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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.

A total of 693,954 people live in the largely rural 11,859 square mile AHI North Country PPS (AHINCPPS) service area. The PPS population is older than the state average. All nine counties have fewer children and five counties have more adults age 65 plus. Three counties have very high percentages of older adults, Warren, 17.3%, Essex, 18.4%, and Hamilton, 23.3% compared to Upstate at 14.6%.

In the AHINCPPS service area, there is lower primary care use and higher ED use compared to the state, especially for adults aged 18-64 years old and older adults aged 64+.
The PPS population disproportionately suffers from chronic disease compared to NY State as a whole. Clinton, Essex, Franklin, St. Lawrence, and Warren Counties have a higher percent of Adults with Diabetes (ranging from 9.8% to 11.7%) than NY State (9%). The percent of Adults with Asthma is higher in seven of the nine counties (ranging from 11.0% to 15.3%) than in NY State (9.7%). Six of the nine counties have higher rates of Adults with Heart Disease (ranging from 8.6% to 11.2%) than NY State (7.6%). Eight of the nine counties have a higher percent of Adults with High Blood Pressure (ranging from 28.2% to 33.1%) than NY State (25.7%).

Admissions for ambulatory sensitive conditions (Prevention Quality Indicators, or PQIs) point to a need to improve primary care quality and access. The PQI overall composite measure and

the acute, chronic, diabetes, respiratory, and circulatory composites all show poorer performance in Franklin, Clinton, St. Lawrence, and Fulton counties compared to NY State for the overall composite PQI and each sub-composite score. Essex County had an overall composite better than the state in 2011, but worse than the state in 2012.

In the PPS' service area the behavioral health Major Diagnostic Categories (mental diseases and disorders and substance abuse) accounted for 49% of inpatient admissions and 58% of ED visits by MDCs. Based on NY State data, 68% of adults with mental health disorders also have a medical disorder, and 29% of adults with a medical disorder also have a mental health disorder.

With respect to potentially inappropriate ED use (PPVs) among Medicaid patients, all counties perform worse than NY State, except Washington and Hamilton, and Warren County in 2012. St. Lawrence, Essex, Clinton, Fulton, and Franklin have particularly high rates; these, along with Essex, are the same counties with high PQIs.

The CNA findings point to a need for a more integrated delivery system, with greater access to preventative services, primary care, chronic disease management, transitional care, and community-based supports. The PQIs, PDIs, and PPVs, which focus on ambulatory care sensitive conditions, provide direct evidence of the need to strengthen the primary care infrastructure. The impact of behavioral health and substance abuse disorders on utilization and poor outcomes points to a need for a more coordinated system of primary care integrated with behavioral health services.

The PPS is developing an integrated delivery system that includes providers from across the full care continuum, supported by strong governance, a regional health information technology plan, and a financial model that rewards quality and collaboration. AHINCPPS will also build on the relationships with Medicaid MCOs that have been developed through the Adirondack Medical Home initiative and the four Health Home networks to coordinate efficient care delivery and develop accountable payment reform strategies that aligns provider compensation with patient outcomes. Development of Regional Health Innovation Teams (RHITs) will be a core piece of our IDS strategy. The RHITs will host services that will help coordinate care across the spectrum and ensure optimum utilization of appropriate resources. Hixny, the local RHIO will provide "Dial Tone" services to promote real time information sharing, alerting care givers to changes in status and facilitating care coordination.

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

Current Assets and Resources

The region has a history of collaboration that has served the PPS well through the DSRIP planning activities and will continue to serve it well as it works toward implementation of its DSRIP projects.

The nine county service area includes: 13 hospitals, 7 federally qualified health

centers, 337 PCMH certified primary care practices, 31 nursing homes, 4 Health Homes, 15 Certified Health Home Agencies, 6 hospices, 4 assisted living facilities, and among OMH-affiliated programs, 7 inpatient mental health providers, 25 outpatient mental health programs, 8 emergency mental health programs, and 45 residential mental health programs. The vast majority of all of these organizations have been actively involved in the PAC.

The region's public health departments provide many functions: surveillance, assessment and planning, service delivery, screening, health education, and health promotion. Community health organizations and coalitions are an asset; there are 11 known coalitions in the PPS region, including the Comprehensive Adolescent Pregnancy Prevention Projects and Tobacco Free Coalitions.

Additional resources include a long list of community-based organizations that include food bank services, housing, advocacy, faith based, peer support, and community health education. The State's 211 hotline provides information and access to many of these services.

Resources to be Developed

While some gains have been made in primary care access in recent years, there continues to be a need to increase access to primary care. The data by county shows that for Medicaid beneficiaries in the PPS region primary care utilization tends to be slightly lower than NY State averages. In five counties, ED use is at least five percentage points higher than the NY State average. This trend is most pronounced in the five rural counties that are designated Health Professional Shortage Areas indicating a need for more capacity.

Behavioral health and substance abuse organizations are not well distributed throughout the region and the results from a regional survey indicate that both mental health and substance abuse are perceived as second only to obesity in emerging health issues for the region. The PPS needs to develop better access to these services, and breakdown the historical separation of these services.

There is a need for a stronger, more coordinated system of primary care integrated with behavioral health services. The gap analysis indicates that the challenge may be in expanding this system. Most of the region is a designated shortage area for mental health professionals and large portions are designated as primary care health professional shortage areas. Urgent care is limited to just the most populated areas. Additional care coordination also needs to be developed. As in many rural areas transportation can be a barrier to access as patients may need to travel to attend appointment and public transportation is limited.

Home and community based services need to be strengthened, including promoting awareness of the existence of these services. For the AHI North Country PPS, it is not changing the complement of community based services but creating a system so that providers understand the options and availability and can refer people in need of services or community supports.

Nursing Homes in the PPS have an occupancy rate of over 92 percent. In early 2015, LeadingAge NY will be releasing a study titled, "A Roadmap to a Rational,

Sustainable and Replicable System of LTC Services in the Eastern Adirondacks." This study will be key to identifying the needed configuration of services in the region, assembling an action plan to rebalance the long term care and supportive services system and growing a sustainable, integrated rural health network of services in the region.

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.

The PPS will be challenged to achieve the level of technological integration required under DSRIP. While hospitals and primary care providers have made gains in utilizing technology to support coordinated care, others (i.e., long-term care, mental health, home care) generally have further to go, and there is the additional challenge of utilizing technology to coordinate with community-based organizations. There will need to be significant HIT investments, including EHRs, other technologies, and connections to the RHIO and/or other platforms. Care management activities must be documented in a way that is accessible to the full care team, and supports evaluation. Currently, care management records are alternatively housed in EHRs, in databases, or in stand-alone systems. To address these challenges, the Health Information Technology Workgroup has been established and its membership overlaps in part with the Adirondacks ACO Informatics Committee. These groups will develop a long-range HIT plan that will utilize partnering Health Homes and ACO population health management systems and capabilities to support the development of an Integrated Delivery System. AHI will provide practice facilitators to help providers maximize the benefits of their technology and establish efficient workflows and ensure that the PCP practices meet Meaningful Use Stage 2 and 2014 PCMH Level 3 standards by the end of DY 3 (Refer to 2.a.ii for more details.)

The region is burdened by high rates of severe poverty, proportions that are at or below 138% FPL or at/below 200% FPL, are both higher in the Adirondacks than in Upstate New York. It can be challenging for health care providers and community based workers to effectively engage with persons in poverty. The PPS will offer training to help service providers from many disciplines and organizations better understand and work effectively with people from poverty (i.e., the Community Service Council's Bridges Out of Poverty training).

The shortage of primary care and mental health providers in the Adirondacks is an on-going challenge. Most of the region is a designated shortage area for mental health professionals and large portions are designated as primary care health professional shortage areas. Workforce development activities will be undertaken, and telehealth / telemedicine will be developed and utilized to its full potential.

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.

AHI, the lead organization for the AHI North Country PPS (AHINCPPS) has a strong history of

collaboration and has established relationships with organizations from the other PPS' in our overlapping service areas. Other organizations within the PPS have also developed relationships with partners based on referrals, care coordination efforts and admission patterns. The PPS will build on those relationships to leverage areas of strengths and specific expertise and to ensure seamless coverage for our patients.

The PPS is working in collaboration with neighboring PPSs; the North Country Initiative PPS/Samaritan Medical Center (NCI), Ellis Hospital (EH), and Albany Medical Center (AMC). All neighboring PPSs selected this project. Initial planning conversations have taken place with each of the neighboring PPSs, and follow-up meetings are scheduled.

The PPSs are in agreement to establish a cross-PPS partnership that will address any issues presented by patient, and provider, overlap across the service areas. The first issue the group will address is how to count providers and patients for the scale and speed submission, to ensure that numbers are not inflated due to "double-counting" of patients in more than one PPS. Another aspect of coordination is in regards to sharing information to coordinate care across PPSs. This will be addressed, in part, through the SHIN-NY infrastructure, when available.

Collaboration on the development of regional health information technology initiatives, including telemedicine strategies and population health management capabilities, has been the subject of initial discussions. The PPSs also plan to share information on best practices with the neighboring PPSs via a learning collaborative model. Each region has access to resources to support sharing of best practices, such as funding for Population Health Improvement Programs, and Rural Health Networks. The PPSs will take part in regular meetings to coordinate planning and to leverage training/educational resources as broadly as possible. Workforce development activities will also be coordinated with neighboring PPSs. Overall, the PPSs are highly motivated to work collaboratively, and capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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

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

The Commission for Health Care in the 21st Century report and the more recent North Country Health Systems Redesign Commission (NCHSRC) report point to the regional reliance on institutional providers and the insufficient capacity of home and community based services as key issues for regional health system transformation to address.

A number of transformational initiatives in recent years have addressed realigning capacity;

the Adirondack Region Medical Home Pilot, Health Home, and Adirondacks ACO are improving access to primary and preventive care, including care management /coordination supports. These initiatives have had an impact as evidenced by the trend in declining hospital occupancy rates since 2011. The data shows that there continues to be a need to build on these programs to reduce reliance on institutional providers and increase access to primary care.

An overarching goal of the PPS is to right-size the integrated delivery system, as such, the PPS Governance will monitor health system capacity, utilization, and projections, and use this information to develop action plans to make targeted reductions, or expansions, as needed. The PPS will leverage the regional assessment and planning resources available from the Adirondack Rural Health Network, the soon-to-be-established AHI Population Health Improvement Program, the Adirondack's ACO, and reports issued by advocacy groups. Initial steps towards right-sizing have begun through the DSRIP planning, such as an emerging plan to transform a financially unstable Nursing Home, and four Medical Village projects.

The NCHSRC recommended "skilled nursing facilities enter into transformative change through integration to establish a continuum of home and community based long term care services which will allow residents to receive care in the least restrictive setting, and enabling the down-sizing of facilities and committing existing space to new uses". The Eastern Adirondack Long Term Care Consortium (EALTCC), initiated by LeadingAge NY, in their September 2014 report, recommended a series of reforms considered essential to meet the long term care needs for seniors in the Adirondacks. Two of their positions are (1) use existing Skilled Nursing Facilities, health centers, etc. develop comprehensive campuses for older adults that consolidate the essential health, wellness, prevention, care coordination and social programs required for successful aging; and (2) integrate acute, ambulatory and post-acute care with community based services to improve the customer experience, outcomes and be more efficient.

The Adirondack Tri-County Nursing & Rehabilitation Center (ATC), in consultation with Fort Hudson Health System, and other PPS partners, is working to put in place a plan to transform in accordance with the recommendations summarized above. The plan is to reconfigure ATC to create a multi-service senior care campus, appropriately sized to meet community need, and which allows for the expanded capacity of non-institutional services. The plan includes a reduction in skilled nursing beds; the current number (82) is considered too few to be viable as a stand-alone operation, lacking sufficient revenue to support required infrastructure. Yet adding beds is neither practical from an economic standpoint, nor appropriate for the demographics; and contrary to current health policy. The project proposes to reduce beds down to a yet to be determined number that takes into account the existing client profile (very low case mix average), declining population base, and anticipated expansion of alternatives to institutional care. Recognizing the inherent increase in per unit cost in low-volume conditions, program viability can only be assured with a modest adjustment to the Medicaid formula. With existing precedent in other "higher cost" environments, including a hospital based facility and the over-300 bed facility, a rural conditions adjustment is warranted, and the PPS will advocate for such an adjustment. The combination of appropriately sizing the facility to the community need and providing a modest add-on which recognizes structural inefficiencies will put the ATC on the path to financial sustainability.

Overall in the PPS region there appears to be a potential surplus of hospital beds. Although the average number of 2.1 hospital beds/1000 population is lower than the state average of 2.9, it appears to be in excess of what is needed, given the low bed occupancy rates across the PPS, 52 percent compared to a state percentage of 69. The NCHSRC report reached the same conclusion (although there is not an exact match to the PPS counties). There will be even less need for hospital beds if potentially avoidable hospitalizations, which are high across the PPS, are reduced. Although hospital occupancy rates are lower than the state rate, there are a number of unique issues to take into account in the PPS region concerning hospital capacity. Due to the very rural nature of the region the facilities are far apart, some have seasonal census fluctuations, and ensuring enough surge capacity needs to be taken into account in looking at overall capacity. The PPS is in the process of forming a comprehensive strategy and action plan for reducing the number of unnecessary beds in parallel with building needed community-based healthcare services. A portion of this plan is evident in the Medical Village project plan, the highlights of which are summarized here.

The PPS will create four Medical Villages, all are located at least 50 miles apart, to take advantage of existing infrastructure to realign health system capacity and address community needs. The projects will support the needed behavioral health, substance abuse and outpatient services needed in the communities. They are:

1. The CVPH Medical Village in Plattsburgh will serve residents of Clinton County and northern Essex and Franklin County. The focus will be behavioral health child and adult patients in crisis that present to CVPH for care at the inpatient psychiatric unit. The Medical Village project will create a stabilization pathway for patients in crisis that present to the emergency department.

2. Adirondack Medical Center in Saranac Lake will serve patients in need of medical detoxification from Franklin, Essex, and Clinton Counties. There is currently no medical detox in those counties. AMC will expand outpatient services to serve chemotherapy and transfusion patients in southern Franklin, northwestern Essex, southeastern St. Lawrence, and northern Hamilton.

3. Moses Ludington Hospital in Ticonderoga will expand access to specialty providers and access to medical imaging. In a separate project an existing FQHC will be relocating to the hospital campus. The focus will be on patients with chronic conditions including heart disease, respiratory conditions, and other conditions to improve care coordination to improve outcomes.

4. Glens Falls Hospital in Glens Falls will create a crisis stabilization unit and observation unit. The focus will be behavioral health child and adult patients in crisis that are brought to GFH for the inpatient psychiatric unit. The project will create a stabilization pathway for patients in crisis that present to the emergency department. The Observation Unit will serve patients that may not require admission but need an appropriate setting for observation and stabilization prior to a return to outpatient care. This Medical Village will serve patients from southern Essex, Hamilton, Warren, Washington, and northern Saratoga counties.

-Milestone: 10 CVPH beds are converted to outpatient services by Q4 of DSRIP Year 3.
-Milestone: 2 AMC beds are converted to outpatient services by Q2 of DSRIP Year 4.
-Milestone: 15 MLH beds are converted to outpatient services by Q4 of DSRIP Year 3.
-Milestone: 4 GFH beds are converted to outpatient services by Q4 of DSRIP Year 2.

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

The wide range of providers and community based organizations that have come together to form the AHI North Country PPS (AHINCPPS) are working collaboratively to establish shared governance (delegated model – described in detail in Section 2 of the Organizational Application). An Interim Steering Committee is currently in place; this twenty member group includes representation from the following sectors: hospital/acute care, primary care, post-acute, home and community-based services, prevention and public health, behavioral health and substance abuse treatment providers. The Interim Steering Committee reports to the AHI Board and Members. Upon incorporation, the Interim Steering Committee will dissolve and be replaced by the AHINCPPS Leadership Board. The Leadership Board's list of delegated actions includes "implementing the project plan and monitoring of milestones and metrics". The Leadership Board is also delegated with the authority to make decisions regarding quality and clinical practices; the Board will in turn delegate that authority to a Clinical Governance and Quality Committee. The Board will establish a Governance Committee that will be charged with overseeing the performance of the LLC and recommending operational strategies and structural changes based on the evolution of the projects, changes in leadership, the number and types of partners, as well as transformation towards value based reimbursement methodologies.

The Leadership Board and Committees described above will be held responsible for the following milestones and metrics:

- Milestone: Governance Structure is formalized. Metrics: The AHI North Country PPS, LLC is incorporated. Member Managers, Attributed Lives Managers, and Nominated Managers are appointed. Committees are established and populated.
- Milestone: The integrated delivery system represents the full continuum of care. Metrics: contractual agreements are in place with Network Partners and Affiliates including pediatricians, primary care, hospitals, long-term care, post-acute home and community-based services (including home health, preventive services, and public health), behavioral health and substance abuse treatment providers.
- Milestone: Providers are actively engaged in the Network. Metrics: "actively engaged" is defined by use of a shared or interoperable EHR. Goals: 80% of core providers ("core" providers are those that as a group account for 80% or more of the total attributed lives) are actively engaged by the end of Demonstration Year 2, and 100% of core providers are actively engaged by the end of Demonstration Year 3.
-Milestone: The majority of care is provided by a certified Patient-Centered

Medical Home. Metrics and goals: 100% of primary care providers achieve NCQA 2014 Level 3 certification by the end of Demonstration Year 3.
-Milestone: PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.
-Milestone: PPS has processes for tracking care outside of hospitals and primary care settings, to ensure that all critical follow-up services and appointment reminders are followed.
- Milestone: PPS provides transitional care to high-risk patients; 30-day care transitions programs are adopted as standard practice throughout the region.
- Milestone: Community-based organizations are actively engaged in the Network. Metrics: "actively engaged" is defined by attendance at Regional Health Innovation Team (RHIT) meetings or other appropriate network meetings. Goals: At least 75% of the community-based organizations participating in the Network attend 50% or more of the relevant meetings.
- Milestone: Population Health Management System is implemented. The AHINCPPS will evaluate existing population health management capacities, in place either through the Adirondacks ACO contracted vendors and/or other platforms in use by Network Partners, and will gain consensus on a common platform to be used by all Network partners. Metrics and goals: A population health management system will be selected, vendor contracts signed, and an implementation plan will be in place by the end of Demonstration Year 1. The population health management system will be fully implemented by the mid-point (6 months into) Demonstration Year 2.
- Milestone: The AHINCPPS is actively collaborating with Medicaid Managed Care Organizations (MMCs) to drive payment reform. The AHINCPPS will meet monthly with Medicaid Managed Care Organizations to examine utilization and performance data and develop the core tenants of incentive based payment programs. Metrics and goal: at least 80% of core providers ("core" providers are those that as a group account for 80% or more of the total attributed lives) endorse an incentive-based model developed by the AHINCPPS in collaboration with MMCs.

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

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

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

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

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

will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

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

5. 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 necessary for the substantial investments in health information technology infrastructure necessary for health care providers to effectively communicate and coordinate care across settings. Additionally, some technology will be necessary to coordinate with community-based organizations, such as social services, housing, and transportation. Capital may be needed to establish new primary care sites, and to assist providers in restructuring existing space.

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
Adirondack Health Home	Medicaid	1/2012	n/a	Expanding on the traditional medical home model by placing a greater emphasis on linking community and social supports with health care, and providing

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				enhanced coordination of medical and behavioral health care. Provides comprehensive care management for high-risk Medicaid members with one or more chronic condition and operates in partnership with Hudson Headwaters Health Network, Champlain Valley Health Network, the AIDS Council of Northeastern NY, and several behavioral health organizations.
Adirondack Patient Centered Medical Home Initiative	PCMH multi-payor initiative	2009	2015	An innovative, patient-centered model for the delivery of health care services that strengthens the role of primary care. Focus is on prevention and care coordination to improve quality & contain costs. It includes 42 primary care practices (representing some 225 providers, five hospitals, seven commercial health plans, Medicaid, Medicare, the NYS Department of Health, the Medical Society of the State of New York, and the NYS Association of Counties).
Adirondacks ACO	Medicare Shared Savings Program	2013		A group of 37 health care providers have agreed to share responsibility for the care of a defined population of individuals. They coordinate to improve the individual's quality of care, efficacy of the care and reduce the rate of increasing cost of care over time. The ACO also participates in the Medicare Shared Savings Program which promotes care accountability of

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				Medicare FFS beneficiaries, requiring coordinated care and encouraging investment in infrastructure and redesigned care processes.

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.

The proposed DSRIP project significantly expands upon the current initiatives on several dimensions. The project will increase the number of PCMH practices and providers in the PPS region and it will hold all of the PCMH practices to a much higher level of accountability by using the 2014 NCQA PCMH Level 3 standards and by increasing the connection between

performance and reimbursement. Advanced primary care practices will engage more of the population, including children and parenting adults to improve the rate of screenings and preventive care. The project will increase the behavioral health, care management and social resources available to the PCMH practices and integrate all of those facets more tightly. It will also provide practices with Technical Assistance resources to help ensure a full, persistent and ongoing transformation. Practice EHRs will be enhanced as will the utilization of RHIO tools to connect all members of the care team, including safety net providers, with real time information and powerful surveillance tools monitoring critical changes their patient's health status. More providers will be connected to the RHIO, expanding the information base driving the monitoring capability of care givers. The PPS will implement a multi-tiered Population Health and Performance Management platform that will provide current population health information that can be tied directly to performance and drilled down to the patient level. More Care Managers and providers will have access to disease registries to target at risk patients and integrated care plans that will facilitate and document a variety of screening tools.

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

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

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

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

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

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

7. Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.
8. Implement preventive care screening protocols including behavioral health screenings (PHQ-9, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.
9. Implement open access scheduling in all participating primary care practices.

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

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

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

In the AHI North Country PPS, there is lower primary care use and higher ER use compared to the state, For the PPS region, adults in 6 of the 9 counties report that they are less likely than the Upstate NY population to have a regular primary care provider. In 8 of the 9 counties, the percent of Medicaid beneficiaries with a primary care visit is lower than NY State at 64%. Clinton, Essex, Franklin, Fulton, St. Lawrence, and Saratoga counties range from 61% to 62%, and Hamilton County is significantly lower at 58%. Additionally, the PQIs, PDIs, and PPVs, which focus on ambulatory care sensitive conditions provide direct evidence of the need to strengthen the primary care infrastructure.

For preventable hospitalizations for Medicaid patients the Prevention Quality Indicators (PQI) data shows that the PPS region relies heavily on inpatient care. Five of the 9 PPS counties have higher PQI Acute Composite rates than the NY State at 530. Franklin and Fulton counties are significantly higher at 720 and 846 respectively. Four counties have a higher PQI All Diabetes Composite than the NY State rate.

The Potentially Preventable Visits (PPVs) data shows potentially inappropriate ER usage. All counties, with the exceptions of Washington and Hamilton, show rates higher than NY State, although Warren County's rate fell below that of the state in 2012. St. Lawrence, Essex, Clinton, Fulton, and Franklin have particularly high rates. In 6 of the 9 PPS counties, the PPV data shows that ER use is higher than the state rate of 36.1. In five counties it is significantly higher, St. Lawrence at 70.8, Clinton at 56.7, Essex at 55.7, Franklin at 52.8, and Fulton at 52.5.

By attaining NCQA 2014 Level 3 PCMH recognition, PPS PCP practices will improve the quality and availability of primary care services in the region which has been shown to improve utilization rates including potentially preventable ER visits. Inappropriate ER utilization tends to be related to weak primary care relationships and/or inadequate access to primary care services. PCMH practices improve access by extending hours, providing after hours phone services that can intercept unnecessary ER visits, and increased same day appointments. Care

managers, partnering with primary care practices, use data to identify and target "frequent flyers" and other patients likely to utilize ER services.
PCMH practices, including safety net providers, utilize advanced eHRs and disease registries to improve tracking of at risk patients. In the AHINCPPS, these eHRs will also be connected to Hixny, the local RHIO to improve data sharing, care coordination and reporting. The RHIO will be utilized to transmit real time admission, discharge and transfer (ADT) data so practices can follow up effectively and reduce future ER visits and readmissions. The RHIO also will provide "Dial Tone" services - including direct exchange, secure messaging, patient look up and consent management – to a wide range of PPS partners.

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

The patient population to be engaged includes all patients that can benefit from greater access to high quality primary care services with a particular emphasis on patients with chronic conditions, children and parenting adults and those experiencing barriers to care due age or socioeconomic factors. AHINCPPS includes all of Clinton, Essex, Franklin, Hamilton, Warren and Washington and portions of St. Lawrence, Saratoga and Fulton counties. With the exception of Hamilton County, the PPS population disproportionately suffers from chronic disease compared to residents of the State as a whole. Clinton, Essex, Franklin, St. Lawrence, and Warren Counties have a higher percent of Adults with Diabetes than NY State at 9 percent. Franklin County is significantly higher at 11.7 percent. The percent of Adults with Asthma is higher in seven of the nine counties than NY State. Only Washington and Hamilton counties are lower. Six of the nine counties have a higher percent of Adults with Heart Disease with Clinton County significantly higher at 11.2 percent than NY State at 7.6 percent. Eight of the nine counties have a higher percent of Adults with High Blood Pressure than NY State. The PPS will have a particular focus on ensuring children and parenting adults have access to high quality care including integration of primary, specialty, behavioral and social care services.

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

In addition to organizations from the full spectrum of medical, behavioral health and social services, AHINCPPS assets and resources include a large contingent of providers and support resources that have been active participants in the Adirondack Medical Home Initiative (AMHI) – including over 40 primary practice sites and "Pod"-based Care Management teams that help connect PCPs to community-based supports and Quality Improvement (QI), administrative,

reporting and analytical resources. The AMHI practices as well as all of the PPS hospitals are connected to Hixny, the local RHIO, and several PPS participants are current or former members of Hixny's Board. In addition, the AHI Health Home contractors, including two of the pods, provide additional care management resources with a focus on Medicaid populations, especially those with Behavior Health conditions and multiple comorbidities. AHI's Adirondack Rural Health Network (AHRN) has decades of experience partnering with the region's hospitals, county health departments and community resources to conduct community health needs assessments and develop programs to address the health needs of the community with particular emphasis on underserved populations. AHI was recently selected as a Population Health Improvement Program (PHIP) for the region. These resources will support AHINCPPS partners in meeting NCQA PCMH 2014 standards and functioning as high performing PCMHs. While these resources provide a solid basis for helping practices achieve 2014 NCQA PCMH Level 3 by DY3, they will need to be developed further to meet the needs of the full PPS. The NCQA 2014 standards are rigorous and many PPS practices are small with limited resources so they will need Technical Assistance (TA) from shared Transition Coaches in order to complete the transformation to meet Level 3 requirements. Additional Care Management, community supports, QI, reporting and analysis will be required to support the PPS' greater number of practices, some of whom have not submitted for NCQA recognition in the past. A key strategy of the AMHI was identifying regional Physician Champions to help lead development and deployment of Medical Home programs and will be a key feature of the AHINCPPS, as well. The PPS will also feature a Chief Medical Officer (CMO) who will lead the Clinical Governance and Quality Committee.

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 gap analysis indicates that the challenge may be in expanding the existing system of PCMH practices. Most of the region is a designated shortage area for mental health professionals and large portions as primary care health professional shortage areas. Additionally urgent care is limited to just the most populated areas, limiting access afterhours to Emergency Departments. Additional care coordination also needs to be developed. As in many rural areas transportation can be a barrier to access as patients may need to travel to attend appointment and public transportation is limited.

Many of the PPS PCP practices are small, independent practices that lack the resources and skill sets to develop a full range of PCMH capabilities without assistance. The region is also characterized by shortages of PCP and Behavioral Health capacity and higher disease burdens relative to state averages. The geography is challenging as well with most services clustered in pockets throughout the PPS region.

In addition to Care Managers and other shared resources like reporting and analytics, the PPS

will deploy Transition Coaches to provide technical assistance and help practices reach NCQA PCMH Level 3 status. The transition coaches will help practices meet Stage 2 Meaningful Use, identify and remediate workflow and data capture issues, develop PCMH compliant policies and procedures and coordinate NCQA PCMH submission. The transition coaches and RHITs will ensure all staff are trained on PCMH models, including evidence-based preventive and chronic disease management. The PPS will adopt a workforce strategy to build the capacity of critical services. The PPS will also build on the AMHI "Pod" model with the RHITs delivering care management and other support services such as data collection, reporting and analysis for PPS practices in their region. Working with the RHITs, practices will implement preventive care screening protocols including BH screenings for all patients to identify unmet needs. The RHITs will also be the vehicles to connect practices to community social, economic and logistic services. PPS projects include integration of Behavioral Health and Primary Care as well as telehealth/telemedicine to help address shortages and geographic/transportation challenges.

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.

AHI, the lead organization for the AHI North Country PPS (AHINCPPS) has a strong history of collaboration and has established relationships with organizations from the other PPS' in our overlapping service areas. Other organizations within the PPS have also developed relationships with partners based on referrals, care coordination efforts and admission patterns. The PPS will build on those relationships to leverage areas of strengths and specific expertise and to ensure seamless coverage for our patients.

The AHINCPPS is working in collaboration with neighboring PPSs; the North Country Initiative PPS/Samaritan Medical Center (NCI), Ellis Hospital (EH), and Albany Medical Center (AMC). Only the NCI PPS selected this project. Initial planning conversations have taken place with each of the neighboring PPSs, and follow-up meetings are scheduled. Specifically with regards to project 2.a.ii., the PPSs will work together to ensure that providers taking part in both PPS receive the appropriate support for EHR adoption, training, and workflow, from just one PPS.

The PPSs are in agreement to establish a cross-PPS partnership that will address any issues presented by patient, and provider, overlap across the service areas. The first issue the group will address is how to count providers and patients for the scale and speed submission, to ensure that numbers are not inflated due to "double-counting" of patients in more than one PPS. Another aspect of coordination is in regards to sharing information to coordinate care across PPSs. This will be addressed, in part, through the SHIN-NY infrastructure, when available. Collaboration on the development of regional health information technology initiatives, including telemedicine strategies and population health management capabilities, has been the subject of initial discussions. The PPSs also plan to share information on best practices with the neighboring PPSs via a learning collaborative model. Each region has access to resources to support sharing of best practices, such as funding for Population Health Improvement Programs, and Rural Health Networks. The PPSs will take part in regular meetings to

coordinate planning and to leverage training/educational resources as broadly as possible. Workforce development activities will also be coordinated with neighboring PPSs. Overall, the PPSs are highly motivated to work collaboratively, and capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital funding will be required for this project to provide the technology required for practices to comply with 2014 NCQA PCMH Level 3 and Stage 2 Meaningful Use standards and to fund vendor work to integrate the practices effectively with the RHIO and remediate connectivity and data issues. Standard RHIO "Dial Tone" services can be obtained at no cost to qualified practices but there may be a need to enhance those tools to enrich the service to care team members and completely leverage their utility. Capital funding will also be required to implement a PPS

Population Health and Performance Management platform that facilitates effective monitoring, engagement and reporting of the PPS population as well as support the allocation of DSRIP payments among projects and organizations.

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
Adirondack Patient Centered Medical Home Initiative	PCMH	2009	2015	An innovative, patient-centered model for the delivery of health care services that strengthens the role of primary care. Focus is on prevention and care coordination to improve quality & contain costs. It includes 42 primary care practices (representing some 225 providers, five hospitals, seven commercial health plans, Medicaid, Medicare, the NYS Department of Health, the Medical Society of the State of New York, and the NYS Association of Counties).
Adirondack Accountable Care Organizaion	Medicare Shared Savings Program	2013		A group of 37 health care providers have agreed to share responsibility for the care of a defined population of individuals. They coordinate to improve the individual's quality of care, efficacy of the care and reduce

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				the rate of increasing cost of care over time. The ACO also participates in the Medicare Shared Savings Program which promotes care accountability of Medicare FFS beneficiaries, requiring coordinated care and encouraging investment in infrastructure and redesigned care processes.

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 proposed DSRIP project significantly expands upon the current initiatives on several dimensions. The project will increase the number of PCMH practices and providers in the PPS region and it will hold all of the PCMH practices to a much higher level of accountability by using the 2014 NCQA PCMH Level 3 standards and by increasing the connection between performance and reimbursement. Advanced primary care practices will engage more of the population, including children and parenting adults to improve the rate of screenings and preventive care. The project will increase the behavioral health, care management and social resources available to the PCMH practices and integrate all of those facets more tightly. It will also provide practices with Technical Assistance resources to help ensure a full, persistent and ongoing transformation. Practice EHRs will be enhanced as will the utilization of RHIO tools to connect all members of the care team, including safety net providers, with real time information and powerful surveillance tools monitoring critical changes their patient's health status. More providers will be connected to the RHIO, expanding the information base driving the monitoring capability of care givers. The PPS will implement a multi-tiered Population Health and Performance Management platform that will provide current population health information that can be tied directly to performance and drilled down to the patient level. More Care Managers and providers will have access to disease registries to target at risk patients and integrated care plans that will facilitate and document a variety of screening tools.

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

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

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

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

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

2.a.iv Create a Medical Village Using Existing Hospital Infrastructure

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

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

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

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

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

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

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

The AHINCPPS CNA clearly demonstrates the need for increased levels of capacity to treat patients with behavioral health and substance abuse diagnoses. It also indicates a need for improved treatment and management of chronic conditions. The PPS will create four Medical Villages throughout the service area to take advantage of existing infrastructure throughout the region to realign health system capacity and address community needs. These Medical Village locations are:

1. Clinton County: CVPH in Plattsburgh, renovate to add crisis stabilization, ability to treat dual diagnosis patients, and create ED access to outpatient pharmacy
2. Franklin County: Adirondack Medical Center in Saranac Lake, renovate to expand outpatient behavioral health and outpatient services, and add medical detoxification
3. Essex County: Moses Ludington Hospital in Ticonderoga renovate to expand access to specialists to manage chronic conditions and expand access to medical imaging services
4. Warren County: Glens Falls Hospital, renovate to add crisis stabilization services and medical observation

All of the Medical Villages are located at least 50 miles apart.

In the AHINCPPS' service area the conditions causing most inpatient admissions for Medicaid members were mental diseases and disorders and diseases and disorders of the cardiovascular system. These conditions account for 64% of admissions when grouped by major diagnostic categories (MDC). The behavioral health MDCs accounted for 49% of admissions. This data is consistent with the data on prevalence of disease conditions, where depression and hypertension were the two most prevalent conditions in the Medicaid beneficiary population. The all-payer PPR observed rate for all AHI PPS facilities combined is 7.93%, lower than the expected rate of 8.26%. For Medicaid-insured patients the observed PPR of 5.98% is lower than the expected PPR of 7.48%.

A similar pattern is seen for ER utilization in the AHI North Country PPS' service area. The underlying conditions that were at the root of most ER visits for those insured by Medicaid were mental diseases and disorders and diseases and disorders of the cardiovascular system, accounting for 67% of visits. The behavioral health conditions accounted for 58% of ER visits by MDCs. The PPV rates show potentially inappropriate ER usage for Medicaid patients. All counties, with the exceptions of Washington and Hamilton, show rates higher than NY State, although Warren County's rate fell below that of the state in 2012. St. Lawrence, Essex, Clinton, Fulton, and Franklin have particularly high rates.

The counties of Franklin, Clinton, St. Lawrence, and Fulton have higher rates than NY State for the overall composite PQI and each sub-composite score. The counties of Saratoga, Washington, and Warren show lower rates for the overall composite PQI and each composite score. Essex County had an overall composite better than the state in 2011, but worse than the state in 2012. The rates in Hamilton County are unstable due to its small population and small

number of cases.

Behavioral health and substance abuse conditions are top drivers of ER visits. Chronic conditions such as Circulatory and Respiratory Conditions are major drivers of inpatient utilization. This is consistent throughout the PPS. By better utilizing existing infrastructure and developing stronger partnerships between providers, the Medical Villages will expand programing to mitigate the identified potentially preventable inpatient and emergency department utilization. The behavioral health programs will develop crisis stabilization and inpatient detoxification programs that do not currently exist in the AHINCPPS region. The expansion of primary care will be PCMH certified and expand care management for chronic conditions.

The four Medical Villages will also enable key institutional providers to continue to transform their business model and better address community health needs.

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 Medical Villages will support the DSRIP Project Plans by converting underutilized space to develop needed programs. The programs will support the behavioral health, substance abuse and outpatient services needed in the communities. From a demographic standpoint each of the medical villages will serve a distinct geographic population with focused conditions:

1. The CVPH Medical Village in Plattsburgh will serve residents of Clinton County and northern Essex and Franklin county. The focus will be behavioral health, child and adult, patients in crisis that present to CVPH for care at the inpatient psychiatric unit. The Medical Village project will create a stabilization pathway for patients in crisis that present to the emergency department.

2. Adirondack Medical Center (AMC) in Saranac Lake will serve patients in need of medical detoxification from Franklin, Essex, and Clinton Counties. There is currently no medical detox in those counties. AMC will expand outpatient services to serve chemotherapy and transfusion patients in southern Franklin, northwestern Essex, southeastern St. Lawrence, and northern Hamilton.

3. Moses Ludington Hospital in Ticonderoga will expand access to specialty providers and access to medical imaging. In a separate project, an existing FQHC will be relocating to the hospital campus. The focus will be on patients with chronic conditions including heart disease, respiratory conditions, and other conditions to improve care coordination to improve outcomes.

4. Glens Falls Hospital (GFH) will create a crisis stabilization unit and observation unit in Glens Falls. The focus will be behavioral health, child and adult, patients in crisis that are brought to GFH for the inpatient psychiatric unit. The project will create a stabilization

pathway for patients in crisis that present to the emergency department. The Observation Unit will serve patients that may not require admission but need an appropriate setting for observation and stabilization prior to a return to outpatient care. This Medical Village will serve patients from southern Essex, Hamilton, Warren, Washington, and northern Saratoga counties.

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 Medical Villages will support the DSRIP Project Plans by converting underutilized space to develop behavioral health, substance abuse and outpatient services needed in the communities. This will reuse the physical assets and begin the transformation of traditional inpatient hospital space. The behavioral health and substance abuse projects will mobilize existing resources in the form of existing providers.

Clinton County: CVPH is the sole inpatient provider in Clinton County. CVPH will develop a new partnership with Clinton County Mental Health Services to create a stabilization unit for ER patients. Clinton County Mental Health is responsible for the planning, development and coordination of services for chemical dependency, mental health, mental retardation and other developmental disabilities within the geographic boundaries of Clinton County. The department directly operates both mental health and addiction treatment outpatient clinics. Thais partnership will strengthen both providers and expand their scope of services.

Franklin County: Adirondack Medical Center is the only full service hospital in the Adirondack Park. The hospital serves patients in northern Essex, southern Franklin, and northern Hamilton counties. Adirondack Medical Center will partner with St. Josephs Addiction Treatment & Recovery Center also located in Saranac Lake. Adirondack Medical Center will renovate existing inpatient space for a medical detox unit that will be leased and managed by St. Josephs. St. Josephs provides inpatient, outpatient and aftercare programs for individuals suffering from chemical dependency and substance abuse.

Essex County: Moses Ludington Hospital will mobilize existing resources in that they will capitalize on partnering with a larger health system to bring needed specialty services to their service area. MLH is a critical access hospital with outpatient services that serves patients in southern Essex and northern Washington counties. MLH, partnering with the University of Vermont Health Network, will give up all inpatient beds, maintain a free-standing ER, renovate inpatient space to accommodate visiting specialists to better manage and treat chronic conditions, and expand medical imaging capabilities. This will bring providers to patients now travel to Burlington, VT for care. MLH will also be partnering with Hudson Headwaters Health Network, a FQHC serving multiple counties in the PPS. In a separate project Hudson Headwaters will be relocating to the hospital campus. Although not physically in the Medical Village, this proximity will enable care coordination between the Primary Care Medical Home FQHC providers and the specialists on campus.

Warren County: Glens Falls Hospital provides a comprehensive range of outpatient and

inpatient behavioral health services to patients in five counties. GFH will mobilize existing resources by reducing the size of the existing inpatient behavioral health unit and reallocate resources to avoiding hospitalizations through the implementation and utilization of crisis stabilization and observation.

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.

Across all projects the greatest challenge will be workforce. Most of the region is a designated shortage area for mental health professionals and large portions as primary care health professional shortage areas. This indicates that staffing these new programs may be a challenge. There will be a need for workforce expansion including recruitment and retention of care managers, therapists, social workers, and peer support staff. There will also be a need for retraining inpatient staff. As the DSRIP projects have an impact on inpatient admissions and ER visits, there will be an opportunity to retrain staff to work in the new service lines. The DSRIP resources will enable the PPS to address recruitment, retention and retraining on a regional level instead of each provider implementing programs individually for small numbers of staff. As the DSRIP project plans are implemented, there will be overlaps in programing and the needs can be coordinated on a regional level and implemented on a local level.

A continued challenge for hospitals is to balance the pace of change with ensuring financial stability. The Commission for Health Care in the 21st Century report and the more recent North Country Health Care Redesign Commission report outlined the regional reliance on institutional providers such as hospitals and nursing homes. As the region moves toward population health management, it is vital to maintain all levels of the continuum while realigning the system. The AHI PPS will work closely with the hospitals through the finance and governance structures so that the hospitals have the resources that they need to plan services that ensure sustainability and meet community need. The PPS has developed a DSRIP distribution plan that allocates significant fund to support providers for revenue loss and costs related to redesign initiatives. The plan also provides incentive payments for providers to achieve their project goals and to support the broader PPS goals. This support will enable the hospitals to withstand potential financial uncertainty while transforming to Medial Villages.

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

The AHINCPPS is working in collaboration with neighboring PPSs; the North Country Initiative PPS/Samaritan Medical Center (NCI), Ellis Hospital (EH), and Albany Medical Center (AMC). At one point, all PPS were planning Medical Villages, but we understand these plans may have changed. Initial planning conversations have taken place with each of the neighboring PPSs, and follow-up meetings are scheduled. Specifically with regards to project 2.a.iv., the PPSs will work together to ensure that planned changes in services due to Medical Village

implementations are made known and any impact to neighboring communities is taken into account.

The PPSs are in agreement to establish a cross-PPS partnership that will address any issues presented by patient, and provider, overlap across the service areas. The first issue the group will address is how to count providers and patients for the scale and speed submission, to ensure that numbers are not inflated due to "double-counting" of patients in more than one PPS. Another aspect of coordination is in regards to sharing information to coordinate care across PPSs. This will be addressed, in part, through the SHIN-NY infrastructure, when available.

Collaboration on the development of regional health information technology initiatives, including telemedicine strategies and population health management capabilities, has been the subject of initial discussions. The PPSs also plan to share information on best practices with the neighboring PPSs via a learning collaborative model. Each region has access to resources to support sharing of best practices, such as funding for Population Health Improvement Programs, and Rural Health Networks. The PPSs will take part in regular meetings to coordinate planning and to leverage training/educational resources as broadly as possible. Workforce development activities will also be coordinated with neighboring PPSs. Overall, the PPSs are highly motivated to work collaboratively, and capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.
Expected number of Staffed Beds to be Reduced is 31.

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

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

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

The Adirondack Region Medical Home Pilot, Health Home, and Adirondacks ACO are improving access to primary and preventive care. These initiatives have had an impact on the hospitals as evidenced by the declining hospital occupancy rates and emergency department visits which has been a trend over the past few years. These delivery system reform projects are working. All of the hospitals have supported and fostered these initiatives. This is the right approach, but it has taken a significant financial toll on the hospitals as they did not plan to see the changes taking place this quickly. Establishing four Medical Villages will enable the hospitals to partner with community providers to convert space that is being made redundant through delivery system reform into needed outpatient services.
The hospitals that are proposing to implement the Medical Villages have been investing in Medical Home, Adirondacks ACO, and other transformation projects already. These projects have had the intended consequence of reducing inpatient admissions and ER visits. These reductions have had an impact on the hospitals' bottom lines. Each of the hospitals has implemented cost saving measures including layoffs over the past two years. Currently they do not have the resources to now invest in large scale capital improvements to continue moving toward pay for value. One of the hospitals has received IAAF funding to help bridge the gap. They are rightsizing as quickly as possible, but the financial situation does not allow for this type of transformation investment.

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

Yes	No
☐	☒

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

2.b.viii Hospital-Home Care Collaboration Solutions

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

Project Description: Many patients who previously were transferred to skilled nursing facilities (SNFs) are now being discharged to less restrictive alternative locations, primarily home-based. Aside from the many benefits of returning to a known and personal setting, there are the risks of potential non-compliance to discharge regimens, missed provider appointments, and less frequent observation of an at-risk person by medical staff. This project will put services in place to address these risks by matching services with transition care management. Services are expected to last more than 30 days.

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

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

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

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

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

A total of 693,954 people live in the largely rural 11,859 square mile AHI North Country PPS (AHINCPPS) service area. The PPS population is older than that of Upstate NY and NY as a whole. All nine counties have fewer children and five counties have more adults age 65 plus. Three counties have very high percentage of older adults, Warren at 17.3%, Essex at 18.4%, and Hamilton at 23.3% compared to Upstate at 14.6%.

Data from the AHINCPPS CNA indicates that the PPS population disproportionately suffers from chronic disease compared to NY State as a whole. Clinton, Essex, Franklin, St. Lawrence, and Warren Counties have a higher percent of Adults with Diabetes (ranging from 9.8% to 11.7%) than NY State (9%). The percent of Adults with Asthma is higher in seven of the nine counties (ranging from 11.0% to 15.3%) than in NY State (9.7%). Six of the nine counties have a higher percent of Adults with Heart Disease (ranging from 8.6% to 11.2%) than NY State (7.6%). Eight of the nine counties have a higher percent of Adults with High Blood Pressure (ranging from 28.2% to 33.1%) than NY State (25.7%).

Three of the top six underlying conditions at the root of most inpatient admissions for Medicaid recipients were chronic conditions: Diseases and Disorders of the Cardiovascular System, Diseases and Disorders of the Respiratory System, and Diabetes Mellitus. The same pattern in seen for ED utilization consistently throughout the PPS.

Admissions for ambulatory sensitive conditions (Prevention Quality Indicators, or PQIs) for Medicaid patients point to a need for better management of ambulatory sensitive condition. The PQI overall composite measure and the acute, chronic, diabetes, respiratory, and circulatory composites all show a fairly consistent pattern: poorer performance in Franklin, Clinton, St. Lawrence, and Fulton counties compared to NY State for the overall composite PQI and each sub-composite score, while Saratoga, Washington, and Warren perform better than rest of the state, on the overall composite PQI and each composite score. Essex County had an overall composite better than the state in 2011, but worse than the state in 2012. Given the small population in Hamilton, the rates are unstable and conclusions cannot be drawn.

With respect to potentially inappropriate ED use (PPVs) among Medicaid patients, all counties perform worse than NY State, except Washington and Hamilton, and Warren County in 2012. St. Lawrence, Essex, Clinton, Fulton, and Franklin have particularly high rates; these are the same counties with high PQIs, with the addition of Essex.

The underlying conditions driving admissions for Medicaid recipients were mental diseases and disorders and diseases and disorders of the cardiovascular system. These conditions account for 64% of admissions when grouped by major diagnostic categories (MDC). The behavioral health MDCs (mental diseases and disorders and substance abuse) accounted for nearly half (49%) of admissions by MDCs.

In terms of PPRs (Potentially Preventable Readmissions), the all-payer observed rate for all AHI North Country facilities combined is 7.93 percent, lower than the expected rate of 8.26 percent given patient assigned DRGs. However, there is variation by facility, and implementations are planned at facilities with the highest rates.

High rates of chronic conditions, and elevated PQIs and PPVs, point to the need for better management of chronic conditions. The implementation plan will seek to leverage best practices in high performing counties and spread them, via a learning collaborative model, to areas with more room for improvement.

The project will establish Rapid Response Teams to facilitate patient discharge to home and assure needed home care services are in place. Team members, including care managers and home care staff, will receive training in how to support evidence-based medicine and chronic care management, and how to identify and respond to patient risks for readmission.

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 Hospital to Home Care Collaborative Solutions project is designed to meet the needs of persons with chronic conditions, who are at high-risk of re-hospitalization following discharge. More than 100,000 residents in the largely rural service area are over age 65, many suffer from chronic conditions and lack adequate family or other care-giver supports. The target population is specifically defined as:

(1) Patients determined to be high-risk for readmission based on predictive modeling software and/or provider/care manager referral.
(2) Patients discharged from an acute care hospital following an inpatient stay, observation stay, or emergency room visit with one or more of the following conditions: diagnosed hypertension, CHF, pneumonia, diabetes, COPD/asthma, hearth failure, mental health or substance abuse disorders.
(3) Patients readmitted within 30 days or 3 admissions within a six-month period.
(4) In some portions of the service area, the project will exclude dementia patients and patients with significant cognitive disabilities, unless they have a coachable care-giver or other coachable support person. In other areas, this exclusion will not apply. The availability of partner agencies and care managers with the skill set to work with this population will be the deciding factor, and developing workforce to meet this need will be part of the workforce strategy.
(5) Patients with no primary caregiver in the home and elderly persons with health conditions

of their own who are providing care for others will be included.

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 region has many assets and resources that will be built upon to ensure success of the project. Assets include:

(1) Proven model of care management and disease management programs that can be tailored to the target population, and expanded, to meet the needs of the community. A variety of chronic disease management, transitional care, and other care management supports, (including PCMH based resources, and Medicaid Health Home care management resources) and will be mobilized to support this project. Resources include hospital liaisons, care managers, supervisors. Clinical protocols and disease management pathways for certain conditions and specific patient populations are in place.
(2) Canton-Potsdam Hospital has an established Health Coach program that is operated in conjunction with Potsdam State University and St. Lawrence University. Students are trained as advocates/care coaches, to provide supportive service to patients in their homes. This program can be a model for other areas and be expanded upon.
(3) Some PPS partners have adopted the INTERACT model and will be a resource to others.
(4) Home Health aide training is well-established, including North Country Home Services, BOCES, Health Services of Northern NY, Northern Lights, and others).
(5) Many PPS providers currently use electronic medical records and have met Meaningful Use standards, and have worked with vendors to implement decision support and quality metrics related to other chronic conditions. This experience can be built upon for this project.
(6) The Adirondack Health Institute's funding as a Rural Health Network and Population Health Improvement Program will provide resources including support for education and training, learning collaboratives, etc.

Needed Community Resources Include:
(1) Telehealth / home monitoring technologies are needed to support the model. For example, certain types of conditions lend themselves to remote monitoring for early identification of signs and symptoms, such as weight gain, that may indicate risk of re-admission.
(2) There is a need for more home health aides, and for a reimbursement model that supports deployment of home health aides in a rural region with extensive travel time between visits.
(3) There is a need for more patient, family, and caregiver education and supports, to better equip patients and their families to manage chronic conditions more effectively in the home.

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

A primary challenge is "coordinating the coordinators" or "managing the management programs". There are numerous care management initiatives in place, and while this provides

resources and experience to build on, it can be challenging to manage issues such as overlapping roles, overlapping eligibility criteria and multiple assessment/referral tools. Potential solutions include the development of a Role Delineation Guide, to clearly explicate the roles of various care management functions, and the use of a population health management system. Disparate reporting requirements for various care management programs also presents a challenge. These issues will be addressed by the regional Health Information Technology plan. In addition, it will be necessary for the PPS to develop consistent referral processes to ensure patients and families are well-informed about options for home-based services.

Ensuring that care managers are knowledgeable about the vast array of social and community-based services, and how to help patients access them, is a challenge. Some teams address this by including a social worker or community services expert on the care team. Maintaining a current, accessible, directory of services is something many communities have struggled with. Resources available to the region through the Adirondack Health Institute's Rural Health Network and Population Health Improvement Program funding will address this need.

Another barrier is that home care staff are not always readily able to document their work in a system that facilitates information sharing with the entire care team. Mobile technologies (tablets, other portable devices) will be utilized to facilitate documentation and information sharing.

Shortages of primary care and specialty providers are an issue for all projects. Tele-health strategies are being explored, and the workforce component includes strategies to address the shortage of primary care providers.

Establishing the necessary information systems to identify, and stratify, high-risk patients is costly and time-consuming. Some partners rely on their own EHRs and/or population health products, but there is not a comprehensive regional platform to support common identification/stratification methodologies across the region. This will be addressed by the regional Health Information Technology plan, and capital application.

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.

No overlapping PPS is doing this project.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital funding may be needed for technology, including population health management functionality and hardware/software to support communication across the care continuum (mobile devices, tablets, telephony). Renovation of existing space, or building new space, to provide respite and/or transition beds may be necessary.

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

Yes	No
☐	☒

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This project will engage and activate individuals not utilizing the health care system in order for this population to benefit from the PPS transformation of services and delivery, particularly primary and preventive care. Identified gaps include lack of access and readily available community resources. The region is burdened by high rates of severe poverty. It can be challenging for health care providers and community based workers to effectively engage with persons in poverty. The uninsured and non/low utilizers may avoid care due to perceived high cost of co-payment and ongoing treatment/screening/testing. Additionally urgent care is limited to just the most populated areas, limiting access afterhours to Emergency Departments (ED). As in many rural areas, transportation can be a barrier to access as patients may need to travel up to 50 miles to attend appointments and public transportation is limited. Lower educational attainment and literacy levels are challenges to increasing individuals understanding of appropriate, available health services. These barriers hinder accessing primary or preventive care on a regular basis with a consistent provider, negatively impacting the patient-provider relationship.

The Engaging community members that are uninsured or are low/non utilizing Medicaid beneficiaries has the potential to improve the quality of life for the beneficiary and will assist them to utilize the health care system through preventive care. Ultimately this can reduce the number of preventable ED visits and hospitalizations. The data for the PPS indicate that there is lower primary care use and higher ED use compared to the state, especially for

adults aged 18-64 years old and older adults aged 64+. The Potentially Preventable Visits (PPV) data shows potentially inappropriate ED usage. All counties, with the exceptions of Washington and Hamilton, show rates higher than NY State, although Warren County's rate fell below that of the state in 2012. St. Lawrence, Essex, Clinton, Fulton, and Franklin have particularly high rates. Sporadic, episodic care of this type results in poor health outcomes. The leading causes of premature death in the region are cancer, heart disease and some combination of respiratory disease, unintentional injuries, diabetes, and suicide, depending on the county. All have rates higher than the Upstate NY rates, across all counties and all conditions with one exception, which is Saratoga County. Chronic disease and poor mental health rates are also higher on average throughout the region compared to Upstate NY. Undetected and unmanaged conditions such as these lead to more expensive care, with far greater negative health outcomes.

Research finds that health behavior, the leading non-medical determinant, accounts for up to 50% of health outcomes, which increases to 70% when environment and social circumstances are included, areas where increased individual engagement can mitigate these influencers [Schroeder, S., We Can Do Better – Improving the Health of the American People, New England Journal of Medicine, 9.20.07].

As the PPS is transformed and care is coordinated efficiently and effectively, community members will be empowered and educated about appropriately accessing services, utilizing community based navigators when faced with barriers. Provision of supportive services and information to the uninsured, non/low-utilizing Medicaid member populations, along with health care workforce training in cultural competency and health literacy (Section 7), will result in activated, engaged patients, making informed health care decisions, advocating for themselves, thereby reducing avoidable ED visits and hospital admissions.

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

The State-set portion of documented uninsured that are attributed to the AHINCPPS is 50,142, with more than 10% of that number under the age of 20. Even with expanded eligibility for Medicaid and the State of Health Marketplace, some workers without employer provided health insurance plans, have declined to pay for coverage. Some individuals view applying for Medicaid to be burdensome or believe there is a stigma to accepting a "government handout", preferring to go without coverage, particularly if they are currently healthy. In addition to the uninsured, there are 25,447 non/low utilizing Medicaid members, resulting in a total target population of 75,589 across the nine county region. Through the implementation of this five year project, the subset of the total attributed population that will be actively engaged is 75 % or 56,691 patients.

Based on the community needs assessment data, the patient population expected to be

engaged through the implementation of this project will reflect the entire population of the region with mental diseases and disorders and diseases and disorders of the cardiovascular system accounting for a majority inpatient admissions for Medicaid recipients. The behavioral health major diagnostic categories {MDC} (mental diseases and disorders and substance abuse) accounted for nearly half (49%) of admissions by MDCs. More than 100,000 residents in the largely rural service area are over age 65, many suffer from chronic conditions and lack adequate family or other care-giver supports. The population will likely have lower income levels as 31% to 38% of the population lives below 200% of the Federal Poverty level. They will also have lower educational attainment with six of nine counties having from 13% to 16% of the population with less than a high school education. Lastly, there will likely be higher unemployment rates with six counties having unemployment rates higher than Upstate New York's 7.7% rate, and some are higher than New York state's 8.7% rate (Essex: 8.2%, Franklin: 9.3%, Fulton: 9.9%, St. Lawrence: 10.6%, Washington: 9.8%).

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.

The PPS has a strong record of designing and delivering innovative models of care by collaborating with partners through the Adirondacks ACO, the Adirondack Region Medical Home Pilot and Health Home projects that provide chronic disease management, transitional care, and comprehensive care management for high-risk patients that addresses medical, behavioral, and social needs from a patient-centered approach. These programs have demonstrated success in disease management and in reducing admission and readmissions as evidenced by the declining trend in occupancy rates and ED visits over the past few years. Reform initiatives such as these have resulted in more financially accessible health care resources, including expanded primary care locations/hours of operations, and utilization of pharmacy and public health services.

This project will build upon existing, and develop new, partnerships with primary and preventative care services. The Adirondack Rural Health Network (ARHN) has convened and coordinated regional stakeholders, including eight public health departments, eight hospitals and the region's only federally qualified health center, to complete community health planning activities and to assess regional needs. Initiatives include developing access to primary care and oral health; integrating mental health and primary care; increasing first responder medical service capacity; growing a transportation program for the elderly and disabled; leading regional activities that advanced health literacy, obesity prevention, workforce and behavioral health priorities. Experience from other AHI programs working with this population include EASE (Enrollment Assistance, Support and Education) for insurance access in one on one sessions with community members; outreach to more than 450 organizations about the State of Health Marketplace; Sexual Trauma and Recovery Service program advocates for survivors of sexual abuse; and the Community Health Advocate program that assisted patients in receiving the health care benefits they were entitled to.

The PPS' on-going strategic planning will be informed by the work of regional health care stakeholder forums, convened by the ARHN and/or PHIP (Population Health Improvement Program). The ARHN is experienced as a neutral convener and the PHIP will provide additional resources to identify and disseminate best practices and local strategies, through a learning collaborative model, to promote population health and reduce health care disparities in the region.

Stakeholders with resources, expertise and experience to fully engage this group of consumers include: (1) county public health departments who serve many functions from surveillance to assessment and planning to service delivery to screening, health education, and health promotion; (2) established coalitions such as the Comprehensive Adolescent Pregnancy Prevention Projects, which operates in three separate counties, and Tobacco Free coalitions in Clinton, Essex, Franklin, Saratoga, St. Lawrence, Warren and Washington counties; (3) prevention agencies; (4) behavioral health providers and advocacy groups; (5) non-medical services including organizations that provide food bank services, housing, refugee assistance, transportation, advocacy, peer support, and community health education; and (6) other community resources such as YMCAs, churches, libraries, schools, youth programs, local universities and colleges, veterans groups, businesses, transportation services, Boys & Girls Club, neighborhood centers, farmers markets, police and fire departments to share information and resources, set priorities, develop and repurpose community resources, including hiring community navigators to do outreach in “hot spots” and training them and current CBO/provider staff members in PAM, and coordinate activities to achieve this project’s goals.

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.

Effectively engaging those in poverty can be challenging. The PPS will train providers to work effectively with people who are in poverty (i.e., Bridges Out of Poverty training). The shortage of primary care providers in the region can be addressed to some degree by leveraging mid-levels to work at the top of their licenses. The workforce strategies will alleviate some of the availability issues while the cultural competency and health literacy efforts will assist in having staff with the right training, providing high-quality care, thereby improving patient engagement.

Some providers were hesitant to place additional resources from an already strained system towards this project. This will be addressed by identifying provider champions and highlighting the research showing improved health outcomes through patient activation initiatives. The PPS will also publish PCP-level performance in improving PAM scores to encourage participation. A population health focus workgroup will be convened to develop strategies to address barriers, including how to identify and contact the target population and to share best practices from those experienced in reaching them. Other challenges at the provider level include staff time to train in PAM, time during the patient visit to complete PAM, and then to monitor and coach the patient to the next level of engagement. Lastly, not all providers will

have the technology resources to have the PAM tool reside electronically on their EHR. Additional resources will be provided for data entry of paper surveys collected.

The rural geography over 11,000 square miles is another barrier. Strategies to address include: "meeting them where they are"-community navigators will go to "hot spots" at hospitals, food pantries, shelters, etc., to engage face to face thereby sending the message that there is "no wrong door" for assistance. Other communication methods will include mail, social media, electronic and telephonic. Those implementing the PAM tool will be trained in escalation techniques if the individual does not respond and training in motivational coaching will assist with resistance. Associations and organizations such as Health Care For All New Yorkers and the Schuyler Center, an advocacy organization for low income and vulnerable populations, along with the workforce vendors, will assist with training content.

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

The AHINCPPS is working in collaboration with neighboring PPSs; the North Country Initiative PPS/Samaritan Medical Center (NCI), Ellis Hospital (EH), and Albany Medical Center (AMC). One or more of our neighboring PPSs will implement this project. Specifically with regards to project 2.d.i., the PPSs will work together to coordinate outreach and engagement activities in portions of the service area that overlap, and to share strategies, resources, and tools to support patient activation and engagement activities.

The PPSs are in agreement to establish a cross-PPS partnership that will address any issues presented by patient, and provider, overlap across the service areas. The first issue the group will address is how to count providers and patients for the scale and speed submission, to ensure that numbers are not inflated due to "double-counting" of patients in more than one PPS. Another aspect of coordination is in regards to sharing information to coordinate care across PPSs. This will be addressed, in part, through the SHIN-NY infrastructure, when available.

Collaboration on the development of regional health information technology initiatives, including telemedicine strategies and population health management capabilities, has been the subject of initial discussions. The PPSs also plan to share information on best practices with the neighboring PPSs via a learning collaborative model. Each region has access to resources to support sharing of best practices, such as funding for Population Health Improvement Programs, and Rural Health Networks. The PPSs will take part in regular meetings to coordinate planning and to leverage training/educational resources as broadly as possible. Workforce development activities will also be coordinated with neighboring PPSs. Overall, the PPSs are highly motivated to work collaboratively, and capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those

projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

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

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

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

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

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

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

Yes	No
☐	☒

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

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

Yes	No
☐	☒

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

Domain 3 Projects

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

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

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

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

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

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

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

B. Behavioral Health Service Site:

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

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

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

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

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

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

The PPS' CNA outlines a number of health outcomes that indicate the need to increase access to primary care & mental health services and integrate the two.

In the PPS among the 10 most prevalent conditions for Medicaid recipients, depression & hypertension ranked 1 or 2 across counties. Mental health conditions represent the majority of top 10 conditions. The percentage of Medicaid recipients with those conditions in the PPS ranked higher than the percentage of Medicaid recipients with those conditions in NY State.
In 6 of the 9 PPS counties the PPV data shows that ED use is higher than the state rate of 36.1. In 5 counties it is significantly higher, St. Lawrence 70.8%, Clinton 56.7%, Essex 55.7%, Franklin 52.8%, and Fulton 52.5%. At the same time primary care use by Medicaid beneficiaries in the PPS region tends to be slightly lower than NY State averages.

The conditions causing most hospitalizations for Medicaid members are conditions classified as mental % cardiovascular diseases and disorders, 34 & 31% respectively of conditions requiring

hospitalization. Mental health conditions (mental diseases & disorders and substance use) accounted for 49% of admissions. Preventable hospitalizations (PQI -Adult) for Medicaid patients show higher rates than NY State for the overall composite PQI (total preventable) and each sub-composite score (acute, chronic, diabetes, respiratory, and circulatory) in Franklin, Clinton, St. Lawrence, & Fulton counties.

The data on primary care visits & preventable utilization indicates a lack of capacity in the PPS. A substantial area is federally designated as a Primary Care Health Professional Shortage Area (HPSA). The entire counties of Clinton & Fulton, and various areas of Essex, Franklin, Hamilton, St. Lawrence, Washington & Warren encompassing 87 towns, 6 health center service areas, and 2 correctional facilities are designated. There are 10 mental health HPSAs in the PPS: 4 full county-Clinton, Essex, Fulton and Hamilton; 3 correctional facilities; 2 health center service areas; & 1 Native American tribal designation.

A review of the HRSA Health Resources Files data shows that in each of the 9 counties the number of full-time-equivalent psychiatrists per 100,000 population is dramatically lower than the NY State overall figure. In 3 counties, there are no psychiatrists, and in four cases this rate is a small fraction of the overall NY State rate.

The data points to both the documented shortage of mental health providers and the fragmentation between mental health, substance abuse and primary care. Based on NY State data, 68% of adults with MH disorders also have a medical disorder, and 29% of adults with a medical disorder also have a MH disorder. The PPS needs to breakdown the historical separation of these services due to regulatory restrictions for sharing health information between these types of providers, the siloed nature of funding for these two streams of care, the different facilities in which they exist, and stigma related to behavioral health disorders.

To address the needs of the community, the PPS will implement models 1 & 2. Model 1 will integrate behavioral health services into existing primary care practices throughout the PPS region. This model will incorporate behavioral health screening and follow up treatment into the primary care setting and incorporate this into the treatment plans. Model 2 will integrate primary care into the behavioral health setting. This will bring services to a traditionally difficult to reach population, particularly the persistently mentally ill.

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

The patient population to be engaged varies based on the model being implemented, for this reason we are breaking out our target population in the following ways:

PCMH Service Site: All patients at participating sites will be screened using evidence-based tools, for example PHQ-9 or SBIRT. Screenings that show potential need for a patient to receive behavioral health services would be referred to the behavioral health providers on site. Should

this level of care not be appropriate an outside referral would be made. For patients who already have existing behavioral health providers efforts to have coordinated care would be made.

Behavioral Health Service Site: All patients at participating sites will be screened for preventative care and behavioral health needs. Should patients have unmet needs for primary medical care there would be options available. Should a patient have an existing primary care provider and wish to keep this provider efforts would be made to coordinate improving the patient's utilization of this service. Should the patient not have an existing primary care provider there would be the ability for the patient to get primary care right at the behavioral health site. For patients with Severe and Persistent Mental Illness it can be a challenge to make any appointments and having access to primary care at the behavioral health site may be the best way to engage and assist these patients with achieving better health outcomes.

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.

Assets and resources to be mobilized, developed, or repurposed are as follows:
PCMH Service Site:
- Franklin County will have North Star Behavioral Health integrate services into the Malone Health Center. Also Alice Hyde Medical Center and Citizen Advocates are planning to centrally locate primary care, behavioral health, and urgent care services at a new centrally located facility.
- Essex County will have Adirondack Health integrate behavioral health services into the Lake Placid Health Center.
- Clinton County currently has Clinton County Mental Health & Addiction Services co-located at five existing primary care practices; these sites will see integration of care, in addition integration will be added to three more sites.
- Saratoga, Warren & Washington Counties: Hudson Headwaters Health Network will integrate behavioral health services at fifteen primary care sites, expanding on an existing pilot. Four of these sites will receive behavioral health services via tele-medicine due to their remote locations and small patient volume. Glens Falls Hospital will integrate behavioral health into four hub primary care practices.
- Fulton County: Nathan Littauer Hospital will integrate behavioral health services at three primary care centers utilizing Family Counseling Center for staffing.
- St. Lawrence County has multiple organizations willing to integrate behavioral health services into primary care sites.

Behavioral Health Service Site:
- Clinton County: Hudson Headwaters Health Network will provide primary care at the Center for Wellbeing, a program of Behavioral Health Services North.
- Saratoga, Warren & Washington Counties: Glens Falls Hospital will integrate primary care into its four behavioral health clinics. Community, Work & Independence will integrate primary care into its Article 16 Clinic.
- St. Lawrence County has multiple organizations willing to integrate primary care into existing behavioral health services.

Glens Falls Hospital, Hudson Headwaters Health Network, and North Star Behavioral Health all have existing pilot programs which have successfully integrated primary care and behavioral health; this expertise will be leveraged as this project moves forward. Engaged partners are committed to improving access to and quality of services for 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.

Anticipated challenges include:
• Acquisition, implementation, and training on new or upgraded electronic health records. The PPS will assist with funding to get all organizations on board with electronic health records.
• Recruitment, training and retention of qualified staff. Given the workforce shortages efforts to gain new physicians through new family medicine residency programs will be a strategy. Salary support for Licensed Master Social Workers for the three years while they receive supervision to gain clinical licensure can be funded by DSRIP in order to help build a sustainable behavioral health workforce.
• Developing new procedures and work flows to have successful integration could be a challenge. Leveraging our partners who have experience with working in an integrated model will be important in addressing this.
• Confidentiality of health records. It will be important to not only set up high level permissions within electronic health records to make sure access is granted to appropriate parties, but also doing patient education to help reduce potential fear around information being shared without their consent.

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.

AHI, the lead organization for the AHI North Country PPS (AHINCPPS) has a strong history of collaboration and has established relationships with organizations from the other PPS' in our overlapping service areas. Other organizations within the PPS have also developed relationships with partners based on referrals, care coordination efforts and admission patterns. The PPS will build on those relationships to leverage areas of strengths and specific expertise and to ensure seamless coverage for our patients.

The AHINCPPS is working in collaboration with neighboring PPSs; the North Country Initiative PPS/Samaritan Medical Center (NCI), Ellis Hospital (EH), and Albany Medical Center (AMC). All of our neighboring PPSs selected this project. Specifically with regards to project 3.a.i., the PPSs will work together to ensure that providers taking part in both PPS receive the appropriate support for their integration activities, from just one PPS.

The PPSs are in agreement to establish a cross-PPS partnership that will address any issues presented by patient, and provider, overlap across the service areas. The first issue the group will address is how to count providers and patients for the scale and speed submission, to ensure that numbers are not inflated due to "double-counting" of patients in more than one PPS. Another aspect of coordination is in regards to sharing information to coordinate care across PPSs. This will be addressed, in part, through the SHIN-NY infrastructure, when available.

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.

There will be a need for capital funding to support HIT needs, specifically to purchase or upgrade electronic health records. Some behavioral health locations will require funding to build or retrofit space for primary care exam rooms, in addition the medical equipment needed to perform primary care functions would need to be purchased. Telemedicine investments will also be required to provide access to behavior health services in more remote areas in the PPS. Some

primary care locations will need to build out extra space for behavioral health staff to work in as well.

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
Glens Falls Hospital	NYS OMH BHI grant	2013	2016	Pilot development of integration including 2 psychiatric nurse practitioners (with supporting medical assistants) and 2 social workers to serve 2 primary care sites.
Hudson Headwaters Health Network	HRSA BHI funding	2014	2016	Pilot development of screening & stepped process, addition of at least one behavioral health clinician.
Citizen Advocates, Inc.	OMH Geriatric Integration Grant (GTAC)	2013	2015	Provide BH services to persons age 55+ at 4 rural health centers

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

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

The Citizen Advocates: An OMH Geriatric Integration Grant (GTAC) is running from 2013-2015 at four rural service sites. This time limited project focuses on the geriatric population, age 55 and over, regardless of payment source. The DSRIP project will greatly expand upon the collaborative integrated care model for all ages and across a larger nine county region. The current GTAC project focuses on a limited population in a small part of one northern county. The DSRIP project represents a significant enhancement to the entire PPS and a much greater impact on triple aim and Medicaid savings than the short term age limited GTAC grant.

Glens Falls Hospital (GFH) & Hudson Headwaters Health Network (HHHN): Both GFH and HHHN have begun to develop primary care and behavioral health integration. For each organization the current level of funding has allowed initial development of integration models and operational procedures. DSRIP funding will allow for a higher patient impact. GFH plans to expand implementation from 1 to 4 primary care sites. HHHN plans to expand implementation from 3 pilot sites to its network of practices, some via telemedicine. DSRIP funding of more behavioral

health staff to meet the needs of the population will be important to ensure patients are able to receive timely care access. One focus will be expanding efforts to provide behavioral health support for patients who have chronic health conditions such diabetes.

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

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

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

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

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

3.a.ii Behavioral Health Community Crisis Stabilization Services

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

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

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

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

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

1. 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 the PPS, insufficient capacity for emergency mental health programs is resulting in an imbalance in the way that patients are forced to use the system. When a behavioral health crisis occurs, patients present to the emergency department (ED) and are admitted for inpatient care and this scenario is clearly seen in the CNA data.

In six of the nine PPS counties, the PPV data shows that ED use is higher than the state rate of 36.1. In five counties it is significantly higher, St. Lawrence at 70.8, Clinton at 56.7, Essex at 55.7, Franklin at 52.8, and Fulton at 52.5. The conditions causing most hospitalizations for Medicaid members are conditions classified as mental and cardiovascular diseases and disorders, 34 and 31% respectively of conditions requiring hospitalization. Behavioral health conditions (mental diseases and disorders and substance abuse) accounted for 49% of admissions. Preventable hospitalizations (PQI-Adult) for Medicaid patients show higher rates than NY State for the overall composite PQI (total preventable) and each sub-composite score (acute, chronic, diabetes, respiratory, and circulatory) in Franklin, Clinton, St. Lawrence, and Fulton counties.

Of the 10 most prevalent conditions among Medicaid beneficiaries, behavioral health conditions represent 7 of the 10, and represent 62% of the top 10 conditions. Major Personality Disorders are the largest Major Diagnostic Category (MDC) driving both inpatient and ED utilization across all counties. All behavioral health MDCs accounted for 49% of admissions by MDCs and 58% of ED visits by MDCs. Across all counties except Hamilton, Major Personality Disorders and Posttraumatic Stress Disorder are two of the most prevalent diagnoses driving ED Utilization, with anywhere from 2 to 4 visits per beneficiary in 2012.

A population indicator tracked through BRFSS is percentage of the population reporting being in poor mental health 15 or more days in the past month. Twelve percent of the population in Upstate NY reports this condition. Fulton, St. Lawrence, Warren, Saratoga and Washington counties all have higher rates (13.3%, 17.1%, 12.1%, 12.7%, and 12.7% respectively). The Prevention Agenda 2017 goal for this indicator is 10.1%.

According to the New York Office of Mental Health there are 8 emergency mental health programs serving the PPS. Due to the large, rural service area accessibility is challenging and there are insufficient resources to respond to crises in a timely manner. Improving capacity to respond to a

community member in crisis will improve the outcome for the patient and rebalance the system so that patients are seeking the right care, in the right place, and 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.

In 2012 60,427 Medicaid beneficiaries were identified to have Mental Diseases and Disorders, another 14,439 with Substance Abuse conditions in our nine counties. These populations accounted for 31,829 and 14,418 admissions, and 101,343 and 27,069 emergency department visits, respectively. Of this population it is expected anyone who is having a behavioral health crisis would be a potential client for crisis services. The crisis stabilization centers and mobile crisis teams will serve within an hour drive one way of each of the town center where services will be located; this includes Schuyler Falls outside Plattsburgh, Elizabethtown, Malone, Gloversville and Glens Falls. Clients who are in need of medical attention or who are unable to contract for safety will be transported to an appropriate setting such as an urgent care or emergency department.

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.

Clinton County: Behavioral Health Services North (BHSN) will operate a 10-bed crisis stabilization program in Schuyler Falls, NY adjacent to the ambulatory detox facility described in project 3.a.iv. The program will offer crisis stabilization and short-term treatment, including adults with a co-occurring substance abuse issues. The site will have 1-2 adult mobile crisis teams and an intensive in-home crisis team focused on youth at risk of out of home placement. This project will require capital dollars. New staff required: 14 mental health providers, 6 administration/food service staff, 8 Registered Nurses, 12 case managers, 6 youth therapists, and 2-3 maintenance/IT support staff.

Essex County: Mental Health Association in Essex County will expand its existing one mobile crisis worker and one respite bed in Elizabethtown to add additional mobile crisis workers and 4 short-term crisis respite beds. Clinicians from Essex County Mental Health will help with staffing. Families First will provide a specially trained youth case manager to support child/adolescent crisis. Total staff will be approximately 2 social workers, 2 case managers, 1 administrative, and 2 peer support.

Franklin County: Citizen Advocates (CA) will establish a full service 24 hour Crisis Stabilization Center in the former Alice Hyde Hospital Nursing Home 1st floor. It will provide behavioral health crisis triage, intensive crisis services, limited proximity mobile crisis, ancillary withdrawal management services, respite beds, care coordination and Health Home linkage, onsite support groups, and peer and family support. CA will continue the existing 24 hour crisis hotline and will re-establish telepsychiatry capabilities in primary care clinics in the county to further assist in crisis response.

Fulton County: There is currently a youth mobile crisis team operating M-F 9am-5pm, and a county crisis team responding 24/7 to individuals in law enforcement custody. The Mental Health Association in Fulton and Montgomery Counties provides crisis respite beds and peer services. The current system is not cohesive and there is no post-crisis follow up. The county will establish an Assertive Community Team consisting of an LCSW Leader, Psychiatric NP, Psychiatric RN, and Licensed Mental Health Professional with substance abuse experience, both Peer and Family Peer Advocates, and a Program Assistant. This team will provide service to both children and adults 24 hours per day, 7 days per week. The team will follow up with individuals, provide case management, and link individuals to ongoing treatment. The team will coordinate closely with existing crisis services to repurpose existing crisis resources.

Warren/Washington Counties: A 24 hour crisis hotline and a mobile crisis team will be run by Parsons, who has experience running child mobile crisis, with some staffing provided by PEOPLe, Inc. 23 hour crisis stabilization beds will be developed and housed at Glens Falls Hospital, and a care management team will link individuals to care resources and supportive services. New services will require 1 therapist, 14 social workers, 6 peer support, and 2 administrative staff.

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.

-Awareness, getting client to utilize a new service in lieu of going to the emergency department. This can be addressed through education, training and community information sharing. Partnering with community stakeholders throughout initial center development will help with this system change and strengthen the project's success.
-Having a financially viable crisis service. This can be addressed initially through DSRIP funding with a push to get Medicaid Managed Care to provide reimbursements for successful work.
-Transportation is a challenge. Utilizing DSRIP funds to purchase vehicles will mitigate this. Telemedicine can be used to overcome some of these transportation challenges and reach more remote areas.
-Staffing shortages could be a challenge. In regions where ambulatory detox will be co-located the idea of shared staff that are cross-trained will help meet this need.

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.

AHI, the lead organization for the AHI North Country PPS (AHINCPPS) has a strong history of collaboration and has established relationships with organizations from the other PPS' in our overlapping service areas. Other organizations within the PPS have also developed relationships with partners based on referrals, care coordination efforts and admission patterns. The PPS will build on those relationships to leverage areas of strengths and specific expertise and to ensure seamless coverage for our patients.

The AHINCPPS is working in collaboration with neighboring PPSs; the North Country Initiative PPS/Samaritan Medical Center (NCI), Ellis Hospital (EH), and Albany Medical Center (AMC). We believe one neighboring PPS is pursuing this project. Specifically with regards to project 3.a.ii., the PPSs will work together to ensure that projects are coordinated in the overlapping portions of the service area.

The PPSs are in agreement to establish a cross-PPS partnership that will address any issues presented by patient, and provider, overlap across the service areas. The first issue the group will address is how to count providers and patients for the scale and speed submission, to ensure that numbers are not inflated due to "double-counting" of patients in more than one PPS. Another aspect of coordination is in regards to sharing information to coordinate care across PPSs. This will be addressed, in part, through the SHIN-NY infrastructure, when available.

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.

Clinton, Essex, and Franklin counties projects will require capital in order to build out their crisis stabilization centers and make beds available for use. These projects will require infrastructure costs, as well as IT costs to implement proper EHRs that interface with HIXNY.

Glens Falls Hospital will need capital to assist in outfitting a new crisis center.

Across all project sites there may be the need for furniture, phones, laptops and other IT investments. Depending on the region sites may also need to purchase vehicles to run the mobile crisis with.

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 in Fulton and Montgomery Counties	Medicaid-Housing Redesign	2015		SRO-Mixed Usage Housing Complex

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.

Affordable, decent housing is very limited in our Fulton county. This complex will offer one, two, and three bedroom units for both individuals living with a mental illness and possibly a substance use disorder as well as having units for other members of our community including those who may be currently living in a shelter; workforce members whose income is limited; returning veterans with limited resources, etc. The complex will be staffed 24 hours a day, and those

residents who are living in one of the designated single resident occupancy units or one bedroom licensed apartments will also have staff interactions at least once a day to ensure medication compliance; healthy eating; etc. For individuals served through the ACT team a possible residential location in this complex would assist in their monitoring and assessment of their recovery and wellness.

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

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

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

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

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

8. Use EHRs or other technical platforms to track all patients engaged in this project.

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

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

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

Data for our nine counties shows that substance abuse is a driver of utilization, particularly for Medicaid beneficiaries. Five-8% of the Medicaid population has a Drug Abuse condition. Substance abuse is the fourth leading cause of hospital admissions, 14,418, and ED visits, 27,069 ED visits. Among the top 10 conditions driving Medicaid ED visits across all the counties, substance abuse conditions account for 2-4 of the top 10 conditions in each county. Diagnoses include: Delirium Tremens, Drug Abuse Related Diagnoses, Opioid Abuse, Cocaine Abuse, and Chronic Alcohol Abuse – all resulted in 2 or more ED visits among Medicaid beneficiaries for Clinton, Franklin, Fulton, Essex, Saratoga and St. Lawrence counties in 2012.

There are a number of social factors that contribute to a culture where substance use issues can thrive.

Poverty: Most of the PPS counties have higher rates, and in some counties significantly higher rates, of poverty than Upstate NY. Seven of the 9 counties in the PPS have a higher percentage of the population with incomes below 200% of the federal poverty level compared to 26% in Upstate NY. Three counties are more than 10 percentage points above Upstate.

Lower educational attainment: Six of the 9 PPS counties have a higher percent of the population with less than a high school education compared to 11% of the population in Upstate NY. The range in our PPS is from 13-16%. Even more pronounced is the difference between the PPS and NY State for the Population with Associate's Level Degree or Higher. Eight of the 9 counties have a lower percentage of residents completing any higher education. These counties have percentages ranging from 25.5-38.8% compared to NY State at 41.1 percent.

Unemployment: There is a lot of variability in unemployment rates for the PPS counties, from 4.9-10.6 percent. Six of the 9 counties have unemployment rates above the upstate rate of 7.7 percent. Four counties have rates that are far higher at 9.3-10.6%, almost two to three percentage points above the Upstate rate.

Transportation: Lack of transportation was raised as a concern by many stakeholders in surveys and community meetings. Public transportation in mostly rural areas is a challenge. Although Medicaid does cover cabs for certain appointments accessibility is an issue, as is the variety of

appointments a cab is not covered for. The reservation system, timely return rides and urgent appointments were cited as problematic.

The PPS will be implementing multiple projects that will contribute to addressing substance abuse and behavioral health issues. Ambulatory Detox is an important option for care. Detoxification services are in high need and in short supply across the region. Currently the only option is 7 bed inpatient medically managed detox at Canton-Potsdam Hospital in St. Lawrence County, often with a long waitlist. There are no other designated medically managed inpatient detox beds and no designated outpatient detox services in the other 8 counties. The data shows that this lack of capacity forces inappropriate ED use.

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 ambulatory detox is adults age 18 and over. The geography would cover a radius of 25-40 miles from the Plattsburgh community, and a similar region surrounding Malone and Saranac Lake (thus encompassing Franklin, Clinton and Essex Counties). Individuals with an opioid and/or alcohol dependence diagnosis rating from mild/moderate would be potentially candidates for ambulatory detox. It is crucial that a patient is properly evaluated for admission to ambulatory detox as this model may not be the best fit for everyone needing detox services.

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

Only one inpatient detox unit exists and is located at Canton-Potsdam Hospital, and no outpatient facilities exist, thus all services must be built from scratch. Given the expense, risk, and challenges with setting up these programs (building out facilities/beds, hiring an addiction certified medical director, and obtaining opiate prescribing licenses), our region is focusing on developing two detox programs which will serve Clinton, Franklin and Essex counties.

Plattsburgh Program to serve Clinton County:
-Developing detox services including ambulatory detox, short-term respite beds for detox patients, and an outpatient SUD site with integrated primary care and care management. Additional respite beds will be developed to serve crisis stabilization patients through project 3.a.ii, with overlap between patients co-location will be beneficial as it allows for sharing of cost and staff. This will be a new facility and will require capital to repurpose a building in Schuyler Falls. Staffing will require the following: 7 RNs (3 shifts), 7 certified recovery coaches/care managers (some part-time), 3 Credentialed Alcoholism & Substance Abuse Counselors (CASAC), 1 Social Worker, 0.5 medical director, 1 nurse practitioner, and 4 administrative/food service staff. The program will also need transportation services, appropriate referral protocols from local emergency departments, as well as linkage to inpatient services when needed.

Malone/Saranac Lake Program to serve Franklin and Northern Essex Counties:
-In concert with a Medical Village project at Adirondack Health, this region is turning 5 inpatient beds into 5 new medically managed inpatient detox beds that will be run by St. Joseph's Rehab (SJR) & Treatment Center, as well as developing ambulatory detox services at the Malone Outpatient Clinic and in a new Malone Crisis Stabilization Center, both to be run by Citizen Advocates (CA) and North Star Behavioral Health Services (NSBHS). The staffing and costs for the inpatient detox program, and the capital costs for the Malone Crisis Stabilization Center are not discussed here, but are discussed in projects 2.a.iv and 3.a.ii respectively.
-SJR, CA and NSBHS have existing expertise and properly certified physician resources who can meet regulatory requirements for oversight. SJR brings over forty years of expertise in treating substance abuse disorders and will help develop protocols for properly referring patients to the right level of detox services. The CA facility will require the proper ambulatory detox certification, redeployment of an existing Medical Director, a Psychiatric Nurse Practitioner, 2 care managers, and 8 peer support staff. Social Worker staff will be shared with Crisis Stabilization. CA and NSBHS have experience delivering SUD services and coordinating care through Health Home initiatives. They also have a relationship with the Alice Hyde's emergency department which will serve as a referral channel.

Education and training for first responders, physician offices and hospital staff will all be conducted to drive referrals to the outpatient detox programs.

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

In Plattsburgh finding a board certified addiction medicine MD will be a challenge. A waiver request will be sent to OASAS with the ambulatory detox application requesting the time and support to get an MD certified. Staffing for this project will also be a significant issue. There are 3 certified recovery coaches in Clinton County. A five day training will be brought to the region to greatly enhance the recovery coach pool. Overlap of staff with the new crisis center will assist in cost sharing and helping to ensure sustainability of the project.

In Saranac Lake challenges will include the development of and training/certification for the peer support program, development of ancillary withdrawal management protocols and staff training on provision of withdrawal management, establishing patient flow and referral protocols, and recruitment of a Psychiatric Nurse Practitioner. Working closely with the Plattsburgh region as well as bringing in experts, the COO of St. Christopher's Inn, to develop protocols and staff training will help to spread the burden across the region and increase positive outcomes. To address workforce issues Adirondack Health will plan to retrain nursing staff displaced by reduction of 5 inpatient beds and redeploy the staff to work with the inpatient detox program.

Each location will need to address transportation as a barrier to care. The potential to use capital funds to purchase a van is a way to address this need. Also working to get Medicaid Managed Care to pay for the array of detox service will be addressed through meetings with the PPS.

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.

AHI, the lead organization for the AHI North Country PPS (AHINCPPS) has a strong history of collaboration and has established relationships with organizations from the other PPS' in our overlapping service areas. Other organizations within the PPS have also developed relationships with partners based on referrals, care coordination efforts and admission patterns. The PPS will build on those relationships to leverage areas of strengths and specific expertise and to ensure seamless coverage for our patients.

The AHINCPPS is working in collaboration with neighboring PPSs; the North Country Initiative PPS/Samaritan Medical Center (NCI), Ellis Hospital (EH), and Albany Medical Center (AMC). We believe one neighboring PPS is pursuing this project. Specifically with regards to project 3.a.iv., the PPSs will work together to ensure that projects are coordinated in the overlapping portions of the service area and that there is not an excess of capacity developed, due to lack of communication.

The PPSs are in agreement to establish a cross-PPS partnership that will address any issues presented by patient, and provider, overlap across the service areas. The first issue the group will address is how to count providers and patients for the scale and speed submission, to ensure that numbers are not inflated due to "double-counting" of patients in more than one PPS. Another aspect of coordination is in regards to sharing information to coordinate care across PPSs. This will be addressed, in part, through the SHIN-NY infrastructure, when available.

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.

Plattsburgh Region:
Capital funding is essential to providing ambulatory detox as it is a new service. Champlain Valley Family Center is in the process of securing a property from the Department of Environmental Conservation. The property was formerly operated by the NYS Office of Children and Family Services and was closed approximately 7 years ago. There are three large buildings on the site, 7,200, 5,400 and 4,000 square feet. Two of these buildings will require capital dollars to renovate: one building for the ambulatory detox with attached crisis stabilization/respite and the other building for the mental health stabilization respite. Start-up costs for the ambulatory detox will require the setup of medical, nursing, Social Work, CASAC, and recovery coach offices. All of the expenses related to setting these offices up (examples: telephone system, EHR and support, computers, printers, desks, chairs, IT infrastructure, medical supplies) will be needed. The purchase of a van or vans to assist with patient transportation issues is another capital need.
Malone/Saranac Lake St. Joseph's Inpatient Detox Beds:
The Adirondack Health Medical Village Capital Project request is necessary to complete remodeling and construction in the hospital to expand other ancillary services and allow for release of the 5 staffed beds to St. Joseph's for purpose of Medically Supervised Inpatient Detox described in this project. At this time, anticipated funding needs are associated with EHR implementation, software, software licensing, pre-startup costs for staff that will need additional training/retraining, recruitment and marketing, standard new staff costs including laptops, printers, office furniture, and phones.
Malone/Saranac Lake CA Ambulatory Detox:
The Ancillary Detox capital needs will be minimal but necessary and will include EHR licenses and additional costs for equipment and furniture for new staff. Funding for a van or vans to address transportation barriers is needed. Additional capital will be necessary to establish the Crisis Stabilization and Diversion Center where ancillary withdrawal management will also be available following satellite approval, these funding needs are further described in project 3.a.ii.

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

Yes	No

☐	☒

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

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

3.g.i Integration of Palliative Care into the PCMH Model

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

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

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

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

1. Integrate Palliative Care into appropriate participating PCPs that have, or will have achieved NCQA PCMH certification.
2. Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.
3. Develop and adopt clinical guidelines agreed to by all partners including services and eligibility
4. Engage staff in trainings to increase role-appropriate competence in palliative care skills.
5. Engage with Medicaid Managed Care to address coverage of services.
6. Use EHRs or other IT platforms to track all patients engaged in this project.

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

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

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

A total of 693,954 people live in the largely rural 11,859 square mile AHI North Country PPS (AHINCPPS) service area. The PPS population is older than that of Upstate NY and NY as a whole. All nine counties have fewer children and five counties have more adults age 65 plus. Three counties have very high percentage of older adults, Warren at 17.3%, Essex at 18.4%, and Hamilton at 23.3% compared to Upstate at 14.6%.

Data from the AHINCPPS CNA indicates that the PPS population disproportionately suffers from chronic disease compared to NY State as a whole. Clinton, Essex, Franklin, St. Lawrence, and Warren Counties have a higher percent of Adults with Diabetes (ranging from 9.8% to 11.7%) than NY State (9%). The percent of Adults with Asthma is higher in seven of the nine counties (ranging from 11.0% to 15.3%) than in NY State (9.7%). Six of the nine counties have a higher percent of Adults with Heart Disease (ranging from 8.6% to 11.2%) than NY State (7.6%). Eight of the nine counties have a higher percent of Adults with High Blood Pressure (ranging from 28.2% to 33.1%) than NY State (25.7%).

Three of the top six underlying conditions at the root of most inpatient admissions for Medicaid recipients were chronic conditions: Diseases and Disorders of the Cardiovascular System, Diseases and Disorders of the Respiratory System, and Diabetes Mellitus. The same pattern in seen for ER utilization consistently throughout the PPS.

Admissions for ambulatory sensitive conditions (Prevention Quality Indicators, or PQIs) for Medicaid patients point to a need for better management of ambulatory sensitive condition, including chronic conditions. The PQI overall composite measure and the acute, chronic, diabetes, respiratory, and circulatory composites all show a fairly consistent pattern: poorer performance in Franklin, Clinton, St. Lawrence, and Fulton counties compared to NY State for the overall composite PQI and each sub-composite score, while Saratoga, Washington, and Warren perform better than rest of the state, on the overall composite PQI and each composite score. Essex County had an overall composite better than the state in 2011, but worse than the state in 2012. Given the small population in Hamilton, the rates are unstable and conclusions cannot be drawn. With respect to potentially inappropriate ER use (PPVs) among Medicaid patients, all counties perform worse than NY State, except Washington and Hamilton, and Warren County in 2012. St. Lawrence, Essex, Clinton, Fulton, and Franklin have particularly high rates; these are the same counties with high PQIs, with the addition of Essex.

The data summarized above show that the AHINCPPS population disproportionately suffers from chronic diseases compared to NY State as a whole. Palliative care is beneficial for people suffering from serious and chronic illnesses and as such, the population's health will benefit from better integration of Palliative Care into the Patient Centered Medical Home model. The expansion of Palliative Care services provides an opportunity to focus on symptom relief, which contributes to avoidance of ER visits and potentially inpatient admissions.

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 includes patients with: (1) an unacceptable level of pain or other symptoms of distress (i.e. fatigue, dyspnea, nausea), (2) a need for help with complex decisions and setting

goals of care (including family/care team, and including decision-making with regards to advance directives), (3) uncontrolled psychological or spiritual needs, (4) significant medical comorbidities and/or poor baseline functional status (i.e. capable of only limited self-care; confined to bed or chair more than 50% of waking hours), (5) a history of chronic or incurable illness (e.g. advanced respiratory, cardiac, neurologic, or renal disease, metastatic cancer, Stage IV cancer, Stage III lung or pancreatic cancer), (6) frequent ECC visits (>1 per month for same diagnosis), frequent hospital admissions, or a prolonged hospital stay, (7) moderate to late stage Alzheimer's and dementia conditions, or (8) failure to thrive (10% weight loss over the past 6 months or BMI<22 and loss of functional capacity.
In an Intensive Care Unit setting, the target population includes: (1) patients 80 years of age and older, (2) patients with an acute illness (i.e. anoxic brain injury, intra-cerebral hemorrhage requiring mechanical ventilation), (3) patients with chronic critical illness associated with a prolonged ICU stay or prolonged mechanical ventilation, (4) patients considering tracheostomy and/or PEG placement, (5) patients for whom life-sustaining treatments are medically futile (in the clinician's view) and may be inappropriate.

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 Program will include Palliative Care providers who work with nurses, specialists, hospice, social services, care managers, and others. Standardized palliative care referral criteria and care plans, and use of MOLST/Advanced Directives will be implemented and a systematic process will be put in place for early identification of patients who may benefit from palliative care. Assets and resources that can be leveraged include:
(1)The Palliative Care Workgroup, in the Glens Falls/Queensbury region, will be expanded. The hospital's oncology service has started to review/develop evidenced-based treatment guidelines that will incorporate palliative care, and discussion regarding Survivorship plans is underway.
(2)UVM Health Network–Champlain Valley Physicians Hospital (CVPH): inpatient Palliative Care Team, a Home Care–Palliative Care nurse, an ELNEC (End of Life Nursing Education Consortium). The Palliative Care IDT committee will be expanded to include the Community Palliative Care Team.
(3)Nathan Littauer Hospital and community partners have the operating environments and management staff in place, including primary care, nursing home and homecare. Personnel assets include 2 CHPN's and one palliative certified MD.
(4)Hospice and Palliative Care of St. Lawrence Valley has an interdisciplinary palliative care program that provides services to Canton-Potsdam Hospital and Gouverneur Hospitals; the program also has active referral relationships with physician practices.
(5)Many providers experience developing standard protocols and palliative initiatives through their involvement in the Upstate New York Hospice Alliance and the Hospice and Palliative Care Association of New York State. Both of these organizations have access to expert resources that will facilitate the development and implementation of effective palliative care services that our appropriate for each primary care setting.
(6)The service area's largest FQHC (Hudson Headwaters Health Network) currently provides palliative care services to some of their patients. The service includes a physician advisor, 1 FTE

Nurse Practitioner for Inpatient Palliative Care, a PT Nurse Practitioner for Outpatient/Home Palliative Care and a PT Physician Assistant for Home Palliative Care.
(7)Community outreach and education activities are in place throughout the region and can be utilized for palliative care education.
(8)The region has successfully embedded Care Management services at many primary care sites; behavioral health organizations also offer care management.
(9)High Peaks Hospice and North Country Hospice are additional assets.
Additional community resources that need to be developed or repurposed:
(1)Additional Hospice and/or Hospice-like service providers are needed to meet anticipated increases in referrals to both palliative care and hospice providers.
(2)There is a need to develop alternate settings for end-of-life care.
(3)Need to develop and/or expand Community Palliative Care teams (many of the palliative care services and teams described above are for inpatient settings).
(4)Need for more community outreach and education resources, and training/education for providers & staff.

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

A significant challenge to project implementation is the lack of qualified and credentialed professional personnel in palliative care. This will be addressed through workforce development activities to provide training and assistance with recruitment.
A lack of knowledge about what palliative care is, and is not, represents a significant barrier to acceptance and utilization of the service. Historically there has been low utilization of inpatient palliative care consultations and late/short LOS hospice referrals. This will be addressed by an extensive education program. There will be education for providers and staff on the benefits of palliative care to the chronically ill patients they serve, and a considerable level of community outreach will take place to increase community awareness of the benefits of palliative care to patients and families.
There will need to be evidence of return on investment to successfully negotiate adequate payment for the services. This will be addressed by working with an evaluator to develop the statistical model for demonstrating outcomes from the palliative care project, including cost avoidance, relative to the investment.
A final barrier is that the smaller practices are challenged by the lack of “bandwidth” to engage in clinical change processes and do not have adequate patient volume to hire dedicated staff to support the changes. To address this, we will develop centralized training support, provide feedback to clinicians on relevant performance measures, and assist with workflow re-design.

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.

AHI, the lead organization for the AHI North Country PPS (AHINCPPS) has a strong history of collaboration and has established relationships with organizations from the other PPS' in our overlapping service areas. Other organizations within the PPS have also developed relationships with partners based on referrals, care coordination efforts and admission patterns. The PPS will build on those relationships to leverage areas of strengths and specific expertise and to ensure seamless coverage for our patients.

The AHINCPPS is working in collaboration with neighboring PPSs; the North Country Initiative PPS/Samaritan Medical Center (NCI), Ellis Hospital (EH), and Albany Medical Center (AMC). One neighboring PPS is pursuing this project. Specifically with regards to project 3.g.i., the PPSs will work together to ensure that projects are coordinated in the overlapping portions of the service area and that there is not an excess of capacity developed, due to lack of communication.

The PPSs are in agreement to establish a cross-PPS partnership that will address any issues presented by patient, and provider, overlap across the service areas. The first issue the group will address is how to count providers and patients for the scale and speed submission, to ensure that numbers are not inflated due to "double-counting" of patients in more than one PPS. Another aspect of coordination is in regards to sharing information to coordinate care across PPSs. This will be addressed, in part, through the SHIN-NY infrastructure, when available.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital Funding is necessary to develop alternative venues to provide end-of-life care. Glens Falls Hospital is committed to converting hospital space (instead of hospital beds) for Hospice care. Capital funding will be needed to equip the outpatient palliative care center at Hudson Headwaters Health Network, and other primary care sites may require renovations. The project requires technology investments, some of which may quality as capital, including hardware/software and implementation costs for tablets or other IT solution for staff in the field to assist in coordination of palliative care patients, as well as additional at-home monitors

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
Hudson Headwaters Health Network	HRSA	1/1/15	12/31/15	$250,000 to go towards building an outpatient palliative care services

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

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

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

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

and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

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

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

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

Domain 4 Projects

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

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

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

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

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

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

Entity Name
Currently no out of PPS providers are engaged on this project. During the implementation planning phase the following organizations will be reached out to: -WAIT House -Community Action -Salvation Army -Glens Falls Youth Center

-NAMI-Champlain Valley
-Family Service Association
-Law Enforcement Agencies

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

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

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

The CNA data indicates that the PPS region is disproportionately impacted by mental health and substance use issues. Of the 10 most prevalent conditions among Medicaid beneficiaries, behavioral health conditions represent 7 of the 10, and represent 62% of the top 10 conditions.

The conditions causing most hospitalizations for Medicaid members are conditions classified as mental & cardiovascular diseases and disorders, 34% and 31% respectively of conditions requiring hospitalization. Behavioral health conditions accounted for 49% of admissions. Preventable hospitalizations (PQI-Adult) for Medicaid patients show higher rates than NY State for the overall composite PQI (total preventable) and each sub-composite score (acute, chronic, diabetes, respiratory, and circulatory) in Franklin, Clinton, St. Lawrence, and Fulton counties.

In 6 of the 9 PPS counties, the PPV data shows that ED use is higher than the state rate of 36.1. In five counties it is significantly higher, St. Lawrence at 70.8, Clinton at 56.7, Essex at 55.7, Franklin at 52.8, and Fulton at 52.5. At the same time Primary care use by Medicaid beneficiaries in the PPS region tends to be slightly lower than NY State averages.

Major Personality Disorders are the largest Major Diagnostic Category (MDC) driving utilization across all nine counties. Except Hamilton county, Posttraumatic Stress Disorder is the second most prevalent driver of ED Utilization. All mental health MDCs accounted for 49% of admissions by MDCs. Behavioral health MDCs accounted for 58% of ED visits by MDCs.

Mental health and wellbeing is influenced by social circumstances and in the PPS region the data indicates that a number factors that may negatively impact wellbeing.

Poverty: Most of the PPS counties have higher rates, and in some counties significantly higher rates, of poverty than Upstate NY. Seven of the nine counties in the PPS have a higher percentage of the population with incomes below 200% of the federal poverty level compared to 26% in Upstate NY. Three counties are more than 10 percentage points above Upstate.

Lower educational attainment: 6 of the 9 counties have a higher percent of the population with less than high school education compared to 11% of the population in Upstate NY. The range in this set of counties is from 13 to 16 %. Even more pronounced is the difference between the PPS and NY State for the Population with Associate's Level Degree of Higher. Eight of the 9 counties

have a lower percentage of residents completing any higher education. These counties range from 25.5% to 38.8% compared to NY State at 41.1%.

Unemployment: There is a lot of variability in unemployment rates for the PPS from 4.9%to 10.6%. Six of the 9 PPS counties have unemployment rates above the upstate rate of 7.7%. Four counties have rates that are far higher form 9.3% to 10.6%.

To address the current issues and also focus on mental health and substance abuse prevention and health promotion the PPS has developed the following strategies:
-Developing partnerships and regional strategies for mental health promotion and disorder prevention
-Understanding the systemic effects of poverty on accessing/receiving healthcare, and providing poverty-sensitive training to the workforce
-Prevention programs in schools
-Cross-training professionals to know what treatment language is appropriate in the mental health and substance use care
-Developing focused training on how to interact with beneficiaries who have gone through traumatic experiences so that trauma-sensitive care can be provided in healthcare and community settings

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.*

In our nine counties, based on Major Diagnostic Categories, Medicaid beneficiaries are identified as having the following conditions: 60,427 with Mental Diseases and Disorders and 14,349 with Substance Abuse. These beneficiaries will make up our 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.

Assets and resources that can be mobilized:
-Prevention Councils and community organizations across our PPS are willing to expand the following prevention programs: Too Good for Drugs, Too Good for Violence, OLWEUS, Natural Helpers, LifeSkills, Challenge-Based Programs, Class Action, Project Alert, Towards No Drug Abuse (TND), adolescent mental health First Aid, Safe Talk, and evidence based Suicide Prevention programs
-Existing community organizations will form coalitions to engage in successful implementation of project goals

Resources to be developed or repurposed:
-To increase access to knowledgeable professionals providing cross training between clinical behavioral health providers and substance use providers needs to be developed
-Other trainings that need to be developed are poverty sensitive training and trauma informed trainings to help professionals better work with clients

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.

-Competing priorities among organizations and leadership may be a challenge. This will be overcome through accountable budgeting and timeline development, as well as performance payments to motivate and engage these groups.
-Getting trainers or training staff to be trainers, finding time for professional staff to attend trainings, and ensuring successful implementation of skills learned in trainings may all be challenges. One way to overcome part of these challenges would be to reimburse staff, or an agency, for the work time lost due to attending training.
-Developing appropriate curriculums for the identified initiatives (cross training, poverty, and trauma) will take time and investment. This can be address by using funding to hire staff or consultants, and to purchase evidence based curriculums for new trainings.
-Data sharing and information exchange can be challenging. Utilizing a population health management tool the PPS will invest in should aid in this process.

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.

AHI, the lead organization for the AHI North Country PPS (AHINCPPS) has a strong history of collaboration and has established relationships with organizations from the other PPS' in our overlapping service areas. Other organizations within the PPS have also developed relationships with partners based on referrals, care coordination efforts and admission patterns. The PPS will build on those relationships to leverage areas of strengths and specific expertise and to ensure seamless coverage for our patients.

The AHINCPPS is working in collaboration with neighboring PPSs; the North Country Initiative PPS/Samaritan Medical Center (NCI), Ellis Hospital (EH), and Albany Medical Center (AMC). Two of our neighboring PPSs selected this project. Specifically with regards to project 4.a.iii., the PPSs will work together on the implementation plan to develop a coordinated approach.

The PPSs are in agreement to establish a cross-PPS partnership that will address any issues presented by patient, and provider, overlap across the service areas. The first issue the group will address is how to count providers and patients for the scale and speed submission, to ensure that numbers are not inflated due to "double-counting" of patients in more than one PPS. Another aspect of coordination is in regards to sharing information to coordinate care across PPSs. This will be addressed, in part, through the SHIN-NY infrastructure, when available.

The PPSs also plan to share information on best practices with the neighboring PPSs via a learning collaborative model. Each region has access to resources to support sharing of best practices, such as funding for Population Health Improvement Programs, and Rural Health Networks. The PPSs will take part in regular meetings to coordinate planning and to leverage training/educational resources as broadly as possible. Workforce development activities will also be coordinated with

neighboring PPSs. Overall, the PPSs are highly motivated to work collaboratively, and capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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

Important milestones listed below:
-Develop prevention coalitions, with proper representation from PPS and non-PPS stakeholders: 1st quarter DY1
-Hire new staff at prevention agencies identified to own trainings: 3rd quarter DY1
-Train new and existing staff on Poverty curriculums: 3rd quarter DY1
-Determine cross training opportunities through Prevention Coalitions: 3rd quarter DY1
-Engage appropriate source to provide cross training in behavioral health and substance use: 4th quarter DY1

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

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

Yes	No
☐	☒

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

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

Yes	No
☐	☒

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

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

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

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

3. 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. 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
-Pharmaceutical Companies (Boehringer INSPIRED Program) -Population Health Management Vendor -County-based Offices for the Aging -Franklin County CARES -Mercy Care of the Adirondacks -North Country Healthy Heart Network, Inc. -Decker Learning Center -NY Connects -Global Initiative for Chronic Obstructive Lung Disease

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

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

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

A total of 693,954 people live in the largely rural 11,859 square mile AHI North Country PPS (AHINCPPS) service area. The population in the PPS is older than that of Upstate NY and NY as a whole. All nine counties have fewer children and five counties have more adults age 65 plus. Three counties have very high percentage of older adults, Warren at 17.3%, Essex at 18.4%, and Hamilton at 23.3% compared to Upstate at 14.6%. The population in the region is predominantly White. Franklin County is the most racially and ethnically diverse, with 16 percent of its population identifying as other race/ethnicity than White, compared to 92 to 97 percent of the population in other counties identifying as White.

According to data from the NYS DOH's Expanded Behavioral Risk Factor Surveillance System (BRFSS), 27% of Upstate NY's adults (18+) are either obese or overweight. Six of the AHINCPPS counties have percentages higher than this, ranging from 28% in Washington to 34% in Franklin.

According to New York's Expanded BRFSS data, 17 percent of Upstate NY's residents are current tobacco smokers. In the AHI PPS, 8 counties had higher percentages of adults who smoke compared to Upstate. Four counties have rates higher than 20 percent including Franklin County at 27 and Fulton County at 29 percent. Tobacco smoking is the leading cause of Chronic Obstructive Pulmonary Disease.

Chronic Lower Respiratory Disease ranks as one of the top five Leading Causes of Premature Death in all nine counties that comprise the AHI North Country PPS. In looking specifically at data for Medicaid beneficiaries, the Major Diagnostic Category (MDC) "Diseases and Disorders of the Respiratory System" is the third Leading Cause of Inpatient Admissions and the third leading cause of Emergency Room Utilization for all nine counties combined. The Prevention Quality Indicator

data, which includes all county residents, for the All Respiratory Composite indicates five of the nine counties have rates higher than the NY State rate. Two counties, Clinton at 744 and Franklin at 804, are significantly higher than the state rate at 482. The PQIs indicate a need for improved management of respiratory conditions.

Given high rates of tobacco smoking, obesity, and elevated PQIs for respiratory disease, this project will focus on chronic obstructive pulmonary disease prevention and management. Although obesity itself is not a risk factor for respiratory conditions, obesity has been associated with a worsening of COPD symptoms, and decreased quality of life.
The project will be implemented in conjunction with practices that have adopted the patient centered medical home model. All PPS providers plan to achieve NCQA 2014 Level 3 PCMH recognition by the end of year 3 of the demonstration. These practices, and their care management supports (including care managers embedded in primary care and/or behavioral health settings), along with hospital-based care management resources, will connect patients to community preventive resources. The PPS' Health Information Technology plan will include steps to ensure widespread adoption of meaningful use certified EHRs. A regional population health management platform will be implemented. Together, these technologies will provide registry functionality and clinical decision support tools. The technology will make the work of care managers more effective, by providing patient reminders for preventive and follow-up care.

The Clinical Governance and Quality Committee will work closely with the Regional Health Innovation Teams to provide feedback to clinicians around clinical benchmarks, and the financial model incentivizes quality improvement efforts.

The hospitals taking part in the PPS already incorporate Prevention Agenda goals into their Community Service Plans, and the PPS will work in conjunction with them, and the Adirondack Rural Health Network, to coordinate implementation with local health departments and other community partners.

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.*

This population health project will be implemented in the entirety of the AHI North Country PPS (AHINCPPS) service area. Some elements, such as a media campaign, have the potential to reach all 693,954 members of the population. However, the media campaign, and other activities, will be designed to target persons with, or at risk for, chronic obstructive pulmonary disease (COPD), as well as their family members, providers, and caregivers.

A team based care model that includes patient-centered medical homes and care management supports will be utilized. Teams will rely on technology (including registries and/or population health management capabilities) to identify high-risk patients. Shared and/or interoperable EHRs will facilitate communication across the care team. Care managers and other home and community-based workers will utilize tablets or other mobile technologies and patients will be provided with home monitoring equipment and tele-health options as needed. The program will target the following patients:

- Persons with a COPD diagnosis post admission, observation stay or emergency room visit.
- Persons with a diagnosis of COPD currently residing in a Skilled Nursing Facility or newly admitted to SNF if not previously diagnosed.
- Patient considered to be at risk for COPD. Risk factors including: dyspnea that worsens over time, is worth with exercise or is persistent, chronic cough (regardless of whether it is intermittent or non-productive), any pattern of chronic sputum production, smoking, history of exposure to environmental risk factors (tobacco smoke, smoke from home cooking or heating fuels, occupational dust or chemicals), family history of COPD.
- Provider referral and/or risk modeling identification of patients with COPD who are determined to have additional education/monitoring/coordination needs to prevent avoidable emergency room visit/admissions.

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 region has many assets and resources that will be built upon to ensure success of the project. Assets include:

(1) Proven model of care management and disease management programs that can be tailored to the target population, and expanded, to meet the needs of the community. A variety of chronic disease management, transitional care, and other care management supports, (including PCMH based resources, and Medicaid Health Home care management resources) and will be mobilized to support this project.
(2) Given that St. Lawrence County ranks 58 out of 62 counties in terms of population health, Canton-Potsdam Hospital has invested resources in a new Population Health Initiative with a Board Certified Pulmonologist as Medical Director. This resource can be leveraged to provide leadership and act as a 'physician champion' for the project.
(3) Health Services of Northern New York Care and Canton-Potsdam Hospital have established home tele-health programs as a piece of chronic disease management for selected patients. These resources, and tele-health / home monitoring projects in other areas, will be expanded for the project.
(4) Through the Adirondack Region Medical Home Program, providers adopted evidence-based guidelines for the treatment of hypertension, diabetes and coronary artery disease, on a regional basis. Provider's experience working collaboratively on regional best practices will facilitate adoption of a regional approach for COPD.
(5) Many PPS providers currently use electronic medical records and have met Meaningful Use standards, and have worked with vendors to implement decision support and quality metrics related to other chronic conditions. This experience can be built upon for this project.
(6) Glens Falls Hospital's Tobacco Cessation Center funding provides resources to assist in the development and implementation of clinical practice guidelines for assessing and treating tobacco use. The program includes Certified Tobacco Treatment Specialists who can provide trainings.
(7) The resources available from the New York State Smoker's Quitline and New York State's Tobacco Control Program will be utilized.

(8) Preventative care resources, and community outreach/education resources, are available in many of the region's local health departments.
(9) The Adirondack Health Institute's funding as a Rural Health Network and Population Health Improvement Program will provide resources including support for education and training, learning collaboratives, etc.

Needed Community Resources:

(1) A Community COPD Coordinator & Team (with representation from the full care continuum) will be established to develop an educational program and provide assistance with the implementation of standardized COPD Action Plans, and to facilitate training and staffing for a COPD Education Program (e.g., INSPIRE).
(2) An Outreach Educator to deliver primary and secondary prevention activities in targeted communities.
(3) Primary care sites must be equipped with adequate spirometry testing.
(4) Patient education tools and equipment for COPD Self-Management Kits.
(5) Tele-health system / remote monitoring resources will be needed on a larger scale than currently available.
(6) Pulmonary rehabilitation and pulmonary fitness programs may need to be expanded.
(7) One or more mobile primary care units could be used to bring healthcare closer to communities and address geographic / transportation barriers.

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

The project will face significant challenges. Due to the rural geography, patients are often isolated and lack caregivers and transportation. In many communities, there are few, if any, taxi services or public transportation options. Where they do exist, there are often long wait times and they may not be handicapped accessible. This will be addressed through tele-health technologies and mobile primary care units. In addition, implementation plans will include transportation providers. The lack of care-givers will be addressed, at least to some degree, by working to increase awareness and utilization of the Consumer-Directed Personal Assistance Program.

Another challenge is that some providers lack electronic medical records and others do not have interoperable records, or RHIO connections. This will be addressed through a comprehensive IT strategy (and capital request) to ensure the technology is in place to ensure communication / coordination across settings or care.

Another barrier is that the smaller practices are challenged by the lack of "bandwidth" to engage in clinical change processes and do not have adequate patient volume to hire dedicated staff to support the changes. To address this, we will develop centralized training support, provide feedback to clinicians on relevant performance measures, and assist with development of prompts and notifications for ongoing non-urgent care, provide change management support and

work across provider organizations to share resources and enable smaller practices to effectively accomplish this work in a scale relevant to the size of their patient population.

The prevalence of tobacco use in the PPS service area, particularly in communities with low socio-economic status, presents a significant barrier to the prevention of chronic obstructive pulmonary disease. New York State's Tobacco Control Program provides significant resources to providers, patients, and communities and these will be leveraged in the implementation plan. The project will leverage existing resources for training on tobacco cessation strategies. In addition, the project will focus prevention activities (media campaign) on other COPD risk factors as well, such as exposure to environmental risk factors (smoke from home heating fuel, industrial exposures).

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.

AHI, the lead organization for the AHI North Country PPS (AHINCPPS) has a strong history of collaboration and has established relationships with organizations from the other PPS' in our overlapping service areas. Other organizations within the PPS have also developed relationships with partners based on referrals, care coordination efforts and admission patterns. The PPS will build on those relationships to leverage areas of strengths and specific expertise and to ensure seamless coverage for our patients.

The AHINCPPS is working in collaboration with neighboring PPSs; the North Country Initiative PPS/Samaritan Medical Center (NCI), Ellis Hospital (EH), and Albany Medical Center (AMC). Two of our neighboring PPSs selected this project. Specifically with regards to project 4.b.ii., the PPSs will work together to share resources across the larger region. For example, AHI and NCI PPS are working together to develop a shared North Country regional media campaign focused specifically on chronic obstructive pulmonary disease.

The PPSs are in agreement to establish a cross-PPS partnership that will address any issues presented by patient, and provider, overlap across the service areas. The first issue the group will address is how to count providers and patients for the scale and speed submission, to ensure that numbers are not inflated due to "double-counting" of patients in more than one PPS. Another aspect of coordination is in regards to sharing information to coordinate care across PPSs. This will be addressed, in part, through the SHIN-NY infrastructure, when available.

The PPSs also plan to share information on best practices with the neighboring PPSs via a learning collaborative model. Each region has access to resources to support sharing of best practices, such as funding for Population Health Improvement Programs, and Rural Health Networks. The PPSs will take part in regular meetings to coordinate planning and to leverage training/educational resources as broadly as possible. Workforce development activities will also be coordinated with neighboring PPSs. Overall, the PPSs are highly motivated to work collaboratively, and capitalize on one another's resources and skills to provide better, whole patient care to our targeted population.

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

Project milestones are listed below, with target dates in parentheses. (1) Print and Media Campaign is finalized (Q3 2015) (2) Care teams are fully staffed/trained, have the necessary patient education tools/materials in place (Q4 2015) (3) Home monitoring equipment is acquired & fully deployed (Q4 2015) (4) Adoption of primary care evidence-based diagnosis & treatment guidelines for COPD (Q3 2015) (5) Embedded clinical decision supports for evidence-based care are in place in EMRs and/or population health management tools as applicable, all practices (Q2 2016) (6) Adoption by Skilled Nursing Facilities of evidence-based diagnosis and treatment guidelines for COPD (Q3 2016) (7) Supportive resources are established (a COPD hotline, and/or peer led support groups) (Q3 2016)

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

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

Yes	No
☒	☐

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

Capital Funding is necessary for a Mobile Primary Care Unit. The project requires technology investments, some of which may qualify as capital, including hardware/software and implementation costs for tablets or other mobile devices for care managers and community based workers. In-home monitoring devices and related tele-health technology is needed. Rehabilitation programs may need additional equipment. There is a need for spirometry machines in PCP offices that can connect/interface to EHRs.

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.

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