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

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

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

Domain 2 Projects

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

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

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

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

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

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

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

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

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

1. **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.

This project links to CNA findings #1-11:
Across the FLPPS region, widespread system-level gaps have led to inappropriate utilization of services and poor health outcomes for the Medicaid population.

Fragmented clinical services have led to high disease prevalence, poor health outcomes and siloed delivery of care:
*The PQIs attributable to chronic disease (diabetes, respiratory and heart) accounted for 85% of all potentially preventable inpatient hospitalizations in 2012;
*A patient with three comorbidities has an 18-24 percent increased risk of readmission;
*There are higher rates of ED utilization among Medicaid beneficiaries (PPV of 38.83), when compared to the New York State (NYS) average (35.77);
*Over the last 12 months, 12,240 individuals who utilized the ED did not have a Primary Care Provider (PCP)
*There are poor nursing home transitions with high rates of hospital readmissions (21.23%);
*Infant mortality rates are higher than the NYS average (6.7 per 1,000 live births versus NYS 5.00); and

*Mortality due to diabetes (22.11/100,000 vs. 19.7), cardiovascular disease (299/ 100,000 vs. 276.3), cancer (212/100,000 vs. 180.3) and respiratory diseases (61.85/ 100,000 vs. 35.4) is also higher than the NYS average.

Focus groups with high-utilizing Medicaid recipients noted that inadequate and isolated social supports, including insufficient transportation resources, lack of housing and low health literacy, are contributing factors to inappropriate ED use and low patient activation.

Disjointed implementation of Health Information Technology (HIT) has led to gaps in the flow and accessibility of health information:
*The PPS includes at least 33 disparate EHR implementations and three RHIOs that lack interoperability.
*60% of PPS partners do not share data with their local RHIO;
*There are particular gaps among nursing homes and behavioral health providers;
*Community-based organizations (CBOs) lack the HIT infrastructure to perform population health management.

Volume-based incentives inherent to a fee-for-service payment model are a barrier to promoting a model of care focused on value and health. To this end, there is a gap in providing adequate reimbursement to providers and community-based programs offering chronic disease prevention and management services.

The FLPSS recognizes that the long-term viability of the regional health system is contingent upon its ability to successfully navigate changing paradigms, including (1) transition from the treatment of acute illness to the management of chronic disease; (2) integration of HIT; and (3) the critical need to reduce cost while improving both quality of care and patient outcomes.

To this end, the FLPPS will establish an Integrated Delivery System (IDS) that meets all project objectives and Domain 1 metrics, including:
*Developing partnerships with ACOs and Health Homes to provide care management services.
*Establishing a centrally-managed Community Health Worker (CHW) program, and contracting with culturally competent CBOs.
*Ensuring patients receive appropriate health care and community support through the expansion of primary care, co-location of services, redesign of acute ambulatory campuses, expansion of telehealth, and partnership with CBOs.
*Ensuring interoperability by providing technical assistance toward the successful recognition of participating providers as Level 3 PCMH (across 147 PCP sites) and achievers of Meaningful Use by the end of DY3.
*Ensuring the widespread provision of population health management through the development of an integrated care management platform and expanded bidirectional information exchange between partners.
*Engaging MCOs on FLPPS operational committees to facilitate sharing of information, guidance on performance improvement and development of value-based contracts that support the delivery of high-value services such as telemedicine, care navigation and transportation; and
*Aligning compensation with patient outcomes.

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.

There are a number of key community assets that the PPS will utilize when implementing this project:

*Providers across the FLPPS service area have a longstanding culture of collaboration that will be mobilized to develop a comprehensive, coordinated system of care that is necessary for IDS success. This is exemplified by collaboration between the two largest health systems to co-lead the region's DSRIP initiative. The organization structure, including development of Naturally Occurring Care Network (NOCN) workgroups to lead project implementation, and the diverse membership of operational committees will ensure that this asset is fully leveraged through the life of the project and beyond.

*The FLPPS region has a substantial HIT infrastructure, including three local RHIOs. Over 70 PPS provider organizations are currently sending data to the Rochester RHIO for more than one million patients. Additionally the RHIOs offer the ability to perform secure notification and electronic messaging between providers and patients, a requirement under PCMH and Meaningful Use. Going forward, the PPS will work with the RHIOs to develop an integrated IT solution to support population health management and the tracking of the PPS cohort throughout the project period. RHIO connectivity will need to be expanded to include PPS partners across primary care, behavioral health, long term care and community settings.

*An additional HIT-related asset is regional expertise in successful implementation of telehealth. This resource will be used to ensure deployment of a telehealth network to support expansion of services throughout urban and rural areas, thereby increasing access and mitigating geographic and transportation barriers.

*FLPPS partners also have experience in right-sizing physical capacity and existing infrastructure to better meet the needs of rural communities in a sustainable way. To that end, the FLPPS will facilitate the repurposing of acute services in select rural NOCNs by creating an ambulatory campus with co-located services that includes a robust offering of care modalities to best fit the needs of the community, per best-practice paradigms. This will include a consolidation of services and enhancement of primary care access to create an efficient, one-stop primary care shop on select hospital campuses with high Medicaid utilization. Emphasis will be placed on communities with financially distressed hospitals so that appropriate ambulatory services remain as inpatient services are consolidated into other adjacent communities.

*FLPPS partners are committed to expanding primary care capacity. The region's six FQHCs will create new clinic locations to improve access in Chemung, Steuben, Ontario and Monroe counties, providing primary care, mental health, dental and substance abuse services. Existing primary care sites will also be asked to provide extended hours to increase likelihood of PCP use over urgent care.

*The FLPPS boasts wide-spread expertise in the development and implementation of care coordination resources. Health Home partners have extensive experience in care management, with existing protocols to support training, implementation and the development of a capitated payment structure. These assets can be leveraged by creating an interface with a single care management platform and expanding the resource to unserved rural communities. Partner ACOs have existing standards-of-care protocols that can be resourced as well.

*Project teams, with representation from the cross-section of provider types and geographies in the region, have begun sharing best practices and lessons learned from programs that promote similar objectives to DSRIP. This includes collaboration with the region's two Accountable Care Organizations (ACOs) who have experience with managed care contracting and value-based reporting infrastructure, which can be leveraged through DY4 and beyond.

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.

Regulatory relief: Regulations prohibiting shared EHRs for mental health, substance abuse and primary care, and those restricting co-location of services, need to be addressed. FLPPS will request waivers and advocate for consent reform to align regulations with the IDS vision.

Capital funding: The implementation of an IDS will require capital to facilitate modification of the delivery system. FLPPS will work with partners to file a request for:(1)HIT transformation;(2)Primary Care Expansion, including medical and behavioral health services;(3) Medical Village-type delivery system transformations, such as acute-to-ambulatory or SNF-to-alternate-services; (4) Ambulatory ICU; and (5) ED/Primary Care co-locations. Without sufficient funding, access to appropriate levels of care could be jeopardized.

Workforce considerations: The PPS has a shortage of licensed behavioral health providers and PCPs. FLPPS providers will utilize the National Health Service Corps and the Conrad Thirty program to recruit PCPs, Licensed Behavioral Health practitioners and foreign medical graduates. The PPS will also ensure loan repayment incentives in conjunction with the Doctors Across NY program. The PPS will review and develop curriculums, programs and certifications to meet workforce gaps. Finally, the PPS will facilitate the receipt of HPSA designation across appropriate NOCNs.

Cultural Competency (CC)/Health Literacy (HL): Broad ethno/racial diversity of the PSS region coupled with socioeconomic and cultural underpinnings results in significant health disparities. The PPS seeks to reduce these gaps by adopting a multifaceted approach to increase system wide CC and HL, including strategies to promote a robust network of culturally responsive staff, culturally tailored health care settings and HL education initiatives, while promoting the development of best practice CC and HL interventions that are culturally and linguistically representative of the populations the PPS serves.

Transportation: The CNA identified transportation as a major barrier to accessing care. In response, FLPPS will leverage existing call center co-operation and technology to link patient needs with resources in a timely and efficient manner. FLPPS will also create an alternate payment system to purchase services from the community transportation network, including volunteers and non-profit agencies.

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.

For the 2.a.i project, FLPPS recognizes existing overlap with the Millennium Collaborative Care (MMC) PPS, Southern Tier PPS and Central PPS. Specific county overlap occurs in Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Wayne, Chemung and Steuben. This analysis is based on the state's listing for PPS counties served by PPSs prior to merging of PPSs and final attribution. Through the Medicaid Support Team, FLPPS has reached out to: MMC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with three out of four organizations.

Through those PPS-to-PPS phone calls, project leads were able to establish a base for collaboration, recognizing a desire for ongoing dialogue and shared activity throughout the five-year Waiver program. Initial meetings: (1) introduced the leads and members of the project teams; (2) briefly outlined the PPSs' approach to the projects; (3) identified overlapping counties served; and (4) laid the foundation for future discussions. FLPPS will align efforts to minimize impact on downstream providers, and to establish venues for possible learning collaboratives to share best practices and lessons learned. Additionally, PPSs will ensure continuity of care through secure data sharing and bidirectional communication through project implementation.

Project Leads will connect at the state-led training in January, and subsequently plan a kickoff implementation meeting followed by regular check-ins.

In addition to these general next steps, FLPPS has engaged in discussions with outlying PPSs with the intent to consider contracting for services to fill gaps identified within their partnership and to assist in the successful implementation of projects, specifically around services where they have identified a shortage of practitioners needed to serve their population.

FLPPS is committed to the success of all NYS PPSs, recognizing that if NYS fails we all fail.

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

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

It is the ultimate goal of FLPPS to create an Integrated Delivery System (IDS), under the governance of major stakeholders, and build the infrastructure required to integrate and coordinate care. By creating such a structure, FLPPS will offer services at the most appropriate level of care across the community. Providers, working together to coordinate a patient's care, will create healthier, happier, and more satisfied patients, faster recovery for those who are ill or hospitalized, improved quality of life and lower health care costs. This effort will drive a reduction in unnecessary beds. The inpatient occupancy rate of the hospitals in FLPPS is 61.2% but ranges from 15% to 90%. Medicaid is the primary payer for an average of 18.2% of patient days in FLPPS.

Specifically, FLPPS is aiming to reduce hospital utilization by 20% over the next five years. The keys to reducing hospitalization and long-term care are keeping individuals healthier longer, avoiding acute crises through monitoring and proactively managing the individual’s physical and behavioral health, and coordination with the social services they require. An effective system will integrate all of these elements. The FLPPS knows that costs increase when the system fails to coordinate the physical (including dental), behavioral, and social aspects of care. The medical cost of care for patients with chronic medical comorbidities increases if the patient also has a chronic mental diagnosis. The current system emphasizes inpatient care but does not do a good job of providing primary care, medications, or transportation to an appointment that would have prevented an admission.

A PPS strategy to reduce healthcare costs is to reduce the demand for hospitalization and long-term care beds, primarily by avoiding the healthcare crises that initiate the need for these services. Other strategies will focus on reducing readmissions, shortening the length of stay, avoiding admissions, and transitioning the patient to community-based care options by building a system that will eventually not only coordinate care, but also align the financial incentives for providing the care.

Specific strategies include:

One of the FLPPS participating partner organizations, currently receiving IAAF funds, has discussed a specific project with NYSDOH and the FLPPS leadership team to reduce over 100 inpatient beds in a PPS community. Consistent with the CNA, it is proposed that these beds be offset with a robust ambulatory off-campus ED, an urgent care center, an FQHC with primary care, outpatient dental and behavioral health services, and outpatient procedures. In addition, telemedicine will support access to specialty services. It is anticipated that this project will serve as a model for further efforts to rebalance the healthcare delivery system in ways that are consistent with the healthcare needs of communities served by the FLPPS.

Long-term care (LTC) strategy: Sage Commission 2011 results project a net excess of 431 SNF beds in the nine-county area in the FLPPS region. However, occupancy at current nursing homes is 90%, indicating a need to reduce the demand for beds as well as unnecessary beds. To reduce nursing home beds, the FLPPS is proposing the replacement of a certain number of LTC beds with Medicaid-assisted living beds providing safe housing, primary care, and supportive care management services for patients in an environment that has a lower per diem cost than LTC. To reduce nursing home length of stay, FLPPS will work with nursing homes that do not currently use dedicated providers (MDs, NPs, PA) with geriatric training to provide residents with healthcare services. Creating capacity to provide primary care by trained geriatric providers is a goal for nursing homes in the FLPPS. FLPPS will work with MCOs to develop incentives to avoid unnecessary SNF utilization. There will also be palliative education and hospice support service education throughout the region.

Coordinated Care Strategy: The centerpiece of this strategy is a proactive coordinated care model that expands Health Home (HH) care management and establishes the PPS as a point of contact for individuals looking to be connected with services. HHs monitor and guide individuals through the existing fragmented healthcare, behavioral and social systems, partnering with enrollees to improve quality of care, improve social outcomes reduce mental health costs, and lower mental and physical health costs. HH care management has demonstrated 46% decrease in ER visits per enrollee, 53% reduction in days spent in hospitals, and 78% of enrollees reported "dealing more effectively with problems", according to the CNA. PPS will establish the number of HH enrolled patients as a metric tracked across time, anticipating an increase of HH care management services of 400% over five years.

A PPS call center will serve to connect patients with appropriate services, manned by staff trained to triage calls appropriately.

Hospital Discharge Care Transition Strategy: FLPPS will implement programs to obtain patient information on the social determinants of health and arrange for post-discharge community services, during the patient's hospitalization. To maximize adherence to treatment and outcomes, this will include referrals for appropriate levels of housing, consistent with the social and health-related needs of the patient, with the goal of securing the lowest cost, safest level of housing available, consistent with the patient's cultural values.

Hospitalist Strategy: To reduce hospital length of stay, create efficiencies and improve quality of care, FLPPS will work with hospitals that do not currently use hospitalists to implement hospitalist programs.

Information Technology Strategy: To coordinate the care for those most in need, FLPPS will continue to support the implementation of the Health Information Exchange (HIE) and Care Management Enterprise System with supporting analytics to monitor NYSDOH and PPS-established metrics. These infrastructure improvements will enhance care transitions.

Increase Primary Care Access Strategy: To maximize access to primary care, FLPPS will focus on efforts to increase the number of primary care physicians, nurse practitioners and physician assistants to increase the availability of services, especially in community and rural clinics. Furthermore the PPS will reduce barriers to utilization of existing primary care resources by expanding the use of telehealth services to mitigate geographic barriers and contracting with transportation companies to facilitate transportation to and from primary care appointments.

Assessment of the Patients' Physical Health, Behavioral Health, and Social Needs: FLPPS will gather and update a Comprehensive Patient Health and Social Needs Assessment with the goal of eventually populating the assessment for 80% of all individuals in its target population.

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.).

To assure project success, it is crucial to have a provider-led and community-driven governance structure that is representative of the cross-discipline, regional and rural/urban construct of FLPPS.

The success of DSRIP, and transformation of PPS providers and CBOs into an IDS, will be dependent on the commitment to and investment in consistent, adequately capitalized core services and infrastructure by the Board of Directors, coupled with strong leadership from the Naturally Occurring Care Network (NOCN) workgroups, to ensure that specific local needs are addressed and that the right providers and CBOs are engaged in program implmentation. The operating committees and project workgroups will serve as consolidators of ideas and feedback from across the NOCNs, ensuring that both local project work and core PPS processes are designed in such a way as to combine evidence-based practices with deep member engagement and input from local stakeholders.

Specific milestones for the FLPPS governance strategy include:
1. Implementation plan outlining the PPS commitment to achieving its proposed governance structure (due April 1, 2015)
2. Periodic reports, at a minimum semi-annually, providing progress updates on PPS projects and DSRIP governance structure
3. Supporting documentation to validate and verify progress reported on IDS progress
4. Have Medicaid managed care contract(s) in place that include value-based payments
5. PPS holds monthly meetings with Medicaid managed care plans to evaluate utilizations trends and performance issues and ensure payment reforms are instituted
6. PPS has a plan to evolve the provider compensation model to incentive-based compensation
7. Regularly scheduled formal meetings are held with Health Homes and ACOs to develop collaborative care practices and integrated service delivery
8. Clinically interoperable system is in place for all participating providers
9. EHR meets connectivity to RHIO's HIE and SHINY-NY requirements

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.

PPS capital funds will be essential to the successful implementation of a fully Integrated Delivery System (IDS) across the FLPPS. The funds utilized for the implementation of 2.a.i will serve as a driver to the other 10 FLPPS projects and will be utilized to meet all project requirements, integrate technology, and engage providers and Medicaid members. There are four areas that will require capital funding: 1) IT network development; 2) expanding primary care while integrating and co-locating services; 3) transforming acute care and SNF services/campuses to provide enhanced ambulatory need; and 4) addressing care management expansion and social support.

The PPS will require substantial IT capital funds, first, for the integration of 33 disparate EHRs, and 3 RHIOs lacking interoperability, in order to provide bidirectional communication and data. Secondly, some community-based organizations, nursing homes and behavioral health providers currently have no access to adequate equipment or EHR systems needed. Thirdly, capital will be required to fully utilize telemedicine and tele-health technology across the new IDS. Lastly, FLPPS will require centralized capital to support implementation of a data warehouse, Health Information Exchange (HIE) and Care Management Enterprise System with supporting registries and analytics to monitor NYSDOH- and PPS-established metrics.

Capital investments will be needed for expansion of primary care services, which will be accomplished by adding to existing practices, consolidating services into larger ambulatory service centers, expanding tele-health network capacities, co-locating primary care with EDs, and developing high risk ambulatory ICU services for super-utilizers. Also, evolving providers to 2014 PCMH Level 3 and Stage 2 MU will be a heavy lift, requiring capital funds.

There is a need to address inpatient (IP) and SNF bed reduction. There are several hospitals and nursing homes with excess capacity and three hospitals receiving IAAF funds. One medical village-like system transformation project is in the planning phase to reduce 100 IP beds. There is also a desire to convert nursing home bed capacity to Medicaid assisted living units. It is expected that there will be 3-4 additional medical village projects after the IP/SNF bed reduction planning work is complete.

Focus groups with high-utilizing Medicaid recipients noted inadequate access to social supports such as housing and transportation. A PPS call center will be developed and deployed to connect patients with appropriate services, with an additional goal to recuit medical triage professionals to help drive the reduction of inappropriate ED visits.

FLPPS is committed to working with engaged partners to prioritize and file capital requests.

All capital funds requests will be reviewed at the PPS and individual project level and prioritized to ensure the most efficient and effective use of funds to benefit the most Medicaid beneficiaries.

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
Al Jordan Health Corporation/GRHHN	CMMI		12/14	The CMMI grant supports Primary care practice transformation, integrate community services with

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				primary care and develop a community-wide outcome-based payment model for primary care
Arbor Housing and Development	Health Homes Care Management		Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare, by adding care management to Arbor's housing programs.
Arnot Health (3 hospitals, 2 SNFs)	VAP - Southern Tier Mental Health Project	4/14	3/31/17	The Vital Access Provider program at Arnot Health is focused on operating and systems change, increasing professional psychiatric capacity, mental health/substance abuse assessment and management, behavioral health in primary care
Blossom View Nursing Home Inc.	Greater Rochester Nursing Home Quality Consortium - The Meliora Grant	2009	Ongoing	This grant programs brings long term care providers together long term care providers to implement quality improvement projects through training to reduce overall costs.
Blossom View Nursing Home Inc.	Rural Health Network		Ongoing	Provide services and training for healthcare facilities to improve long-term care treatments and reduces costs. Plans and initiates innovative projects for a network of providers.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Catholic Charities Community Services	Health Homes of Upstate New York			The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.
Finger Lakes Addiction Counseling and Referral Agency	Health Homes of Upstate New York	7/1/13	Ongoing	The Health Homes initiative builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.
Genesee County Mental Health Services	PSYKES	2008	Ongoing	The PSYKES program provides data to help improve and adopt psychiatric medications and quality concerns
Genesee County Office for the Aging	Balancing Incentive Program (BIP)	1/1/15	9/30/15	BIP is a federal initiative to increase access to non - institutional community-based services and supports to the elderly and disabled population through the expansion of NY Connects, an information and referral service to become the one-stop shop for long-term services and supports, outreach activities to identify potential Medicaid eligible patients, and develop a single point of entry.
Greater Rochester Health Home Network LLC	Medicaid Health Home	4/1/12	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				services, enhancing coordination of medical and behavioral healthcare.
Jewish Home & Infirmary of Rochester	Certificate of Need - Jewish Senior Life Master Campus Plan	6/1/16	10/1/18	New build of 14 Green House Project Home for long term care, reducing the total number of long term care beds by 34. Renovation of legacy building to increase and serve Transitional Care (post- acute).
Lifespan	BIP Innovation Grant	10/1/14	9/30/15	BIP is a federal initiative to increase access to non-institutional community-based long-term services and supports to the elderly and disabled population through the expansion of NY Connects, an information and referral service to become the one-stop shop for long-term services and supports, outreach activities to identify potential Medicaid eligible patients, and develop a single point of entry.
Monroe County Office for the Aging	Balanced Incentive Program (Still in planning phase at state level)	4/1/14	9/30/15	BIP is a federal initiative to increase access to non-institutional community-based long-term services and supports to the elderly and disabled population through the expansion of Long Term Care Information and Assistance Line (NY Connects) and provide referrals to agencies to include persons under age 60, in addition to our existing directory of services for individuals age 60+

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Oak Orchard Community Health Center	CMMI Grant	2013	2015	The CMMI grant supports Primary care practice transformation, integrate community services with primary care and develop a community-wide outcome-based payment model for primary care.
Perinatal Network of Monroe County	New York State Maternal and Infant Community Health Collaborative	10/1/13	10/1/18	This Statewide initiative to expected increase women's access to insurance and healthcare, and to increase the percentage of families engaging in healthful behaviors with the overall goal to improve maternal and infant health outcomes.
Steuben Co Office for the Aging	ADRC-NYCONNECTS/ BIP	2007	Ongoing	BIP is a federal initiative to increase access to non-institutional community-based long-term services and supports to the elderly and disabled population through the expansion of NY Connects, an information and referral service to become the one-stop shop for long-term services and supports, outreach activities to identify potential Medicaid eligible patients, and develop a single point of entry.
Trillium Health	Health Homes	11/12	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare. Trillium Health is developing an Integrated Care Management Model focused on preventing

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				avoidable ER visits and avoidable Hospitalizations.
Visiting Nurse Service of Rochester and Monroe Co., Inc/SHCG	Health Homes	09/13	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.

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

The proposed IDS project serves to expand upon many of the initiatives mentioned above by leveraging the model workflows and infrastructure, to be implemented throughout the PPS, for the benefit of the region's Medicaid population. Examples of such initiatives include several grants related to care coordination (Health Homes, PSYKES), workflow transformation (CMMI, Home Quality Consortium), increasing access to care (Balancing Incentive Program, Maternal and Infant Community Health Collaborative), and primary care redesign (CMMI, VAP). The IDS serves to expand upon the fragmentation of initiatives by incorporating pieces from each, and establishing one overarching initiative that combines the efforts of all to realize a collective benefit that is more than the sum of its parts. The PPS target population is larger than those served by recognized initiatives.

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

2.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.

This project links to CNA findings #1, #2, #12 and #13.

In the FLPPS region, a gap in access to primary care has led to significant overutilization of the Emergency Department (ED) as evidenced by:
*Nearly 39% of ED visits for Medicaid patients are Potentially Preventable Visits (PPV), with higher adjusted and unadjusted rates in the PPS than the NYS average (36.4%); eight of 13 FLPPS counties have PPV rates in the bottom 80th percentile.
*In 2011, 18% of people seen and released in the ED had another ED visit within 30 days and 24% had another visit within 60 days. The 30 day re-visit rate was higher in the Medicaid population than in the general population, at 24%. Many ED visits resulted in non-definitive diagnosis; 23% were coded for signs/symptoms.

The inappropriate use of the ED is also due to a gap in services caused by transportation barriers and inadequate PCP capacity:
*People living closest to EDs have higher ED utilization, causing regional variations in ED use. Monroe County has 48% of the PPS population, a population density of 1132 residents/square mile, and a PPV rate of 37.98. In comparison, the 12 rural PPS counties account for 52% the PPS population, with a density as low as 48 residents/square mile, and PPV rates ranging from a low of 16.81 to a high of 62.45.
*Of the 45 Urgent Care Centers in the region only 58% accept all types of Medicaid. Two counties in the PPS lack an FQHC and three counties have no Urgent Care. Seven counties are fully designated by HRSA as Primary Care Health Provider Shortage Areas, and portions of five additional counties are designated as such. According to the CNA, 11 of the 13 counties in the PPS have PCP rates lower than the NYS average of 84.5 PCPs/100,000 residents.

The CNA also found that there were a number of perceived obstacles to using appropriate services, including a lack of understanding by patients about available levels of care, and cultural and linguistic barriers. Focus group results included patients who received referrals to PCPs while in the ED but did not follow through, and those who chose the ED over a PCP due to convenience of location and/or operating hours, immediate access versus waiting to get appointments, language and cultural barriers, and habit.

In response, the PPS will address identified gaps and meet the project requirements, as well as Domain 1 objectives by:

*Implementing an on campus location of extended hours primary care and urgent care at the highest volume EDs (Rochester General and Strong Memorial Hospitals), and elsewhere, to promote ED diversion.
*Establishing or enhancing ED-based patient navigation staff that can help facilitate primary care linkages and connectivity between the ED and PCPs.
*Establishing ambulatory ICU services for managing patients with advanced illness.
*Collaborating with community partners and leveraging best practices to educate Medicaid and other low-income patients about the availability and appropriate use of community-based primary care services.
*Leveraging FQHCs and PCMHs located throughout the PPS region to increase open access scheduling and patient capacity across several sites in the Monroe, Southern and Finger Lakes NOCNs.
*Co-locating emergency departments with primary care and FQHCs, wherever possible, to help facilitate triaging of patients to most appropriate settings.
*Exploring the possibility of developing a call triage process to potentially divert non-emergency EMS calls to non-ED settings to promote appropriate reassignment/referral.

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

This program will be implemented at all PPS-partner hospitals. Monroe County is a top priority focus area, given the high ED volumes at the two largest hospitals, and because it has the largest and densest population. Additional priority focus areas will include the Southeastern and Western NOCNs, as they experience higher than average PPV rates, and include counties lacking an FQHC, highlighting regional opportunities to improve access to and use of primary care.

Across all NOCNs, priority patient populations include: Medicaid patients presenting to the ED who have no identified PCP, pediatric populations, frequent and repeat ED users, and patients who present to the ED for treatment of non-emergency conditions (whether they have a PCP or not). Patients with behavioral health conditions will also be targeted--the PPS will coordinate efforts with project 3.a.ii for this population. Furthermore, the PPS will target patients who qualify for, but are not currently linked to Health Home care management, including those with behavioral health diagnoses, as this resource has been underutilized outside of Monroe County and can help with successful community care linkages to decrease ED use.

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.

Partnerships: The PPS contains a broad depth and scope of partner agencies, many of whom have a history of successful collaboration. The commitment of all PPS partner hospitals to this project, along with primary care practices and FQHCs, highlights a large network willing to work collectively. Several of the committed hospital partners own primary care practices, most with

PCMH certifications. In addition to hospital-owned practices, there are regional FQHC PCMH-certified partners who have committed to expanding open and timely new patient access. There are also large Health Home care management programs, which are well known in Monroe County. There is an opportunity for increased awareness of and referral to this service across several partner NOCNs

Workforce: Staffing assets in the PPS include several partner hospitals with existing staff, some of whom may be retrained to provide a focused navigator role within the ED, although initially new navigators will need to be hired. In smaller hospitals where ED volumes are relatively low, staff may function in dual roles (such as Medicaid liaisons and patient navigators). Having larger health care systems in the PPS who have more than one hospital ED site will allow for shared staffing efficiencies, with opportunity for an ED navigator based in one ED to provide navigation, through telehealth, to lower volume EDs during low utilization periods.

IT: IT assets important to project success include a widely used RHIO which can interface with 23 different EMR systems. This asset can be used to provide real time notifications to members of the care team when patients are seen in the ED, deliver ED discharge summaries to receiving providers, and facilitate project requirements of patient tracking and milestone reporting. The RHIO also has diabetes and asthma disease registries, which can be used to coordinate primary care for patients. Additionally, several of the hospitals in the PPS share an EMR platform with their medical practices, which can help facilitate better triaging.

Model Programs: Scattered throughout the PPS there are pockets of unique services and successful programs that can be leveraged. The PPS can help facilitate the use of these best practices across the region. These projects include but are not limited to: a home care agency staffed with on-call RNs who provide immediate/urgent home visits to chronically ill patients 24/7; programming for palliative care managers deployed to EDs; behavioral health care managers and outreach workers allocated to EDs; and a program training the developmentally disabled population on when to use or not use the ED.

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.

Primary Care Provider Capacity: There is a need to significantly expand the overall capacity of PCPs, as well as open access scheduling. The PPS intends to offer extended primary care hours; however, because much of the PPS is rural with low population density, staffing challenges may make it difficult to financially support this intervention in some areas. This challenge can be addressed by shifting hours of operation, when appropriate, to offer more evening/weekend hours to meet patient demand.

PCMH Level 3 Designation: Within this project, PCPs will need to become designated as PCMH Level providers. The PPS will provide training and support for PCP practices to ensure that they can successfully obtain Level 3 designation.

IT: There are 33 different EMRs in use across the PPS and only 23 interface with the RHIO. The PPS will address this challenge through coordinated efforts with other DSRIP projects, particularly Projects 2.a.i and 3.a.i. Significant effort and capital for investment in IT infrastructure and equipment will be required. This request is being managed by the IT Operations Committee.

Transportation: Lack of adequate transportation, particularly in rural areas is an on-going challenge for the PPS. In response, the PPS has developed an Operations Workgroup focused on Transportation, which is developing a slate of potential strategies, including development of transportation resource directories. FLPPS will create an alternate payment system using DSRIP dollars and/or other funding sources to purchase services from the community transportation network including volunteers and non-profit agencies.

Behavior Change: Changing individual patient behavior, such as use of the ED out of comfort or habit, must be addressed. Community education strategies to promote accessing appropriate levels of care will be developed with patient input and completed in conjunction with Project 4.b.ii; Project 2.d.i will promote patient activation using the ED as one hotspot for PAM completion; and the PPS Cultural Competency Workgroup is focusing on identifying health literacy gaps and responses in support of this and all projects.

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.

For the Project 2.b.iii, Finger Lakes PPS recognizes existing overlap with Millennium Collaborative Care (MMC) PPS and the Central PPS. There is not an overlap with the Southern Tier PPS for this project. Specific PPS county overlap occurs in Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Wayne, Chemung and Steuben. This analysis is based off of the state's listing for PPS counties served, by PPS, prior to merging of PPSs and final attribution. Through the Medicaid Support Team, FLPPS has reached out to: MMC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with three out of the four organizations.

Through those PPS-to-PPS phone calls, the leads were able to establish a base for collaboration, and recognized a desire for ongoing dialogue and shared activity throughout the five-year Waiver program. Initial meetings introduced the leads, members of the project teams, and briefly outlined the PPSs' approach to the projects; identified overlapping counties served; and laid the foundation for future discussions. The intent is to align efforts to minimize impact on downstream providers, and to establish venues for possible learning collaboratives to share best practices and lessons learned. In recognition of the fact that overlapping PPSs will share providers and patients, there is intent to ensure continuity of care through secure data sharing and bidirectional communication in the future.

The overlap in this project should only serve to be a support to implementation, as there will be more community resources available to these partner hospitals for post-acute linkages. Specific to collaboration on this project, there has been a preliminary conference call to develop a framework to insure coordination of information, data tracking, and establishment of complementary project strategies in caring for any shared patients. This framework will include project manager-to-project manager communications during implementation planning phase as well as best practice sharing throughout the project duration. In recognition of patients that flow between FLPPS and Central PPS in Rochester and Buffalo, communication between RHIOs is an expectation. Rochester RHIO is a SHIN-NY QE (Qualified Entity) - and the RHIO is actively participating in that work effort. Statewide Patient Record Lookup (sPRL) is expected to be fully operational by all QEs early in the project's implementation which will allow providers to query other RHIOs and receive a CCD/CCDA response.

Project leads will connect at the state-led training in January, and subsequently plan a kickoff implementation meeting; followed by regular check-ins.

In addition to these general next steps, FLPPS has also engaged in discussions with outlying PPSs, with the intent to consider the contracting of services to assist in gaps identified within their partnership, for neighboring PPSs (no shared territory). The goal is to assist in the successful implementation of projects in response to their CNA, specifically around services where they have identified a shortage in practitioners needed to serve their population.

FLPPS is committed to the success of all NYS PPSs, recognizing that if NYS fails we all fail.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital funding will be needed for renovation, repurposing, and expansion of existing space in the Emergency Departments (ED) in order to allow for offices and furnishings for navigators, nurse triaging, and co-location/consolidation of primary care, behavioral health, dental and ancillary support services (lab/pharmacy) on the campus of existing EDs to create convenient one stop shopping alternatives to ED use. Given the need to connect patients to primary care and behavioral health services, there will be a need to expand the footprint of many of the community based providers, including FQHCs and county health departments, to accommodate patient volume. In some instances this will require capital enhancement of a tele-health network, instead of bricks and mortar, to expand capacity and access given the transportation and provider shortage issues. Significant capital will be needed for HIT, both in establishing EMRs where they are not currently in use, as well as enhancing those that are, in order to allow for information sharing in real time and realization of PCMH designation requirements. Related computer equipment will require capital funds. Small partner hospitals do not have cash on hand to support physical renovations and equipment purchases upfront. Based on the plans for bed reduction strategies in some communities, there will be a need to plan for ambulatory sites with collocated services to support community needs. An ambulatory intensive care strategy will be examined in communities with high volume utilization and high disease burden, which will require capital planning.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Arnot Health	VAP Southern Tier Mental Health Project	4/1/14	3/1/17	The Vital Access Provider program at Arnot Health is focused on operating and systems change, amongst other improvement project.
Lifespan	BIP Innovation Grant	10/1/14	9/30/15	BIP is a federal initiative to increase access to non-institutional community-based long-term services and supports to the elderly and disabled population through the expansion of NY Connects, an information and referral service to become the one-stop shop for long-term services and supports, outreach activities to identify potential Medicaid eligible patients, and develop a single point of entry.

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.

These initiatives do not significantly overlap with DSRIP programming or initiatives, though in some cases they will support or enhance the work of this project. The project will actively engage a large population of the 13-county service area. FLPPS will leverage structures, protocols, and lessons learned from its participation in MRT initiatives. The VAP will be used to prepare a provider for, and supplement its efforts in, participation in this project. BIP provides funding to providers in long term care, behavioral health and developmental disability programs who are working on objectives that will help FLPPS meet the goals of this project. These providers will have bench strength in shifting care from institutional settings and better integrating and making accessible community services, especially following the conclusion of the program in September 2015 (DSRIP DY1).

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.

6. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
7. 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.
8. Ensure required social services participate in the project.
9. 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.
10. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
11. Ensure that a 30-day transition of care period is established.
12. Use EHRs and other technical platforms to track all patients engaged in the project.

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

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

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

This project links to CNA findings #1, #2, #7, and #12.

Within the PPS, poor care transitions after discharge, and lack of overall management of chronic health conditions, pose a gap in care leading to high readmission rates as follows:
*According to the CNA, all but two of 18 partner hospitals have PPR rates in the bottom 80th percentile for the state.
*Readmission rates within the region are consistently higher for Medicaid patients than non-Medicaid, and highest for people with FFS Medicaid (18.9%) and those who are dual-eligible (22.2%).
*Readmission rates for Medicaid patients who are discharged to home care (23.95%) represent a statistically significant higher risk of readmission
*Five hospitals have unadjusted PPR rates that are at least 10 percent worse than the NYS average.

Data from the CNA indicate that certain disease states and lifestyle choices increase patient risk, resulting in greater rates of readmission:
*Carrying a primary diagnosis of COPD, diabetes, CHF, cardiovascular disease, ischemic heart disease or pneumonia is linked to higher risk for readmission; as is having secondary diagnoses of hypertension, serious mental illness or heart disease. While the PPS has a similar chronic disease prevalence in its Medicaid population as NYS, it has a higher prevalence of mental health disorders (411.2 vs 289.4/1000).
*Smoking and overweight/obesity rates in 11 of 13 counties are above the NYS rates of 17% and 59.3% respectively. These risk factors contribute to many of the conditions associated with higher risks for readmission.

CNA focus groups and PPS partners cited gaps in health literacy, particularly around patient understanding of disease and the role of medications in disease management. Patients cited medication adherence issues, including confusion around the need for multiple medications, and medication non-compliance due to the inability to fill prescriptions upon hospital discharge. Furthermore, patients lack acess to basic necessities, adequate support networks and resources to attend to complex health needs.

CNA data also described a gap in access to primary care across the PPS. Most (11 of 13) counties have lower than the NYS average of 84.5 PCPs/100,000 residents. Seven counties are fully designated primary care HPSAs; and portions of an additional five counties are designated as such; in total 12/13 counties are designated as full or partial PCP HPSAs.

To address identified gaps the PPS will meet all project requirements, in addition to Domain 1 objectives, including:
*Develop system-wide, standard discharge protocols based on best practices, such as the Coleman model, to include real time record transmission from inpatient to outpatient teams.
*Facilitate and support partnerships between community care agencies and PPS hospitals to provide 30 day post-acute transition care management to targeted Medicaid patients.

*During hospital stays, identify and refer eligible patients to Care Managers (CMs) who will:
1. Meet with patients pre-discharge and review discharge plans, verifying patient understanding through teachback methods;
2. Work with patients to decrease barriers to adherence such as accessing follow-up care in the community, and developing basic health literacy around their condition(s);
3. Ensure that needed home-based resources are in place such as home care, telemedicine, medical equipment, food service and medications; and
4. Post-discharge, work with patients for 30 days to ensure adherence to plans such as appointment attendance and medication compliance, and work through any barriers.
*Link the CM and patient to Health Homes and Managed Care Organizations to ensure smooth transitions post discharge.
*Use IT infrastructure to track patients providing continued information exchange between hospitals and PCPs.
*Support expansion of primary care and high risk primary care clinics with capability to manage patients efficiently with multiple co-morbid chronic 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.

This project will be implemented across all counties of the PPS, as readmission rates for the Medicaid population consistently and uniformly exceed readmission rates for the non-Medicaid population.

The initial targeted patient population will be adult Medicaid patients who are being discharged to home care or self-care following inpatient admissions for chronic conditions, particularly diabetes, respiratory diseases, cardiac and circulatory conditions.

Within this identified population, additional focus will be given to patients with medical co-morbidities, limited social supports, secondary behavioral health conditions and/or patients with more than one recent admission.

Patients in Monroe County will be considered high priority, as the county accounts for 48% of attributed lives within the PPS, has multiple hospitals, and has higher than average PPR rates. The county also has the highest population density at 1132 residents per square mile, which allows for more efficient delivery of in-home care management (less travel time).

Western NOCN counties will also be considered high priority target areas, given that the region has high PPR rates as well as above average rates of COPD and heart disease.

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 PPS has a solid infrastructure of complimentary assets:

Existing Collaborations: There are existing, well-functioning, professional collaborations between partner hospitals and community-based providers, including relationships between several post-hospitalization service providers and many of the PPS's large hospital systems. In addition, large Health Home care management providers, with significant experience and expertise providing care management to patients with serious mental illnesses and substance use disorders, can be leveraged to help with the development of care management protocols for patients with these conditions. Additional partners include a community-based organization with care transition experience through a palliative care program in the Southeast NOCN, and another partner agency that provides home delivery of medications and medical equipment, as well as home care, in low population density parts of the PPS.

Existing Standards and Protocols: Regional home care agencies, in partnership with several hospitals, are implementing Community-Based Care Transitions Programs to targeted Medicare populations through a CMS demonstration project. Existing protocols for the identification and referral of high readmission-risk patients, from hospital inpatient units to care transitions managers, as well as a small workforce of Coleman Care Transitions Model-trained care managers, can be leveraged to help with training additional staff and implementing this model. In addition, there have been lessons learned, which support efficient project deployment.

Strength of the Workforce: There are large number of well-trained health professionals in the PPS, including social workers, LPNs, RNs and home health care providers, among other disciplines. This existing workforce can assist with the training of current staff and workforce additions to allow for the development of a broad, skilled team who can provide focused, time-limited, care transitions management to a diverse target population.

Existing Practices for Sustainability: Project deliverables will build upon the existing relationships among home care, Health Homes, Medicaid Managed Care and hospital systems, to ensure that reimbursements will support financial viability of this program, long-term. Regional MCOs understand the value in covering care transitions, as they ultimately reduce higher cost services, as demonstrated through earlier experience with the Medicare population. This past experience is an asset that the PPS can leverage, along with a solid Operations Finance Committee experienced with negotiating payor contract to assist with facilitating shared savings.

Information Technology: In addition to HL7 integration, the Rochester RHIO direct messaging system supports referrals and peer-to-peer communication, alert/notification and can be used in addition to the outbound CCD-only direct messaging supported by Epic

Integration with other DSRIP projects: Integration with other projects also will be an asset, including Project 3.a.i, Project 3.a.ii, Project 2.b.iii, as well as Project 2.a.i. This will promote consolidation of efforts and thus efficient use of resources and PPS efforts.

Despite strong existing assets, additional case managers will need to be hired in certain hospitals to ensure adequate workforce. There is also a need to develop additional IT infrastructure and capabilities.

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 a number of challenges associated with this project including information technology, workforce, transportation, and cultural competency as follows:

Information Technology: It will be challenging to ensure consistent/timely communication between inpatient units, Health Home providers, home care services providers, transition care managers, and community-based practitioners. There are 33 different EMRs in use throughout the PPS with some providers/programs using paper charts. This challenge will be addressed through development of a standardized discharge notification process as well as implementation of project 2.a.i, which will improve interoperability. The PPS's Operations IT Committee will be active in ensuring that there are technical platforms to meet project requirements for patient tracking and reporting.

Workforce: The current workforce is insufficient to offer care transitions across the PPS. In sparsely populated NOCNs, longer travel times between client homes and services limits the caseload size a care manager can serve, and thus requires higher care manager-to-patient ratios. The PPS will need to add staff and provide training on care transitions models as well as culturally, linguistically, and ethnically appropriate care. Contracting for Medicaid managed care reimbursement is a project priority so that partner agencies are able to expand staffing.

Regional Variations: Variations in population densities and urban versus rural settings will require a region-specific approach to care management, such as caseload variations.

Transportation: Transportation is a challenge, as inconsistent access to transportation impacts adherence to discharge plans and attendance at follow-up medical appointments. The PPS is addressing this challenge by convening an active Operations Transportation Workgroup. FLPPS will create an alternate payment system using DSRIP dollars and/or other funding sources to purchase services from the community transportation network including volunteers and non-profit agencies.

Cultural Competency: Cultural competency, language differences, and health literacy have been identified as key barriers for this project; the PPS has formed an Operations Cultural Competency Workgroup to identify strategies for ensuring that all programs meet needs of the target populations.

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.

For the 2.b.iv project Finger Lakes PPS recognizes existing overlap with Southern Tier PPS and the Central PPS. Although Millennium (MMC) PPS has not elected to implement this project, there has been a preliminary conference call between our PPSs to ensure establishment of complementary project strategies in caring for shared patients. Specific PPS-county overlap occurs in Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Wayne, Chemung and Steuben. This analysis is based off of the state's listing for PPS counties served, by PPS, prior to merging of PPSs and final attribution. Through the Medicaid Support Team, FLPPS has reached out to: MMC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with three out of the four previously listed PPSs.

Specific to collaboration on this project, opportunities for resource sharing including group training costs and best practice sharing have been initially proposed, with plans to more fully explore during DY1. Likely one of the bigger challenges is that there will be different RHIOs in use, and communication of information is critical to project success. However, this is not unique to this project; therefore Project 2.a.i will address RHIO and communication issues both within and across PPSs. As Rochester RHIO is a SHIN-NY QE (Qualified Entity) - communication between RHIOs is an expectation and the RHIO is actively participating in that work effort. In addition, the Statewide Patient Record Lookup (sPRL) is expected to be fully operational by all QEs by Q2 2015 per which will allow providers to query other RHIOs and receive a CCD/CCDA response.

Through those PPS to PPS phone calls, the leads were able to establish a base for collaboration, and recognized a desire for ongoing dialogue and shared activity throughout the five-year Waiver program. Initial meetings introduced the leads, members of the project teams, and briefly outlined the PPSs' approach to the projects; identified overlapping counties served; and laid the foundation for future discussions. The intent is to align efforts to minimize impact on downstream providers, and to establish venues for possible learning collaboratives to share best practices and lessons learned. In recognition of the fact that overlapping PPSs will share providers and patients, there is intent to ensure continuity of care through secure data sharing and bidirectional communication in the future.

Project leads will connect at the state-led training in January, and subsequently plan a kickoff implementation meeting; followed by regular check-ins.

In addition to these general next steps, FLPPS has also engaged in discussions with outlying PPSs, with the intent to consider the contracting of services to assist in gaps identified within their partnership, for neighboring PPSs (no shared territory). The goal is to assist in the successful implementation of projects in response to their CNA, specifically around services where they have identified a shortage in practitioners needed to serve their population.

FLPPS is committed to the success of all NYS PPSs, recognizing that if NYS fails we all fail.

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.

Implementation of this project will require dedicated staffing who are working in the community and thus will need equipment including laptops, phones, and vehicles. There are workforce training costs for both existing and new staff. Office space, including renovations to existing space and furnishings, is necessary to accommodate care transitions managers staff. IT costs including EMR, interfaces, database development and equipment are identified as capital needs. Significant work effort, cost and IT support is needed to assist practices that need to upgrade and/or implement an EHR to achieve PCMH designation and to meet the interoperability requirements for connectivity with the Rochester RHIO (WE of the SHIN-NY).

There will be a need to expand the footprint of many primary care provider/FQHC practices and sites and develop new high risk primary care practices to support co-management of patients with multiple chronic diseases. There will regional planning initiatives to help support these efforts.

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	Description of Initiatives
Visiting Nurse Service of Rochester and Monroe Co. Rochester Regional Health System Greater Rochester Health Home Network LLC Finger Lakes Addiction Counseling and Referral Agency URMC STRONG	Health Homes Care Coordination	2012	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare. Trillium Health is developing an Integrated Care Management Model focused on preventing avoidable ER visits and avoidable Hospitalizations.
Lifespan, in partnership with Lifetime Care, Visiting Nurse Service, URMC, RRHS	Community Care Transitions Program, CMS	2013	2015	CMS demonstration project focused on reducing readmissions for Medicare patients through use of Coleman care transitions coaching model

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End	Description of Initiatives
Genesee County Office for the Aging	Balancing Incentive Program	1/1/15	9/30/15	BIP is a federal initiative to increase access to non-institutional community-based long- term services and supports to the elderly and disabled population through the expansion of NY Connects, an information and referral service to become the one-stop shop for long- term services and supports, outreach activities to identify potential Medicaid eligible patients, and develop a single point of entry.

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

The Community Care Transitions Promotion (CCTP) CMS demonstration project is in alignment with this project's goals, though it is only for Medicare patients. Any overlap would be found within the dually eligible population, who will be covered through the demonstration project and not counted toward actively engaged scale for this project for the duration of the CMS project. The benefit of participation in the CCTP program is that there are a number of staff already trained in the Coleman model and referral processes. Relationships have already been established, and implementation protocols including lessons learned can be applied to the whole. Thus our new project has opportunity for greater success and will not be duplicative in that currently Medicaid-only patients are not eligible. Other programming such as Health Homes are an enhancement or asset but not an overlapping project, because the role of the post-acute transition care manager is a very specific and time-limited role, which is a different role than that of a Health Home care manager. For patients who are not eligible for or not yet linked to health home care coordination, transition care management can fill a void, and it is supplement to the health home care coordinator role during a very high needs time for those who are already receiving care coordination services. Care transitions managers can also facilitate referrals to Health Home care coordination for eligible patients, which is beneficial as Health Homes are effective and cost effective, yet have been underutilized in several areas. This project would enhance the BIP project by helping to prevent institutional levels of care and thus is in alignment with but not overlapping with this project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

2.b.vi Transitional Supportive Housing Services

Project Objective: Participating hospitals will partner with community housing providers and home care service organizations to develop transitional supportive housing for high-risk patients who, due to their medical or behavioral health conditions, have difficulty transitioning safely from a hospital into the community.

Project Description: Access to safe transitional supportive housing is a key determinant in stabilizing chronically ill super-utilizers of health care. The availability of secure housing and home care services includes services which will allow the discharged patient to stabilize in the outpatient, community setting instead of "ping-ponging" back to the hospital due to housing instability. This project will establish partnerships with community housing providers and home care service organizations to develop transitional housing for high-risk patients. In addition to transitional supportive housing, this project will provide short-term care management and a coordinated transition to a longer term care management or a PCMH, allowing additional time to support stabilization, rehabilitation and recovery.

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.

13. Partner with community housing providers and home care service organizations to develop transitional supportive housing for high-risk patients.
14. Develop protocols to identify chronically ill super-utilizers who qualify for this service. Once identified, this targeted population will be monitored using a priority listing for access to transitional supportive housing.
15. Establish MOUs and other service agreements between participating hospitals and community housing providers to allow the transitional supportive housing and home care services staff to meet with patients in the hospital and coordinate the transition.
16. Establish coordination of care strategies with Medicaid Managed Care Organizations to ensure needed services at discharge are covered and in place at the transitional supportive housing site.
17. Develop transition of care protocols to ensure all chronically ill super-utilizers receive appropriate health care and community support including medical, behavioral health, post-acute care, long-term care and public health services.
18. Ensure medical records and post-discharge care plans are transmitted in a timely manner to the patient's primary care provider and frequently used specialists.
19. Establish procedures to connect the patient to their Health Home (if a HH member) care manager in the development of the transitional supportive housing plan or provides a "warm" referral for assessment and enrollment into a Health Home (with assignment of a care manager).
20. 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.

This project addresses CNA finding #4, #7, and #12.

Homelessness creates significant gaps in care across the PPS region and results in unnecessary readmissions (PPRs) and increased health care utilization.
*FQHCs in the region report that in 2013, between 1% (rural areas) and 5.5% of their patients were homeless or receiving public support.
*Also in 2013, the Monroe County Department of Human Services (MCDHS) made 8,857 emergency housing placements for individuals and families, an increase of 6% over 2012. The second leading cause of this homelessness (11% of cases) was release from an institution (hospital, substance abuse treatment program, jail) without a plan for permanent housing.

Focus group data and data provided by CBOs finds that unsupported care transitions represent a significant gap in services:
*Coordination between hospitals and care management providers (Health Homes and home care services) lacks a formalized process, leading to inconsistencies.
*Notification of care managers often occurs less than 24 to 48 hours prior to discharge, leaving little time to assess a patient's needs and arrange appropriate housing or home care services.
*The Western Region Behavioral Health Organization (WRBHO) found that 15% of patients with mental and behavioral health conditions were homeless at the time of admission, yet only 62% of patients had improved housing status at the time of discharge.

Severe and persistent mental illness and substance abuse is common among the homeless, and inadequate housing for unstable individuals creates additional gaps in the delivery of coordinated care:
*The PPS has a higher prevalence of mental diseases and disorders among Medicaid beneficiaries compared to the NYS average (411.2 vs. 289.4 per 1,000).
*Sixty-five percent of Medicaid and uninsured adults admitted to an inpatient Medical or surgical bed in had a co-occurring behavioral health diagnosis documented.

In response to these identified gaps, FLPPS will meet all project requirements and Domain 1 objectives, with a focus on strengthening care transitions, so patients with unstable housing are identified early after admission to a hospital. The PPS will do this by:

*Establishing formalized protocols to ensure hospitals link patients, in a timely fashion, to both a community housing provider and an appropriate care manager or patient navigator to assist with the transition from the hospital.
*Developing partnerships and formal service agreements between community-based housing providers, health homes, home care services and hospitals to leverage new and existing transitional supportive beds across multi-unit scattered and single site complexes within each of the five NOCN regions.
*Establishing a robust health information exchange network that can track patients, identify super-utilizers, provide real-time notifications to Health Home care managers, and transmit time-sensitive health information between providers across the FLPPS network, especially patients' Primary Care Provider and specialists.
*Coordinating medical care management with housing, mental health and substance abuse support services, using either telemedicine or home care providers, or by including the capacity on-site.
*Strengthening institutional capacity and responsiveness among partner providers to ensure that the range of necessary culturally, linguistically and ethnically appropriate support services are available.
*Partnering with Managed Care Organizations to ensure coordination of care and other needed services are covered at the time of discharge.

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.

Protocols will be used to target sub-segments of patients in the FLPPS that will be prioritized for transitional supportive housing. These sub-segments will be identified from current super-utilizers, or those facing mental health or chronic conditions that make them eligible for enrollment in a Health Home. Patients will be screened for evidence of housing instability and homelessness, and prioritized based on the type and location of housing available, support service needs, and risk for readmission. Evidence-based criteria examining housing status will be incorporated into hospital risk assessment practices, including screening for Health Home eligibility. This protocol will ensure that identification of appropriate housing is included early in the patient discharge planning process.

Using claims data from Salient to estimate patient scale, estimates of super-utilizers are being proxied by patients attributed to the PPS who had four or more emergency department (ED) visits in 2013; Health Home-eligible patients are being proxied by patients attributed to the PPS who have a behavioral health and chronic illness co-morbidity. Data requests from Salient will provide more accurate patient counts using standard criteria for these profiles (four plus hospitalizations for super utilizers and Health Home eligibility criteria). Housing instability is approximated by the regional estimate for homelessness (5.5%). The PPS will undertake additional localized research to more clearly identify the risk factors for homelessness and housing instability that will ultimately be used to identify the target population subset and establish the assessment criteria. Evidence and existing programs suggest that such criteria may include history in foster care, single parent households, low income and educational attainment.

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.

Expertise: PPS partners committed to this project have a wide range of complementary expertise and decades of experience in care management, support services and housing provision across several key population segments at high risk for becoming chronically ill super-utilizers, due to housing instability and/or their behavioral and medical health conditions. This includes two Health Home administrating agencies, eight housing organizations, four home care/care management agencies and several other community-based social service providers that ensure comprehensive service partnerships in each NOCN. The GRIPA Medicare ACO and the Elder One PACE program both have experience to provide lessons learned on protocols and process development.

Capacity: The majority of PPS community-based housing partners already offer mental and behavioral health support services. This is particularly valuable in rural NOCNs that are behavioral health personnel shortage areas (BH-HPSA). The PPS can leverage these partners to facilitate economies of scale to ensure a smooth continuum of care transition and behavioral health service delivery across the region. Other care management service providers offer a complementary range of services that will enable the PPS to make an array of service options available to patients based on their individual needs. In addition to transition coaches and Health Home care managers, partner providers offer consumer-directed personal assistance, a workforce of home health aides, nursing and rehab services, as well as tele-health biometric monitoring and Meals on Wheels.

Integration: The participation of all or the majority of hospitals, FQHCs, safety net providers and CBOs across several other projects including 2.b.iv (Care Transitions), 3.a.i (BH/PC integration) and 3.a.ii (BH Crisis Stabilization) will greatly facilitate the identification of high-risk patients and the ability to refer/secure appropriate post-acute care management and transitional settings.

Governance and Oversight: PPS-level Operational Workgroups for Transportation and Housing will include network partners from all NOCNs as well as other key players in each sector including Housing Authorities and county EMS agencies, to improve coordination, maximize the range of housing options available to patients and secure adequate transportation to relevant support services.

Repurposing: Several skilled nursing homes have experessed an interest in downsizing of their beds to create affordable supportive transitional housing, which is less costly than skilled nursing. This asset will be leveraged to support transitions for patients that need enhanced medical support at discharge.

Developed: The hospitals will partner with small, local short stay hotels to develop transitional supportive housing needs, as well give limited access to housing for patients needing housing and some standard home care services to avoid placements in skilled nursing facilities.

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.

Information Technology: Across the PPS, providers use inconsistent processes and data management tools. The majority of partners offering housing options and/or supportive services (particularly for mental/behavioral health patients) do not currently use EHR technology. This will be addressed by the PPS by implementing new IT strategies that can effectively track and report on actively engaged patients across the care continuum.

Key Regulatory Barriers: Current regulations restrict eligibility for placement in housing, creating significant challenges for the project's success. FLPPS will address this challenge by establishing a number of new or repurposed housing options that can be used by these patient populations. Also, the PPS will leverage partnerships with home care providers and telemedicine to push in support services. This will improve the availability of flexible housing options for behavioral health patients, particularly in the more rural NOCNs.

Industry Segmentation & Lack of Affordable Permanent Housing**:** Segmentation and regulatory inconsistencies across housing initiatives funded by OASAS, OMH, HUD, DSS and DOH create disincentives and significant barriers, particularly for hospitals, to understand and maximize available housing options. FLPPS will aim to streamline data on available housing inventories and eligibility rules to improve efficiency of moving people through the housing continuum (emergency, transitional, permanent). FLPPS will work with payers to align incentives for transitional housing initiatives that reduce overall cost of care.

Lack of Cultural Competency: The PPS does not have an adequate workforce that is culturally, linguistically and ethnically capable regarding the identification of patients who suffer from housing risks or the complex set of socioeconomic issues faced by patients who are homeless. The FLPPS will work to build an assessment tool and training module to assist the workforce in identifying risks and modifying treatment plans accordingly.

Lack of Transportation**:** In a study of care transitions from hospital to shelter for people experiencing homelessness, 59% of those surveyed reported no post-discharge transportation plan. FLPPS will create an alternate payment system using DSRIP dollars and/or other funding sources to purchase services from the community transportation network including volunteers and non-profit agencies.

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.

For the 2.b.vi project Finger Lakes PPS there is no project overlap with surrounding PPSs.

Specific PPS-county overlap occurs in Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Wayne, Chemung and Steuben. This analysis is based off of the state's listing for PPS counties served, by PPS, prior to merging of PPSs and final attribution. Through the Medicaid Support Team, FLPPS has made outreach to: MMC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with three out of the four previously listed PPSs.

Through those PPS-to-PPS phone calls, the leads were able to establish a baseline for collaboration, and recognized a desire for ongoing dialogue and shared activity throughout the five-year Waiver program. Initial meetings introduced the leads, members of the project teams, and briefly outlined the PPSs' approach to the projects; identified overlapping counties served; and laid the foundation for future discussions. The intent is to align efforts to minimize impact on downstream providers, and to establish venues for possible learning collaboratives to share best practices and lessons learned. In recognition of the fact that overlapping PPSs will share providers and patients, there is intent to ensure continuity of care through secure data sharing and bidirectional communication in the future.

The next step is for the leads to connect in Albany, at the state-led training in January, and to subsequently plan a kickoff implementation meeting; followed by regular check-ins between project teams of each PPS.

In addition to these general next steps, FLPPS has also engaged in discussions with outlying PPSs, with the intent to consider the contracting of services to assist in gaps identified within their partnership, for neighboring PPSs (no shared territory). The goal is to assist in the successful implementation of projects in response to their CNA, specifically around services where they have identified a shortage in practitioners needed to serve their population.

FLPPS is committed to the success of all NYS PPSs, recognizing that if NYS fails we all fail.

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.

Implementation of this project will require dedicated staffing who are working in the community, and thus will need equipment including laptops, phones, and vehicles. There are workforce training costs for both existing and new staff. Office space, including renovations to existing space and furnishings, are necessary to accommodate the staff of care transitions managers. IT costs including EMR, interfaces, database and telemedicine development and equipment are identified as capital needs. Several community housing providers request capital to support renovation, secure additional scattered multi-unit sites, and/or as a small percent of matching funds for new large scale multi-unit complex construction projects already in progress. Capital will be needed to repurpose nursing home beds as well.

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

Yes	**No**
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start	Project End Date	Description of Initiatives
Arbor Housing and Development	Health Homes of Upstate NY	4/1/12	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare, by adding care management to Arbor's housing programs.
Chemung County Dept of Aging and Long Term Care	Balancing Incentive Program	8/1/14	9/30/15	BIP is a federal initiative to increase access to non-institutional community-based long-term services and supports to the elderly and disabled population through the expansion of NY Connects, an information and referral service to become the one-stop shop for long-term services and supports, outreach activities to identify potential Medicaid eligible patients, and develop a single point of entry.
FLACRA	Health Homes of Upstate New York	4/1/12	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.
Finger Lakes UCP	MRT - Supporting Housing Initiative	10/1/14		The MRT Supportive Housing Initiative provides funding to build affordable housing units.
GRHHN	Health Homes of Upstate New York	4/1/12	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.

Name of Entity	Medicaid/Other Initiative	Project Start	Project End Date	Description of Initiatives
Hillside Children's Center	Balancing Incentive Program	8/1/14	9/30/15	BIP is a federal initiative to increase access to non-institutional community-based long-term services and supports to the elderly and disabled population through the expansion of NY Connects, an information and referral service to become the one-stop shop for long-term services and supports, outreach activities to identify potential Medicaid eligible patients, and develop a single point of entry.
HHUNY	Health Homes of Upstate NY	4/1/12	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.
Medical Solutions, Inc.	Balancing Incentive Program	2009	Ongoing	BIP is a federal initiative to increase access to non-institutional community-based long-term services and supports to the elderly and disabled population through the expansion of NY Connects, an information and referral service to become the one-stop shop for long-term services and supports, outreach activities to identify potential Medicaid eligible patients, and develop a single point of entry.
Visiting Nurse Service (VNS)	Health Homes of Upstate New York	4/1/12	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.

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

This project and DSRIP will expand upon the initiatives listed above by leveraging the systems, experience, knowledge, and infrastructure support these organizations have gained by participating in them. The BIP program provides funding for care transitions, however this program ends in September of DSRIP Year 1 (DY1). Additionally, this DSRIP project can benefit from the engagement of these providers in Health Homes by expanding the care management program to a larger population across more organizations. Overall the actively engaged patients in this project's target population will benefit from system redesign.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This project addresses CNA finding #8.

The FLPPS region has a large number of unenrolled individuals to be engaged, educated and activated into appropriate health system utilization. The New York State (NYS) Prevention Agenda goal of 0% uninsured recognizes that even one uninsured individual (UI) is unacceptable, yet 8% of the FLPPS target population lacks coverage.

High rates of UI can be attributed to gaps in services and resources, particularly in rural counties where the percentage of UI can be as high as 36%, compared with 7% in Monroe County and 15.1% nationally. Additionally, available resources that can potentially serve the UI are disproportionately concentrated in urban Monroe County. The need to expand existing healthcare infrastructure and navigator outreach in these areas, as informed through PPS/CBO/beneficiary partnerships, cannot be underscored.

Insufficient culturally responsive staff, coupled with low health literacy (HL), is a system-wide gap impacting the UI as well as the Low -Utilizing (LU) and Non-Utilizing (NU) Medicaid population. In Monroe County, the population is 62% white, 22% African American, 6% Hispanic, and includes over 5,200 refugees. The PPS's ability to appropriately engage these individuals is predicated on recruiting greater numbers of health care and outreach workers that mirror the linguistic and cultural variety.

Though data on regional HL is limited, lower HL scores have been tied to poverty, which is well demonstrated with all counties having a per-capita income below the NYS median income and 12 out of 13 counties having greater than 10% of their population living below the poverty threshold. Additionally an analysis by Health Resources and Services Administration determined that 7% of the region's population consistently delayed or did not seek care on a regular basis, due to cost. Poor HL adds to the consistent improper utilization of the ED. The PPS region demonstrates a PPV rate of 38.83 per 100 population, higher than the statewide average of 36.43, and 15% of Medicaid beneficiaries have at least one ED visit during the attribution period, while having no PCP visit.

A final glaring gap is the lack of specific and available data to determine who and where the UI/LU/NU population is, so the PPS might engage in targeted implementation.

In response to identified gaps, the PPS will meet all project requirements and Domain 1 objectives, including but not limited to:
*Establishing CBO/PPS partnerships to develop resources and expertise in Patient Activation (PA) techniques, as premised on the collective work of more than 6000 sociobehavorial, dental and social support service programs across the PPS region.
*Ensuring UI, NU and LU representation on development teams to induce PA in a manner that is patient centered and drives individual ownership
*Conducting widespread training of PAM to key community penetration staff (e.g. community health workers, social workers, faith leaders) to improve PA, HL and appropriate utilization of the health system in identified hot-spots utilized by the target populations, such as EDs, colleges and universities, jails, places of worship and CBOs.
*Expanding the workforce of navigators, including those with bilingual capacity that can provide extended linkage to care and ensure needed cultural responsiveness training
*Conducting measurement around levels of PA and HL using an integrated IT solution to track an identified patient cohort, paired with results reporting from patient advisory boards to stimulate system improvement towards enhanced PA
*Developing and executing media-driven and/or marketing strategies to educate and engage target populations on key health messages, available healthcare resources and importance of a proactive health approach
*Developing multilingual health promotion education materials and approaches specific to our LU, NU and UI populations
*Facilitating targeted expansion of FQHCs who are already poised to serve the uninsured

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.

Uninsured (UI): There are currently 100,903 uninsured living the FLPPS region. Of those, 56,095 live in urban Monroe County. Other counties with high numbers of UI include rural areas such Steuben (9,168), Wayne (8,080), Ontario (7,656) and Chemung (6,647). HRSA reports that during 2008 - 2012, approximately 29% of the total FLPPS region population belonged to a low income grouping (state average is 14.9% below poverty level), with approximately 66% of these being unserved by the available Community Health Centers. In addition, Enroll America indicates that, across the PPS region, the age groups with the highest number of uninsured appear to be 19 - 34 years old, (51%, 41% composition of UI in Monroe County and Steuben respectively). The Urban Institute has also identified UI in the PPS to be predominantly in low-income brackets (i.e. incomes below 138% of the Federal Poverty Level [FPL]) and between the ages of 25-44. The UI in this region vary widely by racial and ethnic composition even within the same county, and is thus not consistent across the FLPPS region. Therefore the primary target population is defined as belonging to age range 19 – 44, belonging to a household with income below 138% of the FPL and either living within a rural (particularly in zip codes with >20% UI) or urban setting. The project design will adopt a multipronged approach of tailored Patient Activation and engagement techniques to capture the variety of racial/ethnic and cultural paradigms in this group.

Non-Utilizers (LU and NU): There are 68,918 low and non-utilizers in the FLPPS region. Since there is very limited data on this population, the PPS will use the same target population parameters as those of the UI.

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.

As part of an extensive RFQ process, the FLPPS surveyed its partner organizations and determined there was sufficient capacity to effectively implement an 11th project. Forty organizations have committed to project participation, including Hospitals, 5 FQHC's and CBOs. In addition, the PPS is fortunate to have a foundation of existing assets to support successful project implementation:

Organizations Currently Using PAM: PPS will work with organizations currently utilizing the PAM to determine best practice approaches to administration and training of designated workforce to implement.

FQHCs: Local FQHCs provide medical, dental and integrated behavioral health services for the uninsured at little to no cost and saw 28435 UI last year. The PPS will coordinate efforts to inform target populations about such resources and strategize to bring them into care while providing support to these centers for the needed additional infrastructure to accommodate the anticipated influx of patients.

Telemedicine Capacity: Various PPS providers have achieved outstanding success with telemedicine programs providing behavioral health, medical and dental services to patients in counties with limited transportation and access to services. Implementation of telemedicine at one site resulted in a 55% reduction in PHQ9 (depression) scores and a 97% success rate of pediatric dental patient adherence. The PPS will utilize and expand upon this infrastructure to deliver PA programs, conduct PAM and deliver cultural competency training to healthcare providers.

Social Support Services: The FLPPS region boasts 1082 social support programs providing basic needs, 195 providing income support and employment, and 1137 supporting individual and family life. The PPS can engage these sites to serve as ‘hot spots’ for PAM administration and PA programs.

CBOs: With over 500 CBOs in the region, the PPS can establish extensive partnerships and networks to gain best practice guidance on patient engagement, particularly for the target population. These partnerships can also be leveraged to develop strategies on provider sensitivity and accountability planned processes.

Rochester/Finger Lakes Partnership on the Uninsured: This longstanding coalition comprises members from insurance companies, providers, enrollers and CBOs, and tracks the profile of the uninsured, monitoring barriers to enrollment over time. The PPS will engage this group to garner up-to-date information on the target population and inform the development of best practices.

Local Media Companies with Nationwide Reach and Proven Success in Patient Engagement: The PPS plans to implement a strategic media campaign to disseminate critical PA programs, messages and information on healthcare resources. The PPS can gather strategic implementation guidance, infrastructure implementation support from these entities as well as research support on consumer usage of PPS delivered programs and relevant social media patterns at individual, group and population levels.

Referral Call Centers: The FLPPS region has referral call centers with demonstrated efficacy in reaching individuals who may not have adequate access to care or limited knowledge of resources. For example, 211 directs callers to resources such as emergency food, shelter and provides bilingual support in crisis counseling, substance abuse issues, employment, physical and mental health needs received over 120,000 calls, live chats, email contacts for help in 2013 alone. The PPS can leverage the expertise and infrastructure of this asset to identify target populations, and direct persons to PAM and PA programs and other health care access points.

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.

Individuals may need several touches/interventions before they are willing to actively engage in primary care: As this project seeks to promote a paradigm shift in individuals approach to their health care from reactionary (treatment) to being proactive and engaged, as measured by an increase in PAM score, individuals will need continuous and supported guidance to help transition their behaviors. The PPS will address this by working with established CBO/PPS partnerships to develop and train an adequate body of community health workers and navigators to support these individuals and provide extended linkage to care.

Tracking identified cohort for PAM or PA over time: The health system currently lacks a means for measuring and tracking the defined cohort as persons may be engaged in a variety of settings including churches, CBOs, and EDs. This will be addressed through enhancement of existing regional IT networks through the parallel implementation of the Integrated Delivery System (Project 2.a.i) than can track the progress of the defined cohort over time.

Transportation: Transporation is an issue, particularly for the PPS target populations in rural areas where there is little to no transport system. The PPS will counteract this by using a telemedicine infrastructure to reach these individuals. In addition, FLPPS will create an alternate payment system using DSRIP dollars to purchase services from the community transportation network including volunteers and non-profit agencies.

Cultural and Linguistic Needs: Cultural competency and health literacy are identified barriers to care in the PPS region causing limited or no access to vital health care resources, poor adherence to treatment regimens, promotion of negative Medicaid stigmas and/or improper utilization of EDs. The PPS will address this on multiple fronts. First the PPS will implement PAM & PA education of existing and added workforce that includes cultural humility and responsiveness training. Second, the PPS will coordinate, through PPS/CBO partnerships and strategic media campaigns, widespread distribution of educational materials to address HL shortages. Third, the PPS will coordinate multifaceted PA programs in various formats to reach multiple target audiences: print, audiovisual materials, in person activation, webinars and community engagement forums.

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.

For the 2.d.i project Finger Lakes PPS recognizes existing overlap with Millennium Collaborative Care PPS (“MMC”), Southern Tier PPS, and the Central PPS. Specific PPS county overlap occurs in Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Wayne, Chemung and Steuben. This analysis is based off of the state’s listing for PPS counties served, by PPS, prior to merging of PPSs and final attribution. Through the Medicaid Support Team, FLPPS has made outreach to: MMC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with three out of the four previously listed PPSs.

Specific to this project, FLPPS will work with other PPSs to develop procedures and tools that facilitate referrals for newly-activated patients based on patterns of mobility and patient choice. In addition, FLPPS will encourage the development of common language and dissemination of best practices to facilitate patient understanding and prevent mixed messaging.

Through those PPS to PPS phone calls, the leads were able to establish a baseline for collaboration, and recognized a desire for ongoing dialogue and shared activity throughout the five year Waiver program. Initial meetings introduced the leads, members of the project teams, and briefly outlined the PPSs' approach to the projects; identified overlapping counties served; and laid the foundation for future discussions. The intent is to align efforts to minimize impact on downstream providers, and to establish venues for possible Learning Collaboratives to share best practices and lessons learned. In recognition of the fact that overlapping PPSs will share providers and patients, there is intent to ensure continuity of care through secure data sharing and bi-directional communication in the future.

Project Leads will connect at the State led training in January, and subsequently plan a kickoff implementation meeting; followed by regular check-ins.

In addition to these general next steps, FLPPS has also engaged in discussions with outlying PPSs, with the intent to consider the contracting of services to assist in gaps identified within their partnership, for neighboring PPSs (no shared territory). The goal is to assist in the successful implementation of projects in response to their CNA, specifically around services where they have identified a shortage in practitioners needed to serve their population.

FLPPS is committed to the success of all NYS PPSs, recognizing that if NYS fails we all fail.

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.

This project will require capital funding primarily to support:

1. The additional IT infrastructure required to track and monitor patients, including but not limited to increased server capacity at PPS provider sites, enhanced social media data mining and outreach tool development, database development and management, mobile tablets or devices for community health workers and other outreach staff administering PAM and other patient activation monitored activities. Additionally in rural areas where Wi-Fi hot spots, internet service, cell phone coverage and cable television in unavailable, thus limiting the PPS's ability to administer telemedicine, additional infrastructure will have to be created.

2. Transportation vehicles (e.g. vans) to increase access for patients to health care facilities and resources, including home visits for follow up by community health workers, which maximizes patient activation and can produce better patient outcomes

3. The creation of additional triage and exam room space, either through renovations of existing facilities or creation of new workspaces to Article 28 standards, to accommodate increased patient volume. The creation of space for a home base of care and coordination and training of outreach workers and community partners may also need to be established in certain areas where health care resources and/or facilities are more spread out or where there is inadequate space for family engagement and education.

4. Central call center for Medicaid members and providers to answer questions, begin enrollment processes and connect patients to care or providers to outreach support and 24/7 connection to care management support services.

5. Increased FQHC and community-based provider infrastructure will require rennovations in certain areas.

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
Chemung County Department of Aging and Long Term Care	Balancing Incentive Payment Program			The Balancing Incentive Program (BIP) is a federal initiative authorizing grants to States to increase access to non-institutional community-based long-term services and supports. New York was awarded $598.7 million through BIP, a portion of which will be used to strengthen and expand NY Connects, an information and referral service mostly operated by local offices for aging. With the expansion, New Yorkers will come to know NY Connects as the one-stop shop for long-term services and supports.
Finger Lakes Addictions Counseling and Referral Agency	Health Homes of Upstate New York	7/1/13	Ongoing	Health Homes and Care Management
Genesee County Office for the Aging	Balancing Incentive Program	1/1/15	9/30/15	A federal initiative to increase access to non-institutional community-based long-term services and support by strengthening and expanding NY Connects, an information and referral service mostly operated by local offices for aging. With the expansion, New Yorkers will come to know NY Connects as the one-stop shop for long-term services and supports. Through outreach activities to identify potential Medicaid eligibles, "No Wrong Door" single point of entry, "Level 1" screen to identify Medicaid eligibility and need for/linkages to life services and support.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Greater Rochester Health Home Network LLC	Health Home	4/1/12	Ongoing	Health Homes and Care Management
LDA Life and Learning Services	Supervised and Supported Certified Residential Services	1990	Ongoing	24/7 and less restrictive daily living, medical and clinical supports
Oak Orchard Community Health Center	CMMI grant	2013	2015	The CMMI grant seeks to facilitate practice transformation and patient activation
Planned Parenthood of Central and Western New York	Family Planning Benefits Program	Ongoing	Ongoing	This program covers family planning care in lieu of insurance to preserve confidentiality for the patient.
Rochester Regional Health System	CMMI Care managers	02/13	06/15	Care managers in some practices until 6/15 to help engage and manage chronic ill patients
Finger Lakes Community Health- Penn Yan	CMMI grant	6/13	6/15	The CMMI grant seeks to facilitate practice transformation and patient activation (2 sites)
Finger Lakes Community Health- Geneva	CMMI grant	6/14	6/15	The CMMI grant seeks to facilitate practice transformation and patient activation (2 sites)
Finger Lakes Community Health	Health Home	7/14	Ongoing	Health Homes and Care Management

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.

Project 11 speaks to a much broader audience than captured in these initiatives, which focus largely on those with chronic illnesses, the elderly and families with the exception of the CMMI grant at Oak Orchard. It expands significantly on the foundations of these projects to activate and engage not just these populations but the substantive body of the uninsured, and non and low-utlizers of Medicaid in the FLPPS region which in our region primarily belong to a younger demographic (18 – 44), low income and split between the rural and urban centers of the PPS region. The majority of the existing Medicaid initiatives support persons already in care to help manage their conditions, however this project distinguishes itself by creating infrastructure that would activate persons to not only get into care, enroll insurance and become better navigators of the local health system, but create avenues whereby the behavioral paradigm shift of reactive and treatment approach to managing health conditions to a proactive and preventative health care engagement approach is promoted and supported. The scale of project 11 is substantially larger than these programs and requires more complex and dynamic infrastructures including additional workforce, larger IT support and coordination across PPS providers to track activated patient cohort, more sustainable and greater number of partnerships across PPS service providers across the region for efficacy. However these additional layers of complexity for project 11, are merited by the larger impact that it hopes to have on the region as a whole, than these programs which are more selective and smaller in reach to immediate counties.

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.

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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. 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.

This project addresses CNA findings #2 and #6. The CNA shows that long-standing silos between physical health, mental health and substance abuse have created significant service-level gaps leading to poor outcomes for those seeking care in both primary care and behavioral health settings: *The region has a higher prevalence of mental illness (411.2/1000 pop.) when compared to the NYS average (289.4/1000 pop.) *The prevalence of substance abuse disorders is higher than the NYS average, with rates of 99.5/1000 population compared to 86.8/1000 population *Regional rates of Poor Mental Health for 14 or More Days in the Last Month (11.9%), Adult Binge Drinking (16.1%) and Suicide (9.31/100,000 pop.) are higher than NYS Prevention Agenda goals; *7% of all ED admissions have a primary diagnosis of behavioral health, the highest of all disease states; *17% of all hospital readmissions are associated with an individual having a behavioral health diagnosis;

*77% of inpatient mental health or substance abuse admissions have a co-occurring medical diagnosis.
*Less than 50% of children prescribed ADHD medications receive appropriate follow-up care.

Service-level gaps are exacerbated by a shortage of licensed behavioral health professionals, and the lack of cultural and behavioral health competence among physical health professionals to appropriately diagnose and manage behavioral health disorders:
*12 of the 13 FLPPS counties received designation as mental health HPSAs. Further, few behavioral health providers are multicultural and/or multi-lingual.
*Medical providers lack the time and training to manage the behavioral health needs of their patients. As a focus group participant maintained, “My PCP refuses to deal with anything psychological. She says she can’t.”

In response to these gaps, the PPS will meet all program requirements defined under project 3.a.i, facilitating integration of behavioral health and primary care to achieve Domain 1 objectives. Specific interventions include: (1) co-location of behavioral health into primary care; (2) co-location of primary care into behavioral health; and (3) the implementation of the IMPACT model in the primary care setting.

While the settings differ, project-related interventions will be relatively the same including achievement of NCQA PCMH Level 3 using 2014 standards, and implementation of evidence-based standards around medication management and care engagement.

In addition, given workforce shortages, the PPS will implement the IMPACT model, in lieu of full physical integration, in some cases. Implementation of IMPACT will be achieved through the development of collaborative care standards and implementation of evidence-based practices including employment of depression care managers, utilization of consulting psychiatrists, and stepped care.

Finally, to support integration, the PPS will ensure:
*Implementation of preventive care screenings, including those targeting behavioral health and chronic disease; and
*Implementation of EHRs and integrated IT solutions to identify and track patients and project-related outcomes.

Coordination with FLPPS projects 2.a.i, 4.a.iii and 4.b.ii will be paramount.

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 includes 150,000 patients that are cared for across 41 participating primary care and behavioral health provider practices. Four partner agencies are responsible for nearly 100,000 of these patients. These organizations operate a majority of the 35 participating FQHC locations, and will play an integral role in project success.

The PPS will focus on deploying this project where the highest concentration of Medicaid patients will benefit, ensuring the wide-spread application of PHQ-9 screening and integrated care. The target population will be further identified through screening and risk assessment, and includes: (a) Those in need of secondary prevention service to stop the development of chronic illness or a Mental, Emotional or Behavioral (MEB) health disorder. This includes, but is not limited to those who are obese (27.7% of the region's population), those who smoke (21.1% of the region's population), those who are uninsured (11.3% of the region's population), those who are depressed or have recently experienced trauma (to be determined through implementation of project 4.a.iii), and those who have low health literacy and are in need of patient activation (to be determined through implementation of project 2.d.i); and (b) Those who currently have a diagnosis of chronic illness, mental illness (411.2/1,000 population) or substance use disorder (99.5/1,000 population) and are at "high-risk" for further deterioration.

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

There are a number of existing assets that the PPS will leverage in order to ensure project success:

*The FLPPS network has working examples of all three forms of behavioral health integration in varying states of implementation. Long-standing programs will be held as models for success and will be sources for readily-available evidence-based protocols, policies and procedures. Programs under development will also be utilized to test and improve implementation of project-related standards of care and best practices. 74% of providers cite experience with this type of integration from the FLPPS provider survey.

*Fifty-two percent of FLPPS primary providers have already been recognized as Level 3 PCMH by NCQA. The PPS will build on this knowledge and experience as the organization provides technical assistance to those working to achieve recognition under 2014 standards.

*All FQHCs in the FLPPS are screening for depression, per HRSA requirements, and several have received funding to fully integrate behavioral health services in the primary care setting. Again, the PPS will leverage this knowledge and experience to ensure successful program implementation.

*Health Homes in the FLPPS region, including the Greater Rochester Health Home Network (GRHHN) and Health Homes of Update New York (HHUNY) have an existing model to screen high-risk patients based on the presence of a behavioral health diagnosis and/or chronic conditions. The PPS will utilize this experience and fill identified gaps, as needed.

*Several providers in the FLPPS network have tele-health capability and expertise. The PPS will work with these providers to assess and establish best-practice solutions to utilize tele-health across integration paradigms.

Additional assets that the PPS will need to develop to ensure project success include:

*Regional expertise in the IMPACT model, including collaborative care standards and procedures for care management. The PPS will ensure the development of this asset by facilitating widespread training of project implementation leads in each Naturally Occurring Care Network (NOCN).

*Training and certificate programs that help to ease the burden of behavioral health workforce shortages. The PPS will work with regional institutions of higher education to ensure appropriate curriculum development. In addition, the PPS will work to develop the appropriate use of a wide range of skill sets (such as social workers), across care settings, as an alternative to the traditional RN, for depression care management. This work will be driven the Workforce Operations Workgroup.

*Cultural competence in managing both MEB disorders and chronic illness. The development of this asset will be facilitated through implementation of projects 4.a.iii and 4.b.ii.

*An expanded HIT infrastructure that will be used to enable completion of EMR-related metrics and milestones. This will be facilitated by successful implementation of project 2.a.i.

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.

Workforce**:** The FLPPS region has a shortage of licensed health professionals, including physicians, psychiatrists, psychologists and licensed social workers. This shortage will impact the PPS's ability to ensure widespread implementation. To address this challenge, the PPS will maximize the use of telemedicine, share provider resources across settings and partners, and consider a wide range of skill sets that might function as depression care managers. The PPS will work with local universities to develop behavioral health training programs for mastered prepared health professionals.

Screening: The current rate for screening for MEB disorders is not well-tracked, largely due to it being an unbillable service. The rate of screening for chronic illness in the behavioral health setting is also largely undocumented. To address this, the PPS will ensure that protocols include minimum annual screening for both behavioral health and chronic illness, across settings. In addition, screening will be documented in PPS-wide registries developed under project 4.b.ii.

HIT Interoperability: Due to the presence of long-standing silos, there are gaps in interoperability between primary care & behavioral health providers. To address this challenge, the PPS will ensure that the implementation of Project 2.a.i considers 3.a.i.

Regulatory Challenges: Regulatory relief was cited by 47% of potential project participants as a crucial factor in ensuring programmatic success. The PPS will work to secure necessary waivers & will leverage scarce resources to the extent that regulatory relief permits.

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.

For the 3.a.i project FLPPS recognizes existing overlap with Millennium Collaborative Care PPS (MMC), Southern Tier PPS, and the Central PPS. Specific PPS county overlap occurs in Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Wayne, Chemung and Steuben. However, FLPS is the only PPS to utilize the IMPACT model, to the PPS understanding. This analysis is based off of the state's listing for PPS counties served, by PPS, prior to merging of PPSs and final attribution. Through the MST, FLPPS has reached out to: MMC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with 3 out of the 4 PPSs.

Through those PPS-to-PPS phone calls, the leads were able to establish a base for collaboration, and recognized a desire for ongoing dialogue and shared activity throughout the five-year Waiver program. Initial meetings introduced the leads, members of the project teams, and briefly outlined the PPSs' approach to the projects; identified overlapping counties served; and laid the foundation for future discussions. The intent is to align efforts to minimize impact on downstream providers, and to establish venues for possible learning collaboratives to share best practices and lessons learned.

FLPPS has also engaged in discussions with outlying PPSs, with the intent to consider the contracting of services to assist in gaps identified within their partnership, for neighboring PPSs (no shared territory).

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital funding, not covered under project 2.a.i, will be needed to develop bricks and mortar infrastructure at behavioral health and primary care practices to increase capacity and ensure that existing space can support updated workflows. In addition, there are IT costs associated with this project including EMRs, interfaces, database development and equipment. Significant work effort, cost and IT support is needed to assist practices that need to upgrade and/or implement an EHR to achieve PCMH recognition and to meet the interoperability requirements for connectivity with the Rochester RHIO (WE of the SHIN-NY).

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
Arnot Health	VAP/So. Tier MH Project	4/1/14	3/31/17	The Vital Access Provider program at Arnot Health is focused on operating and systems change, increasing professional psychiatric capacity, mental health/substance abuse assessment and management, behavioral health in primary care.
FLACRA	Health Homes	7/1/13	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.
Genesee County Mental Health Services	PSYKES	2008	Ongoing	This program provides data to help improve and adopt psychiatric medications and quality concerns
Greater Roch HH Network	Health Homes	N/A	Ongoing	The Health Homes initiative emphasizes care management to build linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.
UR Medicine Primary Care	NYS Child Clinic Plus Program	N/A	Ongoing	This program is a service model aimed at improving mental health outcomes of children through comprehensive assessments, screenings, and evidence-based treatment. UR Medicine Primary Care received 5 years of funding through the NYS Child Clinic Plus Program and 5 subsequent years of funding through the NYS Early Recognition and Screening Program to facilitate this program.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
UR Med PC	FLHSA/CMMI Grant	N/A	07/2015	The CMMI grant supports Primary care practice transformation, integrate community services with primary care and develop a community-wide outcome-based payment model for primary care. This grant supports one care manager.
UR Med PC	Doctors Across NY	N/A	06/2016	This program expands access to primary care services for underserved populations through education and curriculum development. The program's target population is adults with special health care needs such as intellectual and developmental disabilities, movement disorders, cystic fibrosis, sickle cell disease, among others.

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

This project will benefit from and be able to leverage the experience and processes developed from participation in the initiatives listed above. Several of these initiatives align with the objectives of this project, specifically around expansion of the primary care and mental health services, especially the integration of these two services. However, several of these projects are limited in scope as they impact a small percentage of the population, such as the Doctors across NY program, or they have limitations in the array of services they provide, such as the Child Clinic Plus Program. The participation of these organizations in this project will allow the PPS to leverage lessons learned and receive best practices from these initiatives. It will allow the PPS to develop comprehensive infrastructure and services that will impact a larger subset of the population by bringing these fragmented programs together. The NYS and grant-funded initiatives have enabled us to collect data regarding the prevalence of mental health in our practices, but has not allowed us to implement models that would achieve the overall goals including co-location, coordination, and practice innovation. These practice enhancements will allow us to routinely screen for mental health disorders, impact patient perceptions of mental health treatment as stigmatized and separate from their medical health, and do so in a comprehensive care setting due to the waivers from current regulatory barriers. The proposed projects will enable us to provide timely access to mental health services within primary care setting for children, adolescents, and adults identified through our screening programs and will impact as many approximately 35,000 DSRIP-eligible patients.

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

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

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

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

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

3.a.ii Behavioral Health Community Crisis Stabilization Services

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

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

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

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

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

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

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

This project address CNA findings #2 and #13.

High behavioral health disease prevalence in the PPS has led to a gap in access to appropriate services for patients experiencing a behavioral health crisis, as evidenced by:
*A higher prevalence of mental diseases and disorders (MDDs) among Medicaid beneficiaries (411.2/1000 pop.) when compared to the New York State (NYS) average (289.4/1000 pop.)
*A higher prevalence of substance use disorders (SUDs) (99.5/1000 population) than the NYS average (86.8/1000).
*Suicide is the fifth leading cause of premature mortality across the region and is the only cause trending upward since 2002.

A gap in crisis stabilization services, including 24/7 outreach, ambulatory and intensive services has led to inappropriate health care utilization, as evidenced by:
*ED "treat and release" visits for many chronic conditions, with MDDs and SUDs accounting for over 50 percent of all "treat and release" visits across the PPS.
*High PPRs with 17% of all hospital readmissions in the PPS associated with an individual having a behavioral health diagnosis.
*High emergency department utilization for behavioral health needs as evidenced by 7% of all ED admissions in the PPS having a primary diagnosis of behavioral health, the highest of all disease states.
*Monroe, Wayne and Chemung are significantly below NYS average for adherence to anti-psychotic medication and antidepressant use (acute and maintenance)

In addition, focus group data provided evidence regarding a gap in the availability of community-based crisis intervention services. Partners across the region have acknowledged that there is a low threshold for the utilization of emergency department services as residential staff, school staff and outpatient providers cannot provide or access the necessary assessments, interventions, monitoring, and follow-up in their setting.

In response, the PPS will address the identified gaps, and meet the project specific requirements as well as Domain 1 objectives by:
*Establishing collaborative, community-based crisis stabilization services by working with partner organizations, including Health Homes, detox, and transitional housing partners who can focus on early identification of patients at risk, provide crisis prevention planning, and

facilitate support and stabilization services within the community following a hospital discharge.
*Providing outreach and improving access to 24/7 crisis services in up to five geographically strategic hubs, and by expanding existing Mobile Crisis Teams (MCTs) to provide consultation and/or "push-in" support during a crisis to patients, families, PCPs and community staff.
*Facilitating early identification of patients at risk by including a central triage system that will operate in "real time", connecting the needs of the individual to the resources available. This system will combine EHR data with local health information exchange data, as well as regional policies, procedures and protocols.
*Reducing language and cultural barriers by working with community partners to develop a culturally, linguistically and ethnically diverse workforce.

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

The target population for this project will initially include current high utilizers of emergency services for MDD and SUD crises who reside across the PPS service area. Based on CNA data, communities with high levels of "treat & release" visits for MDDs and SUDs include Monroe, Western, Southern and Southeastern NOCNs. The PPS also will target the general population who currently have low or no utilization of crisis services but who would engage, as needed, if the services were more accessible, lower cost, culturally and linguistically accessible, and patient, family and community-centered. Additionally the PPS will target community-based staff and organizations to assure their awareness and collaboration in utilizing community crisis stabilization services in lieu of emergency services, and to provide support and education around the importance of screening and early identification of mental health needs.

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.

A number of important assets exist within the PPS to support this project, including:

Expertise: Organizations within the PPS have expertise and resources in behavioral health community crisis intervention and stabilization. Two organizations within the PPS have comprehensive specialty psychiatric services and crisis-oriented psychiatric services, and can provide assistance, leadership and share best practices throughout the implementation of this project. They plan to leverage existing programs to create 24/7 accessibility, to provide training to new teams, and to include more outreach, extended observation and follow-up. They also plan to repurpose existing space for two crisis stabilization hubs.

Partners: The PPS will partner with regional chapters of the National Alliance on Mental Illness (NAMI) who have signature programs that align with the aims of this project. Throughout the PPS region there are multiple local crisis response and prevention programs, along with several peer run initiatives that include, but are not limited to, a Self-Help Drop-in Center and peer run Warm Line lead by the Mental Health Association, and a Peer lead/Peer-Driven Recovery

Center for people with SUDs. These organizations will offer best practices to support the expansion of these services.

Best Practices: The PPS will collaborate with a number of well-established crisis and transitional housing programs including Unity House, DePaul and East House, and with new housing options being piloted or established. The PPS also will leverage programs including the NYS START Program for OPWDD individuals, a community-based crisis and prevention program that has been established in the PPS and uses many of the same components, as well as Planned Parenthood of Western and Central NY who have expertise in providing crisis intervention and support services.

Information Technology: The Rochester RHIO has integrated with 23 different EHRs to help with the coordination and communication across the PPS. Providers will be part of a FLPPS EHR, so that information will be available, even in rural areas. In addition, telemedicine resources in several NOCNs, which have been utilized in clinics, urgent care centers, day care centers, skilled nursing facilities and emergency departments, will provide further access. Wireless devices may also be used to provide network capability in the more rural areas of the PPS.

New resources that will be developed for this project include the following:

With the pending closure of St. James Mercy Hospital, some funding is allocated to intensive intervention services for individuals in crisis. Wyoming County Community Health System has space that may be suitable to support aspects of this project and Finger Lakes Addictions Counseling and Referral Agency is interested in establishing a 15-bed Safe Haven program that will help fill a gap in access in that area.

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.

Information Technology: The PPS IT infrastructure is evolving, but is currently inadequate for the ready integration of care across NOCNs, and for distance conferencing and learning. The PPS has an opportunity to explore sharing/leveraging IT infrastructure with the NYS START program to address this challenge, as well as participating in Project 2.a.i.

Provider Availability: To address this challenge the PPS plans to take advantage of established programs to train non-behavioral health clinicians and non-clinical staff to become certified in behavioral health care and cultural competencies. In addition, the capacity for remote access to psychiatric experts for rural MCTs is also limited. The PPS will address this challenge by building upon existing infrastructure and expertise.

Transportation: Transportation for follow-up behavioral health visits is a challenge across the PPS. EMS, in particular, will assist the PPS to help direct more care to community-based services. The PPS will create a comprehensive transportation data base to ensure transportation needs are efficiently met. FLPPS will create an alternate payment system using

DSRIP dollars and/or other funding sources to purchase services from the community transportation network including volunteers and non-profit agencies.

Cultural/Linguistic: Increasing services that are culturally and linguistically matched to the target population poses challenges as well. However, the integration of CBOs and peer/family supports will help to ensure a culturally, linguistically and ethnically diverse workforce.

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.

For the 3.a.ii project FLPPS recognizes existing overlap with Millennium Collaborative Care PPS (MCC), Southern Tier PPS, and the Central PPS. Specific PPS county overlap occurs in Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Wayne, Chemung and Steuben. This analysis is based off of the state's listing for PPS counties served, by PPS, prior to merging of PPSs and final attribution. Through the Medicaid Support Team, FLPPS has made outreach to: MCC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with 3 out of the 4 PPSs.

Through those phone calls, the leads were able to establish a baseline for collaboration, and recognized a desire for ongoing dialogue and shared activity throughout the five-year Waiver program. Initial meetings introduced the leads, members of the project teams, and briefly outlined the PPSs' approach to the projects; identified overlapping counties served; and laid the foundation for future discussions. The intent is to align efforts to minimize impact on downstream providers, and to establish venues for possible learning collaboratives to share best practices and lessons learned. In recognition of the fact that overlapping PPSs will share providers and patients, there is intent to ensure continuity of care through secure data sharing and bi-directional communication in the future.

FLPPS has also engaged in discussions with outlying PPSs, with the intent to consider the contracting of services to assist in gaps identified within their partnership, for neighboring PPSs (no shared territory).

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.

Implementation of this project will require dedicated staff who are working in the community providing behavioral health crisis intervention services; while the staff are not capital, their ability to provide quality care in the field that is well documented and accessible will require equipment such as laptops, phones, and vehicles.

With many partners actively engaged in this project, successful IT integration will be required. As the PPS will centralize multiple services, capital funds related to IT will be reviewed both at the PPS and individual project level, to provide the most efficient and effective use of funds to benefit the most number of projects and providers. Among these IT resources would be equipment to administer telemedicine services in various provider sites across the care continuum. Other IT costs will include EMR, interfaces, database development, and RHIO connectivity.

Funds will be needed to ensure space is properly utilized to provide evidenced based crisis

Intervention services. It is anticipated by engaged providers that existing offsite locations could be renovated, repurposed, or expanded. Off-site crisis residence requires acquiring and renovating appropriate space to meet the specific needs of this population. Office furnishings will also be needed.

Capital funding would potentially provide opportunity to implement project design elements without utilizing debt.

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
Arnot Health	VAP--Southern Tier Mental Health Project	4/1/14	3/1/17	The Vital Access Provider program at Arnot Health is focused on operating and systems change, increasing professional psychiatric capacity, mental health/substance abuse assessment and management, behavioral health in primary care.
FLACRA	Health Homes of Upstate New York	7/1/13	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
GRHHN	Health Homes			The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.

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.

These initiatives expand upon and greatly support this DSRIP project by allowing the PPS and the member providers involved in this project to leverage the systems, processes and best practice knowledge from these initiatives. The Health Homes care management infrastructure currently support a limiting population, primarily those that have multiple chronic illnesses. Through DSRIP these organizations can increase service delivery to a significantly larger population and leverage this structure to support the development of a crisis intervention model. Additionally, the primary care redesign efforts through the VAP program can be leveraged to identify patients in need of these services.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

3.a.v Behavioral Interventions Paradigm (BIP) in Nursing Homes

Project Objective: To reduce transfer of patients from a SNF facility to an acute care hospital by early intervention strategies to stabilize patients with behavioral health issues before crisis levels occur.

Project Description: Many patients in long term care have behavioral health issues as a primary disease or as the result of other ongoing chronic diseases. Despite the prevalence of such problems within the SNF, staff may have inadequate formal training to manage these problems or rely on medication to manage these patients. These patients are a significant cause of avoidable admissions and readmissions to hospitals from SNF. This program provides a pathway to avoid these transfers and to ensure better care for the SNF patient with these diagnosis. Interventions that rely on increased training of the usual care staff to identify and address behavioral health concerns have been found to be effective management tools.
Resources from other evidence based SNF initiatives to reduce avoidable hospital admissions, e.g., INTERACT (http://interact2.net/index.aspx) may be integrated into this program.

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 BIP Model in Nursing Homes model using SNF skilled nurse practitioners (NP) and psychiatric social workers to provide early assessment, reassessment, intervention, and care coordination for at risk residents to reduce the risk of crisis requiring transfer to higher level of care.
2. Augment skills of the clinical professionals in managing behavioral health issues.
3. Enable the non-clinical staff to effectively interact with a behavioral population.
4. Assign a NP with Behavioral Health Training as a coordinator of care.
5. Implement a Behavior Management Interdisciplinary Team Approach to care.
6. Implement a medication reduction and reconciliation program.
7. Increase the availability of psychiatric and psychological services via telehealth and urgently available providers.
8. Provide holistic psychological Interventions.
9. Provide enhanced recreational services.
10. Develop crisis intervention strategies via development of an algorithm for staff intervention and utilization of sitter services.
11. Improve documentation and communication re: patient status.
12. Modify the facility environment.
13. Form agreements with the Medicaid Managed Care organizations (including MLTC and FIDA plans) serving the affected population to provide coverage for the service array under this project.
14. Use EHRs or other technical platforms to track all patients engaged in this project.

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

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

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

This project addresses CNA findings #2, #9 and #13.

The CNA found that the prevalence of behavioral health issues in patients requiring a Skilled Nursing Facility (SNF) level of care has led to gaps in the availability of appropriate care:
*Between April 2013 and March 2014, roughly 40% of SNF patients had a behavioral health or substance abuse disorder diagnosis, compared with 32% across NYS.
*Between July 2013 and March 2014, the percentage of SNF residents in the PPS with depression and/or anxiety symptoms increased, with eight SNFs having averages of worsening depressive and anxiety symptoms greater than the NYS average (11.6 %), and 19 SNFs having averages greater than the national average (6%)
*Readmissions to acute care beds following a discharge to a SNF account for about 16% of all Medicaid readmissions, with behavioral health symptoms among the top 11 “Most Frequent Primary Diagnosis Clusters at Readmission” for SNF Readmissions.

The CNA also found that the FLPPS region has a significantly higher prevalence of mental illness among Medicaid beneficiaries (411/1000 pop.) when compared to the NYS average (289/1000 pop.) and a higher prevalence of substance abuse disorders than the NYS average (99.5/1000 pop. vs. 86.8/1000 pop).

The CNA highlighted population trends in the PPS region that have led to a gap in service capacity for dependent elders:
*From 1992 to 2012 the number of persons over age 65 has increased by nearly 40,000 and accounts for 15.4% of the region’s total population.

Behavioral health workforce gaps across the PPS are evidenced by:
*Eight counties within the PPS designated as MH HPSAs, and six counties are identified as having subsets of their populations in need of additional mental health services. Half of the 13 counties specifically identify the Medicaid population as needing additional mental health services.
*Focus groups and other data indicate safety concerns for staff and residents as well as staff turnover in light of these safety issues.

To address these identified gaps, the PPS will meet all project requirements in addition to Domain 1 objectives by:
*Employing early assessment, reassessment and intervention strategies with NPs and

psychiatric social workers to stabilize patients with behavioral health issues before crisis levels occur.
*Modifying facilities, as needed, to ensure adequate recreation and holistic interventions can be carried out.
*Implementing a medication reduction and reconciliation process across all SNFs within the PPS.
*Focusing on education and training for SNF clinical and non-clinical staff using local, online and web-based training already underway.
*Using EHR and other documentation to develop algorithms that identify patients in need of intervention before a crisis requiring a transfer occurs.
*Improving access to psychiatric expertise along with enhanced mental health care at the SNFs leveraging telehealth and forming agreements with Medicaid managed care organizations serving these populations.

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

The target population for this project will eventually include patients across all SNFs in the PPS, but will initially include those SNFs that currently have expressed interest, do not have access to consistent and effective psychiatric expertise (most of them), have high rates of acute psychiatric hospitalizations for their residents, and have low quality indicator scores. Allegany, Chemung, Orleans, Seneca, Steuben, Wyoming, and Yates Counties are all identified, in their entirety, as lacking mental health services. Cayuga, Genesee, Livingston, Monroe, Ontario, and Wayne counties are also identified as having subsets of their populations in need of additional mental health services with geriatric psychiatry among these needs.

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

There are a number of assets available to the PPS to implement this project including:

Best Practices: Several SNFs (Blossom View SNF in Sodus, NY, and St. Anne's NH in Rochester) have successfully implemented best practices that are aligned with the components of this project, including the INTERACT Model. Another promising model includes telementoring access through the Project ECHO® model, an inexpensive and readily accessible web-based program. Project ECHO is currently being used by one of the lead PPS organizations to improve geriatric mental health across the region, via biweekly case reviews with an interdisciplinary team and weekly didactic sessions on caring for residents with behavioral health concerns. The PPS will leverage these programs by expanding models to participating SNFs across the PPS.

Tele-health: Several SNFs in the PPS have successfully utilized telepsychiatry and tele-health when access to these services has been available, providing evidence that this technology can work in SNFs to overcome our shortage of behavioral health providers, and improve the care of this population. The PPS will expand the tele-health infrastructure using the expertise of the

SNFs that have implemented this model. This intervention will be supported through project 2.a.i.

Access to Services: SNFs who have already employed best practices have agreed to repurpose some of their existing beds to accommodate residents with behavioral health diagnoses, in a separate unit at their facility, to expand capacity to manage more challenging BH concerns, transitionally, at the SNF level. There are also many low cost environmental enhancements that some SNFs already have in place that can be readily replicated in other facilities, including, but not limited to, a calming room, safe access to the outdoors, and social networking for residents through outpatient day programming or events with non-residents.

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 a number of challenges the PPS faces in implementing this project, including:

Availability of Mental Health Practitioners: There is significant variation in the number of mental health clinicians across the PPS. Expanding the current tele-health capability is one way the PPS plans to meet this challenge. The PPS also will provide behavioral health certification training for onsite SNF nurse practitioners through two of the local nursing schools where this training already exists. Expanding the ECHO telementoring provides another opportunity. This supports projects 3.a.i also.

Lack of communication: Communication, especially around transitions with acute services, is often a challenge, in the absence of a “warm handoff” or “facilitated discharge,” sometimes due to distance. The PPS will address this challenge by leveraging best practices for improved communications, including processes for medication reconciliation.

Information Technology: In some SNFs, Information Technology (IT) infrastructure is absent or inadequate for the integration of care across the care continuum, and for distance conferencing and learning. The PPS will need to consider how to support SNFs in acquiring the necessary IT infrastructure to enable project success.

Stigma: Another challenge is the stigma that is associated with behavioral health symptoms and diagnoses in the SNF setting, which can interfere with care and exacerbate behaviors. Providing training and competencies in managing these behaviors as well as increasing awareness of stigma will be a part of the SNF staff training.

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.

For the 3.a.v project Finger Lakes PPS there is no project overlap with surrounding PPSs.

Through the Medicaid Support Team, FLPPS has made outreach to: MMC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with 3 out of the 4 previously listed PPSs.

Through those PPS-to-PPS phone calls, the leads were able to establish a baseline for collaboration, and recognized a desire for ongoing dialogue and shared activity throughout the five-year Waiver program. Initial meetings introduced the leads, members of the project teams, and briefly outlined the PPSs' approach to the projects; identified overlapping counties served; and laid the foundation for future discussions. The intent is to align efforts to minimize impact on downstream providers, and to establish venues for possible learning collaboratives to share best practices and lessons learned. In recognition of the fact that overlapping PPSs will share providers and patients, there is intent to ensure continuity of care through secure data sharing and bi-directional communication in the future.

FLPPS has also engaged in discussions with outlying PPSs, with the intent to consider the contracting of services to assist in gaps identified within their partnership, for neighboring PPSs (no shared territory). The goal is to assist in the successful implementation of projects in response to their CNA, specifically around services where they have identified a shortage in practitioners needed to serve their 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.

Implementation of this project will require capital funds utilized for space renovation, IT infrastructure and equipment, and enhanced recreational services (all project requirements).

From the perspective of space, the project requires modification to the facility environment, which will include creation of private rooms in facilities, remodels to accommodate integrated technology, space for rehabilitation and recreational services, , and creation of some specific behavioral health "units" in Nursing Homes. For all renovated space, implementation will require proper equipment and beds be utilized to meet standards of care.

Enhanced recreational services will not only require space, but also equipment (equipment, music, art supplies, etc.).

With respect to information technology, infrastructure is absent or inadequate in some SNFs for the ready integration of care across the continuum and for distance conferencing and learning. The PPS will need to consider how to support SNFs in acquiring the necessary IT infrastructure. This would include utilizing computers, mobile devices, telemedicine (project requirement), and a tracking platform for engaged patients (requirement). IT infrastructure will provide improved documentation (requirement) and enhance the required medication reconciliation program. Providers will also need the ability to securely transfer data and communicate between providers and systems. Other IT costs will include EMR, interfaces, database development, and RHIO connectivity.

With many partners actively engaged in this project, successful IT integration will be required. As the PPS will centralize multiple services, capital funds related to IT will be reviewed both at the PPS and individual project level, to provide the most efficient and effective use of funds to benefit the most number of projects and providers.

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

Yes	No
☐	☒

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

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

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

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

No known initiatives.

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.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies)

Project Objective: To reduce avoidable poor pregnancy outcomes and subsequent hospitalization as well as improve maternal and child health through the first two years of the child's life.

Project Description: High risk pregnancies do not end with the birth of the child, but can continue with high risk parenting situations. Women with high risk pregnancies due to age, social situation or concurrent medical or behavioral health conditions may need significant support beyond obstetrical care to grow a healthy child. Nuclear families and single mothers may not have access to functional parenting skill advice to assist them in the crucial first two years of a child's life.

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.

For performing partner systems where the community assessment identifies significant high risk obstetrical/parenting cases, there are **three models** for intervention that may be utilized for this project. Systems should choose one primary project but may also choose requirements from the other two projects to add as part of their project.

Model 1: Implementation of an evidence-based home visiting model for pregnant high risk mothers including high risk first time mothers. Potential programs include Nurse Family Partnership.

1. Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high-risk mothers including high-risk first time mothers.
2. Develop a referral system for early identification of women who are or may be at high risk.
3. Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.
4. Use EHRs or other technical platforms to track all patients engaged in this project.

Model 2: Establish a care/referral community network based upon a regional center of excellence for high risk pregnancies and infants.

1. Identify and engage a regional medical center with expertise in management of high risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).
2. Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high risk mother and infant with local community obstetricians and pediatric providers.
3. Develop service MOUs between the multidisciplinary team and OB/GYN providers.
4. Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.

5. Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms 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.
6. Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
7. Use EHRs or other IT platforms to track all patients engaged in this project.

Model 3: Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program.

1. Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.
2. Employ a Community Health Worker Coordinator responsible for supervision of 4 – 6 community health workers. Duties and qualifications are per NYS DOH criteria.
3. Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.
4. Establish protocols for deployment of CHW.
5. Coordinate with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other IT platforms to track all patients engaged in this project.

Project Selection

For this project, one of the following three project models can be selected. Please indicate which of the three will be chosen:

☐ Model 1: Implementation of Nurse-Family Partnership program model for pregnant high risk first time mothers.
☐ Model 2: Establish a care/referral network based upon a regional center of excellence for high risk pregnancies and infants.
☒ Model 3: Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaborative (MICHC) program.

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.

This project links to CNA finding #3

The CNA shows service-related gaps that impact maternal and child health, including:
*A lack of coordinated services for high-risk mothers, such as psychosocial supports, transportation, health literacy and education about healthy behaviors;
*A lack of attention to the causal factors of toxic stress (of which poverty is an indicator) and their effect on high-risk pregnancies.

In addition, in the city of Rochester, 76% of children ages 6 and live at or near the poverty level.

These disparities have led to (1) poor pregnancy outcomes, (2) subsequent hospitalizations, and (3) poor maternal and child health through the first two years of its life.

Poor pregnancy outcomes:
*The infant mortality rate in the FLPPS region has remained relatively stagnant over the last two decades, moving from 7.3 deaths per 1,000 births in 1994 to 6.4 deaths per thousand in 2011.
*Twenty-one percent of women reported smoking during or within three months prior to pregnancy, which is a risk factor for low birth weight.
*Allegany (8.9%), Monroe (8.7%) and Seneca (8.3%) counties have higher rates of low birth weight (< 2500g) when compared to the New York State (NYS) average (7.9%).
*The CNA cites poor perinatal outcomes as the fourth leading cause of Years of Potential Life Lost in the FLPPS region, with rates higher than the upstate New York average.

High utilization:
*Per regional SPARCS data, infants covered by Medicaid (aged 0-1) utilize the ED 30% more than the non-Medicaid population.
*Gaps in substance abuse prevention services and healthy pregnancy habit education have resulted in seven FLPPS counties with a drug-related newborn discharge rate higher than the NYS average (85 per 10,000 live births).

Maternal and child health through the first two years of the child's life:
*Only 65.1% of children, ages 0-24 months receive appropriate lead screening
*Only 53% of children complete the 4:3:1:3:3:1:4 vaccination series

In response to these gaps, the PPS will reduce avoidable poor pregnancy outcomes and subsequent hospitalizations, as well as improve maternal and child health through the first two years of life using the Community Health Worker (CHW) model based on the Maternal and Infant Child Health Collaborative (MICHC) framework. Specific interventions include:
*Expand existing best-practice CHW programs to needy communities, including the use of home visits as a means for early intervention in detrimental behaviors and the provision of transportation to ensure prenatal and well-child appointments are attended
*Utilize NYSDOH-funded CHW training programs
*Employ CHW coordinators and staff per NYSDOH criteria around cultural competence, communication, experience and training
*Review, improve and implement protocols for deployment of CHWs
*Coordinate with Medicaid managed care organizations (MCOs)

*Utilize IT platforms to assess risk, and link and monitor outcomes

In addition, the PPS will leverage the work being done in other FLPPS projects. For example smoking cessation is addressed in project 4.b.ii and patient navigators will redirect expecting mothers to PCPs through project 2.b.iii.

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.

Generally, the target patient population for this project includes high risk, expectant mothers and mothers with children aged newborn to 24 months; however targeted interventions will vary based on geography and identified needs.

Monroe County, the region's population center, accounts for half of the total number of Medicaid births (3,163 of 5,957 in 2012). Based on the CNA, the project focus, in Monroe County, will be on those receiving pre- and perinatal care. African American and Latino populations will be particularly targeted, as infant mortality rates among these populations are between two and four times higher than Whites.

The remainder of the target population lives in the 12 outlying counties in the FLPPS region, which are largely rural in nature. Across these rural counties, the project will target mothers of children age 0-24 months, and will work to improve the rates of well child visits, immunizations and lead screenings.

Through Project 2.d.i, pregnant mothers who are presumptively eligible for Medicaid will likely be activated, enrolled, and then referred to CHW staff. Patient navigators from 2.b.iii will also refer uninsured pregnant mothers to CHW programs.

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

There are a number of assets that the PPS can utilize when realizing this project. First and foremost, the FLPPS region boasts a wide-range of evidence-based programs with demonstrated success in achieving DSRIP-defined metrics and project-specific requirements. For example, Monroe and Livingston counties have implemented the MICHC Community Health Worker model, in partnership with the Perinatal Network of Monroe County. Under this prototype, the Perinatal Network employs CHWs, as well as outreach workers, and is the process of launching Peer Place, an automated referral system that will potentially act as a resource in facilitating integration and collaboration across community-based programs and services. The PPS will capitalize on these assets by collaborating with established programs, strengthening linkages and emphasizing cultural competency and health literacy. In addition, the PPS will aid the expansion of model programs across the region.

Monroe County also has a highly successful Nurse Family Partnership (NFP) program that has existed since 2006, and has demonstrated improved health outcomes as well as a reduction in overall Medicaid spending. In addition, Cayuga County implemented a NFP program in 2012, and Chemung County was the original pilot for NFP and continues to maintain a solid maternal and child health infrastructure on which this program might build. Again, the PPS will leverage this asset by supporting the expansion of model programs across the region.

Additional evidence-based programs that currently exist with FLPPS region include Healthy Moms and Healthy Families. The PPS will facilitate the deployment of these national model programs based on an assessment of need.

Assets that the FLPPS will need to develop to ensure project success include:

*The development of a registry that tracks and manages patient outcomes, over time. This will be facilitated by the deployment of an integrated IT solution, across the PPS network, and may be included as part of a collaborative intervention along with project 4.b.ii.

*Enhanced relationships and collaborations with Medicaid MCOs. This will be facilitated by inclusion of MCOs on project implementation committees and through the development of contracts and agreements.

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.

Toxic Stress: As toxic stress is an indicator for poor pregnancy outcomes, program implementation must consider the challenges of poverty, close proximity to crime, unemployment, etc. The PPS will deliver the full gamut of psychosocial services, using a culturally competent CHW or NFP nurse. In addition, services will be provided in an individual’s home, where social circumstance, health behaviors and physical environment are apparent. Connections to social support services such as the labor bureau and job coaching will be incorporated into the CHW framework.

Transportation: Seventy-five percent of mothers identified transportation as a major barrier to accessing care. Home visitation allows the PPS to surmount this challenge, as CHWs and NFP nurses will visit homes and arrange transportation. FLPPS will create an alternate payment system using DSRIP dollars and/or other funding sources to purchase services from the community transportation network including volunteers and non-profit agencies.

Workforce: Workforce strategy and attendant qualifications criteria is a challenge. Inherent to this model are training programs that will teach CHWs the skills necessary to be successful. Also, qualification criteria will be established to guide hiring protocols across the network.

Cultural Competence: CHWs and NFP nurses must be culturally competent and have expertise that allows for the provision of customized supports. The PPS will address this challenge ensuring the recruitment of multicultural workforce who are indigenous to and have knowledge of the community.

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.

For the 3.f.i project Finger Lakes PPS recognizes existing overlap with Millennium Collaborative Care PPS ("MCC"). Also of note, no other PPSs in the state are including Nurse Family Partnership in their project plan. The FLPPS includes an expansion of Nurse Family Partnership as an integral part of the success of improving health outcomes for high risk pregnancies. There is an intent to expand Nurse Family Partnership programming to the rest of the FLPPS counties – NFP already exists in Monroe and Cayuga Counties. Any patients eligible for NFP will be referred to that program.

Specific PPS county overlap occurs in Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Wayne, Chemung and Steuben. This analysis is based off of the state's listing for PPS counties served, by PPS, prior to merging of PPSs and final attribution. FLPPS has made outreach to: MCC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with three out of the four previously listed PPSs.

Through phone calls, the leads were able to establish a baseline for collaboration, and recognized a desire for ongoing dialogue and shared activity throughout the five-year Waiver program. The intent is to align efforts to minimize impact on downstream providers, and to establish venues for possible learning collaboratives to share best practices and lessons learned. In recognition of the fact that overlapping PPSs will share providers and patients, there is intent to ensure continuity of care through secure data sharing and bi-directional communication in the future.

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.

Since this project includes home visitation and therefore does not require physical space, the capital needs are for:
1. Laptops
2. Information management (server, software, Peer Place system)

Each Community Health Worker, and similarly each BSN engaged in Nurse Family Partnership, needs a laptop and access to Peer Place. Peer Place is an automated referral system that communicates with the Rochester RHIO and will allow for coordination across physician practices as well as connect the Community Health Workers with the appropriate programs. As part of the Integrated Delivery System, all outreach workers and participants will share information within the network.

In the areas that do not have existing programs that are appropriate for the target population, we intend to build the infrastructure by providing Community Health Workers who will provide home visitation and ensure care for both the mother and the child. Nurse Family Partnership (NFP) will also be expanded in Monroe and Cayuga Counties where programs currently exist as well as into the 12 other counties where NFP does not yet exist.

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
RRHS	Healthy Moms	09/2014	05/2019	This program is an office based program with four arms: Case managements; Psychiatric support; prenatal/parenting education; GED and job training
RRHS	Healthy Start	9/2014		The Healthy Start program target pregnant women and new mothers by connecting them to resources they need and providing them with case management services.
VNS	Nurse Family Partnership		Ongoing	Targeted Case Management

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.

While a few partners participate in the Medicaid initiatives identified above, this project and the Community Health Worker model are meant to prevent programs from working in silos and improve interconnectivity within the FLPPS region. Each program has a slightly different emphasis and scope of work. The FLPPS plans to build on these existing initiatives, and others in the region, to form a coalition of supports, together improving pregnancy outcomes and the health of the mother and child. It is our belief that increasing the linkage between programs and building upon the existing foundation of programming will serve to better support mothers and families thereby reducing poor pregnancy outcomes and subsequent hospitalization. Due to the model selected for this project, all similar initiatives, such as the VNS model, will be expanded through DSRIP to engage more patients and integrate delivery across the PPS. With the expansion of the program, there is not a direct conflict.

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.

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
University of Rochester Rochester Institute of Technology St. John Fisher College Monroe County Medical Society Finger Lakes Health Systems Agency Managed Care Organizations

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.

This project links to CNA findings #2, #12 and #13.
Gaps in the availability of Mental, Emotional and Behavioral (MEB) health prevention and promotion services has led to poor health outcomes for those with MEB health disorders:
*Regional rates of Poor Mental Health for 14 or More Days in the Last Month (11.9%), Adult Binge Drinking (16.1 %) and Suicide (9.31/100,000 pop.) are higher than NYS Prevention Agenda goals;
*Seven percent of all ED admissions have a primary diagnosis of behavioral health, the highest of all disease states;
*Seventeen percent of all hospital readmissions are associated with an individual having a behavioral health diagnosis;
*Suicide is the fifth leading cause of premature mortality and is the only cause trending upward since 2002;
*Among the African American population homicide is the third largest cause of Years of Potential Life Lost and a significant source of trauma;
*Less than 50% of children prescribed ADHD medications receive appropriate follow-up care.
The FLPPS region has a significantly higher prevalence of mental illness (411.2/1000 pop.) when compared to the NYS average (289.4/1000 pop.). In addition, the prevalence of substance abuse disorders is higher than the NYS average, with rates of 99.5/1000 population compared to 86.8/1000 population.
Service-level gaps are caused by a shortage of licensed behavioral health professionals. The regional behavioral health workforce is less robust than the NYS average across all licensed provider types. As a result, 12 of the 13 counties in the region have received designation as Mental Health HPSAs by the Health Resources and Services Administration. Further, few behavioral health providers are multicultural and/or multi-lingual, and there is a shortage of doctors providing Suboxone therapy, a key intervention in managing opiate addiction.
System-level gaps are largely driven by long-standing silos between physical health, mental health and substance abuse, and were identified by focus groups and in meetings with subject-

matter experts:
*Medical providers lack cultural and technical competence to manage the behavioral health needs of their patients. As a focus group participant maintained, "My PCP refuses to deal with anything psychological. She says she can't";
*Medical providers lack the time, skill and information to engage in appropriate pain and anxiety management. As one PCP noted, "During a 15 minute appointment, the easiest way to fix pain or anxiety is to prescribe a pill, particularly when there is no information about alternative programs or therapies." The potential consequences of such actions are addiction and/or abuse; and
*There is a shortage of partnerships, programs, quality information and trained workforce to effectively deliver MEB health prevention and promotion activities. Across the full breadth of the PPS region, only 40 prevention programs are available to reach hundreds of thousands of individuals.

In response, this project will meet all program requirements, address identified gaps, and strengthen the MEB health infrastructure by:
*Convening and participating in MEB health promotion and prevention partnerships. These partnerships will collect and analyze population-based data, stratified by race/ethnicity, age and geography, and use this information to implement and evaluate targeted evidenced-based programing;
*Sharing data and information on MEB health promotion and MEB disorder prevention and treatment, including information around best practices and high-value interventions; and
*Providing cultural and linguistic training on MEB health promotion, prevention and treatment across the breadth of the PPS network to ensure that the behavioral health needs of patients are addressed in a culturally and technically competent manner.

These interventions are further described below.

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.*

There are two target populations associated with this project. First, per evidence presented by the Institute of Medicine in the cornerstone study: Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities (2009), the FLPPS recognizes that the greatest opportunity for MEB disorder prevention is among youth. Evidence suggests that such interventions will reduce the incidence of behavioral health disorders, over time. To further clarify the target population among this cohort, the PPS will collect local data to determine the mental health (i.e. the presence of positive affect, absence of negative affect, and satisfaction with life) of individuals ages 10-24, and the prevalence of environmental and protective risk factors associated with MEB disorders across this age group. This age cohort was selected based on the age-specific onset and diagnosis of behavioral health disorders, with a particular focus on those disorders most prevalent across the FLPPS patient population, including depression, anxiety and schizophrenia. The results of this study will be used to define a set of evidence-based interventions to be applied throughout the region, in collaboration with key community stakeholders

The second target population for this project is individuals currently living with an MEB disorder, diagnosed or otherwise, and those living on the precipice of illness. This target population requires interventions that assess risk and trauma to diagnose and manage potential or existing MEB disorders to prevent crisis and reduce further deterioration. Several of the FLPPS Domain 3 projects focus on the improvement of screening, management and treatment of MEB disorders in the clinical setting. This project will complement those interventions, increasing the cultural and technical competence of behavioral health and primary care providers. In addition, this project will work to develop sustainable community- based resources and evidence-based interventions. Again, this will require the PPS to undertake population-based data collection to drive and focus program implementation.

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 development of an MEB health prevention and promotion infrastructure represents a paradigm shift that: (1) uses a population-based approach (2) breaches the silos currently maintained by physical health, mental health and substance abuse, and (3) focuses on behavioral health and wellness instead of illness. As such, most assets will either need to be enhanced or developed.

The FLPPS's greatest asset is its robust and multi-faceted network. Organizations committed to this project include hospital systems, departments of mental health, public health and social services, substance abuse providers, community-based organizations, FQHCs, mental health providers and Health Homes. These organizations have each committed to recruiting complimentary stakeholders including law enforcement, school districts, universities, service clubs, etc. This network will act as the foundation for the development of a MEB Health Prevention and Promotion Partnership. This Partnership will: (1) Eliminate silos and work collaboratively; (2) Collect and analyze data, establishing a baseline around sources of trauma and quality of life; (3) Identify, evaluate and determine high-value programs; (4) Train/prepare the clinical and community-based workforce through curriculum development and supported implementation; and (6) Confront social stigma around MEB disorders and treatment.

A second key asset are the 18 colleges and universities in the FLPPS region. The PPS will leverage this asset to ensure the provision of cultural and linguistic training on MEB health prevention, promotion and treatment. To this end, institutions of higher learning will work with the MEB Health Partnership to develop and modify curriculums that embrace changing paradigms and teach best practices in supporting MEB health. New curriculums will teach the healthcare workforce to recognize and assess trauma and address the behavioral health needs of patients in a culturally competent manner. In addition the PPS will define and disseminate best practice interventions in pain and anxiety management, including a compendium of local resources to use as an alternative to medication-based treatment, in an effort to minimize local sources of addiction. Training will be targeted at both the existing and future workforce. Furthermore, the PPS will engage established workgroups, such as the Addiction Committee of the Monroe County Medical Society, to act as project champions. All PPS members will be required to participate in MEB health-related trainings.

Finally, an important asset that the PPS must develop is data and information on MEB health promotion and MEB disorder prevention and treatment. Successful transition from a hospital-focused health system to one that values prevention of disease and promotion of health will be facilitated by the widespread sharing of high-quality data and information. To this end, the

PPS will define, collect and analyze population-based data, identify and implement targeted evidence-based programs, monitor lessons learned, and conduct cost-benefit analysis. As a result, the PPS will develop and share a compendium of high-value evidence-based interventions to facilitate wide-spread adoption. In addition, the PPS will have created a replicable strategy for identification and implementation of such programs, which can be redeployed as the needs of the target population change, over time. This asset will act as the centerpiece of future MEB Health infrastructure improvement.

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.

Paradigm Shift: As previously noted, a sustained focus on MEB health promotion and disorder prevention represents a substantial paradigm shift for the health system. The PPS will address this challenge by ensuring a focus on behavioral health by the Clinical Operations Committee, building partnership, proving the value of model programs, engaging the workforce, facilitating cultural competence and confronting stigma.

Stigma: Behavioral health disorders are often associated with false stereotypes/ prejudice, making it difficult to engage the wider population in MEB health promotion and prevention activities. The PPS will confront stigma by supporting media campaigns around the value of health, including MEB health, employing best practices in social norming, and engaging culturally-competent community champions.

Silos: Tremendous silos still exist between physical health, mental health and substance abuse providers. The PPS address this challenge by facilitating data sharing, colocation of BH/MH/SA services and training.

Financing: The implementation of programs to support MEB health promotion and disorder prevention requires resources not readily available to project participants. In recognition of these financial constraints, the PPS will create an “incubator fund” to help green-light adoption of evidence-based programs across the region.

Sustainability: Many of the Evidence-based interventions(EBI) are not currently reimbursed. Community-based providers must implement infrastructure improvements and demonstrate the value of those EBIs. The PPS will work with payers to align value based quality payment incentives to support ongoing EBIs.

Workforce: As previously noted, there is a shortage of licensed behavioral health professionals across the PPS region. As such, the PPS cannot rely on clinical interventions to fully drive MEB promotion and prevention activities. The PPS will address this challenge by focusing on the development of community-based prevention services that do not require licensed providers for implementation. However, PPS will work, in tandem with local universities on development of behavioral health training programs for masters prepared health professionals and will work with regulatory bodies to advocate to approve larger suboxone panels.

Regulations: Waivers needed for data sharing and will be applied for.

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.

For the 4.a.iii project Finger Lakes PPS recognizes existing overlap with Southern Tier PPS, and the Central PPS. Specific PPS county overlap occurs in Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Wayne, Chemung and Steuben. This analysis is based off of the state's listing for PPS counties served, by PPS, prior to merging of PPSs and final attribution. Through the Medicaid Support Team, FLPPS has made outreach to: MCC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with three out of the four previously listed PPSs.

Through those PPS-to-PPS phone calls, project leads were able to establish a baseline for collaboration, recognizing a desire for ongoing dialogue and shared activity throughout the five-year Waiver program. Initial meetings: (1) introduced the leads and members of the project teams; (2) briefly outlined the PPSs' approach to the projects; (3) identified overlapping counties served; and (4) laid the foundation for future discussions. FLPPS will align efforts to minimize impact on downstream providers, and to establish venues for possible learning collaboratives to share best practices and lessons learned. Additionally, PPSs' will ensure continuity of care through secure data sharing and bi-directional communication through project implementation.

Project leads will connect at the state-led training in January, and subsequently plan a kickoff implementation meeting; followed by regular check-ins.

In addition to these general next steps, FLPPS has engaged in discussions with outlying PPSs, with the intent to consider the contracting for services to fill gaps identified within their partnership and to assist in the successful implementation of projects, identified through their CNA, specifically around services where they have identified a shortage in practitioners needed to serve their population.

FLPPS is committed to the success of all NYS PPSs, recognizing that if NYS fails we all fail.

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.

Establish MEB health Partnerships (DY1 Q1/Q2)
Assess workforce training needs (DY1 Q3/Q4)
Collect and analyze population-based data (through DY2 1/Q2)
Establish "incubator fund" (DY2 Q1/Q2)
Identify IT solutions to support program evaluation (DY2 Q1/Q2)
Develop curriculums for MEB health competency (DY2 Q3/Q4)
Begin roll-out of evidence-based programs (DY2 Q3/Q4)

Begin workforce training initiatives (through DY3 Q3/Q4 and beyond)
Begin cost-benefit analysis of evidence-based programs (DY4 Q1/Q2 and beyond)
Develop compendium of best practices (DY5 Q/1/Q2)
Develop value-based payment methodology for MEB health prevention programs (DY5 Q3/Q4)

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.

As previously noted, there is a lack of existing infrastructure to deliver MEB health prevention and promotion programs. As evidence-based practices are identified for implementation, capital funding will be required to ensure that integrated IT solutions are available and used by participating partners. In some cases, space redesign may be necessary to facilitate successful program deployment. Specific capital needs will be identified during implementation planning (January-March 2014). Additionally, some capital investment will be driven by participation in project 2.a.i, and will be included therein.

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
Arnot Health	VAP Southern Tier Mental Health Project	4/2014	3/2017	The Vital Access Provider program at Arnot Health is focused on operating and systems change, increasing professional psychiatric capacity, mental health/substance abuse assessment and management, behavioral health in primary care.

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

The PPS entire population is larger than those served by recognized initiatives, and no conflict is anticipated.

3. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

4.b.ii Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings (Focus Area 3) (This project targets chronic diseases that are not included in Domain 3, such as cancer)

Project Objective: This project will help to increase access to high quality chronic disease preventative care and management in both clinical and community settings for chronic diseases that are not included in Domain 3 projects, such as cancer.

Project Description: The delivery of high-quality chronic disease preventive care and management can prevent much of the burden of chronic disease or avoid many related complications. Many of these services have been shown to be cost-effective or even cost-saving. However, many New Yorkers do not receive the recommended preventive care and management that include screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications. This project is targeted on increasing the numbers of New Yorkers who receive evidence based preventative care and management for chronic diseases.

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

1. Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services.
2. Offer recommended clinical preventive services and connect patients to community-based preventive service resources.
3. Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and other community partners.
4. Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management.
5. Adopt medical home or team-based care models.
6. Create linkages with and connect patients to community preventive resources.
7. Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts.
8. Reduce or eliminate out-of-pocket costs for clinical and community preventive services.

Partnering with Entities Outside of the PPS for this Project

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

Entity Name
Finger Lakes Health Systems Agency Alzheimer's Association of Rochester and Finger Lakes Region Genesee Valley Health Partnership St. Joseph's Neighborhood Center, Inc. Managed Care Organizations (MCO)

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.

This project links to CNA findings #1, #7 and #5.

Chronic disease prevention and management is the responsibility of the individual, requiring life and behavior change skills. Unfortunately, many lack the knowledge and health literacy to take on this level of accountability (Plumb et.al), and there is a lack of available clinical and community-based interventions to support them in doing so. This gap has led to poor health outcomes:

*The region falls short of New York State (NYS) Prevention Agenda goals for: adult obesity (29.9% vs. 23.2%); adult smoking (21.1% vs. 15%); age-adjusted heart attack hospitalizations/10,000 pop. (17.3 vs. 14); and rate of hospitalizations for short-term complications of diabetes/10,000 pop. (7.21 vs. 4.86).

*African Americans and Hispanics are more likely to experience potentially avoidable hospitalization across all disease types. The ratio of African Americans experiencing preventable hospitalizations when compared with Whites is 2.22, well above the Prevention Agenda goal of 1.85. Similar disparities exist for the Hispanic population, with a comparative ratio of 1.88, whereas the Prevention Agenda goal is 1.35.

*Prevention Quality Indicators (PQIs) which are attributable to chronic disease accounted for 85% of all potentially preventable inpatient hospitalizations in 2012. Furthermore, the most common causes of premature death across all population types are cancer, heart disease, COPD and stroke. These illnesses share a number of conditional risk factors including smoking, physical inactivity and unhealthy diet.

There is also a gap in the PPS's ability to assess and target high risk populations, while social and economic risk factors increase the probability of experiencing health disparities:
*Having an inadequate income affects many aspects of health, including access to care, ability to buy and eat a healthy diet, adequacy of housing etc.
*Thirty-one percent of the regional population has low SES, earning less than 200% of the Federal Poverty Line; 13% live in poverty. Poverty rates are highest in the city of Rochester but poor and near-poor live in all areas of the region. Racial and ethnic populations living in Rochester are especially affected by poverty. Almost two-thirds (65%) of African Americans and 69% of Hispanics have household incomes below 200% of the FPG. Also in the city of Rochester, over three-quarters (76%) of children, ages six and under, live in or near poverty.
*Across the FLPPS region, 7% of the population has delayed or failed to seek care due to cost.
*Other social factors impacting risk across the regional population include: limited English proficiency (2%), less than high school education (11%), presence of a disability (11.4%), geographic isolation, and having inadequate transportation to services.

Per the Community Needs Assessment (CNA), volume-based incentives inherent to a fee-for-service payment model are a significant barrier to promoting a model of care focused on value and health. To this end, there is a gap in providing adequate reimbursement to providers and community-based programs offering chronic disease prevention and management services.

In response to these gaps, the PPS will meet all the requirements outlined in Project 4.b.ii and Domain 1 objectives:
*Deliver evidence-based clinical preventive services
*Connect patients to community-based preventive resources, including self-care management and support
*Adopt medical home paradigms, including the use of clinical decision supports, reminders and registries.
*Provide feedback to MCOs around clinical outcomes and incentivize the delivery of high-quality services
*Reduce or eliminate out-of-pocket costs for prevention services.

All interventions will be targeted toward high-risk patients who will be identified using a standardized tool and tracked using an integrated IT solution that will be implemented in both clinical and community settings.

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

The target population for this project includes those individuals identified as being "high-risk" for developing chronic illness and those who currently have a diagnosis of chronic illness and are at "high-risk" for further deterioration.

High-risk populations in need of prevention services include those who are obese (27.7% of the region's population), those who smoke (21.1% of the region's population), those who are uninsured (11.3% of the region's population) and those who have low health literacy and are in need of patient activation (to be determined through implementation of project 2.d.i)

High-risk populations in need of targeted chronic disease management support include those with two or more chronic conditions, and those with a diagnosis of mental illness (411.2/1,000 population) or substance use disorder (99.5/1,000 population).

To facilitate the identification of those individuals falling with the project's target population, the PPS will select and implement a standardized risk assessment to be delivered in clinical and community settings using an integrated IT solution. Those found to be of high risk will be referred to medical homes and community-based programs developed to support individuals in their management and/or prevention of chronic illness.

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

There are a number of critical community assets and resources that the PPS will utilize when implementing this project:

*Fifty-two percent of FLPPS providers are designated as Patient Centered Medical Homes (PCMHs). This number will only grow through 2017 with the implementation of Project 2.a.i. Under this project (4.b.ii), medical homes will function as the hub for tracking and improving clinical outcomes for high-risk patients. PCMH will also spur the adoption and use of certified electronic health records, especially those with clinical decision supports and registry functionality. Providers will send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management. Success will be determined by establishing innovative ways to connect with a highly mobile patient population. This can be facilitated by an integrated IT solution.

*There are already common priorities in Community Health Improvement Plans (CHIPs) and hospital Community Services Plans (CSPs), both of which focus on Prevention Agenda Goals; however, CHIPs are underfunded and some plans will need to be updated to include the targeting of high-risk populations. The PPS will support widespread implementation of CHIPs and CSPs, facilitating collaboration across counties and providing resources, as needed.

*The region has some readily established community-based, population-oriented prevention programs. Partner organizations have Master Trainers specializing in the delivery of Stanford-Model Chronic Disease Prevention Programs. In addition, over 20 CBO's in the city of Rochester offer weight management and nutrition programs targeting a range of age groups, neighborhoods and communities. Going forward, the PPS will document available community-based resources. Using this information, the PPS will work across its partnership to define and fill gaps, as needed. In addition, the PPS will create linkages between providers and CBOs to facilitate referrals to community-based preventive resources offering self-management support.

*The region and the co-lead ACOs boast a number of model disease registries that can be further developed under this initiative, including a regional hypertension registry and disease-management dashboards utilized by local hospital systems.

In addition, some assets will be need to be developed to ensure project success:

*Given that individuals access services across a variety of care settings, including behavioral health and family planning, there is a need to expand chronic disease management and prevention services to these provider types. To support this growth, the PPS will facilitate the adoption of best practice paradigms, including clinical interventions, motivational interviewing, health coaching, and self-care management, providing technical assistance, as needed.

*CBOs are also an important asset in assuring population health. To this end, the PPS must establish and integrated IT solution for CBOs to share and exchange information with the health system. The development of this asset will facilitate standardized performance measurement in terms of risk assessment, referrals, quality, and outcomes.

*Given the target population associated with this project, the PPS will need to adopt a standardized risk-assessment to be utilized across systems to identify and target "high-risk" individuals.

*The PPS must review gaps and best practices to ensure that providers are properly incentivized to deliver chronic disease prevention and management activities, with a particular focus on the care provided to high-risk patients. The PPS will also use this opportunity to review the charge schedule for prevention services and will modify, as needed, to ensure full access for the target population.

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.

Paradigm Shift: The high prevalence of chronic illness is forcing the health system to redefine the way it delivers and reimburses care. In response, the PPS will engage providers and the community at large, developing and disseminating a new and shared lexicon around the value of health and wellness, and incentivizing the deployment of high-value programs.

Coordination across counties: Each county is currently working towards implementation of their CHIP and CSP. To be successful, the PPS must ensure regional integration and the development of targeted interventions for high-risk populations. For example, nearly all counties have a Worksite Wellness component in their CHIP/CSP. Some Worksite Wellness interventions are well-developed and scalable, while others focus on employers of low-earning workers. In these instances, the PPS will need to facilitate collaboration among key stakeholders.

Sustainability: CBOs often track programmatic success using process measures. What is lacking, however, is an integrated data system that monitors the effectiveness of a given prevention program in improving and maintaining a participant's health status. An integrated IT solution that includes community-based prevention programs would have the ability to monitor a patient's health status before, during and after participation. Over time, this type of evaluation will allow the PPS to identify best practices and determine programmatic value in preparation for the inclusion of high-quality prevention and disease management programming in a value-based payment contracts.

Infrastructure gaps. Many CBOs do not have the infrastructure in place to bill for services -- they lack the administrative depth, technology, compliance programming, etc. Over the next five years, those CBOs delivering high-value programs may need to position themselves for the receipt of payment. Technical assistance must be provided, as needed, to ensure successful transitions in this area.

Facilitation of Partnerships. Likewise, not every CBO delivering prevention activities will be interested in direct billing. In this case, prevention service providers will require a mechanism for partnering with PPS providers. The PPS must facilitate these partnerships to ensure that high-value programs remain intact.

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.

For the 4.b.ii project Finger Lakes PPS recognizes existing overlap with the Southern Tier PPS. Specific PPS county overlap occurs in Allegany, Genesee, Orleans, Wyoming, Cayuga, Seneca, Wayne, Chemung and Steuben. This analysis is based off of the state's listing for PPS counties served, by PPS, prior to merging of PPSs and final attribution. Through the Medicaid Support Team, FLPPS has made outreach to: MCC PPS, Southern Tier PPS, Central PPS, and Mohawk Valley PPS, and has successfully connected with three out of the four previously listed PPSs.

Through those PPS-to-PPS phone calls, project leads were able to establish a baseline for collaboration, recognizing a desire for ongoing dialogue and shared activity throughout the five-year Waiver program. Initial meetings: (1) introduced the leads and members of the project teams; (2) briefly outlined the PPSs' approach to the projects; (3) identified overlapping counties served; and (4) laid the foundation for future discussions. FLPPS will align efforts to minimize impact on downstream providers, and to establish venues for possible learning collaboratives to share best practices and lessons learned. Additionally, PPSs' will ensure continuity of care through secure data sharing and bi-directional communication through project implementation.

Project leads will connect at the state-led training in January, and subsequently plan a kickoff implementation meeting; followed by regular check-ins.

In addition to these general next steps, FLPPS has engaged in discussions with outlying PPSs, with the intent to consider the contracting for services to fill gaps identified within their partnership and to assist in the successful implementation of projects, identified through their CNA, specifically around services where they have identified a shortage in practitioners needed to serve their population.

FLPPS is committed to the success of all NYS PPSs, recognizing that if NYS fails we all fail.

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.

In order to meet the goals set forth in this project, the PPS must:
Achieve PCMH as outlined in project 2.a.i
Establish contracts with CBOs (DY1 Q1/Q2)
Identify and test standardized risk assessment (through DY1 Q3/Q4)
Expand clinical interventions across diverse provider-types (DY2 Q1/Q2)
Assess gaps and support the implementation community-based programming (DY2 Q3/Q4)
Implement Integrated IT solution including standardized risk assessment (DY3 Q1/Q2)
Review and expand incentive programs (DY3 Q1/Q2)
Reduce out of pocket cost (DY3 Q1/Q2)
Begin cost-benefit analysis (DY4 Q1/Q2 and beyond)
Develop value-based payment methodology (DY5 Q3/Q4)
Facilitate long-term partnerships (DY5 Q3/Q4)

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 funding, not covered under project 2.a.i, will be needed to develop bricks and mortar infrastructure at community-based organizations to support the development or expansion of chronic disease self-management programs. Similar infrastructure will be necessary for clinical providers looking to expand these services on-site. There will need to be an investment in mobile application technologies to facilitation member education and connectivity.

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	Description of Initiatives
Finger Lakes Addictions Counseling and Referral Agency Trillium Health Finger Lakes Migrant Health Care Project	New York State Health Home	7/13	Ongoing	The Health Homes initiative emphasizes care management to builds linkages, for patients with multiple chronic illnesses, to other community and social support services, enhancing coordination of medical and behavioral healthcare.
Finger Lakes Migrant Health Care Project, Inc. Rochester Primary Care Network Rochester Regional Health System	CMMI through Finger Lakes Health System Agency	6/13	5/15	The CMMI grant supports Primary care practice transformation, integrate community services with primary care and develop a community-wide outcome-based payment model for primary care. This grants provides support for a Nurse Care Manager and practice transformation.

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

The proposed project will not duplicate, but instead expand upon existing Medicaid initiatives by sharing lessons learned across a large geographic area and a diverse set of provider types (e.g. behavioral health and community-based providers). Some funded projects, such as Health Home, have begun to stratify the population based on level of risk. The PPS will learn from this experience.

3. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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