement speed

Context: All DSRIP projects in Section 4, excluding Domain 4 projects, ask for the "patient engagement speed" of the project

Definition: How quickly the PPS actively engages 100% of the patients that the PPS has promised to actively engage in total (i.e., how quickly the PPS reaches its goal as stated in 'patient scale').

Project speed

Context: All DSRIP projects in Section 4, excluding Domain 4 projects, ask for the "project speed"

Definition: How fast all Domain 1 project requirements are met for all committed sites or providers or entities

Total committed

Context: All DSRIP projects in Section 4, the term "total committed" is used to conjunction with "project scale"

Definition: Similar to "project scale," it is the total number of sites, programs, and/or providers the PPS intends to include in the project

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