Table of Contents

Using this document to submit your DSRIP Project Plan Applications

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

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

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

Domain 2 Projects

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

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

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

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

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

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

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

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

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

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

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

As our CNA noted, coordinated care in the Hudson Valley is a significant gap and one that we will address through this project (CNA Need #1). Within our PPS, based on Salient interactive miner, 10% of the ~38,000 inpatient visits and 14% of the ~81,000 emergency visits were preventable. This project will integrate providers and community organizations to ensure that members receive holistic care.

There are gaps (CNA Need #2) in infrastructure that prevent such connectivity. Only ~40% of our partners are connected to the local RHIO, ~20% are PCMH level 3 2014 (compared with the State average of 25%), and ~30% receive Meaningful Use incentives. These statistics highlight gaps in technology preventing communication and care plan development between organizations. Given these disparities, our goal through project 2.A.I is to develop a two-stage approach for improving connectivity in the region. In stage one, we will build on existing platforms and develop short-term solutions for integration; in stage two, we will develop long-term and sustainable technology interfaces.

In our stakeholder engagement sessions as a PPS, our partners noteddisconnects in service that impede appropriate care. For example, same-day urgent outpatient appointments exist for behavioral care providers in the Hudson Valley (specifically with Westchester County), but medical transportation must be booked five days in advance. Our PPS also conducted focus groups in the

region, in which members noted a desire for integrated care (CNA Need #1), with improved communication between providers, community organizations, and insurance companies to save time, money, and duplication of services. We seek to address these types of disconnects as we develop our integrated system; as with goals in other projects, such as project 2.A.III, we will coordinate care for members with the highest utilization needs, and with project 3.A.I, we will integrate primary care and behavioral health services to reduce redundancy.

Notable gaps in resources in the Hudson Valley include transportation services, temporary housing, peer resources, and primary care and behavioral health providers (CNA Need #6, 7). For example, 5 of 7 counties have primary care HPSAs and 6 counties have mental health HPSAs. The primary reason patients cite for traveling out for services is better care in another county. For primary care, staffing levels are much lower in medically underserved areas (which exist in every county except Putnam). To provide seamless care for members, we will develop capacity by expanding current hours/days of services for current providers. We will ramp up staffing according to our workforce plan. We will also leverage our medical village to bridge gaps in necessary resources, and employ telehealth options for accessing scarcer health resources (e.g., child psychiatrists).

A third component of this project is ensuring our partners are prepared for value-based payments, which will help move our PPS into a sustainable financial future. We estimate that only approximately ~20% of partners are in shared-savings arrangements. Given that value-based payments are the financial models going forward, we will help our partners prepare for this change. As lead applicant, Montefiore has extensive experience in risk-based arrangements and longstanding relationships with Medicaid payors. Montefiore currently manages 300,000 members under value-based payments and will work with partner organizations to grow their capabilities.

As a PPS we are uniquely positioned to address these gaps. Understanding that a member's health and well-being go beyond traditional healthcare and include transportation, vocational coaching, and family support, our PPS encompasses over 750 partners and uses both traditional and nontraditional providers who can improve care for our over 200,000 attributed lives.

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

To best implement our project model, we will focus on several key areas, including establishing connectivity and sustainable payment arrangements for partners, and improving provider/organization shortages.

Establishing connectivity:

We are partnered with two of the region's three Health Homes, Hudson Valley Care Coalition and Hudson River Healthcare (Community Health Care Collaborative), which account for over 20,000 individuals (in outreach or enrollment) and currently operate on a single IT platform. They have also

developed connectivity with 25 community-based organizations. These organizations will be starting platforms from which to expand IT connectivity in the Hudson Valley.

Community Health Care Collaborative has also integrated beyond the outpatient setting. They have partnered with St. Luke's Cornwall hospital within our PPS to facilitate care transitions from acute to post-acute settings through standardized protocols and connected platforms. They are using the interoperability between providers to best leverage each organization's capabilities. We will expand the existing platforms of these Health Homes to others (where possible) in the region. Realizing that our partners vary in their IT capabilities and connectivity, we have developed a two-stage model of IT expansion to allow all organization types to connect at a realistic rate. We have formed an IT implementation plan along six key components: reporting, EHR, HIE/DIRECT, claims-based analytics, care plan sharing, and consumer technology.

Improving shortages: We will integrate this project with 2.A.IV; the medical village will be developed in concert with local gaps and needs, and will repurpose excess hospital capacity into space for care management services and additional capacity for ambulatory care, diagnostic, and community-based initiatives (e.g., transportation, housing, peer support).

Outside the medical village, we will work with our partners to establish new care facilities, and expand current hours and days of service of regional providers where shortages exist. As there will be a shift from inpatient to outpatient workforce (given the goals of DSRIP in decreasing preventable ER and inpatient admissions), staff from acute care and SNF may be redeployed into outpatient settings. Where specialty healthcare resources are scarce and recruiting/redeployment/retraining is unrealistic, we will pursue telehealth options, which many of our partner organizations have already implemented. For example, we have heard from our partner organizations at stakeholder meetings that there is an acute shortage of child psychiatrists in the Hudson Valley, particularly in rural regions; to bridge this gap, we will expand usage initiatives such as Project TEACH, which, operated by CAP-PC, provides access to rapid child/adolescent psychiatric consultation for PCPs across our PPS partners.

Establishing value-based payments:

As lead applicant Montefiore has actively engaged with many Medicaid and other payors in the region and will leverage its 20+ years of experience in risk-based arrangements to help other partners' transition into the new payment structure. We will leverage this experience and that of some of our PPS partners to drive quality and cost-effective care, and negotiate such structures with the Medicaid Managed Care Plans serving the Hudson Valley region.

Our PPS is positioned to become an integrated delivery system that meets the needs of our community, with over 750 providers along the care continuum (the region's largest PPS), critical in providing end-to-end care for members. Within our 7 counties, we have access to over 1,300 community-based organizations, which have been compiled as an online directory/community resources workbook, to be integrated within our care delivery system.

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

IT connectivity will be an important component in ensuring integrated care plans and interactions among partners. Realizing partners within our PPS are at differing levels of IT capabilities and are on differing platforms will create a challenge in integration. However, we intend to tackle this challenge with a two-phase approach, as detailed above. Additionally we will leverage the experience of our partners innovating in this realm (e.g., Health Homes) to develop practical IT solutions for our partner organizations in the early stages of IT development.

Additionally, helping our partners with the transition from traditional payment models to value-based payments and increasingly risk-based arrangements will be challenging, as many are not culturally or financially prepared for this shift. However, we will leverage Montefiore's (as well as some of our partners') experience with value-based payments and established record in practice transformation. Additionally, we are developing a dedicated stakeholder track, with committee members focused on aligning providers to shifting payment models and focused on regular outreach and communication with providers.

Additionally, a challenge will be in engaging members in the new delivery system. As members noted in our resident survey as part of the CNA, 20-30% of respondents were not aware of how to get access to healthcare services. In order to engage these patients in our PPS and overcome this challenge, we have developed a stakeholder engagement and communication committee within our PPS that will actively outreach to community organizations and local health departments to educate patients about our PPSs projects. Additionally, we have a public facing website to help engage the community in our efforts.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across the Hudson Valley and New York State. Together with Refuah and WMC, the HVC has developed a Regional PPS Council to advance cross-PPS collaboration in targeted areas that ease implementation complexity for shared partners, align community wide messaging or implementation, leverage meaningful economies of scale where appropriate and ensure prudent resource utilization.

Montefiore is also partnering with Albany Medical Center to advance a common approach across regions that will result in seamless, coordinated effort regarding this project and others over the

combined regions. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

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

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

To meet the current gaps in access and care, we are pursuing the medical village project, which will allow us to repurpose current excess capacity to develop broader community-based healthcare services. We will design our medical villages using an iterative four-pronged process, a) Engage partner hospitals to cocreate a future-state vision for facilities providing an integrated care experience tailored to the need of the local communities. The PPS will facilitate discussions between hospital systems and encourage a regional planning approach to ensure we meet the needs of our communities and avoid redundancy, b) Conduct facility surveys to assess suitability of space for potential uses and estimate required capital, c) Engage local communities to seek input on the services to be provided in villages. This is a critical step to ensure that there is demand for these services, and may entail going beyond medical services, d) Ensure financial sustainability by providing services capable of generating alternative revenue streams while maximally leveraging additional sources of capital, including philanthropy.

- Our PPS is uniquely positioned to carry out this strategy given the breadth of our network, with over 20 hospital campuses that serve patients from all 7 counties. This breadth will allow our partners to work together to strategically adapt care delivery, taking into consideration both demand as well as quality of care, so as to achieve the maximal savings from the removal of unnecessary capacity. Similarly, creation of multiple villages at our partners will allow us to coordinate the services to be provided at these sites to best meet community needs

- Another key asset is the well trained workforce at these hospitals that can be leveraged to provide their expertise at medical villages

- We have strong engagement from local stakeholders including regulatory authorities, which will make getting local input easier and plans can be drawn up collaboratively to ensure the facility is useful

- We have the partnership of major ambulatory providers including FQHCs and also both health homes in the region to serve as regional experts

-We also have over 400 community-based organizations whose services could be made available to patients in medical villages in order to engage them directly at the point of care

- Finally, our regional PACs are a resource we will continue to draw upon for their deep knowledge of local context as we engage our communities and develop implementation plans

- Lastly, the PPS will be able to draw heavily our partners' strategic insight. Our approach is embodied by the bold vision and implementation plans that many of our partners are already proposing for our medical villages. For example, St. John's Riverside Hospital envisions a medical village that will increase the total number of treatment areas (including urgent care, resuscitation and behavioral health) and introducing a Rapid Assessment Zone that will enable more effective ED triage.

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

Building on the structure we established for the planning phase, the Montefiore Hudson Valley Collaborative (HVC) selected Model 1 (collaborative contracting) for implementation planning. We intend to investigate Model 2 in implementation, and may develop a new IPA for this purpose.

Under Model 1, Montefiore will be the fiduciary, and we put in place a multifaceted organizational structure, similar to the structure used to date.

First, we will evolve our Leadership Steering Committee to broaden representation. This committee sets overall direction, ensures HVC is on track to achieve goals, validates implementation plans, and makes recommendations on strategic decisions such as collaborations and the process for member removal.

Second, we will evolve our Transformation Teams, which were created to set PPS-wide standards across the region. For the implementation period, we will put in place four Transformation Teams:

1) Finance & Sustainability: Provides input into funds flow model, budget, and approach for value-based arrangements.

2) IT Infrastructure: Informs approach for data collection and reporting, EHR deployment, care management platforms, other IT enablers, and approach for driving adoption and connections with RHIO/SHIN-NY.

3) Care Management & Coordination: Aligns on common approach for care management and coordination, determines mechanism to balance central support vs. partner-based infrastructure, and identifies additional requirements for system & practice transformation.

4) System & Practice Transformation: Defines and implements change management strategy, assesses current capacity and future need of delivery systems, defines common clinical models, and identifies supports required for implementing evidence-based, coordinated and integrated care delivery.

Third, we will evolve our four Regional PACs, which will remain a forum for partner engagement and collaboration. In addition to acting as a vehicle for the PPS to facilitate individual partner implementation planning, the PACs will define an approach for local learning collaboratives during the implementation period, and will be asked to provide input on the PPS-wide support functions cross-PPS initiatives like public health campaigns. Lastly, the PACs will inform investments in regional resources for projects like 3.a.ii., Crisis Stabilization Services.

As stated above, we expect our governance model to continue to change to meet the changing needs of our PPS. As we move toward implementation, the HVC will leverage Montefiore's experience and legal standing as NYS's only Pioneer ACO to support value-based arrangements to support ongoing transformation and to ensure the long-term stability of the integrated healthcare system.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

We would seek capital budget funding to improve connectivity within the PPS. Initially, the goal will be to "onboard" as many providers as possible onto an electronic interface; over the course of the DSRIP 5 years, we will use capital funding to develop a common IT platform so that data sharing and reporting can be performed implemented easily. We will also seek to access funds for capitalizable expenses for EHR adoption. Lastly, we plan to make investments to ensure adequate access to services across our PPS. This could include development of new sites or renovation of existing sites for ambulatory care, urgent care and community based services and supports.

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
Maternal-Infant Services Network of Orange, Sullivan and Ulster Counties, Inc.	MICHC	Present		Maternal-Infant Collaborative identifies high risk Medicaid eligible and uninsurable women of childbearing age and connects them to health and behavioral health care and community support services related to social determinants of health; identifies and reduces community and organizational barriers to health care and healthy lifestyle choices to reduce preventable chronic diseases related to obesity and tobacco/substance se.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				Funding from Medicaid and NYSDOH.
St. Joseph's Hospital, Yonkers	Medicaid , grant from NYS DOH, and HRSA	1988	Jun-15	The YonkerSpectrum School Health Program (YSHP) is a school-based health clinic operative in 5 Yonkers elementary schools. The program is managed by Saint Joseph's Medical Center in collaboration with Yonkers Board of Educations. YSHP provides health services to children and families, including comprehensive physical assessments, care of acute and chronic illnesses, dental services, referral for mental health assessments and counseling, screening, care of minor injuries, health education
St. Joseph's Hospital, Yonkers	Emblem Shared Savings Program and Medicaid	31-Dec	Dec-15	The Shared-Savings Program initiative focuses on transition of care routines across all practices and provides outreach to patients utilizing the emergency room. Funded by Medicaid and Commercial payments.
St. John's Riverside Hospital	RYAN WHITE PARTS A,B,C	Current	N/A	HOPE Center receives Ryan White Parts A, B, & C to fund HIV-related primary care for under served and at risk populations.
St. John's Riverside Hospital	Health homes care management	Current	N/A	Care management funded by Medicaid provides services for individuals with two or

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				more chronic health conditions.
Dutchess County Department of Mental Hygiene	Health Homes	5-Jul	N/A	Integrate primary care with behavioral health and provide care management funded by Medicaid.
New Hope Manor, Inc.	OASAS Residential Redesign	2015	2016	OASAS Residential Redesign. Funded by Medicaid.
Visiting Nurse Service of New York	NYS DOH HWRI	1/1/2014	N/A	this grant provides funding to train nurses as Population Care Coordinators (PCCs), VNSNY's prospective role in DSRIP might to utilize those and other staff to act as PCCs, not train them.
Hebrew Home	HHAR	4/20/1964N/A	N/A	Supporting patient behavior. Funded by Medicaid and integrated in Svc delivery.
Rehabilitation Support Services	Health Home Care Management	Mar-13	N/A	We provide health home care management through Hudson Valley Cares Coalition and Community Cares Collaboration in Westchester, Dutchess, Sullivan and Orange counties. Funded by Medicaid.
Occupations, Inc.	Funded by Medicaid and Health Plan for IDD	2015	N/A	CBHS is a member of NYIN who is applying to be a DISCO.
Mental Health America Dutchess	Funded by Medicaid and Managed Care.	2015	2016	We are working with CBHCare as a member of CBHS to develop integrated care pilots leading to full range of integrated care.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				These services will integrate primary care and behavioral health services for the clients receiving care from HRHCare article 28 sites.
Mental Health America Dutchess B2H	funded by Medicaid	2015	2018	Childrens HH
Human Development Services of Westchester	Funded by Medicaid,MCOs.	2015	N/A	Health Home care managers will work within article 28 clinics (FQHCs) and article 31 clinics to facilitate care coordination with medical and behavioral health clinicians and to support follow-up activities with the patients to achieve better health.
Human Development Services of Westchester	Medicaid, OMH, HUD, Westchester County DSS and DCMH.	Current	N/A	Licensed housing is transitional in nature and provides rehabilitation services. Supported housing is permanent housing consisting or rent subsidies and care management supports.
Haverstraw Pediatrics	Medicaid	2011	N/A	Comprehensive care of patients within the patient centered medical home to reduce admissions for chronic conditions like asthma.
Haverstraw Pediatrics	NY State Health Innovation Plan	2011	N/A	Encourage providers to practice standard of care within clinical practice guidelines by providing financial awards for PCMH, pay for performance.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Crystal Run Village	OPWDD BIP Grant	12/1/2014	N/A	Proposal includes conversion of ICF's to Community Based Living Arragements and Technological improvements needed for Managed Care Environment.
Centerlight Healthcare	VAP Award	2015	2017	CenterLight skilled nursing facilities is participating in a grant coordinated through CCLC to help non for profit SNF's transition to a managed care environment.
The Greater Hudson Valley Family Health Center	CDC, HRSA	Current	8/31/2017	Staffing and Equip. for HIV/AIDS to engage/re-engage those affected with care.

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

With this project, the Montefiore Hudson Valley Collaborative (HVC) intends to significantly expand the scale, scope, and reach of the initiatives listed above; we will build upon the "pilots" (and subsequent experience) of our partner organizations to expand these projects broadly. We will also reach a broader target population than that of the initiatives undertaken by our partner organizations.

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

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

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

implementation of the IDS strategy and action plan, governance, completion of project requirements, scale of project implementation, and patient engagement progress in the project.

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

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

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

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

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

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

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

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

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

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

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

From our CNA, gaps in effective healthcare for PPS members include insufficient care management and integration resources (CNA Need #1) and availability of providers and community resources (CNA Need #6,7). This project will identify Medicaid beneficiaries who are at risk for Health Home, develop an integrated care management system, and coordinate community organizations to address both the health and social needs of this group.

In our experience, approximately 10% of the population falls into the high utilization category for healthcare; often these individuals are already integrated into care-management infrastructures (e.g., Health Home, FQHCs, PCMH, payors, etc.). Another 25% are at risk of entering this category if appropriate interventions are not undertaken.

In our PPS (Salient miner), the top ~10% of utilizers account for 55% of ED visits and the next ~25% of utilizers account for an additional 45% of ED visits. Similarly, the top ~5% of utilizers account for 55% of IP discharges and the next ~15% account for another 45% of IP discharges. These numbers highlight the gap of effective care coordination for these high utilizing patients. Thus, our goal is to provide these members with active outreach and care management to address their physical and behavioral needs and the social determinants of their health. In our focus groups, uninsured Medicaid beneficiaries and individuals indicated a gap in an integrated approach to care and requested to have a manager that "helps navigate the system and secure needed transportation." (CNA Need #1, 7). Through this project, we intend to develop a comprehensive care management system that holistically addresses members' needs.

As described in project 2.A.I, we will also work to bridge gaps in care within the Hudson Valley, including shortages of providers and community resources (e.g., HPSAs), in order to provide effective care management for our members. For example, 5 of 7 counties have primary care HPSAs and 6 counties have mental health HPSAs (CNA Need #6).

Shortages of community resources within the Hudson Valley include (CNA Need #7,9):

a) Transitional housing services: ~120 agencies provide these services, but according to our CNA, these agencies are unevenly distributed and often unavailable in rural counties.

b) Given that behavioral health issues are among the top 5 issues noted by residents in our resident survey, there is a notable gap in select peer resources (e.g., only 7 recovery coaches in the Hudson Valley).

c) Transportation: Our focus groups revealed a lack of transportation as a major barrier to proper healthcare, particularly in the rural counties and a lack of information about where to seek assistance in accessing transportation. Only 13 transportation agencies were identified across the Hudson Valley, indicating a distinct shortage.

Where shortages exist, our PPS will work to expand capabilities through project 2.A.I. These shortages are likely a high driver of utilization for at risk members. Connecting these patients to medical, behavioral, and community organization services will be addressed through our integrated care management model in 2.A.III, in which we will offer a single point of contact (an accountable care manager) for qualifying members. This manager will coordinate both medical care and community services for recipients.

In addition to a shortage of resources, gaps in technology prevent care managers from effectively accessing resources and health information across providers and organizations. For example, ~40% of our partners are connected to the local RHIO, ~20% are PCMH level 3 2014, and ~30% receive Meaningful Use incentives (CNA Need #2).

Our PPS—both the lead applicant, as well partners including Health Homes, FQHCs, primary care, and behavioral health providers—is in the unique position of having significant experience in care management and will leverage this experience to address these care gaps.

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

We plan to target those members who are at risk of becoming high utilizers of healthcare, and will use our members' claims data to identify those who would most benefit from care management. Based on Salient interactive miner data, the top utilizers in our PPS visited the ER (>= 3 times/year) most frequently for diseases of the heart (4%), complications related to pregnancy (4%) respiratory infections (4%), alcohol related disorders (4%), and asthma (3%). Further, the top utilizers of the ER tended to be female (62%), aged 20-39 (42.5%), and live in Orange county (19%) and Westchester county (40%). Based on Salient interactive miner, the top utilizers in our PPS had inpatient admissions (>=2 times/year) most frequently for substance related disorders (18%), alcohol related disorders (15%), mood disorders (7%), schizophrenia (6%), and diseases of the heart (6%). Further the top utilizers of IP admissions

tended to be male (55%), aged 20-39 (51%), and live in Westchester (43%) county and Orange county (11%).

This project will target those diagnoses most responsible for repeat ER visits and IP admissions in our PPS (behavioral health (substance abuse and mental health), cardiovascular disease, asthma, and infectious disease). A number of other projects outlined in this application coincide with the interventions above (behavioral health- 3.A.I, 3.A.II; cardiovascular – 3.B.I; asthma - 3.D.III), and we will leverage the infrastructure we will build in those projects to target these populations. Further, this project will improve active outreach for care management in hotspot geographies (Orange and Westchester counties).

As we involve these high utilizing patients in care management, we will expand the diagnoses and definition of "at risk" beyond those associated with traditional Health Homes; additionally, we will also expand the definition to include the social determinants of health (e.g., lack of housing, history of criminal behavior, domestic violence, or unstable housing).

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.

We will address the gaps described above in the following manner:

Build care management resources and integration: We will work with and build upon the region's existing care management infrastructures in our PPS (e.g., the two Health Homes--Community Health Care Collaborative and Hudson Valley Care Coalition, FQHCs, PCMHs, payer lead care managers, behavioral and primary care provider care managers).

Establish a care management pathway: Through this project we will identify new members who will benefit from care management services and adopt a centralized approach with specific steps for care management eligibility (e.g., risk stratification—building upon Montefiore's asset of population health expertise and software capabilities) and a "common best practices" approach for the remainder of the steps (building upon current care management experience of Montefiore and our partners above).

Ensure quality services and uniformity across the care management continuum: We will utilize Montefiore Care Management Organization's modules, 1199 Training Fund programs, other external vendors (e.g., the Learning Network), and some key partners for area-specific expertise (e.g., Asthma Coalition for asthma care, Lung Association for smoking cessation, OMH, and OASAS for behavioral health) to retrain the existing and the new workforce in best practices. Additionally the focus groups revealed language and cultural barriers, as well as general health literacy barriers that prevent members from receiving quality health care. As such, we will retrain our care management workforce to improve health literacy and cultural competency and will work with the training vendors at the Montefiore CMO and the 1199 Training Fund, which both have existing modules for this purpose. In addition, we will collaborate with community based organizations that are recognized for their ongoing commitment to

Cultural and Linguistic Competence in key clinical areas – such as the Mental Health Association in Orange County and the Asthma Coalition – to assess performance and evolve the strategy.

Several key steps will occur as part of this care management model.

Thorough needs assessment: A thorough needs assessment (including health and social factors) will be performed for members, and a personalized care plan will be developed and tailored to each member's needs. An accountable care manager assigned to that member, will use resources available centrally and locally (medical, behavioral health, social services, community based resources, and peer support) to best serve the member's needs.

Resource sharing: Sharing of care management plans, member needs and goals, and member visits/utilization is critical in ensuring success of a truly integrated delivery system. Our PPS will develop the IT infrastructure (described under project 2.A.I) to enable such sharing.

Availability of providers and community resources: Additionally, gaps in service described above will be addressed in the following means:

1) Recruiting required for PCP/NP/PA and specialists, given the known shortage across several counties (e.g, Ulster)

2) Recruiting from partners under financial distress, with staff needing placement

3) Recruiting from partners most susceptible to volume reductions (e.g., nursing homes, hospitals implementing the medical village project)

4)Where shortages exist in primary care and behavioral health, telehealth options will be developed, particularly in the more rural counties (e.g., expand usage initiatives such as Project TEACH, which, operated by CAP-PC, provides access to rapid child/adolescent psychiatric consultation for PCPs)

Where shortages in community services such as transportation and housing exist, we will work with local partners (St. Christopher's Inn, TRIPS) to increase service areas, times, and staffing. As outlined in project 2.A.I and 2.A.IV, we will address shortages where possible through our medical village.

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

IT connectivity: An important component to ensure integrated care plans and interactions among partners is IT connectivity. With our partners at differing levels of IT capabilities and using differing platforms, we will pursue a realistic approach to IT development with a two-step implementation plan. First, we will focus on easily implementable integration strategies, such as increasing EHR and RHIO adoption. Second, we will focus on longer-term solutions, including building a more uniform and sustainable IT infrastructure with a common IT platform and common care-management tools. It is very helpful that there is one RHIO for the Hudson Valley area, Healthlink NY, with which we have built a

strong relationship. We also participate in the SHIN-NY Policy Committee and the NYeC Board of Trustees, where we can help shape the vision for interoperability statewide which will help us get a more complete lens on the care of patients who travel outside the Hudson Valley for care.

Member enrollment: Once we identify members who may benefit from care management, contacting members to enroll them in these services may be a challenge. From Montefiore's and our partners' experience in care management, often contact information is outdated and unavailable for members. To address this challenge, we will leverage our IT infrastructure to enable our partners to quickly share data and access member contact information, often available through inpatient discharge paperwork, community signup sheets, etc.

Scaling: Additionally, scaling the care management model from the smaller models in existence today (both at Montefiore and within the Hudson Valley) and gaining partner alignment will be a challenge. To ensure consistency and quality in services and to address the diverse population of the Hudson Valley, we plan to address this challenge with the workforce plan described above (retraining the workforce in best-in-class practices and cultural/health literacy competency) and redeploying them as needed throughout the region.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across the Hudson Valley and New York State. Together with Refuah and WMC, the HVC has developed a Regional PPS Council to advance cross-PPS collaboration in targeted areas that ease implementation complexity for shared partners, align community wide messaging or implementation, leverage meaningful economies of scale where appropriate and ensure prudent resource utilization.

Montefiore is also partnering with Albany Medical Center to advance a common approach across regions that will result in seamless, coordinated effort regarding this project and others over the combined regions. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

1. <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.

2. 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.

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

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

Yes	No
☒	☐

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

As part of this project, we hope to develop uniform and sustainable IT infrastructure, with the development of common IT platforms and care management tools; in order to implement this in a reasonable time frame and widely across the PPS, we would seek capital budget funding. Additionally, we intend to develop care management hubs as part of this project; which may require additional capital to develop the infrastructure (e.g. workspace/facilities).

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
St. John's Riverside Hospital	Health homes care management	Current	N/A	Care management funded by Medicaid provides services for individuals with two or more chronic health conditions.
Human Development Services of Westchester	Medicaid, OMH, HUD, DCMH - Westchester County, Acces-VR, OTDA-Westchester County	Current	N/A	Currently serving in OMH-funded care management, HUD Rental Assistance, OMH Supported Housing, Neighborhood Preservation Program, Clubhouse Program
Human Development Services of Westchester	Funded by Medicaid, OMH, Westchester County DCMH	Current	N/A	HDSW care managers provide the five Health Home services. By DSRIP year one, we anticipate that our care managers will provide services in each of the DSRIP projects.
Haverstraw Pediatrics	Medicaid	2011	N/A	Comprehensive care of patients within the patient centered medical home to reduce admissions for chronic conditions like asthma.
Health Quest	Medicare	Current	Dec-15	This is the comprehensive primary care initiative. It invovles about 50% of our primary care physicians. It provides additinal funding

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				for primary care to estalish medical homes and care management
St. Mary's Healthcare System for Children	Medicaid	8/1/2014	9/30/2015	Remote patient monitoring of medically complex pediatric home care patients via interactive voice response system to identify changes in condition, lapses in medication adherence, etc to prevent avoidable ED visits and admissions.
Centerlight Healthcare	NYS DOH	2015	2017	CenterLight skilled nursing facilities is participating in a grant coordinated through CCLC to help non for profit SNF's transition to a managed care environment.
The Greater Hudson Valley Family Health Center	NYS AIDS Institute	Current	6/30/2015	Provides for specific case management for AIDS patients and HIV Primary Care.
The Greater Hudson Valley Family Health Center	NYS DOH	N/A	N/A	Provide Care Management services to high need Medicaid Patients, Health Homes

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.

With this project, the Montefiore Hudson Valley Collaborative (HVC) intends to significantly expand the scale, scope, and reach of the initiatives listed above; we will build upon the “pilots” (and subsequent

experience) of our partner organizations to expand these projects broadly. We will also reach a broader target population than that of the initiatives undertaken by our partner organizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

example, identify how the project will develop new resources or programs to fulfill the needs of the community.

We aim to meet two gaps with our medical village project:

1) Excess capacity leading to inefficient healthcare resource usage: In recent years, average daily census for hospitals in the Hudson Valley was <70% of licensed bed capacity, and below a targeted 85% for staffed beds. Utilization trends and DSRIP will further affect occupancy. We estimate by 2019, >1000 licensed hospital beds will be unutilized. These trends are unsustainable and will threaten the viability of these important safety net hospitals, many of whom operate with thin or negative operating margins today. Our PPS includes five hospitals that have received IAAF funds. Repurposing this capacity is therefore imperative to preserve the safety net for these communities.

2) Unmet community needs: Our CNA defined current or projected unmet needs that suggest constructive uses for this excess capacity, most notably the need to provide more primary and ambulatory care services in locations and times that are more convenient and accessible to patients.

a) Access challenges due to fragmented care [CNA GAP 11]: In our focus groups, Hudson Valley residents noted challenges due to travel required between appointments and ancillary services not typically centrally located. Transportation is a particularly acute issue in parts of the region (e.g., rural areas of Rockland and Sullivan). In our resident survey, 25% of respondents reported using the ED either because the doctor's office was closed or harder to get to. Those who use a multi-specialty practice were more satisfied, lauding the integrated experience and noting time and money saved.

b) Existing and anticipated shortages of ambulatory care capacity [CNA GAP 3]:

Current shortages exist in multiple ambulatory care capabilities. Additionally, increased demand for these capabilities is anticipated as a result of DSRIP initiatives as more patients receive care management.

i) Primary care and Mental health care: 5/7 counties in our service area have primary care Health Professional Shortage Areas (HPSAs) and 6/7 have mental health HPSAs. Rockland and Sullivan are affected the most by these shortages. In Rockland and Sullivan, 43,421 members are affected by primary care shortages and 107,605 by mental health care shortages.

ii) Shortages of ancillary services[CNA GAP 6]: Our CNA revealed widely varying accessibility of needed resources, including laboratory and radiology services; e.g. 3-4 providers in Sullivan and up to 50 in Westchester, a difference that cannot be explained simply by demographics.

iii) Urgent care [CNA GAP 6]: Only 13 urgent care centers were identified across the region, which are unevenly distributed. Moreover, challenges were noted in these centers accepting Medicaid and access on nights and weekends.

iv) Care management: We anticipate a need for care management for up to 30,000 more members during the DSRIP period. This will require engaging ~250 additional FTE's in the care management process, and a need to house these personnel and associated infrastructure.

v) Community-based resource shortages: Capacity could also be used to address shortages in community-based resources (e.g. expansion of crisis bed capacity for Orange and Sullivan)

To meet these gaps, we will design our medical villages using an iterative four-pronged process, a) Engage partner hospitals to cocreate a future-state vision for facilities providing an integrated care experience tailored to the need of the local communities. The PPS will facilitate discussions between hospital systems and encourage a regional planning to meet community need and avoid redundancy, b) Conduct facility surveys to assess suitability of space for potential uses and estimate required capital, c) Engage local communities to seek input on the services to be provided in villages. d) Ensure financial sustainability by providing new services and generating alternative revenue streams while maximizing additional sources of capital, including philanthro

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 for this project will be members that will benefit from colocation of services. The main categories of members that benefit will be:

1) Members with more than one chronic medical condition (approximately 10,000 members) will benefit from all medical villages

2) Members with one chronic condition at risk of a second (Health Home at-risk) (approximately 27,000 members) will benefit from all medical villages

3) Members with co-occurring behavioral health and medical conditions (approximately 34,000 members) will benefit from medical villages with co-located primary care and behavioral health

4) Members living in areas of health resource shortages: Expanded primary care and mental health capacity for members in Rockland and Sullivan (approximately 20,000 members)

5) Members unable to access or inappropriately using emergency services for ancillary services

6) Members in need of supportive services such as transitional housing/crisis respite services (approximately 1800 members a year across 7 counties)

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

- Our PPS is uniquely positioned to carry out this strategy given the breadth of our network, with over 20 hospital campuses that serve patients from all 7 counties. This breadth will allow our partners to work together to strategically adapt care delivery, taking into consideration both demand as well as quality of care, so as to achieve the maximal savings from the removal of unnecessary

capacity. Similarly, creation of multiple villages at our partners will allow us to coordinate the services to be provided at these sites to best meet community needs

- Another key asset is the well trained workforce at these hospitals that can be leveraged to provide their expertise at medical villages

- We have strong engagement from local stakeholders including regulatory authorities, which will make getting local input easier and plans can be drawn up collaboratively to ensure the facility is useful

- We have the partnership of major ambulatory providers including FQHCs and also both health homes in the region to serve as regional experts

-We also have over 400 community-based organizations whose services could be made available to patients in medical villages in order to engage them directly at the point of care

- Finally, our regional PACs are a resource we will continue to draw upon for their deep knowledge of local context as we engage our communities and develop implementation plans

- Lastly, the PPS will be able to draw heavily our partners' strategic insight. Our approach is embodied by the bold vision and implementation plans that many of our partners are already proposing for our medical villages. For example, St. John's Riverside Hospital envisions a medical village that will increase the total number of treatment areas (including urgent care, resuscitation and behavioral health) and introducing a Rapid Assessment Zone that will enable more effective ED triage.

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.

- Financial: Given the financial duress faced by several of our partners, loss of potential revenue due to bed reduction may pose a challenge. The PPS will mitigate this risk by ensuring that medical villages generate alternate revenue streams, and will accelerate the path to value based arrangements to allow hospitals to benefit as volume declines.

- Some of the services that need to be provided in our medical villages may not generate sufficient revenue to be self-sustaining. We will mitigate against this by fully exploring all sources of funding including philanthropy to preserve these services for our communities.

- Reduction in staffed beds will inevitably cause some workforce displacement. We have invested in creating a thoughtful workforce strategy to minimize wage loss for these employees and to ensure that they are given the full breadth of training opportunities to continue pursuing their aspirations.

- Reduction in hospital capacity could face resistance within the community due to public misperceptions about the need for that capacity. To mitigate against this, strong community engagement from the outset is a core part of our strategy during the implementation planning phase.

- In creating one stop, convenient medical villages, we realize that there will be co-location regulatory issues of services (e.g. co-location of primary care and behavioral health) that currently preclude such efforts. We will apply for regulatory waivers through DSRIP to overcome this challenge.

- Another regulatory challenge we envision is delays in obtaining certificates of need, which will delay construction, timing, and development of medical villages. As such, we will apply for regulatory waivers under DSRIP to speed our time to implementation.

-Additionally, in these medical villages, multiple services will be provided in the same day to best benefit members; however, current payer methodologies often limits the number of services that are reimbursed in one day. We will work closely with the payers in the Hudson Valley building on the dialog that we have already initiated to ensure that multiple services and visits performed in one day will be covered.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be important to achieving DSRIP goals across the Hudson Valley and New York State. Together with Refuah and WMC, the HVC has developed a Regional PPS Council to advance cross-PPS collaboration in targeted areas that ease implementation complexity for shared partners, align community wide messaging or implementation, leverage meaningful economies of scale where appropriate and ensure prudent resource utilization.

Montefiore is also partnering with Albany Medical Center to advance a common approach to developing Medical Villages across regions. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

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

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

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

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

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

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

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

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

4. <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.

In this project, we will be repurposing unused/excess hospital capacity into needed alternative resources. In order to develop useful, sustainable medical villages that offer a broad complement of services, we would seek capital budget funding for demolition, rebuilding, and repurposing of available space.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
St. John's Riverside Hospital	HCB	2015	N/A	Funding is the proposed 1915i waiver funds for home and community based services.
St. John's Riverside Hospital	Medicaid Revenue (primary & specialty care)	Current	N/A	Medicaid revenue supports primary & specialty care, including substance abuse treatment services.
Human Development Services of Westchester	Medicaid, OMH, HUD, ACCES-VR, NY State Homes and Community Renewal, OTDA eviction prevention	2015	N/A	We will provide care management, crisis respite, supported housing, eviction prevention, supported employment and education services, recovery services, peer supports.

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.

With this project, the Montefiore Hudson Valley Collaborative (HVC) intends to significantly expand the scale, scope, and reach of the initiatives listed above; we will build upon the "pilots" (and subsequent experience) of our partner organizations to expand these projects broadly. We will also reach a broader target population than that of the initiatives undertaken by our partner organizations.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

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

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

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

In 2012, 5 (of 7) counties in the Hudson Valley region were within the top 25 counties in New York with the highest number of potentially preventable ER events. Within our PPS, from Salient interactive miner, 14% of the ~81,000 emergency visits were preventable in 1 year. Given these statistics, early intervention and improved access to alternative sites of care will greatly impact healthcare delivery and efficiency in the Hudson Valley.

In 2012, the top three ER diagnoses across the population of the Hudson Valley were hypertension (9%), asthma (8%), and depression (8%). These are also the top three diagnoses for ER utilization across the region's 7 counties. Behavioral health diagnoses in aggregate (mental health and substance abuse) accounted for 56% of ER visits. These numbers highlight the gap in adequate outpatient treatment and utilization for these conditions. Our PPS intends to pursue an integrated approach to decrease ER utilization. Through care triage, we plan to divert members to appropriate levels of alternative outpatient care sites and increase connectivity of members to outpatient providers. We also intend to improve outpatient treatment and management of these key diagnoses (through projects 3.A.I, 3.A.II, 3.B.I, and 3.D.III) to prevent the initial ER visit.

Diverting care to outpatient sites within the Hudson Valley, however, is contingent on appropriate and sufficient outpatient access and support services. The community health needs assessment has highlighted certain gaps in outpatient care (CNA Need #6). For example, only 13 urgent care centers were identified, and these are unevenly distributed throughout the region. Based on our consumer survey, about 25% of consumers went to the ER last year and 29% of consumers indicated that limited access to alternatives was the primary reason for their ER visit.

Transportation was also indicated as a barrier to care in our focus groups (CNA Need #7), particularly among the elderly and mothers. Given that the ambulance is seen as the relevant option for the community to access care, we will work closely with community-based organizations to provide transportation services between the ER and outpatient diversion sites, when needed.

Additionally, our partners have noted that many people in the region see the ER as a "one stop shop" for their care and that integrated service centers are a gap in the community (CNA Need #11). Given this limited access, many members go to the ER to have all services (e.g., laboratory, x ray, specialty care)

performed in one visit to one location. This perception and gap will be addressed, through better access to transportation, increasing urgent care and outpatient capacity and hours, and the development of "medical villages" capable of serving the array of clients' needs.

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

Across all members and all visits in our PPS, based on Salient interactive miner, the diagnoses with the highest total ER visits are: respiratory infections (7% of all visits), complications related to pregnancy (4%), and diseases of the heart (4%). Preventable diagnoses with the highest total ER visits are respiratory infections (35% of preventable diagnoses), urinary system diseases (15.0%), spondylosis (14.9%), headaches (10.7%), and ear conditions (9.6%).

These will be targeted diagnoses within our project to decrease absolute ER utilization. When these diagnoses arrive at the participating ER, the member will be "flagged" to our patient navigators and care practitioners in the participating ERs to actively determine whether care diversion can be pursued.

Based on Salient interactive miner, four hospitals in our PPS account for 38% of ER visits (St Josephs, St Lukes Cornwall, Nyack, and St Johns Riverside). We will work with these hospitals and regions in early implementation efforts to truly impact utilization within our PPS.

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

To implement this project, we will use a comprehensive model that incorporates the following components to meet members' needs:

1) Developing clinical patient navigators and connectivity to outpatient providers: Once a member is deemed not to need emergency-level care, patient navigators will work to coordinate that member's outpatient care. We will leverage the expertise of our partners who have implemented several "pilots" in the Hudson Valley, notably the one between St. Luke's Cornwall Hospital and the Greater Hudson Valley Family Health Center, which has resulted, based on preliminary data, in a 10% reduction in ER visits for health center members.. We will also use Montefiore's experience with its ER care triage patient navigator in place in hospitals in the Bronx, which has resulted in up to 60% diversion for patients that were seen by a clinical navigator. In the Montefiore-Bronx model, the navigator is clinically trained (RN, LPN, MSW) and works closely with the ER physicians to transition members to an outpatient setting. We will ensure navigators are capable in both medical and behavioral health pathways and are familiar with the communities they serve and the resources available. Additionally, navigators and staff will target the frequent diagnoses highlighted in our target population. Where

possible we will current staff into this role, given that there may be excess capacity due to the decrease in ER and in-patient utilization. Navigators will also be able to access social services directories which have been informed by the CBO resource analysis undertaken in the CHNA. This will allow navigators to address non-medical issues that may be driving up ER use, like lack of insurance or stable housing.

2) Organizing community-based organizations and peer support to work alongside clinical patient navigators: We will leverage (and expand upon) current resources in our PPS, such as PEOPLe, Inc's diversion peer specialists model, where peers aid in transitioning members to different levels of care.

3) Connections to care managers: Coordinating care with a member's established care manager (e.g., Health Home, FQHC, PCMH, payor, behavioral health or primary care provider) is important to prevent future preventable ER visits, and will be done by the clinical navigator. Additionally the navigator will be able to identify and refer members to our care management structure that will be built under project 2.A.III, who can also address medical and social needs.

4) Paramedics and 911 are crucial first responders in our community. We will work with PPS partners, such as Rockland Paramedics and TransCare Ambulance, to develop plans for diversion. We will develop EMT alert systems that integrate with EMRs of providers, so that EMT and the primary provider can discuss the direction of care. If the member does not have a provider, data sharing will be enabled between the EMT and the supervising ER physician, who can then triage cases and assist in diversion.

5) As a PPS we have a robust physician group of ~5,000 providers that understand the health conditions of our members. We will work with these providers in our PPS to expand urgent care appointment availability, particularly in the "hotspot" high ER utilization areas noted in our target population.

6) While our PPS has an expansive hospital and emergency room network, we need to change the perception of the ER as a "one stop shop": Peer navigators within the ER will educate members on other sources of care and will help them find transportation to those sites. We will work with transportation agencies in the region (e.g., TRIPS) to expand hours/routes/services areas. Education will also be done at a community level at town hall meetings, community service organizations (e.g. YMCA), and other external stakeholders. Where such care sites are lacking, we will develop medical villages under project 2.A.IV.

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.

We have heard from our partners that often it is the default of physicians to refer patients to the ER, particularly when covering members unfamiliar to the provider. Challenges include shifting the culture of physicians in sending patients to the ER, changing ER physician risk tolerance, and shifting members to outpatient settings. We will address this through our dedicated stakeholder engagement team we are developing for physicians, so that physicians understand not only the transition to value-based payments (connected to project 2.A.I) but also the financial incentives in meeting outcome metrics.

Second, we will work to improve connectivity and access to member care plans (as referenced in project 2.A.I) so that physicians can make appropriate decisions for members.

Regulatory restrictions on paramedics present a third challenge. We are applying for regulatory relief to facilitate the necessary diversion away from the ER for non-emergency patient needs. Where we implement such diversion models, we will recruit supervising ER physicians to aid in diversion and support services (both for the EMT as well as for the member's primary care provider).

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.

Montefiore is partnering with Albany Medical Center to advance a common approach across regions that will result in seamless, coordinated effort regarding this project and others over the combined regions. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

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

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

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

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

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

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

4. <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.

In order to successfully divert patients from the ER, we must develop sufficient outpatient capacity. Where sufficient providers exist in a region, we will work with our partners to increase capacity for outpatient appointments. However, where there are shortages in providers, we will seek to build outpatient and urgent care centers. For these capital requirements, we will seek funding.

Additionally, a known shortage in the Hudson Valley, which has been shown to increase ER utilization, is lack of transportation services. Given this gap, we may also seek capital budget funding to grow transportation fleet available for members.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Visiting Nurse Service of New York	NYS DOH HWRI	1/1/2014	N/A	this grant provides funding to train nurses as Population Care Coordinators (PCCs), VNSNY's prospective role in DSRIP might to utilize those and other staff to act as PCCs, not train them.
Hebrew Home	HHAR, Medicaid	4/20/1964	N/A	Supporting patient behavior.
The Greater Hudson Valley Health System	Vital Access Provider (VAP) Funding	2014	2016	VAP provides funding to safety net,/vital healthcare providers to improve access to needed healthcare services. Catskill Regional meets this criteria and

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				VAP funds have been awarded to help develop a primary care network in Catskill Regional's service area of Sullivan County. Funds have been primarily used to recruit and hire physicians and mid-level providers in this area.

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.

With this project, the Montefiore Hudson Valley Collaborative (HVC) intends to significantly expand the scale, scope, and reach of the initiatives listed above; we will build upon the "pilots" (and subsequent experience) of our partner organizations to expand these projects broadly. We will also reach a broader target population than that of the initiatives undertaken by our partner organizations.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

Domain 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.

As identified in our CNA, integrated and coordinated care in the Hudson Valley is a significant gap in behavioral health (CNA Need #1). In our resident survey, mental health and schizophrenia were rated among the top five health issues in the community, and more than 20% of consumers did not know where to go to obtain mental health services, substance abuse services, or alcohol abuse services in their county.

Behavioral health diagnoses are abundant in the IP setting. Last year in our PPS, 15% of IP diagnoses were for substance-abuse disorders, 10% were for alcohol-related disorders, 6% were for mood disorders, and 5% were for schizophrenia. This data is corroborated by SPARCS data that shows that behavioral health disorders are one of the top five medicaid IP conditions in the Hudson Valley. Given the prevalence and coordination of care needed to treat behavioral health, this data indicates that there is a significant opportunity for this gap in care in our PPS.

Those with behavioral health diagnoses have marked disparity in health outcomes when compared to the general population. The Journal of the American Board of Family Medicine notes that the number one cause of death for patients with SMI is cardiovascular disease, with cardiovascular death among those with SMI being 2 to 3 times that of the general population. One of the reasons for these poor outcomes is related to lack of primary care access. Staff at medical clinics may not have experience in working with members with SMI, and these members may not have the ability to advocate for themselves. Co-location and integration of care is a primary means of addressing this issue.

From our focus groups, we understand that community members desire co-location of services: "Bring PCPs into BH settings to establish relationships in safe places", "Develop strategies, including education and training, to break through the traditional siloes of mental health, substance use and primary care".

Moreover there is substantial evidence that patients with chronic diseases in primary care settings are more likely to have mood and anxiety disorders which is inadequately recognized and treated, which adds to the substantial burden to patients and to cost, with US estimates of cost savings of $250 billion if integrated models were widely employed (Milliman, 2014). These disparities (CNA Need #8) highlight the role of integration of primary care and behavioral health, including both mental health and substance abuse.

As identified in the community needs assessment, there are provider and community resource gaps (CNA Need #6, 9, 12) Focus groups conducted with staff and peers of partner organizations regarding the integration of behavioral health services with primary care services revealed the need for active involvement of peer organizations in this integrated model of care; within our PPS stakeholder meetings, we learned that peer involvement can significantly improve outcomes. As a PPS, we will leverage the over 1,300 community organizations in the Hudson Valley to address this gap.

In addition to resources, there are gaps in the infrastructure that prevent integrated and coordinated care (CNA Need #2). Only ~40% of our partners are connected to the local RHIO, ~20% are PCMH level 3 2014 (compared with the State average of 25%), and ~30% receive Meaningful Use incentives. Focus groups with staff and peers of partner organizations show that there is a gap in systems for sharing treatment plans and EHR across provider sites. These statistics highlight the gaps in technology preventing ideal communication and care plan development between primary care and behavioral health organizations. We propose to develop systems for sharing treatment plans and EHRs across provider sites including community-based crisis stabilization services.

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 addressing an integrated model of primary care and behavioral health care, we sought to identify the most common co-occurring diagnoses within our PPS. We analyzed the top co-diagnoses for behavioral health disorders in our PPS and found that 32% of unique members had both a behavioral health and non-behavioral health diagnosis; the most common medical diagnosis was

hypertension (32%) and tobacco use disorder (20%), pain in limb (19%), hyperlipidemia (19%), diabetes (17%) and chest pain (17%). These diagnoses will be key areas of focus for our integration models. Additionally, as a significant percent of co-morbid conditions fall into cardiovascular and tobacco use categories, we will also target the behavioral health populations in our projects involving these disease categories, including 3.B.I (cardiovascular) and 4.B.I (tobacco cessation).

This project will be implemented at both adult and pediatric sites, targeting both patient populations. We will aim to reach members with both behavioral health and medical needs and will tailor model implementation to the predominant needs of members. We will aim to complement the already ongoing relationships members have with their care providers.

From our CNA, behavioral health, mental health, and substance abuse hotspots were noted in Ulster, Rockland and southern Westchester counties. Alcohol abuse rates showed smaller, more discrete hotspots around Kingston, Monticello, and Poughkeepsie, and clusters in northern Rockland, Nyack, and southern Westchester. As such, these will be target regions for implementation of these models to reach the members most in need.

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.

To meet the varied needs of behavioral health clients with co-morbid conditions, we plan to implement all 3 models within our PPS, and plan to explore both real and innovative virtual integration models.

We will leverage the significant experience of Montefiore and our partners (e.g., CHBS, Hudson River Healthcare) in developing these models.

We will plan to apply the existing and newly developed care management infrastructure to support these clients, either through Health Homes or or through a care manager under project 2.A.III.

We will also maintain strong involvement of community based resources, since peer resources and social supports are key components of recovery. We will expand on current resources available within our PPS (e.g., recovery mentors from the Empowerment Center, supported housing programs from PEOPLe, Inc) to help supplement care for members. Finally, through project 2.A.I, we will improve integration of IT infrastructure to enable these programs.

1) Model 1: Traditionally, members with multiple BH/physical diagnoses do not receive adequate time or care for their behavioral health needs. We will work to have a behavioral health care provider on site (MD, PhD, or LCSW) to accept the “warm hand off” from the primary care provider, with ongoing consultation and collaboration. This model will be emphasized within the pediatric population

Besides Montefiore in the Bronx, there are several “in flight” programs within the Hudson Valley that we will also grow. For example, CBHS and Hudson River Healthcare have implemented such a model, whereby an article 31 provider is co-located within the FQHC. Three pilots are in place, one in Orange,

Rockland, and Westchester counties; two of which are adult focused and one of which is pediatric focused.

2) Model 2: We will deploy this model to meet the medical needs of members with complex behavioral health needs. Additionally, where co-location is not possible, we will pursue other innovative models, such as telemedicine for primary care providers into the behavioral health setting.

3) Model 3: This model will be deployed when physical co-location is not possible. We will include members with depression diagnoses (including adolescent and post-partum depression) but will also expand to include anxiety and heavy alcohol use diagnoses.

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 community health needs assessment highlights the overall gap in behavioral health providers within the Hudson Valley; even more specifically, discrete pockets of need are also identified. Given these shortages, there may be challenges in direct co-location of behavioral health and primary care providers. In such situations, alternative structures to the model are proposed, including virtual integration of primary care into behavioral health and behavioral health into primary care. We intend to also support tele-mental health services using web based video since the State has issued billing guidelines on the usage of such technology. Additionally, as a PPS, we will explore virtual consultations of primary care providers for behavioral health clinics, particularly in areas where physical co-location is not possible or there is shortage of primary care physicians preventing co-location. In such a model, primary care physicians can perform routine follow up/medication adjustment via a telemedicine approach.

Additionally, there will likely be infrastructure challenges to direct co-location to fully meet the full scope of services (i.e., building office capacity for a primary care exam room in a behavioral health setting). We will apply for capital budget funding in order to accommodate these capital requirements.

Regulatory relief will be an area for continued advocacy; we will advocate for swift regulatory relief in order to ensure the models can be implemented in a timely and integrated fashion, with colocation as well as integration of care plans.

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.

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across the Hudson Valley and New York State. Together with Refuah and WMC, the HVC has developed a Regional PPS Council to advance cross-PPS

collaboration in targeted areas that ease implementation complexity for shared partners, align community wide messaging or implementation, leverage meaningful economies of scale where appropriate and ensure prudent resource utilization.

Montefiore is also partnering with Albany Medical Center to advance a common approach across regions that will result in seamless, coordinated effort regarding this project and others over the combined regions. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Where possible, we seek to actively co-locate primary care and behavioral health providers. Realizing that this will require infrastructure changes (e.g., building primary care exam rooms in behavioral health

clinics), we will seek capital funding to enable increased number of sites for co-location.

Additionally, where co-location is not feasible or where there are provider shortages, we will pursue telemedicine options to facilitate consultations. This will also require infrastructure and building of IT capabilities, for which we will also seek capital funding.

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
Dutchess County Department of Mental Hygiene	Health Homes, Medicaid	5-Jul	N/A	Integrate primary care with behavioral health and provide care management
Hudson River Healthcare	The Patient Protection and Affordable Care Act, Section 10503.	8/1/2014	7/31/2015	Support and enhance the full integration of HRHCare's behavioral health and primary care services at 8 of its federally qualified health centers located in New York State's Hudson Valley and Long Island.
Mental Health America Dutchess	Medicaid and Managed Care	2015	2016	We are working with CBHCare as a member of CBHS to develop integrated care pilots leading to full range of integrated care. These services will integrate primary care and behavioral

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				health services for the clients receiving care from HRHCare article 28 sites.
Human Development Services of Westchester	Medicaid, OMH, Westchester County DCMH	Current	N/A	HDSW care managers provide the five Health Home services. By DSRIP year one, we anticipate that our care managers will provide services in each of the DSRIP projects.
Gateway Community Industries, Inc.	Medicaid	N/A	N/A	Psychosocial rehabilitation, community psychiatric support treatment, vocational services, residential support services, non medical transportation services, mobile crisis services.
The Greater Hudson Valley Family Health Center	HRSA	Current	8/31/2016	Build out space for additional care management and behavioral health.
The Greater Hudson Valley Family Health Center	NYS OASAS	Current	1/1/2016	Supports our Methadone Treatment Center.

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.

With this project, the Montefiore Hudson Valley Collaborative (HVC) intends to significantly expand the scale, scope, and reach of the initiatives listed above; we will build upon the "pilots" (and subsequent experience) of our partner organizations to expand these projects broadly. We will also reach a broader target population than that of the initiatives undertaken by our partner organizations.

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

attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

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

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

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

3.a.ii Behavioral Health Community Crisis Stabilization Services

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

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

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

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

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

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

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

Behavioral healthcare (BH) as related to inpatient/ER utilization within the Hudson Valley is an area for great potential impact. Based on Salient interactive miner, in our PPS last year, there were 4,181 unique recipients of IP admissions in behavioral health (13,923 total number of IP admissions). Similarly, there were 3,453 unique recipients of ED visits in behavioral health (6,904 total ED visits). Thus, the region has a significant opportunity to decrease inpatient/ER utilization and increase needed urgent care and outpatient crisis stabilization services.

As identified in the community needs assessment, patients with behavioral health diagnoses lack sufficient resources for treatment and support in the Hudson Valley (CNA Need #6,9). For example, 6 of 7 counties in the Hudson Valley have mental health HPSAs (Dutchess, Orange, Rockland, Sullivan, Ulster, and Westchester counties). Further, there are only 21 crisis intervention programs throughout the region (CNA Need #12). In our stakeholder PPS meetings, our partners indicated that many regions also do not have same day appointments for urgent behavioral health issues. These gaps in care likely drive IP/ER utilization for behavioral health. Our PPS intends to bridge these service gaps with improved triage capabilities for crises, growth of mobile crises units, development of alternatives to inpatient hospitalization, use of comprehensive community-based services, and development of additional outpatient capacity (as part of our medical village) in order to decrease ER utilization and inpatient admission for BH needs.

Focus groups conducted with staff and peers of partner organizations in behavioral health services revealed a need for increased peer involvement in care. As noted in our CNA (CNA Need #9), there are a shortage of certain peer organizations; for example, there are only 7 recovery coaches in the Hudson Valley. With this project, we intend on expanding the availability of peer organizations and improving current utilization of peer organizations across the continuum of care (from urgent care/mobile crisis to outpatient co located models in project 3.A.I).

In addition, focus groups revealed that there is a need to improve patient transitions in behavioral health (e.g., from inpatient to intensive outpatient treatment services, from intensive outpatient treatment to less intensive services, and from crisis intervention to follow-up care). We plan to address this gap by providing “warm hand-offs” to support transitions, by involving peers in transitions early in the process, by establishing follow-up procedures to verify transitions, and by creating an integrated IT infrastructure to allow care plan sharing (as part of 2.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.

Based on the Salient interactive miner, in our PPS, four hospitals were responsible for billing 36% of ED visits for behavioral health primary diagnoses: St Joseph's Hospital (13%), Orange Regional Medical Center (12%), White Plains Hospital Center (6%), and Mount Vernon Hopsital (5%). The most common diagnoses for ER admissions were: alcohol abuse (26%), opioid dependence (14%), mood disorders (12%), cannabis disorders (11%), cocaine disorders (10%), schizophrenia (9%), and bipolar disorder (3%).

We will actively work with the 4 hospitals above on the potentially preventable ER visits and inpatient admissions. As all 4 hospitals reside in Westchester and Orange county, we will work to develop expansive mobile crisis services (described below) in these 2 counties as "hotspots" for our PPS. As a large percentage of ER visits were for substance use (over 60%), we will focus efforts on expansion of outpatient substance abuse treatment and detoxification centers.

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.

24/7 crisis hotline: Members, community-based health and human service providers and organizations, peers, healthcare providers, hospitals, law enforcement, schools, and 911 services can call this hotline, staffed by behavioral health (BH) clinicians, who can determine care and provide links to outpatient centers. Several models exist in the Hudson Valley, including an "inflight" model, for Orange County partners, which has a 24/7 call center. Between 10 PM-8 AM, the clinician is available offsite. We seek to expand these models regionally, in scale (e.g., staffing in-house 24/7), and in access to appointments.

Mobile crisis team: This interdisciplinary team provides assessment, crisis intervention and de-escalation, supportive counseling, information, appointments for ongoing treatment, links to other services (e.g., housing, transportation), and essential follow-up care. Pilots of these units exist in the Hudson Valley; we will expand their capacity, resources, and geographic scope.

a) Orange: The team—the Department of Mental Health, CBHS/Occupations, Independent Living, Inc. and St. Luke's Cornwall Hospital—after 1 year of mobilization, has demonstrated success in preventing transfer of 67% of contacts from transferal to a 9.39 psychiatric facility.

b) Westchester: The team, trained in evidence-based Trauma Systems Therapy and targeted to children ages 0-8, worked with 30 families in 2014; no children were hospitalized.

Urgent care centers: We will incorporate mental health, substance abuse, care coordination, and other essential services (e.g., housing, public welfare, disability, domestic violence, children & family services) in these centers.

Increased access to Article 31 clinics and other outpatient BH providers: We will expand scheduling hours and flexibility for urgent care appointments and allow the hotline triage to schedule appointments on an acuity basis. Orange County Department of Mental Health uses this model; we will build upon its best practices.

Navigators from community organizations (supplements project 2.B.III): ER Navigators will help prevent inpatient admissions for patients whose needs would be better served by community providers and resources by creating linkages and facilitating referrals. Our partner, PEOPLe, Inc., provides emergency department peer advocacy services to a local hospital ER. The peers work with hospital staff and patients to advise on community resources and empower patients to take a role in treatment; we will replicate such relationships.

Crisis respite: Services will vary in intensity of care, ranging from peer to intensive crisis respite; we will expand capacity and increase respite beds. Within our PPS, we have Rose Houses, which are 100% peer-operated short-term (5-7 nights) crisis respites open 24/7.

External stakeholders: Police, jails, & ambulances are members' first point of contact and often opt for the ER. We will build community and stakeholder education programs on ER alternatives. We will leverage the 19+ years of experience of Orange County Department of Mental Health, CBHS/Occupations, Independent Living, Inc. and St. Luke's Cornwall Hospital in mobile crisis

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.

Given that we will be increasing volume in the community setting, we must ensure there are sufficient behavioral health treatment options available and are available for members within 24-48 hours. Given that there is a known shortage of behavioral health providers in the Hudson Valley, this will likely pose a challenge. However, we plan to address this challenge in 3 ways. First, involving peer organizations in behavioral health treatment, where appropriate, and reserving appointments for behavioral health care providers when deemed necessary. Second, we will build extra behavioral health capacity in our medical village project as needed. And third, we will utilize telemedicine services where possible, particularly in areas of acute behavioral health shortages and in rural areas.

Additionally, there will be regulatory issues for which we will be applying for regulatory relief. This will occur in instances of co-location of behavioral health and primary care providers (e.g., medical village, urgent care centers), when using telemedicine services, and when integrating medical and behavioral health records.

For co-location of behavioral health providers into the primary care urgent care setting, we will also work with Medicaid Managed Care Organizations to reimburse such services, as they are not currently reimbursed.

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.

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across the Hudson Valley and NYS. Together with Refuah and WMC, the HVC has developed a Regional PPS Council to advance cross-PPS collaboration in targeted areas that ease implementation complexity for shared partners, align community wide messaging or implementation, leverage meaningful economies of scale where appropriate and ensure prudent resource utilization. Montefiore is also partnering with Albany Medical Center to the north, and St.Barnabas, Bronx Lebanon and HHC to the south to advance a common approach across regions that will result in seamless, coordinated effort regarding this project and others over the combined regions. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

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

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

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

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

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

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

4. <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.

In this project, we will develop both triage capabilities as well as mobile crisis units to divert members from unnecessary ER visits and inpatient admissions. In order to develop triage infrastructure (e.g., triage call centers locations, phones, computers, IT systems) and to develop the mobile crisis units (e.g., mobile vans, equipment on the vans, etc.), we will apply for capital funding.

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
St. Joseph's Hospital, Yonkers	NYS OMH funded annually through Westchester County.	2012	Renewed annually	mobile crisis services in Westchester County. The multi-disciplinary team offers bi-lingual services in Spanish. Currently funded to operate from 8:00 a.m. to 9:00 p.m. on Monday to Friday.
Pinnacle Health Consultants	NYS OMH	2015	N/A	Received funding for a Mobile Crisis Intervention Team and have issued an RFP to contract out this service.
Rockland County Department of Mental Health	OMH	4/17/2013	N/A	RFP to be issued for Mobile crisis. Will be contracting out this service.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Human Development Services of Westchester	by Medicaid, OMH, HUD, Westchester County DSS and DCMH.	Current	N/A	Licensed housing is transitional in nature and provides rehabilitation services. Supported housing is permanent housing consisting or rent subsidies and care management supports.
Gateway Community Industries, Inc.	Medicaid	N/A	N/A	Psychosocial rehabilitation, community psychiatric support treatment, vocational services, residential support services, non medical transportation services, mobile crisis services.
Gateway Community Industries, Inc.	Medicaid	2017	N/A	Personalized recovery oriented services (PROS).

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

With this project, the Montefiore Hudson Valley Collaborative (HVC) intends to significantly expand the scale, scope, and reach of the initiatives listed above; we will build upon the "pilots" (and subsequent experience) of our partner organizations to expand these projects broadly. We will also reach a broader target population than that of the initiatives undertaken by our partner organizations.

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.

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

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

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

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

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

Improve Medication Adherence:

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

Actions to Optimize Patient Reminders and Supports:

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

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

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

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

Cardiovascular disease in the Hudson Valley is an area for health improvement. Based on Salient interactive miner, in our PPS, 29% of members have a cardiovascular diagnosis code on IP admission and 12% have a cardiovascular diagnosis code on an ED visit. Further, cardiovascular disease was reported by consumers in the resident survey to be the third ranked (out of 17) health issue in the community. In our CNA based on vital statistics data, cardiovascular disease was the primary cause of death and the second leading cause of premature death (CNA Need #3). These statistics highlight the potential impact for effectively treating cardiovascular conditions on an outpatient basis. Based on Salient interactive miner, a majority of cardiovascular patients in our PPS (72.7%) have had a PCP visit; however, this figure is lower than the PPS average across all therapeutic areas of 79.8%. Further, only 65.5% of IP and ER utilizers for cardiovascular diagnoses in our PPS have had a PCP visit. This disparity indicates that many members with cardiovascular conditions are not getting sufficient outpatient care. We will address this gap by implementing evidence-based guidelines for cardiovascular management including the Million Lives campaign and actively engaging patients in outpatient care.

Only ~20% of our partners are PCMH level 3 2014 (compared with the State average of 25%, New York State Innovation Plan report, Dec. 2013), and ~30% receive Meaningful Use incentives. As such, it is unlikely that our partners currently have electronic capabilities to track and recall patients with elevated blood-pressure and cholesterol readings. We plan to address this gap (CNA Need #2) using the IT strategy outlined in project 2.A.I. We will improve technical capabilities of providers in using evidence based practices to treat cardiovascular diagnoses and to better track and follow patients and their care.

Additionally, those with behavioral health diagnoses have marked disparity in health outcomes when compared to the general population. As published by the CDC Report: Mental Illness Surveillance Among Adults in the United States, mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease; additionally, mental illness is associated with lower use of medical care, reduced adherence to treatment therapies for chronic diseases, and higher risks of adverse health outcomes. Within our PPS, the most common medical diagnosis co-occurring with a behavioral health diagnosis was hypertension (32%), with fourth being hyperlipidemia (19%), and sixth being chest pain (17%). Given the common co-occurrence and disparity in outcomes for behavioral health patients, we will work to integrate our efforts in this project with that of 3.A.I, integration of primary care and behavioral health. Additionally, we will work with care managers and coordinated care teams to ensure that care for patients with complex needs are integrated and easily communicated between providers (CNA Need #1)

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.

Based on Salient interactive miner, in our PPS, the highest number of beneficiaries with a primary cardiovascular diagnosis on IP or ER visit reside in Westchester county (49%), Orange county (14%) and Rockland county. In particular, St. Joseph's (Westchester county) and St.Luke's Cornwall (Orange county) have the most overall cardiovascular primary diagnosis IP and ER visits. Additionally, of these members, a cluster of patients (24%) fall within the age range of 50-59. Although we will implement this project broadly across our primary care providers, we will focus additional resources within Westchester, Orange, and Rockland counties, as these regions are focal "hotspots", both in terms of member residence and in terms of hospital utilization for cardiovascular diagnoses. Additionally, given a focal age cluster at 50-59, we will also focus efforts on patients in this age group.

Further, there is significant overlap in members with cardiovascular and behavioral health diagnoses (29% of IP admissions and 12% of ER visits for behavioral health also have a cardiovascular diagnosis in our PPS). We will address this target population of co-occurring behavioral health and cardiovascular patients in this project, along with projects 3.A.I and 3.A.II.

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.

We will implement the following components:

1) Expanding use of EHR: For providers, we will improve EHR capabilities to include decision support, prompts for asking the 5As of tobacco cessation (integrated with our project 4.B.I), and resources for evidence-based guidelines. We will develop (also with project 4.B.I) an electronic fax capability for patient consent forms to the State quit lines. We will use electronic medical systems to track patients who need follow up appointments for cardiovascular conditions. For those partners not using EHR, we will work to build technical capabilities to meet Meaningful Use and PCMH Level 3 standards by end of year 3. We will work with external partners (e.g.,the University of Albany Quality and Technical Assistance Center/Center for Excellence in Aging and Community Wellness) to develop sustainable evidence-based practice models.

2) Training: We will teach providers to implement the Million Hearts Campaign guidelines, including increased use of the ABCs for cardiovascular disease prevention. We will leverage the 1199 Training Employment Fund to train partners and staff to measure blood pressures and to counsel and educate patients.

3) Coordinating care: As members have complex needs, we will integrate this project with 2.A.I and 2.A.III to ensure coordinated care. Through project 2.A.I, we will ensure connectivity of our vast partner network so that efforts are communicated (to Health Homes, care managers, etc.) and integrated into the patient's overall care plan.

4) Appointing site champions: At each site, one individual will help pull in providers and community resources, as needed, to address each patient's care. As part of project 2.A.I, we will develop an integrated delivery system and develop connectivity between providers. The cardiovascular site champion will be able to leverage the resources from our vast network in order to best serve the patient. We will work to ensure adequate access to consultations with pharmacists (part of our project 2.A.I) to simplify medication regimens for members.

5) Integrating community-based resources: We will ensure that providers connect members to community education and peer resources, including our PPS partner the American Heart Association of Rockland county.

6) Home monitoring of blood pressure: We will encourage patients to record blood pressure readings at home and call their providers when readings are abnormal. For members unable to come to the provider's office, we intend to use ambulance services during off hours or home health aides. We will also work with external partners, such as IPRO, to develop innovative blood pressure monitoring techniques and means for transmittal.

7) Incorporating behavioral health (BH): As reaching patients with BH needs is a focus of our PPS, we will emphasize to all primary care providers the need to assess cardiovascular risk in all patients with BH diagnoses. Through project 3.A.I, we will ask our BH sites to assess these risk

factors and refer to primary care as needed. This core training will be built into that with our partners from the 1199 Training Education Fund, for BH providers.

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 Managed care plans offer varying coverage policies for home health services, community resources, and simplified medication regimens. We intend to work with the other PPSs in the Regionwide Quality Council to advocate for expansion in coverage for home health and community services and coverage of medications used to improve patient adherence in Medicaid managed care plans. The Council, including input from providers, payors, government agencies, and others, will review DSRIP project plans and make recommendations to align overlapping project approaches.

We will also seek regulatory relief to allow home health aides and paramedics to monitor blood pressure and do home health visits, and work to ensure that these services are billable under Medicaid.

IT connectivity and ensuring MU and PCMH level 3 standards will be an important component in ensuring that integrated care plans and IT capabilities are used to improve patient tracking and provider use of evidence-based guidelines. Realizing partners within our PPS are at differing levels of IT capabilities, we will work closely with them to develop needed capabilities; we will also seek capital budgeting funding to help providers reach these capabilities.

As the highest ER and IP utilizers have among the lowest PCP visits, it may be difficult to engage them in our new practices. We will work with key hospitals that see many members with cardiovascular diagnoses (St. Joseph's and St Luke's Cornwall) to ensure that discharged patients are connected with a PCP.

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.

Montefiore is partnering with Albany Medical Center to advance a common approach across regions that will result in seamless, coordinated effort regarding this project and others over the combined regions. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

In addition, Montefiore has partnered with St. Barnabas in the Bronx, and is working collaboratively with the other Bronx PPS to help align and coordinate strategies, where possible.

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.

To ensure successful and widespread implementation of this project, we intend to develop IT capabilities with our partners to facilitate tracking of members with high blood pressure and facilitate provider implementation of evidence based practices and clinical decision support tools. Also, where possible, we will implement telemedicine approaches for blood pressure monitoring and blood pressure reading submissions by patients. Developing these new tools and platforms will require capital funding.

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

Yes	No
☒	☒

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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.

Improving the treatment of asthma is an area poised for impact in the Hudson Valley. Based on Salient interactive miner, in our PPS, 11% of members have asthma as a diagnosis code on inpatient admissions and 9 % of members have asthma as a diagnosis code on an ED visit within one year. Further, 21% of all members with a primary asthma diagnosis in our PPS have an inpatient admission or ER visit, and all of these inpatient/ED primary asthma diagnoses visits are potentially preventable. As such, these statistics suggest that improved treatment of asthma represents a large opportunity to improve health outcomes and reduce inpatient and ED utilization in our PPS.

Based on Salient interactive miner, while 90% of all members in our PPS with an sasthma diagnosis had a PCP visit within the last year, only 81% of patients who utilized the ER or inpatient services within a hospital in the past year for a primary diagnosis of asthma had a PCP visit in the last year. Given these statistics and the findings from our CNA, this highlights the gap in appropriate outpatient care for members (CNA Need #13), which may be in the form of lack of sufficient primary care providers (CNA Need #6) or lack of engagement of members who are high utilizers into integrated outpatient care (CNA Need #1). For primary care, staffing levels are much lower in medically underserved areas in our PPS (which exist in every county except Putnam). In order to develop healthcare capacity, we will expand current hours/days of services for current providers. We will also ramp up staffing according to our workforce plan. Additionally, we will leverage our medical village to bridge gaps in necessary resources, as well as employ telehealth options for accessing scarcer health resources (e.g., pulmonologist consults), particularly in rural neighborhoods. These gaps will also be addressed within project 2.A.I.

To address the lack of engagement of high utilizing patients in the outpatient healthcare system, we will actively work with the hospitals in the regions driving utilization for asthma (see target population section); as such, when patients are seen in the ER, we will "flag" this diagnosis code as one that will trigger both the ER patient navigator (as part of 2.B.III) as well as the ER physician to both determine if the ER visit can be diverted, as well as connect these patients to a primary care provider and a care manager (as part of project 2.A.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.

We will first identify areas of high ER and IP utilization within our PPS and seek to target implementation to those relevant providers.

In order to "hotspot" areas within our PPS for asthma ER/IP utilization, we used the Salient interactive mining tool to identify the top hospitals by utilization for primary asthma diagnoses. Within our PPS, 51% of members with a primary diagnosis of asthma on an ER or IP admission within the past year received services in Westchester county. In Westchester county (within 1 year) 14% and 8% of unique ED visits for a primary asthma diagnosis were at St. Joseph's hospital and St. John's Riverside hospital, respectively. Similarly, in Orange county, 12% of ED visits were at St. Luke's Cornwall hospital. St Joseph's hospital and Westchester County Health Care Corp are responsible for 20% and 14% of unique IP admissions for a primary asthma diagnosis, respectively.

We also identified the age groups associated with these IP/ER visits in the past 1 year: 1/3 of asthma patients in our PPS were less than 20 years old and another 1/3 are 21-40 years old. This data highlights a younger distribution of patients, with 1/3 being pediatric. As such, we will work with pediatricians, primary care clinics, and providers to implement our project plan.

Given the "hotspots" in Westchester county and the age distribution, we will focus initial targeted interventions in Westchester county hospitals (and the relevant primary care providers/pediatricians) and then subsequently roll out the project to the rest of the counties in our PPS.

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

We will expand on the model of our partner, the Hudson Valley Asthma Coalition (HVAC), in improving asthma care in the region, specifically to reduce asthma morbidity and mortality, enhance the quality of life for individuals with asthma, and reduce ED visits and hospitalizations, particularly in areas of high prevalence. The model, already initiated at a few providers (e.g., St. Joseph's Medical Center and Greater Hudson Valley Family Health Center), with impressive outcomes: 89% reduction in unplanned visits for asthma over a 1-year period. We plan to broadly expand the model to other providers.

Expanding the plan comprises multiple steps:

1) Identify hotspots of high ER/IP asthma utilization

2) Assign an asthma site champion at each project site

3) Develop an interdisciplinary asthma improvement team

4) Communicate the program's primary goal of decreasing asthma IP/ER utilization

5) Establish an asthma patient registry

6) Integrate key elements of the asthma guidelines into the EHR

7) Train clinicians on how to implement asthma guidelines

8) Monitor and track asthma progress and outcomes according to the Hudson Valley asthma coalition

9) Disseminate the project to other providers in the community

10) Establish evidence-based protocols to refer patients to specialists/telemedicine 11) Link community based organizations (e.g., family training and support services, Hudson Valley asthma coalition)

11) Refer members to home health agencies for evaluation of home triggers

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

There are varying coverage policies among Medicaid Managed care plans for home health services and community resources; we intend to utilize both types of organizations to aid in family and patient education as well as perform environmental assessments for triggers. We intend to work with the other PPSs in the Regional wide Quality Council to advocate for expansion in coverage for home health and community services in Medicaid managed care plans. This will also occur under project 2.A.I, as we will also be transitioning to contracting as an integrated delivery system.

Additionally, an ongoing challenge will be ensuring appropriate medication supplies for members; we will address this challenge in multiple ways. First, home health aides and community organizations will reinforce teaching around the need for sufficient medication supplies and refills. Second, alerts will also be put in place in the EMR for providers; if members are within 2 weeks of requiring refill, asthma coordinators (or the patient's care manager, if applicable) at the provider's office can contact the family and arrange for medication refills/delivery. Third, we will also employ creative solutions where appropriate; for example, paramedics can be used as "paramedicine" providers in off hours for home delivery of urgent asthma medications.

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.

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across the Hudson Valley and New York State. Together with Refuah and WMC, the HVC has developed a Regional PPS Council to advance cross-PPS collaboration in targeted areas that ease implementation complexity for shared partners, align community wide messaging or implementation, leverage meaningful economies of scale where appropriate and ensure prudent resource utilization.

Montefiore is also partnering with Albany Medical Center to advance a common approach across regions that will result in seamless, coordinated effort regarding this project and others over the combined regions. As we are with the Regional Clinical Council, we will look to develop standardized reporting metrics to decrease administrative work for our partners. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

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

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the

application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

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

3. **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.

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across the Hudson Valley and New York State. Together with Refuah and WMC, the HVC has developed a Regional PPS Council to advance cross-PPS collaboration in targeted areas that ease implementation complexity for shared partners, align community wide messaging or implementation, leverage meaningful economies of scale where appropriate and ensure prudent resource utilization.

Montefiore is also partnering with Albany Medical Center to advance a common approach across regions that will result in seamless, coordinated effort regarding this project and others over the combined regions. As we are with the Regional Clinical Council, we will look to develop standardized reporting metrics to decrease administrative work for our partners. In addition to being beneficial to organizations and individual providers, this approach is efficient, cost effective and draws on the strengths of leaders who have a proven track record of success while allowing for local influences and control to help insure long term success.

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
St. Joseph's Hospital, Yonkers	Medicaid, NYS DOH, HRSA	1988	Jun-15	The YonkerSpectrum School Health Program (YSHP) is a school-based health clinic program operative in 5 Yonkers elementary schools. The program is managed by Saint Joseph's Medical Center in collaboration with the Yonkers Board of Educations. YSHP provides health services to children and families enrolled in the program including comprehensive physical assessments, care of acute and chronic illnesses, dental services, referral for mental health assessments and counseling, and screening
Human Development Services of Westchester	Medicaid, OMH, Health Home funding, Westchester County DCMH, HUD	N/A	N/A	We will more strongly establish evidence based protocols for asthma management and targeted implementation in regions with poor asthma control through collaboration with our FQHC partners (CBHCare) and the

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				DSRIP medical villages in our region.
Haverstraw Pediatrics	Medicaid	2011	N/A	Comprehensive care of patients within the patient centered medical home to reduce admissions for chronic conditions like asthma.
Haverstraw Pediatrics	Medicaid	2011	N/A	Encourage providers to practice standard of care within clinical practice guidelines by providing financial awards for PCMH, pay for performance.
St. Mary's Healthcare System for Children	Medicaid	8/1/2014	9/30/2015	Remote patient monitoring of medically complex pediatric home care patients via interactive voice response system to identify changes in condition, lapses in medication adherence, etc to prevent avoidable ED visits and admissions.

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.

With this project, the Montefiore Hudson Valley Collaborative (HVC) intends to significantly expand the scale, scope, and reach of the initiatives listed above; we will build upon the "pilots" (and subsequent experience) of our partner organizations to expand these projects broadly. We will also reach a broader target population than that of the initiatives undertaken by our partner organizations.

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

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

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

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

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

Domain 4 Projects

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

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

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

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

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

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

1. Adopt tobacco-free outdoor policies.
2. Implement the US Public Health Services Guidelines for Treating Tobacco Use.
3. Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).
4. Facilitate referrals to the NYS Smokers' Quitline.

5. Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.
6. Promote smoking cessation benefits among Medicaid providers.
7. Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.
8. Promote cessation counseling among all smokers, including people with disabilities.

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

Entity Name
American Cancer Society
American Lung Association

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.

Smoking is a prevalent issue in the Hudson Valley and smoking cessation is an area of addressable impact for the health of the community. Data from the 2010 New York State expanded behavioral risk factor surveillance system and the New York City community health survey demonstrated that the percentage of adults smoking cigarettes within the Hudson Valley ranged from 9.7% in Rockland up to 28.9% in Sullivan County; this high smoking rate in Sullivan county corresponds to a region of the highest poverty in the Hudson Valley (CNA Need #10, 14). Despite the high smoking rates, there is low utilization of smoking cessation tools in our region, with only 17% of smokers using the smoking cessation benefit (vs. State target of 40%). Specifically within our PPS (from Salient interactive miner data), while 77.9% of members with a tobacco use diagnosis code have a primary care visit, only 22.5% of those with a smoking diagnosis receive cessation intervetions. This represents a gap in care and an opportunity to use integrated and coordinated care to increase the use of cessation methods.

Consumers in our CNA focus groups indicated a desire to be empowered to lead healthier lives but don't feel they have the information or support resources to accomplish the goal. From our stakeholder engagement meetings with our partners, they indicated that most NRT is prescribed through primary care practices; however, stakeholders believe that the inability of the quit line to provide sufficient NRT

was a hindrance to getting patients to quit. Primary care providers may provide patients with prescriptions for NRT but many never get filled. Providers do not traditionally have samples or starter-packs on hand to distribute to patients, thereby foregoing an opportunity to get the patients engaged right away. We will address this gap by working to make sure that the quit line and other community resources can dispense sufficient NRT and ease use for patients.

Segments of the population with higher rates of tobacco dependence include those with mental illness; the most prevalent substance abuse disorder among individuals with mental illness is nicotine dependence. Cigarette smoking rates vary among those with mental illness diagnostic groups, with particularly high rates among individuals with schizophrenia, bipolar disorder, and co-occurring alcohol and illicit drug disorders. Those with mental illness or substance use disorder die on average 8 years younger than the general population, part of which can be attributed to tobacco related diseases. This will be an important population for our PPS to target with our smoking cessation efforts, given this disparity in outcomes.

Within the behavioral health population, the young adult population is also a focus of our efforts. Studies have shown that more than 80% of young adults with substance use disorders report current tobacco use (most report daily smoking) and many become highly dependent, long-term tobacco users. Smoking may additionally serve as a gateway to other drugs of abuse for youth with substance use disorders.

Additionally, there is a true need for behavioral health provider education and preparedness for counseling on smoking cessation, as well as a need to move from asking patients about nicotine use to transitioning providers into assisting patients in tobacco cessation. Studies show that 90% of psychiatrists and psychiatric nurse practitioners believe that helping patients stop smoking is part of the role of mental health professionals and 80% usually ask about smoking status. However, only 34% typically recommend nicotine replacement therapy, 29% prescribe cessation medications to smokers, and only 12% felt well prepared from prior education to treat tobacco.

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.*

With this project, we will target 4 populations.

We will aim to target patients with behavioral health (including mental health and substance abuse diagnoses) needs and tobacco use; as described above, this is a community with disparity in outcomes and would significantly benefit from smoking cessation efforts. Based on the Salient interactive miner, in our PPS, 70% of smoking diagnoses are on a claim with a behavioral health diagnosis, most notably with depression (26%), anxiety (17%), and alcohol or opioid dependence (14%). Thus we will target interventions with behavioral health patients with those diagnoses by integrating this project with that of 3.A.I to ensure members with behavioral health benefit from smoking cessation efforts.

We will focus efforts on members with low socioeconomic status, as there continue to be high smoking rates in this population. Sullivan county, with the highest rates of smoking and the highest rates of poverty within the Hudson Valley will be a "hotspot" for increased efforts with providers and community organizations.

We will target smoking cessation efforts at our providers who see the most members with smoking diagnoses. In our PPS, 54% of members with a smoking diagnosis reside in Westchester and Orange counties. The most claims for members in our PPS with smoking diagnoses with partner hospitals are within St. Luke's Cornwall (Orange county) and St. Joseph's (Westchester county) for ER care and St. John's Riverside (Westchester county) for inpatient and primary care. We will begin implementation of this program in these provider hotspots and as a subset will focus on low-SES and patients with disabilities. We will then broaden these programs to the rest of our PPS.

Fourth, we will target the young adult population (particularly those with co-occurring behavioral health conditions), as this population would long term greatly benefit from smoking cessation efforts, as detailed above. In our PPS, 23% of smoking diagnoses are for members below the age of 30.

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.

We will leverage the in-flight programs of our partners, including those from the Center for a Tobacco Free Hudson Valley, such as automatic referrals to the NY state smokers quit line by community health centers, facility-wide mental health provider tobacco-free campuses, and on-site quit-smoking medicines prescribed at mental health providers.

We will focus on treating tobacco dependence at behavioral health settings (young adult and adult), providers and community organizations working with low socioeconomic clients and providers and organizations working with clients with disabilities (e.g., Gateway Community Industries, Independent Living, Inc., and Occupations, Inc). We will focus on change efforts as follows:

Assessment: For all providers with EMR or moving toward implementation of EMR, there will be prompts for providers to perform the "5 A's". Additionally, to facilitate the provider's ease, we will work to develop an electronic fax capability using the "Click to Quit" technology.

Environment: We will ask all of our 750+ PPS partners to enforce tobacco free policies at their institutions.

Training: We will teach providers to use and implement the US Public Health Services Guidelines for Treating Tobacco Use. We will also leverage the programs in place with our partners at Center for a Tobacco Free Hudson Valley. We will perform provider and staff training in cessation best practices. We will train non-clinical staff (e.g., peers) to deliver tobacco cessation efforts. There will also be a focus on education for providers and development of patient education seminars at behavioral health facilities, FQHCs, and community services organizations. We will leverage the experience in these classes from

our partner Greater Hudson Valley Family Health Center and from within Montefiore to develop such models broadly.

Improved access to NRT: We will work with Medicaid Managed Care organizations to develop improved, simplified, and extended coverage benefits for NRT. We will also increase point of care access to NRT

Targeted use of media: We will employ targeted and proven media campaigns similar to NYC's campaign "suffering stroke," which received 54,000 calls to the quit line upon airing and "reverse lung cancer," which received 57,000 calls in 16 days. The NYC DOHMH has provided us access and consultation on the use of the media they developed. In addition, the local county health departments will also help shape the media campaign.

Partner with local agencies in promoting cessation: The American Legacy Foundation has partnered with community colleges to allow students to access cessation services and support tobacco free campuses (led by the American Cancer Society). We will partner with such organizations in order to reach the young adult population and provide access to cessation services for this population.

Staff smoking: We will encourage all our PPS partners (esp. those working at BH facilities, as these staff members often have the highest smoking rates) to teach staff to quit and highlight available cessation resources.

Follow up: We will integrate smoking cessation efforts in care coordination (overlapping with project 2.A.III). Additionally, we will work with our partners in hospitals (particularly those in the target population listed) to begin cessation efforts early when patients are admitted to hospitals for other reasons.

Metrics: We will work with Healthlink NY to develop standardized dashboards with clinically based metrics (e.g., rates of client tobacco use, provider recommendation to quit, and provider assistance in quitting—synchronized with meaningful use/NQF measures) for providers. These will be longitudinal, quality based measures with 6 month trend lines, benchmarked to peers. We will work with the NYS Quit Line to provide feedback on several metrics, including numbers of referrals to the quit line, distribution of NRT,and improvemement of baseline volume of referrals

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

There are a number of variations in tobacco cessation coverage policies in Medicaid Managed care plans (e.g., variations in length of treatment covered, initial out of pocket costs). Despite evidence that relapse rates are lower with 24 week coverage (and even longer coverage periods required in clients with behavioral health diagnoses), often only 12 weeks are covered. This variation in coverage is confusing for providers and patients, and discourages both provider encouragement of cessation therapies and client use of the therapies.

We intend to work with the other PPSs in the Regional wide Quality Council to advocate for uniformity in coverage and extension of coverage for cessation benefits for Medicaid managed care plans. We will also utilize peer and education community-based organizations in our network to help work with members to facilitate reimbursement paperwork.

Providing training for behavioral health providers to counsel and coach patients on tobacco cessation will also be a challenge, as many feel unprepared to do so. We will work with our partner, the 1199 Training Education Fund and with Montefiore's Care Management Organization training modules to develop training and curricula for these providers regarding tobacco cessation.

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

As described above, we intend to work with the other PPSs in a Regional Public Health Council to advance a unified agenda for this project. We will include input from providers, payers, government agencies, and others. Some areas for collaboration might include joint advocacy, joint campaigns to advance a public health agenda, and/or group purchasing for resources required to achieve objectives. The Council is committed to exploring other public health efforts to support projects in other Domains.

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.

Several milestones ensure success of our project:

1) Assessment: We estimate by end of Yr 1, prompts for providers to perform the "5 A's" will be in place for providers with EMR in place. By end of year 2, we will have electronic fax capability for patient consent forms to the New York State quit lines.

2) Training: This will be an ongoing effort, with training available and scaled by end of Year 1.

3) Media: By end of year 2, we will work closely with State partners to roll out select media campaigns in targeted markets within our PPS.

4) Metrics: We are working closely with the RHIO and our partners to develop metric assessment and evaluation tools. We will have an interim portal solution operational by end of Year 1, with the goal of increasing the role of the RHIO over time

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.

We intend to increase ease of referrals to the New York State Quitline by implementing electronic fax capability for patient consent forms, which will be electronic on both the provider and Quitline sides, using the "Click to Quit" technology. Additionally, we intend to improve connectivity and IT capabilities with our partner organizations to facilitate clinical decision support systems and evidence based practices. We will seek capital budget funding to support the development of these new tools.

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
Maternal-Infant Services Network of Orange, Sullivan and Ulster Counties, Inc.	Medicaid and NYSDOH	Current	Sep-18	Maternal-Infant Collaborative identifies high risk Medicaid eligible and uninsurable women of childbearing age and connects them to health and behavioral health care and community support services related to social determinants of health; identifies and reduces community and organizational barriers to health care and healthy lifestyle choices to reduce preventable chronic diseases related to obesity and tobacco/substance use.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
The Council on Alcoholism & Drug Abuse of Sullivan County	Medicaid	N/A	2016	Develop capabilities to increase provider use of cessation tools.
American Lung Association of the Northeast	Bureau of tobacco control	7/1/2014	3/31/2019	Support, guide CHCs and MH facilities in Tobacco Dependence Treatment Systems change.
Human Development Services of Westchester	Medicaid, OMH, Health Home funding, Westchester County DCMH , HUD	N/A	N/A	As stated, we are providing a series of smoking cessation supports to our clients that have enabled whole programs to radically reduce the incidence of smoking. Funded by Medicaid, OMH, Health Home funding, Westchester County DCMH , HUD. Through care management, health homes, housing, clubhouse, supported employment and education programming, we are currently working with our service recipients to provide smoking cessation supports, including quit-line referrals.
The Greater Hudson Valley Family Health Center	Orange county DOH	N/A	N/A	Provide Free tobacco cessation programs to Orange County residents.
Friendship ADC LLC	Medicaid	2014	2019	We are running a smoking cessation program for our enrolled members using a clinical psychologist.

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.

With this project, the Montefiore Hudson Valley Collaborative (HVC) intends to significantly expand the scale, scope, and reach of the initiatives listed above; we will build upon the "pilots" (and subsequent experience) of our partner organizations to expand these projects broadly. We will also reach a broader target population than that of the initiatives undertaken by our partner organizations.

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

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

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

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

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

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

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

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

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

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

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

Entity Name
American Cancer Society

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

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

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

Within the Hudson Valley, there is significant opportunity to increase preventive cancer care in clinical and community settings. Based on Vital Statistics data the leading cause of premature death and the second leading cause of overall death in the Hudson valley is cancer (CNA Need #4). On average, the ratios of Black non-Hispanics and Hispanics to White non-Hispanics percentage of premature death for the Mid-Hudson region are 1.99 and 2.29, respectively (CNA Need #5). A closer look at each county indicates a wider range of 1.92 – 3.01 for these groups compared to their White non-Hispanics counterparts. Given that cancer is the number one cause of premature death, this highlights the need to improve preventive cancer care within the Hudson Valley, most notably among minority populations. Our PPS intends to target cancer prevention (particularly among minority populations) for preventive care initiatives.

In our community health needs assessment, clusters of cancer hospitalization rates demonstrated hotspots in northern Ulster (including Kingston), a large cluster spanning much of Rockland (from Nyack to Stony Point), and a cluster in lower Westchester ranging from the Bronx border in the south up to Hartsdale. Cervical cancer clusters revealed a large hotspot occupying most of Ulster County, and smaller clusters around Yonkers/Mt. Vernon and in Bedford Hills. Breast cancer had a large cluster in Ulster and a large area of elevated risk which encompassed the majority of Westchester and Rockland Counties (excluding Yonkers and Mt. Vernon). Colon cancer revealed two clusters in Ulster (Pine Hill and Kingston) and a relatively large hotspot in southern Westchester and southern Rockland.

In accordance, screening rates for these cancers are lower in the Hudson Valley than State average. The percentage of patients with recommended cervical cancer screening in the Hudson Valley was as low as 52% in Dutchess county and 57% in Ulster county (with the state average at 67%). Additionally, recommended breast cancer screening was as low as 49% in Ulster county and 51% in Sullivan county (with state average at 63%). Colorectal cancer shows the most significant disparity, with Sullivan county noting only 36% of patients and Ulster county with only 37% of patients with recommended screening for colorectal cancer (with state average at 49%). Our resident survey indicates that across all counties, 25% of members do not know where to go for cancer screening even though0020it is their top health concern (of 17). Given these gaps, we will focus on patient education and engagement.

From our conducted focus groups, we learned that consumers want to be empowered to help themselves lead healthier lives; however, many do not feel that they have the information, support, or

resources needed to accomplish this goal. The consumers indicated that creating a system that emphasizes and supports ways to help consumers achieve healthier lifestyles coupled with offering of more preventative care options could be a step in the right direction. Thus, patient education, empowerment, and advocacy will be important components of our project plan.

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.*

Using the Salient interactive miner, we found that our PPS has a higher rate of cancer diagnoses (2.1%) of members than New York State (0.5%). The highest rates are in breast (22.8% of cancer diagnoses) and colorectal (10.0% of cancer diagnoses). Overall screening rates in our PPS are also low (15.5% of the total population has a preventive screen of any kind). Screening for at-risk populations in our PPS is also extremely low (32% of women aged 40-69 receive a breast cancer screen; 28% of women aged 20-59 receive a cervical cancer screen; 13% of the population aged 50-69 receive a colorectal cancer screen).

We plan to focus on improving rates of recommended screening for cervical, colorectal, and breast cancer, given the low rates in our PPS. These high rates of diagnosis and low rates of preventive screening demonstrate the need for our PPS to focus on these areas for our project. As highlighted above, minority populations have a higher rate of premature death (of which cancer was the leading cause of premature death); thus, we will focus on minority populations for increasing screening efforts.

Using Salient data for our PPS, we also identified Westchester and Rockland as having the highest number of cancer diagnoses. Further, there are zip codes with particularly low rates of screening in Westchester (10511, 10502, 10510, 10803) and Rockland (10965). We will begin implementation of our program in these “hotspot” regions and subsequently expand to the other counties in our PPS.

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

Central to our project plan is incorporating the New York State Prevention Agenda goals to improve preventive care, particularly among minority populations. Our design’s key components are:

Culturally competent healthcare: We will work with provider organizations to ensure cultural and linguistic healthcare training to reduce racial and ethnic health disparities. We will offer training to front-line staff and executives about healthcare-specific beliefs of different communities and religions and how they affect service design. Both our identified training vendors – Montefiore CMO and 1199 Training Fund –have existing modules for this purpose.

We will develop programs to recruit and retain staff members who reflect their community’s cultural diversity (we will leverage from the experience of Montefiore) and institute the widespread use of interpreter services or bilingual providers for clients with limited English proficiency. Also, as part of

project 2.A.III, in which we as a PPS are increasing scope of care management, we will train community volunteers to become community health workers and patient navigators.

We will measure disparities in outcomes for different cultural groups; monitor progress on reducing these disparities; and publish the results to encourage peer-pressure and best practice sharing

In addition, we will plan to collaborate with community based organizations that are recognized for their ongoing commitment to Cultural and Linguistic Competence in key clinical areas – such as the Mental Health Association in Orange county– to assess performance and evolve the strategy.

EMR prompts: Where providers use electronic medical records, we will implement EMR prompts to remind providers to recommend preventive care. Where possible, we will implement clinical decision supports and registry functionality.

Follow up: We will integrate this project with project 2.A.III, where we intend to expand the Hudson Valley's existing care management infrastructure. Care managers will also follow up with members to ensure that screening recommendations are made to clients and the recommended care is received.

Metrics: Standardized dashboards with clinically based, longitudinal quality measure (synchronized with meaningful use/NQF measures) for each provider (6 month trend lines) benchmarked to their peers will be provided. We will use data for quality improvement efforts and feed data back to providers. We will use this data to establish/enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services.

Community resources: We will ensure providers in our PPS are aware of community resources and providers, particularly those that offer preventive care services and education to the community. We have created a community based organization workbook (with over 1,3000 organizations in the Hudson Valley); in the implementation phase, we will have organizations describe the array of services offered so that providers may connect clients to areas of care. Through project 2.A.I, we will work to foster collaboration among our ~750 PPS partners to identify underserved groups and implement programs to improve access to preventive services.

Advocacy: Ensuring that preventive care services are covered under Medicaid will be of vital concern; we will work with the MCOs in the region to reduce or eliminate out of pocket costs for preventive services described.

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

There are varying coverage policies among Medicaid managed care plans for preventive services, particularly those provided by the community. As such, this often prevents community organizations from financially being sustainable in providing these services. We intend to work with the other PPSs in the Regional wide Quality Council to advocate for expansion in coverage for preventive care services in

Medicaid managed care plans. Additionally, as part of project 2.A.I, we will contract as an integrated delivery system and further advocate for coverage under that project.

There are varying IT capabilities among our partners within the PPS; as such we will be working to develop long term sustainable connectivity within the Hudson Valley. In order to facilitate electronic decision support systems and prompts, as well as to provide dashboard style feedback to providers on screening rates, we would need to further develop the IT infrastructure among our partners. We are working closely with the local RHIO, THINC, on these issues. Additionally, we will be applying for capital budget funding in order to improve the IT infrastructure.

Given that our goal is to increase screening rates, this will inevitably drive need for specialty providers (e.g., oncologists, breast, gynecologic, and colorectal surgeons) as detection rates will increase, for which we may not have sufficient capacity for the Medicaid population. In order to address this challenge, as a PPS and integrated delivery system, we will work with specialists in the area to increase acceptance of Medicaid.

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

As described above, we intend to work with the other PPSs in a Regional Public Health Council to advance a unified agenda for this project. We will include input from providers, payers, government agencies, and others. Some areas for collaboration might include joint advocacy, joint campaigns to advance a public health agenda, and/or group purchasing for resources required to achieve objectives. The Council is committed to exploring other public health efforts to support projects in other Domains.

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.

Several project milestones will ensure project success:

1) Training: We will begin immediately. An ongoing effort throughout the 5 years, we expect sessions to be fully operational by end of Year 2.

2) EMR prompts: Where providers have EMR systems, we expect operational prompts by end of Year 2. We will work throughout our 5 years to ensure the maximum number of partners are using EMR by end of Year 5.

3) Follow up: Will begin immediately, with full ramp up expected by end of Year 3. Follow up methods for providers who already use EMRs will be ramped up by end of Year 2.

4) Metrics: We estimate an interim solution for evaluating these metrics operational by end of Year 1, with the goal of shifting to the RHIO over time.

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

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

Yes	No
☒	☐

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

We intend to create provider dashboards for quality improvement and data collection at our partner organizations for this project, and potentially create clinical decision support systems to facilitate the implementation of evidence based guidelines. In order to widely develop these needed capabilities within our PPS, we will seek capital budget funding.

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
Maternal-Infant Services Network of Orange, Sullivan and Ulster Counties, Inc.	Medicaid and NYS DOH	Current	Sep-18	Maternal-Infant Collaborative identifies high risk Medicaid eligible and uninsurable women of childbearing age and connects them to health and behavioral health care and community support services related to social determinants of health; identifies and reduces community and organizational barriers to health care and healthy lifestyle choices to reduce preventable chronic

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				diseases related to obesity and tobacco/substance use.
Human Development Services of Westchester	Medicaid, OMH, Health Home funding, Westchester County DCMH, HUD	N/A	N/A	Through our wellness initiatives our service recipients are receiving cancer screenings with their medical providers to whom we refer them and with whom we maintain consistent contacts. We will utilize incentives to create performance dashboards so that our care managers can continue to focus on outcomes.
The Greater Hudson Valley Family Health Center	HRSA	N/A	N/A	Navigating the Health benefits exchange.

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.

With this project, the Montefiore Hudson Valley Collaborative (HVC) intends to significantly expand the scale, scope, and reach of the initiatives listed above; we will build upon the "pilots" (and subsequent experience) of our partner organizations to expand these projects broadly. We will also reach a broader target population than that of the initiatives undertaken by our partner organizations.

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.