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Using this document to submit your DSRIP Project Plan Applications

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

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

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

Domain 2 Projects

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

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

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

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

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

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

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

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

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

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

The population demonstrates high prevalence of cardiovascular, diabetes, asthma, and mental illnesses. Health disparities exist. Blacks have higher prevalence of heart disease, diabetes and hypertension. Whites have higher rates of heart disease and Asians cerebrovascular disease. While the 2012 PQI and PDI rates are lower than the expected, there are several zip codes where rates are higher than expected pointing to the need for better management of chronic conditions. All hospitals in the service area demonstrate high preventable readmissions rates suggesting that there is a need to improve care transitions. Within the network, patient alerts for hospital admissions or emergency room visits are received daily, and the care coordinator at the PCMH site schedules a follow-up visit with the patient's PCP. This is not consistent outside of the network. Primary care services are lacking in the north and northwest sections of the Service Area where the highest concentration of Medicaid beneficiaries live. There is high use of behavioral health ED visits suggesting services are inadequate. Housing, food, and creating healthier places to live do not meet level of demand and quality. Health literacy is also an issue for the population of English as a second language and an educational level less than a high school diploma.

Primary care service locations will be added in areas that lack safety net providers and/or shortage areas. Catchment areas will be coordinated with HHC PPS to avoid duplication. Corona has the highest safety net shortage of 29.5 PCPs / 100,000 population; Woodside follows with a shortage of 24.2/100,000 population; and Ridgewood needing 19.6 additional PCP's/100,000 population. These three neighborhoods are within five zip codes containing the highest concentrations of Medicaid beneficiaries in the service area.

The Patient Centered Medical Home NCQA certification process is a systematic way to address service gaps, focus culturally sensitive care delivery on the patient/family, and integrate a team based approach. This project is twofold: first, ensuring beneficiaries have adequate access to PCP

care; second, ensuring all PCP practices in the service area achieve PCMH certification using 2014 standards.

Integrating the requirements of the PCMH standards into practice workflows establishes the population management processes, systems, measures and infrastructure to provide person-centered care for patients along the risk continuum. Interdisciplinary care teams that include the PCP, behavioral health, are coordinator, dietician, social services, pharmacists and other practitioners indicated by patient's condition, will offer a comprehensive, approach to care for complex patients. For example, the team treating the patient's cardiovascular disease provides: education about the disease; guidance on activity; assistance with prescribed medicine; coordination with specialists; instruction about nutrition; and arranging home delivery of low salt and other nutritional foods. Patient engagement/communication will be enhanced by utilizing a patient portal.

PCMH's will use risk stratification and predictive modeling to assess needs and focus the appropriate level of care delivery, including integrating home care services to address patient care needs. For low risk beneficiaries care is focused on prevention and disease management; and for moderate risk beneficiaries the focus is a more intense level of disease management. For high risk beneficiaries with chronic conditions, care is focused on more intense care coordination and prevention of future exacerbations.

The PMO will implement a Chronic Disease Self-Management Program based on the Stanford Model with master trainers serving as instructors in the communities. This program will offer a continuous array of courses in centralized and community-specific locations.

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 targeted population will be all attributed persons minus those associated with SNF, hospice, palliative, and long term health facilities. This broad population was chosen in order to maximize the impact on the system. The number of engaged participating persons are those attributed through committed participating providers that receive preventive care screenings from the provider such as age appropriate immunizations, an annual depression screen and other age and gender appropriate screenings. The targeted population are those with higher readmission rates, and/or emergency department visits Comorbid conditions are also considered such as behavioral health diagnoses and chronic disease.

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

Existing practices which are at various stages of NCQA PCMH recognition will be mobilized including HANYS Solutins, an external expert that will be engaged to assist, coach, and track progress to PCMH certification. These practices include: Jackson Heights Family Health Center, Theresa Lang Children's Center and NYHQ Ambulatory care center and Dr. Gonzalo Sabogal. We will expand PCMH certification to safety net primary care providers within our PPS, as well as an article 28 site providing services to the developmentally disabled and an AIDS designated center. Partners that are recognized are Community Health Network and HELP/PSI. Physician champions will be identified at each site to promote the PCMH model. CBO's, home care providers, post-acute network, and other providers will be introduced to the care team and forums will be created to facilitate coordinated care, health literacy, management of chronic disease and transitions of care.

Existing PCP capacity will be expanded. One PPS safety net clinic is located in Jackson Heights, a neighborhood that is between Corona's western border and Woodside's eastern border. This practice is in an area with an accessible transportation hub, making travel easy. The PPS will extend operating hours and increase the physical footprint to broaden the reach of primary care in NW Queens. Elmhurst, a concentrated Medicaid area, also borders Jackson Heights, and will benefit.

Care coordination, care management and case management services will be expanded, strengthened and linked throughout the provider network. PPS partners have described numerous types of roles within their operations that provide care coordination functions. We will conduct a gap analysis and introduce work-flows to ensure compliance with recommended standards and avoid duplication in services. The general sectors of care coordination are hospital/SNF/home care transitions aimed at preventing potentially avoidable transfers and readmissions and PCMH/mental health/chronic disease management to coordinate and align care from multiple sources such as behavioral health, specialty care and social services and prevent hospital admissions from ambulatory sensitive conditions. Oversight for the coordination of care transitions will be centralized at the PMO with local management be provided at each site of service (i.e. PCMH, mental health provider, etc.).

Community Health Workers will be increased in their own areas of residence who have been described as "frontline public health workers who are trusted members of and/or have close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." The PPS will work with community leaders in ethnically concentrated geographies to collaborate on selection and deployment of community health work teams. In addition to cultural competency training, interpreters, and reading materials in multiple languages will be available.

The IT survey revealed that most practices have EHRs. However, most lack interoperability. Practices will be requested to participate with Healthix (RHIO) for real-time exchange of

information. The NYHQ PPS will provide technology guidance through this process. A solution will be pursued for practices that currently operate on paper through available low cost solutions in the marketplace. Population health management technology will be needed to support population health management processes and measurement. The PPS will seek capital funds through the Capital Restructuring Financing Program to purchase population health management technology which would be extended to practices and all participating providers. We will also use the EHR as a vehicle for patient-provider communication through the utilization of the patient portal.

The number of physicians, behavioral health and mid-level professionals that will be recruited will be planned for in the implementation plan due on 3/1/15.

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

There are four predominant racial groupings (white, black, Asian, Hispanic) each comprise between 18% and 30% of the Queens County and service area population. Numerous ethnic groups are subsets of these racial groups. Asian includes Chinese and Korean; Hispanic/Latino Mexican, Ecuadoran, Columbian, Honduran, and Peruvian. This diversity presents incredible challenges with cultural influences, disease prevalence and disease manifestation. Of the population greater than five years old, 56.5% of the population speaks a language other than English at home with one half of those self-reporting that they speak English well. Language diversity brings challenges associated with health literacy and communication with providers. Behavioral Health issues, chronic disease, obesity and asthma in pediatrics are disease specific challenges with the population. Working with culturally competent CBOs and training staff will allow the PPS to address some of these challenges. Gaps in coordination outside of the network is also a challenge, which can be addressed through the use of RHIO's/SHINY.

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.

The NYHQ PPS is coordinating with HHC PPS, a lead PPS. We have already discussed and shared our C N As. Although our projects are not identical, our goal is to coordinate projects and assist each other in achieving DSRIP goals. A committee will be developed to lead this implementation. For this project, the two PPS's will work closely to determine catchment areas for adding primary care service locations in areas that lack safety net providers and / or shortage. There also needs to be a determination for functioning on the same electronic medical record platform for improved care coordination. PCMH will be a core initiative for all. Sharing cultural competency efforts will also be important. The PPS will also explore utilizing learning collaboratives, joint educational opportunities for the community, and the MRT Innovation Exchange (MIX) website.

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.

Expansion of examination rooms and adding behavioral health consultation rooms within the existing clinical footprint.

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

Yes	No
☐	☒

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

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

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

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

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

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.v Care Transitions Intervention for Skilled Nursing Facility (SNF) Residents

Project Objective: Utilizing a similar model as 2.b.iv, this project will provide a supported transition period after a hospitalization to ensure discharge directions are understood and implemented specifically for skilled nursing facilities (SNF) at high risk of readmission, particularly those with cardiac, renal, diabetes, respiratory and/or psychiatric disorders.

Project Description: Nursing home patients with recent hospital discharges are at risk for re-hospitalization. This is often due to inadequate care coordination between the SNF staff and the hospital staff. For example, discharge summaries may not be complete nor include minor facts that can become significant in the SNF environment. PPS' undertaking this project must complete the following requirements to meet the two main objectives: 1) SNF staff access to hospital patient record and hospital staff prior to patient discharge and 2) timely care record transition to SNF and receiving practitioner. Additional resources for this project can be found at www.caretransitions.org

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. Partner with associated SNFs to develop a standardized protocols to assist with resolution of the identified issues.
2. Engage with the Medicaid Managed Care Organizations and Managed Long Term Care or FIDA Plans associated with their identified population to develop transition of care protocols, ensure covered services including DME will be readily available, and that there is a payment strategy for the transition of care services.
3. Develop transition of care protocols will include timely notification of planned discharges and the ability of the SNF staff to visit the patient and staff in the hospital to develop the transition of care services. Ensure that all relevant protocols allow patients in end-of-life situations to transition home with all appropriate services.
4. Establish protocols for standardized care record transitions to the SNF staff and medical personnel.
5. Ensure that all participating hospitals and SNFs have shared EHR system capability and HIE/RHIO/SHIN-NY access for electronic transition of medical records by the end of DSRIP Y3.
6. 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.

While there have been efforts to reduce avoidable readmission rates in Queens County and some reductions have occurred, challenges still remain. All Queens County Hospitals have higher than expected PPR rates when both rates are compared on a risk adjusted basis. According to the Community Needs Assessment performed by the NYHQ PPS, the 2012 actual risk adjusted PPR rate for Queens County ranges from 6.16 to 7.50 with an expected PPR rate ranging from 4.34 to 6.65, per 100 persons, depending on the facility. The average improvement of PPR rate needed to meet the expected PPR benchmark is 1.69 across the county, per 100 persons, with the largest improvement needed by North Shore Hospital (2.7) and the least improvement by NYHQ (.45).

New York's average annual nursing home resident hospitalization rate is 27.4% (DHHS, OIG, November 2013, OEI-06-11-00040).

The variety of NYHQ PPS partners allows for significant collaboration among nursing home facilities and hospitals with a focus on improving care coordination and therefore reducing potentially preventable readmissions. This project focuses on care coordination and complements other projects chosen by the NYHQ PPS in order to maximize the benefits of the interrelated implementation needs of these projects. The three related projects have a shared aim of improving transitions of care or preventing them altogether. The project bundle is essential to reducing hospital readmissions whether the source is SNF or Home Care.

Project 2.b.v Care Transition SNF strengthens clinical care, communication, and collaboration processes associated with transitions from the hospital (inpatient or ED) to a nursing home/SNF.

2.b.vii INTERACT for SNF strengthens the clinical care processes in nursing homes/SNF's to provide consistent, evidence-based care, identify problems early, and provide timely interventions to avoid transfer or readmission to an acute care hospital.

2.b.viii Hosp-Home Care addresses the previous two objectives in the home care setting.

This bundle of projects has the added benefit of implementation efficiencies given their commonalities in project requirement, clinical practice, and population health management approaches. The three-project bundle is being implemented with the committed partner nursing homes in the Queens Service Area. This critical mass of nursing homes will play a crucial role in changing the way health care is delivered to benefitting beneficiaries with greatly improved services while reducing avoidable costs.

Nursing homes throughout the PPS have been involved in various projects to help improve care within the facilities and transitions between the hospital and nursing home. This project will spread best practices and successes to create a common and reliable standard of care for beneficiaries regardless of the nursing home in which they reside and to establish a PPS-wide planning and improvement structure to formalize communication and collaboration.

Implementation of INTERACT communication tools (Project 2.b.vii) in nursing homes will ensure consistent methods for information exchange between hospital and SNF's. Relationships between nursing home clinical staff and hospital clinical staff will be strengthened by implementing a phone consultation line with ED triage nurse, ED physicians, and hospitalists to assist nursing homes in differentiating conditions that may be treated in the nursing homes from those requiring hospitalization.

Every failed discharge resulting in a readmission will be analyzed together by the hospital and nursing home to identify system problems and apply rapid cycle improvement methods to address these breakdowns. A multi-organizational, PPS operating committee will be established to review select cases, identify PPS system breakdowns, and apply rapid cycle improvement methods to address the breakdowns.

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 targeted population for this project will include all patients who are associated with a long term care facility. The CNA findings for the NYHQ PPS service area indicated that there are an appropriate number of SNF beds (7,727 beds) for the patient population. An important note indicated by the CNA findings that there are no skilled nursing facilities in some neighborhoods with high Medicaid beneficiaries (zip codes 11385 and 111373). By enacting the 3 care transition projects, 2.b.v, 2.b.vii, and 2.b.viii, the NYHQ PPS aims to provide these services to patients across the PPS, whether through a transition from inpatient to a SNF or to home care.

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

According to the partner surveys conducted by the NYHQ PPS, some of the nursing homes have implemented protocols regarding care transitions. The PPS will leverage this experience to inform the implementation process across participating partners in this project. Health plans will be consulted to identify their protocols and promote uniformity of procedures in the region. The three project bundle approach, 2.b.v, 2.b.vii, and 2.b.viii, to implementation will create efficiencies for projects that are being implemented across partner organizations; this will enable the PPS to leverage its implementation assets.
One of the main objectives of this project is to ensure SNF staff have access to hospital patient records and hospital staff prior to patient discharge; therefore, Information Technology is an integral key to success. The NYHQ PPS IT survey revealed that most partner nursing homes have EHR systems, however, there is a lack of interoperability among partners. The PPS will seek capital funds through the Capital Restructuring Financing Program to purchase population health management technology, which would be extended to the nursing homes and all participating providers. In addition, the nursing homes will be requested to participate with Healthix (RHIO) for the real-time exchange of information. The NYHQ PPS will provide technology guidance through

this process of implementation. A solution will be pursued for nursing homes that currently operate on paper through available low cost solutions in the marketplace.
Licensure costs associated with any needed programs such as Care transitions will be considered. Administrative costs to implement the program across the 27 committed nursing homes will be required.

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.

DSRIP healthcare transformation shifts the paradigm from improving care received in a facility to improving the process of care coordination and population health management with a focus of the right care in the right setting. Claims Data ranging from March 2013 to February 2014 for the PPS attributed beneficiaries show discharges from 80 different hospitals and claims from 105 different SNF's both inside and outside the service area. The challenge of this project will be to balance beneficiary choice with the focus to improve transitions among this huge array of provider organizations available in the area.

This project will take an incremental implementation approach by first establishing an internal best practice benchmark at New York Hospital Queens by ensuring stellar processes and outcomes from beneficiaries discharged to SNF's. The PPS will then establish a PPS-wide planning and improvement structure to formalize communication and collaboration utilizing the internal best practice standard in order to meet project requirements for all committed partners.

The extraordinary diversity of Queens County could present an additional challenge for this project. The Community Needs Assessment outlined a population of over 54% of the county that is comprised of non-white or black ethnicities with cultural and language barriers. As part of the overall PPS strategy, family engagement, care giver training and, culturally and literacy appropriate learning materials will be used to reduce cultural and language barriers.

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.

NYHQ PPS intends to collaborate with the PPS' in the area that will be implementing this skilled nursing facility transition of care project. The complexity of our health care service area provides a vast opportunity for many organizations to establish cohorts centering on similar projects and outcome metrics to ensure successful project outcomes. Every effort will be made to collaborate in developing consistent policies and procedures to ensure a rapid implementation process and promotion and consistency of best practices in the region. The PPS will look to utilize the MRT

Innovation exchange (MIX) website to collaborate and foster innovative ideas for project implementation between PPS'.

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

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

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

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

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

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

Yes	No
☒	☐

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

IT Intrfastructure / Population Health Management Tool

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

Yes	No
☐	☒

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

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

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

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

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.

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.

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

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

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

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

As noted in the CNA, all Service Area hospitals have higher than expected risk adjusted PPRs. Queens County has a risk-adjusted readmission rate per 100 persons of 6.89 as compared to NYC at 7.19 and NY at 6.73. While Queen's County rate is lower than NYC's, there are 2,873 preventable readmissions in the Service Area.

Readmissions associated with nursing homes were also explored finding that the nursing home readmissions rate in NY is 27.4% according to a study conducted by the Office of the Inspector General (DHHS, OIG, November 2013, OEI-06-11-00040). The NYHQ PPS confirmed this rate through its own survey of 25 out of 27 nursing home partners. MedPac estimates that 47.3% of readmissions would be preventable.

NYHQ discharges to nursing homes can be used to calculate the impact of this project on readmissions. NYHQ discharged 5,309 patients to SNFs in 2013. Of these, 27.4% or 1,455 patients would be expected to be readmitted within 30 days. According to MedPac (March 2014), 47.3% of the readmission or 688 would be preventable.

This project will have a positive ripple effect of reducing readmissions when considering that 27 nursing homes in the NYHQ PPS will be implementing the INTERACT program and that these nursing homes do business with several hospitals. When the previous rates are applied to the 25 sample nursing homes there would be approximately 1,160 preventable readmissions.

Readmission rates point to system failures that usually stem from inadequate primary care, poor nursing facility quality of care, poor communication among providers, and family preferences. The INTERACT quality improvement program addresses these systems failures or gaps. Several nursing home residents who participated in the NYHQ PPS focus group for the CNA were interested in receiving outside medical consultations because they perceived the care to be better or more sensitive to their individual needs than what received within the nursing home facility. They also reported that nursing home medical providers were reluctant to communicate or coordinate their treatment with their external providers. This sometimes resulted in conflicts with nursing home medical providers over their treatment. Participants expressed interest in maintaining their health so that they did not have to be transferred to an Emergency Room or be admitted to a hospital.

NYHQ PPS is implementing three projects as a bundle to enhance implementation efficiency as the three projects have common requirements and can share resources along the continuum. These projects are: SNF, 2.b.vii INTERACT-SNF 2.b.v Care Transition, 2.b.viii

Hospital-Home Care. Project commonalities exist in project requirements, clinical practice, and population health management approaches.

Nursing homes face the dual challenge of preventing avoidable patient transfers from their facilities and preventing avoidable patient readmissions after an acute care episode of care. A source of avoidable admissions originating from nursing homes is patients with deteriorating health going unnoticed until conditions reach crisis levels requiring visits to the ED with potential subsequent admissions.

The INTERACT programs creates an environment where patients are observed and changes in health are identified quickly and addressed in the nursing home preventing avoidable transfers and readmissions.

The NYHQ PPS service area has 32 nursing homes with 7,727 beds. The NYHQ PPS includes 27 participating nursing homes in its network and all are committed to implementing the INTERACT project. This means that 27 INTERACT programs will be implemented in the Service Area.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population 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 populations to be engaged are the nursing home residents that have been attributed to the NYHQ PPS with most common illnesses that cause transfers and readmissions. These illnesses include acute mental status change, new or worsening change in behavior, dehydration, fever, GI symptoms, shortness of breath, lower respiratory illness, symptoms of congestive heart failure and urinary tract infections. While the focus of the project will be on NYHQ PPS attributed nursing home residents, the project will benefit all nursing home residents once the INTERACT program is adopted as routine practice nursing home operations.

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 INTERACT Program offers a comprehensive implementation package on its website which includes the INTERACT tools, workflow illustrations of when to use the various tools, case studies, implementation guide, implementation checklist, information about INTERACT licenses for EHRs and HIT and eCurriculum training modules.

This project is well suited to using a quality improvement collaborative model (“learning system that brings together teams to seek improvement in a focused topic area”) to implement the INTERACT program and will be used by the NYHQ PPS. Since the processes and materials are already developed and available, the nursing homes can focus collectively on the systematic implementation of the tools while learning from each other, leveraging common resources such as physician and staff training and support each other throughout the process. The early adopter

in the group can share lessons learned with others just starting. This project will build upon and strengthen established relationships between hospital and SNFs as well as SNFs with other SNFs.

The focus on continuous improvement provides the structure for ongoing implementation, evaluation, and refinement until the INTERACT tools are all in place. The improvement collaborative model also provides a structure for coaching teams throughout the process of implementation.

The NYHQ PPS conducted a survey of participating nursing homes to assess if the INTERACT program had been adopted and the degree of adoption. One facility reported the adoption of seven of the tools designed for nursing homes and was advanced in its practice of INTERACT principles. This entity will be a great resource for the quality improvement collaborative.

During the assessment, nursing homes were also asked to complete the Interact Version 3.0 Nursing Home Capabilities List to strengthen the match between SNF selection and patient needs at hospital discharge. This is a first step towards the adoption of the INTERACT program and therefore the implementation has begun.

Capabilities offered by Healthix (RHIO) will be leveraged to promote the exchange of information and offer pertinent services to the providers in the network.

The three interrelated projects (SNF, 2.b.vii INTERACT - SNF 2.b.v Care Transition, 2.b.viii Hospital - Home Care) and committed partners will be leveraged to learn from each other as implementation progresses.

Licenses for the electronic use of INTERACT will also be required for those that wish this option. The nursing homes and the PPS will need resources for the implementation of the INTERACT program which will ideally be executed through a learning collaborative and budgeted under Section 8 of the Organizational Application. For example, the INTERACT program offers educational decision support tools (Care Paths) that need to be carefully planned for teaching and dissemination to the nursing homes staffs. The Care Paths provide guidance to staff on the recognition, evaluation, and management of 9 conditions that commonly cause hospital transfers and provides guidance for when to contact the primary care clinician. The 9 conditions include: acute mental status change, new or worsening change in behavior, dehydration, fever, GI symptoms, shortness of breath, lower respiratory illness, symptoms of congestive heart failure and urinary tract infections.

Resources to manage the collaborative at the PMO will be required.

Population health management technology will be needed to support population health management processes and measurement. The PPS will seek capital funds through the Capital Restructuring Financing Program to purchase population health management technology which would be extended to practices and all participating providers.

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

A common barrier for an improvement effort such as this is enabling time for project team participation and for the training required to support implementation. Nursing home leaders will be requested to support team participation and training as part of, not in addition to, their day to day job responsibilities. Successful implementation will require funding in the project budget to allow for training participation without causing understaffing at the bedside.

The extraordinary diversity of Queens County could present a challenge for the effective implementation of INTERACT with patients and families if means of communication are limited. Throughout the implementation of the INTERACT program in the nursing homes, participants will continue to build upon their current practices of identifying and adapting care to cultural differences in their patient populations. These practices include care giver training; culturally and literacy appropriate learning materials; facility provider and care giver ethnic composition that reflects their own patient population and community; using spiritual assessments; offering spiritual support by clergy of multiple denominations; and, using family councils.

The INTERACT Implementation Guide identifies several barriers with suggested strategies to address them. Strategies to overcome these barriers will be taught through the learning collaborative under the rubric of change management. The program will teach about the personal change curve that individuals experience when confronting change. The personal change curve includes four phases: denial, resistance, exploration of new ideas, acceptance and commitment.

- Not having objective data to support the claim that current practices work well and there is no need to change.
- The nursing home staff has not control over resident transfers and hospital admissions.
- Lack of physician collaboration and cooperation.
- Families want residents hospitalized.
- Citing other important projects or accreditation surveys as an excuse to not implement INTERACT.

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.

The NYHQ PPS is committed to working with other PPSs that overlap services in Queens County. NYHQ PPS has held collaborative discussions with HHC PPS to avoid duplication of services and interventions. The HHC PPS has not selected Project 2.b.vii and will benefit from the ripple effect described above as NYHQ PPS implements INTERACT within the service area.

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.

Information Technolog Infrastructure

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.b.viii Hospital-Home Care Collaboration Solutions

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

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

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

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

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

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

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

According to the CNA performed by the NYHQ PPS, the 2012 actual risk adjusted PPR rate for Queens County ranges from 6.16 to 7.50 with an expected PPR rate ranging from 4.34 to 6.65, both per 100 persons, depending on the facility. The average improvement of PPR rate needed to meet the expected PPR benchmark is 1.69 across the county, per 100 persons, with the largest improvement needed by North Shore Hospital (2.7) and the least improvement by NYHQ (.45). The CNA Illustrated that there are substantial gaps in quality care transitions throughout the service area as all of the hospitals in the area have higher than expected PPR rates. The qualitative data showed similar concerns with focus group respondents voicing that community based health resources and care coordinators are vital to breaking the cycle of hospital admissions. Additionally, although there are 639 home health and hospice agencies that serve Queens County, not all are located in the area and therefore may be difficult to access for residents making care coordination plans essential for the community.

The NYHQ PPS will address DSRIP goals to reduce avoidable hospital use by transforming how health care is delivered in Queens County. Readmission rates will be addressed through projects that are sensitive to transitions of care. Avoidable admissions will be addressed through projects that impact ambulatory care sensitive conditions. Avoidable ED use will be addressed by projects that are sensitive to both ambulatory conditions and transitions of care. In turn, these projects will be tailored to the specific health needs and infrastructure of the populations served.

To reduce avoidable admissions and 30 day readmissions, the NYHQ PPS selected 3 projects that align with this goal: 2.b.v Care Transition SNF, 2.b.vii INTERACT for SNF, and 2.b.viii Hosp-Home Care. These three projects are interdependent with the shared aim of improving transitions of care.
For patients identified as high risk for readmission, transitions from hospital to home will be managed using an interdisciplinary, multi-agency discharge team including patient and family, hospital, PCMH, home care, DME, social services and specialty services as needed. A transition care coordinator will ensure timely patient follow-up with their PCP, that the plan of care is communicated to all involved, and that guidelines and criteria are in place for early identification and treatment of worsening patient conditions. Telehealth and mobile health technology will be evaluated and implemented to best meet the needs of the beneficiary population.

An integral part of the home care team will be Community Health Workers, “frontline public health workers who are trusted members of and/or have an unusually close understanding of the

community served. This trusting relationship enables CHWs to serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." The Community Health Workers will be a bridge for ensuring care instructions are understood and followed and that cultural preferences and requirements are accounted for as care processes move from hospital to home.

Every failed discharge will be analyzed together by the team to identify system problems and apply rapid cycle improvement methods to address these breakdowns. A multi-organizational, PPS operational committee will be established to review select cases, identify PPS system breakdowns, and implement system solutions.

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 implementation of this home health collaboration project is aimed at engaging patients who both utilize the home care system as well as those who could be transferred to home health instead of a nursing facility upon hospital discharge. The goal of reducing readmission for this project will directly relate to the reduction of hospital admissions and ED visits that DSRIP aims to reduce. The PPS and its partner network will work to implement interoperable EHR systems and population health management tools to track patients and identify those at a high risk of readmission.

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 INTERACT Program offers a comprehensive implementation package which is compatible with EHR and paper based systems. The NYHQ PPS will support the adoption and implementation of the INTERACT tools by the home care agencies. This project is well suited to using a quality improvement collaborative model ("learning system that brings together teams to seek improvement in a focused topic area") to implement the INTERACT program and will be used by the NYHQ PPS. Since the INTERACT processes and materials are already developed and available, the home health agencies can focus collectively on the systematic implementation of the tools while learning from each other, leveraging common resources such as physician and staff training, and support each other throughout the process. The early adopter in the group can share lessons learned with others just starting. This project will build upon and strengthen established relationships between hospital and home health as well. The focus on continuous improvement provides the structure for ongoing implementation, evaluation, and refinement until all of the INTERACT tools have been implemented. The improvement collaborative model also provides a structure for coaching teams throughout the process of implementation.
Licenses for the electronic use of INTERACT will be required for those that implement this project and choose the electronic version or process tracking.

The home health organization and the PPS will need resources for the implementation of the INTERACT program which will ideally be executed through a learning collaborative and budgeted under Section 8 of the Organizational Application. For example, the INTERACT program offers educational decision support tools (Care Paths) that need to be carefully planned for teaching and dissemination to the home health staffs. The Care Paths provide guidance to staff on the recognition, evaluation, and management of 9 conditions that commonly cause hospital transfers and provide guidance on when to contact the primary care clinician.
Several of the home care partners have already implemented programs for monitoring congestive heart failure in patients, and the PPS will work to standardize this plan, along with the Care Paths throughout the PPS partner system.

As part of the implementation, the PPS will examine the opportunity to move towards telehealth and mobile health technology in home care. As care transitions from the inpatient setting to the home and community setting, telehealth and mobile health technology will have the opportunity to play a bigger role in disease management for patients. The PPS will explore the options to utilize these technologies to help reduce missed appointments and patient adherence to medications and care plans and therefore reduce inpatient and ED visits. As the lead PPS site, NYHQ has encouraged onsite involvement of home care to expedite care once the patient is discharged, utilizing case management and home care to share risk stratification for the patient. Additionally, NYHQ has recently implemented a coaching program with DEFTA for Medicare patients that will transition into the Medicaid population. NYHQ wil utilize these programs and successful experiences to ensure that collaboration with home care results in successful transition for patients between the inpatient and home setting.

Partner home care agencies will adopt Healthix (RHIO) for real-time exchange of information. The PPS will provide technology guidance through this process. A solution will be pursued for agencies that currently operate on paper through available low cost solutions in the marketplace. Population health management technology will be needed to support population health management processes and measurement. The PPS will seek capital funds through the Capital Restructuring Financing Program to purchase population health management technology which would be extended to the agencies and all participating providers.

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

DSRIP healthcare transformation shifts the paradigm from improving care received in a facility to improving the health of a defined population of Medicaid beneficiaries. Between March 2013 and February 2014, claims data for the PPS attributed beneficiaries shows discharges from 80 different hospitals and claims from numerous home care agencies. The challenge is to support beneficiary choice while concurrently improving transitions among this huge array of provider organizations.

Because home care agencies in the PPS receive patients from multiple hospitals within the service area, improvements initiated in the NYHQ PPS will have a ripple effect and ideally improve transitions from other hospitals used by the PPS beneficiaries as well. This project will take an incremental approach by first establishing an internal best practice benchmark by ensuring stellar processes and outcomes from beneficiaries discharged to homecare from NYHQ and then establishing a PPS-wide planning and improvement structure to formalize communication and collaboration with other hospitals.

The extraordinary diversity of Queens County could present an additional challenge for this project. An integral part of the PPS strategy for implementing improved home care transitions is to reduce the cultural and language/comprehension barriers present by incorporating family engagement, care giver training and, culturally and language-appropriate learning materials into the home care process.
Finally, IT presents a potential challenge for the successful implementation of this project. The home care agencies will need to ensure that they have a IT system- whether teleheath, mobile health- that is adaptable to the needs of the population and the transition from inpatient to home care. The NYHQ PPS will support the acquiring and implementation of these IT systems in addition to the licenses that will need to be acquired for the electronic INTERACT tools. The PPS will explore the best options for all of the partners to determine what systems will have the maximum benefit.

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.

NYHQ PPS intends to collaborate with PPS' in the area implementing this or similar projects. Every effort will be made to collaborate in developing consistent policies and procedures to ensure a rapid implementation process and promotion and consistency of best practices in the region. One strategy for collaboration that the NYHQ PPS will consider is to create a joint learning collaborative for all of the applicable PPS' in the area; this would allow the participants to learn from both their own experiences as well as what has been successful in the other PPS'. In addition, NYHQ PPS will utilize the MRT Innovative exchange (MIX) website as a mechanism for feedback and gaining insight on successful implementation of these Interact principles for home 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. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

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

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

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

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

Yes	No
☒	☐

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

Information Technology Infrastructure, Telehealth program

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

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.

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.

The NYHQ service area contains 66 outpatient mental health programs; thirty-four are mental health clinics. There is one inpatient behavioral health unit at Flushing Hospital. The outpatient mental health service providers are in two general geographic areas: Western (zip codes 11372,, 11374,11376 and 11375) and South East (zip codes 11432, 11433, 11435 and, 11423). NoOutpatient mental health services are offered where a high concentration of Medicaid beneficiaries live.

According to the NYHQ PPS Community Needs Assessment, in 2012, 1,756 inpatient admissions and 3,078 emergency department visits were related to depression and chronic stress / anxiety diagnoses for the neighborhoods with the highest concentration of Medicaid beneficiaries (Flushing, Elmhurst, Corona, Woodside and Ridgewood).

The top psychiatric diagnoses at Mental Health Providers of Western Queens (PPS Partner) and HELP/PSI (PPS Partner) are: major depressive disorder, ADHD, bipolar disorder, schizo and psycho affective disorders, oppositional defiant disorder, and anxiety disorder, which is consistent with

the top conditions requiring medical management are: hypertension, HIV, high cholesterol, diabetes, back/lumbar issues and asthma.

Deaths from intentional self-harm is the tenth leading cause of mortality in Queens. This is notable as intentional self-harm is not found in the top ten leading causes of mortality in New York City overall.
There is geographic disparity of services in reference to where large concentrations of Medicaid beneficiaries live. Patients with behavioral health needs may not be cared for appropriately. Screening for depression and alertness to suicide tendencies are needed. There is also a lack of care coordination in Queens.

The NYHQ PPS will use a hybrid model for integration of primary care and mental health services. The project will most likely be achieved by using a mix of the three models (co-colocation at PCP/BH service sites and use of IMPACT) depending on what best fits the community and the practice resources already in place. The final decision on the mix will be completed by March 2015. All practices will conduct preventive care screenings, using the PHQ-9 and the SBIRT tool.

The primary care sites that will incorporate one of the three models are, The Jackson Heights FHC, The Ambulatory Care Center in Fresh Meadows, The Center for the Developmentally Disabled and the Special Care Center.

The mental health provider partners in the PPS will establish new, dedicated primary office/treatment rooms for their facilities.

Prevalent psychiatric diagnoses require complex care coordination. Care coordinator roles will be reviewed to ensure actual and potential gaps in care are closed. A cost-benefit analysis will be conducted to determine whether a primary care sites will be built or a mobile primary care van will be used. Project 2.a.ii (PCMH) will serve as the platform for implementing the co-located approach to behavioral health integration. The PHQ screener will be adopted and aligned across the PPS primary care practices. An online version offers the tool in over 70 languages.

A disease management program for depression will be established and aligned among primary care practices. The program will incorporate evidence-based guidelines, patient learning, and linkages to community resources. An assessment of care coordinator roles and capacity will be done and positions added accordingly.

Community based organization support will be further defined during the project plan implementation. Medical practices will be taught how to refer to social services available for individuals with behavioral health conditions, including substance abuse facilities.

The PPS will also review the potential of utilizing the partner school based programs to screen high risk populations for behavioral health conditions.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease

type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The targeted population will be all patients that are associated with committed providers in the PPS network. Initially to start this project, behavioral health providers will target existing patients who do not have a PCP and coordinate that interdisciplinary team. Actively engaged population will be defined depending on the model selected at each practice. Therefore definitions will include: Number of patients screened using PHQ-9 / SBIRT at PCMH. Number of patients receiving primary care services at a participating mental health or substance abuse site. Number of patients screened using PHQ-9 / SBIRT at practices implementing the IMPACT model. Patients with a primary mental health diagnosis, specifically Schizophrenia/Schizoaffective disorder, bipolar disorder, major depression, recurrent or post-traumatic stress disorder in combination with chronic medical diagnsoses such as diabetes ,corornary heart disease, hypertension and obesity. Patients with a chronic disease and a mental health comorbid diagnosis. Other targets include patients that are poor, minors, and Medicaid.

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.

Existing and new primary and behavioral health practices will be mobilized to implement the project using any of the three optional integration models. Community based organizations including housing and social services supports will be invited to participate in the PPS. The expertise of PPS partners will be utilized to expand this service line. HELP/PSI is a partner that is currently co-locating primary care and behavioral health services. This would help to provide a co-located service and crisis intervention program. This resource will help to not only to draw upon resources but incorporate best practices and lessons learned. In addition, the PPS will leverage the expertise of the NYP healthcare system as it has experiste in this area; the NYHQ PPS will build upon their best practice and lessons learned. Required resources. The IT survey revealed that most practices have EHRs, however, most lack interoperability. Practices will be requested to participate with Healthix (RHIO) for real-time exchange of information. The NYHQ PPS will provide technology guidance through this process. A solution will be pursued for practices that currently operate on paper through available low cost solutions in the marketplace. Population health management technology will be needed to support population health management processes and measurement. The PPS will seek capital funds through the Capital Restructuring Financing Program to purchase population health management technology which would be extended to practices and all participating providers. Understanding the sensitivity of this project, the governing body of the NYHQ PPS will work with appointed attorneys to create appropriate waivers to ensure compliance with

regulations. Will also seek capital for construction costs related to expansion of existing facilities, a mobile van and the addition of a new outpatient clinic, in one of the identified areas in the C N A as having a shortage of safety net providers.

The number of physicians, behavioral health and mid-level professionals that will be recruited will be established during the implementation plan development due on March 1, 2015.

Mid-level providers may also be considered to meet the challenge of asset allocation.
Enhanced coordination may include embedding Primary Care physicians and Nurse Practitioners as outreach coordinators, providing needed services.

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

A challenge associated with this project is patient engagement due to cultural stigmas, as cited in the Community Needs Assessment interview process. These patients can be difficult to engage for treatment and experience higher suicide rates. Education in the community and outreach assistance is needed. Patient activation methods will be explored, selected, implemented and aligned across sites of care. The Chronic Care self-management program discussed in Project 3.b.i. (Cardiovascular) will include this population in planning its size and capacity.

Access needs to be provided including expanded hours, and open access. Care is easier for patients to obtain and care must be coordinated.

Another challenge defined by the partners is access and use of emergency services. Adding primary care services will help to improve primary care access for patients with behavioral health conditions. Enhancing primary care providers' ability to identify, manage as appropriate and refer to psychiatric providers as needed should help to alleviate behavior health management access in the primary care setting.

Once engaged, continued compliance to treatment plans may be an issue for these patients.. Underserved behavioral health populations will need to have awareness of available resources, through the utilization of care coordination. Several of the PPS partners have expertise in patient engagement and care coordination because they care for health home patients. These best practices will be utilized throughout the provider sites.

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.

NYHQ PPS intends to collaborate with any Queens PPS that is implementing this or similar projects. Every effort will be made to collaborate in developing consistent policies and procedures to ensure a rapid implementation process, promotion, and consistency of best practices in the region. Preliminary discussions have been had with HHC, on collaboration. Coordination will occur with our behavioral health partners exclusive to our PPS and also with others outside of the PPS in order to prevent duplication of services.

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.

Creation of examination rooms and consultation rooms for co-location, IT Infrastructure.

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Improve Medication Adherence:

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

Actions to Optimize Patient Reminders and Supports:

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

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

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

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

The Community Needs Assessment identified cardiovascular disease as a top priority for project selection. The prevalence of cardiovascular disease among Medicaid beneficiaries in Queens is 30.7% and leads to 197,816 hospitalizations and 144,585 ED visits annually. Although deaths from diseases of the heart have fallen from 208 per 100,000 in 2002 to 161 per 100,000 in 2012, they are the leading cause of deaths for 72.9% of the non-Hispanic blacks, non-Hispanic whites, and Hispanics of Queens and the second leading cause of death for Asian/ Pacific Islanders (23.1% of the population of Queens).

The NYHQ PPS attributed population has 35% incidence rate of cardiovascular-related diseases including acute myocardial infarction, atrial fibrillation, congestive heart failure, hypertension, ischemic heart disease, and stroke. More specifically, 45% of this cohort demonstrates congestive heart failure, and 18% hypertension

Hospitalizations from congestive heart failure (CHF) and hypertension are considered potentially preventable conditions. Throughout Queens, the circulatory disease PQI composite index, which encompasses hypertension and CHF, varies greatly from 160.4 per 100,000 population to 654.7

and highlights health disparities in the county. The difference between risk-adjusted observed and expected rate also demonstrate variation from 203.99 per 100,000 fewer than expected to 337.11 per 100,000 more than expected. In the U.S., preventable hospitalizations for congestive heart failure have been decreasing more slowly for blacks than whites and been increasing for young, black males and represent a source of health disparities.

Preventing cardiovascular disease, its complications and resulting hospitalizations is essential due to the insidious nature of the disease. . Hypertension can lead to debilitating conditions such as stroke, congestive heart failure and renal disease.. Unemployment and poverty, also prevalent in Queens, contribute to higher risk for cardiovascular disease.

Reaching the population with, and at risk for, cardiovascular disease requires a concerted effort on the part of individuals, the community and providers in ambulatory, hospital, SNF and long term care facilities.

This project aligns with the disease management requirements for the Patient Centered Medical Home recognition (Project 2.a.ii.). A common cardiovascular evidence-based protocol will be implemented by all primary care practices, nursing homes, home health, and hospitals in the PPS to ensure a consistent standard of care along the continuum. Patients will be stratified and managed to ensure the appropriate level of care..

Interdisciplinary care teams will offer a comprehensive, coordinated approach to care for complex patients that incorporates behavioral, specialty care, home care and social services.
New Services. The NYHQ PPS will increase the use of Community Health Workers in their own areas of residence. Community Health Workers have been described as “frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison...between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.” The PPS will work with community leaders in ethnically concentrated geographies to collaborate on selection and deployment of community health work teams.

A health education team is being established in the PMO to implement a Chronic Disease Self-Management Program based on the Stanford Model with master trainers in the communities. This program will offer a continuous array of courses in centralized and community-specific locations. The education team will also standardize and supply cardiovascular learning materials across the PPS. The health education team will also coordinate all educational programs across the PPS network.

The Community Needs Assessment identified a prevalence of cardiovascular disease among Medicaid beneficiaries in Queens is 30.7% (281,421 people) and leads to 197,816 hospitalizations and 144,585 ED visits annually. Although deaths from diseases of the heart have fallen significantly from 208 per 100,000 in 2002 to 161 per 100,000 in 2012, they are the leading cause of deaths for 72.9% of the population of Queens (non-Hispanic blacks, non-Hispanic whites, and Hispanics) and the second leading cause of death for Asian/ Pacific Islanders (23.1% of the population of Queens).

The NYHQ PPS attributed population (41,172) has 35% incidence rate of cardiovascular-related diseases including acute myocardial infarction, atrial fibrillation, congestive heart failure, hypertension, ischemic heart disease, and stroke. More specifically, 45% of this cohort demonstrates congestive heart failure, and 18% hypertension. (Salient data, March 2013-April 2014).

Hospitalizations from congestive heart failure (CHF) and hypertension are considered potentially preventable conditions given appropriate provider care and health system support and are reported as Prevention Quality Indicators (PQIs). Throughout Queens, the circulatory disease PQI composite index, which encompasses hypertension and CHF, varies greatly from 160.4 per 100,000 population (best) to 654.7 (worst) and highlights health disparities in the county. The difference between risk-adjusted observed and expected rate also demonstrate huge variation from 203.99 per 100,000 fewer than expected (best) to 337.11 per 100,000 more than expected (worst). In the U.S., preventable hospitalizations for congestive heart failure have been decreasing more slowly for blacks than whites and been increasing for young, black males and represent a source of health disparities.

Preventing cardiovascular disease, its complications and resulting hospitalizations is essential due to the insidious nature of the disease. Hypertension is called the "silent killer" because it may not show symptoms. Hypertension can lead to debilitating conditions such as stroke, congestive heart failure and renal disease, which affect morbidity and functional status for life and lead to higher health services utilization. Unemployment and poverty, also prevalent in Queens, contribute to higher risk for cardiovascular disease.

This project aligns with the disease management requirements for the Patient Centered Medical Home recognition (Project 2.a.ii.). A common cardiovascular evidence-based protocol will be implemented by all primary care practices, nursing homes, home health, and hospitals in the PPS to ensure a consistent standard of care along the continuum. Patients will be stratified and managed to ensure the appropriate level of care, ranging from blood pressure screening and evaluation at any health system encounter to evaluation for complex care coordination for patients with hypertension and one or more comorbidities.

The NYHQ PPS will increase the use Community Health Workers in their own areas of residence. Community Health Workers have been described as "frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison...between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." The PPS will work with community leaders in ethnically concentrated geographies to collaborate on selection and deployment of community health work teams.
A health education team is being established in the PMO to implement a Chronic Disease Self-Management Program based on the Stanford Model with master trainers serving as instructors in the communities. This program will offer a continuous array of courses in centralized and community-specific locations.

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 targeted population will be individuals who are associated with participating committed providers. The engaged population will be patients who receive services from participating providers with documented self-management goals in medical records (diet, exercise, medication management, nutrition, etc.). Targeted diagnoses within the cardiovascular population would include congestive heart failure, hypertension and hyperlipidemia patients. The higher incidence of cardiovascular diagnoses is found among the African American population and those residing in Southeast Queens.

Those patients without provider connectivity may be engaged in the project through community advisory groups or public health initiatives. Heightened community awareness is important.

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 NYHQ Cardiac Health Center is the expert, role model, and benchmark for best practices and will lead this project. These best practices will be explored and utilized to assist in this project. The Center provides wellness, cooking, yoga and tai chi classes to promote a wholistic view of health for patients. In addition, weight management services are offered to patients to aid in the prevention of additional cardiac events and promote the focus of cardiac rehab to prevention.

The Center's assets will be lerveaged to implement this project. The expertise of the NYHQ Cardiac Health Center will be used along with new resources such health educators to ensure the success of this project. Community health workers will need to coordinate care and efforts with the participating providers and patients. The health education team will need to explore and mobilize resources and tools for 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.

Because cardiovascular diseases, such as hypertension, are treated for life, the greatest challenges associated with this project will be sustaining patient engagement and adherence to medication regimens. Living with cardiovascular disease, not just treating it, will be achieved with care coordination, home care and visits by community health worker assistance.

Local solutions within the diverse communities are key as behavioral risk factors, such as diet and exercise, vary according to the ethnic groups with the service area. The local community action

advisory council (CAC) will be important conduits to reach patients/persons at risk and to encourage participation in outreach activities. The CAC is a 24 member multi-ethnic council that acts as a liaison for the community at large and will be enlarged through this process. The NYHQ will work with the CAC to train local instructors on the Stanford model for chronic disease and implement self-management programs in their own communities. The CAC will also help to ensure training materials are culturally appropriate and facilitate collaboration with faith-based organizations, schools, and businesses.

Challenges with partners include the care coordination and standardization across multiple partners and managing a network of PCPs and other providers. Best practices and the expertise of the partners and the NYHQ Cardiac Center will be utilize to implement standardized procedures across the PPS.

IT challenges are around data integration and telemedicine. The PPS will support the implementation of an interoperable EHR system and connectivity with the RHIO for partner organizations.

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.

The NYHQ PPS will coordinate the Self-Management Program and other community-based events the HHC PPS to avoid duplication of services and health promotion offerings. The PPS will coordinate with any PPS that is implementing this or similar projects including engaging the population.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

IT Infrastructure / Population Health Management, Telehealth program

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

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

3.d.ii Expansion of Asthma Home-Based Self-Management Program

Project Objective: Implement an asthma self-management program including home environmental trigger reduction, self-monitoring, medication use, and medical follow-up to reduce avoidable ED and hospital care.

Project Description: Despite best efforts of practitioners to implement evidence based practices, patients continue to have difficulty controlling their symptoms. The goal of this project is to develop home-based services to address asthma exacerbation factors. Special focus will be emphasized on children, where asthma is a major driver of avoidable hospital use.

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. Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.
2. Establish procedures to provide, coordinate, or link the client to resources for evidence based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.
3. Develop and implement evidence based asthma management guidelines.
4. Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.
5. Ensure coordinated care for asthma patients includes social services and support.
6. Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.
7. Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.
8. Use EHRs or other technical platforms to track all patients engaged in this project.

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

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

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

According to the CNA, the PDI indicator for the Queens County pediatric population of 0-4 year old is 229.9 per 10,000 lives as compared to the state objective rate of 196.5 and the adult rate of 81.1, which directly reflects a need to focus to the reduction of emergency room utilization for episodic care. Hotspots defined as those areas with the largest gap in risk-adjusted observed and expected composite PDI include Bayside, Little Neck, and Fresh Meadows ranging from 256.6, which is twice the number of expected hospital admissions, to 117.7. In 2012, respiratory disease affected 8.1% of beneficiaries in Queens and was the primary driver of 46,615 admissions and 70,489 ED visits.

Additional research reflects that people in poverty are twice as likely to suffer from asthma and that Medicaid recipients with asthma has grown by 30% within the last five years. Estimated PPS attributed children show asthma claims from 157 zip codes, 85% reside in 35 zip codes which mirror the areas with large PDI gaps.

In order to address the CNA findings, this program will develop a collaborative approach with the Asthma Coalition of Queens and the School Health Services of New York City Department of Health, to create the NYHQ PPS Asthma Resource Center (ARC) and implement a home based self-management program. The ARC will be a navigation style patient centered resource that will focus to on continuity of care, health literacy, treatment optimization, coordination of care, and environmental analysis to benefit the patient and family members. The site will also offer assistance to patients and their families for government resources, such as financial assistance programs, etc.

As a compliment, the ARC will provide a central site for population health management, care coordination, and clinical integration with a focus to decrease hospital utilization through the promotion of asthma self-management tools, environmental trigger awareness, and evidence-based medicine protocols.

The core of the resource center will be a team of nurses, social worker, asthma educators, community health worker, respiratory therapist and child life personnel. The team will be supervised by the Director of the Pediatric Asthma Center who will be responsible for the development of project milestones and timelines and ensuring utilization of evidence-based guidelines.

The PPS will convene an Asthma Work Group (AWG) to develop a home based environmental assessment and asthma self-management prototype for implementation, identify best practice standards, and outline additional community gaps to serve the population. The AWG will be composed of the NYC Department of Health and Mental Hygiene, the Asthma Coalition of Queens, Medicaid Managed Care plans, community based organizations, school-based clinics, EPA, home health, community health workers, physicians and other professionals from the asthma center.

Along with the ARC and AWG, the PPS will expand services of the asthma mobile unit by the addition of a second unit and will ensure care access utilizing the existing platform of the Pediatric Asthma Center, Asthma Urgent-Care Centers, and other community resources.

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 targeted population for this project will consist of all the attributed individuals under the age of 19 who have a diagnosis of asthma. The engaged population will be the number of attributed patients under the age of 19 associated with committed physicians that show on home assessment log, patient registry, or other IT platform. In order to focus on the highest potential of improvement opportunities, the highly problematic areas of Southeast Queens, Central Queens, Western Queens, and Rockaway will be targeted through collaborations of school based activity, mobile unit, and resource center outreach.

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 Pediatric Asthma Center will serve as the PPS best practice, as it is the longest-running community based program in Queens County dedicated to the care of children with asthma. The Center's goals are to minimize the impact of asthma related symptoms and illness on both the patient and family, and to reduce acute episodes that require hospitalization. Under the direction of a pediatric Pulmonologist, patients undergo a complete medical and environmental assessment and participate in treatment and maintenance. Routine follow-up care and progress is closely monitored. Disease management education is also provided at all visits and personal counseling is available, when needed, to assist patients and families in handling the emotional stress related to asthma. Services are offered at NYHQ's main campus in Flushing and the Jackson Heights Family Center.

An additional resource that is offered to provide accessibility to asthma specialty care is the asthma mobile unit. The unit operates Tuesday & Friday from 1PM – 7PM is wheelchair accessible, and facilitates access to prevention education and asthma screenings. The mobile unit hours will be expanded in its current capacity and the team will identify a plan of action to deploy an additional unit that will focus to highly dense asthma expansion areas such as Hollis and Richmond Hill. This unit will require capital funding to be included in the CRFP application process.

The project will be championed by a physician lead, Dr. Hadi Jabbar, who is well recognized in the asthma community and holds numerous affiliations with organizations such as the American Lung Association, NYS Consensus Asthma Guidelines, Asthma Coalition of Queens, and the Asthma Coalition of Long Island. Dr. Jabbar will utilize existing collaborations among organizations to expand on expertise and partnerships to benefit the vision of the project.

One example of this collaboration is the ALA program, Open Airways for Schools ®, and the Asthma Educator Institute. The American Lung Association's Open Airways for Schools is a

school-based curriculum that educates and empowers children through a fun and interactive approach to asthma self-management. It teaches children with asthma ages 8-11 how to detect the warning signs of asthma, avoid their triggers and make decisions about their health.

An additional collaboration with Mental Health Provider of Western Queens (MHPWQ) and New Horizons organizations will allow for an expansion of the footprint in school based clinics to increase awareness and health literacy.

Population health management technology will be needed to support asthma management and measurement. The PPS will seek capital funds through the CRFP to purchase population health management technology which would be extended to participating providers. The PPS will review HIPPA compliant methods to communicate with the patient base to include patient portals and communications such as texting. The IT survey of the PPS partner network revealed that most practices have EHRs, however, most lack interoperability. Practices will be requested to participate with Healthix (RHIO) for real-time exchange of information.

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 main challenges for this project are child and parent/guardian psychosocial factors such as understanding of the chronicity of the disease, engagement, adherence to treatment and prevention regimens, literacy, missed appointments, and reduced cognitive ability. The PPS' strategy for improved health literacy and the Ask Me 3 program will help to address these issues of comprehension and adherence to treatment regimens. The ARC and AWG will be valuable resources to address this concern. The PPS will implement a population health management strategy through the utilization of an IT tool which will help track and identify patients who either need a home based asthma plan or who already have a plan but need to be monitored for adherence.

Other challenges for this project are associated with living spaces, including care givers gaining access to conduct environmental assessments and the presence of second hand smoke. A robust health literacy program will be a top priority for the ARC to address this concern. Leveraging partner resources such as the MHPWQ locations in school based clinics will enable the PPS to enhance education outside the traditional hospital or home setting. Engaging Community Health and Home Health workers will aid in building relationships over time to build trust between patient and care giver.

Interoperability of IT systems pose a challenge for partners. The PPS plans to support the implementation of EHRs at provider sites as needed as well as implement a population health management tool to help track and monitor these 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.

This program will be strengthened by the coordination of efforts among other PPSs with overlapping service areas. Along with the vast amount of collaborations listed above, the NYHQ PPS will coordinate with other PPS leads and providers to avoid service duplication services and interventions. As the PPS moves into implementation, workflows and processes will be aligned to ensure collaboration and coordination of resources for Queens County. The PPS will explore utilizing learning collaboratives, joint educational opportunities for the community, and the MRT Innovation exchange (MIX) website.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Asthma Mobile unit, IT Infrastructure / Population Health Management

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

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

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

3.g.ii Integration of Palliative Care into Nursing Homes

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

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

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

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

1. Integrate Palliative Care into practice model of participating Nursing Homes.
2. Contract or develop partnerships with community and provider resources, including Hospice, to bring the palliative care supports and services into the nursing home.
3. Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.
4. Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.
5. Engage with Medicaid Managed Care to address coverage of services.
6. Use EHRs or other IT platforms to track all patients engaged in this project.

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

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

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

Each of top ten causes of death described in the Community Needs Assessment are conditions that will benefit from palliative care to improve beneficiaries' quality of life, emotional and

spiritual support, well-being and dignity, care at time of death, and lighten symptom burden.[1] Seven of the top ten causes of death are chronic diseases that over time reduce a person's ability to function and their life expectancy. These conditions are: diseases of the heart, malignant neoplasm, cerebrovascular disease, diabetes, chronic lower respiratory diseases, essential hypertension and renal disease, and Alzheimer's disease. Two of the causes, intentional self-harm and accidents except drug poisoning, can leave patients with chronic pain or loss of function if death is not immediate. The final cause, pneumonia and influenza can quickly change from an acute condition to a terminal one.

Even though the Medicaid claims data states that close to 5,000 beneficiaries in the NYHQ PPS attributed population have received or are receiving palliative care, the Dartmouth Health Atlas data suggests that the Queens' community standard represents very high-utilization and costly end of life care. Much opportunity exists to improve end of life care by strengthening and expanding palliative care services in the PPS. The Flushing area and New York Hospital Queens ranked in the 90th percentile (high) for Medicare dollars spent during a patient's last six months of life and the 90th percentile (high) for number of physician visits in the last six months of life. In 2007, they ranked in the 90th percentile (high) for percent of Medicare patients who died in the hospital and in the 90th percentile (high) for the percent of decedents admitted to ICU/CCU during the hospitalization in which death occurred. Across the PPS, only nine of twenty six nursing homes surveyed, use MOLST (Medical Orders for Life Sustaining Treatment) or POLST (Physician Orders for Life Sustaining Treatment), indicating gaps in advance planning between medical providers and patients.

This project aims to improve quality of life resulting from serious conditions, reduce unnecessary hospitalizations, and deliver person-centered, family-oriented end of life care by strengthening and expanding existing palliative care programs or implementing new programs in those nursing homes throughout the PPS. This project aligns with and is supported by 2.b.vii Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF) as advance care planning tools are part of the INTERACT program. Much opportunity exists to improve end of life care by strengthening and expanding palliative care services in the PPS.

Current processes, documentation and tools are being reviewed to assure alignment with national guidelines and standards of care, including implementing MOLST at each site. Learning materials will be standardized for collective use to provide a common standard of care for PPS beneficiaries. Current processes, documentation and tools are being reviewed to assure alignment with national guidelines and standards of care, including implementing MOLST at each site. NYHQ has a certified EPIC Trainer that will be providing intensive two education targeted to Physicians, NP and PA's. Elnec the nursing parallel to this will be offered to each facility.

A public education campaign will be implemented in collaboration with the PAC, the Community Stakeholder Committee, community advisory councils, clergy, community based organizations, media, local businesses and other community leaders to raise awareness of and offer tools and guidance about palliative care.

[1] Institute of Medicine. 2014. Dying in America: Improving Quality and Honoring Individual Preferences as the End of Life, Key Findings and Recommendations. Retrieved 12/10/14 from: www.NAP.edu

This palliative project has 27 committed nursing homes which will benefit the attributed members and members of other PPS in the region.

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 targeted population are attributed beneficiaries associated with the committed nursing homes. The engaged population is defined as the number of participating patients receiving palliative care procedures at participating sites as determined by the adopted clinical guidelines. With the vast amount of partners participating in this project, the targeted and engaged population will be significant and cover all disease categories and chronic conditions to benefit the majority of our 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.

NYHQ has a well-established interdisciplinary Division of Geriatrics and Palliative Medicine. It will serve as a role model for the nursing home palliative care teams and will serve as the lead for this project. Since implementation of Palliative care at NYHQ we have had a decrease in long-term ventilator discharges and a gradual culture change where more and more physicians use the Palluative Care Team Services. In partnership with the NYHQ Palluative Team, participating Nursing homes will gain palliative care subject education and facilitation tools to enable them to develop site specific Palliative Teams. Each nursing home will choose a recognized Hospice provider (5 hospices in PPS) that will leaverage their experience and advisement from many years of providing hospice and palliative care. NYHQ will collaborate with nursing home partners to develop and adapt National Quality Palliative Standards including services and eligibility. The collaboration of Nursing Homes, Hospices, Hospitals, and Community Based Organizations will be critical to the success of the project.

NYHQ has started a pilot project to implement the paper MOLST form for all new nursing home transfers that have are being transferred. In future we will use the electronic version between all post-acute providers and the facilities.

This project is well suited to using a quality improvement collaborative model to promote implementation of new programs and expansion of current palliative care programs. A quality improvement collaborative is a “learning system that brings together teams to seek improvement in a focused topic area.” This approach promotes learning from and supporting each other throughout the project duration. The experience and knowledge of the partners who have a history of providing palliative care are benchmarks for the other partners.
The improvement collaborative approach allows the partners to explore possibilities in leveraging common resources. Rather than develop and implement staff training separately, the partners

may collectively develop and offer training for providers, care givers, and families. Opportunities for sharing palliative care teams across facilities will also be evaluated as a way to provide services for low volume facilities in an efficient and cost-effective manner.

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.

This is a well-recognized issue in America that death is an option. There has been very little professional training to identify, educate, treat or communicate with the family or other healthcare professionals.

A prominent challenge in palliative care stems from religious and cultural beliefs about death and dying for both patients/families and providers/care givers. The PPS will take time for staff to explore their own beliefs, understand the purpose of palliative care services, and learn care giving behaviors and language that respect patient / families wishes even if they are different than their own. Cultural sensitivity is extremely important in palliative care services. PPS partners will be part of the overall PPS cultural competence strategy and will build upon interventions they are currently using; these include physicians fluent in the beneficiary's language of choice (a preference identified in the Community Needs Assessment); provider and care giver ethnic composition that reflects their own patient population; community; spiritual assessments and clergy of multiple denominations to support spiritual needs; interdisciplinary teams; and, input from family councils.

A challenge identified by the partners is reimbursement for services. The PPS and nursing home leaders will work together with Medicaid Managed Care plans to discuss issues and identify solutions related to reimbursement for palliative care services.

A common barrier for an improvement effort such as this is enabling time for project team participation and for the training required to support implementation. Nursing home leaders must agree to support team participation and training as part of, not in addition to, their day to day job responsibilities. Successful implementation will require funding in the project budget to allow for training participation without causing understaffing at the bedside. The NYHQ PPS will plan funding specific to projects during the implementation process and have annual budget planning processes that are built into the governing process of committees and sub-committees.

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.

The NYHQ PPS will coordinate with the HHC PPS to avoid service duplications and interventions. As the PPS moves into implementation, workflows and processes will be aligned to ensure collaboration and coordination of resources for Queens County. The PPS will explore utilizing learning collaboratives, joint educational opportunities for the community, and the MRT Innovation Exchange (MIX) website. The process of monitoring partnerships among PPS's and ensuring the lack of duplication of interventions will be the responsibility of the NYHQ PPS governing body consisting of committees and sub-committees.

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.

Information Technology Infrastructure / Population Health Management system

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

and scale submissions with the project application will directly impact Domain 1 payment milestones.

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

4.c.ii Increase early access to, and retention in, HIV care (Focus Area 1; Goal #2)

Project Objective: This project will increase early access to, and retention in, HIV care.

Project Description: This project is targeted at increasing the percentage of HIV-infected persons with a known diagnosis who are in care by 9% to 72% by December 31, 2017.

This project is also targeted at increasing the percentage of HIV-infected persons with known diagnoses who are virally suppressed to 45% by December 31, 2017.

Project Requirements: Each of the four HIV/STD Projects contain the same 13 sector projects. PPS implementing this project will need to review these projects and chose at least 7 or more that are impactful upon their population, state why the sector projects were chosen, and then develop their Domain 4 project using those sector projects. The PPS at any time may add additional sector projects if it is determined these will add to the impact of their project.

1. Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care.
2. Increase peer-led interventions around HIV care navigation, testing, and other services.
3. Launch educational campaigns to improve health literacy and patient participation in healthcare, especially among high-need populations, including: Hispanics, lesbian, gay, bisexual, and transgender (LGBT) groups.
4. Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration, and mental health.
5. Assure cultural competency training for providers, including gender identity and disability issues.
6. Implement quality indicators for all parameters of treatment for all health plans operating in New York State. An example would be raising the percentage of HIV-positive patients seen in HIV primary care settings who are screened for STDs per clinical guidelines.
7. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care.
8. Educate patients to know their right to be offered HIV testing in hospital and primary care settings.
9. Promote interventions directed at high-risk individual patient, such as therapy for depression.
10. Promote group or behavioral change strategies in conjunction with HIV/STD efforts.
11. Assure that consent issues for minors are not a barrier to HPV vaccination.
12. Establish formal partnerships between schools and/or school clinics, and community-based organizations to deliver health education and support teacher training programs.
13. Promote delivery of HIV/STD Partner Services to at risk individuals and their partners.

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
HHC, Community Care of Brooklyn
Bronx Partners for Healthy Communities
Lutheran Medical Center
Bronx-Lebanon Hospital Center
New York Hospital Queens
Mt. Sinai Hospital Group
NYCDOH

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.

According to the Community Needs Assessment, the prevalence rate of HIV in Queens County is 22.6 per 100,000. Although this rate is almost twice as high as The Prevention Agenda goal of 14.7 per 100,000, Queens County demonstrates a substantially lower rate than Bronx (43.1), Kings County (33.2) and New York (48.5). Of total Medicaid beneficiaries in Queens, approximately 7,428 (0.8%) have been diagnosed with HIV leading to 2,624 inpatient admissions and 4,379 emergency department visits in 2012.

Most neighborhoods in Queens are home to Medicaid beneficiaries living with HIV/AIDS. The primary data of the CNA reflects concerns of physical health issues such as HIV. The five zip codes of the top seven with high volumes of Medicaid beneficiaries also demonstrates the highest numbers of people living with HIV/AIDS ranging from 272 (zip 11372 Jackson Height) to 790 (zip 11355 Flushing). South Eastern Queens ranging from 118 (zip 11423 Hollis to 531 (11432 Jamaica).

The CNA identifies healthcare gaps relating to the lack of safety net providers and geographic disparities of access to care. Both gaps, along with the challenge of cultural diversity, create an impractical situation for proper diagnosis, prevention, education, and treatment.

NYC has identified HIV/AIDS as a significant population-wide public health epidemic with 8,298 new cases diagnoses between 2010 and 2012.

The following offers justification for the chosen sector projects.
Sector 1: The interventions chosen for this sector are based on NYS Department of Health (DOH) AIDS Institute (AI) priorities for increasing HIV testing and linkage to care services, increasing viral load suppression, and increasing access to evidence-based prevention efforts, such as pre-exposure prophylaxis.

Sector 2: Peer involvement has been proven to enhance HIV prevention and care services and will be a significant aspect of several of the project interventions. Interventions addressing this sector will focus on integrating peers as compensated members of the care teams, building their capacity to provide support, and ensuring that their voices and experiences guide program activities.
Sector 3: To address significant issues related to retention and viral suppression, culturally sensitive educational campaigns are essential. Evidence-based educational campaigns will be established and supplemented by a broad social marketing campaign, these efforts will be supported by all of the PPS groups for maximum reach and impact.
Sector 4: HIV-infected persons often have co-occurring diagnoses and other life factors that play a strong role in their ability to access care and maintain care routines. Interventions related to this sector will build upon the DSRIP work in Domains 2 and 3 and existing resources to improve the identification, referral, and linkage to services for individuals in need.
Sector 5: Given the cultural, ethnic, gender, and age diversity within the target population there is a strong need for services to be provided in a welcoming environment that respects this variety. Cultural competency training and programming will be central to improving the access and utilization of services to ensure that key issues, such as conducting effective and respectful sexual histories, are addressed.
Sector 7: Given that HIV is an incurable illness, it is crucial for people living with HIV be able to help themselves and their peers. Interventions addressing this need will center on the use of peer leaders and support groups to provide relevant, effective resources.
Sector 9: Improving access to services for high-risk individuals and working to improve the identification, referral, and linkage for those individuals into existing services will be at the center of interventions for this sector.
Sector 13: DSRIP efforts will be directed at supporting improved utilization and access to Partner Services as this is a central component of the NYS and NYC departments of health HIV control campaigns.

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 the Special Care Center strives to provide high quality HIV care to all patients within our service area, the engaged population will be the populations identified as high risk such as the MSM and LGBT community, HIV positive minorities to include black, hispanics, and women of color, young adults, and at risk populations that include high risk HIV negatives. To be effective, HIV prevention efforts must reach the highest risk populations while being perceptive of the cultural diversity among the county as well as the HIV population as cited in the Community Needs Assessment.

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.

As mentioned above, efforts within the NYHQ PPS are linked with larger city-wide efforts. The NYDHMH are expert resources of convening, guidelines, training, and education materials.

The DOHMH provides eighteen Ryan White funded sites to meet beneficiary needs in Queens for food and nutrition, home care services, drop-in center for HIV+ recently incarcerated, housing placement assistance, harm reduction and recovery services, legal services, medical case management and care coordination, mental health services, outreach to homeless youths, and the Rikers Island Transitional Services project.

Within the PPS, the NYHQ Specialty Care Center is an AIDS Designated Center, by the NYS DOH. It operates five days a week with evening hours on Thursdays. The interdisciplinary team is composed of physicians, nurses, a nutritionist, social workers, oral pathologists and pastoral care representatives. In addition to providing state-of-the-art medical therapy, the center offers HIV testing, psychosocial intervention. Ophthalmology, OB-GYN services, dental care, nutrition counseling and supplements are offered at other NYHQ article 28 sites. Care coordination and disease management will be expanded and aligned among partners and the role of Community Health Worker Navigators will be expanded as part of the care team.

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.

Some of the challenges and issues we anticipate confronting while implementing this project include:

Effectively addressing the social co-factors that constrain successful access and retention in care. This includes being better able to more effectively identify needs and working with a wide array of on-medical service providers to address these needs.
Collaboration of resources across the PPS collaborative – particularly knowledge, experiences, and perspectives – to address needs of sub-populations to improve project design and implementation.

Ongoing communication/education activities between partners to ensure common understanding and implementation at the service level.

Effectively keeping patients engaged to allow for project objectives to be realized. Understanding the evolution of the NYC HIV epidemic and effectively identifying new sub-populations at risk and changes within known sub-populations.

To properly address the challenges associated with this project, the NYHQ PPS will implement the following interventions:

Increase early access to and retetion in HIV care in order to decrease HIV and STD morbidity and disparities.
Increase peer-led interventions around HIV care navigation, testing, and other services.
Assure cultural competency training for providers, including gender identity and disability issues.
Implement quality indicators for all health plans operating in New York State.

Promote interventions directed at high-risk individual patient, such as therapy for depression.
Promote group or behavioral change strategies in conjunction with HIV/STD efforts.
Promote delivery of HIV/STD Partner Services to at risk individuals and their partners.

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

Given the scope of the issues involved, seven PPS's in NYH care engaged in joint planning. Via a charter agreed by our PPS's, we intend to continue this commitment through implementation planning and operations to address major gaps in access to, and retention in, HIV care. The joint planning workgroup consists of the following PPS's: HHC, Community Care of Brooklyn, Bronx Partners for Healthy Communities, Lutheran Medical Center, Bronx-Lebanon Hospital Center, New York Hospital Queens, Mt. Sinai Hospital Group, as well as the NYCDOH.

Each PPS will be accountable for the implementation of the HIV project, but this collaborative will be critical in the implementation planning, reporting, and trending of the populations to ensure consistency of care and coordination of efforts to avoid duplications. The collabortive will meet frequently to define implementation planning strategies, review key healthcare findings of populations, discuss anticipated and actual challenges of each program, and define or review best practice standards.

As the the HIV collaborative will not focus to other initiatives, it will produce interactive discusions of topics that relate to other projects, such as access to behavioral health services which ties to the NYHQ PPS project of integrating primary care and behavioral health services. With the PPS expectations of committees and sub-committees partners will have substantial opportunities to continuously share information among projects and partners.

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.

The HIV Care Continuum is a "way to visualize care engagement among persons with HIV in a population." [2] The goal ultimately is to ensure viral suppression of all diagnosed persons. Of the 133,635 persons estimated to be HIV infected in 2012 In New York, only 45,471 persons achieved viral suppression. To focus the project, the following milestones apply:

Identify consistent patient activation methods that link primary and behavioral health services

Implement the Chronic Care self-management program

Define a robust health literacy strategy in partnership with CBO's

[2] Braunstein, Sarah. The New York City HIV Continuum of Care. Retrieved 12/10/14 from: http://livelifeplus.amidacareny.org/Collateral/Documents/English-US/ONAP-Brooklyn-Presentations.pdf

Establish performance dashboards

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.

Information Technology Infrastructure / Population Helath Management Registry

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
New York Hospital Queens	Ryan White HIV	Ongoin	Ongoing	HIV Ryan White Funding

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.

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.