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Using this document to submit your DSRIP Project Plan Applications

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

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

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

Domain 2 Projects

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

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

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

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

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

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

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

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

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

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

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

Our CNA identified a gap in our five-county service area that will be addressed with this project. Care is neither integrated nor coordinated. There were over 6,700 potentially preventable ER visits in 2012 for an attributed Medicaid population of 62,194 in the PPS. Conditions related to substance abuse are a significant driver of our inpatient admissions, especially within the subset of our beneficiaries who have 10 or more admissions per year. Even though the total number of patients is less than 1,000, they utilize inpatient services that are frequently avoidable or preventable. For example, for the top 500 patients with the most inpatient admissions, 8% of the admissions were for alcohol dependence, 4% for alcohol withdrawal and 10% for cocaine dependence. In the absence of EHR connectivity, patients with multiple co-morbidities see several providers who do not routinely coordinate with one another. Care delivery can be integrated in the region by waiving barriers that make co-location of behavioral and physical health a challenge. There are gaps in the infrastructure that prevent connectivity among and between providers. Based on our IT member survey, only ~40% of our partners are connected to the local RHIO, HIXNY. Only 1 in 5 of the PCP practices participating are NCQA PCMH level 3 certified, which is below the state average of 25%. Pay for performance and value based purchasing have not yet had a significant impact on the region, with less than 10% of the current payer contracts requiring risk sharing arrangements. There are gaps in technology preventing ideal communication and care plan development between organizations. Given these gaps, it is

our goal to develop a sustainable, affordable and realistic plan for regional connectivity. We will build upon existing platforms and develop short-term solutions for integration. We will develop long-term and sustainable technology interfaces. We will work with Montefiore Medical Center to manage this transformation. All PPS partners will participate. All PCP sites will evolve by DY3 to become PCMH level 3 2014 and MU certified. Given shortages of behavioral health providers within the service area, we will provide seamless care for patients by increasing healthcare capacity by expanding current hours/days of services for current providers, creating new services like urgent care centers in selected neighborhoods, and ramping up staffing according to our workforce plan. We will employ tele-health options and other emerging technologies for accessing scarcer health resources. We will ensure our partners are prepared for value based payments to sustain our financial future by aligning compensation to outcomes. AMCH, as lead applicant, has limited experience in shared savings arrangements. We will partner with Montefiore Medical Center, which has extensive experience developing risk based arrangements, population health management and long standing relationships with Medicaid payers. We will draw on the expertise of health home and accountable care organization partners to help support our integration strategies. We will have monthly meetings with MCOs to discuss utilization issues, performance and payment reform. We will engage patients through CBOs, peers, health workers and others to become partners in their care.

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.

AMC PPS has numerous assets and resources that will be deployed. In most areas, there are good patient to provider ratios. There is adequate capacity in most nursing homes, hospitals and behavioral health providers. There are numerous providers who are designated Health Homes, including: AIDS Council of NENY; Albany County Department of Children, Youth and Families; Albany County Department of Mental Health; Astor Home for Children; Catholic Charities/Albany; Clearview Center MH (Conifer Park); Columbia County Mental Health Center; Greene County Mental Health; Mental Health Association IN; MHA of Columbia-Greene; Parsons Child and Family Center; Rehabilitation Support Services. These organizations are assets to the PPS and have experience in care management and execution of evidence based strategies that the PPS can leverage to improve care integration and coordination. We will utilize their expertise as well as that of other PPS members, such as the FQHC, and PCMHs that are part of our provider network, to improve care coordination and management. We have a well-trained workforce. We have substantial physical plant and infrastructure, although repurposing and renovating some of it will be necessary. We have a large enough cadre of patients, concentrated in a small enough region, to generate economies of scale and efficiencies as well as mitigate concentration of risk. We have IT infrastructure and connectivity, but it is too limited. We will build on the existing resources and scale up to increase connectivity to the RHIO and enable real-time secure messaging between providers. While we have a number of PCP sites that are level 3 NCQA PCMH certified, initial efforts will be made to get all of the providers who accept Medicaid certified under the PCMH Level 3 2014 standards. This effort will be both time consuming and resource intensive.

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.

AMCH and our PPS face substantial challenges to transform the regional system of care through integration, coordination, connectivity and payment reform. Several of these challenges relate to IT connectivity. Realizing partners within our PPS are at differing levels of IT capabilities and are on differing platforms will create a challenge in integration. We will utilize a 2 stage model of IT expansion to allow all organization types to share in connectivity at a realistic rate. This includes: 1. developing manual and semi-manual reporting via portals and web forums in DY1-2, converting to automatic reporting in DY3-5. 2. EHR adoption in DY1-2 in a tiered approach, with universal adoption in DY3-5. 3. ADT integration and secure messaging in hospitals and ambulatory providers in DY1; in DY2 and beyond, full integration with SHINY and e-prescribing. 4. In DY1-2, utilization of claim based analytic resources for risk stratification to deploy resources and develop provider performance metrics, converting to advanced performance analytics across the PPS in DY3-5. 5. In DY1-2 develop semi-manual care plan sharing, converting to automated processes in DY3-5. 6. In DY1-2 expand technologies to engage beneficiaries using mobile platforms. Significant changes in procedure and operations will be required at many locations in order to make information available to care coordinators and other members of each patients care team in real time. These process changes will be addressed as components of what is required to become NCQA certified PCMH level 3 under the 2014 standards as well as under rapid cycle improvement activities spearheaded by our Quality Affairs Committee, all in collaboration with Montefiore. Waivers of selected State rules and regulations will be required in order to overcome a challenge posed by differences in licensure, billing and compliance issues between article 28 and 31 providers, in particular. Integration of care delivery will require that these differences be minimized, allowing increased coordination and communication across different systems. Ultimately, value based payments will reduce these barriers to integration across the delivery system. This will help our partners with the transition to value based payments, the shift toward increasingly risk based arrangements and away from traditional payment models.

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

The other PPSs in the region are also undertaking this project; roughly 15% of our providers overlap with Ellis Hospital's PPS. As such, we will work with them and with Montefiore Medical Center and the Hudson Valley Collaborative to explore common IT and care management tools that can be used across partners participating in more than 1 PPS, where possible. We will collaborate on efforts to increase integration and connectivity with the RHIO. AMCH is collaborating with all of the neighboring and overlapping regional systems serving as lead applicants. We have initiated several conversations with Ellis Hospital, Adirondack Health Institute and Mary Imogene Bassett to identify ways to pool regional resources to address challenges and make the most efficient use of limited funding. Training is a prime example of

where we all believe economies of scale can be realized. More importantly, however, AMCH intends to form a virtual partnership with Montefiore Medical Center. They are serving as the lead applicant for a 7 county service area in the Hudson Valley known as the Hudson Valley Collaborative, or HVC, located immediately to the South of our catchment area. We are working with them in several concrete ways that will result in seamless, coordinated efforts regarding this project over the combined regional areas of both their and our PPS. This contiguous area runs from metropolitan New York City to the Adirondacks, following the Hudson River to its headwaters. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success, while allowing for local influences and control to help insure long term success.

2. System Transformation Vision and Governance (Total Possible Points – 20)

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

A key goal of this project is to create the infrastructure needed to improve care coordination across the network of participating providers. This includes better coordination and allocation of staffing resources, physical plant, IT infrastructure and equipment. The approach to integration includes seamless care that is accessible. In many instances, the approach will include co-location of services to facilitate one stop shopping. The initiative will also address quality by insuring that information needed by providers to make informed decisions about care and treatment is available when and where needed. Interdisciplinary treatment plans will also be key to the success. Integrating primary and behavioral health, which has not been tried in any significant way in the region, will be an extremely important component, as evidenced by other projects we are pursuing as a PPS. We also recognize that a renewed focus on population health management and outcome based payment reforms will help evolve the system towards an integrated preventive care model. As a PPS, we let the community needs assessment shape the projects we would pursue. To be successful over the long term, the projects need to be integrated into a bigger picture. We selected projects in domain 2 that fit well together, ultimately facilitating the integration of the system of care across the region. For example, the components we propose to develop in ED care triage have a direct relationship to integration of primary and behavioral health, the development of a health home for at risk intervention, and our approach to crisis stabilization for targeted patients. Our clinical and population health transformation projects including asthma, cardiovascular disease, tobacco use and cancer, are all supported as important needs in our community and are also integrated with our other projects. Requiring all of our PCP sites to become NCQA level 3 certified patient centered medical homes is a key and important strategy for numerous reasons. The 2014 standards require connectivity, treatment plan development and management, care coordination between primary and specialty care providers, a focus on prevention and best practice guidelines, meaningful use measure compliance and reporting, quality improvement and patient engagement. None of the 12 PCP sites participating

are currently certified under the 2014 standards. We will have 8 certified by mid DY2 and the remaining 4 certified by the end of DY2. We plan on integrating primary and behavioral health at all 12 PCP sites. We will have 6 sites operational by the first quarter of DY2 and the remaining sites by the first quarter of DY3. To help insure that efforts move forward expeditiously and all milestones are met and consistent with flow of funds, providers will be incentivized for their performance. They will also be educated about the shift from fee for service financing to pay for performance. Extensive training is a key component of nearly every project. Staff cannot be expected to modify behavior, adapt to changing environmental conditions in the workplace, incorporate new ways of providing care and documenting their efforts without this extensive training and support. We identify in 2.a.v that our PPS will work with four skilled nursing facilities in to reduce the number of unnecessary long term care beds and repurpose them for ambulatory care services. In each case, one or more units will be redesigned to allow for the co-location of outpatient services, including primary and specialty care at three of the four facilities and urgent care at the fourth. One of the nursing homes is also converting space to alternative housing, but that initiative is not part of our DSRIP efforts, since it is a collaborative activity occurring with the Veteran's Administration. In each case, the nursing homes will be partnering with health care providers and CBOs to help staff, integrate and coordinate care delivery, consistent with several domain 2 and 3 projects included in this application. We estimate that nearly 200 beds will be converted to better purposes, consistent with the intent of this project to integrate the delivery system. Additional information is provided about this in the project narrative for 2.a.v. While the PPS has created a multi-part strategy to achieve the aims of this project, the detailed action plans are under development. They will be fully articulated during the implementation phase and will identify in great detail all of the action steps required. We will also rely on our partner, Montefiore Medical Center, whose extensive experience in creating a pioneer ACO and in transforming care in the Bronx to an integrated, connected healthcare system, we will emulate. We are committed to meeting the domain 1 milestones that pertain to measuring system integration. Continued stakeholder engagement will help insure that the evolving process is collaborative, transparent and accountable.

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.).

AMCH's PPS along with Montefiore Medical Center, will work together to identify specific strategic steps that will be developed and implemented to evolve all participants into an integrated health care delivery system. This will not be easy, but there is willingness on the part of the PPS, the executive committee of the PAC and institutional leadership to aggressively pursue this strategy. We have a clearly defined governance structure in place that will facilitate the steps needed. We provide additional information about our governance structure in section 2 of this application. It is clear that this project is the cornerstone upon which many of our other projects will be built. By ensuring that it is well managed, resourced and governed, it will help make other projects easier to implement and manage. DSRIP must be viewed in its entirety. This project – designed to integrate the delivery system – directly impacts every domain 2, 3 and 4 project. Given this, AMCH's PPS and the project management office will focus substantial resources on this effort to ensure its success. We will work with Montefiore to incorporate our transformation

team efforts into the larger Project Transformation Teams they have created. AMCH's team will be held accountable for securing active involvement of all relevant PPS partners in the project that have a clinical or community based provider role in system integration. Of the 175 total organizational partners, there are approximately 150 who meet this criteria. While Montefiore's IDS Transformation Team will not directly manage or control the other projects, they will complement our efforts and avoid duplication through effective communication and coordination. Until Montefiore's and AMCH's PPSs are allowed to merge, there may be some unnecessary inefficiencies, but we intend to minimize them through delineation of responsibilities, accountability and coordination. The distinct advantage that AMCH has is that it knows the region, the participating organizations, how they operate and are governed, and where gaps and duplication in service delivery occurs across the 5 county area. Drawing on the institution's leadership as the tertiary care provider, we will engage the primary care providers in the region in the project's implementation and ultimate success. We will work with them to obtain 85% PCMH certification by the middle of DY3. AMC's Faculty Group Practice includes a very high percentage of all of the adult and pediatric specialty providers in our PPS. In fact, we have all of the pediatric cardiologists, pulmonologists, rheumatologists, infectious disease specialists, endocrinologists and geneticists in the region and the vast majority of all of the adult specialists. This greatly streamlines and facilitates care coordination for several projects including best practice guidelines for asthma and cardiovascular disease and screening for cancer, for example. Thus, specialty and primary care coordination is significantly easier when "handoffs" are occurring through a single practice entity using a shared IT platform and already established communication protocols. As mentioned previously, we will drive payment reform through the creation of outcome based contracts in collaboration with the MCOs. Our leadership team will meet monthly with the region's MCOs to facilitate clear expectations in terms of performance indicators, utilization, quality metrics and payment reform, including methodologies to incentivize behavior that supports project success. Finally, the collaborative contracting model we have chosen affords us substantial flexibility. As our population health management capabilities evolve and expand, we may need have flexibility to pursue either a different structure or decision making authority in order to accommodate changing payment methodologies and the need to delegate decision making within the PPS. Some of this may be based on evolving contractual relationships with the MCOs. There are numerous other factors that can and will affect this, including needed capital investment, willingness and ability to assume additional risk-sharing responsibility, potential mergers or acquisitions, regulatory reform and other things that can require modifications to the current organizational and governance structure. We believe we have the ability to quickly adapt to changes that might require prompt changes, if and when they may be needed .

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

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

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

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

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

Yes	No
☒	☐

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

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

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

Yes	No
☐	☒

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

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

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

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

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

19. Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).
20. Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.

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

1. <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.

Salient Data Summary: For recipients with 10-15 IP admissions per year, the top 3 diagnoses are BH / substance abuse related. These account for ~26.5% of admissions. Respiratory failure accounts of 5.8% of visits. For the recipients with 15-20 IP admissions per year, the top 2 diagnoses are BH/ mental illness. These account for ~25.6% of admissions. For recipients with 20+ visits a year, the top diagnoses are alcohol dependence which accounts for 16.3% of admissions and PTSD which accounts for 13.6%. 0.7% of recipients have >10 ER visits and account for 17% of ER visits. 5.3% of recipients have >4 ER visits and account for 46% of ER visits. 0.1% of recipients in our PPS have >10 IP admissions and account for 4% of admissions. 4% of recipients in our PPS had >2 admissions and account for 49% of IP admissions. Compared to the other areas, the PPS has a higher ED utilization among those who use the ED more than 2x a year (16.9% vs. 12%), and a similar but still higher proportion of extreme utilizers (0.7% vs. 0.5%). These figures suggest that interventions should be developed that will help reduce ED and IP admissions among those who are high utilizers and that additionally interventions should be implemented that will prevent patients from advancing to that level of care. There are currently no efforts integrated across the continuum of care to "manage" patients that are at risk of becoming health home eligible or super utilizers. This gap in our PPS will be filled by this project. Based on our CNA and the inordinately high utilization rates demonstrated above, the PPS region has inadequate Care Management. Through this project we will develop a Health Home at Risk Intervention Program (HHARIP) by utilizing and expanding our existing Health Homes and working collaboratively with the PCMH certified at Level 3 via the 2014 standards. Each of the providers participating in the HHARIP will be able to actively share information through an integrated EHR or Portal that will connect their organization to the HIXNY or the Montefiore Medical Center's Care Management Portal. The IT platform and EHR integration will allow the PPS to actively manage the health of the population through the use of patient registries across the continuum of care. As focus groups identified a lack of understanding regarding how to access services and what services are available, case management services will act as care navigation services to help develop comprehensive care management plans and ensure that each patient is actively engaged in their care. This involves developing new resources in evidence-based care management with expertise in behavioral health as well as case management skills. Our partner, Montefiore Medical Center has expertise

in this area, and we will use that in our PPS to expand this service. Currently 12 Health Homes are in the PPS. These health homes will provide a basic structure from which we will be able to expand and provide services to the next stratus of patients.

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.

We will target individuals at high-risk who do not otherwise qualify for enrolment in health home services. These patients will be identified based on claims data and risk stratification. Claims data analysis will allow us to stratify patients beyond just the traditional health home definition. We will expand this definition to include diagnoses such as high risk pregnancy, hepatitis C, diabetes, cancer and behavioral health needs. This analysis will include social determinants of health, including: criminal behavior, domestic violence and housing status. Risk stratification based on these factors as well as SMI and multiple comorbid conditions will allow us to identify and target those most at risk allowing the PPS to focus our efforts in the areas of highest need where they will be most effective.

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 AMC PPS includes the following designated Health Homes: AIDS Council of NENY; Albany County Department of Children, Youth and Families; Albany County Department of Mental Health; Astor Home for Children FBT; Catholic Charities/Albany; Clearview Center MH (Conifer Park); Columbia County Mental Health Center; Greene County Mental Health; MHA of Columbia-Greene; Parsons Child and Family Center; Rehabilitation Support Services. These organizations are assets to the PPS and already have experience in care management and execution of evidence based strategies that the PPS can leverage to provide health home like services for the patients identified as 'at risk'. We will then utilize their expertise as well as that of other PPS members, such as the Federally Qualified Health Centers, and Patient Centered Medical Homes that are part of our provider network, to provide training and other integrated multi-disciplinary care plan development. Other community based organizations are involved to expand our care management capacity for at risk populations by linking to our provider network through the Montefiore Medical Center's Care Management Organization. This will allow them appropriate secure access to any portion of the care plan that is relevant to the services they offer. We will adopt a centralized approach for specific steps in the care management process including risk stratification – an area where our IT partner Montefiore Medical Center has expertise. This centralized approach will impact multiple projects including this project as well as Crisis Stabilization. We will develop standardized roles, competencies, trainings and performance capabilities to ensure quality care across the continuum. The existing workforce as well as new hires, will be trained on common best practices using Montefiore Medical Center's Care Management Organization modules as well as training developed by our regional AHEC organizations. Our workforce will be trained to assist in bridging the gaps among culturally diverse populations, as well as addressing health literacy needs. We will leverage our partnership with Montefiore Medical Center and their significant experience and expertise in care management

for patients with complex medical and psychosocial needs. Their technical, clinical, and IT expertise will be key to successful implementation of this project. Their care management model includes: a thorough needs assessment, a personalized care plan tailored to the needs of the patient including the consideration of health and social factors. Upon completion, a single point of contact, the Accountable Care Manager (ACM), will be assigned in order to connect available resources to best serve the patient's needs. Many of the care plans, protocols, and human resources needed to expand and create these services will be developed during the course of this project.

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.

IT connectivity is an important component to ensuring integrated multi-disciplinary care plans and interaction among partners. Our partners are at significantly different levels of IT capabilities, which presents a challenge to integration; however, we will address this challenge by leveraging the experience of our IT partner, Montefiore Medical Center. Together we will pursue a realistic approach to IT development following a 2 step implementation plan. Continuity of care and information sharing will also be a significant challenge. The most efficient way to overcome this challenge will be through an effective IT strategy. First we will focus on strategies for integrations, such as increasing EHR and RHIO adoption. Then we will focus on longer term solutions, including building a uniform and sustainable IT infrastructure, and development of a common IT platform with common care management tools. Once we identify members who may benefit from care management, contacting members to enroll them in care management services may be a challenge. From AMC's and Montefiore's experience in care management, contact information is often outdated and unavailable. In order to address this challenge, we will leverage our IT infrastructure to enable our partners to quickly share multi-disciplinary care plans and access member contact information (e.g., by using alternate and creative sources such as inpatient discharge paperwork, community organization sign ups, etc.). Scaling the care management model from the smaller models in existence at Montefiore will be a challenge. We will address this challenge by aligning performance payments to encourage adoption and compliance. Gaining partner alignment will be a challenge in order to ensure consistency and quality in service and to address the diverse population of the Hudson Valley. However, we plan to address this challenge with the workforce detailed plan described above in retraining on evidence-based best practices, cultural/health literacy competency and redeployment.

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.

AMCH is collaborating with all of the neighboring and overlapping regional systems serving as lead applicants. We have had several conversations with Ellis Hospital (IHANY), Adirondack Health Institute and Mary Imogene Bassett to look at ways we can pool regional resources to address challenges and make the most efficient use of limited funding. Training is a prime example of where economies of scale can be realized. More importantly, AMCH intends to form a partnership with Montefiore Medical Center. They are serving as the lead applicant for a 7-county service

area in the Hudson Valley known as the Hudson Valley Collaborative (HVC) located immediately to the South of our catchment area. We are working with them in several concrete ways that will result in seamless, coordinated efforts in direct relation to this project over the combined regional areas of both of our Performing Provider Systems. This contiguous area runs from metropolitan New York City to the Adirondacks, following the Hudson River to its headwaters. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long-term success.

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.

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

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.

2.a.v Create a Medical Village/Alternative Housing Using Existing Nursing Home Infrastructure

Project Objective: To transform current nursing home infrastructure into an infrastructure consistent with the long term care programs developing in the state to help ensure that the comprehensive care needs of this community are met.

Project Description: As more services are delivered in the community, New York State intends for this Medical Village/Alternative Housing Project to allow nursing homes to reduce their bed capacity. This project will convert outdated or unneeded skilled nursing hospital capacity into a stand-alone comprehensive care center. In addition to bed reduction, this project seeks to create other services in the continuum of care that meet community needs, such as respite services (Scheduled Short Term Admissions), NYS certified adult home, a certified Enriched Housing Program, licensed assisted living residence (Basic, Enhanced, Special Needs), and transitional supportive housing (as defined in DSRIP Glossary). This project will convert outdated/unneeded hospital capacity into a stand-alone emergency department/urgent care center and/or spaces occupied by local service organizations and primary care/specialized/behavioral health clinics with extended hours and staffing.

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. Transform outdated (underperforming) nursing home capacity into a stand-alone emergency department/urgent care center or other healthcare-related purpose.
2. Provide a clear statement of how the infrastructure transformation program will promote better service and outcomes (service volume, occupancy statistics, etc.) for the community based upon the community needs assessment including evaluation of specific planning needs for any Naturally Occurring Retirement Community (NORC) occurring within the PPS.
3. Provide a clear description of the re-configured facility will fit into a broader integrated delivery system that is committed to high quality care and willing/able to participate in payment reform.
4. Provide documentation that demonstrates housing plans are consistent with the Olmstead Decision and any other federal requirements.
5. Identify specific community-based services that will be developed in lieu of these beds based upon the community need.
6. Use EHRs and other technical platforms to track all patients engaged in the project.
7. 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.
8. 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.

9. Ensure that EHR systems used in Medical Villages meet Meaningful Use and PCMH Level 3 standards.

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.

There are 4135 certified beds in our PPS territory. There are a number of identified nursing homes with excess bed capacity that have expressed an interest in converting to alternate uses. Much of this space is outdated and either underperforming or not utilized at all. We will convert this space to primarily urgent care centers or other health related purpose. This transformation will promote better outcomes for the community by providing same facility treatment for nursing home residents that currently require either medical transportation or are sent to the ED for conditions that could be treated in a less intensive setting. These reconfigured facilities will work within the redesigned system through effective EHR integration and be open to serve the entire community as well as the nursing home in which they are housed. EHRs and other technical platforms will be used to engage patients in their own care as well as track the patients engaged in this project. EHRs enabled in these sites will be connected to the local HIE (HIXNY) as well as SHIN-NY which will help to facilitate smooth data exchange and the sharing of integrated care plans across the continuum of care. These integrated services are not now available to nursing home residents and this represents a gap within our PPS that this project will close. While sites are not currently slated to be converted to alternative housing, any decision to create alternative housing arrangements within this project will be consistent with the Olmstead Decision and any other federal requirements such as the ADA. These sites will house newly developed care navigators that will assist residents, beneficiaries, and others to make connections with community based organizations to meet the needs of the patients. Appropriate community based organizations will be provided space where they are able to connect with the populations they serve. These urgent care centers or multi-specialty sites will have established relationships with PCMH Level 3 2014 primary care sites. This will facilitate more coordinated care as the urgent care sites will also utilize EHRs that meet the guidelines for PCMH Level 3 2014 as well as meaningful 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.

Geographically, these new medical villages will be located in key underserved neighborhoods and communities. Including residents of Suburban Albany, Guilderland, Colonie and parts of lower Saratoga County, Albany, Albany's South End, Albany's Pine Hills, Delmar, Center Square, area as well as suburban Albany; rural Greene County, and Hamlets and towns in and around the Catskills, with possible Hudson as well. Medical Villages will be located in NYS DOH Hot Spot Cancer

mapping sites for colorectal cancer, colorectal cancer screenings, mammograms, female breast cancer and lung cancer. These sites are in areas with high rates of poverty, low HS graduation rates, stigma of health care systems, minority populations, working poor, neighborhood crime and violence, density, access to transportation, illegal immigrants, non-English speaking residents, as well as areas where residents who use the hospital ER/ED as their "default" for all health care and medical services live. These are minority populations who are disproportionately affected by various diseases (e.g. diabetes, HIV/AIDS, cervical cancer) and who reside in poverty, as well as live in areas lacking in medical specialists that accept Medicaid, as well as where the uninsured, under-utilizers and low-utilizers of medical services reside.

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.

Four nursing homes have already volunteered space for conversion. Willing partners with available space is an asset of the PPS. There may be additional space identified among the 4135 beds in our territory. Not all certified beds are staffed. These assets of the PPS will need to be transformed by this project. The Daughters of Sarah Nursing Home: Present total certified beds are 210. As of NYS DOH vital statistics, they have a 93.8% occupancy rate (197 of 210 = 13 vacant beds). Based on recent trends in nursing home beds it is anticipated that over the 5 years of the project 50 beds can be converted to areas for alternative medical services. Albany County Nursing Home: Present total certified beds are 250, with an additional 150 beds not currently in use (400 total bed capacity). According to NYS DOH the occupancy rate of existing certified beds in use is 89.2% (223 of 250 = 17 unused certified beds in circulation and 150 beds out of circulation). Kaaterskill Care Skilled Nursing and Rehabilitation Services: Present certified beds are on record as 120. According to NYS DOH, as of October 29, 2014 this facility has an occupancy rate of 74.2% (89 of 120 beds in use = 31 unused beds ready immediately for change of use consideration). Catskill Crossings: Presently certified beds are 136. According to the NYS DOH, as of October 29, 2014, this facility has an occupancy rate of 92.6% (126 of 136 beds in use = 10 unused beds ready immediately for change of use consideration. This site also houses a pharmacy, diagnostic services, an optician, a dentist, PT and on site behavioral health and social services available for crisis, referral and safety net purposes. These existing services will ease the creation of alternate use space. It is Medicaid/Medicare certified, and abides in the Olmstead Decision Law. These beds will be repurposed by this project. Current IT infrastructure will need to be upgraded in order to meet the needs of these facilities as they install EHRs that are compliant with Meaningful Use standards and are compatible with PCMH Level 3 2014 standards. AMCH brings considerable expertise in dealing with the nursing home population. Recently implemented programs have demonstrated reductions in readmissions from area nursing homes. That project has demonstrated success the PPS will build on to further reduce avoidable hospital admissions. The PPS has two organizations that operate successful Urgent Care facilities. Community Care and AMC Faculty Group Physicians currently operate Urgent Care facilities, and will be able to establish new sites or provide the expertise training and technical support necessary to operate and staff the new facilities. The added capacity of these

sites will increase access to care for currently underserved populations. The care provided in such close proximity to the nursing homes will help the PPS achieve the goals of DSRIP by eliminating the need for ED visits when Urgent Care or a strong connection to primary care is the more appropriate course of treatment.

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.

Legal and licenses (Nursing Home Regulations to Medical Facility Regulations) and other regulatory issues will challenge successful implementation. The PPS is pursuing regulatory relief in connection to this project including NY State approval of change in bed use. Provider availability: Given current shortages in areas of the workforce particularly nursing, the development of sufficient staffing capacity will challenge this project. The PPS will work with our workforce development subcommittee to develop the necessary recruiting and training resources. Integrating care is a challenge: With a wide assortment of specialty services co-located under the roof of each facility barriers to integrated care can be overcome. The implementation of a comprehensive IT solution allowing for the dissemination of integrated care plans will help address this challenge. Further the PPS will ensure connections to PCMH Level 3 2014 are in place including open access scheduling, expanded hours, and commitments to IT development that will meet the standards for meaningful use and connections to the RHIO/SHIN-NY. Cultural Competency: PPS will train staff, providers and safety-net providers on cultural competency issues, including best practices in working with our populations. Awareness of these facilities will be a challenge in the early stages of operation. To address this challenge, Community Health Navigators will be trained and deployed via 3 hospitals (Albany, Saratoga, Columbia memorial in connection with project 2.b.iii – ED Care Triage) in order to refer and connect patients to the new Medical Villages in their respective communities.

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.

AMCH is collaborating with all of the neighboring and overlapping regional systems serving as lead applicants. We have had several conversations with Ellis Hospital (IHANY), Adirondack Health Institute and Mary Imogene Bassett to look at ways we can pool regional resources to address challenges and make the most efficient use of limited funding. Training is a prime example of where we all believe economies of scale can be realized. More importantly, however, AMCH intends to form a partnership with Montefiore Medical Center. They are serving as the lead applicant for a 7-county service area in the Hudson Valley known as the Hudson Valley Collaborative, or HVC, located immediately to the South of our catchment area.

We are working with them in several concrete ways that will result in seamless, coordinated efforts regarding this project over the combined regional areas of both their and our PPS. This contiguous area runs from metropolitan New York City to the Adirondacks. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long-term success.

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

Project Scale	Number of Beds Committed For Reduction
Expected Number of Staffed Nursing Home Beds to be Reduced	100

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

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

2.b.iii ED Care Triage for At-Risk Populations

Project Objective: To develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health condition(s). Objective is also to improve provider-to-provider communication and provide supportive assistance to transitioning members to the least restrictive environment.

Project Description: Emergency rooms are often used by patients to receive non-urgent services for many reasons including convenience, lack of primary care physician, perceived lack of availability of primary care physician, perception of rapid care, perception of higher quality care and familiarity. This project will impact avoidable emergency room use, emphasizing the availability of the patient's primary care physician/practitioner. This will be accomplished by making open access scheduling and extending hours, EHR, as well as making patient navigators available. The key to this project's success will be to connect frequent ED users with the PCMH providers available to them.

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. Establish ED care triage program for at-risk populations.
2. Participating EDs will establish partnerships with community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.
    a. All participating PCPs Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of Demonstration Year (DY) 3.
    b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.
    c. Ensure real time notification to a Health Home care manager as applicable.
3. For patients presenting with minor illnesses who do not have a primary care provider:
    a. Patient navigators will assist the presenting patient to receive a timely appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.
    b. Patient navigator will assist the patient with identifying and accessing needed community support resources.
    c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).
4. Establish protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)
5. 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.

Although only 35% of the Medicaid beneficiaries in the PPS use the ED, the highest utilizers drive a significant number of visits, most of them avoidable. In our PPS 0.7% of recipients have >10 ED visits and account for 17% of total ED visits. Of the 52,002 visits at the participating EDs between 3/2012 and 2/2014, over 13% were classified as preventable. There are opportunities to reduce these numbers. Three of the four participating EDs report high rates of patients leaving without being seen (17% AMCH), long wait times (average 5 hours Columbia Memorial) and overcrowding. Given these statistics, the possibility of early intervention and improved access to alternative sites of care will greatly impact healthcare delivery and efficiency in the service area . ER utilization in the service area is driven by several prevalent diagnoses, the top 3 being hypertension (9%), asthma (8%), and depression (8%). For patients who have between 10 and 20 visits per year, the top five conditions are abdominal pain, chest pain, alcohol abuse, backache, and disorders of the teeth. Behavioral health diagnoses in aggregate (mental health and substance abuse) accounted for 56% of ER visits. This highlights the gap in adequate outpatient treatment for these conditions. As the primary approach to decrease preventable ER utilization, our PPS will improve integration of care across the region. Through care triage, we plan to divert members to appropriate alternative PCMH 2014 Level 3 outpatient care sites, health home organization, or community based crisis stabilization service (project 3.a.ii), and also increase connections of members to primary care providers. Diverting care to outpatient sites within the five-county service area is contingent on appropriate and sufficient outpatient access and community based services, including development of a robust network of PCMHs certified to Level 3 2014 standards, development and use of protocols for first responders, developed and supervised by ED physicians, to divert patients with non-acute disorders to an appropriate level of care, patient navigators to help guide and educate patients regarding where appropriate care is available as well as other community based services, and expanded use of the Electronic Health Record (EHR) real time ADT notification of primary providers. The community needs assessment highlighted gaps in outpatient care, including inadequate hours of operation of primary care sites, insufficient number of urgent care centers and a lack of access to behavioral health services, and particular lack of integrated services. For example, there are only 8 urgent care centers in the region, with none in Greene County and only one in Warren and Columbia counties.

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 terms of a targeted approach to patients, our PPS will focus on inappropriate use of the emergency room, including those at risk for becoming high utilizers. As patients arrive, initial triage will confirm that they are medically stable and then determine whether there is an alternative site available for the level of care needed. Given the total number of attributed lives in our area (62,194), 35% use the ER at least once during the year and 6.5% drive over 25% of the volume. We will stratify the data to identify high utilizers for intervention. Based on review of our internal data, we know vulnerable populations reside in the Arbor Hill, West Hill and South End neighborhoods of the City of Albany, in smaller cities along the Hudson River like Cohoes, Watervliet and Waterford and smaller cohorts in the City of Hudson and suburban areas in Albany County. Patients in Glens Falls and Saratoga Springs utilize hospital ERs in those cities as well. Additionally, we will aim to target vulnerable populations who access the ER as an alternate method of outpatient care due to the gaps stated above (e.g., lack of transportation to appropriate outpatient sites or inability to get outpatient primary care/specialty care/behavioral health appointments). Based on our demographic profile, we have a higher percentage of females (58%) and individuals under the age of 45 (72%). In fact, 27% of the usage is attributed to individuals under the age of 18. Given this added variable, we will insure that pediatric and family services are addressed in the development of alternative sites of care.

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

Currently there are 3 EDs connected to hospitals in our PPS each of them brings with it a significant cadre of expertise and experience. Their experience in their respective communities will prove to be a significant asset in the development of this project's implementation plan. The have existing connections to first responders which will be essential in establishing the protocols to allow first responders to transport patients with non-acute disorders to alternate care sites. Within our PPS there are already several safety net providers certified to the PCMH 2011 standards. Their experience with prior certification includes significant commitments to IT infrastructure, reporting and NCQA Standards. This will prove to be an asset as the PPS moves all safety net primary care providers through the certification process to PCMH Level 3 at 2014 standards. AMCH will leverage its recent experience and human resource assets to facilitate training, reporting and project management support to providers becoming PCMH Level 3 certified. This certification will help us establish partnerships with these community primary care providers. A resource we will need to develop concurrently with the PCMH certifications is the expansion of operating hours for primary and open scheduling policies which will facilitate the connection of the patient from the ED to a primary care provider. Our member CBOs are also a strong asset of our PPS. The CBOs will be leveraged to help our patients navigate a confusing system. They will be able to help patients address some of the social determinants of health that are preventing them from accessing the healthcare system in the appropriate manner. Our partnership with Montefiore will be an asset that helps us use EHRs and other technical platforms to track patients we have engaged in the project. Real-time notification of the primary care when a tracked patient presents at the ED will be a capability that needs to be developed. We will need to develop patient navigator resources to assist the presenting patients in acquiring immediate appointments at the participating PCMH sites. Patient navigators will also need to be trained regarding the significant existing resources within the community and community

based organizations that can help provide support to patients and their families. After patients receive adequate medical clearance, navigators will need to provide access to appointments, which may require transportation. Resources to provide transportation from the ED to PCMH sites will need to be repurposed from existing slow and unresponsive options to dedicated transportation resources specifically tasked with helping patients access the right care in the right place in a patient centered way.

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.

Appropriate connections to primary care are essential for this project to succeed. The first challenge the PPS will address is the certification of primary care sites as 2014 Level 3 PCMH; we hope to achieve this by DY2 Q1/Q2. This is a significant commitment made by the primary care partners in our PPS. AMCH has significant experience in practice evolution to PCMH standards and will coach other primary care providers through the process with dedicated teams of PCMH experts. Sharing data across the continuum of care will also be a significant challenge. AMCH has partnered with Montefiore Medical Center to leverage their expertise in IT, care plan development and care management. Automatic ADT feeds will be used to facilitate real time notification when patients with a care plan are identified at one of our participating EDs. This will be a significant technological challenge. An additional challenge will involve changing the patient's perception and culture, and connecting them with their primary care provider and necessary community based organizations who can help them address may of the real life challenges like transportation that prevent them from accessing care appropriately. These are long established norms in the community that will have to be changed. As a PPS, we intend to develop a collaborative means for community based education of optimal utilization of medical services by working with the entire PPS, the Clinical Affairs Committee, Workforce Development, Finance, Data and IT Management and Consumer Affairs.

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.

AMCH is collaborating with all of the neighboring and overlapping regional systems serving as lead applicants. We have initiated several conversations with Ellis Hospital (IHANY), Adirondack Health Institute and Mary Imogene Bassett to look at ways we can pool regional resources to address challenges and make the most efficient use of limited funding. Training is a prime example of where we all believe economies of scale can be realized. More importantly, however, AMCH intends to form a formal partnership with Montefiore Medical Center. They are serving as the lead applicant for a 7-county service area in the Hudson Valley known as the Hudson Valley Collaborative (HVC) located immediately to the South of our catchment area. We are working with them in several concrete ways that will result in seamless, coordinated efforts regarding this project over the combined regional areas of both their and our PPS. This contiguous area runs from metropolitan New York City to the Adirondacks, following the Hudson River to its headwaters. In addition to being beneficial to organizations and individual providers, this

approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long-term success.

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.

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

a. 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

As reported by the State, there are 63,689 individuals included in our five county PPS for project 2.d.i, including 20,857 individuals who are low (LU) and non-utilizing (NU) members and 42,832 individuals who are uninsured (UI). They are not engaged in the health care system. Because of this, they do not receive preventive care and health screenings or routine care to identify and treat health and mental health problems as they emerge. They also do not benefit from early access and identification of problems, when treatment options may be more numerous and clinical outcomes more successful. Our project will help our PPS achieve the goals of reaching the UI and LU and NU of the Medicaid system, while also achieving a reduction in avoidable ER visits by 25% over the project term. As a result we will increase the numbers of uninsured seeking health care services in the ER as well as address the overall DSRIP goal of reducing avoidable and unnecessary hospital admissions by 25%. The project will activate and engage patients in the following ways: UI, LU and NU patients will be pro-actively engaged to reduce their utilization of the ER for care that could be avoided; Peer advocates and CBOs will educate them about benefits and alternatives to ER utilization; and all three groups will be integrated into primary care by linking them to services that continuously address retention, engagement and preventive services. Unlike patients and consumers targeted in other projects in this application, there are key differences with this population. Since they do not generally access health care, engaging them will require a different approach, one that will require linkages and coordination with CBOs and other community partners, since they will have access to the population in ways that we will not. There is a direct correlation between persons living in poverty and their access

to health care, health literacy, comprehension of and trust in health care systems and the overall health of the community. Our CNA also shows this by recognizing that there are numerous unnecessary and avoidable ER visits and unnecessary hospitalizations. Our focus groups demonstrated that poor health literacy and a lack of understanding of alternatives and options available is a key factor explaining why patients do not seek routine, primary care. They also noted that our fragmented care system creates barriers to use and duplication inherent in the system increases the costs they must bear. When transportation, limited hours of operation, co-pays and other factors are added in, UI, LU and NU decide to postpone care until they have few choices, one of which is to use the ER, which is something this project will change.

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.

As reported by the State, there are 63,689 individuals included in our five county PPS for project 2.d.i, including 20,857 individuals who are low (LU) and non-utilizing (NU) members and 42,832 individuals who are uninsured (UI). The UI number includes individuals who are the working poor who cannot afford private insurance and do not receive coverage from their employers. In addition to these important numbers, there are over 46,000 illegal immigrants, some of whom are migrant farmworkers, who do not get captured in census data and are not included. Should circumstances for these individuals change and they become eligible for participation, we are prepared to assist them in patient activation, financial accessibility and linkages and retention in care with a primary care provider. The total provided by the state does not provide a county breakdown. However, from other source data, the counties and their total number of uninsured, as of 2012, are: Albany -24,450; Columbia – 7,469; Greene – 5,814; Saratoga – 17,092 and Warren – 9,207. We know we have 100% of the uninsured in Columbia and Greene counties, since we are the sole PPS. We have not been provided distribution for Albany, Saratoga or Warren and therefore do not know what percentage of the total target population we will serve. It is clear from the data, however, that the highest number of UI, LU and NU reside in Albany County. Based on all of the other population data we have reviewed and pockets of poverty and lower SES, there are a limited number of zip codes or neighborhoods where a high percentage of the UI, LU and NU reside. These would include smaller cities along the Hudson River (Cohoes, Watervliet, Waterford, Stillwater) and inner city neighborhoods in Albany, including Arbor Hill, West Hill and the South End.

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.

When offered the option of adding project 11, the leadership at AMCH, the executive committee of the PAC, the PAC and PPS enthusiastically endorsed applying. There was a general consensus that this was the right thing to do and would benefit thousands of additional residents in our

community who are poor and in need of care. AMCH currently has linkages and collaborations with over 175 organizational partners in our PPS. In addition, as a tertiary care safety net hospital and medical college and a center of excellence for HIV/AIDS, Eating Disorders, Bariatric Surgery, Stroke, Epilepsy, Children's Hospital, and a level 3 trauma center, among others, we have extensive bi-lateral referral agreements in place with hundreds of organizations throughout the region. As the region's only academic health science center, CBOs, county health and mental health departments, health and mental health providers, long-term care providers and others rely on us for comprehensive, integrated and high quality care, community engagement and leadership, training and a commitment to population health. These attributes represent key organizational assets and strengths that both encompass and go beyond DSRIP. We have deep roots in the community and can leverage the substantial resources and assets we have to meet the goals of this project. CBOs play an integral part of this project and AMCH has a long history of working with them. They will assist the PPS in identifying "hot spots" for outreach and health navigation activities in key communities, especially where the under-served are located. Base on long-standing relationships with them, we can utilize their resources and capabilities to reach the target population. We also have substantial resources which will be deployed to identifying, engaging and retaining hard-to-reach individuals in care. We will work with Montefiore Medical Center and our PPS to build upon current IT assets. CBOs not directly involved in care management activities may not need to adopt an EHR. It will depend on what aspect of intervention they are involved with in engaging and activating the patient/client into care. We will work with them to facilitate data capture and reporting so that we can track activation measures as they engage their clients. Given the medical college's extensive grants portfolio and expertise, we can assist CBOs in data reporting that is primarily limited to grant or contract reporting requirements. However, we will more intensively engage those CBOs who will be involved at a higher level with patient activation measures (PAM). Training will be provided about PAM, cultural competency, health literacy, data documentation and reporting to all necessary staff. ACMH constantly assesses its capacity to achieve new initiatives. As a result, the Center for Regional Health Transformation, utilizing a vibrant multi-disciplinary inter-departmental team, was established and will continue to spear head Project 11 activities, assurances, checklists and reporting requirements. This Center provides adequate staffing for DSRIP initiatives as well as the clearinghouse and organizers of Chapter 11 activities, involving but not limited to coordinating project activities, data collection and data management analysis, CQI activities, evaluation activities, as well as house the management of Community Health Navigators and the ongoing activities addressing both Cultural Competencies and Health Literacy issues.

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.

Since many of these individuals are not engaged in care, it will be harder to identify them. There are no claims data, medical records, laboratory findings, etc. that may apply to them. CBO partners will reach out to their clients to encourage engagement and participation. Hot spot areas where patients do appear, like ERs, will also be actively involved in assisting the patient to obtain a PCP, health insurance if able to do so and appropriate linkages to CBOs, peer navigators and others trained to provide assistance. We will insure that DSRIP funds compensate these staff for

services that may or may not result in measureable PAM scores. We will also work with all impacted sites and organizations to assist with training and technical support needed to insure data is collected, entered and reported correctly. We face an additional challenge of building trust with underserved populations. We will work with peer educators and other stakeholders, including consumers, to identify ways to build trust and establish sustainable engagements with patient centered medical homes.

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.

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.

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

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

Domain 3 Projects

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

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

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

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

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

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

A. PCMH Service Site:

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

B. Behavioral Health Service Site:

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

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

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

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

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

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

Of the roughly 63,000 Medicaid beneficiaries attributed to the AMC PPS 24,300 have both physical and behavioral health conditions. Most commonly tobacco, hypertension, vaccination needs, hyperlipidemia, reflux and pain in a limb. Most of these conditions are best treated by the primary care physician. Within the AMC PPS region Albany, Saratoga and Columbia County have 1,221 unique patients generating 2,193 ED visits. Of these visits more than 50% are connected to alcohol abuse, anxiety, and depression. It is evident that the high frequency consumers of expensive emergency room and inpatient services include individuals with mental health and substance abuse disorders who are also compromised by acute and chronic medical conditions. Within physical health care settings, individuals' chemical dependency and psychiatric conditions often go unaddressed due to the patient's reluctance to disclose, or the staff's lack of experience and comfort with how best to engage patients or lack of knowledge of resources in the community. In behavioral health settings, practitioners cannot adequately evaluate the patient's physical conditions and when confronted with a patient's somatic complaints, staffs too readily refer them to EDs, particularly when quick access to primary care services is not available. Due to the lack of integration and coordination among the different providers, in each scenario,

emergency room and inpatient services serve as the default provider of care. This proposal seeks to address such impediments to comprehensive care by pursuing a multi-pronged, best practice approach. This strategy involves 1) developing greater and same day access to primary care settings through development and expansion of PCMH Level 3 2014 certified sites as well as redeploying hospital-based staff to community sites; 2) embedding behavioral health staff in primary care sites 3) establishing new care management capabilities in primary care sites; and 4) instituting interdisciplinary training throughout all service sectors. The PPS will also seek to close the gap by developing collaborative evidence based standards of care including medication management and increased engagement in the care process. Another gap that exists is the ability to share integrated care plans across the continuum of care. In order to track all patients engaged in this project, the PPS will use EHRs and other technical platforms with assistance and guidance from our partner, Montefiore Medical Center who has extensive care management experience. We will also integrate preventative and behavioral health screenings such as PHQ-9 and SBIRT into the EHR for all patients to identify unmet needs for care.

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

Individuals with co-morbidity factors of mental illness and substance abuse disorders residing within the AMC PPS are among the highest risk group for preventable ED visits and avoidable hospitalizations. In many instances, these individuals present to the hospital with complications of acute and chronic conditions that are either caused or exacerbated by their psychiatric and substance abuse conditions (e.g., diabetes, asthma, hepatitis, HIV, CAD, pneumonia, and renal failure). These individuals may already be engaged with behavioral health providers, but given the lack of primary care providers (PCP) available with same day appointments, the ED becomes the provider of first resort for both the patient and the behavioral health staff caring for the patient. A significant number of individuals with a PCP are not engaged in sorely needed SOMH/OASAS services. Had their behavioral health needs been identified and better met within primary care settings, their frequent use of ER and inpatient resources for behavioral interventions could have been avoided or minimized. The 24,300 sub-set of the attributed population who have both physical and behavioral health coniditions will largely benefit from engagement in this project.

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

Within the AMC/CMH DSRIP's region, there are numerous group and family practices, where a major thrust of this project will be to reengineer these settings to allow for greater, timelier access by instituting same day appointment scheduling, expanding hours of operation and creating additional slots to accommodate walk-ins. This asset of the PPS will be transformed by their certification as PCMH Level 3 2014 care sites by DY3 Q3/Q4. This would permit behavioral health providers to readily refer patients to the primary care site rather than to the ER. In order to better

serve MI/SUD not engaged in behavioral health programs, this project proposes to embed behavioral health teams consisting of a licensed mental health professional and care managers within these primary care settings to serve as a resource for identifying disorders, making medication recommendations when appropriate, and for facilitating solid, care managed linkages with MI/SUD providers for ongoing care. Care management teams will need to be developed. Each embedded staff member will serve as a care manager to develop a rapport with patients and providers, educate patients, monitor symptoms and communicate findings with other providers with whom they have established collaborative agreements to render more truly, holistic, patient-centered, comprehensive care. Equally essential to the success of this project will be clearly defining the roles and skill sets of embedded staff, developing a consistent language across the various disciplines, establishing communication venues (e.g., telemedicine, EMRs) and interdisciplinary training across all service sites which will include the implementation of the IMPACT model, cultural competency and health literacy education. These efforts will be critical to integrating what is a presently a fragmented system of care that does not serve individuals with co-occurring physical and behavioral health disorders. An asset of the PPS is a significant number of highly engaged SOMH/OASAS licensed members. The DSRIP program proposes to embed additional primary care providers within behavioral health settings (e.g., community residences) where a majority of patients have acute and chronic medical conditions; however, for the lack of in-house medically-trained staff, patients are most often referred to the ER for routine and episodic care. An embedded medical practitioner can provide consultation to the behavioral health staff as well as provide patient education, and foster linkages with primary care providers. Such new medically-oriented resources will significantly contribute to a reduction in ER and inpatient utilization.

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.

There are numerous challenges ahead in order to better integrate physical and behavioral health care services, on behalf of individuals with mental health and chemical dependency disorders who are further compromised by acute and chronic medical ailments. To address the need for increased access to primary care settings, the PPS will ensure that safety net primary care sites will be certified as PCMH Level 3 2014 sites. This will involve same day appointment scheduling, extended hours, and a capacity to accommodate walk-ins. Behavioral health providers can then readily refer patients without relying on the ED. This will reduce avoidable ER visits and inpatient stays and permit hospital staff to be redeployed within community-based primary care settings; thus, augmenting capacity in behavioral health care settings to assist with addressing physical health needs and prevent more costly hospital-based services. Additionally, the culture among providers is another barrier to collaborative care. The PPS will provide training and encourage a culture shift across organizational boundaries and create a more collaborative, whole-person

approach whereby primary care practitioners are more attentive to behavioral health disorders - "treating the patient, not the disease". Regulatory barriers also inhibit true integration. As part of the DSRIP initiative, the AMC PPS is seeking regulatory relief from these barriers.

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.

AMCH is collaborating with all of the neighboring and overlapping regional systems serving as lead applicants. We have initiated several conversations with Ellis Hospital (IHANY), Adirondack Health Institute and Mary Imogene Bassett to look at ways we can pool regional resources to address challenges and make the most efficient use of limited funding. Training is a prime example of where we all believe economies of scale can be realized. More importantly, however, AMCH intends to form a partnership with Montefiore Medical Center. They are serving as the lead applicant for a 7-county service area in the Hudson Valley known as the Hudson Valley Collaborative (HVC) located immediately to the South of our catchment area. We are working with them in several concrete ways that will result in seamless, coordinated efforts regarding this project over the combined regional areas of both their and our PPS. This contiguous area runs from metropolitan New York City to the Adirondacks. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long-term success.

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.

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

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.

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. <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.

Behavioral health diagnoses are a significant driver of ED visits for the Medicaid population in both the ED and inpatient settings. As discovered in our focus groups the ED has become the primary care provider of choice for many Medicaid beneficiaries, due to perceived convenience, and limited access to primary care. The ED has become the default referral site for some behavioral health organizations due to a lack of other sub-acute options such as community based crisis stabilization. One provider in our PPS identified over 150 referrals to the ED, most of which could have been treated by primary or urgent care. Alcohol abuse or intoxication are two of the top 4 diagnoses driving ED utilization in the Medicaid population within our PPS with 385 unique recipients generating 785 ED visits in a one year period 3/2013-2/2014. This project will fill the gap for behavioral health providers and patients who are in need of crisis intervention, or services that are delivered less expensively in a sub-acute setting. The PPS will implement an intervention program that will integrate and develop outreach, mobile crisis teams, and community based Intensive crisis services. We will follow successful models that have been demonstrated in other areas of the state. The behavioral health subcommittee will work with health homes, PCMHs, The Capital District Psychiatric Center (CDPC) and EDs to develop a centralized triage that, when appropriate, will divert patients from the ED to less intensive settings by leveraging new and existing resources such as outreach, mobile crisis intervention and intensive crisis services, as well as written protocols to ensure that patients are treated in the most appropriate setting. The CDPC, a specialty psychiatric hospital, will have a leadership role due to their expertise in specialty and crisis psychiatric services. The PPS will provide resources which will allow CDPC to expand their services to better serve the affected population. Currently our PPS is not able to share data effectively. This identified gap will be closed by the end of DY 3 using HIXNY (RHIO) and SHIN-NY as well as an integrated care management model as developed by our partner, Montefiore Medical Center. This IT solution will allow the PPS to track and proactively reach out to patients actively engaged in this project. The PPS Quality committee will establish oversight and monitor this project to ensure compliance with protocols and quality of care.

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

This project will target the behavioral health population, together with other projects (2.a.iii & 3.b.i) and will serve patients with behavioral health diagnoses who need crisis stabilization services that could be delivered in settings other than the ED or inpatient settings. Patients in crisis presenting at the ED are often also admitted to inpatient settings. We will focus specifically on individuals presenting at the ED with behavioral health diagnoses and who are in crisis. In our PPS, 2,009 unique recipients generated 3,568 ED visits during the year ending March 2014. Albany, Saratoga, and Columbia counties are the top 3 counties driving BH visits to the ED within our PPS region, these counties will be the focus of our interventions. ED visits are evenly distributed between male and female, 49.2% and 50.8% respectively. The project will serve primarily adult and adolescents. Resources will be developed according to need, but will be developed separately for adult and adolescents. Behavioral health admissions spike at age 15 and increase in 10 year bands through age 65 according to Salient data and our CNA. High utilizers of ED and Inpatient crisis services especially those with co-morbid conditions will be engaged during this project.

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

The Capital District Psychiatric Center (CDPC) is a specialty psychiatric hospital that provides specialty crisis services and is a key asset not only to our PPS, but to this project in particular. This project will expand those services, and develop new resources within the community to provide appropriate care in a less restrictive setting. Current crisis services in the PPS are primarily mobile services. However, as the consumer affairs sub-committee reports, response times are inadequate to provide timely support for patients and families in crisis. These crisis services will serve as the starting point for the project. By leveraging their expertise in crisis stabilization, the PPS will use these resources to train and develop additional community based resources based on evidence based best practices as well as successful demonstration projects. The PPS will develop a centralized triage system allowing real-time notification of crisis stabilization outpatient bed availability. The following existing infrastructure is an asset to the project: hospitals, homeless shelters, Veterans service organizations, social and human services agencies, County Departments' of Social Services and Mental Health, treatment providers, the legal system, community support meetings, and self-referrals. The PPS will develop or repurpose the coordination of these services. Community based organizational resources will be developed and repurposed to provide short-stay sub-acute crisis stabilization beds. Mobile crisis teams, street outreach, 24/7 care managers, emergency departments, shelters and other community resources will have access to the newly developed centralized triage. We will develop evidence based needs assessments for addiction and mental health to be conducted upon patient arrival, as well as a medical exam conducted by a physician or nurse practitioner (Project 3.a.i). Patients will be assisted by navigators to access necessary services including: medical, mental health, dental, social services, housing supports, and legal assistance. Crisis services available will vary by location based on the CNA data and hot-spotting, but could include: Emergency/Transitional Housing, evidence based practices such as SBIRT (Screening, Brief Intervention and Referral to Treatment); Cognitive Behavioral Therapy (CBT); Motivational Interviewing (MI); Integration/co-location of Mental Health services, Healthcare Navigators, direct access to primary care through

integrated clinical and case management services, recovery peer support services, supportive housing referrals, ambulatory detox (medication assisted) and/or referral to ambulatory detox providers and Wellness Centers that include prevention services for individuals and families. These resources will be marshalled from the existing community services and repurposed to work within the centralized triage system to accomplish the goals and objectives of DSRIP.

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.

Establishing agreements with the Medicaid Managed Care Organizations to provide coverage under this project will be a challenge. The PPS has reached out to MCOs to discuss payment reform. Our partner, Montefiore Medical Center, has experience developing value based contracting. Their experience will help us address this challenge. Lack of protocols is a challenge which will be addressed by collaboratively developing protocols and centralizing triage for patients in need of stabilization services. We will leverage the expertise of CDPD and Four Winds in crisis stabilization to build consensus on protocols. Tracking patients engaged in this project will be a challenge. To address this we will utilize innovative technological solutions based on the IT infrastructure of our partner Montefiore. We will then be able to develop registries facilitating patient tracking and outreach including real time notification of ED presentation or IP admission. Behavioral health service providers are in short supply. The consumer affairs committee reported waiting times of several months for urgent psychiatric services. This project will work with our workforce development vendor and Albany Medical College to develop additional capacity including potential expansion of training opportunities at the LCSW, PNP, PA, and MD levels.

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.

AMCH is collaborating with all of the neighboring and overlapping regional systems serving as lead applicants. We have had several conversations with Ellis Hospital (IHANY), Adirondack Health Institute and Mary Imogene Bassett to look at ways we can pool regional resources to address challenges and make the most efficient use of limited funding. Training is a prime example of where we all believe economies of scale can be realized. More importantly, however, AMCH intends to form a partnership with Montefiore Medical Center. They are serving as the lead applicant for a 7-county service area in the Hudson Valley known as the Hudson Valley Collaborative (HVC) located immediately to the South of our catchment area. We are working with them in several concrete ways that will result in seamless, coordinated efforts regarding this project over the combined regional areas of both their and our PPS. This contiguous area runs from metropolitan New York City to the Adirondacks, following the Hudson River to its headwaters. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long-term success.

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.

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics.

Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only)

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

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

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

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

Improve Medication Adherence:

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

Actions to Optimize Patient Reminders and Supports:

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

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

1. <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.

Cardiovascular (CV) disease in AMCH's service area is a driver of both ED and inpatient utilization. In our PPS 13.1% of recipients had a CV diagnoses but only 1.5% had a CV primary diagnosis. The Medicaid population has higher rates of hypertension than the NYS averages. Effectively treating CV disease will reduce inpatient and ER utilization. Patients with co-morbid physical and behavioral health conditions have higher rates of ED utilization; 11% of Medicaid patients with co-morbid behavioral and physical health conditions generate 53% of ER visits. Current EHR connectivity prevents using evidence based practices and care management to treat cardiovascular diagnoses and to better track and follow patients across the continuum of care. The PPS will close the gap by leveraging the IT infrastructure of our partner Montefiore Medical Center and their experience in developing care management protocols. We will integrate community resources and community based programs into traditional health care delivery. We will improve data sharing by utilizing HIXNY and SHIN-NY thus facilitating sharing of appropriate patient level data among clinical partners including secure messaging. This will be accomplished by DY3. We will develop coordinated care teams at participating PCMH sites to ensure that care for patients with complex needs is integrated and easily communicated between providers. The PPS will ensure all primary care safety net providers are certified as PCMH Level 3 2014 and meet

Meaningful Use requirements, and will implement the strategies and components of the Million Hearts campaign including patient tracking, registries and sharing care plans across the continuum of care. Modifications to the EHR will automatically prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange). Those with behavioral health diagnoses have marked disparity in health outcomes when compared to the general population. Cardiovascular death among those with serious mental illness is 2 to 3 times that of the general population. We will work to close this gap by integrating this project with 3.a.i, integration of primary care and behavioral health. Identified gaps will be closed by adopting standardized treatment protocols for hypertension and cholesterol. Care coordination teams including nurses, pharmacists, dieticians and community health workers will help patients address lifestyle changes, medication adherence, health literacy, and patient self-advocacy and effective self-management. The AMC PPS will implement the Million Hearts Campaign to improve the management of cardiovascular disease using evidence based strategies in the ambulatory setting.

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 this project we will target patients living in poverty between the ages of 19-64 in our 5 county catchment area with known cardiovascular diagnoses and co-morbid behavioral health conditions. We will target our efforts at patients with behavioral health conditions, as there is a marked disparity in cardiovascular outcomes in this patient population, as described above. Additionally, we will also target those patients who have had elevated blood pressure readings in the past but without a hypertension diagnosis in order to develop a treatment plan for an undiagnosed condition. We will follow the guidelines provided by the Million Hearts Campaign in terms of clinical processes and treatment. A majority of these adults who are in care live in Albany County and are followed by AMC. Geographically Columbia County has heart disease mortality rates significantly higher than the NYS average.

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.

All current primary care safety net providers are certified PCMHs. This is an asset that represents an existing investment in the necessary EHR to increase certification to PCMH Level 3 2014. We will improve EHR capabilities to include decision support, and prompts for asking the 5As of tobacco cessation. Resources for evidence based guidelines, patient tracking for follow up appointments and patient identification of hypertension will need to be developed. AMCH is home of world renowned experts in cardiovascular care. The AMC PPS will leverage this asset of expertise and train providers to utilize and implement the guidelines in the Million Hearts Campaign. We will leverage the programs already in place in the Capital District for training partners in CV disease management. Care managers will help perform blood pressure checks to identify patients with undiagnosed hypertension and follow up readings for diagnosed patients as well as counseling and education for patients and tracking and following patients through

patient registries. The PPS will develop new IT strategies to integrate this project with project 2.a.i and 2.a.iii and use integrated care plans and care coordination teams including nurses, pharmacists, dieticians and community health workers. Participating providers will designate site champions at each site, responsible for overall implementation and reporting of metrics. The site champion will leverage network resources to best serve the patient. Care management teams will provide patient referrals to public assets and community organizations, such as the NYS Smokers Quit line, and peer resources to ensure optimal care in a community setting and document any changes in behavioral or health status. We will train patients to record blood pressure readings at home exporting results remotely to their EHR and alerting their providers in real time when abnormal readings occur. We will use additional novel mechanisms, such as home health aides, to follow up with members who are unable to come into the provider's office for follow up blood pressure readings. As described above, reaching patients with behavioral health needs will be a focus for our PPS. Through our trainings, we will emphasize to all primary care and behavioral health providers the need to assess for cardiovascular risk factors in all patients with behavioral health diagnoses. We will also conduct public outreach efforts (health fairs, free blood pressure clinics, etc.) in areas known to be at risk for cardiovascular disease such as Columbia County and other hot spots.

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

The current payment structure does not adequately reimburse for prevention efforts like the Million Hearts campaign. The AMC PPS has reached out to local MCOs to begin the process of evolving the payment structure to a value based system. Our partner, Montefiore Medical Center, has experience in this area. We will overcome this challenge by working with the MCOs to develop a payment structure that recognized the value in providing preventative care. The challenge to implementing evidence based best practice guidelines is in obtaining compliance. AMCH's Clinical Affairs Committee will provide technical assistance to all participating providers to reduce this challenge and improve adoption and reporting compliance with all guidelines and protocols. Additionally, IT connectivity and ensuring MU and PCMH level 3 standards will be an important component in ensuring integrated care plans and ensuring IT capabilities are used to improve patient tracking and provider use of evidence based guidelines. Realizing partners within our PPS are at differing levels of IT capabilities, we will work closely with our partners to develop needed capabilities. Additionally, we will seek capital budgeting funding to help providers meet the requirements of Meaningful Use and PCMH Level 3 2014 certification.

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.

AMCH is collaborating with all of the neighboring and overlapping regional systems serving as lead applicants. We have had several conversations with Ellis Hospital (IHANY), Adirondack Health

Institute and Mary Imogene Bassett to look at ways we can pool regional resources to address challenges and make the most efficient use of limited funding. Training is a prime example of where we all believe economies of scale can be realized. More importantly, however, AMCH intends to form a partnership with Montefiore Medical Center. They are serving as the lead applicant for a 7-county service area in the Hudson Valley known as the Hudson Valley Collaborative (HVC) located immediately to the South of our catchment area. We are working with them in several concrete ways that will result in seamless, coordinated efforts regarding this project over the combined regional areas of both their and our PPS. This contiguous area runs from metropolitan New York City to the Adirondacks, following the Hudson River to its headwaters. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long-term success.

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.

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

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

Yes	No
☐	☒

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

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

and scale submissions with the project application will directly impact Domain 1 payment milestones.

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

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

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

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

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

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

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

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

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

The CNA identified asthma as a high impact condition. In 2012, 8% of asthma ER visits (39,700 visits) and 5% of inpatient admissions (13,100 admissions) were driven by asthma diagnoses. ER visits for asthma ranged between ~540 in Columbia County and ~14,700 in Albany county. This highlights the "hotspots" for targeting. Asthma ER visits and hospitalization rates are significantly higher than the regional average in 3 of the counties served. The PPS is collaborating with the Asthma Coalition of the Capital Region (ACCR), to conduct this project. By engaging providers, care managers, certified asthma educators (AE-Cs), behavioral health specialists, and pharmacists to implement evidence-based medicine guidelines, the project will improve asthma quality of life indicators by assuring appropriate diagnosis, classification of severity, prescription of controller

medications, medication adherence, self-management support and trigger control interventions. PPS and ACCR will be responsible for achieving project goals by addressing the following gaps: Training: Train primary care providers and staff on the Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma developed by the National Heart, Lung and Blood Institute. Support staff training through the asthma educator program to become Certified Asthma Educators. Implement treatment pathways: Specialists and PCPs will produce simplified algorithmic treatment pathways within the whole continuum of care. Metrics will be followed to ensure adherence to pathway recommendations. Within hospitals, asthma order sets and EHR templates will be pathway-compliant. Referrals/Linkages: Develop a list of Certified Asthma Educators and establish linkages for patient referrals. Medication Adherence: PPS and ACCR will implement system changes needed to achieve high medication adherence. This will include role of pharmacies in patient education. IT Connectivity: All providers will use standardized templates in EHR and real-time secured ADT communication, including requirement to connect to RHIO / HIXNY. Asthma Registry: PPS will develop a web-based asthma registry for care management support, medication adherence, health service utilization and to track project metrics across the system. Registry will also identify high-utilizers of ED and hospital services for referral for additional service interventions to decrease further use of hospital services. Telemedicine: Develop a telemedicine model using video-conferencing technology and case-based learning to train and mentor primary care providers to deliver best-practice management of asthma and other complex health conditions, particularly in rural areas. MCO Coordination: Identify available care management support, community linkages, formulary inclusion and co-pay issues related to medication access in collaboration with MCOs and Health Homes.

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.

We will identify areas of high ER and inpatient utilization throughout the 5 county region and target implementation at providers that care for those patients. There are concentrations of both adult and pediatric patients in Arbor Hill, West Hill and South End neighborhoods of the City of Albany that will be an initial focus. An additional target population is the cohort of asthma patients enrolled in Medicaid/Medicaid Managed Care and uninsured/underinsured with high service utilization for asthma. Specifically, the project will aim to target the following groups: low income children and adults with diagnosed asthma residing in PPS service area; low income children with asthma enrolled in schools located in PPS service area; patients with recent asthma related visit to an emergency department/urgent care/hospitalization; high-risk asthmatics as identified and referred by their primary care/specialist provider, Managed Care Organization, Health home and/or pharmacy; patients with poor medication adherence; and patients with current tobacco exposure, primary or secondary. School based health clinics and school nurses will also serve a dual role of identifying target patients for enrollment and intervention and being the first line of support to address onset of illness, consistent with their scope of practice and license requirements.

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.

AMCH and the PPS are fortunate to have the NYS certified Asthma Coalition of the Capital Region (ACCR) as a key asset and resource; the ACCR adheres to all national guidelines for asthma management and protocols. Although they are assisting Ellis Hospital's PPS with a slightly different asthma project (3.d.i), the fact that they are working with both PPSs is viewed as a significant strength and asset. Many of the partners of this coalition are also members of our PPS. They have made progress over the last few years in developing their coalition. With additional support from DSRIP, ACCR will be able to build on the core infrastructure already established, including educational materials leading to certification as an Asthma Educator, linkages with MCOs to facilitate care management and coordination, protocol development for use in the ERs and other items. Perhaps their most valuable asset and resource is the dedicated staff that are passionate about working with us to help control asthma. Based on our PPS membership, we are in a strong position to leverage both adult and pediatric asthma/allergy specialists' services to implement the objectives of the proposed project plan. The majority of prescribing practitioners including specialists are part of the two hospital systems, large physician groups or other partnering provider systems. Several regional home health care agencies are part of the PPS and ACCR will assist our PPS in establishing linkages with other community resources. Participation of local hospital/community pharmacies will enable our PPS to improve medication adherence. The majority of the participating provider systems are current members of a HIE with varying capabilities for seamless data exchange. As a well-run and respected institution housed in the region's largest FQHC (Whitney Young CHC), ACCR is capable of utilizing DSRIP resources to the complete work they have started, close gaps, improve medication adherence in close collaboration with participating safety net pharmacists, improve early identification and referral activities within school based health programs and reduce avoidable ER visits and hospital admissions for both adults and children who have asthma.

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.

Lack of evidence based medicine guidelines are challenges. Working with ACCR, AMCH PPS will strengthen collaborations, develop training, and provide incentive payments for performance. AMC PPS will collaboratively develop evidence based medicine (EBM) approaches including severity assessment, control assessment, medication adherence and self-management components and Asthma Action Plans. AMCH's PPS will facilitate adoption of EBM guidelines, develop medication adherence programs, self-management and educational support, including engaging safety net pharmacies during implementation. Lack of current infrastructure to support telemedicine prevents implementation as well as readiness of providers to be part of the initiative and lack of reimbursement for telemedicine services. Lack of real-time access to prescription fill and refill data and lack of medication adherence monitoring are challenges created

by current HIT capabilities. Existing IT infrastructure is inadequate to support a region-wide interoperable system, and a comprehensive patient registry. AMC PPS will develop and implement a system-wide IT solution to facilitate real-time data exchange for effective care management including structured EHR templates to meet the needs of meaningful use and an asthma patient registry. MCOs currently don't reimburse the proposed services. PPS leadership will engage MCOs to participate and develop new payment methodologies based on EBM algorithms including medication formularies.

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.

AMCH is collaborating with all of the neighboring and overlapping regional systems serving as lead applicants. We have had several conversations with Ellis Hospital (IHANY), Adirondack Health Institute and Mary Imogene Bassett to look at ways we can pool regional resources to address challenges and make the most efficient use of limited funding. Training is a prime example of where we all believe economies of scale can be realized. More importantly, however, AMCH intends to form a partnership with Montefiore Medical Center. They are serving as the lead applicant for a 7-county service area in the Hudson Valley known as the Hudson Valley Collaborative (HVC) located immediately to the South of our catchment area. We are working with them in several concrete ways that will result in seamless, coordinated efforts regarding this project over the combined regional areas of both their and our PPS. This contiguous area runs from metropolitan New York City to the Adirondacks. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long-term success.

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.

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

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

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

Domain 4 Projects

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

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

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

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

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

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements. The implementation must address a specific need identified in the community assessment and address the full service area population.

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

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

Entity Name
American Cancer Society
American Lung Association
American Heart Association

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.

To align our projects with Montefiore's, we have adapted some of this material, with their permission. Smoking is a prevalent issue in our 5 county region and smoking cessation is an area of addressable impact for the health of the community. Data from the 2010 New York State expanded behavioral risk factor surveillance system and the New York City community health survey demonstrated that the percentage of adults smoking cigarettes within the region ranged from xx% in Saratoga up to YY% in Greene County. Despite the high smoking rates, there is low utilization of smoking cessation tools, with only 17% of smokers using the smoking cessation benefit (vs. State target of 40%) There are segments of the population with even higher rates of tobacco dependence. (MCKINSEY IS LOOKING FOR NUMBERS FOR REGION?) Those with mental illness are particularly likely to be smokers as well; the most prevalent substance abuse disorder among individuals with mental illness is nicotine dependence (American Psychiatric Association 1994). Cigarette smoking adversely affects the quantity and quality of life for patients with mental illness (Colton & Manderscheid 2006). Nicotine dependence is predictive of future suicidal behavior (Oquendo et al. 2004) and can adversely affect therapeutic blood levels of psychiatric medications (Zevin & Benowitz 1999). Those with mental illness or substance use disorder die on average 8 years younger than the general population, part of which can be attributed to tobacco related diseases1. For example, the risk of a schizophrenic patient dying from illnesses related to tobacco use compared with general population is 2.5 times2. Thus, this will be an important population for our PPS to target with our smoking cessation efforts. Additionally, there is a need for provider education and preparedness for counseling on smoking cessation, as well as a need to move from asking patients about nicotine use to transitioning providers into assisting patients in tobacco cessation. Studies show that 90% of psychiatrists and psychiatric nurse practitioners believe that helping patients stop smoking is part of the role of mental health professionals and 80% usually ask about smoking status. However, only 34% typically recommend nicotine replacement therapy, 29% prescribe cessation medications to smokers, and only 12% felt well prepared from prior education to treat tobacco4. As such, education for providers, particularly behavioral health providers will be a key aspect of our strategy for this project. A

variety of medical curricula have been developed to address cigarette smoking, and a recent systematic review (Lancaster et al. 2000) suggested that training health professionals had a measurable effect on professional performance, including offering counseling, setting quit dates and follow-up visits, distributing self-help materials, and recommending nicotine replacement. To reach the general population and the low socioeconomic status population, we will also implement educational efforts regarding treatment and counseling for smoking cessation with a variety of providers, including primary care physicians (also integrated with our project 3.B.1) and specialty care providers.

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.*

We will target 4 sub-groups: First, patients with behavioral health (including mental health and substance abuse diagnoses) needs and tobacco use. Population-based studies have shown that individuals with mental illness smoke at approximately double the rate of the general population (41% versus 23%); there are even higher rates among the seriously mentally ill and those with additional addictions (Lasser et al. 2000, Rohde et al. 2003). Cigarette smoking rates vary among those with mental illness diagnostic groups, with particularly high rates among individuals with schizophrenia, bipolar disorder, and co-occurring alcohol and illicit drug disorders (de Leon et al. 1995, Lasser et al. 2000, Prochaska et al. 2004b). Second, we will focus on members with low socioeconomic status, as there continue to be high smoking rates in this population, with disparity in outcomes. Third, we will target smoking cessation efforts at our providers caring for those with disabilities. Fourth, we will target the young adult population (particularly those with co-occurring behavioral health conditions), as this population would also greatly benefit from smoking cessation efforts. The young adult population is a focus of our efforts because of high smoking rates and likelihood to become long term smokers. Studies have shown that more than 80% of young adults with substance use disorders report current tobacco use (most report daily smoking) and many become highly dependent, long-term tobacco users (McDonald et al. 2000, Myers & MacPherson 2004, Upadhyaya et al. 2002). Smoking may additionally serve as a gateway to other drugs of abuse for youth with substance use disorders (Brown et al. 1996, Lindsay & Rainey 1997). Research shows that smokers with severe mental illness likely require extra duration and intensity of treatment to quit & stay quit.3 Thus, ensuring adequate duration of cessation efforts will be an area of focus for our PPS.

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

Our PPS and CBOs have assets and resources that will be mobilized to reduce tobacco use. The Healthy Capital District Initiative, with DOH funding through PHIP, is working with 4 of our counties to focus on the state's Prevention Agenda. They are part of our PPS and will coordinate specific prevention efforts, mobilize community partners and local county health departments and assist with the development and dissemination of a targeted media campaign to raise community awareness. Hundreds of CBOs in our region act as safety net providers in their communities. Many are in our PPS, but we will enlist additional CBOs to participate in this prevention initiative. They possess crucial assets and resources needed to assist and refer

underserved populations to programs designed to assist individuals to quit smoking. We have close working relationships with regional and national organizations, like the American Cancer Society and the American Lung Association, and offer tools, techniques, tips and nicotine replacement therapy for free. We refer patients to the NYS Smoker's Quitline, provide incentives for patients to give up tobacco and have created smoke free zones on all AMC property. Another asset AMC has relates to training. As the region's only medical college, we provide training in the community to health and CBO providers. The medical college is the recipient of a National Cancer Institute/NIH multicenter, multidisciplinary grant for the development of resources to assess competency in tobacco cessation counseling. Building on this important asset, we will present training that is culturally and linguistically appropriate, to providers, stake holders, safety net participants and CBO's on the importance of asking the 5 A's (Ask, Assess, Advise, Assist and Arrange). We will work with the 35 participating pharmacies in our PPS to provide free counseling and nicotine replacement therapy, in additional to other tools and techniques designed to get patients to quit smoking cigarettes. We have the ability to create and disseminate public service announcements to get the word out to the entire community. We also have EHR as an asset, but will need to implement clinical decision supports and registry functionality. We will integrate this project with project 2.a.iii, where we intend to expand and build upon our care management infrastructure. In doing so, care managers will also follow up with members and their providers to ensure that all patients are screened for tobacco use and offers of assistance to quit are documented. ing recommendations are made and care was received. Where providers have electronic medical records, we will implement reminder prompts into the EHR. Standardized dashboards with clinically based, longitudinal quality measures for each provider will be benchmarked to their peers and shared. We will use data for quality improvement efforts and feed data back to providers. We will use this data to establish/enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services.

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

Assessment: For all providers with or moving toward implementation of EHR, there will be prompts to perform the "5 A's". We will develop an electronic fax capability for patient consent forms to the NYS Smoker Quitlines - using the "Click to Quit" technology. Environment: We will require all of our PPS partners to enforce tobacco free policies at their institutions. Training: We will emphasize and teach providers to utilize the US Public Health Services Guidelines for Treating Tobacco Use. We will also build upon the programs already in place in the medical college. Improve access to NRT: We will work with MCOs to develop improved, simplified, and extended coverage benefits for nicotine replacement therapy. Targeted use of media: In an effort to bring smoking cessation efforts to the broader population and to the young adult population, we will employ targeted and proven media campaigns. Partner with local agencies: We will partner with local agencies to identify resources for smoking cessation in order to reach the young adult population and provide access to cessation services for this population. Staff smoking: We will encourage all our PPS partners (particularly those at behavioral health facilities) to encourage and teach staff to quit smoking. Follow up: We will integrate smoking cessation in care coordination

efforts (overlapping with project 2.a.iii). We will begin cessation efforts when patients are admitted to hospitals. Metrics: We will develop standardized dashboards with clinically based metrics (e.g., rates of client tobacco use, provider recommendation to quit, and provider assistance in quitting—synchronized with meaningful use/NQF measures) for providers. We will provide provider level feedback on metrics, including numbers of referrals to the quit line, distribution of NRT, and improvement of baseline volume of referrals over time.

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

As described above, we intend to work with the other PPSs in the region and in surrounding regions to advocate for uniformity in coverage for cessation benefits for Medicaid managed care plans. Additionally, we will work with other PPSs to develop training plans for providers in smoking cessation treatment. Also, we will work together to help aid the "Click to Quit" initiative in making the fax referral from providers to the quit line electronic on both sides; this will require an IT investment and through group purchasing may afford some discounts. Additionally, we can partner with the other PPS on group purchasing for NRT and oral quit medications to receive lower rates and have supplies available for providers to dispense. AMCH intends to partner with Montefiore Medical Center. They are serving as the lead applicant for a 7 county service area in the Hudson Valley known as the Hudson Valley Collaborative, or HVC, located immediately to the South of our catchment area. We are working with them in several concrete ways that will result in seamless, coordinated efforts regarding this project over the combined regional areas of both their and our PPS. This contiguous area runs from metropolitan New York City to the Adirondacks, following the Hudson River to its headwaters. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

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.

1) Assessment: PPS with EMR- prompts 5 A's" will be in place end DY1; fax capability for Quitline by DY2. 2) Training: will be available and scaled by end DY1. 3) Media: We will work closely with State partners to roll out select media campaigns in targeted markets within the Hudson Valley. We estimate that this will occur by end of Year 2. 4) Metrics: We will work with HIXNY and PPS implement metric assessment and evaluation tools, interim DY1, full DY3.

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.

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

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

Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

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
American Cancer Society American Lung Association Susan G. Koman

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.

Within our 5 county region, there is opportunity to increase preventive care in numerous settings with corresponding improvement in population health. Gaps have been previously identified in our CNA which have an impact on chronic disease preventive care and management, including: wait time for appointments, lack of specialists, transportation, stigma and mistrust of the medical and health care system, and lack of knowledge about screening tests. According to NYS Vital Statistics and our CNA, cancer is the second leading cause of death in both the State and our region. According to the NYS DOH "Screening Amenable Cancers in New York State", there is often a correlation between cancer incidence rates and cancer screening test utilization. In addition, although incidence of colorectal cancer has declined in the last decade, future screening efforts should focus on populations least likely to be screened, including those with low annual household incomes, those with a high school or less education, and those without health insurance. There are pockets of these key demographics throughout most of our service area. In regards to specific "hot spots" that have higher than expected cancer rates, there are many areas determined by the State DOH by zip code to meet the criteria of highest need with higher than average cancer rates. Based on NYS DOH Cancer Mapping, clusters of cancer hospitalization rates demonstrated hotspots in Albany (including Delmar, Latham, Glenmont and Albany), in Schenectady, in Saratoga (Saratoga Springs, Ballston Spa, Mechanicville, Waterford, Stillwater, South Glens Falls and Gansevoort and Clifton Park), in Columbia (Ghent, Germantown, Chatham, Kinderhook, Claverack, Tivoli), and in pockets throughout neighborhoods in Greene and Warren County as well. Hot spots of female breast cancer include the areas of Delmar, Greenville, Troy, Watervliet, Albany, inner city of Schenectady, Ballston Lake, Ballston Spa, Clifton Park, Mechanicville, Chatham, Ghent, Kinderhook, Claverack, Germantown, Tivoli, Greenville, and inner city of Albany. Rates of colorectal cancer range from Albany County's high of 79.6 annual cases/100,000 to Greene County's rate of 60.4 annual cases /100,000. Failure to receive colorectal screening is related to increased rates of mortality from colorectal cancer. Not surprisingly, areas with higher rates of colorectal cancer have lower screening rates. Lung cancer is also a concern in our service area, with hot spots in the

inner city of Albany, Ballston Spa, Mechanicville, Stillwater, South Glens Falls, Gansevoort, Glenmont, Delmar, Selkirk, Cohoes, Latham, Hudson, Pine Plains, Chatham, Ghent, Valatie, Copake, Craryville, Ghent, Kinderhook and Hillsdale. From our consumer focus groups, we learned that patients want to lead healthier lives; however, many feel they do not have the information, support, or resources needed to accomplish this goal. We know that screening rates for breast, lung, and colorectal cancer are lower among the poor, the uninsured and those with less than a high school diploma. Thus, patient education, empowerment, and advocacy will be important components of our project plan along with facilitating access to screenings for those who have low utilization rates. Simply stated – cancer screening allows for earlier detection and treatment and saves lives.

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

Our project intends to increase rates of colorectal screening, mammograms and cervical cancer screening in hard to reach populations of our service area. Based on health care disparities, these populations include: people living in poverty, people living in rural areas, people without regular access to a primary care provider, people for whom English is not their primary language, foreign-born patients, illegal immigrants, migrants (particularly itinerant farm workers), minorities, people with special needs as well as the uninsured and those who are under-utilizers of health insurance. Populations will also be targeted based on the "hot spots" as mapped in our service area, as identified above. Following evidence based medicine and best practice guidelines, we plan to focus on improving rates of recommended screening for cervical, colorectal, and breast cancer. As a priority, we also plan to target minority populations and patients with low socioeconomic status, who have lower than average rates of screening compared to the general population. We will reduce or eliminate out-of-pocket expenses for these screenings, working with MCOs and clinical and community preventive service providers to fund these costs. In order to make these services easy-to-use, convenient and affordable, we will work with our community based partners to utilize mobile vans, provide screenings in community settings, facilitate transportation for tests that cannot easily be completed in community settings, like colonoscopies, and work with other key stakeholders in the community to reach out to the target population to educate them about the importance of getting these screenings when recommended.

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

Our PPS and CBOs have assets and resources that will be mobilized to improve cancer screening rates. The Healthy Capital District Initiative, with DOH funding through PHIP, is working with 4 of our counties to focus on the state's Prevention Agenda. They are part of our PPS and will coordinate specific prevention efforts, mobilize community partners and local county health departments and assist with the development and dissemination of a targeted media campaign to raise community awareness. Hundreds of CBOs in our region act as safety net providers in their

communities. Many are in our PPS, but we will enlist additional CBOs to participate in this prevention initiative. They possess crucial assets and resources needed to assist and refer underserved populations to appropriate cancer screenings through the community programs they deliver to their clients, located throughout the "hot spot" areas and targeted areas. These CBOs are frequently not connected to health care, but are connected to the underserved in their communities. Services they provide include literacy training, family and youth programs, domestic violence counseling, Alcoholics and Narcotics Anonymous programs, community gardens and food banks, senior service programs, after school youth programs, and case management and peer programs, to name only a few. In addition to these community assets, we have strong advocacy organizations, like the Capital District Council of Churches, the Homeless Action Network, and the Interfaith Alliance who have large organizational memberships with a mission of social justice and advocacy. We will enlist their support, follow their advice and direction and coordinate outreach efforts to encourage the underserved to get screened and tested. Another asset AMC has relates to training. As the region's only medical college, we provide training in the community to health and CBO providers. We will present training that is culturally and linguistically appropriate, to providers, stake holders, safety net participants and CBO's on the importance of screening for cancer, and will address topics like: Assertive Community Treatment, Clinical Competency, Health Literacy, Cultural Competency, Engagement and Motivational Techniques and Interviewing, Cognitive-Behavioral techniques, and group team skills. Training will be offered on site and online. We have ability to create and disseminate public service announcements to get the word out to the entire community. We also have EHR as an asset, but will need to implement clinical decision supports and registry functionality. We will integrate this project with project 2.a.iii, where we intend to expand and build upon our care management infrastructure. In doing so, care managers will also follow up with members and their providers to ensure that screening recommendations are made and care was received. Where providers have electronic medical records, we will implement reminder prompts into the EHR. Standardized dashboards with clinically based, longitudinal quality measures for each provider will be benchmarked to their peers and shared. We will use data for quality improvement efforts and feed data back to providers. We will use this data to establish/enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services.

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

Cancer deaths can be prevented with better screening, early identification and treatment. We will make screening tests affordable and accessible. We will work with MCOs to insure that cancer screenings are affordable and payments are financially sustainable. We will insure providers follow evidence based guidelines. Each care team will utilize protocols to track patient appointments and that the results of screening(s) are available. We will expand hours of operation to accommodate the needs of the working poor and others. We will deploy mobile breast cancer screening vans to "hot spot" areas in the region. Many community residents do

not understand why screenings are important. Their distrust of the medical system, lack of empowerment and barriers to obtaining convenient and appropriate care are challenges that need to be overcome. We will ensure that screening information and forms are available in the appropriate language and reading level and that staff are trained to complete health literacy assessments. Translation services will be available wherever needed. We will employ and deploy culturally competent Health Navigators to assist patients and clients to address referral, stigma, empowerment, resources and other pertinent issues in "hot spot areas". We will limit unnecessary visits to health care facilities and integrate screenings into intake procedures, including in medical village models. We will take advantage of EHR capabilities and EHR prompts. We will use EHR prompts, follow-up calls, health navigators and other case managers in order to treat and address cancer screening results in a timely manner, with rapid response capabilities to bring patients in quickly for follow up where necessary and appropriate. IT capabilities and capacities vary across providers. We will apply for capital funding to enhance IT infrastructure. We will also work closely with the local RHIO, HIXNY, to develop long term sustainable connectivity for all participating providers.

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.

Standardized dashboard data will be collected and benchmarked for provider comparison. This data will be used for a variety of CQI efforts. Data will also be integral in influencing reimbursement rates and also impact incentives in order to increase delivery of high-quality services as well as addressing the on-going needs in chronic disease prevention and linkages of services. In addition, face to face meetings will occur on a quarterly basis, in order to address any patient issues and complaints. AMCH is collaborating with all of the neighboring and overlapping regional systems serving as lead applicants. We have had several conversations with Ellis Hospital, Adirondack Health Institute and Mary Imogene Bassett to look at ways where we can pool regional resources to address challenges and make the most efficient use of limited funding. Training is a prime example of where we all believe economies of scale can be realized. More importantly, however, AMCH intends to form a virtual partnership with Montefiore Medical Center. They are serving as the lead applicant for a 7 county service area in the Hudson Valley known as the Hudson Valley DSRIP Collaborative, or HVDC, located immediately to the South of our catchment area. We are working with them in several concrete ways that will result in seamless, coordinated efforts regarding this project over the combined regional areas of both their and our PPS. This contiguous area runs from metropolitan New York City to the Adirondacks, following the Hudson River to its headwaters. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

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.

1) Training begins 4/1/15 through DY5. 2) Where providers have EMR systems, prompts will

be operational by end of DY2; maximum number of partners are utilizing EHR by DY4. 3) Follow up methods for clients begin DY1 1st quarter, full ramp up expected by DY3. 3) Follow up methods for providers, where EHRs are operational, done by DY2. 4) We will work with partners and HIXNY to implement metric assessment and evaluation tools. We estimate there will be an interim solution for reporting and evaluating these metrics operational by DY1, with the goal of shifting to the RHIO over time.

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

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

Yes	No
☒	☐

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

While it is not possible to complete detailed estimates of project needs are more concrete, we believe that there will be capital needs for this project including computer equipment, other IT infrastructure, potential space renovation and additional equipment items, including a mobile mammography van. Capital funding requests and applications are being developed and will be submitted under the direction of the AMC PPS PMO consistent with NYS DOH guidelines, instructions and due dates.

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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