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Using this document to submit your DSRIP Project Plan Applications

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

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

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

Domain 2 Project

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

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

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

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

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

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

6. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
7. Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.
8. Implement preventive care screening protocols including behavioral health screenings (PHQ-9, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.
9. Implement open access scheduling in all participating primary care practices.

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

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

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

The prevalence of avoidable hospital use among Medicaid enrollees 44 ER visits per 100 persons, 196 adult hospitalizations per 10,000, 21 child hospitalizations per 10,000, and 6 out of 100 readmissions following at-risk admissions. Many PCPs operate different EHR systems, which makes interconnectivity challenging. To address these gaps and to lower avoidable hospital use by 25% over 5 years, Leatherstocking Collaborative Health Partners (LCHP) will ensure that all participating primary care providers meet NCQA 2014 Level 3 PCMH accreditation by the end of Demonstration Year 3. Under the proposed project, LCHP will ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and that all participating clinical partners share health information. LCHP's IT/Data Analytics Committee will develop data sharing agreements for standardizing data definitions and for the development of standardized performance dashboards and reports. This committee will oversee data security and will inform compliance processes. Additionally, this committee will ensure that LCHP PPS safety net providers are using EHR systems that meet Meaningful Use and PCMH Level 3 Standards. All participating providers will be trained to actively use integrated EHR systems to track patients through patient registries in an effort to improve the health of the population. Measures of patient access among the counties' internal medicine and family practice patients show that 25% to 47% find it difficult to schedule their appointments. Implementation of Project 2.a.ii will begin to address these access gaps by identifying a physician champion to oversee PCMH implementation activities for each participating primary care practice. All staff at participating primary care sites will be trained in PCMH protocols and practices and clinical staff will be trained to implement preventive care and behavioral health screening protocols to identify unmet patient needs. All participating primary care providers will implement open access scheduling to increase patient access to primary care providers as required under PCMH Level 3 standards. Of the 158,117 service area Medicaid beneficiaries, CNA results reveal a high prevalence of chronic conditions as compared to patients with other sources of insurance: higher rates of diabetes (10% vs. 5%), COPD (8% vs. 2%),

asthma (17% vs. 9%). Measures of communication (health literacy) among service area internal medicine and family practice patients show that on average 25% of patients do not fully understand the way their provider explained their condition, while 25% to 41% of patients do not fully understand instructions given for their follow-up care. These data reflect gaps in care coordination that can be address by 2.a.ii. Patients will receive culturally & linguistically appropriate care. LCHP agrees to meet all requirements for Project 2.a.ii.

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.

Project 2.a.ii will focus on the attributed population for this project.

The target patient population will include patients who receive appropriate preventive care screenings to identify unmet medical or behavioral health needs in the primary care setting. This project was selected based ondemographics identified through CNA findings. Project 2.a.ii will serve all patients, with an emphasis on providing integrated primary, specialty, and behavioral healthcare services to high-utilizing patients. Of the 158,117 Medicaid beneficiaries in the service area, 65% are adults (ages 18 and older) and 35% are children.

Based on CNA findings, the service area includes a subpopulation of high-risk persons who are high service utilizers—persons with a chronic condition of diabetes or asthma and have a mental health comorbidity of anxiety or depression. At the project implementation outset, focused analysis of CNA, census, ED visits, and hospitalization records will occur to estimate the number of undocumented uninsured patients in the LCHP PPS to fully estimate the target population to be engaged.

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

In LCHP, 81% of Bassett Healthcare Network (Bassett) PCPs and 100% of Community Memorial Hospital (CMH) PCPs have achieved NCQA 2011 Level 3 PCMH recognition and are pursuing 2014 Level 3 recognition. There are four physician champions with extensive medical home knowledge and experience and two advance practice clinicians who are committed to becoming NCQA PCMH certified content experts in the first year of the project. PCMH recognition includes enhanced training, implementation of preventive screening and evidence-based decision protocols for behavioral health and other chronic conditions, open-access scheduling, referral coordination, and population health management. LCHP will leverage existing staff, peer mentoring resources, and experience with employing PCMH standards. Additional staff will be recruited or retrained as required to meet the project requirements.

Bassett has a robust infrastructure and comprehensive service delivery system across a multi-county service area with more than 700,000 ambulatory patient visits annually. Its medical center offers extensive primary and specialty care services. Bassett has a workforce of more than

3,200 employees, a solid information technology infrastructure, financial stability, executive management experience, and stakeholder relationships that are essential to implementing transformational change.

In 2014, Bassett joined the HIXNY Regional Health Information Organization (RHIO), while CMH joined the HealtheConnections RHIO, both of which enable sharing of health information across the continuum of care. The RHIOs will provide a secure health information exchange and patient registry for LCHP providers. Access to the RHIO/SHIN-NY and other EHR systems will further support LCHP's ability to manage the health of the service area population. To bolster service area's EHR connectivity, the IT/Data Analytics Committee will utilize DSRIP funds to integrated EHR systems to meet meaningful use and PCMH Level 3 standards. Bassett is part of the Chenango County Coalition which filed an application to the Department of Defense to provide Innovative Readiness Training (IRT) to the county in 2015. Providers and staff will receive the requisite training to leverage information technology enhancements in the care of its population.

LCHP has both internal and external care coordination resources. PPS partners include CNY Health Home Network, L. Woerner, Inc. and At Home Care, all providing care coordination within the LCHP region. LCHP will leverage partners such as Area Health Education Center System (AHEC), whose staff have PCMH accreditation experience, and the Slocum-Dickson Medical Group, a private entity with experienced nursing and support staff, to meet the project's goals.

Project 2.a.ii complements other projects chosen by LCHP and will assist LCHP partners in efficiently utilizing current assets and sharing new resources to achieve the project goals and objectives.

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.

Many LCHP partners do not have an EHR. Among the providers with EHRs, many use different operating systems, making interconnectivity a challenge. LCHP is dedicated to achieving interconnectivity between and among care sites by leveraging its experts on the IT/Data Analytics Committee in order to track and measure quality metrics to improve the care of our patients and achieve the project goals and objectives. Care coordination is a requisite function of achieving the highest quality care measures and transforming care across the continuum. The pool of experienced RNs in the service area is limited. A workforce impact consultant will work closely with LCHPs Collaborative Learning Committee and partners, such as AHEC, to employ creative workforce strategies. Staff training is an essential component of the PCMH project due to the dearth of requisite skill sets of the employees in the PPS. Utilizing the expertise of the workforce impact consultant, AHEC and the Collaborative Learning Committee, online and in-person training will be offered to retrain existing employees. The PPS will leverage Bassett's relationship with local colleges, as well as nationally recognized universities, to create programs necessary to serve the population. Additionally, economies of scale will be implemented when training staff across the PPS, sometimes utilizing a "train the trainer " model for sharing learning and/or

providing onsite training for multiple partners. DSRIP funds will be utilized to encourage the transformation necessary to achieve PCMH 2014 Level 3 recognition DY3.

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.

LCHP overlaps with United Health Services Hospitals, Inc., PPS, CNY DSRIP PPS, and Westchester Medical Center PPS. Westchester Medical Center PPS has chosen this project. Current areas for strong collaboration across the region include sharing CNA data, developing regional educational initiatives through learning collaboratives, and formal regional support groups for specific project staff. Additional opportunities include developing data sharing agreements to make health information exchange capacity more robust across the State through RHIOs, as well as development of clinical integration agreements for patients receiving care at multiple facilities across the service area.

As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS [and others throughout the state] by participating in quarterly learning collaboratives. The transformative nature of this work will require ongoing collaboration and sharing of resources between and among PPS'.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

For Project 2.a.ii, LCHP will require capital funding for renovations to reconfigure space to expand the number of offices dedicated to primary care and accommodate changes in workflow at PCMH sites. In addition, per project requirements, LCMH will need to meet 2014 PCMH level 3 standards, share data with local RHIOs, and share health information across clinical partners, including secure messaging alerts and patient record look. To achieve electronic interoperability, appropriate infrastructure will need to be developed, including enhanced modules for existing EMRs and software interfaces.

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
N/A				

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.

N/A

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

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

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

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

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

2.b.vii Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)

Project Objective: Skilled nursing facilities (SNFs) will implement the evidence-based INTERACT program developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation, with the support of a contract from the Centers for Medicare and Medicaid Services (CMS).

Project Description: INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program focusing on the management of changes in a resident's condition, with the goal of stabilizing the patient and avoiding transfer to an acute care facility. The program includes clinical and educational tools and strategies for use in everyday practice within long-term care facilities. The current version of the INTERACT Program was developed by the INTERACT interdisciplinary team under the leadership of Dr. Ouslander, MD, with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) and supported by the Commonwealth Fund. This DSRIP project will further increase the impact of INTERACT by integrating INTERACT 3.0 tools into SNF health information technology through a standalone or integrated clinical decision support system.

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. Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.
2. Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.
3. Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.
4. Educate all staff on care pathways and INTERACT principles.
5. Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.
6. Create coaching program to facilitate and support implementation.
7. Educate patient and family/caretakers, to facilitate participation in planning of care.
8. Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.
9. Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.
10. 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.

Nursing homes are a significant source of hospital readmissions and critical partners for inclusion in the goal of reducing avoidable hospitalizations. Nationally, 25% of Medicare residents are transferred to hospitals for admission (DHHS, OIG). Grabowski, et. al. (2007) found that 29% of long-stay nursing home residents are hospitalized each year, and 29% of their hospitalizations are avoidable. In a HANYS report on the leading causes of preventable readmissions (PPRs) to the largest hospital in the LCHP PPS, the observed PPR rate was consistently greater than the expected rate for patients who had been discharged to skilled nursing facilities before readmission. The cohort of 10 nursing homes participating in the INTERACT project experienced an overall higher rate of potentially avoidable hospitalizations than the average for NYS facilities – 50% of homes scored in quintile 4 or 5 vs. 40% (CNA). Overall, the 10 homes had the worst performance for the following conditions with potential risk for hospitalization: 1) % of long stay residents experiencing one or more falls with major Injury (80% in quintile 4 or 5); and 2) % long stay residents who self-report moderate to severe pain (70% in quintile 4 or 5).

The average hospital admission rate for adult Medicaid recipients with acute conditions (588/100,000 enrollees) is higher than both Upstate (566) and NYS (555); chronic hospital admission rates for the LCHP PPS (1,170) were slightly better than Upstate (1,213) and NYS (1,294), although three counties had rates that significantly exceeded these benchmarks (Salient). Combining acute and chronic conditions, a total of 4,514 annual Medicaid hospital admissions were considered avoidable. The LCHP PPS also performed unfavorably on Medicaid readmissions within 30 days of discharge (5.7 readmissions per 100 at-risk admissions), ranking 79th out of the State's 192 hospitals. By implementing INTERACT 3.0, nursing home staff will have evidence-based tools to help with the recognition, evaluation, management, and reporting of resident symptoms and signs that may result in hospital admission.

Based on high rates of hospital admissions and PPRs in the LCHP PPS, the 10 LCHP partners committed to implement the INTERACT 3.0 toolkit. The goal of INTERACT is to reduce avoidable nursing home to hospital transfers by preventing conditions from becoming so severe as to require hospitalization, utilizing palliative care practices, and reducing potential hospital complications that can lead to declines in a residents' health.

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 patient population to be engaged in the project are the estimated 3,020 Medicaid beneficiaries that are residents of the 10 nursing homes in the LCHP service area, including short- and long-stay resident. By definition, LCHP will focus on longer-stay residents who are generally covered by Medicaid insurance. INTERACT will have less of an impact on short-stay residents who are often covered by Medicare. The participating nursing homes are: Alpine Rehabilitation and Nursing Center, Aurelia Osborn Fox Memorial Hospital (Oneonta), Charles T. Sitrin Health Center (New Hartford), Chase Memorial Nursing Home (New Berlin) , Focus at Otsego (Cooperstown), Katherine Luther Residential Health Care and Rehabilitation Center (Clinton), Masonic Care Community of New York (Utica), Norwich Rehabilitation and Nursing Center (Norwich), St. Johnsville Rehabilitation and Nursing Center (St. Johnsville), and Valley Health Services (Herkimer).

The 10 skilled nursing facilities represent 1,580 licensed residential health care beds and serve the residents of the seven-county LCHP service area. In 2013, the nursing homes collectively provided care to 4,337 patients. 79% or 3,020 patients were Medicaid beneficiaries, constituting the target population. Although the target population is Medicaid patients, the nursing homes will implement INTERACT facility-wide, serving all residents regardless of payor.

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.

Leatherstocking Collaborative Health Partners (LCHP) conducted a survey of the 10 nursing homes that chose to implement INTERACT to determine each facility's quality improvement practices and clinical strategies for avoiding transfers to an acute care facility, as well as their use of INTERACT or INTERACT-like principles, including level of implementation, how long the tools have been in place, which staff utilize the tools, and how they use them. From the survey results, LCHP learned that most facilities were familiar with INTERACT, had implemented one or more INTERACT or INTERACT-like components; and that the average implementation level was 2.4 (with 5 being the highest). Nursing homes were most advanced in using the following INTERACT tools: Medication Reconciliation Worksheet, Comfort Care Order Set, and in providing educational materials for residents and families. Several home have generated enthusiasm for implementing INTERACT among their staff. One nursing home (Masonic Care Community) is fully committed to implementing INTERACT, has hired an RN champion, and is in the early stages of INTERACT implementation.

The base of knowledge and experience among the project partners will be an asset to LCHP's INTERACT project. Nursing homes that have formally implemented components of INTERACT (e.g., Masonic Care Community) will provide content expertise and serve as a best practice advisor to facilities that are in the early stages of project implementation. Masonic Care Community staff will provide advice on such topics as the skills required for a project champion, how to gain staff acceptance of INTERACT, and phasing and speed of implementation. As some nursing homes are not starting from "ground zero", they will implement INTERACT more expeditiously . Half of the participating nursing homes are projected to complete the project in 16 months mid-DY2. The remaining facilities will reach project completion no later than mid-DY3. Achieving rapid implementation will provide each facility with time to achieve INTERACT proficiency and experience a reduction in nursing home transfers.

All of the participating homes have human resources that will support project implementation, including staff development, nurses experienced in curriculum development and evaluation and staff training. Each partner will hire a champion to lead the INTERACT initiative who will become a certified INTERACT trainer in DY1. Nurses will support the INTERACT champion by assessing staff skill sets, identifying knowledge gaps, helping to develop curriculum content, assisting with staff education (e.g., care pathways and INTERACT principles), and maintaining training records. Curriculum materials will be developed by the INTERACT champion, nursing home partners, with the support of the Collaborative Learning Committee, area nursing schools, unions, and professional associations. Several participating nursing homes are part of larger organizations with corporate Human Resources departments. LCHP will leverage their expertise in developing the INTERACT champion job description and recruitment for the position.

AHEC, an LCHP partner, has extensive expertise in developing recruitment and training initiatives in a variety of health care disciplines, particularly in rural areas. LCHP will engage AHEC to assist with ongoing training initiatives.

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.

Potential challenges to implementing Project 2.b.vii include staff acceptance of the phasing in of INTERACT principles and the nursing home/hospital relationship. Recruitment of an INTERACT champion with the requisite skill set, who can engage other staff and serve as coach and leader of the INTERACT program, will assist in eliminating immediate challenges. Utilizing resources within LCHP (i.e., existing Interact champion), employees will receive training and "shadow" the current champion to understand the skill sets required to perform the role. Obtaining staff "buy-in" of the project is another potential issue. Nursing staff may have reservations about INTERACT due to changing job expectations or fear of learning new skills. Engaging leadership and other INTERACT champion(s) is key to allaying staff concerns, as is providing ongoing training and support. Additionally, the nursing homes have incorporated clerical staff to support the champion in managing the additional workload, particularly during implementation. The Collaborative Learning Committee will offer assistance and support in this regard.

Currently, the ten nursing homes have varied relationships with local hospitals, experiencing inconsistent communications and relying on outdated communication technologies to transfer patient information. To improve hospital-nursing home communication, LCHP will develop care coordination agreements with hospitals, determining transfer procedures, utilize the INTERACT communication tools, and with the support of the IT/Data Analytics Committee, address the larger issues of EHR and HIE connectivity.

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.

LCHP overlaps with United Health Services Hospitals, Inc., PPS, CNY DSRIP PPS, and Westchester Medical Center PPS. United Health Services Hospitals, Inc. has also chosen to implement this project.

Current areas for strong collaboration across the region include sharing CNA data, developing regional educational initiatives through learning collaboratives, and formal regional support groups for specific project staff, such as INTERACT champions. Additional opportunities include developing data sharing agreements to make health information exchange capacity more robust across the State through RHIOs, as well as development of clinical integration agreements for patients receiving care at multiple facilities across the service area.

As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS [and others throughout the state] by participating in quarterly learning collaboratives. The transformative nature of this work will require ongoing collaboration and sharing of resources between and among PPS'.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

For Project 2.b.vii. LCHP will require capital funding to acquire and install clinical information technology to support the Project 2.b.vii program requirements. LCHP nursing homes will use EMRs and other technical platforms to track all patients engaged in the project and establish enhanced communications with hospitals using health information exchange. To achieve electronic interoperability, appropriate infrastructure will need to be developed, including enhanced modules for existing EMRs and software interfaces.

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
N/A				

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.

N/A

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

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

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

initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

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

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

2.b.viii Hospital-Home Care Collaboration Solutions

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

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

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

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

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

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

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

In the LCHP service area, there is a need for improved transitional care for patients with chronic conditions to reduce avoidable hospital utilization and worsening of a patient's condition. Lack of evidence-based discharge planning protocols, post-discharge primary care appointments, and follow-up contact with patients post discharge were identified as areas of dissatisfaction with discharge planning services. Six out of 100 at-risk admissions are potentially avoidable, ranking the service area 79th (if the counties are ranked as a single county). Some of the leading causes of preventable hospital readmissions for Bassett Healthcare Network hospitals are CHF, major and small bowel procedures, other pneumonia, COPD, and other vascular procedures. Many of the conditions exceed the NYS hospital and rural hospital PPR rates. Further, all but one condition (major small and large bowel procedures) increased between 2012 and 2013. As a solution to the gap identified, Project 2.b.viii will improve transitional care for patients with chronic conditions by employing a Rapid Response Team, consisting of hospital and home care clinical staff, to facilitate patient discharge to home and assure needed home care services are in place. Service components will include patient risk/need assessment, use of best practice models (INTERACT), patient/caregiver education and engagement, scheduling primary care follow-up before discharge, and conducting follow-up contact with patients and families after discharge.

An additional gap identified is the need for comprehensive training in the INTERACT model. This will allow home care and hospital staff to acquire the skills to identify patients at risk for readmission, implement care pathways and monitoring for chronically ill patients, and identify early the potential instability and intervene to avoid hospital transfer. LCHP home care data shows significant differences in hospital and ER use 30- and 60-days post-discharge compared to national averages. In the LCHP PPS, 15.4% of home care patients were readmitted within 30 days of hospital discharge, compared to 13.3% nationally. ED use (without hospitalization) is also higher for LCHP patients—13.7% visit the ED within 60 days of discharge vs. 11.8% nationally. As a solution to the gap identified, LCHP Collaborative Learning Committee will identify training needs through Project 2.b.viii and develop educational resources for all staff in care pathways, INTERACT principles, and other staff needs. All project participants will have access to the Bassett Institute for Learning, an online warehouse of available training resources for employees, which will be enhanced to align with staff training needs required for DSRIP projects.

Lastly, LCHP identified gaps in clinical outcomes, related to care coordination, medication, and behavioral health management that were below national averages when compared to the most recent CMS Home Health Agency Risk-Adjusted and Descriptive Outcome Report. Improvement in management of oral medications (50.5%), for example, was below the national average of 53.8%. Behavioral problems and anxiety levels in patients also showed less improvement in

the LCHP service area. Compared to the U.S. (68%), improvement in the frequency of behavioral problems was 64.8% in the LCHP service area. Locally, 49.4% of home care patients showed improvement in anxiety levels, lower than the national average of 56.6%. As a solution to improve care coordination and health management, LCHP will increase system-wide, integrated relationships with home care, primary care, behavioral, health, and pharmacy providers. LCHP has begun this process through the recruitment of project partners that have not previously worked closely together for the purposes of improving health outcomes and population health.

LCHP agrees to meet all of the 2.b.viii project requirements.

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.

Leatherstocking Collaborative Health Partners (LCHP) PPS has defined the patient target population for Project 2.b.viii as adult (aged 18 and older) Medicaid beneficiaries residing in the LCHP service area based on the following criteria: patients who receive medical care for chronic conditions by LCHP primary care providers; patients who are discharged from the hospital to a home-based setting; and patients requiring transition care management for more than 30 days post-discharge. LCHP expects that most patients will qualify for care management services through one of the four Medicaid health homes serving the region for the first 30 day after discharge. Per 2012 SPARCS discharged disposition data, 7,107 patients were discharged from hospitals in the LCHP service area and returned home for either self-care, home hospice care, or received services through a home health service organization.

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.

Leatherstocking Collaborative Health Partners (LCHP) PPS has assets and resources that can be mobilized and employed to implement Project 2.b.viii and achieve all project requirements.

LCHP has enlisted three hospice and palliative care agencies, two home health agencies, 10 nursing homes, one care management provider, and two health homes experienced in the provision of palliative care. These partners are engaged in supporting 40 primary care sites that will be implementing this project. Each of these agencies will assist with the delivery of transitional care curricula to train primary care providers, as well as patients and community groups. All of the nursing homes implementing INTERACT (Project 2.b.vii) have developed palliative care pathways protocols and tools for delivering care models, including communication guides, comfort control care sets, and educational materials for residents and families. All have implemented one or more INTERACT or INTERACT-like components. One facility has a trained INTERACT champion and has begun INTERACT implementation. Nursing homes that have implemented components of INTERACT will provide content expertise, clinical tools, educational materials, and coaching to home care and Rapid Response Team staff.

Many LCHP partners are also engaged in 2.a.ii which will further the goals of Project 2.b.viii. The enhanced level of care coordination within the tenets of the PCMH project will lend itself to reaching the goals of this project. That is, utilizing the expertise of experienced nursing and support staff to care for patients in the outpatient or home setting.

LCHP's goal of improving telemedicine capabilities will further assist in improving care for patients in the home care setting. As transportation is a challenge for many patients in LCHP's rural service area, this technology will ensure patients receive the necessary care and advice in a timely manner.

With LCHP's goal of reducing unnecessary hospital admissions and utilization of emergency services, the impact of care coordination and collaboration among providers will be far-reaching.

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

A significant hurdle in meeting project requirements (i.e., tracking patients and provider communications) is the varying degree of technology adoption across LCHP project partners. The resources required to acquire new technology and to achieve interoperability are substantial. For agencies without an EHR, the LCHP IT/Data Analytics Committee will offer its expertise, with a primary focus on standardization of IT products. For project participants who do not currently submit patient-level data to HIXNY or another RHIO, the IT/Data Analytics Committee will assist these partners in joining RHIOs, while working with the state to develop electronic interfaces for HIE. Through the RHIO/SHIN-NY, enhanced health information exchange will ultimately lead to the rapid and secure transfer of patient health information for LCHP providers.

Another anticipated challenge will arise in building relationships among disparate health providers in LCHPs service area. Leveraging LCHP's Project Management Office, the Clinical Performance, Collaborative Learning Committee, and IT/Data Analytics Committees, home care agencies will continue to develop and enhance cooperative relationships with hospital in the PPS and those with whom the PPS overlaps, with the goal of creating clinical protocols based on evidence-based guidelines for patient care. Enhanced EHR connectivity will promote sharing of patient-specific information and communication among caregivers

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.

LCHP overlaps with United Health Services Hospitals, Inc., PPS, CNY DSRIP PPS, and Westchester Medical Center PPS. None of the overlapping PPS are implementing Project 2.b.viii.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

To achieve electronic interoperability, appropriate infrastructure will need to be developed, including enhanced modules for existing EMRs and software interfaces.

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

Yes	No
☐	☒

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

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

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

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.

n/a

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

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

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

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

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

2.c.i To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently

Project Objective: This project will develop community-based health navigation services to assist patients in accessing healthcare services efficiently.

Project Description: Health literacy, community values, language barriers, and lack of engagement with community health care services can result in avoidable use of hospital services. People who do not understand how to access and use the healthcare system cannot be expected to use it effectively. This project is focused on persons utilizing the system but doing so ineffectively or inappropriately. The intended navigation services will provide bridge support until the patient has the confidence to self-manage his/her health. These community resources will not necessarily be licensed health care providers, but persons trained to understand and access the community care system. For example, navigators will assist patients with scheduling appointments and obtaining community services. Navigators will be resourced in-person, telephonically, or online; they will also have access to language services and low literacy educational materials.

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. Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.
2. Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.
3. Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.
4. Resource appropriately for the community navigators, evaluating placement and service type.
5. Provide community navigators with access to non-clinical resources, such as transportation and housing services.
6. Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.
7. Market the availability of community-based navigation services.
8. Use EHRs and other technical platforms to track all patients engaged in the project.

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

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

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

The CNA and the CNA Needs Table indicate that a number of gaps and disparities exist in the service area in terms of health care utilization and access.

Medicaid recipients are more likely than those otherwise insured (others) to report that lack of transportation precluded a doctor's appointment (11.76% vs. 2.65%). They were also more likely than others to report that appointments were not available (2.35% vs. 1.87%) and that cost was preclusive to seeing a doctor (5.4% vs. 3.21%).

Relative to the State's 62 counties, the service delivery area collectively ranks 43rd in avoidable adult hospitalizations with Herkimer, Oneida and Otsego all ranked in the least favorable quartile. In terms of potentially avoidable ER visits, Chenango and Delaware Counties rank in the least favorable quartile.

Medicaid recipients with diabetes were over ten times as likely than others with diabetes to have ER visits or hospital admissions for it in the previous 12 months (24.59% vs. 1.61% and 20.73% vs. 1.66%, respectively). Further, 53.73% of Medicaid recipients aged 50-75 abided by colonoscopy guidelines relative to 60.67% of those with other insurance. Mammography guidelines were followed for 63.31% of Medicaid recipients relative to 75.81% of those with other insurance.

To meet these gaps, the Leatherstocking Collaborative Health Partners (LCHP) will fulfill all requirements of project 2.c.i. and will recruit, hire, train and place navigators throughout the LCHP PPS. Navigators will ensure appropriate access to care, helping to address the gaps identified above. LCHP will develop an online community care resource guide to assist navigators in accessing resources and to ensure compliance with protocols. Oversight will be provided by a special subcommittee, which will include medical/behavioral health, community nursing, and social support services providers, who will play an advisory role to projects 2.c.i. and 2.d.i.

The recruitment plan for community navigators will include community outreach led by residents in each of the LCHP counties. Candidates will be evaluated for representativeness in terms of the population served. Leveraging the lead agency's strong relationships with community-based organizations, community navigators will have access to non-clinical resources including transportation and housing services. Navigators will identify gaps in services and will bring this information back to LCHP via the PAC to address concerns at the PPS- and patient- levels.

To ensure efficiency, monthly caseloads will include an appropriate ratio and will be assigned by county and acuity. Unless they opt out, patients will be reassessed over time using the Patient Activation Measure and will be discharged from navigation when they reach level three or four.

Navigators will include former Medicaid consumers and will be trained in a variety of services to enhance the PPS's ability to achieve DSRIP metrics with cultural and linguistic competence. The Collaborative Learning Committee will market the program by networking and distributing brochures in English and Spanish to community-based organizations and providers.

LCHP will use current Medicaid Health Home practices as best practice, building upon the current Medicaid Health Home IT platform to develop patient registries, track services, generate reports, and monitor outcomes.

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.
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LCHP derived the target population for this project based upon the percentage of Medicaid recipients who could be expected to score a one or a two on the Patient Activation Measure at intake. A score of one indicates that a patient is disengaged and overwhelmed with low knowledge, weak goal orientation, and poor adherence to health recommendations. A score of two indicates some improvement over stage one, although large gaps in knowledge remain and the patient does not believe that their health is within their control. LCHP anticipates that 25% of Medicaid beneficiaries can be expected to score a one or a two on the PAM. A total of 38,584 Medicaid lives have been attributed to LCHP's service area, resulting in a target population of 9,646 adults for this project, based on anticipated PAM scores. LCHP expects that some low- need patients may need help on a situation-specific basis and will tailor navigation services according to low, medium and high 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.

LCHP will leverage a number of resources currently in place through the Bassett Community Health Navigation program. Currently serving Chenango, Delaware, Otsego and Schoharie Counties and recently designated in April 2014, it is the only Health Home in its four-county area. This existing program provides coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes the use of health information technology, and avoids unnecessary care. With 195 patients enrolled in this program since October, Bassett anticipates that enrollment will soon increase to over 2,000 patients. While these patients will require more intensive services relative to those who will receive navigation services in this project, LCHP will leverage this existing Medicaid Health Home infrastructure and will expand upon Bassett's current relationships with community support services to quickly mobilize navigation services in all seven counties. Currently established Medicaid Health Home IT tools will be leveraged to develop patient registries, referral and service tracking capabilities and reporting functions. A brochure advertising the Bassett Community Health Navigation Program is

currently under development. This resource will be leveraged in this project to provide a template for outreach materials, which will be provided throughout the LCHP in English and in Spanish. A community resource database (Community Health Assistance Network or C.H.A.N.) is currently under development as part of the Medicaid Health Home. This resource will be expanded in this project to cover the whole LCHP service area, providing community information on LCHP's website that will be available to partners, stakeholders and the public and creating a "one stop shop" for information about community resource information. The current Health Homes subcommittee is poised to develop into an advisory committee for both projects 2.c.i. and 2.d.i. and will assume responsibility for oversight of the C.H.A.N. The Community Health Navigation program is currently staffed by a Program Director, an Education and Outreach Specialist, a cohort of Community Health Navigators and a Data Coordinator, who will assist the PPS during phase one implementation of this project. Finally, LCHP has well-established contracts and relationships with care management agencies, including Catholic Charities Care Coordination Services, Southern Tier Aids Program and Schoharie County Mental Health. These resources will be leveraged to provide coordinated services to meet the goals of this project.

New resources that will need to be obtained or established include other staff (0.50 Program Data Coordinator, 0.25 Business Analyst and an Education and Outreach Specialist). Additionally, it will be necessary to either purchase or reconstruct facilities to house a central office for projects 2.c.i. and 2.d.i., including navigators and support staff.

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

LCHP anticipates that identifying or repurposing a new space for this project could present challenges in terms of cost. To use resources most efficiently, LCHP will combine projects (e.g., 2.c.i. and 2.d.i.) to house navigators and support staff and to deliver related services in shared space.

Staffing could pose a challenge in this largely rural service area. As part of the governance structure, the Project Committee will post these openings on the DSRIP website and will visit departments and partner organizations where employees have been identified for potential retraining or redeployment. The project committee will also work with the Community Navigation Advisory Committee to identify community leaders who could spearhead community outreach activities including recruiting former Medicaid consumers, who could be trained to fill positions for community-based navigators in their counties. This recruitment strategy would enhance the representativeness and diversity of the LCHP workforce. LCHP will also avail of career fairs, external websites, community-based organizations and schools to advertise position openings.

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.

LCHP overlaps with United Health Services Hospitals, Inc., PPS, CNY DSRIP PPS, and Westchester Medical Center PPS. United Health Services Hospitals, Inc. has also chosen to implement this project.

Current areas for strong collaboration across the region include sharing CNA data, developing regional educational initiatives through learning collaboratives, and formal regional support groups for specific project staff. Additional opportunities include developing data sharing agreements to make health information exchange capacity more robust across the State through RHIOs, as well as development of clinical integration agreements for patients receiving care at multiple facilities across the service area.

As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS [and others throughout the state] by participating in quarterly learning collaboratives. The transformative nature of this work will require ongoing collaboration and sharing of resources between and among PPS'.

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.

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
N/A				

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.

N/A

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.*

The Leatherstocking Collaborative Health Partnership (LCHP) has identified significant gaps in the service area for individuals who are uninsured. CNA data indicate that 83% of Medicaid members have a regular provider while 58% of the uninsured do not. Further, 39% of the uninsured needed to see a doctor but were precluded by cost, relative to 5% of Medicaid members. Relative to state counties, the LCHP service area is in the least favorable half for potentially avoidable hospitalizations and ER use by adults. The estimated baseline prevalence of annual ER use by uninsured persons is 5,763 visits per year, representing a sizable usage of resources that could potentially be avoided if these patients were connected to the right services and the right time and at the appropriate level of intensity.

Approximately 17% of Medicaid members in the service area did not have claims history data for primary care and preventive services over the past year, representing a cohort that needs to be identified and proactively engaged in primary care to prevent the escalation of emerging health issues in order to avoiding unnecessary utilization.

Poverty presents a challenge within the service area, where the median household income is $4,536 to $15,708 below the State median ($56,657) and the prevalence of poverty is higher for individuals than families. Further, the service area is largely rural and access to care is often precluded by lack of transportation. This is particularly problematic for Medicaid recipients, who are almost 4 times more likely than those with other coverage to miss a doctor's appointment due to lack of transportation.

LCHP will address gaps in health care access and unnecessary utilization by fulfilling all project requirements. Using a population health focus leveraging hot spots, LCHP will contract with community based organizations ("CBOs") to use PAM® to fulfill requirements for base-lining, screening, ongoing assessment/activation and for connecting the target population to their designated PCPs. Project staff will obtain lists of primary care providers from MCOs and will actively reconnect beneficiaries to their providers while linking persons not accessing services to appropriate providers.

LCHP will use culturally competent navigators, representative of the service area, to connect patients with CBO partners and community health care resources. The LCHP will meet all LCHP-wide training requirements for providers and navigators. Navigators, and other staff will be trained to work with MCOs and PCPs to establish patient connectivity through proactive outreach and will collect data on the health care needs in the service area.

Project 2.d.i. will include a special emphasis on patients with level one or two PAM® scores. A warm hand-offs will be provided for all patients from primary, behavioral, and dental care providers to community-based navigation services using referrals to LCHP's partners and leveraging existing relationships with community agencies.

Through partnerships with primary and preventive care services, the LCHP will educate patients regarding available and appropriate use of community and health services, increasing the volume of non-emergent care provided to the target population. Staff will work collaboratively across Projects 2.c.i and 2.d.i to identify hot spots and to educate patients, physicians, and stakeholders regarding LCHP services. LCHP will strengthen its EHR interconnectivity through DSRIP to manage the health of the target population through patient registries.

LCHP will create a task force in which beneficiaries and partner CBOs will play a robust role in project development including customer service processes. CBOs will help identify the target population and will assist LCHP to apply PAM assessments and other strategies using a population-based approach.

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.

Project 2.d.i will focus on the attributed Medicaid recipients in the LCHP service area, 13,097 of whom are uninsured and 6,252 of whom are low-utilizer and non-utilizer Medicaid members. The target patient population will include these uninsured, low-utilizing and non-utilizing Medicaid members who are in need of LCHP services. These patients will be identified using PAM® or other patient engagement and assessment tools also in use in corresponding DSRIP PPS projects (i.e., Project 2.c.i.). This population was selected based on service area demographics identified through CNA findings. LCHP will access the target population using service area hot spots, high saturation areas where high need patients frequent local organizations and services including Planned Parenthood, the Catholic Charities network (located in Herkimer, Otsego, Delaware, and

Schoharie Counties), food pantries, local Social Services departments in all participating counties and affiliated agencies, and Community Action Program sites.

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.

In support of Project 2.d.i, LCHP has a host of internal assets and resources already on-board.

Bassett, the lead agency, has a robust infrastructure of facilities including six corporately affiliated hospitals, 24 primary regional health clinics plus internal medicine and family practice physicians. The Bassett Medical Center sees 17,500 ED visits yearly. In addition to leveraging known community hot spots, LCHP will leverage this infrastructure to place navigators in EDs and other hot spots along the care continuum where patients will be redirected to a more appropriate level of care as needed.

Bassett currently offers a Community Health Navigation program, serving as a Medicaid Health Home (HH). While this program serves the most highly engaged patient population, it features a number of assets that are pertinent to this project. Program staff possess the cultural and linguistic competence needed to engage the diverse target population. Existing staff use patient needs assessments that are similar to PAM and use of PAM could be easily incorporated. LCHP is currently in discussions with Insignia to pursue this plan. Through the HH program, Bassett has established strong relationships with the community-based support system, relationships that will be leveraged to access the target population in this project. These established HH teams have the capacity to facilitate communication across providers as well as between providers and patients working within feedback loops that ensure continuous monitoring and quality assessment. Their activities produce population-level and individual improvements in patient care outcomes which will be significantly leveraged in this project to engage, activate, and educate members of the target population not utilizing the health care system appropriately enabling them to effectively utilize primary and preventive care services.

LCHP has strong relationships established with CBOs and it will leverage these relationships to reach out to the target population. Several CBOs have already been identified as hot spots for patient engagement (e.g., Planned Parenthood of the Mohawk Valley; the Catholic Charities of Herkimer, Otsego, Delaware, and Schoharie Counties; food pantries, Schoharie Department of Social Services and affiliated agencies, and Community Action Program sites). The frontline staff at these agencies will work in conjunction with other CBO partners—Community Maternity Services of Schoharie and Otsego Counties, Hospice and Palliative Care, Rehabilitation Support Services—and Bassett Medical Center to provide patient activation, financially accessible health care resources, and engagement and linkage to primary and preventive care services. Current contractual relationships with CBO partners will be broadened to effectively reach the required project scope and scale over the five-year project period.

Bassett has joined the HIXNY Regional Health Information Organization (RHIO) with access to the RHIO/SHIN-NY, which enables sharing of health information across hospitals, provider practices, health plans, and health care associations. This current asset will need to be expanded to increase capacity to

support LCHP's ability to manage the health of the service area population and to integrate these services across providers, MCOs, and CBOs. LCHP will install integrated EHR systems to support required project screening, assessment, referral, tracking, marketing and other activities.

LCHP will leverage the navigator workforce across the entire system for this and other DSRIP projects. LCHP's executive leadership will ensure that DSRIP projects efficiently utilize current resources, including the workforce, to achieve the project goals and objectives. The aforementioned assets demonstrate that LCHP has the network capacity to meet the objectives of Project 2.d.i to serve the uninsured (UI), non- and low-utilizing populations in the service 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.

A key challenge will be to engage a culturally diverse population that does not usually seek care at the right time at the right place and in the right location. LCHP anticipates that locating these individuals will be a primary challenge. Integrating diverse and segmented programs for critically important services such as transportation will be a challenge. The navigators will have timely access to these resources, will continuously collect information on new resources and will report this information back to LCHP.

It will be crucially important to engage representatives from the service area's CBOs, from the LCHP Consumer Committee and beneficiaries from the hot spot locations to strategize on ways to recruit the target population. LCHP will explore the use of community champions to distribute information regarding available services to area food pantries, religious organizations and other agencies that offer services to those facing financial hardships and to network with community residents to raise awareness of available services.

Financial resources will be needed to provide some resources (e.g. transportation) and to recruit and retain the necessary project staff. Extensive staff training and resources will be needed to educate all CBO partners, physicians, and other stakeholders in delivery system transformation through Project 2.d.i. Through the Collaborative Learning Committee, staff will be trained to provide marketing of LCHP's services to CBOs, physicians, and stakeholders, as well as how to effectively provide outreach to the hard to reach patient populations targeted with warm hand-offs. Trainers will develop and implement the appropriate system-wide training tools, assessments, screenings, and evaluations for use. To offset some of the financial needs, a performance-based payment strategy has been developed in alignment with LCHP's governance model. LCHP will develop contracts with CBOs located in hot spots to share in the monthly provision of patient engagement and activation services. Educational and screening services will be paid at a negotiated rate.

The project subcommittee has identified a short list of "hot spot" CBO agencies, however, subsequent agencies will need to be identified throughout project implementation. LCHP will leverage its well established relationships with CBOs to engage other CBOs in this project.

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.

LCHP will coordinate with others in the service area in a number of ways. It will share its knowledge of community resources and access to its online database with navigators from these PPSs and will request that information and resources that are developed for other service areas are likewise shared. It will document in the EHR when a patient is referred to a provider affiliated with these other PPSs and will attempt to follow-up with these providers to maintain coordinated care including navigating patients between PPS service areas. To facilitate familiarity with the programs and providers active in overlapping PPSs, LCHP will invite navigators, healthcare providers, social service providers, and community members from others PPS service areas to sit on the Community Navigation Advisory Committee and will network with other PPSs to explore collaborative projects and grant opportunities. LCHP will establish an information exchange with other PPSs to share best practices and educational materials developed in languages other than English. LCHP will network with these other PPSs to explore the possibility of offering collective continuing education, in-services and networking opportunities for all community-based navigators in the shared service areas.

As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS [and others throughout the state] by participating in quarterly learning collaboratives. The transformative nature of this work will require ongoing collaboration and sharing of resources between and among PPS'.

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

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

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

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

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

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

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

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

Yes	No
☐	☒

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

N/A

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
N/A				

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.

N/A

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

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

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

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

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

Domain 3 Projects

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

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

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

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

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

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

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

B. Behavioral Health Service Site:

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

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

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

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

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

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

Unless otherwise noted, the data presented below were taken from the PPS Community Needs Assessment (CNA) and correspond to the needs identified in the CNA Needs Table.
A significant percentage of Medicaid beneficiaries in the LCHP service area have a behavioral illness, many with medical comorbidities. Under the current care model, primary care patients with behavioral health issues receive counseling at the county and other mental health sites. Patients with a mental illness receive care at mental health clinics, but visit a primary care practice for their medical needs. A result of this fragmented system is that many patients do not follow through with referrals and do not receive the care they need to maintain their physical and mental health.
Forty percent (49,487) of service area patients have a mental health disorder; 9% (11,313) have a substance abuse disorder. Medicaid beneficiaries with behavioral health conditions utilize ERs at higher than expected rates, accounting for 57% of all ER visits. Drug-related hospitalizations have increased by 65% to 103% across the LCHP PPS since 2003-2005. Individuals with serious mental illness are more likely to have medical comorbidities, such as diabetes, asthma, and

metabolic syndrome. In the LCHP PPS, beneficiaries with depression or anxiety are up to 2.2 times more likely to smoke, be obese, or have diabetes or asthma, than those without mental illness diagnoses. Five of seven LCHP counties are mental health HPSAs due to provider shortages. HPSA is due to provider shortages. Nevertheless, for Domain 3 metrics, LCHP is performing the same or better than the upstate average on five of seven measure.
To address these gaps, LCHP will implement models A and B, accomplished by 1) co-locating LCSWs and navigators in primary care sites; and 2) co-locating nurse practitioners (NPs) at mental health clinics. Co-location of services will improve medication management, as all patient prescriptions will be written by one provider. Both care teams will implement evidence-based standards of care developed with the support of LCHP Clinical Performance Committee. Further, project 3.a.i will address identified gaps in care by treating patients with mild to moderate mental illness in the primary care setting and utilizing a collaborative team approach (i.e., RNs, LCSWs, and navigators). LCSWs will conduct brief psychotherapy for patients with behavioral health symptoms; navigators will facilitate patient appointments and referrals. Primary care providers (PCPs) will conduct preventive screening (e.g., PHQ-9, SBIRT, the five A's and other substance abuse). All primary care sites will meet 2014 NCQA PCMH level 3 (Project 2.a.ii), facilitating better tracking of medication adherence and incorporation of evidence-based protocols.
At the county sites, NPs will serve as the patient's PCP, conducting medical triage, preventive screenings, primary care, health education; and patient follow-up. The county sites will work collaboratively with the LCHP IT Committee, HIXNY, and SHIN-NY to achieve interoperability with primary care sites and conduct data exchange to improve inter-provider communications and track patient engagement.
LCHP will meet all program requirements for Project 3.a.i.

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.

LCHP's intent is to be as inclusive as possible in defining the patient population for Project 3.a.i. It has defined the patient population as adults and child Medicaid beneficiaries who present to receive care at the participating primary care practice sites and county mental health clinics in the seven-county LCHP service area (i.e., Chenango, Delaware, Herkimer, Madison, Oneida, Otsego, and Schoharie Counties). Currently, there are 158,117 Medicaid recipients (Salient) in LCHP's service area; 34,434 (28%) have a behavioral health diagnosis and receive health care services (Salient); and 36% are served by the LCHP PPS partners. At the LCHP primary care sites, 90,257 Medicaid patients are served annually; all patients will be routinely screened for mental illness and substance abuse, using SBIRT, the PHQ-2, PHQ-9, and other screening tools. For primary care, 18% of patients can be expected to score 10 or higher, signifying potential moderate depression, and requiring follow-up and treatment planning (Kroenke, 2002). LCHP anticipates that 11,199 patients will be engaged in the project by the end of DY 3. At the county mental health clinics, medical screenings will be conducted for diabetes, obesity, cardio-metabolic syndrome and

smoking, with referral/treatment mechanisms in place to address need. Further, based on the literature (Madras, et al., 2009), it is estimated that 3.6% of those who are screened for substance abuse will require a behavioral intervention at the primary care sites.

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 LCHP PPS is fortunate to have developed a modicum of internal expertise and experience among its project participants that will be invaluable to the successful implementation of Project 3.a.i. Bassett and Community Memorial Hospital have already achieved NCQA 2011 PCMH level 3 recognition at their 31 sites and are pursuing 2014 level 3 recognition. Bassett has begun to pursue NCQA PCMH Content Expert certification for its primary care staff; two clinicians plan to take the required learning modules in early 2015. One administrator has completed the 20-hour training and is ready to sit for the exam. Bassett's PCMH content experts will work jointly with the LCHP IT/Data Analytics Committee to share their implementation approach and mentor other sites. PCMH content experts from another LCHP PPS partner, the Catskill Area Health Education Center, will also contribute to project implementation. The LCHP Project Management Office will provide tools for tracking progress and will help to identify and alleviate implementation barriers. As meeting 2014 NCQA level PCMH standards is a requirement for Project 3.a.i, 31 sites will be prepared to integrate behavioral health and substance abuse services into primary care earlier and at a faster than other sites. Of LCHP's 43 primary care sites, all but 12 have implemented an EHR system, and will be able to track all patients engaged in this project, including documentation of screenings. The remaining sites are budgeted and scheduled for installation of an EHR. Bassett is the only partner in LCHP who has achieved any level of behavioral health integration. It has co-located behavioral services into three of its primary care sites (i.e. Cobleskill, Herkimer, and Delaware County), using LCSWs, which will provide practical information for other project participants as they pursue this project. All providers have incorporated preventive care screenings into their practices to identify behavioral health needs (e.g., PHQ-2, PHQ-9, and prospectively, SBIRT). LCHP's Collaborative Learning and Clinical Performance Committees will assemble the Project Champions, who will identify additional screening tools based on an assessment of patient profiles and the target population; develop screening policies and procedures; develop collaborative evidence-based clinical pathways and standards of care, including medication management and care engagement process (incorporating motivational interviewing and patient navigators). Multiple resources will be added to the primary care and mental health clinic sites to successfully complete Project 3.a.i. In addition to recruiting new clinical staff (i.e., psychiatrists, LCSWs, RNs, behavioral health navigators, and nurse practitioners) for the 50 project sites (43 primary care; seven county mental health clinics), the following resources will be provided: staff training (e.g., team-building, motivational interviewing, screening tools, and new software); consultants with content expertise; office space for new staff, as well as computers and furniture; and specialized IT software (for EMR, registration, and billing systems).

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.

LCHP considers staff recruitment to be its main challenge in implementing Project 3.a.i. Under the integrated care model, licensed behavioral health professionals (NPs, RNs, and LCSWs) and behavioral health navigators will share many patient care responsibilities with physicians as team members. Recruitment of RNs and LCSWs is currently an obstacle; behavioral health navigators are a new position. A Collaborative Learning Committee has been assembled Workforce Committee to identify all project workforce requirements, develop recruitment and retention strategies, develop certificate programs with local colleges, and provide staff training programs. LCHP partners are experienced in effectively responding to rural workforce challenges and will work collectively to develop innovative regional strategies.

The costs and amount of time to achieve PCMH recognition and interoperability at all sites will be challenging. Twelve primary care practices will be implementing EMRs, pursuing PCMH recognition, and implementing the project concurrently. Fortunately, nine are affiliated with Bassett, which has implemented an EMR and achieved 2011 level 3 PCMH recognition at 27 sites. Bassett will provide the necessary IT and clinical support to practices implementing an EMR and pursuing PCMH. The County mental health clinics utilize different EMRs, which will make it difficult to electronically exchange data with PCPs. Most project sites currently submit patient-level data to a RHIO. The LCHP IT Committee will assist the remaining sites to join a RHIO and work with them to develop interconnectivity and HIE.

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.

LCHP overlaps with United Health Services Hospitals, Inc., PPS, CNY DSRIP PPS, and Westchester Medical Center PPS. All overlapping PPS are implementing this project.
Current areas for strong collaboration across the region include sharing CNA data, developing regional educational initiatives through learning collaboratives, and formal regional support groups for specific project staff. Additional opportunities include developing data sharing agreements to make health information exchange capacity more robust across the State through RHIOs, as well as development of clinical integration agreements for patients receiving care at multiple facilities across the service area.
As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS [and others throughout the state] by participating in quarterly learning collaboratives. The transformative nature of this work will require ongoing collaboration and sharing of resources between and among PPS'.

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.

For Project 3.a.i, LCHP will require capital funding for renovations to reconfigure space to expand clinical and office space to accommodate additional primary care or behavioral staff at PCMH and mental health clinic sites. In addition, per project requirements, appropriate infrastructure will need to be developed, including enhanced modules for existing EMRs and software interfaces.

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
N/A				

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.

N/A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The prevalence of substance abuse in the LCHP service area (Chenango, Delaware, Herkimer, Madison, Oneida, Otsego, and Schoharie Counties) is high and growing. Treatment options are limited within the LCHP service area and surrounding region, and focus on inpatient care. Almost 20% of service area adults (age-adjusted) report binge drinking; 8.3% report heavy drinking, higher than the State averages - 8.1% and 5.1%, respectively. Drug-related hospitalizations totaled 3,009 (2010-2012). Drug-related hospitalization rates in the counties of the PPS have risen dramatically in the last 7 years. While the percentage change in this rate between 2003-2005 and 2010-2012 has been +5% for upstate NY counties overall, the change has been greater than +60% in 6 of the 7 PPS counties, with the biggest change being a 104% increase in Otsego County. Similar trends are observed for poisoning hospitalization rates.

For the Domain 3 metric, initiation and engagement of alcohol and other drug dependence medication, LCHP falls in the third last favorable quartile in the State (if the 7-county LCHP PPS were ranked as a single county) - 79%. Rankings varied considerably by county. Delaware (87%) and Schoharie (81%) were in the most favorable first quartile, while Madison (75%) was in the least favorable fourth quartile. To address these gaps, LCHP will expand access to substance abuse services by developing an ambulatory substance abuse clinic with a co-located ambulatory detox service.

Ambulatory detox services are new in New York State and none currently exist in the LCHP service area. Conifer Park in Schenectady County (a LCHP partner) recently launched an ambulatory detox program, focusing on opioid addiction. Distances to that facility can be more than a two-hour drive from the LCHP service area. Establishment of a community-based withdrawal management program for alcohol, sedative, and opioid dependency and co-located with an outpatient substance abuse clinic, will provide an alternative for residents who currently must travel long distances to obtain theses services.

To address the rise in substance abuse and increases in drug-related hospitalizations, LCHP will: 1) establish an ambulatory detox service, focusing in withdrawal from alcohol, sedatives, and opioids, in conjunction with an outpatient substance abuse clinic; 2) establish formal relationships with inpatient substance services located inside and outside the service area, County outpatient clinics, and community prevention programs; using LCHP member substance abuse providers as liaisons; and 3) develop care management programs in conjunction with the two Medicaid health homes in the region,

as well as community-based organizations. The Medical Director hired for the substance abuse programs will assemble a substance abuse task force to include LCHP members, expertise from the Finger Lakes PPS, and Medicaid MCOs, as well as inpatient, outpatient, and care management providers, to develop ambulatory detox management protocols based upon evidence based best practices and staff training curricula.

LCHP agrees to meet all program requirements for Project 3.a.iv.

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.

LCHP has identified the target population as adult Medicaid beneficiaries (aged 18 and older) from the LCHP PPS service area that have one of the following substance abuse disorders: alcohol, sedative, or opioid dependency. In 2012, 6,020 Medicaid beneficiaries from the service area were admitted to hospitals for substance abuse; 2,624 were admitted for chronic alcohol abuse, opioid abuse, and opioid abuse-continuous. The largest percentage of beneficiaries (54%) who were admitted for these conditions lived in Oneida County. Admissions for chronic alcohol abuse were more prevalence than for opioid abuse in Herkimer, Oneida, and Otsego Counties. Opioid abuse hospitalizations were more common in Chenango County, while Madison County experienced an equal amount of admissions from both addictive substances.

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.

LCHP has assembled the expertise of its lead agency (Bassett) and PPS partners that operate behavioral health programs to help achieve the Project 3a.iv requirements. The Bassett Healthcare Network operates more than 40 community-based primary care clinics and school-based health centers throughout the LCHP PPS service area, that offer substance abuse awareness and prevention services. Bassett has co-located behavioral health serves (including substance abuse counseling and referral) at three of its primary care sites, and will expand this model to all its primary care clinic sites over the next three years (Project 3.a.i). Primary care practices operated by Community Memorial Hospital and Slocum Dickson Medical Group will also integrate substance abuse services into primary care. Social workers, CASACs, and behavioral health navigators, hired as integrated care team members, will be a large source of referrals to the new ambulatory substance abuse clinic and detox programs. Likewise, the ambulatory detox program will refer patients back to their provider in LCHP's extensive primary care network to manage medications and provide follow-up care and support services. Other LCHP partners have expertise in designing and delivering clinical and supportive substance abuse services in the LCHP service area, including: Conifer Park (inpatient medically supervised detoxification and rehabilitation; ambulatory detox for opiate addition, and outpatient substance abuse clinics), Leatherstocking Education on Alcoholism/Addictions Foundation or LEAF (education/prevention), Schoharie County on

Alcoholism and Substance Abuse (education/prevention), Alcohol and Drug Abuse Council of Delaware County (education/prevention), Hospitality House (residential program), Herkimer County HealthNet (prevention), Catholic Charities of Delaware and Otsego Counties (drug treatment case management), Otsego County Community Services (outpatient clinic) and Chenango County Alcohol and Drug Abuse Services (clinic, school-based prevention. Collectively, these LCHP partners will utilize their skills, experience, and organizational resources to: develop protocols for ambulatory detox and referrals; develop care management services; develop MOUs with inpatient detox services, primary care sites with co-located behavioral health services, and county chemical dependency clinics; and form agreements with managed care organizations to provide reimbursement for ambulatory detox. LCHP is developing a relationship with Finger Lakes PPS to provide patient assessments and addiction counseling services from their providers via telemedicine. URMC's Strong Recovery Addiction Psychiatry Service, in addition to other Finger Lakes PPS expertise, provides outpatient chemical dependency and opiate treatment services for adults, led by ABAM Certified Physicians in Addiction Medicine. It is a primary goal for LCHP to engage staff from URMC and the Finger Lakes PPS to serve as mentors during project development and implementation and collaborate on outpatient medication management for opiate addiction, particularly for specialized patient subpopulations where they have developed best practices.

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.

Recruiting qualified substance abuse professionals will be challenging in the rural LCHP region. LCHP will seeks a physician who is board-certified in addiction medicine and thus credentialed to treat opiate addiction using buprenorphine. Currently, only 19 physicians are certified to prescribe buprenorphine in the region. LCHP is seeking a regulatory waiver for expansion of this credential to primary care physicians. The Collaborative Learning Committee will develop staff recruitment and retention solutions for the project that may include collaboration with Conifer Park, which recently opened an ambulatory detox program and has an extensive staff recruitment network. Mohawk Valley Community College offers a CASAC certificate program and will be a resource to increase CASAC supply. LCHP will implement two other DSRIP projects that will require substance abuse staff (Projects 3.a.i. and 4.a.iii) and will consolidate recruitment efforts for these projects. A second challenge will be the time required to submit applications to OASAS for the clinic and ambulatory detox services. The process may take a year or more, delaying the start of these programs. County chemical dependency centers and Conifer Park have clinic licenses and will help guide the PPS through the regulatory requirements. The Substance Abuse task force, as well as the LCHP Workforce Development and Clinical Operations Committees, will help to develop clinical protocols based on evidence-based practices, staff training modules and provider agreements.

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.

LCHP overlaps with United Health Services Hospitals, Inc., PPS, CNY DSRIP PPS, and Westchester Medical Center PPS. The overlapping PPS have not pursued this project. Although LCHP does NOT overlap with the Finger Lakes PPS, the leaders are working closely to collaborate to share best practices and resources to most effectively develop a project implementation plan and sustain the project's success.

Current areas for strong collaboration across the region include sharing CNA data, developing regional educational initiatives through learning collaboratives, and formal regional support groups for specific project staff. Additional opportunities include developing data sharing agreements to make health information exchange capacity more robust across the State through RHIOs, as well as development of clinical integration agreements for patients receiving care at multiple facilities across the service area.

As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS [and others throughout the state] by participating in quarterly learning collaboratives. The transformative nature of this work will require ongoing collaboration and sharing of resources between and among PPS'.

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.

For Project 3.a.iv, LCHP will require capital funding for construction/renovations to build an outpatient chemical dependency clinic with a co-located ambulatory detox service in the LCHP service area. In addition, per project requirements, LCMH will need to connect with inpatient facilities and other community-based treatment providers through EMR systems and telemedicine to obtain specialty consultation and for health information exchange. To achieve electronic interoperability, appropriate infrastructure will need to be developed, including enhanced modules for existing EMRs and software interfaces.

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
N/A				

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.

N/A

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

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

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

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

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

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

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

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

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

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

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

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

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

In the LCHP service area, the prevalence of asthma among Medicaid patients (17%) is nearly twice that of patients with other types of insurance (9%). Medicaid patients with asthma are more than four times as likely to visit the ED (per year) than other patients. The rate of potentially avoidable ER visits is 44/10,000 Medicaid enrollees. The hospitalization rate for asthmatic pediatric (2-17 years) Medicaid patients is 18.4/10,000. If the seven-county LCHP PPS were one of New York State's 62 counties, it would rank 32nd for pediatric hospitalizations.

The hospitalization rate for younger adult (18-39 years) Medicaid patients with asthma is 14.7 per 10,000, ranking 45th. For older adult (> 40 years) Medicaid patients with asthma

and COPD, the hospitalization rate is 97.8 per 10,000, also ranking 45th. Several LCHP counties have high rates of avoidable Medicaid asthma utilization including: Otsego, Chenango, and Delaware Counties for pediatric hospitalizations; and Otsego, Oneida, and Madison Counties for younger adult hospitalizations. Among older adults with asthma and COPD, hospitalizations are higher in Oneida, Otsego, and Madison Counties. LCHP, headed by Chris Kjolhede, Medical Director, Bassett School-based Health Program, will lead a regional coalition, consisting of primary care practices, schools, specialty providers, hospitals, MCO's, health homes, home care providers, and county health departments, to identify and implement national evidence-based asthma guidelines (e.g., National Heart Lung and Blood Institute, PediaLink Asthma Curriculum) in primary care practices. The coalition will focus on asthma self-management, tobacco control, and air quality, leading to a more consistent approach to asthma management and reduced use of hospital services.

In the seven-county service area, there are 30 asthma specialists (7 allergists and 23 pulmonologists) for the more than 4,040 asthmatic Medicaid beneficiaries with annual hospital admissions. LCHP will develop asthma care pathways for children and adults that will provide primary care practitioners with tools for early asthma diagnosis and indicators for referring patients to asthma specialists. It will also develop collaborative agreements between asthma providers and LCHP to ensure adherence to established guidelines. Specialists will be instrumental in structuring and delivering educational activities to facilitate adoption of care pathways and improve provider competency in the diagnosis and treatment of asthma.

A majority LCHP primary care sites have achieved NCQA Level 3 PCMH status. Under Project 3.d.iii, LCHP will enhance EHR-HIE capacity through all providers attaining NCQA Level 3 PCMH 2014 recognition. Increased capacity will improve patient and primary care provider access to asthma specialists via telemedicine. Provider agreements will be established for EHR-HIE connectivity, and telemedicine as well as the use of EHR systems to track all patients engaged in the project.

LCHP agrees to meet all requirements for Project 3.d.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.

The target population defined for Project 3.d.iii was selected based on the prevalence of asthma in LCHP's service area. This project will target child and adult patients diagnosed with asthma, or patients with asthma symptoms (e.g., coughing, wheezing, chest tightness, and shortness of breath), as defined by the National Heart, Lung, and Blood Institute, who are treated in LCHP's EDs, hospital inpatient units, and primary care practices. Project 3.d.iii will focus on current and future pediatric and adult patients at risk for avoidable ED visits, hospitalization, and readmissions due to asthma mismanagement and inconsistent care.

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

Several current assets will be leveraged to accomplish the primary project objective implementing evidence-based medicine guidelines for asthma management to ensure consistent care, including expertise and experience in providing asthma care. The Bassett Healthcare Network currently includes over 150 primary care physicians, five pulmonologists, 19 school-based health centers, and one board-certified allergist that treat children and adults with asthma. Slocum Dickson Medical Group has an allergist, a pulmonologist, and a nurse practitioner specializing in pulmonology; Community Memorial Hospital has a pulmonologist. All LCHP hospital partners provide respiratory therapy. Bassett offers smoking cessation therapy.

Other LCHP resources include the many community-based collaborators, such as the nine-county Catholic Charities organizations that are committed to helping individuals and families receive needed care by providing intensive case management, medical transportation and other support services. Additionally, LCHP's network includes the County Health Departments (providing asthma awareness education), three home health care organizations, a durable medical equipment supplier, and three pharmacies. A relationship is evolving between LCHP leadership and Medicaid Managed Care Organizations (MMCOs). Throughout this project, LCHP will ensure coordination with MMCOs and the four Medicaid health Homes (including Bassett's) serving patients with asthma.

Current LCHP assets requiring changes include primary care sites that will attain NCQA PCMH 2014 level 3 certification by the end of Demonstration Year 3. Under the new PCMH guidelines, increased EHR-HIE connectivity will streamline health care delivery and enable patients to be more involved in their care through patient portal access to their medical records, appointment requests, prescription refills, referrals, and test results. Comprehensive EHR connectivity will allow providers from multiple locations to simultaneously view patient medical records in real-time, with decision support tools, promoting health care quality and efficiency goals.

Under Project 3.d.iii, enhanced EHR-HIE connectivity is required to enable tracking for patients engaged in the project. The Bassett Healthcare Network has implemented a diabetes patient registry. With improved connectivity for all LCHP partners, LCHP will create an asthma patient registry to track patients and ensure that patients keep their appointments, track symptoms, adhere to treatment, and prevent exacerbations, maximizing their individual asthma action plans.

New resources that LCHP will need to implement this project will include adding more providers to bolster the primary care and asthma specialist workforce across the region. While Bassett has led the way in the service area with its information technology advances (e.g., the Telehealth program supports in-home monitoring, stroke identification, and specialist consultation in Nephrology and Dermatology), enhancements are needed to broadband access and telemedicine services to increase patient access to needed asthma care in LCHP's rural service 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.

LCHP anticipates three main project implementation challenges.

Recruiting primary care providers and specialists to the service area is challenging. There are no pediatric pulmonologists in the region currently. To overcome this challenge, LCHP will use creative regional recruitment and retention strategies, such as incentives, to attract providers and will use telemedicine to increase patient access to asthma specialists and increase provider (e.g., primary care providers, nurse practitioners in pulmonology) education and training.

A comprehensive asthma patient registry will be required to track asthmatic patients care in the service area. Universal EHR connectivity is not present across service area providers; 11 sites have not achieved 2011 PCMH level 3 status. Other proposed DSRIP projects (e.g., 2.a.ii and 3.a.i) will also rely on EHR systems and other technical platforms to track patient engagement in the projects and will work collaboratively with the LCHP IT/Data Analytics Committee to achieve this goal.

Patient engagement will be an integral part of the success of the proposed project. Care coordinators, patient navigators, case managers, and health educators will be critical team members at community-based provider sites. These staff will engage patients in care, facilitate implementation of asthma action plans, and champion patient self-management for better asthma control. Referral tracking and patient follow-up will be part of the ongoing strategies used to engage and re-engage patients in care.

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.

LCHP overlaps with United Health Services Hospitals, Inc., PPS, CNY DSRIP PPS, and Westchester Medical Center PPS. The Westchester Medical Center PPS is implementing this project.

Current areas for strong collaboration across the region include sharing CNA data, developing regional educational initiatives through learning collaboratives, and formal regional support groups for specific project staff. Additional opportunities include developing data sharing agreements to make health information exchange capacity more robust across the State through RHIOs, as well as development of clinical integration agreements for patients receiving care at multiple facilities across the service area.

As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS [and others throughout the state] by participating in quarterly learning collaboratives. The transformative nature of this work will require ongoing collaboration and sharing of resources between and among PPS'.

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.

N/A

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
N/A				

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.

N/A

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

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

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

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

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

Across the Leatherstocking Collaborative Health Partners (LCHP) PPS, there is wide variation in the percentage of Medicare patient deaths that occur while in hospice care, ranging from 11% to 49%,

although patients with serious life-limiting illnesses frequently express their wish to die without life-prolonging technology. Herkimer and Oneida Counties ranked 61st and 62nd respectively among NYS's 62 counties (2010), with 13% (Herkimer) and 11% (Oneida) of Medicare deaths occurring in hospice care. Even when patients elect to receive hospice care, enrollment does not occur until the patient's last days of life. At Bassett's comprehensive community cancer program, 21% of hospice enrollment occurred within three days of death (2014, CNA). For those patients not referred for hospice care, palliative care was discussed within the last two months of life for only 7% of patients, compared to 22% for patients participating in the American College of Clinical Oncology's Quality Oncology Practice Initiative.

The previous data highlight the fact that the majority of terminally ill patients in the LCHP service area die in a hospital due to lack of access to hospice services. Six hospice providers offer palliative care services in the region, though many patients do not receive such care because their provider has not initiated a palliative care discussion. As part of Project 3.g.i, social workers will provide training to primary care practitioners and other staff to increase competence in palliative care skills. Having these conversations will encourage use of hospice services for patients with terminal illnesses. Three hospice providers and other long-term care agencies will provide palliative care supports and services for patients in the participating primary care practices. LCHP will pursue coverage of palliative care service by Medicaid managed care organizations to improve patient access.

Congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) are among the leading patient diagnoses in hospice care (2009 Medicare Hospice Data), and the leading causes of 30-day preventable hospital readmissions (PPRs) at PPS hospitals (CNA). CHF, the leading PPR at Bassett (18% of CHF patients were readmitted within 30 days), is also the fourth-ranked hospice diagnosis nationally. COPD also ranks among the 10 leading causes of PPRs for Bassett. Patients with COPD, especially those on Medicaid, are at high risk for utilizing ER services; 21% of COPD patients went to the ER for COPD in the past year, compared to 23% for Medicaid patients (CNA).

Integrating palliative care into LCHP primary care practices is an effective strategy for reducing hospital readmissions for patients with high-risk diagnoses. Through the proposed project, LCHP will assemble a palliative care support team, trained to follow the "Aspire Health" model that will be instrumental in formulating clinical guidelines, a customized EMR that can track patient outcomes, and a consistent, systematic approach to outpatient palliative care, resulting in more effectively management of end of life care and preventing unnecessary hospitalizations.

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

In 2013, 90,257 unique Medicaid beneficiaries in the LCHP PPS service area received primary care services (Salient, Member Counts and Utilization by Major Services). This data was abstracted from a

seven-county service area, including Chenango, Delaware, Herkimer, Madison, Oneida, Otsego, and Schoharie counties.

The LCHP PPS has defined its target patient population for Project 3.g.i as adult (aged 18 and older) Medicaid beneficiaries residing in the LCHP service area who receive primary care services for a serious medical condition from providers participating in the PCMH 2.a.ii project. In 2013, LCHP partners served 27,619 adults and provided 68,624 primary care visits (Salient, Member Counts and Utilization by Major Service).

For adult Medicaid beneficiaries diagnosed with serious conditions and a limited life expectancy, providing integrated palliative care services at participating LCHP PCMH sites will increase the number of terminally ill Medicaid patients who receive hospice services and decrease the number of avoidable hospitalizations during the last year of life.

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.

LCHP PPS will engage patients from the 40 primary care sites in its service area that are participating in Project 2.a.ii. Within its project members and partners, LCHP has acquired many of the assets and resources that can be mobilized and employed to successfully achieve the project requirements.

Thirty primary care sites operated by Bassett Medical Center and Community Memorial Hospital have fully implemented an EMR, achieved NCQA 2011 level 3 recognition, and developed sufficient experience in PCMH implementation to assist the remaining sites in successfully achieving PCMH by the end of project year 3. Each hospital has trained PCMH champions. One is actively pursuing PCMH Content Expert Certification. Staff members with PCMH expertise from Catskill Hudson Area Health Education Center (AHEC), a PPS partner, have offered their expertise to project participants in achieving PCMH certification, the foundation for being able to integrate palliative care services. These sites will integrate the palliative care model into their practices and will assist others in leading the transformation.

Two hospice and palliative care agencies have joined the LCHP PPS and will participate in Project 3.g.i.: Hospice and Palliative Care of Chenango County; and Catskill Area Hospice and Palliative Care, Inc. Together, these agencies provided 81,502 days of hospice care to 1,413 Medicare patients in 2011 (CMS Health Care Information System). Their experienced staff will train primary care providers, as well as patients and community groups. Patients will be educated in how to engage their families and practitioners in conversations about their wishes for end-of-life care, an important component of the Conversation Project. Other LCHP partners provide institutional or home-based palliative care services and can offer project support by mentoring staff in primary care sites and assisting with training - At Home Care, Access to Home Care, and eight nursing homes. Several long-term care providers have developed palliative care pathways, protocols, and tools for delivering care and will assist LCHP in developing clinical standards for the primary care setting. Involving these providers will help to develop

effective communications among clinicians and will ensure that palliative care services are available to patients as they move through the care continuum.

LCHP has identified the following resources as being vital to successfully achieving the project requirements: external consultants to develop training curricula for clinical staff at primary care sites, deliver staff training, provide financial and legal advice to establish reimbursement agreements with Medicaid Managed Care, and customize EMRs to provide IT platforms for data reporting; trained staff and additional staffing resources – both clinical and administrative - to implement new clinical pathways and guidelines, conduct staff training and community outreach, and support primary care practices; and technology to support training, quality assurance, and reporting.

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

The LCHP Palliative Care project subcommittee identified potential challenges that may develop during Project 3.g.i implementation and has shared its concerns with other relevant LCHP committees to be incorporated into the overall DSRIP implementation plans. It is anticipated that many of the identified challenges will be common to other project groups and solutions will be addressed collectively to encourage transformational change. The primary challenge to integrating palliative care into primary care practices will be the wide differences in acquisition of EMRs and achieving PCMH recognition throughout the LCHP service region. Ten participating practices have not implemented an EMR or achieved PCMH recognition. To achieve the project requirements, administrative and clinical staff will have to establish aggressive timelines in which to meet the requirements. Coordinated efforts with LCHP's Collaborative Learning Committee, Data/IT Analytics Committee and area partners will assist practices in making the transformational changes required to implement the project elements into their practices.

Physician and clinical engagement will be enhanced through training and education in having end-of-life conversations with patients, but also by engaging palliative care professionals in the care early enough so to develop trusting relationships with the patients.

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.

LCHP overlaps with United Health Services Hospitals, Inc., PPS, CNY DSRIP PPS, and Westchester Medical Center PPS. United Health Services Hospitals, Inc. and CNY DSRIP PPS have chosen this project.

Current areas for strong collaboration across the region include sharing CNA data, developing regional educational initiatives through learning collaboratives, and formal regional support groups for specific project staff. LCHP will also share clinical pathways for palliative care services with overlapping PPS with the hope that much can be gained from this collaboration. Further opportunities include developing data sharing agreements to make health information exchange capacity more robust across the State through RHIOs, as well as development of clinical integration agreements for patients receiving care at multiple facilities across the service area.

As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS [and others throughout the state] by participating in quarterly learning collaboratives. The transformative nature of this work will require ongoing collaboration and sharing of resources between and among PPS'.

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.

N/A

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

Yes	No
☐	☒

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

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

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

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

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

N/A

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

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

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

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

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

Domain 4 Projects

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

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

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

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

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

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

Entity Name
Four Winds; Phoenix House

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

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

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

findings from the Community Needs Assessment with the project design. For example, identify how the project will develop new resources or programs to fulfill the needs of the community. All data below are from the CNA (YRBSS and BRFSS) and correspond to the CNA Needs Table.

Gaps in mental health: In the LCHP service area, 11.3% of adults (age-adjusted) reported frequent poor mental health days in the past month, compared to 10.2% for NYS (2009-10); among the 62 NYS counties, Chenango and Oneida are ranked 58th and 54th respectively. Schoharie and Delaware Counties are ranked 48th and 59th respectively on suicide mortality rate.

In Herkimer and Oneida Counties, 26% and 29% of 11th grade boys respectively, endorsed feeling sad/hopeless almost every day at least 2 weeks in a row, relative to the national rate of 23% for the same group. In Oneida County, almost 20% of 11th grade boys seriously considered suicide in the past year, compared to the national rate of 14% for 11th grade boys. In Herkimer and Oneida Counties, 6% of 9th grade boys attempted suicide (past year), relative to almost 5% nationally. Similar patterns were not seen for girls.

To address these gaps, LCHP will work with DOH and OMH to expand upon Bassett's current use of 'Collaborative Care' in primary care settings to all counties, incorporating telemedicine (sector 2). LCHP is implementing project 3.a.i. integration of behavioral health into primary care. Further, LCHP will pilot a community in-reach program in schools involving, as members of the care team, college-aged peer health coaches who have "lived experiences" with mental, emotional, and behavioral (MEB) issues (sector 1).

The following data represents gaps in substance use: approximately 20% of adults (age-adjusted) in the service area reported binge drinking and 8% reported heavy drinking, higher than the State averages of 18.1% and 5.1%, respectively. Oneida County is ranked 48th for adult binge drinking.

In Herkimer County, 12% of 11th graders use smokeless tobacco, relative to 10.5 % nationally. In Oneida County, 43% of 11th graders use alcohol, relative to 39% nationally.

To address gaps LCHP will work with the regional four-county coalition of community service directors to explore options for the project required implementation team. If successful, strategies and tactics will be identified for promotion of MEB health and disorder prevention. Additionally, LCHP will collaborate with project 3.a.1 to expand the use of the Screening Brief Intervention Referral to Treatment (SBIRT) across all participating primary care and behavioral health sites (3.a.i) by providing continuing medical education to an expanded population of health care providers in LCHP (sector 1). LCHP will mobilize the IT committee to expand EMR capabilities, bolster interconnectivity and facilitate coordinated care of MEB problems (sector 4). Additionally, the PPS will distribute Bassett's "We are Here to Help Guide" in Spanish and English to inform providers of substance abuse referral options and recommendations in each PPS county (sector 3). LCHP is committed to partnering with a member organization, the Leatherstocking Education

on Alcoholism Addictions Foundation Inc. (LEAF), to offer the Too Good for Drugs program to high school students in the service area. Finally, LCHP will share data and information on MEB health promotion and MEB disorder prevention and treatment with other PPSs, including United Health Services Hospitals and CNY DSRIP Performing Provider System (sector 4).

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 seven counties in central NY comprising the PPS service area (Chenango, Delaware, Herkimer, Madison, Oneida, Otsego, and Schoharie Counties) have a population of 566,304 people (2010 U.S. Census) and represent the project's target population. The median age of residents is 41.6 years, older than the NYS average (38 years); 15.4% of the population is 65 years of age and older. Residents are predominantly White (92.1%). Minority residents are more concentrated in Oneida County (87.1% White), the most populated of the seven counties. Bassett's service area faces rural poverty and transportation challenges, which affect health care needs and access to services. Bassett's service area counties ($60,313 weighted mean household income in last 12 months) are poorer than the State average ($83,578). Although the number of residents living below the Federal Poverty Level is lower overall than NYS (13.4% vs. 15.1%, 2009-2011), three of the counties experience higher rates—Herkimer (15.8%), Otsego (15.7%), and Oneida (15.4%). Pockets of poverty exist in the cities of Rome (15.9%) and Utica (28.2%). Childhood poverty rates are up to 60% higher than the total population. The service area's unemployment rate is higher than the rest of the State (except NYC), averaging 7.7% for 2013, compared to 6.9%. The lack of a comprehensive public transportation system in each county makes it difficult for poor people who do not own a car to get to work or to attend medical appointments. Therefore, lack of public transportation is a barrier to residents' timely access to primary health care services.

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

There are a number of existing resources that will be leveraged for this project. Currently, there are scattered administrative resources dedicated to behavioral health and substance abuse throughout LCHP. With respect to project administration, LCHP will organize a highly-effective team led by a well-credentialed, high caliber individual to address projects 3.a.iv, 4.a.iii, and 4.b.i. The team will enhance relationships with all related organizations. In this fashion, a coordinated, integrated approach will be attained. Further, Bassett's 19 School-Based Health centers use the GAPS to screen for MEB disorder risk. The peer health coach pilot program will build upon these established processes (sector 1), and the Bassett Research Institute staff will be leveraged to evaluate the results. Bassett's community health coordinator and existing SBIRT training curriculum (presented to all Bassett primary care providers) will be leveraged to provide SBIRT training to an expanded population of health care providers in the LCHP PPS (sector 1). Bassett's experience using the 'Collaborative Care' model in primary care settings will be leveraged to expand this model to all counties (sector 2) incorporating telemedicine. The substance abuse resources guide, "We Are Here to Help" (presented to all Bassett primary care

providers) will be made available in English and Spanish and will be distributed to all PPS partner organizations (sectors 1, 3).
The project will leverage LCHP's existing relationships with facilities, institutions, and educational groups (Four Winds Saratoga and the Beacon Center in Utica) to provide substance abuse treatment to patients referred from LCHP providers (sector 1). Bassett's record of collaboration with LEAF to provide substance abuse education to high school students (sector 1) will be expanded. LCHP will build upon its existing relationships with area colleges, including SUNY Cobleskill, to recruit peer health coaches for its pilot program (sector 1). Importantly, the Mobile Crisis Assessment Team serves six of the counties in the LCHP service area to deescalate crisis situations and link those in need to services. LCHP will work with this team to integrate its services with those of this team (sector 1).
LCHP will make every effort to link to an existing consortium of county community service directors from four of the seven counties in the service area, which is unique to the state of New York. This group has been meeting for approximately 20 years to share best practices and resources. The intent is to explore linkages where efforts may be synergized to achieve even greater outcomes. Topics to be discussed include tactics regarding MEB promotion and a collaborative approach to three related projects - 4.a.iii, 4.b.1, and 3.a.iv.
Key resources will be strengthened to meet project goals. Bassett's extensive EMR systems will be strengthened to bolster interconnectivity and facilitate coordinated care of substance abuse and MEB problems. As part of DSRIP, the LCHP IT/data subcommittee will work with project teams and partners to implement consistent and interconnected EMR systems PPS-wide (sector 4). Community health outreach workers will be added to connect with schools, service clubs, community based organizations, churches, etc., in order to fulfill the disease prevention, promotion, and advocacy objectives.

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.

Cultural and linguistic differences within the rural service area will pose a challenge. LCHP will leverage its well-established relationships with CBOs and with providers serving diverse patient groups (e.g., residential services for the developmentally disabled) to tailor the treatment approach to the population. The expertise and network relationships in the proposed implementation team will be leveraged to identify culturally and linguistically competent strategies.
LCHP anticipates that recruitment of new mental health staff could be challenging, as workforce shortages exist in the area. LCHP plans to redeploy or retrain existing staff for clinical roles or positions in outreach or in education as patient volume shifts from acute care to primary care settings over the life of the DSRIP program. Additionally, telemedicine will be incorporated into the collaborative care model, currently in use at Bassett, when psychiatrists are not readily available to consult with the multidisciplinary teams.
Stigma and fear of arrest are challenges that individuals with MEB problems face that may prevent them from seeking help for themselves or others. LCHP will design public

health campaigns to address these challenges, including raising awareness of the 911 Good Samaritan law. The pilot program will provide high school students with culturally salient support from coaches who are close in age to their peer group and who have similar lived experiences, thus decreasing feelings of stigma and isolation in adolescents screened to be at risk for MEB disorders.
Interconnectivity of EHR will be a major challenge through the DSRIP period, for all projects. In 2014, Bassett joined the HIXNY Regional Health Information Organization (RHIO), which enables wide-spread sharing of health information. Development of access to the RHIO/SHIN-NY and other EHR systems will support LCHP's ability to manage the health of the service area population.

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.
LCHP overlaps with United Health Services Hospitals, Inc., PPS, CNY DSRIP PPS, and Westchester Medical Center PPS. United Health Services Hospitals, Inc. PPS and CNY DSRIP PPS have chosen this project.

As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS'. LCHP will coordinate by offering joint training, sharing best practices and screening tools, combining marketing and outreach efforts, sharing health education materials printed in other languages, and sharing and exchanging other strategies for delivering culturally competent mental health and substance abuse interventions. LCHP will share the results of the high school peer coach pilot project and will collaborate with other organizations who may wish to replicate it, guiding them on lessons learned. LCHP will make the "We are Here to Help" resource available to these PPSs, in English and in Spanish. LCHP will invite members of these PPS' to liaison with the proposed implementation team to pursue potential collaborations and to explore pilot projects. It will cross-collaborate on public information campaigns and advocacy activities to leverage DSRIP funds. LCHP will reach out to the PPSs who did not select this project, offering its best practices and its expertise on how they may be implemented. It will explore ways in which its public health messages can be disseminated to these communities to help decrease stigma and encourage residents in other areas to seek out help for possible MEB disorders. As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS [and others throughout the state] by participating in quarterly learning collaboratives. The transformative nature of this work will require ongoing collaboration and sharing of resources between and among PPS'.

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.

Milestones Year 1:
Establish MEB health promotion and disorder prevention partnerships (Q1Y1).
Design collaborative care strategy by the end of year.
Recruit executive leadership
Initiate workforce retraining and redeployment including cultural and linguistic strategies.
Begin to recruit health coaches.

Milestones Year 2: Implement public health promotion efforts. Implement pilot program. Expand Care Coordination model. Offer SBIRT training to expanded population of health care providers. Milestones Year 3: Integrate EMR by the end of year to share data through integrated referral systems. Milestones Year 4: Disseminate results of peer health coach pilot program.

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

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

Yes	No
☐	☒

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

N/A

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
N/A				

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.

N/A

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

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

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

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

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

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

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

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

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

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

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

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

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

Entity Name
Seton Health Center for Smoking Cessation

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

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

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design. For example, identify how the project will develop new resources or programs to fulfill the needs of the community. All data for the service area are based on surveys and Salient data queries documented in the Community Needs Assessment (CNA) and the CNA Needs Table.

Out of the 62 counties in New York State, four of the seven LCHP PPS counties are ranked in the least favorable quartile for adult smoking rates. Smoking in New York State has declined, yet it has not changed for adults with low socioeconomic status and poor mental health, factors that characterize many in the service area. Herkimer, Otsego and Oneida face higher rates of poverty than the statewide average (15.8%, 15.7%, 15.4%, vs. 15.1%, respectively). Among PPS Medicaid beneficiaries, rates of depression and anxiety disorders are three to five times higher than others in the service area. Over one third (36%) of Medicaid patients in the service area are smokers (a rate that is nearly 2.5 times higher than that for others) with the smoking rate nearing 50% for those with depression or anxiety.

Among the Medicaid residents in the LCHP service area, 8% have COPD and of these beneficiaries, 23% had an ER visit within the past year and 12% had a hospital admission due to COPD. The 30-day readmission rate for COPD is higher in the service area (15.5%) than in New York State hospitals (13.8%) and other rural New York hospitals (12.7%).

To close these gaps, Leatherstocking Collaborative Health Partners (LCHP) will take a population-based approach to promoting services to all smokers during primary care, mental health and other visit experiences. LCHP will enhance EMR to prompt providers to complete the 5 A's (ask about smoking status, advise them to quit, assess readiness, assist them in quitting, arrange follow-up), and to make referrals to treatment resources. LCHP will work with community-based organizations, county mental health clinics, dentists, school-based health centers and local colleges to prevent or reduce smoking in the service area. LCHP will implement the US PHS

Guidelines for Treating Tobacco Use and will form a coalition to promote legislative awareness of the need for smoke-free outdoor policies.

Further, Medicaid recipients in the service area are almost four times more likely than others to miss a doctor's appointment due to lack of transportation. To close this gap, LCHP will integrate care coordinators system-wide to arrange transportation.
Not all smoking cessation treatments are covered in New York and coverage for the Medicaid expansion population is still being determined. Coverage for the Medicaid population is not comprehensive.
To close this gap, LCHP will form a task force to work with MCOs and insurance companies to increase coverage of tobacco dependence treatment and to promote smoking cessation benefits among Medicaid providers. Partner government relations experts will coalesce to affect this effort.
Of note, the project team will include chewing tobacco behavior in its work.
By meeting all requirements of 4.b.i, LCHP will meet project metrics and the overall primary goal to reduce avoidable hospitalizations and ER visits in the service area.

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 seven counties in upstate NY comprising the LCHP service area (Chenango, Delaware, Herkimer, Madison, Oneida, Otsego, and Schoharie Counties) have a population of 566,304 people (2010 U.S. Census). The median age of residents is 41.6 years, older than the NYS average (38 years); 15.4% of the population is 65 years of age and older. Residents are predominantly White (92.1%). Minority residents are more concentrated in Oneida County (87.1% Caucasian), the most populated of the seven counties.
The LCHP service area experiences a high prevalence of mental illness and substance abuse. In the 2008-2009 BRFSS survey, 11.2% of adults (age-adjusted) reported experiencing poor mental health 14 or more days in the past month, compared to 10.2% for NYS. Chenango (13.5%) and Oneida (13.0%) Counties reported higher poor mental health rates than the service area average. Alcohol abuse was also high; 19.9% of adults (age-adjusted) reported binge drinking and 8.3% reported heavy drinking, higher than the State averages of 18.1% and 5.1%, respectively.
The CNA data indicate that 23.3% of adults overall in the PPS service area smoke. Based on the American Community Survey (2013 5-year estimates) for the 7 counties, there are an estimated 445,552 adults living in the LCHP PPS. With smoking rates at 23.3%, the target population is comprised of 103,814 adults in the service area who smoke, including the portion of 2,000 patients who smoke and are reachable through the Medicaid Health Homes program.

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.

LCHP will leverage a number of resources to promote cessation per project requirements. The Bassett Network currently provides the evidence-based The Butt Stops Here program at several sites. Medicaid beneficiaries are eligible to participate at reduced rates. LCHP will work with all partnering organizations to use this program to implement the US PHS guidelines to promote cessation. LCHP will leverage its relationships with ARC, Springbrook, and Pathfinder Village to promote cessation among the developmentally disabled, delivering anti-smoking messages in a culturally appropriate manner and integrating with other wellness-based activities. It will also explore the need for cessation programs for this population onsite or at a central location. LCHP will leverage its relationships with to encourage screenings by all PCPs to achieve PCMH standards and introduce patients to available smoking cessation resources (e.g., The Butt Stops Here, NYS Quitline, Legacy Foundation's BecomeAnEX.org). All PCPs, as part of achieving PCMH standards, will screen patients for tobacco use. To promote cessation, LCHP will form a subcommittee to review and compile a catalogue of cessation resources, which will be shared with all partner organizations including schools and colleges. The Legacy Foundation, for example, has developed a number of bilingual resources that will be leveraged here. LCHP will build upon the population health management and public health experience of the Bassett Research Institute by recruiting community health navigators. These staff will link to "hot spots" in the service area to promote non-smoking behavior and access to cessation resources. They will also assume a similar role with projects 3.a.iv and 4.a.iii.

A number of additional resources will be strengthened or developed. In collaboration with projects 3.a.i and 2.a.ii, LCHP will strengthen its ability to offer smoking cessation services to its behavioral health patients. LCHP will conduct public health and smoking awareness initiatives leveraging its relationships with CBOs including Friends of Recovery of Delaware and Otsego Counties, Inc. (providing The Butt Stops Here in Delaware and Otsego), LEAF, Schoharie County Council on Alcoholism and Substance Abuse, Inc, Reality Check, New York State Quitline, the Seton Center for Smoking Cessation, and the St. Joseph's Center for Smoking Cessation in collaboration with the services area's mental health facilities and the county substance abuse prevention offices.

Additionally, evidence indicates that addressing efforts with the inpatient population who smoke yields a high level of success. A formal smoking cessation program will be implemented by all hospitals in LCHP.

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. Medicaid does not cover all smoking cessation treatments and counseling in New York. Thus, LCHP will form a regional task force to work with MCOs to ensure coverage.

Lack of transportation will be a challenge for LCHP patients. To meet this challenge, LCHP will pilot a program using care coordinators in one county to prepare and maintain smoker registries, provide follow-up and coordinate transportation using strategies developed by the project team. Once evaluated, the program will be initiated in all other counties.

The higher prevalence of smoking among low SES populations indicates that they still consider smoking to be a "normal" part of life, posing a large barrier to cessation. LCHP will promote smoke-free lifestyles through education, advocacy and social marketing. LCHP will target teachers and other school workers who smoke with cessation messages so that they may be cessation role models for youth.

Interconnectivity of EHR will be a major challenge. The IT/Data Analytics Committee is comprised of a number of IT experts who will be responsible for implementing EHR interconnectivity across the numerous non-interoperable EMR systems in the LCHP PPS to ensure continuity of care for smoking cessation treatment and for all other LCHP care activities and interventions.

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.

LCHP overlaps with United Health Services Hospitals, Inc., PPS, CNY DSRIP PPS, and Westchester Medical Center PPS. Westchester Medical Center PPS shares this project with LCHP.
Current areas for strong collaboration across the region include sharing CNA data, developing regional educational initiatives through learning collaboratives, and formal regional support groups for specific project staff. Additional opportunities include developing data sharing agreements to make health information exchange capacity more robust across the State through RHIOs, as well as development of clinical integration agreements for patients receiving care at multiple facilities across the service area.
As implementation planning begins, LCHP leadership will coordinate and share best practices with overlapping PPS [and others throughout the state] by participating in quarterly learning collaboratives. The transformative nature of this work will require ongoing collaboration and sharing of resources between and among PPS'.

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.

MILESTONE 1: The PMO will coordinate this project with each project team to integrate efforts PPS-wide by the end of DY 0.
MILESTONE 2: Patient recruitment for the pilot will be complete by the end of DY 1.
MILESTONE 3: The pilot program, the coalition and the task force will be implemented in the second quarter of DY 1.
MILESTONE 4: EMR modification will integrate the 5 A's into the EMR systems beginning in DY 1 and will be complete by the end of DSRIP DY 3. Pilot program will be expanded to other counties in DY3.

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

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

Yes	No
☐	☒

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

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
N/A				

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.

N/A

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

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

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