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.

The NQP will endeavor to simplify the complex landscape of health care by creating an integrated delivery system (IDS) focused on evidence-based care for at-risk populations, specifically those with behavioral health challenges and chronic illnesses. The Community Needs Assessment reveals fragmentation and hospital overutilization in the Nassau/Queens community. Patients seek care at the emergency department (ED) for complaints readily handled in ambulatory care settings—a crisis of access. Patients are readmitted at high rates—a failure in care transitions. High risk patients struggle to navigate a complex system and often get redundant care—revealing gaps in information sharing and care coordination. A number of data points verify this: -50% of surveyed Medicaid recipients visited the ED in the last year. Reasons for potentially preventable ED use included: ED is the closest provider, doctor's office closed, and no other place to go. -Nearly 71% of Nassau and 75% of Queens Medicaid ED treat & release visits are avoidable. This is largely driven by ill-defined diagnoses (e.g., cough, headache) and respiratory illness (e.g., viral infections).

-Avoidable inpatient and ED utilization is associated with cardiovascular disease, diabetes, psychiatric disorders and substance abuse.
-Roughly 30% of PQIs (adult ambulatory sensitive admissions) are due to acute conditions such as UTI or dehydration.
-Psychiatric disorders and substance abuse combined are the number one driver of 30 day readmissions.
-Stakeholder forums identified communication as a major barrier. Patients, caregivers and providers state that information was incompletely transferred after discharge from the ED or hospital. Behavioral health providers noted that they rarely received discharge information at all. As a result medications were poorly reconciled, follow up often was not arranged, and outstanding test results were not followed up, all leaving patients at high risk for readmissions. Problems are most severe when transitioning a patient from one setting to another, such as from the hospital to a skilled nursing facility or home care.
-Interviews and stakeholder forums revealed that the uninsured have extreme difficulty accessing care. Community members' difficulty in accessing health care was cited in both community member surveys and stakeholder forums. Barriers included cost, a lack of information regarding care options, poor cultural competency in many care settings, mistrust about how to obtain health care and mistrust in health care providers especially among undocumented immigrants. As a result instead of establishing longitudinal relationships focused on prevention and treatment of chronic illnesses, many wait until a moment of medical crisis to access care in the ED, resulting in increased utilization of emergency departments.
The prevalence of chronic diseases including mental health and substance abuse, disjointed health care coordination and health access barriers lead to preventable ED utilization and hospitalizations. This state of health care in NQP calls for a fundamental redesign of care delivery through the creation of an IDS across hospitals and community based providers. NQP is committed to building and expanding the infrastructure necessary to coordinate care, in real time, among providers and bring evidenced-based protocols to bear for all patients with chronic physical and mental health conditions. Partners in NQP will provide community based care management assistance to providers to improve population health management.
NQP, as demonstrated throughout this application, has developed a comprehensive health care redesign plan focused on reducing avoidable hospital use. Care coordination and redesign efforts will improve the health of the community. The IDS will ensure collaboration among partners to care for Medicaid and uninsured patients in the most appropriate settings, with appropriate sharing of information among providers.

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.

-NQP has a network of providers and programs that can be expanded to achieve the goals of DSRIP, including:
-Robust network of providers spanning the care continuum including medical, behavioral, post-acute, long term care, home care, hospice and hospital community based providers, as well as payers, social service organizations and local government agencies. To better manage patients' health, a number of projects will require increased outpatient capacity and a repurposing of facility-based providers.

-All NQP health systems have evidence-based clinical support, information sharing among business units, ambulatory EHRs and care management software.

-LIJ has a comprehensive care management organization for high risk patients and those with chronic diseases. Services include transitional care programs, embedded care management programs, telephonic nurse triage line, remote care management, community paramedicine and advanced chronic illness management.

-LIJ has a HIPAA-compliant, web-based care management platform (Care Tool) that is used to complete comprehensive risk assessments and create subsequent care plans to address mental and physical health needs. This tool supports the LIJ Health Home and can be used by community based providers.

-LIJ uses Optum Pro and Optum Intelligence, United Healthcare-developed population health products, for risk stratification, identification of care gaps, and forecasting of preventable medical events. Reports generated through this tool can be used to engage providers and monitor NQP performance.

-NUMC and LIJ have at least 10 PCMH practices and experience in helping practices achieve NCQA recognition for programs such as diabetes care.

-Efforts will be made to enroll eligible patients in Medicaid health homes in the region including FEGS, Health and Human Services System, LIJ, Queens Coordinated Health Partners and NYC Health and Hospitals Corporation.

-Zucker Hillside Hospital has inpatient psychiatric beds and outpatient programs including a partial day program, geriatric psychiatry program and substance abuse programs. Cornerstone of Medical Arts Center offers inpatient services for the treatment of alcoholism and substance abuse. These facilities also have robust training programs for psychiatrists and clinical psychologists. The LIJ behavioral health service line has experience embedding psychologists in primary care practices.

-For patients with end-stage disease, the PPS has advanced care models bringing health care to the home through either hospice or home based primary care.

-LIJ and Winthrop have telemedicine programs within their home health agencies that provide nursing oversight and remotely monitor patients 7 days/week across all diagnoses. LIJ has telemedicine in its ambulances to avoid inappropriate admissions and uses telemedicine to bring psychiatry consultation to many of its EDs. Telemedicine will be an important tool in ensuring access for PCMHs to specialty consultations.

-Outreach and navigation activities in the community are provided through community health workers, peers and culturally competent community based organizations. Visiting Nurse Service of New York (VNSNY) provides a wellness partnership in the Rockaways. Health Leads operates in outpatient areas of NUMC/ NuHealth to link patients to social services in the community.

-Risk and value-based payment arrangements are an important asset. There are 6 Medicaid managed care plans in Nassau County and 13 in Queens. LIJ has a new insurance company, CareConnect. Beacon IPA participates in the Medicare Shared Savings Program, and LIJ will begin in the coming year, providing experience that will facilitate the NQP's ability to participate in additional shared savings and other payment models. LIJ and Winthrop are participating in Medicare's Bundled Payment for Care Improvement initiative.

NQP will build on all these various resources to create a single, organized, coordinated system of care.

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.

-Workforce–Demand for care managers in community settings exceeds the supply. NQP is committed to a strategy of redeploying and retraining staff from inpatient and skilled nursing facilities as demand for these facilities continues to decline. NQP will leverage LIJ's corporate university, 1199SEIU Training and Employment Funds and other vendors, particularly those who are Department of Labor-approved, to address training needs. Labor unions are involved in the development of this strategy.

-Creating connectivity across all partners in the PPS will be costly yet vital to building and maintaining an IDS. NQP will develop and/or purchase a cloud-based, HIPAA-compliant, data sharing tool. Patient engagement at the point of care, information sharing and event notification will be aggressively pursued. Providers need to be connected to the RHIO (e.g., Healthix) that will serve as a backbone provider for real-time information exchange.

-Achieving PCMH Level 3 by year 3 will require an assessment of providers' current state and development of a project plan for each practice. NQP has resources to support PCPs on achieving PCMH Level 3 status: NUMC/NuHealth's FQHCs and 2 clinics are all Level 3; LIJ has 3 PCMHs; the Joseph P. Addabbo Family Health Centers are also PCMHs; as are several primary care physician practices. NUMC and LIJ have experience in transforming practices into PCMHs.

-Aligning incentives through pay-for-performance (P4P) programs for potentially thousands of providers, many of whom have little experience with P4P, will be a challenge. Reaching the NQP milestone of improving access will be accelerated by having incentive based payments. The health systems in NQP have early experience in incentivizing around quality and access. These efforts will be expanded.

-Given the diversity of the service area, outreach to and engagement of patients in a culturally competent manner will be difficult. These patients often have mistrust of the health system and have chronic medical and behavioral health illnesses which make regular engagement less likely. Competencies such as motivational interviewing and strategies such as cultural competence training have been shown to increase engagement and will be pursued. These are key to impacting population health and will be a major emphasis of the PPS training strategy.

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.

In Nassau, NQP does not overlap with any other PPS, although patients are free to receive care across the PPS's geographic boundaries and many do. To the east is Suffolk PPS which has no overlap with NQP. Overlap will exist in Queens, particularly in eastern Queens. Advocate Community Partners (ACP) PPS has included eastern Queens in its service area; however, it has not included the Rockaway Peninsula in its 10 projects. The New York Hospital of Queens (NYHQ), Health & Hospitals Corporation (HHC), Mt. Sinai and Maimonides are pursuing becoming a PPS expected to serve Queens and possibly other counties. Due to their geographic location and proximity, particularly eastern Queens, it is possible that there may be overlap if the same projects are chosen. It is expected that most if not all PPSs will choose project 2.a.i

LIJ is a member of the NSLIJ which is a member of ACP and in the first year has 25% of the votes on ACP Board of Directors and in the remaining years of the DSRIP program will have 50% of the votes on the Board of Directors. Leveraging the LIJ role in the Nassau Queens PPS, LIJ will be able to rapidly communicate and share information and best practices or problems being encountered with the other PPS as those surface.

For the Integrated Delivery System project (2.a.i), NQP has experienced hub members who have developed integrated delivery systems with physicians and a care continuum of facilities. In addition, these hub members are experienced in value based payment programs. This project will be focusing on coordinating NQP partners into an integrated delivery system. This will be accomplished in part through linking all partners to the RHIO thereby sharing patient information appropriately for the benefit of the patient. Similarly, ACP and other PPSs will be utilizing the RHIO for data sharing. This common health information technology platform will enable the PPSs to send alerts about patient contacts and improve communication about their patients' clinical needs. The RHIO will become a vehicle for the PPSs to effectively and efficiently share information and understand the patients' clinical history and care plans.

It is quite possible that PPSs will share partner organizations, such as behavioral health care organizations that have multiple sites across Queens. If the same projects are chosen by more than one PPS, like 2.a.i, in the same service area, the shared partner may become overwhelmed and confused about the activities of the multiple PPSs in the sheer number of projects as well as the variations in implementation of the projects. It will be necessary to coordinate with the other PPS how to best achieve the goals of DSRIP and decide which PPS the partner is best suited to achieve those goals. The criteria for choosing which PPS could be based on partner attribution, shared clinical or operational infrastructure, current affiliations, geographic locations, and of course, what is the least disruptive and most complimentary to partners and the patients interests.

Other ways to collaborate with overlapping PPSs is to meet quarterly or more frequently, as agreed, to discuss the shared difficulties in implementation and how to better garner the shared resources to meet the community's needs and the objectives of the DSRIP program shared projects.

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

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

The vision for this PPS is to improve the health and well-being of community members by leveraging and enhancing their relationships with health care providers, social services organizations, housing agencies, religious organizations, and others in the community. The vision is to be achieved by connecting individuals to the most appropriate settings for services, reliably providing evidence-based care, avoiding unnecessary and costly care, sharing necessary information among providers in real time, and addressing patients' cultural and linguistic needs. NQP expects to accomplish this vision and be able to manage (and be paid for) the population on a per member basis by the end of the DSRIP period and to sustain the changes by moving towards value-based payment models by the end of the DSRIP demonstration. Achieving the goal of reducing unnecessary hospital utilization (both admissions, readmissions and emergency department visits) is a primary target of these activities – it relies on working with patients to utilize bring resources appropriately in community settings instead of in the hospital.

Achieving this vision will require multiple and simultaneous steps during the DSRIP period:

-Working to enhance the primary care infrastructure and workforce. Very few organizations in Nassau County are PCMH Level 3 – although NUMC/NuHealth's FQHCs, the Delmont practices, and some of LIJ's clinics are PCMH level 3, many more will be created. Completing PCMH assessments on all 1,773 of the primary care practitioners in the region and assisting those who need assistance to get to PCMH Level 3 will be the highest priority for the PPS as moving care to high quality outpatient settings can reduce unnecessary ED utilization. A core element of all PCMH's is use of care managers to help physicians manage high risk patients. As a result, NQP will invest in retraining existing facility-based staff to meet outpatient care management capacity constraints. One DSRIP project (2.b.ii) will co-locate primary care services next to the ED. These clinics are required to be PCMHs and will need care managers to work with high risk patients, providing an effective alternative to ED care. Other projects (3.b.i, 3.c.i, 4.b.i) will look to bring evidence-based practices into primary care locations and to manage high risk patients through embedded care management, requiring PCMH capabilities and care management workforce.

-Getting all providers engaged in data sharing through the RHIO will be a necessary step for appropriate real-time sharing of patient data. In addition, setting up registries within the EHR for chronic diseases will be foundational for managing diabetes and cardiovascular disease, the aims of two projects in NQP's DSRIP plan.

-Reaching out to specialists in the PPS and working out protocols for appropriate use of specialty care – being sent for a consult only when appropriate, being referred back to the PCP with results, etc. – is key to managing a scarce resource for Medicaid and uninsured populations.

-Setting up an effective care management system, which brings professional care management personnel (i.e. nurses, social workers, psychologists, community health workers), to outpatient and community settings to manage patients with high risk chronic diseases will be essential. Multiple projects (2.b.ii, 2.b.iv, 3.a.1, 3.b.i, 3.c.i) will target high risk patients in need of highly reliable evidence-based care in the least intensive settings so as to prevent acute exacerbations and slow the development of long-term complications. These high need patients tend to consume the most health care resources (inpatient and/or ED) and require intensive care management efforts. This population will reap benefits through fewer hospitalizations and improved quality

utilization and lower costs. Promoting tobacco cessation will help the patient and employee populations in our PPS network to live smoke free lives (Project 4.b.i), but it will also support the strategies for cardiovascular disease, asthma (not a NQP project) and diabetes and serve to improve the overall health of the population.

-Addressing the need for behavioral health services in the community is critical to improving the health of the community and will also result in the reduction of physical health problems. NQP will co-locate behavioral and primary care services by locating behavioral health in primary care settings and locating physical health in behavioral health settings (Project 3.a.i). In addition, the program will create crisis stabilization services, many of them mobile and leveraging telemedicine, in the community to keep patients from the Emergency Department (Project 3.a.ii). Mental health and substance abuse infrastructure will be strengthened through expansion of existing programs and investment in new programs based on community need (Project 4.a.ii).

-Addressing readmissions, and admissions from SNFs through wide adoption of the INTERACT program will help achieve the goal of reducing avoidable hospital transfers and treating patients in the most appropriate locus of care (Projects 2.b.iv and 2.b.vii). In addition to these two projects, the goal will be met by a combination of these other approaches.

-Partnering with community based organizations, such as FEGS and Health Leads, for outreach, patient engagement and meeting non-health needs of patients is key to making the DSRIP plan work. Culturally competent care and assurance of health literacy is important to the proper care of patients and ensuring adherence to treatment protocols. There are hundreds of community based organizations in NQP, who will be relied upon to help develop and execute the strategies in this area. The patient activation project (Project 2.d.i) will rely on the expertise available through community based organizations to find hard-to-reach patients and enroll them in care programs.

-Building on a variety of local care redesign experiences– LIJ has broad risk based contracting experience with MCOs, participation in CMS's bundled payment initiative and Pioneer ACO, as well as CHS' Medicare Shared Savings Program. Through all this and Winthrop and LIJ participation in CMS's bundled payment initiative – NQP has deep experience in the transition from volume to value. Managed care plans serving the region, including Affinity, Fidelis, HealthFirst and United Healthcare, will work with NQP to share incentives and undertake payment reform.

NQP hospitals are aligned into health care systems: LIJ (6 hospitals); CHS (4 hospitals) and NUMC/NuHealth. This transition is expected not to adversely impact hospitals to the point of crisis and significant downsizing. At the same time, as hospital volume shifts to the ambulatory setting, NQP may have an opportunity to repurpose some of its facilities. For example, more outpatient day programs for mental health, substance abuse and geriatrics care can be contemplated. The 5 year DSRIP program and the selected PPS projects will be enable the partners to transition from volume to value. Working together on each project, in a P4P program with incentive payments and bonuses' for meeting metrics and milestones will accelerate the transformation to an integrated delivery system. Year 1 and 2 of the program will focus on pay for reporting and meeting program development goals. Years 3 and 4 will involve pay for performance. Each reporting period the PPS and partners will receive feedback on performance and based on that performance receive a bonus or not.

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.).

As described more fully in the Organizational Application, NQP is governed by three strong systems with the right kind of experience (described in more detail below). The governance structure brings together three health systems into an LLC. NUMC/NuHealth will be the PPS Lead. The LLC will be governed by an Executive Committee (EC) composed of 21 voting members drawn from the safety net entities and their partners. The EC will oversee the Project Management Office (PMO), which shall have defined staff and duties. The PMO will assist the project groups and hubs to coordinate their activities seamlessly.

Governance is designed in a manner that will maximize the positive impact of EC members' experience. At the same time, the project committees will provide a forum for obtaining input and insights of the partners involved in the project committees, and the PAC will provide a forum for obtaining input and insights from partners, stakeholders and community based organizations. Additional input to achieve the DSRIP goals will come from the Clinical Oversight, IT, workforce and finance committees. The combined efforts of these varied groups, their joint participation on the committees, and their inter-play with the governing board will inevitably increase the connectivity and coordination necessary to achieve the DSRIP vision of an integrated delivery system.

At the hub leadership level, each lead has experience with care management for the Medicaid populations Building on their experience, the hub level leaders will be tasked, by the EC, with the responsibility to enhance the connections among the participating providers in their hubs, first by creating the necessary data connections and reporting, achieving participation in care management generally, and in the protocols governing implementation of each project in which the providers are participating.

What will make all these initiatives occur – in a coordinated and coherent manner – is leadership and experience, combined with a governance structure that will bring together the input and perspectives of a broad group of providers, stakeholders and community based organizations working under a defined and transparent incentive and bonus payment structure. Under the guidance of the EC, the PMO will be hired and have developed a project specific implementation schedule aligned with each project's scale and speed plan.

The partners actively engaged on specific DSRIP projects will meet beginning in January 2015 and regularly thereafter (monthly at first) to work on project protocols so that in the third through fifth years, when P4P is fully implemented, all projects are implemented according to the DSRIP program goals. Through the first two years, the work of the IT committee will be of critical importance. Data sharing and reporting principles, adopted by the EC, will be provided to the hubs to work with partners to develop an IT infrastructure for coordinating data sharing and reporting. The workforce committee, making recommendations to the EC, in the first year will engage a job training vendor, refine projections for staff changes (mainly focused on recruitment and redeployment), and help to define population health staff position responsibilities. By March 2015, a detailed workforce action plan for the PPS, will be completed and brought to the EC for approval and hub leads for incorporation into their staffing action plans. Throughout the remaining years of DSRIP, new staff (i.e., care managers) will be trained, existing hospital and outpatient staff will be retrained in population health management principles and care. Redeployment decisions will be made at the hub level. The Clinical Oversight Committee will begin work immediately to develop quality reporting metrics and benchmarks for reporting and performance incentives and bonuses for projects, to be presented to the EC for consideration and potential adoption. The finance committee working with the other committees will refine the overall PPS budget and flow of funds recommendations to the EC.

As the partners work together they will learn about evidence based protocols, how to engage care management staff, the incentive payment and bonus structure, and the required project metrics and milestones. All these activities are required in a risk based environment. This will result in development of an interconnected, value based care delivery system providing for a population with multiple chronic diseases, in medical homes, tracking, monitoring and providing real-time feedback for a rapid cycle evaluation. All these efforts will bring the participating partners closer together at the PPS and hub levels, and thereby closer to the goal of achieving an integrated health care delivery system.

Finally, as the hub leaders work closely on the NQP-wide elements of DSRIP, their respective organizations and hubs will become more closely aligned with each other with respect to the activities necessary to achieve the DSRIP goals for improved health of the Medicaid and uninsured population. Although corporate integration of the hubs is unlikely, this ongoing effort, through the 5-year DSRIP Program, will move the entire NQP PPS closer to an integrated delivery system. Work on this integration has begun with the development of this DSRIP application and will continue throughout the 5 years of the DSRIP Program.

3. <u>Scale of Implementation</u> (Total Possible Points - 20):

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital budget funding is necessary for this project for the following items:

-IT systems for interoperability among providers including interfaces between multiple disparate EMRs as well as data repositories.

-Enhancement of existing internal health information exchanges.-Expansion of existing population health analytic tools to be able to handle both the increase in claims and clinical data as well as the number of users.

-Investments in key PPS providers for data sharing who are not yet connected to the RHIO.-Expansion of current care management software to support management of thousands of high risk members.-Patient registries to manage patients.

- Case management software.

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
Long Island Jewish Medical Center	CMS Innovations Bundled Payment for Care Improvement	1/1/14	12/31/16	LIJ participates in CMS Bundled payment arrangements for COPD and cardiovascular surgery. The arrangement include financial and performance accountability for episodes of care. The intent of this model is to improve quality, coordinated care and reduce costs.
LIJ participates via contract in the Montefiore Medical Center Pioneer ACO	Medicare Shared Savings Program	6/1/15		Facilitates coordination and cooperation among healthcare providers to improve the quality of care and reduce total cost of care for Medicare fee-for-service beneficiaries attributed to participating physicians.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Descript ion of Initiatives
North Shore University Health Home (participating partner and LIJ affiliate); FEGS Health and Human Services System	Health Homes for Medicaid Enrollee s with Chronic Conditions	9/1 /12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared between provider s, notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital.
NUMC/NuHealth	Cancer screening initiative	7/1 /14	6/30 /15	Payment for breast, cervical and colorectal cancer screening for uninsured people
NUMC/NuHealth	Vital Access Point	4/1 /12	3/31 /15	Funds capital for new primary care space, development of care transitions program, clinical integration initiative s for needed services, supportive IT infrastructure

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Descript ion of Initiatives
NUMC/NuHealth	Hospital Medical Home grant	1/1 /13	12/3 1/14	Achieve PCMH recognition in primary care practices that include residents and increase community based primary care residency training.
LIFQHC	New Access Point			Some funding for expanded hours, behavior al health (one social worker), expand clinical support staff.

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.

These initiatives differ from this DSRIP initiative because they are for distinct services and populations, not the entire Medicaid and uninsured population. These initiatives do not involve the entire delivery system in accomplishing their goals either – they are largely about care management. They require managing the care of subpopulations, particularly those with chronic illnesses to improve outcomes and reduce costs. These initial population health programs, however, have given members of the PPS substantial experience in managing high risk patients. The infrastructure underlying these program and the expertise gained will serve as the foundational building blocks for the PPS. These programs will accelerate the success of the PPS. They are good opportunities to learn from and to guide the development of the IDS.

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

2.b.ii Development of Co-Located Primary Care Services in the Emergency Department (ED)

Project Objective: To improve access to primary care services with a PCMH model co-located/adjacent to community emergency services.

Project Description: Patients in certain communities are accustomed to and comfortable with seeking their health care services in the hospital setting, frequently leading to overuse of emergency department services for minor conditions while missing preventive health care services. This project will allow faculty to have a co-located primary care PCMH adjacent to the ED. The PCMH practice will have extended hours and open access scheduling. This will allow patients presenting to the ED who, after triage, are found not to need emergency services be redirected to the PCMH, beginning the process of engaging patients in comprehensive primary 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. Ensure appropriate location of the co-located primary care services in the ED to be located on the same campus of the hospital. All relocated PCMH practices will meet NCQA 2014 Level 3 PCMH standards within 2 years after relocation.
2. Ensure that new participating PCP meet NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of Demonstration Year (DY) 3. At start up, participating PCPs must have open access scheduling extended hours, and have EHR capability that is interoperable with the ED.
3. Develop care management protocols for triage and referral to ensure compliance with EMTALA standards.
4. Ensure EHR utilization including supporting secure notifications/messaging as well as sharing medical records between the participating providers via Meaningful Use standards.
5. Establish protocols and training for care coordinators to assist patients in understanding use of the health system, promote self-management and knowledge on appropriate care.
6. Implement a comprehensive payment and billing strategy. (The PCMH may only bill usual primary care billing codes and not emergency billing codes.)
7. Develop protocols for connectivity to the assigned health plan PCP and real-time notification to the Health Home care manager, as applicable.
8. Utilize culturally competent community based organizations to raise community awareness of alternatives to the emergency room.
9. Implement open access scheduling in all participating primary care practices.
10. Use EHRs and other technical platforms to track all patients engaged in the project.

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

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

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

The population of Nassau and Queens is 3,648,322. Nassau County is home to 223,518 Medicaid beneficiaries (16% of the county's population) and Queens is home to 964,928 Medicaid beneficiaries (42% of the county's population). Approximately 121,639 people in Nassau County (9.0%) and 404,127 people in Queens (17.6%) are without health insurance. In combination, Medicaid and uninsured persons exceeds 47% of the total population within Nassau and Queens Counties. There are 324,510 ED visits combined in both counties. In addition, Queens has 246 federally designated Health Professional Shortage Areas (HPSAs) for primary care, with 11% of the Medicaid population living in a HPSA, further contributing to residents' reliance on the ED for non-emergent care.

Approximately half of participants in the Medicaid member community survey (51% in Queens and 47% in Nassau) reported that they or a family member went to the ED in the previous year. SPARCS data indicates that 71% of Medicaid ED visits in Nassau and 75% in Queens were classified as potentially avoidable. Adults likely to have acute illnesses (ages 18-44) comprised 39% of all avoidable ED treat and release visits and 29% of all ED visits in the region. Adults more likely to have chronic disease (ages 45+) made up more than 20% of the region's avoidable ED Treat and Release visits. General symptoms, diagnosed respiratory infections, and chronic obstructive pulmonary disease drove the utilization and accounted for nearly 50% of ED visits.

When survey respondents were asked why they sought care in the ED, they indicated: the ED is the closest provider, they have no other place to go, they could not get an appointment with a health care provider, or their doctor's office was not open. 10% of respondents noted that all of their care was received in the ED.

A primary care practice is preferred to the ED both in order to manage chronic conditions and more quickly provide episodic care for illness. The NQP CNA indicates a lack of provider continuity and poor handoffs from the ED to community-based physicians, resulting in poor implementation of treatment plans, potentially leading to avoidable hospitalizations and readmissions. The project will provide screening and facilitated access to co-located Level 3 PCMHs and promote effective patient engagement for improved care continuity. This will interrupt current patterns of inappropriate utilization and reliance on the ED. As designed, it will accelerate triage prior to patients arriving in the ED and refer patients to the PCMH for non-emergent conditions.

The limits of public transportation contribute to ED use. A cohort of patients regularly turns to the ambulance to access the ED for non-emergency care. With regulatory waivers (but within EMTALA) we will work in collaboration with EMS to support triage of patients to alternative, more clinically appropriate and cost-effective sites of care.

The EDs that will have co-located primary care practices established in this project include NUMC/NuHealth, Winthrop and South Nassau, which operate the three EDs serving the largest number of Medicaid lives in Nassau County. LIJ, Cohen Children's Medical Center, Franklin, Mercy and St. Johns will also participate in this project. 5 of these 8 hospitals are safety net providers (NUMC, LIJ, Franklin, Mercy, St. John's). Co-locating primary care services in level 3 PCMHs adjacent to the EDs in these hospitals will promote improved care continuity and reduce inappropriate ED utilization. PCMH sites are also more capable of providing care that is culturally and linguistically competent.

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 is current and future ED utilizers who have emergent care needs. In order to strengthen primary care access in the highest need neighborhoods and reach out to the local Medicaid population with targeted educational efforts, the focus will be to improve primary care (PC) access for residents in communities designated as medically underserved (Elmont, Freeport, Hempstead, Jamaica, Long Beach, Far Rockaway, Roosevelt and Westbury). The neighborhoods surrounding NUMC/NuHealth, Winthrop, South Nassau, LIJ, Mercy and St. John's will also be targeted as they generate large numbers of avoidable ED visits. Salient data indicate that the cohorts with the highest utilization include African American and Latina women between the ages of 18 and 44, so this project will also have a positive impact on reducing racial disparities. Additionally Explorys, a population health analytics engine used by Care Solutions, has multiple tools to prospectively identify patients likely to use the ED unnecessarily. These cohorts will be targeted. Some of the specific conditions that can be effectively diverted from the ED to primary care include musculoskeletal injuries, acute respiratory illness and substance use disorders. Treatment in a Level 3 PCMH will offer Medicaid beneficiaries significant clinical benefits and will provide NQP with substantial potential cost savings.

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.

NUMC has started construction of a project to co-locate a primary care center next to its ED. The primary care practices onsite in pediatrics and internal medicine already have 2011 Level 3 PCMH recognition; this project will support the achievement of PCMH recognition under the 2014 standards, as required by DSRIP. South Nassau Communities Hospital has also located its ED near a PCMH on the hospital's first floor and an additional PCMH co-located within another site. Cohen

Children's Medical Center of New York, a dedicated pediatric emergency room, located on the campus of Long Island Jewish Medical Center (LIJMC), in Queens, has the ability to expand ambulatory care space to meet 2.b.ii requirements. Long Island Jewish Hospital (LIJ), the adult ED for both medical & behavioral health, of LIJMC, also has the ability to expand ambulatory care space to meet 2.b.ii requirements.
The knowledge gained by NQP partners in achieving current PCMH recognition will be leveraged to help to educate and transform other practices into PCMHs, as many practices in NQP have not begun the transformation needed to meet PCMH standards. These existing PCMHs can assist with lessons learned and best practices. In addition, LIJ has an algorithm-driven nurse triage hotline that provides symptom-based directions to the right level of care: ambulance, urgent care, or ED. The triage hotline model is readily expandable to other sites that will be participating with the project and can support appropriate referrals prior to patient's arrival in the ED. The LIJ-affiliated Center for Emergency Medical Services (CEMS), the largest private ambulance service in the metro NYC region, provides evaluation and treatment in the home by paramedics for high risk seniors enrolled in an admission abatement program. Additionally, LIJ has instituted a split flow model in the ED. This operational expertise can be leveraged to direct patients to a co-located ED. NUMC operates an Ask-A-Nurse line as part of its care transition program, available 24 hours/day. Callers speak with an RN, who directs them to the most appropriate setting for follow-up care. Finally, all the EDs have fast track services that include protocols for referral to PCMH and are designed to enhance linkages to primary care for appropriate follow-up.
Existing staff capabilities will be leveraged, and if necessary, ED staff can be retrained and redeployed to work in PCMH settings. Care coordinators will be needed in the PCMH to manage the care of individuals with complex conditions, especially high utilizers, and to assist patients in connecting with a PCP. Patient education will be an essential component of the PCMHs. Patients will be educated on how to manage chronic conditions effectively, and how to deal with non-acute care symptoms in the future. In addition, the hospitals will work with their existing outreach programs and with community based organizations to develop educational materials that are appropriate to the diverse populations we serve, recognizing that cultural competency extends beyond traditional cultures and ethnic backgrounds to include special populations such as the LGBT community, individuals with HIV/AIDS, individuals with behavioral issues, homeless individuals and families.

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 availability of appropriate physical space proximate to the ED is variable among the participating institutions. Other hospital functions may need to relocated, space may need to be rearranged, equipment purchased, and additional staff will be needed.
Another implementation challenge is establishing appropriate protocols to deal with patients who show up at the ED with non-emergent conditions, and who also have a designated PCP with whom

they may have a clinical relationship. The goal is to insure that the Medicaid patient population receives primary care in a more appropriate setting than an ED, even co-located next to the ED. Patients with non-emergent complaints who are directed to the co-located primary care practice will be educated about primary and preventive care. Rigorous protocols will be established to engage the patient in primary care with their assigned provider if such a provider exists, to direct and manage the transition to the appropriate level of care, and to communicate with the community-based primary care practice. The billing implications associated with this process will present additional challenges and will need to be addressed as a part of the project implementation plan.

Patient compliance with being re-directed to a co-located primary care practice after an evaluation in an ED will need to be dealt with appropriately, as will EMTALA regulatory issues. Extensive patient education will be required. EMTALA requires that an ED must provide a clinical assessment for any patient that signs in, so a diversion to a co-located PCMH may lead to duplicative care. A main focus of the project will be on EMTALA compliant referral protocols that redirect patients to primary care before they arrive in the ED. The use of the LIJ triage hotline and NUMC's Ask-a-Nurse hotline will also be expanded to direct patients to the appropriate level of care prior to showing up at the ED. Finally, patients will be alerted to the open access PCMH practices via signage and other promotional materials such as pamphlets, available in multiple languages and formats. Other initiatives such as posting average wait times for the ED versus the primary care clinic will help influence patient decision making about location of care.

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.

In Nassau, NQP does not overlap with any other PPS, although patients are free to receive care across the PPS's geographic boundaries and many do. Overlap will occur in Queens. Advocate Community Partners (ACP) has included eastern Queens in its service area; however, it has not included the Rockaway Peninsula. NY Hospital Queens and Health & Hospitals Corporation PPSs also serve Queens. Due to their geographic proximity, particularly eastern Queens, it is possible that overlap will occur.

LIJ is a member of the ACP with Board of Directors representation. Leveraging the LIJ role in the NQP and in the ACP PPS, LIJ will be able to rapidly communicate and share information and best practices or problems being encountered with the other PPS as they arise. ACP does not plan to pursue project 2.b.ii.

In developing protocols and policies for triage and communication, neighboring PPSs will have to be addressed. Overlapping PPSs will develop protocols for re-directing patients who use EDs in multiple PPSs to appropriate primary care. This will include expectations for alerts and communication of visit outcomes both for patients out-migrating to EDs outside NQP and for those in-migrating whose primary care lies outside NQP. In the absence of integrated medical records a process will be needed to flag duplicate patient records and coordinate efforts, which NQP will develop.

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.

IT investments will be necessary for development of internal communications tools and electronic medical records, community para-medicine connectivity, access to remote monitoring equipment, and expanded text messaging capabilities. Integrated communication tools, real time alerts via email or text messaging, transmission of continuity of care documents will all be vital to communicating both within the NQP and with overlapping PPSs.

The PCMH model requires multidisciplinary team-based care including augmentation in staffing such as: nurse care managers, social workers, psychologists, pharmacists, and community health workers. Many of these individuals will need to speak multiple languages, particularly Spanish.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
NUMC/NuHealth	Medical Home Demonstration Project		2014	Demonstration project that focused on PCMH status via residency training, in order to achieve NCQA 2011 standards for PCMH.
LIJ	Medical Home Demonstration Project	1/1/2013	4/1/15	NYS funded demonstration project that focused on transforming resident-clinics into PCMHs. Additionally focused on high quality care transitions and reduction in ED and hospital utilization.
South Nassau	Medical Home Demonstration Project		2014	Demonstration project that focused on PCMH status via residency training, in order to achieve NCQA 2011 standards for PCMH.

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

Project 2.b.ii will establish primary care adjacent to hospital EDs. While these sites are similar to the medical home demonstration projects, these primary care sites will be PCMHs, which has not only residency training requirements, but other requirements. The PCMH requirements were revised in 2014 so the proposed PCMH sites may have to update resources and policies/procedures in order to meet the new standards. In addition, as these PCMHs will be adjacent to hospitals EDs, they will focus on a population that has historically been difficult to steer away from an acute care setting, with the goal of shifting care to a more cost-effective setting.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

11. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
12. Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
13. Ensure required social services participate in the project.
14. Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
15. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
16. Ensure that a 30-day transition of care period is established.
17. 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.

57,592 Medicaid beneficiaries in Nassau and eastern Queens were either hospitalized or treated in the ED for a chronic condition. Of that, 4,555, or 7.9%, were readmitted within 30 days. Common reasons for readmission included psychiatric (22%), circulatory (11%) and digestive (9%) disorders. The population is young, with 88% under 65, although residents with end of life needs also experienced avoidable readmissions. The delivery system suffers from fragmented communication, lack of timely access to post-discharge primary care, and language and cultural barriers.

Poor care transitions are a major contributor to readmission. Care plans provide inadequate self-care and medication management information, lack guidance about resuming activities, and fail to assure connection to a PCP for timely follow-up. Care plans do not always reflect the patient's financial means, support system, or living arrangements, and patient discharge material may not be language and culture-congruent. NUMC/NuHealth's Care Transitions Program readmitted patients experience social issues such as lack of a personal support system, funds to fill prescriptions or adhere to dietary requirements, and lack of transportation to follow-up care. Reasons for readmission may be related to a behavioral health problem or comorbid condition or other factors exacerbated post-discharge. LIJ participates in Bundled Payments for Care Improvement (BPCI) initiative, in which, e.g. a woman was repeatedly readmitted for COPD exacerbations until a home visit identified and addressed environmental factors (mold, poor ventilation, etc.); that are mitigating factors for readmission.

Lack of referral to palliative care contributes to readmissions. Stakeholders noted that very frail people are discharged to SNFs with unreasonable expectations about their potential for recovery, and can ping pong between the hospital and the SNF even when little can be done. Many practitioners are uncomfortable addressing end-of-life issues. Use of the Medical Orders for Life-Sustaining Treatment (MOLST) Program, an initiative to facilitate end-of-life medical decision-making, has resulted in fewer readmission and improved use of palliative care in the SNF. This project will retrain staff to develop electronically shared transition plans based on identified readmission risks. Patients will be supported to manage medications, identify a designated pharmacist, and develop self- management strategies to mitigate readmission risk. Coaching will support patients to raise concerns with their doctor and develop personal health records as a tool for communication. Issues related to homelessness, food insecurity, transportation and health literacy will be proactively addressed via referrals for benefits and community-based resources. Throughout NQP, expanded use of transition care managers will provide support to patients and their families for 30 days post discharge, ensuring that follow-up care occurs within 1 week and that problems such as lack of engagement with the PCP and medication access issues and reconciliation concerns are addressed. They will monitor laboratory and diagnostic test results, track referrals, adhere to advanced directives, and facilitate end-of-life decision-making. Protocols for proactive palliative care consultations at discharge will be implemented based on MOLST screening. Care managers will do home visits for patients at high risk of readmission risk. HIT will be leveraged to improve communication among providers and patients and to facilitate care

coordination in numerous ways such as telephonic and remote monitoring of key biometric indicators, leveraging social media to provide reminders and follow up, as well as communication of discharge and transition plans to the post-acute providers. While these positions are currently in existence in many of the NQP provider organizations, role standardization, training, and deployment strategies are needed.

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 ultimate target population is all Medicaid patients with chronic conditions who are hospitalized. The program can risk-stratify patients, using an evidence-based risk assessment tool such as the LACE tool. The LACE assessment calculates a readmission risk score based on length of stay, acute admission through the ED, comorbidities, and ED visits in the past six months. Patients with a low risk of readmission receive only telephonic follow-up while patients with a moderate or high risk of readmission receive more intensive care management services, including home visits.

In phase 1, the focus will be on patients with two or more chronic conditions, including dual eligibles, scoring a moderate to high risk for readmission, as determined by an evidence-based tool. NQP's experience with the bundled payment initiative will help inform the project. Examples of this include workflows and communication tools to ensure that the transition plan is communicated to all post acute providers and physicians and updated throughout the course of the transition period, coordination of visits and follow up care to prevent duplication of services and development of 24/7 system for patient and family support through use of the Clinical Call Center, which will be instituted as part of this project. NQP will partner with Medicaid managed care plans and health homes to develop protocols that promote coordination for covered services, including durable medical equipment, matched with a payment strategy to sustain provision beyond 30 days. Protocols developed at LIJ's affiliated health home will be leveraged for early identification of eligible patients to ensure referral for available care coordination and access to the appropriate integrated community based services. Health homes play a key role is assuring that patient information and care is language, culture and literacy-appropriate for the patient being served. Peer Bridgers is an example of a service designed to help ease the transition into community life for individuals being discharged from a behavioral health inpatient stay, designed to significantly decrease their need for readmission by offering an array of both intensive individual and group peer support services.

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

Every hospital participating in NQP has established programs to reduce 30-day readmissions. These efforts, many of which were targeted to high utilizers and Medicare patients, will inform the interventions for Medicaid patients with chronic health conditions.

Examples of programs being leveraged with the help of NQP partners include:

- Transport PLUS model can be leveraged in cases where EMS is used to transport a patient home from the hospital. Trained EMS staff review discharge instructions with the patient or caregiver within the home, conduct home fall safety assessments, and perform a home medication inventory. In addition the community Paramedicine program can be utilized to perform in home assessments under the supervision of an MD, implement limited interventions in the home and monitor the patient's response to those interventions via telemedicine connectivity.
- NUMC/NuHealth's Care Transitions Team follows selected patients with a chronic disease for at least 30 days post-discharge, and has seen a 50% reduction in readmissions in one year. The program has noted significant challenges with social issues that increase the likelihood a patient will be re-admitted, ranging from not have a personal support system, to financial issues prohibiting them from picking up their medications and necessary food requirements to transportation for following up with a PCP. Discharge information may not be in the patient's language and or reading level. Caregivers, both family members and paid care-givers, may also have limited English-language health literacy. All are mitigating factors for readmissions.
- Winthrop Asthma Program reduced readmissions by 80% for that population over a 12-month period.
- Four health homes serve the region, including two that are NQP partners (FEGS and NSUH). The health home is care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner, with a goal of reducing readmissions.
- NQP has a number of home care programs whose nurses are valuable partners in providing transitional care management including provision of skilled nursing services, test and treatment follow-up medication reconciliation and patient education related to medications and self-management skills.
- LIJ's 24/7 Nurse Call Center answers patients questions and triages concerns. For patients in a SNF, LIJ's eICU program can bring remote monitoring equipment and telemedicine, and a critical care intensivist to the patient's bedside. These services allow for the remote access to an Intensivist and ICU Nurses who can visualize the patient as well as monitor a patient's vital signs, ECG, oxygenation and physical assessment findings and supervise interventions to stabilize patient condition without requiring transport back to the acute care facility.
- Central Nassau Guidance and Counseling Services operates Stability at Home to reduce admissions by building community based support for those with serious mental illness.

- JASA has a Dual Eligible pilot for home care workers, which provides adherence and medication reconciliation, reporting to an interdisciplinary team.
- Visiting Nurse Service of New York (VNSNY) offers a comprehensive array of transitional programs with hospital partners.
- NUMC/NuHealth works with 6 home care agencies that are at times co-located in the hospital to measure re-admission and the effectiveness of each referral and provides additional support through the Care Transitions team when needed.
- Dominican Sisters home care operates a care transitions coaching program.
- Walgreens WellTransitions program provides post-discharge telephonic support check-ins and consultations regarding issues or challenges related to medication adherence. A retrospective study showed that patients were 46% less likely to experience a readmission within 30 days.

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.

Real-time notification is needed when a patient returns to the ED following discharge. Provider alerts can be developed through the RHIO. NQP partners will need IT systems, processes, policies and procedures to securely and seamlessly share information. Bidirectional communication will facilitate coordination, prevent duplication, and identify readmission risk factors in time for appropriate intervention. NQP will facilitate workforce retraining, new hires recruiting, and call center operations. Scaling up will require a large clinician workforce able to navigate inpatient and outpatient care; a 24/7 call center to support night and weekend coverage; and an RN support line. RNs will need to telephonically provide clinical support based on evidence based clinical algorithms and dispatch paramedics or arrange transport to the ED. They will facilitate contact with providers, assist in scheduling appointments and perform telephonic follow up calls within 24-48 hours of discharge to answer any questions related to care. Challenges include:

Limited HIT interoperability – IT enhancements and coordination across all NQP's DSRIP projects are needed. A common electronic risk-stratification tool such as the LACE Score will provide effective interoperability across systems and with community PCPs.

Workforce – Demand for care management staff exceeds supply. Redeployment and retraining of current inpatient and SNF staff and new midlevel clinician and care manager be recruitment will be required.

Redundancy – Coordination to ensure that patients do not enroll in multiple care management programs will be necessary. NQP will develop a tracking mechanism and coordinate linkages to appropriate programs

Provider engagement – Aligning incentives through pay for performance (P4P) programs for providers in NQP, many of whom have little experience with performance measurement and reporting, and other aspects of P4P. NQP's provider engagement strategy includes communicating goals, objectives, metrics and milestones, and payment incentives and utilizing the experience of those within and outside of the PPS who have begun this integration. The 2.b.iv project committee comprised of transition team members, including practitioners and practice leaders will guide project implementation efforts including training and on site immersion experiences will be provided during implementation.

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.

In Nassau, NQP does not overlap with any other PPS, although patients are free to receive care across the PPS's geographic boundaries and many do. To the east is Suffolk PPS which has no overlap with NQP. Overlap will exist in Queens, particularly in eastern Queens. Advocate Community Partners (ACP) has included eastern Queens in its service area; however, it has not included the Rockaway Peninsula in its 10 projects. The New York Hospital of Queens (NYHQ) and Health & Hospitals Corporation (HHC) are serving Queens and possibly other counties. Due to their geographic location and proximity, particularly eastern Queens, it is possible that there may be overlap if the same projects are chosen. Mt.Sinai, Maimonides and the NYC HHC are undertaking this project. LIJ is a member of NSLIJ, which is a member of the ACP and in the first year has 25% of the ACP Board of Director votes and in the remaining years of the DSRIP program will have 50% of the Board of Directors votes. Leveraging the LIJ role in the Nassau Queens PPS and in the ACP PPS, LIJ will be able to communicate rapidly and share information and best practices with the other PPSs. ACP plans to purse project 2.b.iv. Specific to the Care Transitions Intervention Model project (2.b.iv), NQP has experienced hub members who have developed population health management models with skilled nursing homes, home care agencies, and the health homes. In addition, these hub members are experienced in value based payment programs. This project will be focusing on coordinating NQP partners as patients are discharged from hospital to home, home care or skilled nursing home – sub-acute or long term and assuring that the patient and caregiver understands the care transition plan in the language of the patient. This will be accomplished in part through linking all partners to the RHIO, sharing patient information appropriately for the benefit of the patient. Similarly, ACP and other PPSs will be utilizing the RHIO. This common health information technology platform will enable the PPSs to communicate about their patients' clinical needs. For this project the RHIO will be important PPSs to effectively and efficiently share patient information and understand the patients' clinical history and care plans. It is quite possible that PPSs will share partner organizations, such as skilled nursing or home care agencies that care for the communities across Queens. If the same projects are chosen by more than one PPS in the same service area, the shared partner may become overwhelmed and confused about the activities of the multiple PPSs due to the sheer number of projects as well as the variations in implementation of the projects. It will be necessary for the PPSs and partners to coordinate how to best achieve the goals of DSRIP and decide which PPS the partner is best suited to achieve those goals. The criteria for choosing which PPS could be based on partner attribution, shared clinical or operational infrastructure, current affiliations, geographic locations, and of course, what is the least disruptive and most complimentary to partners' and the patients' interests. Much of this information

is available through Salient data system. Other ways to collaborate with overlapping PPSs is to meet quarterly or more frequently, as agreed, to discuss the shared difficulties and successes in implementation and how to garner the shared resources to meet the community's needs and the objectives of the DSRIP program shared projects.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital funding is needed for IT systems and support to develop and scale integrated communications across all NQP providers. Paramedicine tools such as remote monitoring equipment and expanded text messaging to provide patient reminders and collect biometric indicators like blood glucose, exercise tolerance, will also be needed.

NQP will need to develop job training programs with Department of Labor-licensed vendors in order to hire, redeploy and re-train staff. Expected reductions in inpatient admissions and ED visits will result in excess staff to be re-trained to help with care transitions (RN, SW, Pharmacist, Clerical staff, ED registrars). Increased needs include MH providers such as Peer Bridgers, BH counselors, social workers and substance abuse counselors, as well as primary care locations where physician extenders (nurse practitioners and physician's assistants) are available to support implementation of post-discharge care plans designed to reduce readmission risks, particularly concerning patients with BH conditions.

Decreased use of nursing home (sub-acute) facilities will also be achieved by more appropriate end of life/palliative programs and evidence-based guidelines for post-acute referrals. Staffing reductions within SNFs, should they occur, may yield retraining opportunities for staff to provide intensive observation and stabilization of patients within the SNF under the INTERACT program and support community transitions. Home care volume may increase and home care service intensity will need enhancement. NQP retraining programs will be needed for home care agencies. Data analytics to monitor program outcomes will be important; therefore job descriptions must be standardized across organizations. Consistent titles and competencies must inform curriculum development and will minimize patient and provider confusion about provider roles. Retraining curricula will be required for transitioning staff. Several programs are being developed in support of BPCI and Health Homes, and the Advance Illness Training Collaborative. These programs will be leveraged and expanded as project strategies are refined.

Respite care is needed for those with developmental disabilities, dementia, and behavioral health issues whose needs exceed available service limits. Re-purposing facilities and expanding benefits for respite support will be explored.

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
Long Island Jewish Medical Center	CMS Innovations Bundled Payment for Care Improvement	1/1/14	12/31/16	LIJ participates in CMS Bundled payment arrangements for COPD and cardiovascular surgery. The arrangement include financial and perform accountability for episodes of care. The intent of this model is to improve quality, coordinated care and reduce costs.
LIJ participates via a contract in the Montefiore Medical Center Pioneer ACO	Medicare Shared Savings Program	1/1/16		Facilitates coordination and cooperation among healthcare providers to improve the quality of care and reduce total cost of care for Medicare fee-for-service beneficiaries attributed to participating physicians.
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollees with Chronic Conditions	9/1/12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital.

NUMC/NuHealth	Vital Access Provider	4/1 /12	3/31 /15	Funds capital for new primary care space, development of care transitions program, clinical integration initiative s for needed services, supportive IT infrastructure.
LIFQHC	New Access Point			Some funding for expanded hours, behavioral health (one social worker), and expanded clinical programs

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.

As noted above, several delivery system initiatives related to this initiative are presently underway, Project objectives for current isolated initiatives are consistent with DSRIP, but the planned DSRIP project reaches a broader cohort with a larger scope and scale and facilitates system-wide standardization and adoption of best practices specific to care transitions during the 30-day post-hospitalization period. While the scope is broader for the DSRIP project than with other programs mentioned, the experiences of the programs to date can inform the strategy for DSRIP moving forward. Much effort has been done relative to risk stratification, communication across the continuum, strategies for reducing risk such as comprehensive assessment that includes psychosocial barriers to care, face to face visits in the immediate post discharge period, medication reconciliation and provider follow up. These can be scaled to respond to the needs of this program.

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

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

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

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

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

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

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

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

The NQP service area includes a significant senior population. Nassau residents are slightly older than the statewide average while Queens residents' are slightly younger. Persons over 65 make up 16.1% of the Nassau population and 13.4% of the Queens population; the NYS rate is 14.4%. This is reflected in the Medicaid population as well: 12% of beneficiaries in Nassau and 9% in Queens are over the age of 70. Over 18% of Nassau beneficiaries are duals; in Queens it is 14%. This population is disproportionately likely to require care at a Skilled Nursing Facilities (SNF).

INTERACT is one of several evidence-based models aimed at improving care and care transitions for older residents of SNFs. The potentially avoidable hospitalization rate for patients residing in SNFs in Nassau and Queens Counties is 5.2 hospitalizations per 10,000 long-stay episode days, which represents the highest rate in NYS. Implementation of the INTERACT project will contribute to a reduction in hospital re-admissions by an estimated 25% by the end of the DSRIP period. INTERACT provides sustainable, cost-effective tools and protocols and targets additional quality improvements which can be sustained beyond the DSRIP period, continually generating Medicaid cost savings.

Readmissions from SNFs are most often caused by inadequate clinical coverage in SNFs. SNF rely primarily on LPN staff for clinical coverage. LPN staff are not permitted to perform clinical assessments and in the absence of consultation resources, the SNF must frequently rely on ED care. This gap is exacerbated by a lack of provider continuity to support patients during care transitions (project 2.b.iv), due to inadequate discharge planning as patients' transition from the hospital to the SNF. SNF provider focus groups noted that readmissions could be avoided with improved clinical capabilities, established best practices, utilization of advance directives, and provision of palliative care when appropriate. In addition, ongoing medical staff education and establishing minimum expertise and credentials, are necessary to assure that medical staff can adequately care for the frail institutionalized population. The INTERACT project and project related payment incentives will encourage SNFs to adopt, standardized evidence-based protocols and an all RN care model. This model will enhance clinical expertise, rapid and accurate decision making while partnering with physician staff to achieve the best clinical outcome. Also, hospital discharge planners may have to have enhanced training on thorough and timely discharge reporting for smooth transitions to occur. IT systems will need to be enhanced between the region's EDs/hospitals, improved EMRs to share medical records may also be required, as well as improved patient and family education programs.

66 of the region's 95 SNFs will participate in the INTERACT model. A project committee has already been established that includes representatives from each of the participating health systems and hospitals, their EDs, and the SNFs. Consistent with the INTERACT model this group will identify champions within the SNFs to implement INTERACT. Participation of this magnitude will enable NQP to rapidly reduce the area SNF readmission rates. NQP is confident of the success of the INTERACT program. On a smaller scale, LIJ's SNF-affiliate medical directors group, which has been in existence for 8 years, has established a variety of best practices including advanced illness screening, palliative care protocols, hospice consultations, utilization of MOLST, emphasis on safe handoffs at time of discharge from the SNF, and accurate medication reconciliation. NUMC/NuHealth also has a care transitions team that targets high risk hospital discharges to SNFs.

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.

66 participating Skilled Nursing Facilities will participate in the INTERACT project. These SNFs account for 13,758 beds, or 70% of beds in the region. SNF residents covered by Medicaid (including dual-eligible) with chronic disease(s), advanced illness, or medical and behavioral health co-morbidities will be targeted for the INTERACT project. Patients being discharged from the regions hospitals will also participate and their discharge planning staffs will be part of the INTERACT project committee. The majority patients being discharged will have had prior re-admissions, and it is expected that most will be ages 55 and older and medically frail due to complications related to CHF, COPD, dementia, chronic kidney disease, and other chronic diseases. Readmission risks will most likely relate to recurrent infections, sepsis, urinary tract infections, mental status changes, nausea and vomiting, failure to thrive, and system failure associated with the end of life. Lack of family support and social isolation are common among this population. Cultural differences regarding end-of-life care will guide our planning and development of culturally responsive protocols.

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.

An array of regional resources will facilitate implementation and ensure success. The INTERACT project committee, has been established. The committee representation is comprised of experienced staff committed to readmission prevention and addressing communication barriers between NQP SNFs and hospital EDs.

Implementation and coordination plans are informed by representatives leading the Caring Together INTERACT NY initiative. Caring Together has been operating in the Albany region for the past five years under the guidance of the INTERACT model's developer and will provide NQP with guidance and lessons learned.

Other current assets and resources include several readmission prevention pilot programs, which will be expanded to address population and/or disease-specific needs identified as the INTERACT

model is implemented. For example, hospice relationships are active within more than half of the 66 SNFs and facilitated access to end-of life care. Expanding existing utilization of advance directives will also complement INTERACT's attention to end-of-life planning. Facilities will also initiate the Medical Orders for Life Sustaining Treatment (MOLST) tool, which allows physicians to issue orders related to life-sustaining treatment, including cardiopulmonary resuscitation for hospital patients and nursing home residents, based on the patient's condition, values and wishes. Ensuring standardization of this practice is critical and will be supported by this project. LIJ and its affiliates have Care Solutions, a population health management organization, which provides monitoring and medication management support via an easy-to-use touch screen interface and other simple tools.

Most SNFs rely on the Nurse Practitioner (NP) model for medical coverage to replace a physician. The model facilitates rapid patient evaluation and management when a physician is not available. The INTERACT model includes enhanced clinical care for high risk populations, improved EMR and coordinated case management with a focus on advanced directives and hospital avoidance, and several regional SNFs' geriatric and acute care palliative supports are reinforced by nurse practitioners deployed within the facilities to complement the palliative care models already in place. EverCare, a model that utilizes on-site NPs, is used at a number of SNFs and will be shared as a best practice. LIJ also operates a Mobile Integrated Paramedic Team, which can further reduce avoidable admissions and readmissions. This team provides home and community-based evaluations for the frail elderly and can provide hydration therapy and intravenous treatment, pain medication, and diuretics. Mobile X-rays and EKGs, plus point of care laboratory testing, are also available to prevent unnecessary hospital transfers.

A Holly Patterson Extended Care Facility of NUMC/NuHealth is one of the largest SNFs in NYS, serves a largely Medicaid population (90% of residents), and has numerous medically fragile residents. Its specialized services include a ventilator unit, an AIDS unit, and on-site hemodialysis. The full-time medical director and a full-time medical staff have enabled the facility to adopt the INTERACT Nursing Home Capabilities List. Coupled with close communication with the NUMC/NuHealth ED and the NUMC/NuHealth Hospitalist service, unnecessary hospitalizations have been reduced. A. Holly Patterson can model the INTERACT process for other SNFs in the region.

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

The greatest challenge relates to the historic independence of the region's SNFs. As a result there is a lack of coordination as noted in the SNF community forums. Discussions among the many stakeholders, including SNF leadership, confirm that the DSRIP program can develop the synergy required for successful project collaboration. Other challenges include: a need for INTERACT technical assistance and training; developing a transparent incentive program related to improved quality; a robust HIT-system to share patient information and care plans between hospitals and SNFs; and to ensure that metrics are informing the INTERACT practices and identifying opportunities to improve care. An additional challenge, noted by the Caring

Together leadership, described earlier, is ensuring that the hospitals understand what the SNFs that adopt the INTERACT model of care are capable of providing at the sub-acute and acute-care levels. INTERACT provides the SBAR (Situation, Background Assessment and Recommendation) tool designed to survey SNF capacity to communicate with EDs and our planning effort has emphasized a focus on engagement between the SNF and hospital staff.
A final challenge is that a regulatory waiver is presently necessary to guide patients towards providers with the highest demonstrated quality, based on measurable metrics, and ensure well- coordinated care. When providers referring to SNFs are able to make recommendations related to quality alone, improved family decision-making will drive admissions to SNFs with lower rates of hospitalization and reinforce SNF participation in programs like INTERACT. LIJ is currently developing a beta test of CarePort Health, to provide an electronic decision-making tool for patients and families to make decisions on quality as well as geography.

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.

In Nassau, NQP does not overlap with any other PPS, although patients are free to receive care across the PPS' geographic boundaries and many do. To the east is Suffolk PPS in which there is no overlap with NQP. Overlap will exist in Queens, in eastern Queens in particular. Advocate Community Partners (ACP) has included eastern Queens in its service area; however, it has not included the Rockaway Peninsula in its 10 projects. The New York Hospital of Queens (NYHQ) and Health & Hospitals Corporation (HHC) have been awarded Planning Design Grants and NQP believes each is pursuing becoming a PPS serving Queens and possibly other counties. Due to their geographic location and proximity, particularly eastern Queens, it is possible that there may be overlap if the same projects are chosen. That is not known at the writing of this application so some of the answer is what the intent of the NQP to address possible overlap issues. LIJ is a member of NSLIJ, which is a member of the ACP and in the first year has 25% of the votes on the ACP Board of Directors and in the remaining years of the DSRIP program will have 50% of the Board of Directors votes. Leveraging the LIJ role in the Nassau Queens PPS and in the ACP PPS, LIJ will be able to rapidly communicate and share information and best practices or problems being encountered with the other PPS as those surface. ACP is not pursuing project 2.b.vii. It is possible, however, that the other Queens PPSs may pursue 2.b.vii. In that case the PPSs may share skilled nursing partner organizations. It will be necessary for the PPSs and partners to coordinate on how to best achieve the goals of DSRIP and decide which PPS the partner is best suited to achieve those goals. The criteria for choosing which PPS could be based on partner attribution, shared clinical or operational infrastructure, current affiliations, geographic locations, and of course, what is the least disruptive and most complimentary to partners and the patients interests. For the INTERACT Project (2.b.vii), NQP has experienced hub members who have developed population health management models with skilled nursing homes, home care agencies, and the health home. In addition, these hub members are experienced in value based payment programs. This project will be focusing on coordinating NQP partners as patients are discharged from hospital to skilled nursing home – sub-acute or long term and assuring that the patient and care giver understand the care transition plan. This will be accomplished, in part, through linking all participating SNFs to the RHIO for data sharing thereby sharing patient information appropriately for the benefit of the patient, and minimizing missed handoffs. Similarly, ACP and other PPSs will be utilizing the RHIO. This common health information technology platform will enable the PPSs to communicate about their patients'

clinical needs. The RHIO will become a vehicle for the PPSs to effectively and efficiently share patient clinical information and care plans.

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.

- IT funding for interfacing decision support for providers, patients and families, and connection to the RHIO
- Laptops and tablets for data collection

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 completion of project requirements, scale of project implementation, and patient engagement progress in the project.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The NQP service area is comprised of a large number of minority and underserved areas. Queens County is home to one of the most diverse populations in the country. Its race-ethnicity is 27.7% Hispanic, 27.1% White, 23.5% Asian and 17.6% Black. Nassau is diverse as well with 64.6% White, 15% Hispanic, 10.7% Black, and 7.9% Asian. The immigrant population in Nassau has been growing rapidly, mostly from Latin America and the Caribbean. Nassau also has several high-poverty communities that are largely black and Latino. Eastern Queens is home to a large Asian, Latin American and Caribbean communities. These same areas have some of the highest indicators of health care access issues and of poor health status. The Nassau CNA identified the following communities as having the lowest average household incomes while bearing a higher disease burden: Freeport, Glen Cove, Elmont, Hempstead, Long Beach, Roosevelt, Uniondale and Westbury.

A survey of 3600 Medicaid beneficiaries was conducted to ascertain the health perceptions and key concerns of the consumers, and identify service needs and barriers to care. Lack of health insurance was the most cited reason for not accessing care (19.5% of respondents in Nassau, 18% in Queens). The large number of foreign-born (approx 30%) and non-citizens (approx 20%) residing in the service area is a major factor in the lack of health insurance. One of the chief barriers cited by the uninsured (UI), low health care utilizers (LU), or non-utilizers (NU) was a sense of disempowerment or a lack of knowledge of the health care system. This is exacerbated by

language barriers, as there are many non-English speakers. 23% of respondents stated that Spanish is their preferred language for healthcare. Cultural and literacy level issues also make the health care system challenging.

NYS has indicated as many as 1.1 million Medicaid beneficiaries were NU, and another 750,000 received 3 or fewer services (LU). Many of these individuals have unmanaged chronic diseases. Stakeholders reported that many undocumented immigrants prefer to seek care at storefront medical practices as a way of preserving anonymity for fear of deportation. Prisoners re-entering communities after incarceration have to reconnect to insurance and health care services. The need to encourage these individuals who may be reluctant to engage to become consumers who approach their own healthcare with knowledge, skills and confidence and who will be better able to successfully navigate the health care delivery system will be critical to achieving improved population health.

The primary focus of this project will be to work with community-based partners to find and engage the UI, LU, NU Medicaid populations. All PPS partners will be informed about the project and their role in successful implementation of outreach and activation as measured by Patient Activation Management (PAM) tool. NQP will introduce and train partners on what PAM is and how it is used. Outreach workers will play a critical role in engaging individuals in the community. They will conduct PAM screening to identify high risk individuals who lack insurance, have clinical risk factors, lack self-management skills, and are disconnected from needed care. Baseline screening will also guide the application of disease management services (including other DSRIP projects) based on concentrated hot spots, particular disease cohorts, or areas in which access barriers require invention. Health Information Technology will be critical to this project to track PAM administration in order to avoid duplication and also for data aggregation of results. Data- informed deployment of trained navigators will leverage an array of interventions selected based on identified needs such as Motivational Interviewing, Wellness Self-Management, Health Literacy Training for Medical Professionals, the Health Literate Care Model, and The Chronic Disease Self-Management Program (CDSMP).

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

By implementing this project, NQP will care for the UI, LU, and NU to improve their connectivity to primary care and to engage them in their own wellness. NQP will partner with CBOs to leverage the outreach potential of culturally and linguistically competent community navigators who support engagement, education and skill development related to health care coverage, resources and self-care/self-management. Our project will leverage the region's existing public health workforce, including existing hospital EDs, FQHCs, and peer and community outreach programs to conduct PAM screening and to provide navigators for this project. Nassau University Medical Center is the public safety net hospital for Nassau County, has institutional knowledge in caring for diverse communities and has established a work force capable of addressing

the needs of this diverse population. Since the needs of this population reach beyond the health care delivery system, our efforts will use the resources and reflect the participation of the CBOs currently serving the UI, such as transitional housing, faith based organizations, food pantries, social service providers, peer to peer programs, and our facilitated enrollment/navigator sites. To extend our reach even further, MCOs and PCPs will be trained to motivate engagement with those who underutilize services, as well as those who are uninsured. Health Homes will coordinate to ensure outreach to LU and NUs. PCPs will be trained to identify the needs of low utilizers and partner with MCOs to engage them in care, and our trained public health workforce, including public health outreach workers enlisted for the post-Superstorm Sandy Project Hope program, will conduct assertive outreach to the most disenfranchised populations.
UI, LU and NU who are wary of interacting with the health care system, who may have unstable employment, and who may prioritize immigration and housing over health care will be some of the individuals targeted by this program. Individuals will also be targeted by disease, and will include those whose hospital readmissions have been related to substance use disorders, diabetes, asthma, and COPD. Finally, geographic hot-spot communities such as Freeport, Glen Cove, Elmont, Hempstead, Inwood, Long Beach, Roosevelt, Uniondale, Westbury, Jamaica and the Rockaways will be the focus of targeted outreach activities.

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

Significant regional resources support implementation. Many PPS members are already working to engage and link people to care and can provide workable strategies, active hubs, and scalable models. NUMC/NuHealth has always worked with the UI. 25% of its inpatients 33% of its outpatients are uninsured. It has developed NuCare, a program that provides UI with a medical home. The Nassau health homes have located NU and LU individuals on social media, criminal justice system websites, and other non-traditional networks. The Health and Welfare Council of Long Island is a network that can be leveraged for planning. Hub sites are already reaching the UI, including Visiting Nurse Service of New York (VNSNY) and Planned Parenthood. The NuHealth Health Leads initiative, with Hofstra University and Project Doc, has advocates providing information and navigation services for housing, food, and adult education. In the past 2 years, it has worked with 1060 individuals with over 2500 social needs. Social Service initiatives at NUMC/NuHealth include enrolling patients into the food stamp program and oncology navigation /coordinated care services. The Rockaway Wellness Project (RWP) is staffed by health coaches and wellness workers who use motivational interviewing to promote healthy lifestyle changes. 60% of the 350 RWP participants are in Medicaid and 30% are uninsured, many undocumented. RWP recruits participants in pharmacies, food pantries, and other access points within hot spots. It refers participants to healthcare resources and helps with housing, immigration, domestic abuse, and basic needs. Members of the NQP provide facilitated enrollment for government sponsored entitlement programs at EDs, ambulatory providers and community events. A number of partners are also utilizing planned evidence based interventions to promote self-management and engagement. NuHealth has an ADA certified Diabetes Self-Management Education (DSME)

program and a Diabetes Club, a community support group which holds monthly seminars that are open to patients and families. NUMC/NuHealth supportive programs include VNSNY which utilized the general Chronic Disease Self Management model with social workers and peers, Pilgrim Psychiatric uses Wellness Self-Management, and Planned Parenthood provides Health Literacy training.

The project will also utilize the array of community events that draw the UI. Our hospitals and FQHCs routinely conduct well-attended health fairs in a range of venues with free screenings and services. These events are an opportunity to engage patients and link people to primary care. The RWP program recently provided 900 flu vaccines and NUMC/NuHealth and St Francis both have mobile vans that provide free screening for mammography and for cholesterol and BP respectively. Member outreach services conducted by the MCOs are another asset. One example is Healthfirst's robust member outreach program that connects with patients who are missing key services.

Population health management supported by EHRs and patient registries is critical to project success. A review of PPS partners indicate that the majority of partners have an electronic medical record able to provide some level of reporting and can interface with a patient registry to provide more accessible and actionable data than the EHR alone can provide. The IT Committee of the NQP is dedicated to developing a plan (based on the available funding) to transition any partners with paper-based systems to interoperable EMRs or thin, cloud-based, secure, encrypted applications that will enable them to access data in real time and update patient records with appropriate treatment information. This plan will facilitate appropriate sharing of patient data. Over time, this will enable clinicians at all sites to access data necessary for integrated, coordinated care and will enable the PPS to collect data necessary for outcome monitoring, rapid cycle evaluation and continuous performance improvement.

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

The most significant challenges are in communities where resources are limited making it hard to find services for patients once they are effectively activated and motivated. This is especially true for the uninsured. Other DSRIP projects will offer new care pathways that this project will need to leverage rapidly, especially expanded access to primary care and integrated behavioral health services. Resource sharing, coordination, and expansion of existing programs will be critical to the success of the project.

IT resources will be needed to successfully implement this project. Community partners will require mobile devices to conduct and record PAM responses, as well as connectivity to NQP so that information can be aggregated and analyzed. EMRs will be crucial in the ability to access and share data in order to provide integrated, coordinated care.

The target population is very transient, which will make tracking individuals over the life of the project particularly challenging. Participants of the immigrant Stakeholder forum noted that CBOs have the trust of the UI and immigrant population and suggested that health care organizations trying to engage this population should outreach through the CBO staff that they trust.

Non-English speakers consistently express a preference for communicating with clinical staff in their native language. 69% of Latino respondents to our community survey expressed a preference for communicating about their health care in Spanish. The availability of bilingual staff, particularly clinical, is inadequate. Providers are primarily reliant on telephonic translation services. This is particularly problematic in behavioral health services, where direct communication can be essential to successful treatment. Working to build a culturally diverse workforce is a priority. Access to culturally competent translation services and formalized training in cultural competence that includes dealing with patients whose health beliefs maybe at variance with western medicine is critical. Cultural competency extends beyond traditional cultures and must include special populations such as the homeless and LGBT community and individuals with HIV/AIDS or behavioral health issues,. Developing these competencies is critical in order for NQP to create trusted relationships essential to improved health outcomes.

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.

In Nassau, NQP does not overlap with any other PPS, although patients are free to receive care across the PPS's geographic boundaries and many do. To the east is Suffolk PPS which has no overlap with NQP. Overlap will exist in Queens, particularly in eastern Queens. Advocate Community Partners (ACP) has included eastern Queens in its service area; however, it has not included the Rockaway Peninsula in its 10 projects. The New York Hospital of Queens (NYHQ) and Health & Hospitals Corporation (HHC) have been awarded Planning Design Grants and NQP believes each is pursuing becoming a PPS serving Queens and possibly other counties. HHC will be pursuing project 2.d.i.; as a result ACP and NYHQ are not eligible for the project.

This project in particular calls for coordination across PPSs as it is a community-wide outreach program. NQP will coordinate care practices and results with HHC by meeting with them regularly. This may include the sharing of information electronically on patients who utilize providers in multiple PPSs.

Overlapping PPS' are less of a concern for this project, given that patient activation, regardless of its source, will be expected to drive access to high quality care.

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

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital needs include software, tablets or laptops, and mobile vans. Resource needs include project staff able to direct the initiative, PAM Trainers able to conduct Train the Trainer dissemination, Health Navigators (bilingual and bi-cultural), CDSM community leadership training honorariums, materials and CDSM participant materials. Other expenses include community-based outreach and engagement, IT analytics, tablets for field based work, and the PAM license ($7500 for up to 2,000 individuals/per 12 months).

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	Descript ion of Initiatives
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollee s with Chronic Conditions	9/1 /12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital.

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.

As indicated above, multiple entities are conducting health outreach to engage the uninsured and low utilizers in care. Scalable initiatives include the NUMC/NuHealth Health Leads initiative, the Rockaway Wellness Project (RWP), NUMC's diabetes self-management and diabetes club, LIJ and VNS's use of CDSM and leadership training, Pilgrim Psychiatrics' Wellness Self-Management program, and Planned Parenthood's Health Literacy training. Member outreach services conducted by the MCOs and Health Home outreach are also existing initiatives with goals congruent to those of this project. Continual engagement of additional CBOs who provide immigrant advocacy, entitlement enrollments and basic need services to specific ethnic and multi-cultural populations is important. What sets this project apart from other initiatives is working with community-based partners and utilizing PAM as a health surveillance tool, with the overarching goals of expanding access to care for the UI, LU, and NU; improving their connectivity to primary care; and engaging them in their own wellness initiatives.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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.

Queens and Nassau Counties have 54,200 individuals with serious mental illness (SMI) and 74,245 with serious persistent mental illness (SPMI). 82% are under age 65. The Office of Mental Health (OMH) estimates 46,634 children aged 9 to 17 have serious emotional disturbance. OMH reports that 16,848 individuals have used public mental health services in Nassau, representing about 10% of the SMI population. The comparable state figure is 14.2%: individuals in the NQP service area are receiving services at lower rates. Mental illness is the second most common chronic condition for Medicaid beneficiaries in the NQP service area. The integration of primary care (PC) and behavioral health (BH) services becomes a top priority. An attention to BH needs will be interwoven through all selected projects. It touches many Medicaid patients and is a risk for poor health outcomes/greater service utilization.

Co-occurring medical/BH conditions are common in the Medicaid population. Diabetes patients have double the risk of co-morbid depression compared to non-diabetic controls. Individuals with SMI are more likely to have unmanaged health conditions, and suffer high rates of avoidable mortality. Medications used to manage mental illness increase the risk of metabolic and cardiac

complications, and require monitoring, increasing the need for project interface most notably 3.b.i and 3.c.i.

A focus has already been placed on PC/BH integration along SAMHSA-HRSA framework, including universal screening tools; co-location; health homes; and system-wide integration. NQP proposes to implement two projects: co-locate behavioral health services in PCMH sites, and co-locate PC services in BH programs. A number of existing BH entities have already introduced PC. The scope of this service can be expanded to accommodate more hours/engage medical practice support staff.

A multi-disciplinary leadership team (physicians, psychologist, therapists, nurse practitioners in primary health and psychiatry, social workers, care managers (RN), LPN, health navigators/peer educators/community workers and medical assistants) will identify and facilitate a training curriculum of evidence-based standards of care(disease management and medication management protocols and care engagement processes). The goal is to provide a holistic, physician-directed approach to ensure coordination between PC and BH.

NQP proposes to support 100% of safety net PC sites in achieving NCQA's PCMH Level 3 or Advanced PC Model standards by the conclusion of DY3. The standards require that practices have a process for informing patients/families about team-based care coordination, continuity of care, and access to evidence-based care including BH services. The practice must screen patients for BH, and inform them how their BH needs will be met. Linguistic and cultural needs must also be assessed. The PCMHs will conduct PHQ-2 patients and, if positive, a PHQ-9, referring the patient to BH. The PCMHs will conduct PHQ-2 screenings and, if positive, a PHQ-9.

NQP proposes to improve the quality of physical health care received by people with SMI and substance use disorders by embedding PC clinicians and care managers in BH clinics.

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 PCMH project targets Medicaid beneficiaries in Nassau and Eastern Queens with mild to moderate and/or sub-diagnostic behavioral health disorders. The particular sub-diagnostic behavioral health disorders could include medical non-compliance, maladjustment to medical condition, blues and seasonal affective disorder and those with scores of <10 on the PHQ-9 (sub-diagnostic depression) and substance use disorders of abuse rather than dependence. The project embedding PC in BH locations is targeted at people with SPMI, including Axis I and II diagnoses, and chronic substance use disorders. OMH cites an HHS report that found that 5.4% of the population experiences serious mental illness. LIFQHC conducted a one-month study, running a PHQ-4 screening on all patients receiving primary care with no known behavioral health diagnoses; 27% had a score that would warrant a referral for further evaluation for anxiety and/or depression.

This highlights a significant need for these services, as well as the likelihood that substantial unmet need will be uncovered as a result of interfacing behavioral health and primary care services. The interface between primary care and behavioral health care is also particularly important due to the link between medications used to manage mental illness and an increased risk of various metabolic and cardiac complications, and concomitant side effects that will require monitoring. This issue will also create a need to interface with projects 3.b.i (Cardiovascular Disease) and 3.c.i. (Diabetes).

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.

Fortunately, NQP has many resources to leverage. There are multiple examples of co-located primary care services in BH settings and BH services at primary care sites. NuHealth/LIFQHC has already attained PCMH level 3 for 2011 standards, and has integrated BH care at some of their sites, where social workers and psychologists are assessing patients whose initial PHQ-9 screen is positive, and referring the patient to a psychiatrist from NUMC/NuHealth to provide further care where appropriate. The Mental Health Association of Nassau County has an embedded PCP in its MH program, provided by Nassau Medical Associates, a NUMC/NuHealth affiliate. NUMC/NuHealth's outpatient psychiatry department offers patients primary care during BH visits. The co-located PCP also follows through with preventive screenings and vaccinations.

Mercy Medical Center and Central Nassau Guidance Center's BH programs are recipients of an OMH PC-BH integration grant, and participants in the National Council's Learning Collaborative and are already embedding PC services into BH settings.

Winthrop has attained PCMH level 3 in its pediatric practice located in Hempstead and plans to co-locate behavioral health through the recruitment of a psychiatrist-led mental health team to include nurse practitioners in psychiatry, psychologists, licensed mental health counselors, clinical social workers, case managers, nurses, and medical assistants.

Likewise, LIJ's BH service line has begun embedding non-MD BH extenders (social workers, psychologists) into PC practices with an integration model comprised of the following sequential and interactive elements: universal brief screen for behavioral health disorders (e.g., PHQ-2); if positive, more robust screen (e.g., PHQ-9); if also positive, extender-facilitated diagnosis and treatment by the PCP employing evidence-based psychopharmacological guidelines and extender-provided brief (2-4 sessions) counseling/psychotherapy and – where indicated – referral for longer-term psychotherapeutic services. PCPs may access curbside consultation with a psychiatrist "buddy" via email or telephone on an as-needed basis. This enables PCPs to cost-effectively manage mild to moderate mental illnesses within their practice, with a psychiatrist to serve as back-up. NQP will investigate replicating this model in practices in the other hubs of the PPS.

In 2012, OMH launched the first BH-focused readmission quality collaborative in the country with 45 participating hospitals. The document "Reducing BH Readmissions: Strategies and Lessons

Learned" includes resources, recommendations and strategies to reduce readmissions, including a recommendation that discharge plans include both necessary medical and BH care follow-up. The document recommended strategies, it was not regulatory. The key element was initiation and continuity of medical care follow up when psychiatric patients are discharged to their community mental health clinics. This document will inform the collaborative care efforts of NQP.

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.

- Capital investments are needed for appropriate medical facilities in BH sites.

- Psychiatrists willing to serve the Medicaid population. Financial incentives might motivate more providers. Other mitigation strategies include building a psychiatric residency program and developing partnerships with local medical schools.

- Many PCPs are resistant to addressing their patients' BH issues: NQP will improve the training of medical residents and offer continuing education to PCPs. Similar cross training of psychiatrist residents will be offered to help psychiatrists manage some primary care issues.

- Cultural competency and language barriers: Lack of bilingual providers in BH was cited by stakeholders as a significant access barrier. Providers will be trained, and use peer counselors and language interpreters used to improve communication with patients.

- Stigma: Both Nassau and NYC have anti-stigma campaigns that can be leveraged and expanded to inform patients about the commonplace nature of BH issues.

- Patient compliance with treatment plans: Care managers will be critical to ensure follow up, referral coordination, and patient retention. Staff will be retrained and redeployed, and new hires will be brought on as needed.

- Lack of communication between BH and PC providers: NQP will offer dedicated case conferencing around medication management and care coordination.

- Billing and operations issues: Scheduling PC and psychiatry visits on the same day is more convenient for patients, but is not permitted by most payors.

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.

In Nassau, NQP does not overlap with any other PPS, although patients are free to receive care across the PPS's geographic boundaries and many do. To the east is Suffolk PPS which has no overlap with NQP. Overlap will exist in Queens, particularly in eastern Queens. Advocate Community Partners (ACP) has included eastern Queens in its service area; however, it has not included the Rockaway Peninsula in its 10 projects. The New York Hospital of Queens (NYHQ) and Health & Hospitals Corporation (HHC) are serving Queens and other counties. Due to their geographic location and proximity, particularly eastern Queens, it is possible that there may be overlap. Mt. Sinai, NYHQ, Maimonides and HHC appear to have chosen this project.

LIJ is a member of NSLIJ which is a member of the ACP and in the first year has 25% of the votes on ACP Board of Directors and in the remaining years of the DSRIP program will have 50% of the votes on the Board of Directors. Leveraging the LIJ role in the Nassau Queens PPS, LIJ will be able to to rapidly communicate and share information and best practices or problems being encountered with the other PPS as they arise.

In moving toward better integration of physical and behavioral health, NQP partners will coordinate efforts for patients with BH conditions across the care continuum. This will be accomplished in part through linking all partners to the RHIO allowing for sharing patient information. Other PPSs will also be utilizing the RHIO. This common HIT platform will become a vehicle for the PPSs to understand the patients' clinical history and care plans, and utilization of crisis services. The project team will develop MOUs with the PPSs with whom our geography overlaps that are also implementing project 3.a.i to facilitate communication.

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.

This project will require capital funding. In order to successfully integrate BH care into PC and medical care into BH programs, facility enhancements and changes will be needed both in the physical space allotted for Behavioral Health programming and in Primary Care clinics.

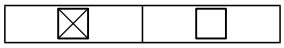
In PC clinics, therapeutically appropriate space for BH professionals and care managers will need to be made available. Culturally competent clinicians, whether psychiatrists, social workers, psychologists or care managers, as well as paraprofessionals, will need private spaces in which to meet with patients. In addition to the general physical plant and IT needs that are consistent with the general clinical space requirements, the physical space of these clinical treatment rooms must be warm, comfortable, welcoming for families and children, and therapeutically designed.

The capital needed to appropriately embed PC in BH programs is more significant because less of the necessary infrastructure is already in place. It is anticipated that the cost for medical equipment and supplies for each exam room will be more than $5,000. Beyond physical space for private visits, significant equipment is needed in order to establish meaningful PC services. Exam tables, EKG machines, blood pressure cuffs, phlebotomy equipment and oto/ophthalmoscopes, secure medical supply storage units are all needed. In addition, few BH treatment rooms have the plumbing needed for hand washing sinks, sharps disposal and other sanitation needs that are required for PC office space. All of these capital and equipment needs have to be addressed in order to implement this portion of the proposed project.

Until an IT/EHR system and the associated infrastructure is developed that facilitates the appropriate sharing of data across all of the clinicians in NQP, it will be it challenging to fully and successfully implement this project. In the interim, practices will have to agree to share clinical date via fax or mail to affiliated medical facilities in order to facilitate data sharing between collaborating providers. By creating an accurate participating providers contact list for all sites as well as the clinical and behavioral services they provide can act as a reference for getting the right data to the right provider in a timely fashion.

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
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollees with Chronic Conditions	9/1 /12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital.

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

This project will place a greater emphasis on the integration of primary care and behavioral health services than has been in the projects listed above.

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

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

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

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

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

3.a.ii Behavioral Health Community Crisis Stabilization Services

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

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

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

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

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

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

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

In the Nassau-Queens PPS (NQP) service area 20.5% of Medicaid readmissions, and 9.6% of avoidable ED visits, have a mental health or substance abuse primary diagnosis. Many people who show up in the ED do not require an admission, but have no alternative. Residential and respite programs are alternatives that, if expanded, could provide assessment and treatment for Medicaid recipients experiencing an acute behavioral health (BH) crisis. Transportation barriers and homelessness further contribute to reliance on the ED. Stakeholder forum participants in Nassau cited a need for alternatives to ED visits and inpatient hospitalization for individuals in a BH crisis.

Other system inadequacies persist:
- The child mobile crisis unit in Nassau is unavailable weekends; the adult mobile crisis unit is open 10:00 am– 8:30 pm but wait times are 24-48 hours. Timely intervention can prevent exacerbation of problems, inappropriate ED use, and in extreme cases, death.
- Nassau provides a BH helpline 24/7, but it is not staffed by clinicians, and does not have bilingual staff (a translation service is used).
- A number of BH agencies have closed (see Assets and Resources), merged, cut back hours of service or maintain waiting lists according to focus group participants.
- First responders and law enforcement officers lack sufficient training to divert individuals in a BH crisis from the ED; uniform standards of evaluation are also lacking.
- Patients in crisis entering an ED on evenings or weekends are often admitted to locked inpatient psychiatric units, in the absence of alternatives.
- Peer support staff may be cost-effective resources for enhancing access to care, but they are not widely available.

Our proposed enhancements include:
- Improving crisis hotline services with paramedic dispatch/enhanced crisis-management capabilities.
- Enhancing mobile crisis team (MCT) services to offer 24/7rapid-response coverage and follow-up visits, and adding a nurse, paramedic and/or a prescriber to the MCT.
- Creating a rapid-response team to serve high ED utilizers in high-density communities to help residents better manage BH exacerbations rather than transferring them to the nearest ED.
- Developing urgent-care BH walk-in clinics and enhancing capacity in existing clinics to provide immediate outpatient treatment on an extended-hours basis.

- Developing or expanding peer-supported, BH crisis respite housing.
- Developing crisis stabilization units, staffed by licensed BH clinicians.
- Expanding telepsychiatry to support availability of licensed BH practitioners.
-Creating observation beds within EDs to allow intensive management of BH emergencies without an inpatient admission.
- Increasing outreach and education to providers, schools, first responders and others who refer to the ED, including local law enforcement officers—who often have first contact with individuals in a BH crisis—about how and when to refer them to the new/expanded services we develop.

NQP will establish a project committee to develop evidenced-based assessments, disposition protocols, and Memorandums of Understanding between providers and partners participating in the project.

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

This project will target all Medicaid beneficiaries, from pre-adolescent to geriatric, who have a mental health (e.g., depression, bipolar disorder, psychosis) and/or substance use disorders and experience a BH crisis, such as suicidality, psychosis, agitation, interpersonal conflict, or due to caregiver burnout.

We will provide services that are racially, ethnically, culturally and linguistically sensitive and appropriate to all subpopulations. Services will also be tailored to outreach to and address the specific needs of the following populations at risk, who are often challenging to reach, including: homeless youth, LGBTQ, and frail elderly, and other low-income populations who may be vulnerable to crisis due to unstable housing, few social supports or illness that impairs problem-solving and impulse control.

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.

NQP has a large number of assets and resources that can be mobilized toward achieving DSRIP goals. These include community-based organizations, health homes, residential providers, mobile crisis teams, hospitals, peer-run services and an array of community support services. However, existing services are limited, and have become more so with closures in recent years, including: continuing day or child day treatment centers (5), psychiatric inpatient units (3) and mental health clinics (4). Existing services are not centrally coordinated, difficult to access when a crisis is occurring, and they are generally not staffed by clinicians.

24 hour, 7 days a week Telephone Triage Center:

- Nassau County operates a crisis-line, 227-TALK (8255), which serves individuals experiencing a BH crisis or urgent care need, countywide 24/7. Additional BH providers are needed to expand service capacity.
- LIJ operates a 24/7 call center staffed by RNs, EMTs and paramedics capable of call intake, care navigation and nurse advice, via a system called ECNS (Emergency Communications Nurse System). Call center currently does not serve BH patients but the existing infrastructure can be used to add BH providers and provide BH training to existing staff.

Rapid Response Mobile Crisis Team:
- Pilgrim Psychiatric Center and South Shore Child Guidance Center operate a Mobile Crisis Team in Nassau County, from 10 am to 11 pm, seven days per week, overseen by the Nassau County Dept. of Mental Health, Chemical Dependency and Developmental Disabilities Services. We will leverage this existing resource to enhance the availability of mobile crisis teams.
- Transitional Services for New York is a community behavioral health residence program. This program will add two 2-person de-escalation teams to serve the more than 500 housing units on and near the grounds of Creedmoor, to help manage the interpersonal/ behavioral health crises of high-utilizers of ED and inpatient services.
- LIJ and its affiliated 24/7 Community Paramedic is a professional trained in care navigation and treatment of mental health situations to respond on demand. Services include clinical assessment, on-hand formulary, care navigation and telemedicine for face-to face interactions with psychiatrists. We will use this existing infrastructure to develop a rapid response mobile crisis team.

Extended Hours Walk-In Crisis Clinics:
- The Charles Evans Health Center provides health services, including mental health services, to any community resident from Nassau, Suffolk and Queens Counties. The Center serves a predominantly developmentally disabled population. This facility is available to add an extended-hours walk-in crisis clinic.
- COPAY, Inc.is a chemical dependency outpatient center located in Great Neck that serves individuals ages 12 and older and is fully bilingual (English and Spanish). COPAY treats clients with chemical dependency, co-occurring mental health problems, and relationship/marital problems. Hours of operation are 9 am to 9 pm. This facility is available to add an extended-hours walk-in crisis clinic.

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 NQP's biggest challenges identified and proposed solutions:
- Funding: Existing services are underfunded. Some newly proposed services are not presently reimbursed. DSRIP funds will be used to establish and sustain the project in the short term. Longer term, we will contract with payers to sustain future access to services.
- Physical Plant: Space is needed to support crisis respite and expand access to urgent care/walk-in clinics outside an ED. Repurposing existing assets is an option (see Resource Needs).

- Staffing: Recruiting and training staff for challenging work during less-than-desirable hours is difficult. Options include pay incentives, leveraging existing 24/7 infrastructure of LIJ EMS services/staff, and telepsychiatry so that a physician can work a shift from a "hub" to provide services to a call center, mobile crisis team, and walk-in clinic.
- Transportation: Clients in a BH crisis often lack transportation. Mobile crisis teams, with non-medically supervised transportation, a call center and telepsychiatry will lessen barriers.
- IT coordination: Implementing a fully integrated system to support scheduling, dispatching, logging, tracking, patient records, etc., is complex. We will adopt interim solutions (e.g., use of secure email and secure messaging) as a bridge to having a fully integrated system.
- Homelessness: If a crisis respite program has a 7-day limit, it is unable to accept homeless patients since this timeframe is insufficient to arrange for longer-term housing. An extension, for example to 21 days, is needed to better serve homeless patients.

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

In Nassau, NQP does not overlap with any other PPS, although patients are free to receive care across the PPS's geographic boundaries and many do. Overlap will occur in Queens. Advocate Community Partners (ACP) has included eastern Queens in its service area; however, it has not included the Rockaway Peninsula. NY Hospital Queens and Health & Hospitals Corporation PPSs also serve Queens. Due to their geographic proximity, particularly eastern Queens, it is possible that overlap will occur.

LIJ is a member of NSLIJ which is a member of the ACP Board of Directors. Leveraging the LIJ role in the NQP and in the ACP PPS, LIJ will be able to rapidly communicate and share information and best practices or problems being encountered with the other PPS as they arise. ACP plans to pursue project 3.a.ii.

In expanding the availability of crisis stabilization services, NQP partners will coordinate efforts for patients with BH conditions across the care continuum. This will be accomplished in part through linking all partners to the RHIO thereby sharing patient information as appropriate. Other PPSs will also be utilizing the RHIO. This common HIT platform will become a vehicle for the PPSs to understand the patients' clinical history and care plans, and utilization of crisis services. The project team will develop MOUs with any other PPS with whom our geography overlaps that is also implementing project 3.a.ii to facilitate communication. It does not appear that any other PPS in our area is undertaking 3.a.ii.

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.

Call Center: Computer hardware and software and expansion of existing space to accommodate call center expanded coverage to NQP's providers' patients.

Mobile Crisis: Vehicles, computer hardware and software, and office space to expand the currently fragmented crisis response system.

Crisis Stabilization Unit/ Urgent Care/Walk-in Centers/ED Observation Beds/Community Crisis Respite: Construction and building resources, as well as computer hardware and software, are needed to repurpose existing building spaces to accommodate the expansion of services that will keep behavioral health patients in crisis out of the ED and out of inpatient units, as well as improve safety. For example, space from Zucker Hillside Psychiatric Hospital can be repurposed for a walk-in clinic and crisis stabilization unit. Transitional Services for New York, Inc. has beds on the grounds of Creedmoor Psychiatric Center that can be repurposed for respite housing. Additionally, Project REAL (Residential Experience in Adult Living) has a building which can be repurposed for a walk-in clinic.

Telepsychiatry: Computer hardware and software to expand the capability to locations where it currently does not exist.

IT: EHR software, hardware and interface development—to connect all entities who serve behavioral health patients in crisis, including hospitals, clinics, mobile crisis teams, call centers, law enforcement, residences, first responders; and implementation, training and maintenance costs to insure that there care is coordinated, non-duplicative and addresses the complicated needs of behavioral health patients experiencing crisis.

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
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollees with Chronic Conditions	9/1/12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital

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

This project will place a greater emphasis on crisis stabilization services than has been in the projects listed above.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

Improve Medication Adherence:

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

Actions to Optimize Patient Reminders and Supports:

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

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

1. 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.

NQP will undertake evidence-based strategies to address cardiovascular disease which is a significant problem in our service area. While avoidable hospitalization rates for all circulatory conditions are below the state rates, selected communities with concentrations of Medicaid beneficiaries/minorities exhibit higher rates, including Jamaica, Far Rockaway, Long Beach, Freeport, Roosevelt and Hempstead. Nassau's Medicaid avoidable hospitalization rate for adult hypertension is 121/100,000 recipients compared to the NYS rate of 104. The highest rates are seen in the communities mentioned above. The Rockaways have one of the highest hypertension rates in Queens. In Queens, Medicaid rates of avoidable hospitalizations for adult angina are above the state average. Lifestyle factors, nutrition, physical activity and smoking impact management of hypertension. In Nassau, 28% of the population consumes the recommended amount of fruits and vegetables, compared to 10% in Queens. One in 4 residents in Nassau and Queens are inactive. Finally, smoking rates are significantly higher for people with low SES (28%), behavioral health conditions (33%) and substance abuse conditions (63%) compared to the general population. The stakeholders' forums identified a lack of culturally competent care coordination, evidence-based chronic disease treatment protocols and self-management

programs. These findings demonstrate opportunities to redesign the care for cardiac patients so that they receive appropriate care.

Patients will be managed with evidence-based care. Over 1,000,000 NYS Medicaid beneficiaries are unconnected to care. This project will link all patients to a PCMH or primary care physician, if they don't have one. All cardiac patients will be enrolled in patient registries. In order to appropriately target care management services, risk stratification software will be employed to categorize patients. Health homes will be linked with this project to prevent duplication of care coordination efforts. Care management teams, (nurses, psychologists, community health workers, social workers, and pharmacists), will follow high risk patients closely. Highest risk patients will be managed with intensive care in their home or in a nursing home. All patients will be managed in systems linked via the local RHIO. A uniform Electronic Health Record with prompts for screening, identification and treatment of tobacco use, and system-wide provider training on how to use the evidence-based "5 A's of Smoking Cessation" (Ask, Assess, Advise, Assist, and Arrange) will be developed. Strategies from the Million Hearts campaign will be integrated into primary care. NQP will create a centralized approach to evidence-based prevention, treatment and management of patients with chronic illnesses, particularly those with cardiovascular disease, diabetes and behavioral health diagnoses.

NQP will undertake access improvement initiatives (a centralized telephone number that allows patients to get linked with medical care navigation and other services in the PPS to avoid unnecessary ED utilization).

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.

Any patient with a cardiovascular diagnosis should be known to the delivery system, with a documented self-management program in their medical record. Stratifying by risk allows interventions and care management resources to be appropriately targeted. Risk-stratification is fluid as members move across categories based on condition, events and/or utilization.

1. Patients with early cardiovascular disease, such as those with hypertension without any complications – intervention will fill gaps in care for preventive services and chronic disease management.
2. Patients with moderate cardiovascular disease, such as those with hypertension and a history of a myocardial infarction – intervention will fill gaps in preventive care, proactively get chronic physical/behavioral health (BH) issues under control by facilitating access to the appropriate medical and/or BH providers, and provide referrals for social issues that may be impacting medical and/or BH conditions.
3.Patients with multiple chronic illnesses including moderate to severe cardiovascular disease, such as those with hypertension, congestive heart failure and diabetes – intervention will develop individual care plan that comprehensively addresses physical, behavioral, cognitive and psycho-social issues.

Patients will be treated in community-based settings instead of the Emergency Department or urgent care settings. The adoption of PCMH in practices will be important, as will electronic linkages among providers. The geographic "hot spots" with large numbers of minorities and Medicaid recipients (above) will be targeted.

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.

NQP partners have assets that will help facilitate this project: Inpatient services, access to PCMHs, connectivity, registries, care management, patient education programs, and experience with risk based payment.

-CHS's St. Francis Hospital, one of the nation's leading cardiac care programs, is NYS's only specialty designated cardiac center. It also offers a Community Health and Education program and the largest Cardiac Fitness and Rehabilitation program on LI, based at the DeMatteis Center for Cardiac Research and Education.

-NuHealth has a "transitions of care" program with a team of coaches, nurses and social workers who follow patients in the community, utilizing Health Leads to link patients with community based organizations.

-NuHealth, in collaboration with LIJ and its affiliates, under a Patient-Centered Outcomes Research Institute grant, uses telehealth programs for self-management of patients with heart failure remotely monitoring vital signs in patient's homes following discharge.

-NuHealth has a comprehensive quality assurance program in the Dept. of Cardiology that analyzes patients admitted for CHF and MI and assesses risk factors for readmission. An educational program of heart failure teaching by an RN/NP occurs upon admission. This program won an award from the American Heart Association.

-Outpatient EHR at LIJ and LIFQHC have disease registry components that could be expanded to other participating provider sites. Some practices have embedded care managers, community based health workers or coaches who ensure compliance with medication and other treatment plans. Many of these workers are culturally competent, reflecting the target population in the community.

-LIJ has a Department of Health Literacy with a strong focus on cultural competency.

-LIJ has processes in place to enroll patients with severe cardiovascular disease into high intensity home based programs, such as home based primary care, intensive home care, and hospice. Other assets include telemedicine, community paramedicine, and biometric patient monitoring.

-LIJ has a cloud-based care management platform (Care Tool), claims-based risk stratification software (Optum), health information exchange with event notification (Intersystems), and will soon have a predictive analytics engine (Explorys). These investments will allow for efficient identification and management of high risk patients.

-LIJ's affiliated Center for Tobacco Control is a leader in tobacco-dependence treatment, and will serve as a resource, educating providers about evidence-based treatment of tobacco dependence.

-All hospitals in NQP have chronic disease health screenings, wellness and self-management programs. LIJ has a health professional and community member leadership training center for the Stanford Chronic Disease Self-Management Program.

-Walgreens does blood pressure screening and medication therapy management. If a patient has not been filling medication on a timely basis, a flag is raised for consultation with a pharmacist related to medication adherence.

All of these services may be scaled up to manage larger populations by adding resources and further coordinating efforts.

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.

Integrating EHRs is a challenge. A majority of providers in the PPS are not connected. NQP will assess connectivity as part of implementation, and connect providers to cloud-based, secure applications, including the RHIO.

Getting physician appointments within 7 days from discharge can be problematic, but as practices adopt PCMH, open access scheduling will ensure high risk patients get timely care and avoid trips to the ED. Prior to PCMH adoption, walk-in protocols for high risk patients will be implemented.

Often inpatient medications are different than outpatient formularies. Partners will receive Medicaid and low cost formularies from major pharmacies to make certain affordable medications are available and will review opportunities to enroll patients in drug assistance programs.

Family/social issues, as well as health literacy, can make following treatment protocols difficult. NQP will provide culturally competent health coaches and community health workers to address this. NQP will standardize an assessment to identify patient needs, challenges, and self-sufficiency.

Pharmacists will require regulatory relief to bill for MTM services and reconciliation counseling.

As with many other projects there are too few care managers in outpatient/community settings for the proposed model. NQP is committed to training and redeploying staff to identify at-risk cardiac patients to ensure they are receiving proper preventative and follow up care as identified by practitioners and the patients' self management 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.

In Nassau, NQP does not overlap with any other PPS. Advocate Community Partners (ACP) has included eastern Queens in its service area; however, it has not included the Rockaway Peninsula. NY Hospital Queens and NYC HHC PPSs also serve Queens.

LIJ is a member of NSLIJ which is a member of the ACP Board of Directors. Leveraging the LIJ role in the NQP and in the ACP PPS, LIJ will be able to communicate rapidly, and share information and best practices with the other PPS.

For this project, NQP partners will coordinate efforts for patients' cardiovascular disease across levels of care, in part by linking all partners to the RHIO. Other PPSs will also be utilizing the RHIO. This common health information technology platform will become a vehicle for the PPSs to effectively share patients and understand the patients' clinical history and care plans. Regular meetings can also be held to discuss the shared difficulties in implementation and how to better garner the shared resources to meet the community's needs and the objectives of the DSRIP program shared projects.

We will take a population-based approach to cardiovascular care and reach out to individuals who may be at risk for cardiovascular disease and, in particular, those who are already ill. These efforts will be coordinated with other PPSs. Every PPS in the region appears to be undertaking this initiative, so we will be certain to coordinate our efforts – regular meetings, using the RHIO for data exchange, coordinating public health efforts.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital funding is necessary for this project for the following items:

- Information Technology for interoperability among providers and for patient registries to manage patients.

- Remote monitoring devices for patients such as blood pressure monitors, scales, in-home blood draws, etc.

- Telehealth equipment, including monitors, cameras and secure network hardware and software to enable specialists to assist primary care providers in managing patients.

- Costs for PCMH Initiative – assuring that all safety net providers achieve PCMH. Costs associated with education of PCMH staff (care managers, navigators and physicians) so they can develop the skills to assist those at high-risk to meet diabetes-related outcomes and metrics.

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
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollees with Chronic Conditions	9/1/12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital

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

These initiatives differ from this DSRIP initiative because they are for distinct services and populations, not the entire Medicaid and uninsured population. These initiatives do not involve the entire delivery system in accomplishing their goals either – they are largely about care management. They require managing the care of subpopulations, particularly those with chronic illnesses to improve outcomes and reduce costs. These initial population health programs, however, have given members of the PPS substantial experience in managing high risk patients. The infrastructure underlying these program and the expertise gained will serve as the foundational building blocks for the PPS. These programs will accelerate the success of the PPS. They are good opportunities to learn from and to guide the development of the IDS.

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.c.i Evidence based strategies for disease management in high risk/affected populations. (Adult only)

Project Objective: Support implementation of evidence-based best practices for disease management in medical practice related to diabetes.

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 diabetes. Specifically, this includes improving practitioner population management, increasing patient self-efficacy and confidence in self-management, and implementing diabetes management evidence based guidelines.

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 best practices for disease management, specific to diabetes, in community and ambulatory care settings.
2. Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.
3. Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.
4. Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.
5. Ensure coordination with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other technical platforms to track all patients engaged in this project.
7. Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3 for EHR systems used by participating safety net providers.

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

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

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

The rate of diabetes in the Nassau County is 5.9%, below the prevalence for NYS of 10.4%, but above the NYS Prevalence Agenda Objective of 5.7%; in Queens, the prevalence rate is 11%, above both NYS and NYSPAO. Diabetes prevalence is higher among the Medicaid population, at 9% of Nassau beneficiaries and 12% of Queens'. Medicaid avoidable hospitalization for adult uncontrolled diabetes in Nassau, at 63 admissions per 100,000, is above the state average of 46 per 100,000. The Queens rate of 36/100,000 belies rates of illness in specific areas. The communities of Bellerose, Freeport, Glen Cove, Jamaica, Far Rockaway and Westbury are "hot spots" for adult diabetes. The rates of avoidable hospitalizations for adult diabetes short term complications follows a similar pattern with areas in eastern Queens exhibiting high rates compared to the rest of the county. Nine low-income communities identified by Nassau County as high-risk for health disparities evidence twice the hospitalization rate for type 2 diabetes when compared with the rest of the county. Lifestyle factors, nutrition and physical activity, impact diabetes management. In Nassau County, 28% of the population gets the recommended amount of fruits and vegetables, compared to 10% in Queens. 1 in 4 Nassau and Queens residents are inactive. Stakeholders identified a lack of culturally sensitive effective care coordination, evidence-based chronic disease treatment protocols and self-management programs.

These findings demonstrate opportunities to redesign the care of diabetic patients so that they receive appropriate care at the right time and in the right setting.

NQP partners will manage diabetes patients through the use of evidence-based care, with the goal of reducing avoidable hospitalizations. Patients will be risk stratified, preferably using uniform care management software among clinical partners to categorize patients by risk level. Patients will receive customized levels of care management based upon their risk level once protocols are established for the initiative. Care coordination teams including diabetes educators, nursing staff, behavioral health providers, pharmacists, community health workers, and home healthcare managers will follow high risk patients closely with higher intensity engagement for patients with more advanced disease. Those teams will work to address health literacy, and support patient self-efficacy and patient self-management. NQP will facilitate patients seeing their PCPs, preferably in a PCMH, and enroll them in patient registries. Highest risk patients will be managed with intensive care in home or in nursing homes.

NQP will work with health homes to coordinate care management of the target population. Health homes have multipronged approaches for diabetes and other chronic illnesses; they also have real-time notification and utilize texting with patients to improve diabetes management (remind patients to check their blood sugar and take their medications). NQP will coordinate with managed care plans to move to different payment incentives for caring for this population.

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.

Anyone who received a hemoglobin A1c in the last year, for either diagnosis of or management of diabetes, will be included in this project. This includes both Type 1 and Type 2 diabetes. Individuals with diabetes who become pregnant will have prenatal care coordinated with the on-going management of their diabetes. Providing care to this population could potentially prevent complications at birth for both mother and baby. In addition, any woman with gestational diabetes is at high risk for developing type 2 diabetes, so there is a prevention aspect to this as well with the proper diabetes education implemented during the gestational period. The patient population will be risk-stratified into four categories for management:

1 - Patients at high risk for developing diabetes (i.e. obesity, family history)
2 - Patients with newly diagnosed diabetes
3 - Patients with diabetes with complications
4 - Patients with diabetes and other chronic conditions in an advanced state.

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

The 3 NQP hubs have extensive experience caring for patients with diabetes in both inpatient and outpatient settings. Combining those resources with those in the community into a single coherent strategy for coordinated, evidence-based care will require combining different approaches to care management, staff and public education into one; and disseminating the strategy to many partners in a way that gains cooperation and trust. Coordination between hubs will be facilitated by working on the project committee, a shared IT infrastructure and sharing of patient information as needed. The existing programs below will work together to manage care of the patients. Most programs will be expanded to meet patient demand.

-CHS has outpatient diabetes education centers throughout their 3 hospitals as well as at St. John's. CHS provides pre-diabetes education at all sites through a Diabetes Prevention Program, which uses ADA curriculum. Bishop McHugh Health Center in Hicksville runs a diabetes education program for uninsured individuals. CHS also has an inpatient diabetes champion program which educates nurses to identify, care for and manage patients with diabetes.

-LIJ and its affiliates have diabetes wellness programs in multiple sites across Queens and Nassau that deploy certified diabetes educators for patients with pre-diabetes and diabetes. NSUH operates a Center for Diabetes in Pregnancy.

-NuHealth's Zaki Hossain Center for Hypertension, Diabetes and Vascular Diseases has a multi-disciplinary approach to diabetes and vascular disease. A team manages these diseases, and provides access to other needed medical specialties (e.g., ophthalmology, cardiology, neurology, podiatry, bariatric surgery and wound management).

-LIFQHC sites run diabetes education groups that are multidisciplinary and include a nurse, a nutritionist and a social worker.

-There are number of other diabetes programs in Queens and Nassau including: Loving Care Diabetes Program at Albright Medical Office in St. Albans, East Coast Diabetes Education Program in Valley Stream, ProHEALTH Care Associates in Lake Success, Institute for Urban Family Health/Family Practice Center of New Hyde Park, Winthrop University Hospital Diabetes Education Center, Beacon IPA outpatient diabetes program at 4 locations in Freeport

-Bariatric surgery programs at LIJ, NUMC/ NuHealth and Winthrop can be an important resource for patients who are obese and have diabetes.

-LIJ has processes in place to enroll patients with severe and end stage disease into high intensity home based programs, such as home based primary care, intensive home care, and hospice.

-Advanced diabetes often requires wound care and hyperbaric therapy, available at Franklin Hospital, NUMC/NuHealth, St. Joseph Hospital, Mercy Medical Center and Winthrop University Hospital.

-LIJ has a cloud-based care management platform (Care Tool), claims-based risk stratification software suite (Optum), health information exchange with event notification (Intersystems), and will soon have a predictive analytics engine (Explorys). These investments will allow for a more efficient identification and management of high risk patients.

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.

- Resources in the health care delivery system have not kept up with the pandemic of diabetes, particularly around patient education and support. Winthrop offers a training program for diabetes educators that can be used as a replicable model. LIJ's corporate university and other vendors will help NQP address this training need.

- Home health aides are not permitted to administer insulin. Removing scope of practice limitations for home health aides is regulatory relief that NQP will seek.

- Provider engagement - Aligning incentives through pay-for-performance programs for many providers, who have little experience with P4P, will be a challenge. NQP will have to model the approach and communicate what to expect among the various partners.

- While not considered food deserts, a number of communities have low access to food, as defined by the USDA. The communities of East Meadow, Far Rockaway, Freeport, Glen Cove, Hempstead, Roosevelt, and Westbury have a significant share of residents living more than ½ mile from the nearest supermarket. One strategy for addressing this is to offer on-site education at local supermarkets, providing community members opportunity to receive hands-on education regarding healthy food choices and portion control.

- The lack of a public transportation infrastructure further limits access to food. Addressing county-wide transportation is a necessary strategy.

- Behavior change can be hard. NQP will use culturally appropriate tools to encourage healthier food options among food stores in the community and to label healthier food choices in the store.

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.

In Nassau, NQP does not overlap with other PPSs. Advocate Community Partners (ACP) has eastern Queens in its service area; however, it has not included the Rockaway Peninsula. NY Hospital Queens and NYC HHC, and Mt. Sinai PPSs also serve Queens. Due to their geographic proximity, particularly eastern Queens, overlap will occur. It appears that Mt. Sinai is pursuing this project.

LIJ's affiliate has ACP Board representation. Leveraging the LIJ role in the NQP and in the ACP PPS, LIJ will be able to rapidly communicate and share information and best practices with the NQP. ACP plans to pursue project 3.c.i.

For evidence-based strategies for diabetes, NQP partners will coordinate efforts for patients identified with diabetes across levels of care. All partners will be linked to the RHIO, sharing patient information appropriately. Other PPSs will also be utilizing the RHIO. This common HIT platform will become a vehicle to share patients effectively and understand their clinical history and care plans. Regular meetings can also be held to discuss difficulties in implementation and how to garner the shared resources to meet the community's needs and the objectives of the DSRIP program.

This project, in particular, is a population-based project in that all individuals with diabetes, particularly with multiple chronic conditions, are the target population. As such, it requires cooperation and coordination across geographic boundaries. NQP will meet regularly with the other PPSs pursuing this project and with the health home about diabetes care and education efforts.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Capital budget funding is necessary for this project for the following items:

IT for interoperability among providers and for patient registries to manage patients. Care management software. Software is also needed to capture Diabetes prevention data to send to NYC.

Remote monitoring devices for patients such as glucose monitoring. Telephonic care management is a significant component of both PCMH and care transitions.

Telehealth to enable specialists to assist primary care providers in managing patients. Telehealth is particularly beneficial for homebound individuals.

Costs for PCMH Initiative – assuring that all safety net providers achieve PCMH. Costs associated with education of PCMH staff (care managers, navigators and physicians) so they can develop the skills to assist those at high-risk to meet diabetes-related outcomes and metrics.

Cost for developing patient education materials. There are very limited patient education materials that meet literacy guidelines. There are costs associated with the development or

purchase of plain-language material. In addition, materials must be available in multiple languages.

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
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollees with Chronic Conditions	9/1/12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital

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

existing project.

These initiatives differ from this DSRIP initiative because they are for distinct services and populations, not the entire Medicaid and uninsured population. These initiatives do not involve the entire delivery system in accomplishing their goals either – they are largely about care management. They require managing the care of subpopulations, particularly those with chronic illnesses to improve outcomes and reduce costs. These initial population health programs, however, have given members of the PPS substantial experience in managing high risk patients.
The infrastructure underlying these program and the expertise gained will serve as the foundational building blocks for the PPS. These programs will accelerate the success of the PPS. They are good opportunities to learn from and to guide the development of the IDS.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

Domain 4 Projects

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

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

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

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

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

Partnering with Entities Outside of the PPS for this Project

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

Entity Name
Nassau Coalition for Behavioral Health Providers Nassau Alliance For Addiction Services (NAFAS) Criminal Justice System – Nassau County and the Borough of Queens Nassau County Department of Mental Health Chemical Dependence and Developmental Disability Services New York State Office of Mental Health Long Island Field Office

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.

NYS Office of Mental Health (OMH) estimates there are 154,200 individuals with serious mental illness (SMI) and 74,245 individual with serious and persistent mental illness (SPMI) in Nassau and Queens. OMH reports that 10% of the population with SMI is served by public mental health services. Long Island Federally Qualified Health Center's (LIFQHC) one-month study, using a Public Health Questionnaire-4 screening on patients with no known behavioral health (BH) diagnoses found 27% had a score that warranted referral for evaluation for anxiety and/or depression.

The Community Needs Assessment showed the PPS service area had 25,422 Medicaid beneficiaries who were hospitalized/visited the Emergency Department (ED) for substance abuse (SA) services in 2012, accounting for 47,000 inpatient admissions/54,000 ED visits. This is more than beneficiaries with respiratory illness or diabetes. PQI data showed the highest rates of SA ED visits in the Rockaways.

In stakeholder forums they spoke about many BH gaps in services. Crisis services are not accessible after hours/on weekends, and aren't always linguistically/culturally appropriate (race/ethnicity, faith, LGBTQ, age). Existing respite programs exclude the homeless, making it difficult to find services for high-utilizing patients. No uniform standards exist to evaluate need for admission, or for extended services post-discharge. Under the current system, patients in crisis are brought to the ED after hours, and are often admitted to locked inpatient psychiatric units. This has also been a growing problem for the child/adolescent population. Schools have lowered their thresholds for certain behaviors in the wake of national episodes of violence in schools. Psychiatric EDs have experienced consistent growth in child/adolescent presentations that could be adjudicated at a lower level of care if available. Peer supports/health coaches have demonstrated success in facilitating connection to the delivery system, yet peer services are not widely available, nor generally, reimbursable.

The BH infrastructure needs repair. This project will address the problem. By working on a population-based level and a clinical interaction level, the way BH disorders are understood, identified and treated will be transformed.

The project focus is culturally competent mental, emotional and behavioral (MEB) Health Promotion and Disease Prevention HPDP). The most recent Nassau County Community Health Improvement Plan identified Promote Mental Health and Prevent Substance Abuse as an important prevention agenda. The need for improvement in this area also emerged as a theme throughout the analysis of community response data.

A project committee will be created and representatives from state and local government, community-based organizations (CBO) in the child welfare, corrections, police, fire, juvenile justice, probation, social services, child welfare, education and affordable housing systems and faith-based organizations will be invited to assist with this.

One proposed initiative is the establishment of culturally/linguistically appropriate training in the basics of BH; basic understanding of the diseases, symptoms, warning signs and how to approach someone who may be entering the early stages of a crisis.

The strength of this initiative is the ability to convene partners to evaluate what should be done to strengthen care, so that efforts are coordinated and reflect a common agenda.

- Survey initiatives across the organizations participating to identify duplication for the purposes of better coordination.

- Expand school-based BH services so children have immediate, convenient access to BH services.

- Public awareness campaign to de-stigmatize mental illness and promote MEB.

- Public awareness campaign about the dangers of prescription drugs (particularly opioids) and easy, convenient and safe medication disposal.

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

The HPDP project will focus on all Medicaid beneficiaries and the uninsured of the PPS service area. A special focus will be targeted to children and families who are involved in social safety net services, such as Department of Social Services, housing agencies, Persons in Need of Supervision Courts and Family Courts, who are at greater risk of developing behavioral health problems, such as depression, anxiety, conduct disorders and substance abuse disorders. As a component of this process, Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs have been implemented in EDs in the LIJ and its affiliates, will be expanded to other EDs serving NQP. SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was initiated due to an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

The IMPACT portion of this project will target people with mild to moderate, sub-diagnostic, or undiagnosed behavioral health disorders. As highlighted in the CNA, targeted communities include Jamaica, Richmond Hill and the Rockaway Peninsula.

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

In 2012, OMH launched the first BH-focused readmission quality collaborative in the country. The document "Reducing Behavioral Health Readmissions: Strategies and Lessons Learned" includes resources, recommendations and lessons learned from the collaborative as well as nationally. This document will be used to inform the development/strengthen efforts in the PPS region.

A disproportionately high number of individuals with mental health (MH) and addictions have contact with the criminal justice system. In Nassau County, coordination of care between the criminal justice system and the community healthcare system is improving with recent mandates that require communication about the incarcerated population, resulting in better care coordination.

Health Homes are charged to facilitate an electronic exchange of clinical information, and expand case management to include MH, chemical dependence and physical health. Key informants indicated that this proposed higher level of communication is still required across health and social services, similar to communication requirements to which the criminal justice system is held.

Clinical information is available through the Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES-M). PSYCKES is a HIPAA-compliant, web-based set of tools designed to support quality improvement and clinical decision-making in the State's Medicaid population.

Recovery networks including peer groups are important part of the MH and substance abuse (SA) infrastructure. Currently, there is an informal recovery network with associations and gatherings, e.g., the Long Island Recovery Center and the veteran's community. These networks will be built upon, as it was acknowledged in stakeholder forums that peer services are lacking.

In Queens, this project can help strengthen the local mental hygiene system and can support with the help of an array of community- and hospital-based services, individuals with MH and SA problems; including crisis, stabilization, supportive and prevention.

The current Nassau Community Health Improvement Plan identifies promoting mental health and preventing substance abuse as an important prevention agenda item. The need for improvement in this area emerged as a common theme by the stakeholders. The fact that this has been identified in the Improvement Plan will provide additional collaborators/resources to support the project.

Examples of MEB resources in Nassau and eastern Queens that can assist with this project include:

Strength-Based Parenting/Coaching Supports
- Early Childhood Home Visiting programs, e.g., Nurse-Family Partnership; Healthy Start
- Circle of Security–parent-child interactions and secure attachment
- Positive Parenting Program–prevention and treatment model through parenting support in home environment

- Strengthening Families–parenting skills training reduces risk of emotional, behavioral, and academic problems and substance useSchool-based MEB wellness promotion
- Parent Corps–family-centered intervention in early care and education settings to promote healthy early childhood development
- The Incredible Years–3 complementary training programs for children, parents, and teachers
- Life Skills Training–to prevent alcohol, marijuana, and tobacco use, and violence in school setting.
- Strengthening Families–youth development and substance use prevention

These assets make it possible to implement the IMPACT collaborative care model in about a year. Likewise, the availability of FIT (Focus on Integrated Treatment) training will facilitate rapid training of clinicians, staff and administrators throughout NQP.

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

The largest anticipated challenges to the implementation of the IMPACT model in primary care practices are financial, training and regulatory. The cost of care managers and consulting psychiatrists is considerable. We anticipate utilizing telepsychiatry to expand consulting psychiatrist capacity and reduce associated costs, although the availability and efficacy of telepsychiatry will be limited until reimbursement and licensing issues are resolved. Telepsychiatry should be reimbursable across location, not just one state licensed environment to another, and include multiple services/providers such as non-prescribers. Currently, various managed care plans including Medicaid/Medicare do not reimburse across the board for telemedicine. Regulatory issues that relate to the different oversights for primary care (DOH-Article 28), mental health (OMH-Article 31) and substance abuse (OASAS) need to be addressed. Legislation is pending for multiple licensing with one lead agency on the horizon in early 2015.

We expect to use technologically enhanced care management that utilizes face-to-face interventions supplemented with telephone, SMS and webchat as a means of expanding access and reducing cost. Training primary care doctors, especially pediatricians, how to screen for, identify and talk to patients about BH is consistently a challenge to the implementation of collaborative care. We intend to leverage simple screening tools and projects, like the PHQ-9, the CAGE and SBIRT (in collaboration with the OASAS SBIRT Policy Advisory Group) as well as the FIT training to overcome these barriers. On the regulatory side, we require relief from regulations that make it difficult to consolidate the services currently offered by article 28, 31 and 32 clinics and regulations that make preventive care and collateral visits difficult to bill. We anticipate that relief will be forthcoming.

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.

NQP has no overlap in Nassau or Suffolk. Advocate Community Partners (ACP) has included eastern Queens in its service area, but not Rockaway Peninsula. The New York Hospital of Queens and Health & Hospitals Corporation are PPSs in Queens. Due to their location overlap is possible

if the same projects are chosen (not known presently). Maimonides and NYC HHC plan to pursue this project.

LIJ's affiliate has ACP Board representation. Leveraging the LIJ role in the NQP and in the ACP PPS, LIJ will be able to rapidly communicate and share information and best practices with the NQP ACP does not plan to pursue this project.

For this project NQP has experienced hub members with developed population health models collaborating with PCMH, primary/specialist physicians, BH and SA providers and the health home. These hub members are experienced in value based payment programs. This project will focus on enhancing the BH and SA infrastructure. This is most important in Rockaway Peninsula. Stakeholder forums in the CNA indicated great concern for behavioral health (BH) and substance abuse(SA) problems. Linking partners to the RHIO to share patient information to benefit the patient is a feature of the infrastructure. ACP/other PPSs utilize the RHIO. This common platform that will enable the PPSs to communicate about their patients' clinical needs. The RHIO is the vehicle for PPSs to share patients, understand patients' clinical history, and care plans.

PPSs will share partner organizations, e.g., BH providers and SA agencies that care for Queens communities. If this project is chosen by more than one PPS in the service area, the shared partner may become overwhelmed and confused about the activities of multiple PPSs. PPSs will have to coordinate how to best achieve DSRIP goals to decide which PPS the partner is best suited for. Criteria for choosing which PPS can be based on partner attribution, shared clinical/operational infrastructure, current affiliations, locations, what is the least disruptive and most complimentary to partners' and the patients' interests.

Other collaboration will include quarterly or more frequent meetings, to discuss implementation difficulties and garnering shared resources to meet community need/objectives of DSRIP shared projects.

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

Key milestones and metrics that we will track are:

- The establishment and bi-monthly meeting of the project team – by end of DY1

- The metrics evaluated as part of the Learning Collaboratives – by end of DY1 and monthly thereafter

- 911 calls regarding overdose and the number of saves resulting from those calls – by end of DY1 and quarterly thereafter.

- Practices that have implemented the IMPACT model and number of patients treated – by end of DY2 and monthly thereafter. We will target 10 practices treating 40,000 patients by end of DY2.

- The numbers of front-line workers trained in programs implementing IMPACT – by end of DY1 and quarterly thereafter. We will have 20% of front-line workers trained by end of DY1 and will train an additional 20% per year.

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.

Three major capital funding needs will make it possible for this project to succeed. The first is the construction of school-based behavioral health clinics. These clinics need not be elaborate, but they will require dedicated space in which the staff can have private conversations with children and adolescents in a warm, welcoming, therapeutically appropriate environment. The second is the development of space in the primary care sites that are implementing the IMPACT model. These locations will require the construction of therapeutically appropriate space for behavioral health professionals and care managers. Clinicians will need private spaces in which to meet with patients. In addition to the general physical plant and IT needs that are consistent with any clinical space, these spaces need to be different from traditional clinical treatment rooms in that they are warm, comfortable, welcoming, therapeutically designed spaces, not the cold, sterile, rooms in which most clinic visits occur. The Information Technology/Electronic Health Record system and associated infrastructure needs to be developed to facilitate the appropriate sharing of data across all of the clinicians in the PPS (including those located in schools). The Mental Hygiene law, as well as federal laws on sharing of substance abuse information at the patient level makes information sharing difficult without consent. The Information Technology implementation solution for interoperability will need to address this.

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
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollees with Chronic Conditions	9/1/12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital.

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

These initiatives differ from this DSRIP initiative because they are for distinct services and populations, not the entire Medicaid and uninsured population. These initiatives do not involve the entire delivery system in accomplishing their goals either – they are largely about care management. They require managing the care of subpopulations, particularly those with chronic illnesses to improve outcomes and reduce costs. These initial population health programs, however, have given members of the PPS substantial experience in managing high risk patients. The infrastructure underlying these program and the expertise gained will serve as the foundational building blocks for the PPS. These programs will accelerate the success of the PPS. They are good opportunities to learn from and to guide the development of the IDS.

3. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

4.b.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
NYS Department of Health Bureau of Tobacco Control
NYC Department of Health and Mental Hygiene
American Lung Association
American Cancer Society
American Heart Association
Tobacco Action Coalition of Long Island

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

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 and other tobacco use are significant risk factors for many chronic conditions identified as priorities, such as COPD, heart disease, diabetes, cancer and pediatric asthma. The prevalence of adult smoking in Nassau County was 10.1% and in Queens 15.5%, while the state rate was 17.0% (2009). While smoking rates in New York have declined, they remain high among certain subgroups. The smoking rate among the general population has declined to 16% but individuals with low SES continue to smoke at a rate of 28%. In fact, between 2003 and 2011, people with incomes below $25,000 were the only group in NYS to see their smoking rate increase. Nassau County Community Health Assessment indicates that smoking continues to be highly prevalent among the mentally ill population. People with mental health disorders have a 33% smoking rate, although studies indicate that people with mental illness who receive comprehensive tobacco dependence treatment (TDT) are able to quit at a rate similar to people without mental illness. Additionally, 63% of people with substance use disorders smoke even though data demonstrate that people who stop using tobacco and other substances simultaneously are more likely to abstain from both in the long term. Finally, rates of asthma in children are substantially higher in homes with an adult smoker.

There is reason to believe smoking rates among the Medicaid population are under-reported. Focus groups with Medicaid patients conducted by the Bureau of Tobacco Control found that they did not know about the Medicaid cessation medication benefit, didn't think the medications were effective, and didn't feel comfortable telling doctors about their tobacco use (they indicated that they felt that doctors "looked down" on them for smoking).

All indoor spaces of health care facilities are smoke-free. We will establish smoke-free outdoor environments at all our hospital facilities. We will advocate for changes in current Medicaid

policies that limit the number of times practitioners can be reimbursed for TDT counseling sessions and limit the coverage for cessation medications. We will advocate for health insurance coverage for all prescription and over-the-counter cessation medications and tobacco dependence treatment.

Targeted interventions
The evidence-based guideline recommends screening all patients for tobacco use; and all patients who use tobacco are at risk for developing tobacco-related illness. NQP will promulgate a protocol that requires tobacco screening upon admission. All patients will be asked about their tobacco use, advised to quit, assessed for readiness, assisted to quit with counseling and cessation medications, and provided planning for discharge, including cessation resources (information about local programs, NYS Smokers' Quitline information, prescriptions for cessation medications). The US Public Health Services Clinical Practice Guideline (USPHS) for Treating Tobacco Use and Dependence will be used by PPS partners. Many NQP practices have electronic medical records, and the lead entities have embedded prompts to ensure the provision of tobacco cessation interventions such as the 5 A's (Ask, Assess, Advise, Assist, and Arrange). NQP will ensure all its members' EHRs prompt and track the five A's. We will ensure that our educational efforts are evidence-based by relying on the USPHS Clinical Practice Guideline.

This project will work with providers in FQHCs and OMH/OASAS funded facilities. Staff at the Center for Tobacco Control will train them in the evidence-based practice of tobacco dependence treatment. In addition, they will help develop and support peer-to-peer counseling models in the behavioral health setting.

By coordinating with the public relations departments of NQP' members, we will use earned media to support NYS DOH and CDC anti-tobacco media campaigns that target the low SES and behavioral health populations.

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

While NQP proposes to address tobacco use and dependence among the entire population of Nassau and Eastern Queens, we will also concentrate efforts on the subpopulations that are suffering from negative health consequences of cigarettes at a much higher rate. NYS data indicate that those with low Socio-Economic Status (SES) and Serious Mental illness (SMI) have the highest rates of smoking and consequently the highest rates of chronic illness. NQP will particularly target the Rockaways, which has one of the highest smoking rates in Queens coupled with a low SES population.

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

Assets related to assisting the population to quit smoking include tobacco-free policies, evidence-based guidelines and prompts for screening and intervention for the patient population, resources to assist in quitting and educating providers, and Medicaid and other health plan

coverage that ensures cost is not a barrier to quitting. Easily accessible providers in the community that are available at all hours, such as pharmacists who are available evenings, and sometimes around the clock, helps to increase the success rate for smoking cessation. Educating the providers who will be recommending and writing prescriptions for both OTC and prescription cessation medications (Medicaid requires a prescription for both types) is essential. Training pharmacists to continue the discussion and counseling would reinforce the message.

Cost can be a barrier to quitting. Although cigarettes are heavily taxed in NYS, many individuals are able to circumvent the tax laws by buying cheaper cigarettes from Native American reservations or online vendors. Although Medicaid Managed Care plans cover cessation medications at low or no cost, patients sometimes perceive cessation medications as too costly. We plan to advocate for better coverage of cessation medications to remove cost as a barrier to treatment.

Public policy assets include NYS's Clean Indoor Air Act, the Adolescent Tobacco Use Prevention Act, prohibitions against smoking on hospital grounds and various taxes imposed by the State; in NYC, amendments to the Smoke Free Air Act of 2002 expanded smoking prohibitions in parks, beaches, and pedestrian plazas. Nassau County has also adopted policies related to the outdoor environment.

There exist two NYSDOH-funded tobacco control multi-sector coalitions: the Long Island Tobacco Action Coalition and the Queens Smoke Free Partnership. In addition the Long Island and Queens Asthma Coalitions provide additional resources.

The USPHS Guideline for Treating Tobacco Use and Dependence will be used by PPS partners. Many NQP practices have electronic medical records, and the lead entities have embedded prompts to ensure the provision of tobacco cessation interventions such as the 5 A's.

The NYS Smokers' Quitline is a multi-lingual resource designed to assist residents with quitting. Services include telephonic quitting assistance, free/discounted cessation medications, an on-line peer support community, linkages to local support programs, and relevant guides and other written materials. Comprehensive "Stop Smoking" programs are located throughout the NQP's region with six in Nassau County and four in Queens.

NYC DOHMH's Tobacco-Free Hospitals Campaign is designed to help every hospital in the city achieve excellence related to comprehensive tobacco-free environments and programs. By joining the campaign, hospitals in Queens can access tools and resources to assess and improve their campus environment, employee cessation programs and patient care systems.

NQP has a robust health care delivery system including 12 hospitals, FQHCs, and OMH facilities. Many have preexisting smoking cessation programs that are resources for this project including NSUH's Center for Tobacco Control, an LIJ affiliate, which has over a decade of experience helping Long Island and Queens individuals quit smoking.

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 anticipate a number of significant challenges with these initiatives, and have proposed methods for overcoming them:

- Engaging staff in TDT training - Concerns that TDT is inappropriate for their clinical role, is time-consuming, and/or ineffective for individuals with behavioral health disorders may result in a reluctance to engage in TDT with patients. By working with our community partners, we intend to provide data to health care providers about: the overwhelmingly negative health impact tobacco use has on patients, particularly those with behavioral health disorders and other chronic conditions; the benefits of quitting tobacco; the desire and ability of individuals to quit; and the significance of treating tobacco dependence, simultaneously with substance use disorders.

- Medicaid benefits that limit clinician reimbursement to six counseling sessions per year and two 3-month courses of cessation medications annually for Medicaid recipients - We will advocate to expand Medicaid coverage and reduce treatment limits. We will also encourage MCOs to expand this covered benefit. NQP may also investigate provider incentive programs which reward high rates of counseling and smoking cessation.

- Health literacy deficits - We will work to ensure our public education materials are simple and easy to understand, and translated into the appropriate languages to ensure residents of the entire area can understand them.

- Enforcement of outdoor smoking bans - NQP intends to provide positive reinforcement for people who choose not to smoke, and work with people wherever they are in their quitting process. Tobacco dependence needs to be treated as an addiction with counseling, medications, empathy, and understanding (recognizing that addiction may include relapses).

- Engaging low SES people in health promotion efforts - We intend to work with CBOs and faith-based organizations in low-SES communities that are already known and trusted. These groups can engage community members in screenings, educational activities and support groups. We will also leverage existing support groups around other issues in order to access people who are open to health messages.

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.

NQP has no overlap in Nassau or Suffolk. Overlap exists in Queens: Advocate Community Partners (ACP) has included eastern Queens in its service area, but not Rockaway Peninsula. The New York Hospital of Queens and Health & Hospitals Corporation are located in Queens. It appears that we are the only one undertaking this project.

LIJ is a member of NSLIJ, which is a member of ACP and in the first year has 25% of the Board of Directors votes, and in the remaining years of the DSRIP program will have 50% of the Board of Directors votes. Leveraging the LIJ role in NQP and in ACP, LIJ will be able to communicate/share information/best practices or problems with the other PPS as they surface. ACP plans to pursue project 4.b.i Promote tobacco use cessation.

NQP has experienced hub members who have developed population health management models collaborating with PCMH, primary and specialist physicians, behavioral health and substance abuse providers and the health home. North Shore University Hospital, a NQP partner, is a state designated Tobacco Cessation Center. Linking all partners to the RHIO and thereby sharing patient information appropriately for the benefit of the patient is one of the features of reducing tobacco use. Similarly, ACP and other PPSs will be utilizing the RHIO. This common health information technology platform will enable the PPSs to communicate about their patients clinical needs. The RHIO will become a vehicle for the PPSs to effectively and efficiently share patients and understand the patients' clinical history and care plans.

The NYC Department of Health has made this project its top priority within the DSRIP program. It is quite possible that PPSs will choose this project. Currently this PPS has a relationship with the NYC DOH that is also working with the overlapping PPS in NYC. We plan to meet monthly in NYC to discuss strategy and how best to adequately coordinate efforts. The Bureau of Tobacco Control funds contractors who have already been working collaboratively on tobacco control in the 5 boroughs and Nassau County and plan to continue that collaboration over the next 5 years. A population-based project like this one calls for cooperation among overlapping PPSs. It provides the opportunity for efforts to build upon each other.

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

Establish monthly meetings with NYC DOHMH and quarterly project team meetings: end of DY1

Evaluate all EHRs evaluations to determine if TDT prompts are guideline-concordant: 100% by end of DY1

Number of practices that have developed/implemented TDT policies: 100% by end of DY2

Number of staff members trained about TDT at community health centers and at behavioral health centers: 100% by end of DY2

Number of health care providers offering TDT and receiving reimbursement for counseling: 75% gradually from DY1-5

Number of established smoke-free outdoor policies: 75% gradually over DY 1-5

Number of health care providers offering TDT and receiving reimbursement for counseling: 75% gradually over DY 1-5

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.

This project requires that all PPS members have EHRs (and the technology infrastructure to support them), that prompt and track the 5 A's.

In addition, this project's success will be supported by capital investments in presentation equipment such as laptops and portable LCD projectors to bring various provider sites, which will enable us to more effectively get our tobacco cessation message to the community.

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	Descript ion of Initiatives
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollee s with Chronic Conditions	9/1 /12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital.

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

Project 4.b.i will build on and expand the work of this initiative, including a population intervention that targets change in public policy affecting smoking. The project will develop PPS-wide protocols on tobacco screening and counseling. It will also train staff at FQHCs and OMH/OASAS funded facilities in the evidence-based practice of TDT and help develop and support peer-to-peer counseling models in the behavioral health setting.

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.