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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.

As described in the CNA, the underlying conditions at the root of most inpatient admissions for those insured by Medicaid are depression, hypertension, drug abuse, diabetes, and asthma. Four of the 6 counties have higher rates of PQI conditions than the NYS average. Further the rates are disproportionately higher in the more rural areas, although there are relatively high rates in pockets throughout the region. Similarly, PPV and other ED data shows higher rates than NYS and a dramatic overutilization of the ED particularly in rural areas. Across the region, poor discharge planning was identified as a barrier to preventing avoidable readmissions. High rates of PPRs, PQIs and PPVs are indicative of the need to focus on transitions.

EBRFSS, indicates rates of the leading chronic medical conditions are all generally higher throughout CNY. Oswego had higher rates for these conditions than NYS across all 4 leading conditions. Cayuga, Lewis, and Madison had higher rates for 3 of the 4 leading conditions than NYS. The county rates for poor mental health and alcohol abuse are also considerably higher than NYS and Upstate averages. The CNA consumer survey shows that only 56% adults and 34% of children surveyed were seen in the ED for a medical emergency. The remaining visits were because those surveyed did not have a primary care (PC) provider, could not been seen by their regular PC due lack of capacity or after-hours care, or were instructed by their provider to go to

the ED.
CNY is an area of contrasts ranging from sparsely populated rural tracts to more densely populated semi-urban areas. In CNY low income is not solely an urban issue and limited access to health care permeates the region for different reasons. Most of the health care and community-based resources in the region are located in the more urbanized areas, as are the minority and foreign-born populations. Limited access and health disparities in these communities often stem from lack of insurance, non- acceptance of Medicaid by providers, and cultural and language difficulties. In the rural areas poverty factors into negative health outcomes, which is further complicated by a lack of health care options and community resource agencies. Transportation is a significant problem in all areas of the region. In some areas it is the distance alone that impedes access to care.
The PC safety-nets only serve 30% of the low-income population in the region. Large proportions of the remaining population either: 1) do not receive regular PC services; 2) is served by small, independent private practices that typically do not provide comprehensive, timely, patient-centered care; or 3) receives intermittent care by EDs. PC access gaps persist, particularly in rural areas. Physician to population based ratios indicate shortages in the number of PC, behavioral health and dental providers, as compared to NYS averages. Most safety-net practices are using EMRs to track quality indicators however most practice sites lack the time and resources to train providers to fully use EMRs to identify those at-risk, manage follow-up, communicate with other providers, and coordinate care.
As CNYCC creates a more integrated delivery system, it will address core issues which cut across the system at the individual, organizational and inter-organizational levels. This will improve the capability and capacity of the workforce by adopting and training providers on evidence based approaches and enabling staff to work to the fullest extent of their scope of practice to improve patient centeredness and outcomes. CNYCC partners will adopt common clinical guidelines and protocols for patient care and coordination of care within and across organizations. Finally, the HIT/HIE approach, including EHR adoption and the creation of a community wide population health management platform will enable coordination of care across the continuum, as well as the identification and tracking of high risk populations.

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.

CNYCC will leverage existing organizational and system resources, facilitated through a new non-profit entity, reflecting the diversity and commitment of the four partner organizations. The PPS region is home to three Health Home agencies (Central New York Health Home Network, St. Joseph Home Health and Onondaga Case Management Services Health Home) which cover all counties in the PPS service area, as well as two locally based and operating Managed Long Term Care Plans (VNA Homecare Options and Senior Network Health). The experience and capacity of these organizations, providing intensive case management to chronically ill and frail disabled individuals to maintain their care in the community, serves as a foundation for the expansion of care coordination and service integration activities. With regard to primary care, more than 40

certified Patient-Centered Medical Homes (PCMH) exist in the PPS network, with more than half at Level 3 accreditation in 2014, and CNYCC partners have initiated local efforts to expand and ensure the preservation of the primary care safety net. For example, the merger of the operation and management of three primary care practices in Oswego County under the auspices of Northern Oswego County Health Services, Inc., a Federally Qualified Health Center. The expertise of these providers will be leveraged through an intra-network learning collaborative to support the development of an integrated delivery system and attainment of PCMH Level 3 certification by all eligible providers.

The current Health Information Technology (HIT) infrastructure of the CNYCC is characterized by a well- established Health Information Exchange (HIE) via the HealtheConnections RHIO, and a high rate of EMR adoption (~70%). Currently, all of the CNYCC hospitals, some ambulatory providers, and a majority of the diagnostic centers (lab and radiology) in the region share information with the RHIO. Access to this information is facilitated through a web based portal that can be made available to any provider with appropriate consent, as well as through results delivery. As part of this project, the CNYCC and the RHIO will collaborate to establish additional bi-direction, real-time, and near real-time data transmission from and to all eligible providers. Point-to-point communications to facilitate transitions of care are currently accomplished through the use of Direct protocols, a HIPAA compliant mode of exchange adopted by EMR vendors as part of MU stage 2. This real time mode of exchange is widely available across the CNYCC region, with 71% of eligible providers on the SureScripts network compared to 21% for the rest of the state. Web-based, secure messaging portals that support Direct will need to be made available to partners without EMRs, or whose current EMRs are not MU certified.

By DY 3, data sharing and collaboration will be bolstered by the implementation of a population health management platform that will combine data from the RHIO, discrete clinical data from partner EMRs, and additional data from relevant sources (e.g. Claims). This platform will allow for the creation and real-time maintenance of shared care plans that can follow the patient throughout the continuum.

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.

Among the primary challenges for developing an integrated delivery system (IDS) is the alignment of vision with organizational culture. The process of alignment is ongoing and supported by a CNYCC governing structure designed to be participatory, transparent and effective. Still, staff ownership of integration processes must be promoted to support the alignment of vision with organizational culture. The PPS proposes to achieve this via the use of a learning collaborative model. This will allow for key stakeholders to come together and to consider experiences across geography, levels of care, and service types; as well as fostering communication and transparency, essential for collaboration, and serves as a vehicle for education, training and problem solving.

An IDS requires a shift in emphasis from providers to patients. To support this shift, the PPS will require multiple inputs in order to be responsive to the needs of Medicaid members and stakeholders. As such, rapid cycle evaluation and annual CNAs will be implemented to facilitate ongoing monitoring to drive continuous quality improvement (QI) processes and service planning. The learning collaborative work will be rooted in the data driven rapid cycle QI approach.
Lack of coordination for clinical and health related services across the continuum of health are also recognized as a barrier to achieving PPS goals. The Clinical Governance Committee (described Section 2) will be responsible for overseeing PPS care delivery, care coordination, quality standards and project quality performance, including the development of standardized processes, evidence-based pathways, and uniform metrics for reporting by partners.
Coordination activities are hindered by the fact that 30% of eligible providers do not have EMRs, or have EMRs that are not capable of sharing information. For these providers, EMRs will be secured through a CNYCC facilitated vendor selection process. The CNYCC also lacks a centralized data analytics and population health management platform. These technologies will be implemented by DY 3 and will support coordinated care management, integrated service strategies and the tracking of at-risk populations. Standardization of reporting requirements and clinical documentation, as well as expanded data sharing through the local RHIO will help close these gaps in the interim.

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.

Through this project, CNYCC will coordinate and collaborate with the neighboring Samaritan Medical Center and Finger Lakes PPS to create a cross-PPS partnership to best serve the shared patients within the overlapping service areas. CNYCC shares the same Regional Health Information Organization (RHIO) with the neighboring PPSs. This is advantageous to all PPS's in that with patient consent, clinical information can be securely shared amongst providers regardless of which PPS they are participating with. This helps to ensure that providers in both

PPS's can work efficiently and effectively amongst each other to ensure the best patient outcomes. Discussions have begun with these PPSs to discuss plans for collaboration. CNYCC will work closely with the implementation teams of other PPSs to identify overlap and areas for collaboration and facilitate coordination. CNYCC anticipates sharing all public engagement media materials and campaigns across regions and collaborating on their development. CNYCC also intends to integrate best practice sharing into all communications with neighboring PPSs. Adopting a learning collaborative model will allow the PPSs to capitalize on one another's resources and skills to provide better, whole patient care to the targeted population.

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

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

The comprehensive strategy and action plan for health services planning will be an inclusive and data- driven process, informed by a wide variety of inputs (e.g. rapid cycle evaluation, CNA, PPS learning collaboratives, workforce assessment and population health management reporting and analytics). The process will be overseen by the PPS Board of Directors, a representative body accountable for DSRIP project performance.

At present, CNYCC does not anticipate a reduction in beds based on available information. In evaluating workforce and potential bed reduction impacts of DSRIP across the network over 5 years, CNYCC utilized a calculated methodology to evaluate the impact on inpatient providers across the PPS. Using the following methodology, CNYCC expects changes in utilization to impact variable costs of participating providers, rather than the more fixed costs associated with licensed beds. The methodology included the following steps: 1) Determined the overall impact of a 25% reduction of preventable hospital visits – 25% of PPV, PPR, PDI, and PQI rates for each of the 6 PPS counties and multiplied it by the Medicaid population to estimate number of reduced admissions and ED visits; 2) Allocated the reduced visits/admissions based on county utilization / market share statistics (reported from dashboards); 3) Evaluated the reduction in ED visits and Inpatient Admissions in total across the PPS inpatient facilities and by each individual facility; 4) Evaluated the impact on work force by comparing the average patient hours per day or ED visit to the total number of reduced admissions and ED visits; and 5)Evaluated the impact on bed reduction by comparing the average length of stay to the total number of reduced admissions.

In total, the reduction of inpatient admissions appeared significant; however, once this number was evaluated at a facility level the reduction was not significant in terms of the inpatient daily census. Even so, CNYCC will be well-positioned to advise partners regarding the appropriate level of services, based on the correlation of clinical and claims data via the analytic

infrastructure of the PPS, as well as the resources the PPS will provide for partner education, strategic planning and targeted regional assistance. DSRIP presents an opportunity for organizations, even financially challenged ones, that understand and plan for service transformation and changes in payment methodologies.

Transformation of the health care system may necessitate market-restructuring which may include the need for organizations to right-size or re-purpose their systems of care.

CNYCC will provide the structure and technical support, as well as the resources and operating systems for engaging providers, employees, and community-based organizations in practical service delivery change as evolutions in the market occur across a six-county region. Beyond DSRIP, CNYCC will develop the knowledge, analytical infrastructure, and professional expertise to accept Medicaid post-FFS payment methodologies.

CNYCC governance will monitor and control the network's performance through a professional, full staffed operating structure, accountable to a representative and capable Board of Directors. CNYCC Operations will involve project and performance improvement professionals, systems support managers, and Board liaison and Partner Outreach staff. The Chief Medical Officer and Performance Improvement Director, relying upon CNYCC analytics function, will track a dashboard of project deliverables and milestones monthly. They will identify issues and recommend solutions.

Staff will generate monthly reports for the Board on project and financial performance, including variance reporting, areas of success and areas in need of improvement. Board Committees will monitor Project Work Teams, identifying performance lags or missed goals, flagging these for Operations and Board.

The development of community-based services will emanate largely from the recruitment, training/retraining and/or redeployment of providers into community settings. Milestones will include contractual agreements (DY0), formal meetings (DY0-5), provider and staff training on integrated delivery system protocols and processes (DY0-5), provider compensation (DY2) and performance management systems (DY3), and the aforementioned inputs of rapid cycle evaluation (DY1-5) and the CNA (DY0-5).

Providers and organizations which sought CNYCC PPS membership have been included where they provide meaningful services within the region. PPS participation contracts will be developed with all Partners, as well as with necessary non-Partner community based organizations. Some organizations may choose participation contracts only, especially where they may be involved in projects with more than one PPS or where their specific project role is limited. Identifying and contracting with non- partner, participation-only organizations will be completed during implementation planning, January- March 2015.

In recognition of the fact that HIT and HIE will play a critical role in enabling integrated care delivery and effective population health management, the CNYCC has developed a comprehensive strategy addressing four key areas: 1) Core Application Systems – CNYCC will establish a "core application systems" enablement program focused on first, standardizing EMR environments across eligible provider's offices, as well as implementing a program to rollout EMRs to physicians without this capability. Second, implementing a centralized revenue cycle environment focused on standardizing front end functions to help manage referrals and scheduling across the network, as well as back end functions for managing DSRIP funds flow into/out of CYNCC. Third, implementing a centralized Population Health

Management solution to enable collaborative care delivery and the centralized tracking of at-risk populations. 2)Data Management, Analytics and Content – CNYCC will implement a shared data warehouse and business intelligence environment to foster information availability and insights. This will be accomplished 2 ways; the RHIO's clinical data warehouse for clinical and quality based analytics, supplemented by a solution implemented by CNYCC to focus on operational, financial and service level management reporting and analytics. In the interim, CNYCC will utilize manual data collection and local reporting capabilities in conjunction with the data available through the MAPP portal. Strong data governance will also be employed to ensure that data collection and documentation are standardized across CNYCC.3)Interoperability, Connectivity and Security – Securely connecting stakeholders to allow access to consolidated patient data and enable information sharing will be accomplished through the RHIO. Functions provided by the RHIO include creating standard patient identification, transforming and standardizing data from multiple points of origin, "pushing" summary data to connected physicians where possible, managing the exchange of unstructured data (i.e. Images/RAD) and providing alerts to CNYCC providers. Direct protocols will also be utilized for point-to-point connections to exchange clinical documentation to facilitate transitions of care. Web-based, secure messaging portals that support Direct will be made available to partners without EMRs to facilitate the secure exchange of information among all applicable CNYCC partner organizations. 4) Engagement Technologies– Data consolidated in the RHIO will be available to eligible providers through the existing web-based portal. In addition, the selected population health management solution will also provide role based access to consolidated data for care coordination resources across the continuum of care. Execution of this strategy will ensure that the HIT infrastructure available to the CNYCC will provide a framework that enables the creation of an integrated delivery network.

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

The PPS formation of the non-profit membership corporation serves as the basis for its stability, sustainability, and ability to mature as an effective integrated delivery network. The organization and structure is broadly representative, intended to generate a high-degree of learning and to require multiparty collaboration. These features are necessary to achieve effective DRSIP performance and, beyond that, to develop a capable contracting vehicle for Medicaid managed care organizations in the expected post fee-for-service environment.

The PPS funds flow model embeds functions, measurements, transparency and trust-building in the process of governing the organization and managing DSRIP projects. These elements are intended to inform and develop partners' knowledge and skills in anticipation of a changed Medicaid payment system. The PPS expects to tie partner rewards to performance by objective measures by DY2. The network will develop a comprehensive strategy for moving beyond incentive payments for organizational behavior to shared rewards for improvement metrics involving system performance.

The Board has the structure, the processes and the resources to enable success. The Board retains responsibility for selecting Directors and Officers, approving committee members, adopting PPS policies, hiring management beginning in DY1, as well as maintaining accountability, and overseeing project performance, rewards, planning and budgets over the life of the DSRIP project and beyond. Directors are accountable for DSRIP project performance. Board committees encompass all the critical functions – clinical governance, data integrity and ongoing information management, funds flow and compliance accountability – and assume these roles in DY1.

The charge of the 1) Clinical Governance and 2) Information Technology and Data Governance Committees is especially relevant to the development of an integrated delivery system. These 11 member committees to be formed in DY1 will possess expertise in differing professional disciplines and settings. The Clinical Governance Committee is responsible for overseeing PPS care delivery, care coordination, quality standards and the quality performance of DSRIP Projects, including the standardization of care management processes and evidence-based pathways in DY2 which are hallmarks of integrated delivery systems.

The Information Technology and Data Governance Committee is responsible for oversight of assessment and strategic planning activities related to the technology capacity and systems of partner organizations. The Committee will also evaluate and recommend information technology systems and applications to partner organizations, among other functions. Salient to the development of collaborative care practices and integrated service delivery is the committee's duty to set goals and develop a strategy to advance data reporting as required by DSRIP, including plans for interoperability of data systems and data sharing among partner organizations. The development of data governance principles in DY1 will establish a framework to support the standardization of documentation and sharing of data across the PPS. This activity will be enhanced by the selection and implementation of electronic medical record vendors who support existing interoperability standards such as Direct exchange (point-to-point, provider-to-provider). This governing body will also oversee the establishment of a comprehensive population health management platform by DY3, in which the CNYCC will be able to consolidate standardized clinical and administrative data from all eligible partners in order to: 1) centralize reporting functions; 2) perform advanced population health analytics including clinical and financial risk stratification; 3) develop patient registries to track the populations at-risk and; 4) coordinate care across the continuum.

As a fail-safe mechanism, the PPS co-leads, as Corporate Members, accept responsibility for assuring the network functions and develops properly. Members have accepted additional responsibility for PPS funding, and they have reserved powers to assure proper function. Members' powers are reserved – not to be used casually or arbitrarily – but to provide additional assurance the PPS can function effectively and develop an effective integrated delivery system.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital expenditures will be required to be successful for the purchase and implementation of EHRs for eligible providers who don't currently utilize this technology, or who have an EHR that is not MU certified. Capital funding will also support the purchase and implementation of a population health management solution and a centralized enterprise data warehouse. Investments will also need to be made to support the influx of connectivity to the local RHIO and to expand ongoing efforts around alerting and clinical analytics. Additionally, investment will be needed to implement direct messaging functionality across the continuum of care. As significant transformation in the model of care occurs, market re-structuring may be needed to right- size and re-purpose PPS Partner organizations. Capital will be required to support these organizations to restructure and re-purpose their current operations to respond to these changes in the market and best meet the needs of the population to support DSRIP outcomes. Additional infrastructure needs will be identified through development of the implementation plan.

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
All Metro Health Care, Central Park Rehab and Nursing Center	1915 (c): Care at Home Waiver	ongoing	ongoing	Home Care and Care Management for OPWDD enrolled children under 18 y
Resource Center for Independent Living, The House of the Good Shepherd, ARISE	1915 (c): NY Bridges to Health	ongoing	ongoing	SED & Medically Fragile B2H DD, SED, Medically Fragile Community based services for Medically Fragile Children
Northeast Parent & Child Society, Parsons Child and Family Center	1915 (c): NY Bridges to Health for Children	ongoing	ongoing	B2H for children w/ SED,DD, Medically Fragile
Hillside Children's Center	1915 (c): NY Bridges to Health for Children with SED	ongoing	ongoing	Bridges to Health For children with SED, Medically Fragile and Developmentally Disabled
All Metro Health Care Hospice of Central New York VNA Homecare	1915 (c): NY Care at Home I/II	ongoing	ongoing	Palliative care education from RN and SW as well as Bereavement services to pediatric Care at Home children and their families residing in Onondaga County.. Home Care and Care Management for OPWDD enrolled children under 18 y

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Community Health Center, HCR Home Care, Visiting Nurses of Utica and Oneida County, VNA Homecare	1915 (c): NY Long Term Home Health Care Program	ongoing	ongoing	VNA of Utica & Oneida County provides in the home custodial care services in conjunction with Oneida County DSS within a specific Medicaid budget. Services include MDC, SN, therapy, social work, HHA, PCA, MOW, PERS, transportation etc. This program allowed SNF eligible patients in the community with supportive agency services to remain in their homes vs. permanent placement. Home and community based services for individuals over age 64 and Physically disabled ages 0-64
Access to Independence, All Metro Health Care, ARISE, Community Health Center. Resource Center for Independent Living, Self Direct, St Camillus RHCF, U.S. Care Systems, VNA Homecare	1915 (c): NY Nursing Home Transition and Diversion Medicaid Waiver			Home Care and Care Management Service Coordination Home and community based services for individuals over age 64 and Physically disabled ages 18-64 Home and community based services for individuals over age 64 and Physically disabled ages 18-64 Home and community based services for individuals over age 64 and Physically disabled ages 18-64 Service Coordination, Independent Living Skills Training, Positive Behavioral Intervention and Supports and Structured Day Program services. provide wri

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Cayuga Counseling Services, Hillside Children's Center, Liberty Resources, Northeast Parent & Child Society, Parsons Child and Family Center	1915 (c): NY OMH SED	ongoing	ongoing	crisis response, family support, case management, skill building; Children with SED care coordination, crisis response services, intensive in-home services, respite care, family support services, and skill-building services.
ARISE, E. John Gavras Center, Liberty Resources, SUNY Upstate University Hospital, The ARC Madison Cortland, Salvation Army, Unity House of Cayuga County	1915 (c): NY OPWDD Comprehensive	ongoing	ongoing	OPWDD Day Habilitation, Respite, Service Coordination service coordination, community and residential habilitation Home and Community based for OPWDD Home and Community based for OPWDD Home and Community based for OPWDD Day Hab

Name of Entity	Medicaid/Other Initiative	Project Start	Project End Date	Description of Initiatives
Access to Independence, All Metro Health, ARISE, Comm Health, Liberty Resources, Resource Center for Independent Living, Self Direct, St Camillus, Upstate University Hospital, U.S. Care Systems	1915 (c): NY Traumatic Brain Injury	ongoing	ongoing	Home & Community Care and Care Management Trauma 1 Center provide written plan/abstract, case coordination, and in some cases HCSS. Provide RN assessment/abstr act/supervision, case coordination including modifications, HCSS staff when requested.
ARISE	Balancing Incentive Program	ongoing	ongoing	Non-institutional Long Term Services and Supports
ACR Health	Care manage ment for all	ongoing	ongoing	Health Home Care Management
Kids Oneida, Inc.	Childrens ACT BIP Innovation Fund 1915i like services	ongoing	ongoing	Children's ACT Program
The Salvation Army	DOH's Nursing Home Transition to Independent Living Pilot	ongoing	ongoing	seniors and individuals with a physical disability out of nursing homes, hospitals and shelters back into the community by providing housing subsidies and direct client assistance services
Central New York Services, Inc.	HCBS Waiver OPWDD Medicaid Service Coordination	ongoing	ongoing	Service Coordination

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
St. Joseph's Hospital Health Center	Hospital Medical Home Demonstration Project	ongoing	ongoing	The program, funded by the Centers for Medicare and Medicaid, provides up to $250 million to New York State teaching hospitals and is operated by the New York State Department of Health. The focus of the Hospital-Medical Home Demonstration is to improve health care provided to Medicaid members in sites that train residents to become primary care physicians. Those sites are required to become recognized as Patient Centered Medical Homes by the National Committee on Quality Assurance (NCQA). Hospi
REACH CNY, Inc.	Maternal Infant Community Health Collaborative (funding from NYSDOH, Bureau of Maternal Child Health	ongoing	ongoing	REACH CNY implements the Maternal Infant Community Health Collaborative (MICHC) that works on both the systems and individual/family levels to improve the health of Medicaid-eligible and/or high-risk women of child bearing age and their families. The risks we focus on include lack of insurance, not being connected to health care services, poverty, chronic health conditions, behavioral and mental health risks, and other medical and social determinants of health.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Central New York Services, Inc.	Medicaid Redesign Supportive Housing	ongoing	ongoing	Supportive Housing
VNA Homecare	MLTC	ongoing	ongoing	MLTC
ARISE	Money follows the Person Demonstration grant	ongoing	ongoing	Transition services for Nursing home to Community

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.

CNYCC during implementation planning (January – March 2015) will work with these partners to ensure that this project differs from and/or significantly expands upon these Medicaid initiatives identified.

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

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

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

Implementation Plan and Quarterly Reports shall demonstrate achievement towards the implementation of the IDS strategy and action plan, governance, completion of project requirements, scale of project implementation, and patient engagement progress in the project.

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

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

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

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

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

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

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

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

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

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

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

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

The rationale for Health Home At-Risk Intervention Program is drawn from three key findings at the core of the CNA. First, despite recent growth in primary care capacity, specifically in FQHCs and hospital- based practice sites, targeted efforts still need to be made to strengthen existing capacity and build new primary care capacity, particularly in the region's more rural areas. Second, the impact of chronic medical and behavioral health conditions is dramatic and a major driver of poor health status and inappropriate utilization. Finally, there is a considerable gap in capacity with respect to care management and chronic disease management services as evidenced by the prevalence of chronic disease in the region, the high rates of PQIs and PPVs, and the community perceptions related to poor care coordination and fragmentation of services. The Health Home At-Risk Intervention Program will leverage and promote the further development of the three existing Health Home programs in CNY.

A review of data drawn from the Expanded BRFSS, shows that the rates of the leading chronic medical conditions and their associated health risk factors are all generally higher throughout the region. Three of 6 counties have higher rates of diabetes than the NYS average, 4 of 6 have higher rates of heart disease, 5 of 6 counties have higher rates of asthma, and 6 of 6 have higher rates of high blood pressure.

A review of hospitalization data from NYSDOH's Medicaid Beneficiary Chronic Health Conditions, Inpatient and Emergency Room Utilization data set strongly corroborates findings from the analysis of Expanded BRFSS data, reinforcing the dramatic impact that chronic medical conditions have on resource utilization. In the CNYCC service area, overall the underlying conditions that were at the root of most inpatient admissions for those insured by Medicaid were depression, hypertension, drug abuse, diabetes, and asthma. In 2012, 30,413 Medicaid beneficiaries in CNYCC's service area were categorized in the depression CRG and 30,885 beneficiaries were categorized in the hypertension CRG. Of those categorized with depression, 9,367 had been admitted to the hospital at least once and these beneficiaries accounted for a total of 18,650 admissions. Of those categorized in the hypertension CRG, 8,883 had been admitted to the hospital at least once and accounted for 15,827 admissions. The remaining leading causes of

admission were a mix of chronic medical and behavioral conditions.

A review of the region's PQI data from NYSDOH, representing avoidable hospital inpatient use, shows that 4 of the 6 counties in the service area have higher rates of PQI conditions than the NYS average. Similarly, a review of the Potentially Preventable Visit (PPV) data from the NYSDOH, representing potentially preventable hospital emergency department (ED) visits, shows that 6 of the 6 counties in the PPS' service area have higher rates of PPVs.

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

The target population for this project is a 1-year, unduplicated count of attributed, utilizing and non- utilizing Medicaid members who have only one chronic medical condition or a diagnosis of serious and persistent mental illness (SPMI) or seriously emotionally disturbed (SED) alone, which makes them ineligible for the existing Health Home Program. Based on statewide data provided by the NYSDOH, in 2013 approximately 13.7% of all Medicaid beneficiaries had only one chronic condition and 1.6% of all Medicaid beneficiaries were categorized with SPMI/SED.

The Program will draw from patients served or recruited by participating PCP into the program, as well as potential patients encountered in the community or through existing Health Home outreach activities. These members would not meet the current criteria for Health Homes but are, by the nature of their health statuses are on a trajectory to becoming super-utilizers. The theory is that by intervening with well-coordinated PCMH services that include strong care management through the Health Homes that this project will result in stabilization or reduction in health risk and lead to lower rates of inappropriate inpatient and emergency department utilization.

The project will be implemented initially in existing safety net primary care clinics with PCMH level-3 certification, moving in later stages to practices that could strengthen their operations and achieve level-3 certification over time. The CNA demonstrated all communities throughout the region could benefit from expanding primary care capacity and strength, but that particular emphasis should be made on the service area's more rural areas in Lewis, Oneida, and Madison Counties. Efforts will be made to target those in high-risk demographic groups such as those in or near poverty, in racial/ethnic minority groups, or are refugees or recent immigrants. According to the CNA, 13.1% of the population of the CNYCC region is non-white, 3.6% are Hispanic/Latino, and 5.6% are foreign born. The incomes of 20.9% of the population of the CNYCC region qualify them for Medicaid, of which 69% live below the poverty line. Racial/ethnical minorities and the foreign born population are concentrated in our urban areas of Syracuse and Utica while and pockets of severe poverty are found both in urban centers and rural areas in Lewis, Madison, Oneida, and Oswego.

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.

CNYCC has multiple assets and resources that can be drawn on to facilitate the successful implementation of this program. First, there are already three Medicaid Health Home programs operating in the service area: CNYHHN, Inc. (Central New York Health Home Network), Onondaga Case Management Services, Inc. (Health Homes of Upstate NY – Central), and St. Joseph's Hospital Health Center (St. Joseph's Care Coordination Network). In addition there are existing FQHC and hospital-based safety net clinics, many of whom already have PCMH level-3 certification and have experience with PCMH principles and with integrating their services with the Health Homes. The FQHCs in the area are prime examples of existing practices. There are currently five FQHCs in the CNYCC service area, including East Hill Family Medical Inc. and East Hill Family Medical Inc./Summit Pediatrics, Port Byron Community Health (Finger Lakes Migrant Health Project), Syracuse Community Health Center, and Northern Oswego Community Health Services, Inc. (NOCHSI), Utica Community Health Center. The major hospital-based practices, including practice sites at Upstate University Hospital, St. Joseph's Hospital Health Center, Faxton-St. Lukes, Auburn Community Hospital, Oswego Health, and many other hospitals will also be integral partners to this program.

The CNYCC is also characterized by a well-established Health Information Exchange (HIE) via the HealtheConnections RHIO, as well as a high density of Direct enabled providers (71% of eligible providers on the SureScripts network compared to 21% for the rest of the state). These assets will help ensure timely access to required clinical information and help facilitate collaboration between Health Homes and PCPs. The implementation of a population health management platform by DY 3 will enable advanced analytics including the systematic identification of high risk populations, as well as enhanced collaborative care planning between project participants.

Another asset are the efforts and resources provided by the Health Foundation of Western and Central New York (HFWCNY), which has been an active and important supporter of the region's primary care safety net for many years. They have invested in numerous assessments and strengthening efforts including efforts to promote PCMH, the effective use of HIT, the promotion of population health management ideas, and the application of evidenced-based care management protocols. The HFWCNY is an important partner in these efforts and has pledged to continue to support improvements in these areas moving forward.

In addition to these core partners and assets, all of the counties that are part of the service areas have networks of other health and community service providers that will be formally identified and included in the CNYCC implementation plans. It will be critical that each PCMH and Health Home partnership identify a core set of partners and ensure that information can flow freely between these partners to facilitate care planning, referral, care coordination, and patient monitoring.

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.

Challenges include:
- Engagement of individuals who are high risk but who only have one chronic condition. If CNYCC is not able to identify individuals who are either currently using hospital services inappropriately or at high-risk of using services inappropriately than regardless of the value of the services that are provided, the project will not meet DSRIP goals. Indicators related to demographics, diagnoses, severity levels, and past utilization trends will be applied to properly identify patients or prospective patients. The introduction of a population health management platform by DY 3 will enable the systematic identification and tracking of high risk populations and the ability to track their care throughout the continuum. In the interim, the target population will be tracked through registries or reports built directly in the EMRs of participating partners.

-Transportation is a critical issue for patients. While HH are allowed to provide transportation for patients on a limited basis under the current program, there are still significant transportation challenges which are not merely an issue for those who need to get to health care appointments, but also have a major impact with follow through on treatment regimens, getting to follow-up appointments with specialists, filling prescriptions, and doing other regular activities of daily living. CNYCC intends to provide adequate transportation services for patients via a homegrown service or partnerships in the community, which will alleviate some of the current transportation challenges faced by the target population.

- Coordination activities are hindered by the fact that 30% of eligible providers do not have EMRs, or have EMRs that are not capable of sharing information. For these providers, EMRs will be secured through a CNYCC facilitated vendor selection process. While many of the primary care practices have EHRs many of these EHR systems are not MU certified and would require upgrades or entirely new systems. Implementing these systems effectively also requires initial and on-going training to ensure that practices sites and individual practitioners and using them in meaningful ways. Participating in the RHIO/SHI-NY efforts will also be challenging and will require resources and on-going investments of time to manage the participation in the exchange networks.

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

No neighboring PPSs have selected this project.

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital expenditures will be required to be successful for the purchase and implementation of EHRs for eligible providers who don't currently utilize this technology, or who have an EHR that is not MU certified. Capital funding will also support the purchase and implementation of a population health management solution. Capital funding will also support the modification of participating partners EMRs to enable the tracking of target populations. Investments will also need to be made to support the influx of connectivity to the local RHIO and to expand ongoing efforts around alerting and clinical analytics. Capital expenditures will be required to be successful for EHR implementation, population health management solution implementation to support reporting and analytics, and engagement technologies to facilitate community

engagement. Finally, additional infrastructure needs will be identified through development of the implementation plan.

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
All Metro Health Care	1915 (c): Care at Home Waiver	ongoing	ongoing	Home Care and Care Management for OPWDD enrolled children under 18 y
Hillside Children's Cente	1915 (c): NY Bridges to Health for Children with SED	ongoing	ongoing	Bridges to Health For children with SED, Medically Fragile and Developmentally Disabled
All Metro Health Care	1915 (c): NY Care at Home I/II	ongoing	ongoing	Home Care and Care Management for OPWDD enrolled children under 18 y
HCR Home Care VNA Homecare	1915 (c): NY Long Term Home Health Care Program	ongoing	ongoing	Home and community based services for individuals over age 64 and Physically disabled ages 0- 64

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
All Metro Health Care ARISE VNA Homecare	1915 (c): NY Nursing Home Transition and Diversion Medicaid Waiver	ongoing	ongoing	Home Care and Care Management Service Coordination Service Coordination, Independent Living Skills Training, Positive Behavioral Intervention and Supports and Structured Day Program services.
Hillside Children's Cente Liberty Resources, Inc.	1915 (c): NY OMH SED	ongoing	ongoing	crisis response, family support, case management, skill building; Children with SED
ARISE Liberty Resources, Inc. United Helpers Organization Unity House of Cayuga County Inc	1915 (c): NY OPWDD Comprehensive	ongoing	ongoing	OPWDD Day Habilitation, Respite, Service Coordination Home and Community based for OPWDD
All Metro Health Care ARISE Liberty Resources, Inc.	1915 (c): NY Traumatic Brain Injury	ongoing	ongoing	Home Care and Care Management
ARISE	Balancing Incentive Program	ongoing	ongoing	Non-institutional Long Term Services and Supports
ACR Health	Care Management for All	ongoing	ongoing	Health Home Care Management
Central New York Services, Inc.	HCBS Waiver OPWDD Medicaid Service Coordination	ongoing	ongoing	Service Coordination

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
VNA Homecare	MLTC	ongoing	ongoing	MLTC
ARISE	Money follows the Person Demonstration grant	ongoing	ongoing	Transition services for Nursing home to Community
Unity House of Cayuga County Inc	NYS Balancing Incentive Program	ongoing	ongoing	Non-institutional Long Term Services and Supports
Lewis County General Hospital	VAP and VAP CAH- 3 yr	ongoing	ongoing	VAP and VAP CAH- 3 yr, allows transition of care program development, coordination of health home services, case management (in-house)

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.

CNYCC during implementation planning (January – March 2015) will work with these partners to ensure that this project differs from and/or significantly expands upon these Medicaid initiatives identified.

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

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

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

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

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

2.b.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.

The CNA points to high ED utilization in the region, with 39% of adults and 44% of children surveyed visiting an ED at least once in the past 12 months, and 14% of adults and 17% of children visiting the ED two or more times during this period. An opportunity exists to reduce utilization of the ED in the region, as only 56% of adults and only 34% of children surveyed were seen in the ED for a medical emergency. The remaining visits were because those surveyed 1) did not have a primary care provider, 2) could not been seen by their regular primary care provider due to lack of capacity or after-hours care, or 3) were instructed by their provider to go to the ED. A Milliman study of adult Medicaid patients corroborated the CNA finding s and found that the rate of Potentially Preventable Emergency Visits was higher than the expected rate for 5 out of the 6 counties in the region. Those counties with a higher-than-expected rate experienced an average rate 22% higher than the expected rate. This project will address overutilization of the EDs by non-emergent patients through the use of a cross-functional ED Care Triage team, and by growing and strengthening the primary care network in the region.

Key informant interviews consistently highlighted shortages in primary care services as one of the leading health care challenges, particularly in more rural areas, as well as the need for strengthening operations with respect to PCMH, care coordination, services integration, and the use of evidence-based practice. The CNYCC selected this project as a mechanism for building partnerships with local primary care practices and supporting their PCMH certification to strengthen the primary care network in the region.

The CNA states that a large portion of the unmet need among the low-income population in CNY is due to a lack of primary care engagement and a lack of consumer awareness about the importance of regular primary care, chronic disease management, and prevention. This project will address this challenge by educating patients who are re-directed to the ED Care Triage team about the purpose and importance of primary care and will connect them with the appropriate resources and follow up to facilitate and encourage consumer engagement. CNA findings suggest, communities and primary care practice sites need to collaborate in an effort to reach out to the community at-large to promote healthy behaviors, provide health education, and promote primary care engagement.

The CNA suggests that maintaining medical appointments is challenged by social factors. The combined regional shortages of housing and transportation, especially in rural areas, lead to barriers in accessing healthcare, maintaining medical appointments, engaging in physical activity, and preparing healthy meal items. The cross-functional ED Care Triage team is designed to recognize and address these issues in real-time for each patient receiving the intervention. The team will work to identify the social supports required by the patient and connect them with the appropriate resources in the community. The team will also facilitate transitions of care across settings and follow up with the patient to help ensure that they can maintain their medical appointments and avoid future preventable visits to the emergency room.

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

The target population for this project is a one-year, unduplicated count of attributed, utilizing and non- utilizing Medicaid members who present to participating partners' Emergency Departments, are found to have non-emergent, ambulatory-sensitive conditions upon medical screening examination, and are then either scheduled for a primary care appointment or are connected to their Health Home care manager.

According to Salient data, approximately 36% of our attributed unique Medicaid members had at least one ED visit between February 2013 and March 2014. Unique Medicaid members with at least one non- emergent (ambulatory-sensitive) ED visit from February 2013 to March 2014 represent approximately 23% of our attributed population. Of this population, approximately 32% were ages 0-18, 64.5% were ages 19-64, and 3.5% were ages 65+. Approximately 15% of those patients had more than one non- emergent (ambulatory-sensitive) ED visit in that time period. Of the patients with more than one visit in the last year, 11% were ages 0-18, 78.2% were ages 19-64, and 10.8% were ages 65+.

The primary diagnoses for these patients will be analyzed individually by each CNYCC hospital to determine and implement programs which specifically address the needs of the local region.
Participating providers will collaborate to share ideas and to coordinate methodologies for overlapping conditions.

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.

St. Joseph's Hospital Health Center has an established model for ED care triage, including a systematic way to identify inappropriate utilization, as defined by three or more ED encounters for a patient over a rolling 12 month period. CNYCC will build upon this successful model along with successful pilots occurring in other PPS EDs. The analytics that support ED triage will need to be replicated by HealtheConnections, the regional HIE, which already receives admission notifications from all participating emergency departments and will therefore be able to apply this logic across the entire CNYCC region.

CNYCC hospitals have strong case management and social work programs which will be expanded to include ED triage functions. Physicians will be used within the ED to first conduct the appropriate clinical assessment and determine whether the presenting patient has a non-urgent need and meets the target population criteria. Case managers, social workers, and/or patient navigators will then be used to evaluate the non-emergent patients' health care and social needs. Case managers, social workers, and/or patient navigators will connect patients with a primary care or behavioral health provider or social supports such as housing or transportation needs. CNYCC will leverage relationships and partnerships with community resources to address patients' social needs. Existing primary care providers and community based resources will used to help meet the patients' non-urgent needs.

Community resources were identified in the CNA survey which will be tapped. A total of 44 organizations reported that they provide community-based, non-medical services. These organizations have expertise serving homeless (57% of organizations); women, infants and children (57%); children with special health care needs (41%); migrants/seasonal farm workers (16%); refugees (20%); the uninsured (68%); and other populations (59%).

Linkages will be built with other projects such as 2.a.iii Health Home for at risk patients. CNYCC has three Health Homes in its service area which will be built upon such as Health Home care managers may be embedded in the ED Care Triage teams. Linkages will also occur with many other projects including 2.biv (care transitions), 3.a.i (Integration of primary care and behavioral health), 3.a.ii (behavioral health community crisis stabilization), 3.b.i (evidence-based strategies for cardiovascular disease management), and 3.g.i (integration of palliative care into PCMH) to provide individuals with the appropriate care in the appropriate setting.

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

Successful implementation of ED care triage associated with DSRIP project requirements is anticipated to successfully reduce the number of hospital admissions from high risk cases. However, once the impact of this reduction is calculated across the CNYCC hospital partners, it is anticipated any corresponding reduction to the workforce will be absorbed through attrition or reduction of contract services. Patient steerage to community primary care providers will also increase demand of already constrained primary care and behavioral health services across CNYCC and required additional outpatient resources. This will be addressed in multiple ways including the development of further telehealth capacity in the region, through a comprehensive workforce strategy, and through integration of primary care and behavioral health. In addition, there may be a shortage of case managers, patient navigators, and/or care coordinators with the added need for this category of worker which will be addressed through training and redeployment. Finally, the CNYCC lacks a mechanism to coordinate referrals and appointments across the continuum. Implementing a centralized revenue cycle environment focused on standardizing front end functions will enable the management of referrals and scheduling across the network.

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.

CNYCC will coordinate and collaborate with the neighboring Finger Lakes PPS to implement the ED Care Triage project and to create a cross-PPS partnership to best serve the shared patients within the overlapping service areas. CNYCC shares the same Regional Health Information Organization (RHIO) with the neighboring PPSs. This is advantageous to all PPS's in that with patient consent, clinical information can be securely shared amongst providers regardless of which PPS they are participating with. This helps to ensure that providers in both PPS's can work efficiently and effectively amongst each other to ensure the best patient outcomes. CNYCC will work closely with the implementation teams of other PPSs to identify overlap and areas for collaboration and facilitate coordination. CNYCC also intends to integrate best practice sharing into all communications with neighboring PPSs. Adopting a learning collaborative model will allow the PPSs to capitalize on one another's resources and skills to provide better, whole patient care to the targeted population.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital expenditures will be required for the purchase and implementation of EHRs for eligible providers who don't currently utilize this technology, or who have an EHR that is not MU certified. Investments will also need to be made to expand the current tele-medicine infrastructure and to implement a centralized revenue cycle management. Capital expenditures will be required to be successful for EHR implementation, population health management solution implementation to support reporting and analytics, and engagement technologies to facilitate community engagement. Additionally, investment will be needed to implement direct messaging and provider scheduling across the network. In addition, additional infrastructure needs such as renovations to EDs in order to have space to do triage will be identified through development of the implementation plan.

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
All Metro Health Care	1915 (c): Care at Home Waiver	ongoing	ongoing	Home Care and Care Management for OPWDD enrolled children under 18 y
All Metro Health Care VNA Homecare	1915 (c): NY Care at Home I/II	ongoing	ongoing	Home Care and Care Management for OPWDD enrolled children under 18 y
Community Health Center HCR Home Care VNA Homecare	1915 (c): NY Long Term Home Health Care Program	ongoing	ongoing	Home and community based services for individuals over age 64 and Physically disabled ages 0- 64
All Metro Health Care ARISE Community Health Center VNA Homecare	1915 (c): NY Nursing Home Transition and Diversion Medicaid Waiver	ongoing	ongoing	Home Care and Care Management Service Coordination Home and community based services for individuals over age 64 and Physically disabled ages 18- 64 Service Coordination, Independent Living Skills Training, Positive Behavioral Intervention and Supports and Structured Day Program services.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
ARISE SUNY Upstate University Hospital	1915 (c): NY OPWDD Comprehensive	ongoing	ongoing	OPWDD Day Habilitation, Respite, Service Coordination Home and Community based for OPWDD
All Metro Health Care ARISE Community Health Center	1915 (c): NY Traumatic Brain Injury	ongoing	ongoing	Home Care and Care Management
ARISE	Balancing Incentive Program	ongoing	ongoing	Non-institutional Long Term Services and Supports
ACR Health	Care Management for All	ongoing	ongoing	Health Home Care Management
Central New York Services, Inc.	HCBS Waiver OPWDD Medicaid Service Coordination	ongoing	ongoing	Service Coordination
Central New York Services, Inc.	Medicaid Redesign Supportive Housing	ongoing	ongoing	Supportive Housing
VNA Homecare	MLTC	ongoing	ongoing	MLTC
Central New York Services, Inc. Community Health Center	NYS Balancing Incentive Program	ongoing	ongoing	Housing services & PROS Non-institutional Long Term Services and Supports
ARC of Onondaga	OMRDD Comprehensive	ongoing	ongoing	OPWDD Day Habilitation, Respite, Service Coordination

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Central New York Services, Inc.	Supportive Housing Initiatives	ongoing	ongoing	OASAS & OMH MRT
Lewis County General Hospital	VAP and VAP CAH- 3 yr	ongoing	ongoing	VAP and VAP CAH- 3 yr, allows transition of care program development, coordination of health home services, case management (in-house)

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.

CNYCC during implementation planning (January – March 2015) will work with these partners to ensure that this project differs from and/or significantly expands upon these Medicaid initiatives identified.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

Project Objective: To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Project Description: A significant cause of avoidable readmissions is non-compliance with discharge regiments. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working one-on-one with the patient to identify the relevant factors and find solutions. The following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30-day transition period post-hospitalization.
Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/.

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

1. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2. Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
3. Ensure required social services participate in the project.
4. Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
6. Ensure that a 30-day transition of care period is established.
7. Use EHRs and other technical platforms to track all patients engaged in the project.

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

1. <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.

As described in the CNA, the underlying conditions at the root of most inpatient admissions for those insured by Medicaid are depression, hypertension, drug abuse, diabetes, and asthma. Four of the 6 counties have higher rates of PQI conditions than the NYS average. Further the rates are disproportionately higher in the more rural areas, although there are relatively high rates in pockets throughout the region. Across the region, poor discharge planning was identified as a barrier to preventing avoidable readmissions. High rates of PPRs, PQIs and PPVs are indicative of the need to focus on transitions.

The CNA highlights the need to improve the transition of care after discharge from the hospital with key informants citing limited follow-up between the hospital, post-acute settings, and primary care and behavioral health providers. An opportunity to reduce the rate of readmissions exists, according to an analysis done by JSI. This analysis shows that between February 2013 and January 2014, roughly half (55%) of the readmissions in the sample of three participating hospitals for adult medicine patients were preventable. One hospital provided additional internal data which showed that this rate was even higher for patients with mental health/substance abuse diagnoses, and for those patients discharged to home care or self care.

The CNA states that maintaining medical appointments is challenged by social factors. The combined regional shortages of housing and transportation, especially in rural areas, lead to barriers in accessing healthcare, maintaining medical appointments, engaging in physical activity, and preparing healthy meal items. The cross-functional Intensive Care Transitions team is designed to recognize and address these issues in real-time for each patient receiving the intervention. The team will collaborate to identify the social supports required by the patient and connect them with the appropriate resources in the community. They will also conduct warm handoffs and follow up with the patient to help ensure that patients can maintain their medical appointments to avoid preventable readmissions to the hospital.

The CNA suggests, a portion of unmet need is closely associated with a lack of consumer awareness about the importance of regular primary care, chronic disease management, and preventive services. Interviews indicated that providers often said that while there is absolutely unmet need and a lack of primary care capacity and behavioral health capacity in nearly all of their communities, they often struggle to engage their patients and their target populations in appropriate primary care services. Many providers are keenly aware that even if they increase capacity or develop new sites, there will be a lag in service until they promote primary care engagement effectively. Transition coaching includes patient activation techniques/tools which are intended to increase consumer engagement. The Intensive Care Transitions team will work to address this challenge by educating patients about primary care, behavioral health, and chronic disease management, as well as conducting warm handoffs to ensure continued consumer engagement in the critical days following discharge from the hospital.

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

The target population for this project is a one-year, count of attributed, utilizing and non-utilizing Medicaid members who are admitted as an inpatient to participating partner acute care hospitals with a chronic disease or behavioral health disorder, discharged with a care transitions plan. Excluded from this population are those readmitted within 30 days, estimated based on the Medicaid-specific readmission rate of 11% for three partner hospital . Patients meeting these criteria who are admitted again during the same year, but not within 30 days of their most recent admissions are counted again for each qualifying admission. According to Salient data, during the attribution period there were nearly 12,000 unique attributed Medicaid members with a chronic disease diagnosis with at least one inpatient discharge, accounting for over 21,000 discharges. Taking into account the 11% readmission rate and an estimated combined 25% rate of refusals and loss to follow-up due to inactive phone numbers or for other reasons, we expect to engage 13,500 patients at maximum capacity.

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

This project will build upon existing infrastructures including existing hospital transition programs, care management initiatives and Health Home. CNYCC has a nationally recognized transitions regional coordinator for the Coleman Care Transitions Intervention Program who will expand upon the existing regional cross-setting collaborative team and will build Intensive Transitions Teams.

The Intensive Transitions Teams are a multi-disciplinary team which can be tailored to the hospitals patient volume and patient mix. Team members may include a nurse case manager, social worker, behavioral health-focused provider, Health Home care manager, transition coach (from a home care agency), oversight physician, consulting inpatient pharmacist, pharmacist/pharmacy technician, palliative care nurse, legal advocate, and appropriate post-acute providers. Each hospital and community-based organizations providing transition services will use existing resources to form these teams, or hire/repurpose additional people to the extent that these resources do not currently exist. Existing community health workers and/or laypeople will need to be trained as transition coaches.

Within the region there are existing chronic disease readmission reduction programs in multiple settings including hospitals, home care agencies, skilled nursing, and chronic disease management programs.

These programs will be built upon and weaved into the infrastructure that will be built through the Intensive Transitions Teams.

The implementation of a population health management platform and centralized

enterprise data warehouse will be required to enable the systematic identification and tracking of patients with the highest risk of readmissions. These tool sets will also allow for more efficient collaboration and access to pertinent clinical information, which will help ensure safe transitions of care from inpatient to outpatient settings.

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.

Capacity constraints will be an issue as the lack of necessary resources/capacity in outpatient and community-based settings will limit the ability to schedule timely follow-up appointments which could result in readmissions. Strategies to address this will be through a comprehensive workforce strategy but may include enhanced recruitment efforts to attract a greater number of PCPs to the area and increase the retention rate of graduating residents from local programs, evaluate ways to improve PCP productivity by applying best practices in patient scheduling and mid-level utilization, investigate creative ways to provide care outside of the office setting to increase PCP capacity such as telehealth or home visits.
Another challenge is the ability of community-based resources in rural areas to conduct warm hand-offs in the hospitals. To address this CNYCC will create contingency plans for these patients where additional follow ups and home supports are provided in lieu of a warm hand-off. CNYCC will explore models of care where teleheatlh services are used. The establishment of a population health management platform will also assist this process, by ensuring consistent access to pertinent clinical information.
Interviews highlight the fragmented care received by those with BH issues, particularly for those with co-morbid medical and BH issues. This is largely because the service systems for medical and BH are distinct and silo-ed. The CNYCC's project design directly addresses this challenge. Patients with mental health diagnoses are included in the target population for this project and a BH focused staff will be part of the ITT to ensure that BH issues are appropriately diagnosed and given adequate consideration in the development of a treatment plan upon discharge. Also a Health Home care manager may be embedded in the ITT to address the social issues driving potential readmission in patients with BH issues.

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.

CNYCC will coordinate and collaborate with the neighboring Samaritan Medical Center and Finger Lakes PPS to implement the Care Transitions project and to create a cross-PPS partnership to best serve the shared patients within the overlapping service areas. CNYCC shares the same Regional Health Information Organization (RHIO) with the neighboring PPSs. This is advantageous to all PPS's in that with patient consent, clinical information can be securely shared amongst providers regardless of which PPS they are participating with. This helps to ensure that providers in both PPS's can work efficiently and effectively amongst each other to ensure the best patient outcomes. CNYCC will work closely with the implementation teams of other PPSs to identify overlap and areas for collaboration and facilitate coordination. CNYCC also intends to integrate best practice sharing into all communications with neighboring PPSs. Adopting a learning collaborative model will allow the PPSs to capitalize on one another's resources and skills to provide better, whole patient care to the targeted population.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital expenditures will be required to be successful for the purchase and implementation of EHRs for eligible providers who don't currently utilize this technology, or who have an EHR that is not MU certified. Capital funding will also support the purchase and implementation of a population health management solution and a centralized enterprise data warehouse. Capital expenditures will be required for EHR implementation, population health management solution selection and implementation to support reporting and analytics, and engagement technologies to facilitate community engagement. In addition, additional infrastructure needs will be identified through development of the implementation plan.

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
All Metro Health Care	1915 (c): Care at Home Waiver	ongoing	ongoing	Home Care and Care Management for OPWDD enrolled children under 18 y
All Metro Health Care Hospice of Central New York VNA Homecare	1915 (c): NY Care at Home I/II	ongoing	ongoing	Palliative care education from RN and SW as well as Bereavement services to pediatric Care at Home children and their families residing in Onondaga County. Home Care and Care Management for OPWDD enrolled children under 18 y
Community Health Center HCR Home Care VNA Homecare	1915 (c): NY Long Term Home Health Care Program	ongoing	ongoing	Home and community based services for individuals over age 64 and Physically disabled ages 0- 64

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
All Metro Health Care ARISE Community Health Center St Camillus RHCF VNA Homecare	1915 (c): NY Nursing Home Transition and Diversion Medicaid Waiver	ongoing	ongoing	Home Care and Care Management Service Coordination Home and community based services for individuals over age 64 and Physically disabled ages 18- 64 Service Coordination, Independent Living Skills Training, Positive Behavioral Intervention and Supports and Structured Day Program services.
Cayuga Counseling Services Liberty Resources, Inc.	1915 (c): NY OMH SED	ongoing	ongoing	crisis response, family support, case management, skill building; Children with SED
ARISE Liberty Resources, Inc. United Helpers Organization Unity House of Cayuga County Inc SUNY Upstate University Hospital	1915 (c): NY OPWDD Comprehensive	ongoing	ongoing	OPWDD Day Habilitation, Respite, Sevice Coordination Home and Community based for OPWDD
All Metro Health Care ARISE Community Health Center Liberty Resources, Inc. St Camillus RHCF	1915 (c): NY Traumatic Brain Injury	ongoing	ongoing	Home & Community Care and Care Management

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
ARISE	Balancing Incentive Program	ongoing	ongoing	Non-institutional Long Term Services and Supports
ACR Health	Care Management for All	ongoing	ongoing	Health Home Care Management
The Salvation Army	DOH's Nursing Home Transition to Independent Living Pilot	ongoing	ongoing	seniors and individuals with a physical disability out of nursing homes, hospitals and shelters back into the community by providing housing subsidies and direct client assistance services
Central New York Services, Inc.	HCBS Waiver OPWDD Medicaid Service Coordination	ongoing	ongoing	Service Coordination
Central New York Services, Inc.	Medicaid Redesign Supportive Housing	ongoing	ongoing	Supportive Housing
VNA Homecare	MLTC	ongoing	ongoing	MLTC
ARISE, St Camillus RHCF Unity House of Cayuga County Inc	Money follows the Person Domonstation grant	ongoing	ongoing	Transition services for Nursing home to Community
ARC of Onondaga	OMRDD Comprehensive	ongoing	ongoing	OPWDD Day Habilitation, Respite, Sevice Coordination

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Central New York Services, Inc. Liberty Resources, Inc. Loretto	Supportive Housing Initiatives	ongoing	ongoing	OASAS & OMH MRT MRT initiative HH Housing , crisis bed diversion supportive Housing porject led by the Salvation Army
Lewis County General Hospital	VAP and VAP CAH- 3 yr	ongoing	ongoing	VAP and VAP CAH- 3 yr, allows transition of care program development, coordination of health home services, case management (in-house)
Central New York Services, Inc. Central New York Services, Inc. Community Health Center Liberty Resources Unity House of Cayuga County	NYS Balancing Incentive Program	ongoing	ongoing	Housing services & PROS

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.

CNYCC during implementation planning (January – March 2015) will work with these partners to ensure that this project differs from and/or significantly expands upon these Medicaid initiatives identified.

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.

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.*

The CNA states that a large portion of the unmet need among the low-income population in CNY is due to a lack of primary care engagement and a lack of consumer awareness about the importance of regular primary care, chronic disease management, and prevention. Interviews showed that practice sites often said that they often struggle to engage their patients and their target populations in appropriate primary care services. This project will address the lack of consumer engagement through increased outreach to the low-income population targeted specifically towards educating and engaging consumers in their own care. Furthermore, it will provide patients with the tools and skills to improve their health status.

The CNA also discusses the impact of low health literacy and culture/norms on how individuals access health services, such as a lack of understanding of health insurance or the role of a primary care provider as a coordinator of health care. As a result, CNYCC's approach to this project includes hiring and training laypeople who are informal leaders in their respective communities to help conduct outreach campaigns.

The CNYCC will address the high levels of morbidity and mortality among patients with chronic medical and behavioral health conditions by accessing the target population via community based organizations.

The CNA discusses the importance of taking action at the community level to improve health status, reduce mortality, and reduce inappropriate utilization. The patients targeted by this

intervention will be identified and accessed through a number of community-based organizations, including FQHCs, free clinics, correctional facilities, and domestic violence shelters.
The CNA discusses the need for collaboration among community providers in an effort to reach out to the community at-large to promote healthy behaviors, provide health education, and promote primary care engagement. The target population for this project can be difficult to identify and engage, so a broad range of providers have been identified as partners in this project in order to provide multiple access points for the population. Once activated, the target population will need to be re-engaged at regular intervals. The provider partners in the project will need to collaborate in order to successfully identify and continue to engage the members of the target population.
The CNA cites substantial barriers to care, including administrative barriers to Medicaid enrollment. In response, one of the defined responsibilities of the trained PAM administrator will be to educate uninsured patients about their health insurance options and help them to apply to the applicable program.

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

The target population for this project is a one-year, unduplicated count of attributed uninsured (UI) and low- and nonutilizing (LU/NU) Medicaid members as defined by the State's performance attribution logic, a portion of whom will be engaged via PAM or other patient activation techniques. The PAM methodology is tailored to both patients and caregivers; therefore, it is applicable to both an adult and pediatric population. The patients targeted by this intervention will be identified and accessed primarily through FQHCs, emergency rooms, and hospitals/hospital-based clinics. In addition, some patients may be accessed via Medicaid managed care organizations, free clinics, and other community based settings such as correctional facilities and domestic violence shelters. Emergency rooms were selected as a primary access point for this project in response to the CNA, which states that initiatives in the emergency department setting are often design to identify high utilizers who are uninsured, not linked to primary care services at all, and/or are infrequent utilizers of primary care services. The managed care organizations produce and send reports to providers identifying the Medicaid managed care enrollees that are non-utilizers and low-utilizers. An integrated IT platform may be used to alert providers when one of these patients arrives in their clinic and prompt them to conduct the PAM assessment. Other members of the target population will be captured by asking probing questions about health concerns and insurance status, and then directing patients to appropriate resources. In addition, laypeople who are informal leaders in their respective communities will be recruited to help conduct outreach campaigns as another access point for the target population.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. Please demonstrate that the PPS has network capacity to handle an 11th project and how the PPS is in a position to serve these UI, NU and LU populations. In addition, identify any needed community resources to be developed or repurposed.

The integration of four PPS's into the consolidated CNYCC improved the organization's ability to take on the 11th project by pooling the resources of the region to increase capacity and integrate and coordinate care more effectively for the attributed population.
Partner organizations within the CNYCC include Medicaid Managed Care Organizations, Health Homes, Emergency Rooms, FQHCs and other Community Based Organizations. These partners provide multiple channels to identify, target, and engage the UI, NU and LU populations. An informal survey was conducted to assess the ability of the FQHCs to absorb additional volume and all of them confirmed that they could do so, despite some physical space constraints. In addition, CNYCC intends to recruit and train laypeople in the communities, particularly non-English speaking communities, to provide further targeted outreach for this population.
The following community resources will be trained to conduct the PAM program: Community health workers, case managers, care coordinators, social workers, ambulatory nurses, and laypeople.

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 largest challenge for this project is the ability to identify and capture UI, LU, and NU patients and track them over time. To address this CNYCC will utilize reports from Medicaid MCOs to help identify eligible individuals. Another challenge is the potential lack of motivation of UI, LU, NU population to engage in their care. CNYCC will engage with target population via multiple channels, including in- person and mobile/online engagement, as well as via clinical personnel and laypeople/peers in order to increase chances for establishing a meaningful connection.
CNYCC will also explore use of incentives for patients to participate in PAM activities or reach certain thresholds and will conduct education campaign around potential benefits of coverage and use of preventive services. Initially, EHRs utilized by providers will be built out to accommodate tracking of the target population, including the development of registries and reports. With the establishment of a population health management platform, tracking of these patients, including the care they receive throughout the continuum, will be centralized.
CNYCC may also face cultural biases against seeking care or receiving services among the target population. The PPS will engage members of the applicable communities and train them in the PAM methodology and use that to reach additional members of the community. In addition, low health literacy may be a barrier to effectively administering the PAM tools. The CNYCC will administer the tool in several ways (e.g. spoken or read). For language-related literacy barriers,

laypeople in the non-English speaking communities will be hired and trained. There may also be a lack of interpreters. Adequate pay and other incentives must be used to engage the required number of interpreters to successfully execute this project.

It is anticipated that by successfully implementing PAM, the volume of non-emergent care provided to UI, NU, and LU persons will provide a substantial increase in the demand for outpatient services. As a result, capacity constraints may be magnified beyond what is currently expected. CNYCC will focus its recruitment efforts on PA, NPs, and other physician extenders. CNYCC will also focus on a variety of methods designed to increase the efficiency of managing the utilization of care from heavy users to free up capacity.

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.

CNYCC will coordinate and collaborate with the neighboring Basset, Samaritan Medical Center and Finger Lakes PPS to implement the PAM Patient Activation project and to create a cross-PPS partnership to best serve the shared patients within the overlapping service areas. CNYCC shares the same Regional Health Information Organization (RHIO) with the neighboring PPSs. This is advantageous to all PPS's in that with patient consent, clinical information can be securely shared amongst providers regardless of which PPS they are participating with. This helps to ensure that providers in both PPS's can work efficiently and effectively amongst each other to ensure the best patient outcomes. CNYCC will work closely with the implementation teams of other PPSs to identify overlap and areas for collaboration and facilitate coordination. CNYCC also intends to integrate best practice sharing into all communications with neighboring PPSs. Adopting a learning collaborative model will allow the PPSs to capitalize on one another's resources and skills to provide better, whole patient care to the targeted population.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital funding will support the modification of participating partners EMRs to enable the tracking of target populations and their associated Patient Activation Measures. It will also support the purchase and implementation of a population health management solution. Additional infrastructure needs will be identified through development of the implementation plan.

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
Cayuga Counseling Services Liberty Resources, Inc.	1915 (c): NY OMH SED	ongoing	ongoing	crisis response, family support, case management, skill building; Children with SED
Liberty Resources, Inc.	1915 (c): NY OPWDD Comprehensive	ongoing	ongoing	Home and Community based for OPWDD
Liberty Resources, Inc.	1915 (c): NY Traumatic Brain Injury	ongoing	ongoing	Home Care and Care Management
ACR Health	Care Management for All	ongoing	ongoing	Health Home Care Management
Lewis County General Hospital	VAP and VAP CAH- 3 yr	ongoing	ongoing	VAP and VAP CAH- 3 yr, allows transition of care program development, coordination of health home services, case management (in-house)

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.

CNYCC during implementation planning (January – March 2015) will work with these partners to ensure that this project differs from and/or significantly expands upon these Medicaid initiatives identified.

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.

There is clear and overwhelming evidence from the needs assessment as to the mental health and substance abuse needs of the population to be served by the CNYCC and the lack of resources to do so. Behavioral health conditions (i.e., critical risk groups (CRGs) labeled as depression, drug abuse, chronic stress/anxiety, chronic alcohol abuse, schizophrenia, bi-polar, and other chronic mental health diagnoses) were a more significant driver of inpatient and emergency department utilization for Medicaid-insured populations than were chronic medical critical risk groups. Specifically, a review of 2012 data for the Medicaid beneficiaries in the CNYCC service area shows that there were 88,967 beneficiaries categorized in various chronic behavioral health-related CRGs. Of these beneficiaries, 20,459 had at least one inpatient admission, and in total these beneficiaries accounted for 63,834 admissions. This translates to 59% of the top ten inpatient drivers of admission were from Medicaid beneficiaries with a behavioral health CRG designation, compared to 41% from beneficiaries with a chronic medical CRG. In the emergency department, the impact of behavioral health was even more dramatic. Data from 2012 shows that there were 45,336 beneficiaries categorized in a behavioral health-related CRG that had at least one emergency department visit, and in total these beneficiaries

accounted for 172,013 visits. Of the top ten emergency room drivers, 66% of visits compared to 34% for Medicaid patients with a chronic medical CRG assignment. These dramatic numbers may in part be due to a shortage of mental health providers in the CNYCC area. All counties are federally designated as mental health shortage areas for the Medicaid-eligible population (and entire county populations in the case of Lewis, and Madison). The sheer number of Medicaid beneficiaries with a mental health or substance abuse condition and the number of emergency department visits and inpatient admissions from beneficiaries with these conditions also justifies the focus on integration of medical care into behavioral health organizations. Additional justification is based on data specific to medical and mental health co-morbidity. Although data is lacking on such co-morbidity for the CNYCC area specifically, research conducted nationally indicates that 69% of those with a mental health disorders also have a medical condition, and 29% of those with a medical condition have a mental health disorder. Applying such proportions to the large number of CNYCC's Medicaid population with a mental health disorder indicates the need for medical integration into behavioral health settings, which often serve as the setting in which persons with mental health conditions feel most comfortable and where they receive the majority of their care. Developing integrated programs can help alleviate these needs through increasing behavioral health capacity within the system and reducing the number of inpatient admissions and emergency department visits for behavioral health conditions and co-morbid behavioral health and medical conditions.

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.

For integrated behavioral health into primary care, the targeted population is a one-year, unduplicated count of attributed Medicaid members with primary care visits seen in participating primary care sites for behavioral health screening (such as the PHQ-9 and/or SBIRT). For integrated medical care into behavioral health, the targeted population is a one-year, unduplicated count of attributed Medicaid members with behavioral health diagnoses seen in participating practices for medical screening and patients with medical conditions or preventive health care needs treated or referred on to treatment.

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 CNYCC has multiple assets and resources to draw upon to do this work. These include FQHC providers and the hospital-associated practices, which constitute the majority of providers who serve Medicaid patients in the area. The FQHC providers, many of which are already doing integrated care at some level and will upgrade their integrated services to include universal screening for behavioral health and the institution of evidence-based practices. The FQHCs in the area are: East Hill Family Medical Inc. and East Hill Family Medical Inc./Summit Pediatrics, Syracuse Community Health Center, Utica Community Health Center, Fort Byron Community

Health and Northern Oswego Community Health Services.

Additionally, St. Joseph's and Upstate have associated outpatient clinics that can serve as resources. Of the primary care clinics involved, nine are already doing integrated care at some level and are committed to fulfilling all of the integrated care requirements, most notably universal screening and the implementation of evidence-based practices. The primary care clinics not yet certified as PCMH Level III are in the process of earning this certification and all will have achieved it by year three of the DSRIP demonstration. Additionally, there are multiple behavioral health and substance abuse providers in the CNYCC as well. They include Oswego Health Behavioral Health, Cayuga County Mental Health, Neighborhood Center, Farnham Family Services, Lewis County Community Health, Neighborhood Center, Insight House Chemical Dependency, ARISE, Liberty Resources, Bridges (Madison County), Onondaga Case Management Services, Crouse Hospital's Chemical Dependency Treatment Center, Hutchings Psychiatric Center, Onondaga Case Management Services, Salvation Army, CNY Services, Harbor Lights, Confidential Help for Alcohol and Drugs, St. Joe's Outpatient Behavioral Health, and Syracuse Behavioral Health. Several of these clinics have been offering integrated services for a number of years and are committed to enhancing their programs to meet the full DSRIP requirements for this project. The behavioral health providers also serve as a resource to the primary care sites that are integrating behavioral health. They may enter into subcontract agreements to provide behavioral health staff to primary care, offer training and/or technical assistance related to behavioral health, and serve as referral partners in cases where patients may require referral out of primary care for optimal health outcomes.

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 challenges integrating BH and PC. In rural areas, there may not be sufficient patient populations within the PC settings to justify a full-time BH provider. Solutions for this may be to employ an IMPACT-based model, whereby there is a case manager on site and the PCP receives enhanced training to care for patients with depression. The case manager assists the PCP in managing such patients, with access to a psychiatrist. Thus, the case manager can adopt other roles within the clinic, which makes the hire more efficient.

Given the differences in training and culture between BH and physical health, it can be a challenge for sites that are newly integrating. It takes time and training to learn how to share in the responsibility for a patient, to conduct warm hand-offs, and to develop joint care plans. CNYCC partners suggest that there is a central support team for this; for example, employing a learning collaborative approach where all integrating practices join together to learn from one another as well as engage external training where needed.

The CNYCC also lacks a systematic way to track target populations. Introduction of a population health management platform by DY 3 will enable the systematic identification and tracking of high risk populations and the ability to track their care throughout the continuum. In the interim, the target population will be tracked through registries and/or reports built directly in the EMRs of participating partners.

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.

CNYCC will coordinate and collaborate with the neighboring Basset, Samaritan Medical Center and Finger Lakes PPS to implement the Integration of Primary Care and Behavioral Health project and to create a cross-PPS partnership to best serve the shared patients within the overlapping service areas. CNYCC shares the same Regional Health Information Organization (RHIO) with the neighboring PPSs. This is advantageous to all PPS's in that with patient consent, clinical information can be securely shared amongst providers regardless of which PPS they are participating with. This helps to ensure that providers in both PPS's can work efficiently and effectively amongst each other to ensure the best patient outcomes. CNYCC will work closely with the implementation teams of other PPSs to identify overlap and areas for collaboration and facilitate coordination. CNYCC also intends to integrate best practice sharing into all communications with neighboring PPSs. Adopting a learning collaborative model will allow the PPSs to capitalize on one another's resources and skills to provide better, whole patient care to the targeted population.

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

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

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

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

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

speed and patient engagement, please complete the following information:

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

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

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

Yes	No
☒	☐

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

Capital expenditures will be required to be successful for the purchase and implementation of EHRs for eligible providers who don't currently utilize this technology, or who have an EHR that is not MU certified. Capital funding will also support the purchase and implementation of a population health management solution. Capital funding will also support the modification of participating partners EMRs to enable the tracking of target populations. Finally, capital expenditures will be required EHR implementation, population health management solution implementation to support reporting and analytics, and engagement technologies to facilitate community engagement. In addition, for construction and renovations are required to expand the capacity of primary care and integrate primary care and behavioral health services.

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
Kids Oneida, Inc.	Childrens ACT BIP Innovation Fund 1915i like services	ongoing	ongoing	Children's ACT Program
Lewis County General Hospital	VAP and VAP CAH- 3 yr	ongoing	ongoing	VAP and VAP CAH- 3 yr, allows transition of care program development, coordination of health home services, case management (in-house)
Syracuse Behavioral Healthcare	Supportive Housing Initiatives	ongoing	ongoing	MRT Housing/case Management: OASAS
VNA Homecare	MLTC	ongoing	ongoing	MLTC

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.

CNYCC during implementation planning (January – March 2015) will work with these partners to ensure that this project differs from and/or significantly expands upon these Medicaid initiatives identified.

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.

Drawing from the Expanded BRFSS, behavioral health conditions such as poor mental health and alcohol abuse are more prevalent among adults in the region versus statewide. The county rates for these conditions are also considerably higher in Cayuga, Oneida, Onondaga, and Oswego. Specific to the Medicaid-insured population, behavioral health conditions (i.e., critical risk groups (CRGs) labeled as depression, drug abuse, chronic stress/anxiety, chronic alcohol abuse, schizophrenia, bi-polar, and other chronic mental health diagnoses) were a significant driver of inpatient and ED utilization. A review of 2012 data for Medicaid beneficiaries in the CNYCC service area indicates 88,967 beneficiaries were categorized in various chronic behavioral health-related CRGs. Of these beneficiaries, nearly 1 in 4 had at least one inpatient admission and more than half (59%) of the top ten drivers of inpatient admission were beneficiaries with a behavioral health CRG designation, as compared to beneficiaries with a chronic medical CRG (41%). In the ED, the impact of behavioral health was even more dramatic. Based on 2012 data, 45,336 beneficiaries categorized in a behavioral health-related CRG had at least one EDvisit and 66% of the top ten ED drivers were by Medicaid enrollees with a behavioral health versus a chronic medical (34%) CRG assignment. These dramatic numbers may be due in part to a shortage of mental health providers in the CNYCC area, as well as consumers' lack of knowledge on how or where to access care outside of business hours. Relative to CAHPS national benchmark data, many adults in CNY (32%) did not know what to do if they needed care on nights, weekends, or holidays, compared to adults nationally (17%).

All counties are federally designated as mental health shortage areas for the Medicaid-eligible population (and entire county populations in the case of Lewis and Madison). Additionally, 32% of adults in CNY (2013 JSI survey) did not know what to do if they needed care on nights, weekends, or holidays as compared to 17% of adults nationally. And so persons experiencing a mental health crisis seek care, or are referred to the emergency department due to lack of access emanating from provider shortages, or lack of information about alternatives. Furthermore, they may be admitted more often, given the lack of options for appropriate discharge.

In response, CNYCC intends to expand the reach of existing crisis stabilization services through the establishment of mobile crisis teams in communities where inappropriate inpatient admissions or ED utilization is most pronounced and telepsychiatry resources in rural communities where mental health provider shortages are prominent (e.g. Lewis and Madison). Finally, to support the use of available and emerging community crisis stabilization services,

outreach and education of first responders (fire, police, and school personnel, among others) and the community at-large will be required. Developing and promoting the use of stabilization programs can address the identified needs and hence, reduce ED visits and admissions related to such causes.

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

The target population for this project is a one-year, count of attributed, utilizing and non-utilizing Medicaid members, both children and adults, experiencing an acute behavioral health (mental health and/or substance abuse) crisis in the community or presenting in the emergency department whose conditions can be stabilized outside of the emergency department or inpatient services. Additionally, the population includes children and adults recovering from an acute behavioral health crisis and discharged from the emergency department, inpatient services, extended observation beds, or respite beds for transition to less intensive services or back to the home. This latter group of patients will receive support of the mobile outreach teams to increase the probability of successful transition. The target population includes children and adults in all counties within the CNYCC service area and those individuals meeting these criteria who receive crisis stabilization services from participating sites more than once during the same year, are counted again each time.

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.

St. Joseph's Hospital has a Comprehensive Psychiatric Emergency Program (CPEP) which serves individuals from across the CNYCC area. As per CPEP requirements, it is fully staffed 24/7, and it has both a locked secured area for involuntary patients and a non-secured area for voluntary presentations. Its major components of service: 1) ED evaluation and treatment; 2) extended observation beds; and 3) mobile crisis outreach (MCO). Crisis respite is an additional service that is provided through a linkage agreement with Hutchings Psychiatric Center. CPEP will serve as the hub of intensive services for crisis stabilization for patients whose level of need is greater than can be provided for in their local communities.

The first point of crisis stabilization is within the community with the mobile outreach crisis (MOC) teams. MOC teams will conduct assessments and evaluations and refer the patient to appropriate services, including local behavioral health, respite, ED, CPEP, and/or additional supports for the person to stay in their home. In addition to CPEP, Cayuga and the Neighborhood Center in Utica both have mobile teams and their experience will serve as an asset to be drawn upon as other MOC teams become established. MOC teams can also support patients recovering from a crisis transition from intense to less intense treatment settings and back to their homes.

All EDs within CNYCC are resources and will serve as critical points for crisis intervention and ED

diversion. This is an area where the implementation team for developing crisis stabilization services will work closely with the implementation team for projects 2.a.iii, Health Home and 2.b.iii, ED Triage to develop and implement protocols for the diversion of patients.
Part of the resources to be developed for crisis stabilization includes telepsychiatry, especially related to assessment and evaluation in the more rural areas of the CNYCC region. The telemedicine programs at St. Joseph's and Upstate can serve as an asset and resource in this emerging health technology realm.
For example the Informatics for Diabetes Education and Telemedicine (IDEATel) project at Upstate demonstrated success with collaborative goal setting, improved diet and exercise knowledge, practices, and behaviors, which in turn was associated with reductions in waist circumference and at 2 years among Medicare beneficiaries with diabetes living in rural Upstate NY.
Hillside Children's Center, serving all of CNY, offers behavioral health stabilization for children, including MCO, residential beds, and care management and will serve as an asset and resource for the pediatric population. Liberty Resources (OASAS provider) in Cayuga, which is in the process of developing a pilot mobile crisis team and has crisis stabilization beds available also bring experience and resources that can be developed to care for patients.
There are 3 designated Health Homes and 3 Assertive Community Treatment (ACT) teams in the PPS. These programs offer essential support and case management services and are highly experienced with the target population. They will be an integral part of crisis stabilization services in the region.

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.

Central to this project is the development of crisis intervention services region-wide. The remote nature of communities poses a challenge in terms of assuring timely accessibility to services as well as assuring an adequate psychiatric workforce. One means of addressing this challenge is to employ the use of telemedicine technology to link crisis intervention hubs to spoke locations and facilitate the sharing of specialized psychiatry resources. Training of police, school, and emergency responder personnel to the availability of crisis stabilization services and when and how to access such services is another challenge. Cayuga County has conducted such training and will provide direction and lessons learned in this regard. Transportation has been raised as a challenge for this project. This includes transportation to the ED or assessment/evaluation sites, to CPEP if needed, and to/and from appointments (outside of the crisis incident). ACT programs and/or Health Homes are being considered as potential resources in this area and this issue of transportation more broadly is being addressed by CNYCC. A specific challenge for Lewis County is that there is no inpatient care and the nearest transfer center is Samaritan, which is not participating in the CNYCC. A solution may be for CNYCC to subcontract such services from Samaritan, which provides a potential solution to this issue.

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.

CNYCC will coordinate and collaborate with the neighboring Finger Lakes PPS to implement the integration of Behavioral Health Community Crisis Stabilization project and to create a cross-PPS partnership to best serve the shared patients within the overlapping service areas. CNYCC shares the same Regional Health Information Organization (RHIO) with the neighboring PPSs. This is advantageous to all PPS's in that with patient consent, clinical information can be securely shared amongst providers regardless of which PPS they are participating with. This helps to ensure that providers in both PPS's can work efficiently and effectively amongst each other to ensure the best patient outcomes. CNYCC will work closely with the implementation teams of other PPSs to identify overlap and areas for collaboration and facilitate coordination. CNYCC also intends to integrate best practice sharing into all communications with neighboring PPSs. Adopting a learning collaborative model will allow the PPSs to capitalize on one another's resources and skills to provide better, whole patient care to the targeted population.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital expenditures will be required to expand the current tele-medicine infrastructure be successful for EHR implementation, population health management solution implementation to support reporting and analytics, and engagement technologies to facilitate community engagement. In addition, expenditures for IT may be required to upgrade IT EHR systems to facilitate integrations between behavioral health providers and clinical providers. In addition, additional infrastructure needs will be identified through development of the implementation plan.

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
All Metro Health Care	1915 (c): Care at Home Waiver	ongoing	ongoing	Home Care and Care Management for OPWDD enrolled children under 18 y
Hillside Children's Cente	1915 (c): NY Bridges to Health for Children with SED	ongoing	ongoing	Bridges to Health For children with SED, Medically Fragile and Developmentally Disabled
All Metro Health Care VNA Homecare	1915 (c): NY Care at Home I/II	ongoing	ongoing	Home Care and Care Management for OPWDD enrolled children under 18 y
VNA Homecare	1915 (c): NY Long Term Home Health Care Program	ongoing	ongoing	Home and community based services for individuals over age 64 and Physically disabled ages 0- 64
All Metro Health Care VNA Homecare	1915 (c): NY Nursing Home Transition and Diversion Medicaid Waiver	ongoing	ongoing	Home Care and Care Management Service Coordination, Independent Living Skills Training, Positive Behavioral Intervention and Supports and Structured Day Program services.
Cayuga Counseling Services Hillside Children's Cente Liberty Resources, Inc.	1915 (c): NY OMH SED	ongoing	ongoing	crisis response, family support, case management, skill building; Children with SED

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Liberty Resources, Inc. The ARC Madison Cortland Unity House of Cayuga County Inc	1915 (c): NY OPWDD Comprehensive	ongoing	ongoing	Home and Community based for OPWDD OPWDD Day Habilitation, Respite, Sevice Coordination
All Metro Health Care Liberty Resources, Inc.	1915 (c): NY Traumatic Brain Injury	ongoing	ongoing	Home Care and Care Management
Kids Oneida, Inc.	Childrens ACT BIP Innovation Fund 1915i like services	ongoing	ongoing	Children's ACT Program
Central New York Services, Inc.	HCBS Waiver OPWDD Medicaid Service Coordination	ongoing	ongoing	Service Coordination
Central New York Services, Inc.	Medicaid Redesign Supportive Housing	ongoing	ongoing	Supportive Housing
VNA Homecare	MLTC	ongoing	ongoing	MLTC
Central New York Services, Inc. Liberty Resources, Inc.	NYS Balancing Incentive Program	ongoing	ongoing	Housing services & PROS Non-institutional Long Term Services and Supports
Central New York Services, Inc. Liberty Resources, Inc.	Supportive Housing Initiatives	ongoing	ongoing	OASAS & OMH MRT MRT initiative HH Housing , crisis bed diversion

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Lewis County General Hospital	VAP and VAP CAH- 3 yr	ongoing	ongoing	VAP and VAP CAH- 3 yr, allows transition of care program development, coordination of health home services, case management (in-house)

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.

CNYCC during implementation planning (January – March 2015) will work with these partners to ensure that this project differs from and/or significantly expands upon these Medicaid initiatives identified.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

3.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.

The CNA noted that cardiovascular disease is not only one of the four leading causes of death in CNY, but also the second leading cause of premature death in all six counties in the service area. Since cardiovascular disease is largely preventable, greater emphasis must be placed on implementing evidence-based chronic disease procedures for managing hypertension and education for behavioral health risk factors.
The CNA shows behavioral risk factors, such as smoking, obesity, sedentary lifestyle, and poor nutrition have a significant impact on the progression of cardiovascular disease. In general, smoking and obesity rates are generally higher in the service area compared to the rest of Upstate. The percentage of adults who currently smoke is between 25.4% and 19.3% for all six counties, while the Upstate is 18.9%. In addition, the percentage of obese adults is between 32.0% and 25.7% for 5 out of the 6 counties, while the Upstate rate is 24.3%. Physical activity rates for adults are also lower in comparison to Upstate for 5 out of the 6 counties. Diabetes rates, which also contributes to the progression of cardiovascular disease, are higher across the 6 counties in comparison to Upstate.
In the service area, Medicaid hospital admissions are largely due to either depression or

hypertension. In 2012, 30,885 beneficiaries were categorized with hypertension and 11,974 unique hypertensive members visited a ED. There is a significant overutilization of the ED particularly in more rural areas. In general, 44% of adults visiting the ED cited that they did not have a primary care provider or could not be seen by their primary care provider because of capacity issues and lack of after-hour availability. A number of other factors impact patient access to care. For example, interviewees noted that supplying care to the refugee and immigrant population is challenged by a number of cultural and socioeconomic factors ranging from general understandings of health care, appointment scheduling, and language issues.

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

The target population for this project is a one-year, unduplicated count of attributed, utilizing and non-utilizing adult Medicaid members across the CNYCC six county service area with either pre-existing cardiovascular disease diagnoses or the risk factors of hypertension, hyperlipidemia, or smoking. Based on Salient data, adults (>18) comprise approximately 64% of our attributed Medicaid members. Of those, 22% have diagnoses of cardiovascular disease (including acute myocardial infarction, atrial defibrillation, congestive heart failure, hypertension, ischemic heart disease, and stroke) or hyperlipidemia. According to the CNA, approximately 20% of the adult population of the 6 counties are current smokers, consistent with national estimates that the cite smoking rate among adult Medicaid members at 37% (Vital Health Stat 2009;10(242):68). Locally, rates of smoking are highest in Madison (25.4%), Oneida (25.1%), and Oswego (24.7%) counties, while hypertension is either the first or second most prevalent chronic disease CRG among Medicaid members in all 6 counties and is particularly prevalent among Medicaid members in Oneida (13.38%) and Onondaga (13.13%) counties. The portion of the target population to be engaged in this project are those who either currently or will be prompted to begin receiving ambulatory care at participating primary care and relevant sub-specialty sites, with particular efforts made to implement the program in those counties where cardiovascular disease risk factors are highest.

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

This project will incorporate the involvement of cardiac rehabilitation services, PCMHs, and other provider organizations that have already successfully implemented evidence-base practices from the "Million Hearts Campaign" and leverage these organizations to facilitate in the design of training programs and best practices for other providers. Other partners, such as Emergency Medical Services (EMS), will assist in making referrals for high risk patients to primary care providers. Each provider organization in the PPS will use existing nurse case managers, health coaches, dieticians, oversight physicians, consulting pharmacists, and social

workers to accomplish the project. Existing community health workers and/or community-based organizations will be trained to incorporate health coaches. In particular, community-based organizations assist members of the immigrant and refugee community to train members as health coaches to promote health literacy.
In addition, CNYCC will leverage partnerships with community-based organizations so that high risk patients are tracked and follow-up is conducted to track patient progress in improving their health status and reducing their risk factors for cardiovascular disease. For example, CNYCC will engage with food banks to ensure that heart-friendly foods are provided for patients with cardiovascular risk factors.

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.

Transportation is a barrier to care. To reduce this barrier CNYCC may offer follow-up BP checks with no advanced appointment - allowing patients to visit their local clinic and improve self-monitoring; enable patients to use home BP monitoring so that they are more active in the management of their own care; and incorporate transportation needs during the scheduling process to ensure more reliable transportation and appointment scheduling.
Another challenge is the lack of awareness regarding the importance of regular PC, chronic disease management, and prevention. This project will improve consumer engagement in PC through utilizing EHR systems and promoting patient team visits. EHRs will enable continuous monitoring and engagement with patients and their self-management goals. Additionally, the EHR system will be leveraged to manage population health and identify patients with high risk factors and bring them into care.
CNYCC lacks the HIT infrastructure to systematically identify high risk patients and track their care throughout the continuum. This functionality will be introduced by the implementation of a population health management platform by DY 3. In the interim, the population will be tracked through registries and/or reports built directly in the EMRs. Additional modifications to partner EMRs will need to be made to enable the workflow automation required to prompt the: 1)capture of the data elements that drive the Million Hearts Campaign metrics; 2)scheduling and follow-up of the target population; 3) engagement with patients and their self-management goals.

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.

No neighboring PPSs have selected this project.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital expenditures will be required to be successful for the purchase and implementation of EHRs for eligible providers who don't currently utilize this technology, or who have an EHR that is not MU certified. Capital funding will also support the purchase and implementation of a population health management solution and a centralized enterprise data warehouse. Capital funding will also support the modification of participating partners EMRs to enable the tracking of target populations, their associated Million Hearts Campaign Measures and the required workflow automation. Capital expenditures will be required to be successful for EHR implementation, population health management solution implementation to support reporting and analytics, and engagement technologies to facilitate community engagement. In addition, additional infrastructure needs will be identified through development of the implementation plan.

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
Hospice of Central New York	1915 (c): NY Care at Home I/II	ongoing	ongoing	Palliative care education from RN and SW as well as Bereavement services to pediatric Care at Home children and their families residing in Onondaga County.
VNA Homecare	1915 (c): NY Long Term Home Health Care Program	ongoing	ongoing	Home and community based services for individuals over age 64 and Physically disabled ages 0-64
ARISE St Camillus RHCF VNA Homecare	1915 (c): NY Nursing Home Transition and Diversion Medicaid Waiver	ongoing	ongoing	Service Coordination, Independent Living Skills Training, Positive Behavioral Intervention and Supports and Structured Day Program services.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
ARISE	1915 (c): NY OPWDD Comprehensive	ongoing	ongoing	OPWDD Day Habilitation, Respite, Service Coordination
St Camillus RHCF	1915 (c): NY Traumatic Brain Injury	ongoing	ongoing	Home & Community Care and Care Management
ARISE	Balancing Incentive Program	ongoing	ongoing	Non-institutional Long Term Services and Supports
VNA Homecare	MLTC	ongoing	ongoing	MLTC
ARISE	Money follows the Person Domonstration grant	ongoing	ongoing	Transition services for Nursing home to Community
St Camillus RHCF	NYS Money Follows the Person Demonstration	ongoing	ongoing	Transition services for Nursing home to Community
ARC of Onondaga	OMRDD Comprehensive	ongoing	ongoing	OPWDD Day Habilitation, Respite, Sevice Coordination
Lewis County General Hospital	VAP and VAP CAH- 3 yr	ongoing	ongoing	VAP and VAP CAH- 3 yr, allows transition of care program development, coordination of health home services, case management (in-house)

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.

CNYCC during implementation planning (January – March 2015) will work with these partners to ensure that this project differs from and/or significantly expands upon these Medicaid initiatives identified.

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

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

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

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

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

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

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

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

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

With respect to hospital utilization, the CNA analyzed data drawn from the NYSDOH's Medicaid Beneficiary Chronic Health Conditions, Inpatient and Emergency Room Utilization data set, which reviews hospital inpatient and emergency department utilization specifically for the low

income, Medicaid insured population. A review of hospitalization data from this dataset strongly corroborates findings from the analysis of Expanded BRFSS data, reinforcing the dramatic impact of chronic medical and behavioral health conditions. In 2012, there were 83,329 beneficiaries categorized in various chronic medical health related CRGs. Of these beneficiaries, 30,799 had at least one inpatient admission and in total these beneficiaries accounted for 57,458 admissions. In 2012, 30,413 Medicaid beneficiaries in CNYCC's service area were categorized in the depression CRG. Of those categorized with depression, 9,367 had been admitted to the hospital at least once and these beneficiaries accounted for a total of 18,650 admissions. Given that chronic disease co-occurs with depression at a significant rate, individuals with a chronic condition as a primary or underlying condition are significantly represented in hospital admissions.

A review of hospital emergency department data shows in 2012, 14,867 unique Medicaid beneficiaries in the CNYCC service area were seen in a hospital emergency department with conditions that were categorized in the depression CRG. These beneficiaries accounted for a total of 51,432 emergency department visits. The remaining leading causes of emergency department utilization were a mix of chronic medical and behavioral conditions.

A review of the region's PQI data shows four of the six counties have higher rates of PQI conditions than the New York State average. Further the rates are disproportionately higher in the more rural areas, although there are relatively high rates in pockets throughout the region. Finally, a review of the region's PPV and other emergency department utilization data shows a dramatic overutilization of the emergency department particular in the more rural areas. According to the Center to Advance Palliative Care, approximately 90 million Americans are living with serious and life-threatening illness, and this number is expected to more than double over the next 25 years. By 2020, the number of people living with at least one chronic illness will increase to 157 million. Today, seven out of ten Americans die from chronic disease. In addition, according to a report published by the Dartmouth Atlas of Health Care, 43% of chronically ill Americans in the last 6 months of their lives were enrolled in hospice, compared to 21.3% in the CNY region. Further, most hospice referrals in NY are for brief stays — a week or less -2.5 times shorter than the national average.

CNYCC's high rates of acute care admission and readmissions are due in part to the lack of attention to palliative care and Hospice referrals. Estimates nationally indicate that a quarter of readmissions are potentially preventable with palliative care. Evidence also suggests that symptom management reduces preventable hospital admissions and ED visits.

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

The population for this project is a 1-year, unduplicated count of attributed, utilizing and non-utilizing Medicaid members with diagnoses of life-limiting conditions including but not limited to cancers of the lung, breast, pancreas, gallbladder, bile ducts, stomach, and metastatic cancer; systolic congestive heart failure; COPD; cirrhosis; dementia; ALS; and stroke. The population was further honed to those with 1 or more ED visits; 1 or more inpatient visit; or 3 or more outpatient visits in 3 months. A health severity assessment using a standard screening tool will be used to identify those most at risk of avoidable ED and inpatient use. Discussion about Advanced Directives will be conducted regardless of severity, recorded in the EHR and alerts will be developed to assure PCMHs review and reassess patients on a predetermined basis. The targeting method effectively raises the bar across the entire population in terms of expected standards of care, creates a system of alerts to reassess patient status in order to promote early intervention with palliative care services and, focuses on closing the gap to reduce avoidable hospital care among those individuals with highest need and disease severity. The CNA suggests increasing utilization of palliative care as a key strategy to reduce preventable ED and inpatient utilization among patients with chronic diseases. Furthermore, according to the 2011 Dartmouth Atlas, only 23.5% of the chronically ill CNYers enroll in hospice in the last 6 months of life, compared to 32% of NYers and 51% nation-wide.

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.

Central New York Hospice is currently engaged in a palliative care PCMH integration project. CNYCC will utilize their expertise and build on their experiences. CNY Hospice will share their experiences in the development of protocols and practices; their approach to integrating community resources into PCMH; and their experiences integrating palliative care assessments and services into the clinical workflow. The CNY Hospice work on establishing clinical protocols will serve as a starting point for partners participating in this project, facilitate discussion and ultimately assist in achieving faster consensus and adoption. Additionally, Hospice and Palliative Care, Inc. in New Hartford is a partner in this project and has established a home care to palliative care pathway which will be adopted in the CNYCC region. As part of this system patients receiving home care services are evaluated for palliative care needs, advanced care planning and symptom management, and a palliative care trained nurse case manager is deployed to visit the patient and provide consultation. CNYCC will spread and expand this work to include PCMHs in the palliative care pathway to create a system which identifies and addresses palliative care needs throughout the system and at every stage of a patient's disease process. CNYCC is well poised to establish this project; currently there are 12 practices meeting level 1 certification or above prepared to participate. By nature of their PCMH Level 1 certification they have demonstrated the capability to meet a critical metric for the project, specifically documenting that an Advanced Directive has been discussed. Finally, during the project planning phase, palliative care physicians have been engaged to participate in ongoing implementation planning as well as the development of palliative care consultation teams to assure PCMHs have adequate expertise to integrate and support palliative care 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.

As stated by PCPs, clinicians receive relevant education and training on palliative care, PCP have not routinely incorporated palliative care discussions with patients in the outpatient setting. Patients with chronic conditions, who would warrant a palliative care discussion, often present with new acute medical problems during their visits which clinicians must prioritize over other activities (such as coordination with community organizations and supportive services). Providing social work or secretarial resources to the PCP to allow them to "warm transfer" a patient to cover the referral to a community based partner is critical. Smaller practices are challenged by lack of “bandwidth” to engage in clinical change processes and have inadequate patient volume to support the hiring of dedicated staff. CNYCC will develop centralized training support, provide feedback to clinicians on relevant performance measures, assist with development of prompts and notifications for ongoing non-urgent care, provide change management support and work across provider organizations to share resources and enable smaller practices to effectively accomplish this work in a scale relevant to the size of their patient population. CNYCC also lacks a systematic way to track populations. Introduction of a population health management platform by DY 3 will enable the systematic identification and tracking of high risk populations and the ability to track their care throughout the continuum. In the interim, the population will be tracked through registries or reports built directly in the EMRs.

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.

CNYCC will coordinate and collaborate with the neighboring Basset PPS to implement the Integrate Palliative Care into PCMH and to create a cross-PPS partnership to best serve the shared patients within the overlapping service areas. CNYCC shares the same Regional Health Information Organization (RHIO) with the neighboring PPSs. This is advantageous to all PPS’s in that with patient consent, clinical information can be securely shared amongst providers regardless of which PPS they are participating with. This helps to ensure that providers in both PPS’s can work efficiently and effectively amongst each other to ensure the best patient outcomes. CNYCC will work closely with the implementation teams of other PPSs to identify overlap and areas for collaboration and facilitate coordination. CNYCC also intends to integrate best practice sharing into all communications with neighboring PPSs. Adopting a learning collaborative model will allow the PPSs to capitalize on one another’s resources and skills to

provide better, whole patient care to the targeted population.

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital expenditures will be required to be successful for the purchase and implementation of EHRs for eligible providers who don't currently utilize this technology, or who have an EHR that is not MU certified. Capital funding will also support the purchase and implementation of a population health management solution. Capital funding will also support the modification of participating partners EMRs to enable the tracking of target populations. Additional Capital expenditures will be required to be successful for EHR implementation, population health management solution implementation to support reporting and analytics, and engagement technologies to facilitate community engagement. Also, additional infrastructure needs will be identified through development of the implementation plan.

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
Hospice of Central New York	1915 (c): NY Care at Home I/II	ongoing	ongoing	Palliative care education from RN and SW as well as Bereavement services to pediatric Care at Home children and their families residing in Onondaga County.
VNA Homecare	MLTC	ongoing	ongoing	MLTC
Lewis County General Hospital	VAP and VAP CAH- 3 yr	ongoing	ongoing	VAP and VAP CAH- 3 yr, allows transition of care program development, coordination of health home services, case management (in-house)

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.

CNYCC during implementation planning (January – March 2015) will work with these partners to ensure that this project differs from and/or significantly expands upon these Medicaid initiatives identified.

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

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

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

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

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

Domain 4 Projects

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

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

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

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

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

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

Entity Name
National Alliance for Mental Illness (NAMI); Prevention Network; CNY Emergency Medical Services; Rural Health Networks; OMH Offices; Public Housing Authorities; Public Housing Authorities; Central OASAS Offices; Law Enforcement; United Way; National Alliance for Mental Illness (NAMI); Prevention Network; CNY Emergency Medical Services

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

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

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community.

Please link the findings from the Community Needs Assessment with the project design. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The CNA demonstrated that mental health and substance abuse are issues at the population level and for the Medicaid population specifically. Population-level indicator examples follow:

-% of adults who are current smokers–range of 19-25% across PPS counties, with all counties (except Lewis) higher than the Upstate NY average of 19%, and all counties below the NY Prevention Agenda (PA) goal of 15%.

-%adults with heavy drinking in the past month-range of 19-23% across PPS counties, with 4 counties (Cayuga, Lewis, Oneida, and Oswego) higher than Upstate NY average of 20%, and all counties below the PA goal of 18%.

-% of adults with poor mental health for 14 or more days in past month-range of 9-15% across PPS counties, with 4 counties (Cayuga, Oneida, Onondaga, and Oswego) higher than Upstate NY average of 11% the PA goal of 10%.

HEDIS measures also show there is need for improved quality of mental health and substance abuse services as illustrated by the following:

-Adherence to antipsychotic medications for people living with schizophrenia-range from 60-76% success across PPS, with 3 counties (Oneida, Onondaga, and Oswego) below Upstate NY rate of 65%.

-Antidepressant medication management (acute phase)-range from 45-57%, success across PPS, with same 3 counties below Upstate NY rate of 51% (which also has plenty of room for improvement).

-Initiation of alcohol and other drug dependence treatment-range from 72-84% success across PPS, with 3 counties (Lewis, Madison, Oneida, and Onondaga) below Upstate NY rate of 78%.

The leading cause of hospitalization (18,650 admissions) and ED use (51,432 visits) in the CNYCC service area is depression. Drug abuse and chronic stress/anxiety is the third and sixth leading cause of hospitalization and the third and fifth leading cause of ED use, respectively. Mental health and substance abuse conditions account for 59% and 65% of the top 10 causes of inpatient admissions and ER visits respectively in the CNYCC area for the Medicaid population. Key informants interviewed cited an increasing epidemic of heroin and opiate addiction throughout the CNY region. There is a lack of Mental Health and Substance Abuse infrastructure, with all counties federally designated as mental health shortage areas for the Medicaid-eligible population (and entire county populations in the case of Lewis, and Madison). HRSA's Area Health Resource Files report psychiatrist rates between 0 and 15.2 per 100,000 population, with only Oneida and Onondaga having more than the average across the US. This puts a huge

burden on the already strained mental health substance abuse services system and contributes to unnecessary ED visits and in-patient hospitalizations. Homelessness and lack of a continuum of supportive housing compounds the problem, with persons suffering from mental illness and/or addictions ending up on the streets, entering the ED for shelter and food, admitted for short-term treatment due to lack of alternatives, and then back on the streets to begin the process anew. Strengthening the mental health and substance abuse infrastructure requires a population-based framework, cross-disciplinary perspective and participation, improved linkages between health providers and public health, and a movement of the system toward a more prevention-based focus, which is the purpose of this project. Creating a multi-disciplinary, cross-regional team will focus on both the promotion of MEB prevention, as well as develop and implement strategies to increase early detection and access to evidence-based care. Utilizing data available through the PPS, this team will be positioned to identify key opportunities for prevention interventions, target areas with limited provider access, and impact existing policies, procedures, and programs affecting vulnerable populations.

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

This project will target three separate groups: 1) current tobacco users and youth who have not yet started smoking; 2) heavy alcohol users and youth who have not yet started drinking heavily; and 3) low income persons suffering from mental illness and/or substance abuse. As noted above, rates of cigarette use are higher in the PPS than in Upstate area generally. The adult smoking population is 618,000. Additionally, all youth will be targeted for tobacco cessation or prevention for those who have not started. This results in an additional 225,600 persons for an approximate total of 843,600.

Heavy alcohol use was another area of concern based on the CNA. The estimate of the number of adults who drink heavily across the counties of the PPS is 125,400. All youth will also be targeted in this area for cessation of drinking or prevention before they start. Adding youth to the adult total equals approximately 350,000 in this group.

The CNA clearly identified the high rates of mental health and substance abuse diseases and disorders among the Medicaid population, which will serve as the proxy measure for estimating this group. This population estimate is approximately 144,000 (based on a 60% proportion of the Medicaid-insured population having a mental health and/or substance abuse disorder).

These groups will be engaged throughout all of the counties of the PPS, whether urban or rural dwelling.

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 current assets and resources that will be used to drive this project are the multitude of health, social service, public, and community-based organizations that exist across CNYCC. There are several organizations already that have as their mission to bring together various stakeholders to address systemic issues, including the Prevention Network, the Rural Health Networks in the area, and CNY Emergency Medical Services. It may be during the implementation planning phase that the decision is made that the MEB Health Promotion and Disorder Prevention Partnership is housed and supported out of one of these organizations. The county health departments and OMH offices, the Central OASAS offices, and public housing offices, are also resources to this project and representative(s) from each will be recruited to be on the MEB Health Promotion and Disorder Prevention Partnership and/or any subcommittees or workgroups that evolve from this project over time. Hospitals (inpatient and EDs), Federally Qualified Health Centers, Health Homes, behavioral health organizations, and managed care organizations across the PPS are health systems resources, and organizations such as schools, law enforcement, and legal/criminal justice programs serve as social capital resources across the region that can be drawn upon to serve on the MEB Health Promotion and Disorder Prevention Partnership, various subcommittees or workgroups, or as resources for consultation or input into various activities undertaken in this area. Community-based organizations are also key assets for this area, including homeless and domestic violence shelters, ARISE, United Way, Center for Community Alternatives (jail diversion), 211 (community referrals system coming to CNY in 2015), peer support programs, and Salvation Army serve the region's more vulnerable populations and are, thus, critical assets to this population-focused work. State and local elected officials are important to engage, especially when policy barriers to this work present. CNYCC partners believe strongly that the consumer's voice is essential to reforming and strengthening the system. Advocacy organizations, such as the National Alliance for Mental Illness (NAMI) and ARISE, are one means of incorporating consumers' voices into the project and, thus, are resources for this project. Also, having consumers themselves as part of the MEB Health Promotion and Disorder Prevention Partnership, various subcommittees and workgroups, and/or as a separate consumer advisory board was noted as the most direct means of making sure their voice is heard; in this sense, all residents within the PPS region can be considered resources for this project. Finally, HealtheConnections was recently awarded the PHIP Project, this work has direct overlap with the types of system improvement approaches and CNYCC will work closely with PHIP towards this end.

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.

Key challenges to implementing this project include the lack of standardized MEB prevention strategies in the region, provider shortages, lack of provider connectivity, transportation barriers, and a frequently disengaged targeted population. Utilizing Collective Impact (CI) framework, to guide the formation and operation of the multi-disciplinary, cross-regional collaborative will assist in making large regional and population health strategy changes. This collaborative will offer policies, procedures and practices for the PPS to implement strategies including: identifying standardized MEB prevention strategies drawing on NY State's Prevention Agenda Interventions to Promote Mental Health and Prevent Substance Abuse for the targeted populations, transportation solutions for both rural and urban consumers, 'hotspot' driven strategies for provider placement, increasing provider cultural competencies, and engagement strategies such as Motivational Interviewing techniques.

The CNYCC lacks a systematic way to track target populations. Introduction of a population health management platform by DY 3 will enable the systematic identification and tracking of high risk populations and the ability to track their care throughout the continuum. In the interim, the target population will be tracked through registries and/or reports built directly in the EMRs of participating partners.

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.

CNYCC will coordinate and collaborate with the neighboring Basset, Samaritan Medical Center and Finger Lakes PPS to implement the Strengthen Mental Health and Substance Abuse project and to create a cross-PPS partnership to best serve the shared patients within the overlapping service areas. CNYCC shares the same Regional Health Information Organization (RHIO) with the neighboring PPSs. This is advantageous to all PPS's in that with patient consent, clinical information can be securely shared amongst providers regardless of which PPS they are participating with. This helps to ensure that providers in both PPS's can work efficiently and effectively amongst each other to ensure the best patient outcomes. CNYCC will work closely with the implementation teams of other PPSs to identify overlap and areas for collaboration and facilitate coordination. CNYCC also intends to integrate best practice sharing into all communications with neighboring PPSs. Adopting a learning collaborative model will allow the PPSs to capitalize on one another's resources and skills to provide better, whole patient care to the targeted population.

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

Key milestones include: -Convening MEB Health Promotion and Disorder Prevention Partnership and designate a CNYCC representative by Year 1 Quarter 2. -Utilizing the Intersect Mapping Model to assess MEB activities in the region and identify where programs and consumers intersect with existing activities by Year 1, Quarter 3. -Developing a strategic MEB Health Promotion and Disorder Prevention Plan by Year 1, Quarter 4. -Implementing two short term and two long term objectives from Strategic Plan by Year 1Quarter 4. -Conducting annual reviews of objectives and activities to determine progress and selection of new objectives and activities.

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.

Capital expenditures will be required to be successful for the purchase and implementation of EHRs for eligible providers who don't currently utilize this technology, or who have an EHR that is not MU certified. Capital funding will also support the purchase and implementation of a population health management solution. Capital funding will also support the modification of participating partners EMRs to enable the tracking of target populations. Capital expenditures will be required to be successful for EHR implementation, population health management solution implementation to support reporting and analytics, and engagement technologies to facilitate community engagement. In addition, additional infrastructure needs will be identified through development of the implementation plan.

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
ARISE	1915 (c): NY Nursing Home Transition and Diversion Medicaid Waiver	ongoing	ongoing	Service Coordination
Cayuga Counseling Services Liberty Resources, Inc.	1915 (c): NY OMH SED	ongoing	ongoing	crisis response, family support, case management, skill building; Children with SED

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
ARISE Liberty Resources, Inc.	1915 (c): NY OPWDD Comprehensive	ongoing	ongoing	OPWDD Day Habilitation, Respite, Sevice Coordination Home and Community based for OPWDD
ARISE Liberty Resources, Inc.	1915 (c): NY Traumatic Brain Injury	ongoing	ongoing	Home Care and Care Management
ARISE	Balancing Incentive Program	ongoing	ongoing	Non-institutional Long Term Services and Supports
Kids Oneida, Inc.	Childrens ACT BIP Innovation Fund 1915i like services	ongoing	ongoing	Children's ACT Program
Central New York Services, Inc.	HCBS Waiver OPWDD Medicaid Service Coordination	ongoing	ongoing	Service Coordination
Central New York Services, Inc.	Medicaid Redesign Supportive Housing	ongoing	ongoing	Supportive Housing
VNA Homecare	MLTC	ongoing	ongoing	MLTC
Central New York Services, Inc. Liberty Resources, Inc.	NYS Balancing Incentive Program	ongoing	ongoing	Housing services & PROS Non-institutional Long Term Services and Supports
Central New York Services, Inc. Liberty Resources, Inc. Syracuse Behavioral Healthcare	Supportive Housing Initiatives	ongoing	ongoing	OASAS & OMH MRT MRT initiative HH Housing , crisis bed diversion MRT Housing/case Management: OASAS

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Lewis County General Hospital	VAP and VAP CAH- 3 yr	ongoing	ongoing	VAP and VAP CAH- 3 yr, allows transition of care program development, coordination of health home services, case management (in-house)

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.

CNYCC during implementation planning (January – March 2015) will work with these partners to ensure that this project differs from and/or significantly expands upon these Medicaid initiatives identified.

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.d.i Reduce premature births (Focus Area 1; Goal 1)

Project Objective: This project will help to reduce premature births.

Project Description: Preterm birth, defined as any birth before 37 weeks gestation, is the leading cause of infant death and long-term neurological disabilities in children. Babies born prematurely or at low birth weight are more likely to have or develop significant health problems, including disabling impairments, compared to children who are born at full term at a normal weight. Preterm infants are vulnerable to respiratory, gastrointestinal, immune system, central nervous system, hearing and vision problems, and often require special care in a neonatal intensive care unit after birth. Longer-term problems may include cerebral palsy, mental retardation, vision and hearing impairments, behavioral and social-emotional concerns, learning difficulties, and poor growth. More than 70% of premature babies are late preterm births, delivered between 34 and <37 weeks gestation. While these infants generally are healthier than babies born earlier, they are still three times more likely than full-term infants to die during their first year.

Prematurity can also pose significant emotional and economic burdens on families. In 2010, 11.6% of New York State births were preterm. Babies who are born preterm cost the US healthcare system more than $26 billion annually. In 2007, about 48% of preterm infant hospital stays nationally were paid by Medicaid, the largest source of health insurance for preterm infants. This project is targeted reducing the rate of preterm birth in NYS by at least 12% to 10.2% by December 31, 2017.

Project Requirements: The PPS must undertake actions that address all sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population.

1. Ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for smokers.
2. Provide timely, continuous, and comprehensive prenatal care services to pregnant women in accordance with NYS Medicaid prenatal care standards and other professional guidelines.
3. Work with paraprofessionals, including peer counselors, lay health advisors, and community health workers to reinforce health education, healthcare service utilization, and enhance social support to high-risk pregnant women.
4. Implement innovative models of prenatal care, such as Centering Pregnancy, demonstrated to improve preterm birth rates, and other adverse pregnancy outcomes.
5. Provide clinical management of preterm labor in accordance with current clinical guidelines.
6. Implement practices to expedite enrollment of low-income women in Medicaid, including presumptive eligibility for prenatal care and family planning coverage.
7. Utilize health information technology to facilitate more robust intake/enrollment, screening/risk assessment, referral, follow-up, and care coordination practices across health and human service providers including Health Homes, where applicable.
8. Refer high-risk pregnant women to home visiting services in the community.

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
Mohawk Valley Community Action Agency Head Start; Mohawk Valley Community Action Agency Early Head Start; County Health Departments; Mohawk Valley Perinatal Network; Maternal and Infant Community Health Collaborative; REACH CNY

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

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

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

The CNYCC County indicators with respect to the leading maternal and child health issues (e.g., infant mortality, prenatal care, adolescent births, and low birth weight) are generally better than the NYS average with the exception of Oneida and Cayuga Counties. However, significant disparities exist for African Americans/Blacks and Hispanics/Latinos and between Medicaid-eligible and higher income populations throughout the region. Moreover, as highlighted in the CNA, County average data does not reflect the difficulties that many of the residents face in accessing care. Prenatal care services are located mainly in high population centers. Several "outpost" clinics in the far rural areas have closed due to finances and there are few private providers in these areas. When the NYS Prenatal Care Assistance Program (PCAP) (the expanded Medicaid eligibility for pregnant women, well known as PCAP) was eliminated and replaced by the expansion of Medicaid eligibility to all women, the changes in funding led to the closing of a number of "PCAP clinics" in both urban and rural areas that had been run by County Health Departments and other entities. These clinics were well accepted, including by teens. There is a need to publicize the prenatal care providers and sites that accept Medicaid and make these more accessible and welcoming to pregnant women and teens, whether insured or uninsured.

Preconception care, which often includes the concept of interconception care (health care between two pregnancies), is an often overlooked aspect of preventing premature births. Unintended pregnancy rates, smoking while pregnant, use of alcohol and illicit drugs during pregnancy can all be used as proxy indicators for preconception care. The rates are particularly poor among minorities and the Medicaid population in the CNYCC region compared to state averages. In 2013, the unintended pregnancy rate was 52.2% for Blacks, and 51.5% for Hispanic groups and 46.9% in the overall Medicaid population (compared to NYS average of 35.2%). For

the Medicaid population, smoking during pregnancy (27%), illicit drug use during pregnancy (10%) also exceed the NYS average. The newborn drug-related discharge rate per 10,000 newborn discharges is higher than the Upstate average in four (Cayuga, Onondaga, Oswego, Oneida) out of the six PPS region counties. There were 809 emergency department visits in the past 12 months for preterm labor.

FQHC Quality Data indicates that dramatic differences in the percent of patients with timely prenatal care exists; ranging from 14.3% to 93.5% with an average across all FQHCs of 77%. All counties have shortages of primary care providers and psychiatrists, and all counties except Onondaga have a shortage of dentists and OB-GYNs. The shortage information is further substantiated through the large number of Health Professional Shortage Area and Medically Underserved Areas/Populations designated. In Oswego the entire Medicaid-eligible population has a primary care HPSA. All Medicaid eligible populations in Syracuse and Utica are designated as a shortage area for primary care. Large areas of the other counties are also HPSA designated. These issues are the primary drivers of the project approach to engage and support pregnant women in obtaining early prenatal care services through outreach, use of peer supports, risk reduction interventions and presumptive Medicaid enrollment and, assuring high quality prenatal care through provider training in best practices.

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.*

Pregnant women throughout the CNYCC region will be impacted by one or more of the program interventions chosen (such as adoption of clinical guidelines) however further targeting of higher risk individuals will also be conducted. In particular the PPS will work with clinical and community non-clinical providers to identify and connect pregnant women who are not accessing timely prenatal services to participating providers and home visiting services. Both clinical and non-clinical partners who have access to these higher risk women targeted in this project, including those in rural areas; those who are incarcerated or are part of the juvenile justice system, those who are smokers, substance users or homeless; African American and Hispanic pregnant women; pregnant women presenting at the emergency department and those with prior history of preterm delivery; and, young pregnant women will be engaged to expand existing outreach and education activities and build capacity where outreach activities are missing.

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

The region's county health departments have been active participants in the region's DSRIP projects. The public health departments serve many functions from surveillance to assessment and planning to service delivery to screening, health education, and health promotion. The county health departments also participate with local community based organizations in regional community health coalitions including Tobacco-Free Coalitions and Maternal and Child Health Coalitions. These coalitions are established mechanisms that share information and

resources, set priorities, and work to coordinate activities across the spectrum of stakeholders to achieve common goals. In this way, the coalitions of existing organizations are an established resource that can be leveraged to implement DSRIP project goals.

A total of 44 organizations reported in the CNA that they provide community-based, non-medical services. These organizations have expertise serving homeless (57% of organizations); women, infants and children (57%); children with special health care needs (41%); migrants/seasonal farm workers (16%); refugees (20%); the uninsured (68%); and other populations (59%). Compared to health care organizations, respondent non-medical organizations serve a more urban population, with an average of 43% of clients living in rural areas.

In particular, the Regional Perinatal Center (RPC) and the Maternal and Infant Community Health Collaborative (MICHC) organizations offer health education services to consumers as well as health and human service providers, provide information on best practices in MCH and resources to adopt and/or adapt these to CNY, promote uniform screening and health guidelines for preconception and interconception health including reducing high risk health behaviors such as smoking, drug use, conduct outreach to increase heath access and health insurance among the high risk, hard to reach population and employ community health workers to provide home visiting services to high risk women. For the region the Mohawk Valley Perinatal Network, Onondaga County Health Department and REACH CNY will leverage resources to continue this work and expand to other counties. CNYCC will expand the current programs in (Lewis, Oneida, Onondaga, and Oswego) which utilize paraprofessionals, including peer counselors, lay health advisors, and community health workers and scale these up to two other counties that do not have CHW's (Madison and Cayuga). In addition, the CNYCC has a network of Federally Qualified Health Centers (FQHCs) and other clinical providers who are already serving this target population to facilitate outreach and delivery of services. On a systems level, there is great potential to create stronger referral networks between community and clinical providers based on uniform screening and referral practices.

Similarly, CNYCC will engage the Regional Perinatal Center and affiliate hospitals to expand evidence-based models of care such as Centering Pregnancy. There are Level 1 (i.e. Auburn and Oswego), Level 2 (i.e. Faxton-St Luke's) and Level 3 (i.e. St Joseph's and Crouse) birthing hospitals in the CNYCC region. The Regional Perinatal Center resides at Crouse and is a partnership between Crouse Hospital and Upstate Medical University.

Finally, while primary care shortages exist, the region providers have systems established to promote excellence in care. The NYSDOH-designated CNY Perinatal Program, a collaboration between SUNY Upstate and Crouse Hospital, also provides a strong foundation from which to continue to build a comprehensive approach and system to assure high risk pregnant women are engaged and provided the prevention and clinical services to reduce adverse outcomes.

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 primary challenge will be to establish referral and information sharing systems between community-based non-clinical organizations and PCPs. Preventing preterm births remains a challenge because the causes of preterm births are numerous and complex and reducing the risk of preterm birth and improving health will require a collaborative approach between clinicians focusing on health improvement and community non-clinical organizations focusing on outreach, engagement, prevention, intervention and addressing issues related to social determinants of health. As a result, a focus will be the development of standardized protocols outlining referral steps, and minimum data sets, obtaining patient consent and defining critical information needing to be collected and shared. Collected information will be aggregated in the RHIO, as well as exchanged point-to-point through the use of Direct protocols. The establishment of a population health management platform by DY 3 will enable the systematic identification of high risk patients and the ability to track their care throughout the continuum. In the interim, the population will be tracked through registries or reports built directly in the EMRs.

An information sharing solution will be developed to take into account the varying levels, or entire lack thereof, of IT to assure timely and secure exchange of information between partners. The scarcity of Medicaid providers in some remote and rural locations in the region, exacerbated by the lack of transportation, presents added barriers to accessing timely prenatal care. Paraprofessionals such as lay health workers, peer counselors and community health workers being deployed in these areas will help to navigate Medicaid transportation services.

While activated and engaged clinical and non-clinical providers are a cornerstone to the project success, it will be necessary to work across DSRIP projects to assure CNYCC promotes systemness (Health Homes, 2.a.iii, Integration of BH and PC, 3.a.i) and develops an activated and engaged patients (PAM, 2.d.i). To address this issue the CNYCC will develop cross project objectives shared with the requisite Implementation Teams and to the extent necessary, appoint common Implementation Team members to assure cross-project collaboration.

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

No neighboring PPSs have selected this project.

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

Key milestones include:
-Trainings on: 5A's, presumptive eligibility, prenatal care standards and current guidelines on the management of preterm labor by the end of Year 2, Quarter 2.

-Establishment of common resource and referral protocols by the end of Year 1, Quarter 2 and expansion to include expanded programs by end of Year 2, Quarter 4. -Recruitment and establishment of a network of paraprofessionals by the end of Year 1, Quarter 4. -Expansion of Centering Pregnancy to two additional sites by the end of Year 2, Quarter 2. -Establishment and integration of common intake and enrollment protocols, referral, follow-up, and coordination practices, and integration into information technology platforms by Year 3, Quarter 4.

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

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

Yes	No
☒	☐

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

Capital expenditures will be required to be successful for the purchase and implementation of EHRs for eligible providers who don't currently utilize this technology, or who have an EHR that is not MU certified. Capital funding will also support the purchase and implementation of a population health management solution. Capital funding will also support the modification of participating partners EMRs to enable the tracking of target populations. Capital expenditures will be required to be successful for EHR implementation, population health management solution implementation to support reporting and analytics, and engagement technologies to facilitate community engagement. Also, additional infrastructure needs will be identified through development of the implementation plan.

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
REACH CNY, Inc.	Maternal Infant Community Health Collaborative (funding from NYSDOH, Bureau of Maternal Child Health	ongoing	ongoing	REACH CNY implements the Maternal Infant Community Health Collaborative (MICHC) that works on both the systems and individual/family levels to improve the health of Medicaid-eligible and/or high- risk women of child bearing age and their families. The risks we focus on include lack of insurance, not being connected to health care services, poverty, chronic health conditions, behavioral and mental health risks, and other medical and social determinants of health.
VNA Homecare	MLTC	ongoing	ongoing	MLTC
Lewis County General Hospital	VAP and VAP CAH- 3 yr	ongoing	ongoing	VAP and VAP CAH- 3 yr, allows transition of care program development, coordination of health home services, case management (in-house)

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.

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