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

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

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

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

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

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

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

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

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

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

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

Suffolk County Medicaid/Uninsured members are served by a fragmented set of providers and payers: 6 Managed Care Organizations (MCOs), 11 acute hospitals, 3 Health Homes, many physicians, Skilled Nursing Facilities (SNF), home health, Behavioral Health sites, substance abuse clinics, etc. There are no defined mechanisms to ensure effective clinical communication, share data on patient care gaps or accomplish the care redesign needed to meet PCMH standards. The CNA data confirms the presence of significant gaps in care that a more integrated system with an effective care management model and sufficient primary care resources can help to close.

OVERUTILIZATION: In 2011/2012, the average of the Inpatient (IP) Prevention Quality Indicators for discharges reveals a significant excess in observed vs. expected rate. In 2011 there were 83K Potentially Preventable ED Visits which rose to 86K in 2012. Three out of 8 participating Suffolk hospitals have Potentially Preventable Readmission rates above expected value.

ACCESS: Suffolk County has only 84.9 Primary Care Providers (PCPs) per 100K population (NY State average of 109.5). 66% of Medicaid adults reported difficulty or delay in obtaining healthcare services in the past year. POPULATION BASED GAPS: 5% of the population is linguistically isolated, 10% of those over age 25 have no high school diploma. 40.2% of Medicaid adults (versus 18.7% of total population) have a depressive disorder.

FROM KEY INFORMATION INTERVIEWS: Significant gaps in case management (CM) standards, metrics, and coordination exist. Knowledge of population health management is low. IT systems do not connect with each other.

ADDRESSING IDENTIFIED GAPS CARE MANAGEMENT: The PPS will provide a platform that allows for promotion of best practice CM standards. The program will contain both IP and Outpatient (OP) CM units, a Special Needs Unit for complex cases, leverage existing Health Home resources, embed CMs in PCP practices and Federally Qualified Healthcare Centers (FQHCs), in emergency rooms; and with 24x7 call coverage. Regional pods will be created so CMs can work as a team and focus on local challenges, while leveraging local resources. The IP CM function will use existing hospital resources but create standardization in how that function promotes better hand-offs to the OP setting. The OP function will require hiring additional nurse, social worker and Care Associate (lay worker) positions to serve the broader Medicaid/uninsured population, leveraging existing community CM resources.

SUPPORT PCMH AND "ADVANCED MEDICAL HOME" (AMH) MODEL DEVELOPMENT: The PPS will work with participating PCPs to help redesign their office and patient care practices to meet the needs of the population they serve and move them to Level 3 NCQA PCMH recognition by the end of DY3, ideally moving many practices to the more effective AMH model as published nationally by Geisinger.

MCO INVOLVEMENT: The PPS will leverage existing value-based arrangements with payers to shift provider compensation to align with outcomes as measured by quality, utilization and cost metrics. Formal interaction between Medicaid MCOs and providers will occur monthly through a PPS/MCO liaison team that will focus on payment models that will lead to sustainability of the IDS.

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

SPECTRUM OF CM SERVICES: The IDS will leverage assets at: 1)Health homes – FEGS, North Shore LIJ and Hudson River Health (HRH); All county DOH clinics (converting to FQHC-like entities under HRH) 2)eight hospitals; six payers – leverage existing CM programs and resources 3)Residency programs at Stony Brook, Mather – (e.g. have residents provide care in community FQHCs).

Mobilize resources to support IMPROVED CARE MANAGEMENT PROCESSES: Warm handoffs between IP, OP and SNF settings. Hold Case review meetings regularly. Use abbreviated notes in EHR to relay information. Use checklists for handoffs at transitions with application of disease-specific protocols, operating protocols (when to call, how often …) and risk stratification to identify high risk patients.

TECHNOLOGY: Use of local RHIO. Safety Net providers already have high connectivity. Knowledgeable Meaningful Use resources exist within the PPS with strong understanding of what needs to be done across PPS partners. Experienced IT team in Population Management platforms, Patient engagement, Care Management tools and Analytics with architecture already completed. Financial incentives will help drive PCMH adoption.

Core assets will help the PPS create and expand CARE MANAGEMENT TECHNOLOGY: Create CM documentation system that captures care plans, productivity, outcomes, care gaps etc. separate

from the EHR and interoperable across all CM entities. Establish governance for managing data, identify key gaps in care provision, utilization, medication adherence.

MCO INVOLVEMENT & REIMBURSEMENTS: Utilize existing P4P programs; Expand the premium dollar that goes into risk contracts; Capitalize on relationship with Health First Medicaid MCO given its joint provider ownership that includes a number of the PPS hospitals who currently have a risk relationship with this Medicaid MCO.

CULTURAL COMPETENCE AND HEALTH LITERACY: Leverage and build upon existing network of care management agencies that have deep knowledge of the communities they serve. Provide patient information and support to address and improve health literacy.

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

STRUCTURAL CHALLENGES: PPS members that have concerns about sharing data. Challenges meeting requirements for Meaningful Use and RHIO connectivity. STRUCTURAL REMEDIES: Create a PPS IT Governance Team that develops data access and security standards and protocols addressing Provider concerns, support interventions assisting PCP practices in technology and EHR implementation, create best practice examples around advantages of RHIO participation and how patient RHIO consents can be obtained.

TECHNOLOGY DIVERSITY CHALLENGES: Myriad data systems and definitions . TECHNOLOGY DIVERSITY REMEDIES: Communicate PPS transition vision for integrated technology model that increases system connectivity and interoperability while maintaining necessary system differentiation required.

CARE MANAGEMENT CHALLENGES: Variation in CM provided. No common standards, protocols and governance. CM REMEDIES: Create a model for uniform PPS governance of CM standards and protocols. Provider Challenges: Provider shortages particularly in primary care and behavioral health. Lack of participation of smaller rural PCP practices in the IDS. Provider Remedies: IDS includes interventions to improve efficiency in PCP practices and capacity (PCMH). Geographic provider shortages addressed by the PPS, leveraging support from PPS providers who have expanded provider capacity in rural areas (HRH, Brookhaven Hospital). Increased PCP practice engagement promoted through communication of resource and financial support to support redesign efforts.

PROVIDER CHALLENGES: Lack of provider financial alignment; reduced utilization reduces revenue across multiple provider types. PROVIDER REMEDIES: Re-write provider contracts to include risk/rewards mechanism that create incentives for providers to move metrics on cost, quality and utilization.

PATIENT CHALLENGES: Patient factors unique to the Medicaid and Uninsured population i.e. health literacy gaps, social/family issues, transportation issues, and REL barriers. PATIENT REMEDIES: Protocols that ensure barriers are addressed in each phase of project implementation, with oversight by a Community Advisory group that includes representation from the patient population and advocacy groups. Telephonic and in-person translation services offered to overcome language barriers.

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

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

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

The PPS will leverage the core components of the IDS project to create the clinical and utilization results needed to reduce the number of IP admissions and to reduce unnecessary acute and long term care beds in Suffolk County hospitals. This project will emphasize the importance of: preventing patients from using the ED as their point of primary care, effective treatment of chronic disease in the OP setting and effective use of care transition processes to ensure that patients get the best outcomes possible. These goals will be achieved through the use of embedded CMs within a County-wide care management platform, primary care practice (PCMH) redesign, and linkage with all appropriate community resources. The care management and practice redesign will improve access to care, improve quality outcomes, and reduce avoidable IP admissions and readmissions. This will allow an opportunity to "right size" the number of acute and long-term care beds in the County.

AN EFFECTIVE CARE MANAGEMENT SYSTEM IS THE CORE APPROACH TO CREATE RESULTS WITHIN THE IDS: A core component of the IDS project will be the design and implementation by the end of DY 1 of an effective County-wide care management system that will leverage existing community resources and optimize the results of the PCMH. This system will be based on a community nurse CM model that provides an embedded CM for higher volume PCMHs to support the patient care process, and then will be supplemented with a regionally-based team of CM, Social Worker (SW) and lay care associate support for smaller PCP practices. Efforts will be made to integrate existing community care management resources (such as Health Homes) with new PPS resources that together will leverage standardized protocols, processes and measures across Suffolk County to help to achieve reduction in avoidable admissions.

PRIMARY CARE REDESIGN: The PPS will work with participating Primary Care practices to help redesign their office and patient care practices to meet the needs of the population they serve, both in access to care and in quality outcomes. These practices will document Level 3 NCQA PCMH recognition by the end of DY3, ideally moving many practices to the more effective AMH model as published nationally by Geisinger Healthcare System. The IDS will work to institute structural practice changes by the end of DY1 to implement PCMH or AMH. Chief among these changes are the creation of expanded practice hours, improved scheduling systems, and creation of more access to Urgent Care locations for afterhours care. In higher patient volume areas of the County with limited patient access, the PPS will build-out additional provider resources, leveraging existing sites of care such as FQHCs to add capacity including PCPs and BH providers, both described as areas of shortage in the CNA.

DEVELOPMENT OF MEDICAL NEIGHBORHOOD: Medical Neighborhoods will leverage existing community resources to provide 360 degree coverage and create a closely-linked referral system between PPS providers. A PPS-wide care management platform will be implemented by the end of DY1 to ensure connectivity with all PPS providers. The PPS will work with community leaders and Community Based Organizations to create access to housing, food, and other social services for the Medicaid/Uninsured population.

IMPACT OF SOCIOECONOMIC ISSUES: Suffolk County Medicaid/Uninsured population suffers from lack of transportation, inherent trust issues in the system, and a lack of PCPs willing to treat this population. These issues drive patients to seek care in less than optimal settings. The care management system, IT and governance components of the IDS project will incorporate consideration of these needs in all implemented projects. This will result in a predicted impact on the number of admissions, ED visits, and therefore on the number of acute care and/or long-term beds in the County.

APPROACH TO ADDRESSING EXCESS INPATIENT CAPACITY IN SUFFOLK COUNTY: Within Suffolk County there is an opportunity to reduce certified beds counts within several bed categories as these categories demonstrate sub-optimal occupancy rates significantly below the targeted 85 percent. These include medical/surgical beds (78.51 occ), neonatal (68.57 occ), OB/GYN (58.00 occ), pediatric (43.74 occ), rehab (61.36 occ), and newborn bassinets (40.89 occ). 1)Meetings will be held with Suffolk County PPS hospital leadership. The objective will be the development of a data-driven plan to understand where there may be excess inpatient bed capacity and opportunities to repurpose that capacity in support of the population's health needs. 2)Third-party facilitator guided conversations will leverage objective data about current and future use of beds, the calculated impact of the DSRIP projects, as well as factor in each hospital's plans for growth and the projected demand for these beds stemming from other populations (e.g. Medicare and commercial patients). This group will review the demand for other types of care (e.g. ambulatory surgery) by submarket within Suffolk County. 3)This group will develop principles for targeting beds for possible closure/repurposing and growth of new, complimentary services, and a plan (work plan and budget) to make these changes within the County over the 5-year DSRIP implementation period. 4)This group will continue to meet throughout the 5-year period to ensure that the work plan is followed and that the budget is on target.

LONG-TERM CARE: 1)A similar process will occur to convene representatives of the PPS nursing care facilities. Current occupancy data available for 38 of the 42 total nursing homes is 91.37%. Woodhaven Nursing Home in Port Jefferson Station and Riverhead Care Center have significantly lower current occupancy rates of 67.10% and 75.70%. Suffolk County can reduce its nursing

facility bed capacity by 50 beds. Utilization data and demand projections combined with the facilities' strategic plans for growth will define the PPS' ability to reduce nursing home bed capacity. 2)Several services are not presently offered by any of Suffolk's nursing home facilities: adult day health care, HIV/AIDS, behavioral intervention services, coma services, dementia programs, hospice, limited transfusion services, and pediatric care. These needs will be taken into account in the planning process for bed capacity and an addition of specific services may be warranted.

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

The PPS will develop a governance strategy that will move all participating PPS Providers into a system that truly functions in an integrated manner to optimize clinical goals, patient experience and financial results. The following components within the governance structure and function will fully integrate all PPS providers into the IDS.

GOVERNANCE STRUCTURE: The structure of the governance system itself will be a key component of the plan to move to a fully integrated system through the participation, learning and growth promoted by this structure. The components will include the following: 1)A Board of Directors that is representative of the PPS. 2)Subcommittees of the Board include Clinical, IT, and Financial Governance. 3)Project Teams will include a Physician Champion, an Administrative lead and a Project Manager; these teams report to the Clinical Governance Committee. Board subcommittees will provide leadership and oversight needed to effectively implement the IDS and other PPS projects. The Clinical Governance Committee will provide the clinical oversight needed and will also be accountable for reaching the PPS key milestones as outlined below. It will work closely with the IT Governance Committee in gaining adoption for and implementing the PPS technical solutions for care management, inter-operability of EHRs and optimization of use of the RHIO. The Financial Governance Committee will oversee all financial/budget models and funds flow within the PPS.

GOVERNANCE STANDARDS: Key standards by which governance will agree to operate will be an important component to gain PPS provider support within the IDS structure: Commitment to a "participatory" approach; Commitment to transparency; Effective communication routes; Effective access to all key data/information; Consistent approach to address issues that arise with individual PPS providers; Commitment to a significant focus on the future/strategy as opposed to simply operations. Key governance functions will support the PPS in its move toward a fully implemented IDS: Board Subcommittee oversight of all key PPS functions with a rapid response to areas with unfavorable results to include a request for and follow-up on assigned corrective action. Sessions for PPS participants that will help inform and educate them on topics such as principals of population management, analysis of data trends, and design of value-based purchasing models. Review of PPS provider "health" of their operational /financial status, with processes to assist those who need to redesign their business models to maintain viability. Monitor PPS provider participation and performance with corrective action process to correct areas of poor performance. The PPS will ensure that key milestones are achieved such as: 1)Hold PAC meetings and track attendance rates, DY 0. 2)Convene at least two PPS training sessions, DY

1. 3)Implementation of a care management documentation and registry tool, DY 1. 4)Complete primary care physician recruiting plan, DY 1. 5)Monthly meetings with MCOs to discuss utilization trends, performance issues, and payment reform, DY 1. 6)PPS safety net providers are sharing EHR systems with local health information exchange and sharing health information among clinical partners, DY 3. 7)All safety net and non-safety net providers recognized as Level 3 PCMH, DY 3.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Technology: Acquisition of software platforms needed to execute analytics and connectivity to the RHIO for population health.
Care Management: Set-up space for CM call center for 24 x 7 access. Remote tele-health equipment for care managers in the field (e.g., wireless tablets). Laptops, printers etc. for care

management personnel. Care Management documentation system (with embedded licensed, clinical protocols) for recording interventions, metrics, etc.
PCMH certification: IP costs associated with helping practices achieve PCMH Level 3 certification, including EMR-upgrade investments to meet MU standards.
Physical PC facilities: Potentially, NP-clinics and/ or mobile units to enhance the access to care in non-conventional primary care settings that can act as extensions to the existing 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
Association for Mental Health and Wellness	Development of Health Homes			Transition of TCM to HH Care Management
Sayville Project - Stony Brook University	NYS Medicaid Health Home Initiative			Care management to persons w/ chronic health and behavioral health population
Outreach Development Corp.				Care Coordination Program with FEGs Health Home
Central Island Healthcare & Daleview Care				NuHealth DSRIP
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination
Town of Babylon Division of Drug and Alcohol Services: Beacon Family Wellness Center				Prevent SA in town of Babylon residents through education and treatment services and partnership in community coalitions. Reduce/prevent mental illness symptoms in patients in SA programs. Provide smoking cessation education/re sources to town of Babylon residents and patients in SA program
Town of Smithtown Horizons Counseling and Education Center	Federal BLOCK grant preceded Medicaid redesign; also participating in "Reconnecting Youth" Program			Reduce smoking among patients with MEB disorders
St. James Rehabilitation and Healthcare Center	NY RAH Project	Septemb er 23, 2012	Septem ber 22, 2016	Reducing Avoidable Hospitalizations

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.

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics.** Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed

by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

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

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

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

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

1. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2. Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
3. Ensure required social services participate in the project.
4. Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
6. Ensure that a 30-day transition of care period is established.
7. Use EHRs and other technical platforms to track all patients engaged in the project.

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

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

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

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

There were 30,678 “at-risk” admissions within Suffolk County in 2012, which in-turn triggered 1,580 Potentially Preventable Readmission (PPR) chains. Implementation of an effective Transitions of Care (TOC) program could address this high level of PPRs. In addition, access to a primary care provider (PCP) would greatly reduce issues with TOC, however, the ratio of PCPs per 100,000 in Suffolk County (84.9) is below the statewide number (109.6). Sixty six percent of the Medicaid population report difficulty/delay in obtaining healthcare services in the past year (versus 43.8% of the County population). The Medicaid population also experienced significantly more barriers than the County population due to inconvenient PCP office hours or a lack of transportation. Interviews were conducted with 249 key informants from community-based organizations as well as multiple in-person interviews with key PPS Providers and helped determine the following baseline care gaps. No PPS provider is currently providing comprehensive 30 day TOC services for their discharged patients. Inpatient Case Manager (CM) patient risk assessment tools vary in the degree of rigor in their application/adoption. Composition of the multi-disciplinary rounding team/frequency of the use of the team is variable. No dedicated, measured processes to ensure that patients consistently make follow-up appointments and receive medication reconciliation. Few warm handoffs between inpatient and outpatient CM resources within the community. To address these gaps we propose to combine current CM resources with redeployed and newly hired CMs to implement TOC protocols that cross the inpatient/outpatient settings, tightly link with the Health Home (HH), primary care medical home, and community-based behavioral health resources. The model for inpatients encompasses patient risk assessment, multi-disciplinary rounding, enhanced patient communication, and proactive care coordination, with patient-centric information. In the outpatient setting, CM outreach will occur to ensure post discharge follow-up; medication reconciliation and a PCP visit post discharge, all facilitated through EHR communication links and a care management tool/registry. We will develop connections with Medicaid Managed Care Organizations (MCOs) and Health Homes (HH) so that post-discharge protocols are followed.

ADDRESSING IDENTIFIED GAPS. INTER-DISCIPLINARY ROUNDING: will include: Social Worker (SW), TOC nurse, physician, rehabilitation specialist, pharmacist and others. The multidisciplinary team will help to ensure ongoing sharing of information between inpatient and outpatient settings. Discharge planning will begin at admission. The SW will ensure communication with community-based organizations to address potential barriers to care post discharge e.g. transportation, housing, linguistic barriers.

COMMUNICATING WITH TARGET POPULATION: The discharge process will focus on culturally and linguistically competent person-centered care including “teach-backs” and culturally appropriate educational materials at 5th grade reading levels.

FACILITATING WARM HANDOFFS: The TOC protocols will ensure patients consistently keep follow-up appointments, receive medication reconciliation and care coordination. This includes protocols that engage the HH CM, home health agencies and Medicaid MCOs at time of discharge, and may include a CM visit to the hospital, home-visits, follow-up calls and urgent care services while awaiting a post-discharge appointment. If there is no existing outpatient (OP) CM, patients will have a case manager assigned to his/her case.

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

The target population for this project is: 1) Suffolk County Residents 2) Medicaid patients, and 3) Inpatient admissions (excluding normal newborn) in 11 County hospitals. Patients will be identified as being at high risk of readmission through a patient risk assessment tool. Patients at high risk include: the elderly; patients entering from/returning to a Skilled Nursing Facility (SNF); patients with surgery/procedural complications, infections, cardiovascular, gastro-intestinal, pulmonary, behavioral health conditions; and patients who already have a 30-day readmission. The TOC approach will be rolled-out initially to higher volume inpatient facilities that have the highest Medicaid/Uninsured volume, highest readmission and avoidable admission rates. Then it will be spread to include all PPS hospitals.

PILOT PROJECTS TO ADDRESS CARE TRANSITIONS: Creation of an ambulatory care/urgent care center (UCC) for people in immediate crisis while connecting them to ongoing care. The UCC, located near the ED at Stony Brook UH, will serve patients in need of immediate follow-up post discharge as a bridge to outpatient care. This UCC is planned to provide a "fail safe" process for patients to be able to see a provider to address urgent/unplanned events. Mental Health issues are higher among the Medicaid population vs. Suffolk County as a whole. 40.2% of adults/Medicaid population (versus 18.7% of total population) has been diagnosed with a depressive disorder. 54.7% of the Medicaid population has experienced symptoms of chronic depression (27.3% of the County population). We will serve this population with a high degree of behavioral health (BH) comorbidities through the implementation of a community collaborative where a fast-track/warm hand-off relationship is created between the hospital and the community BH provider that can serve these patients' needs. Previously piloted at Southside hospital, this model will be further developed at all PPS hospitals.

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.

Inpatient CM support is currently available at all hospitals and will be leveraged to support this project. Additional staff for Outpatient 30 day TOC will come from: redeployment of staff from IP units or UM departments, strong relationships with Health Homes who can expand CM capacity, PPS home health agencies who will deploy staff for home visits, and then newly hired/trained CM staff to meet the needs of the project. Three Health Homes currently exist to serve the complex health needs of this population and will be leveraged to continue their foundational support for the highest risk population as well as to learn from their current knowledge of the community and community based resources. Hudson River HealthCare (HRHCare), is an award winning Federally Qualified Health Center (FQHC) network with 25 sites, serving 100,000+ patients in 10 NY counties regardless of their ability to pay. In Suffolk County, HRHCare currently operates 7 practice sites, projected to grow to 9 by 2015. Over the past 2 years, HRHCare has been assuming the licensure and operation of the previous Suffolk County Health Center network, and transforming the sites to reflect HRHCare's existing model which includes PCMH Level 3 designation, JCAHO accreditation, a system wide EHR with comprehensive data analytics, an integrated model of behavioral health and primary care services, specialty services and comprehensive community

based supports. HRHCare is also one of the 3 HH's in the region, actively engaged with over 5,000 Medicaid recipients in the county through contracts with local community based providers. Patient screening, education and engagement are key factors for success of this TOC project. Many IP facilities have experience with patient risk assessment tools such as LACE as well as with various patient education and discharge planning forms and tools. The PPS will use these core approaches as a foundation for the creation of a standardized risk assessment tool and the further development of patient education materials/tools especially to make them more culturally and linguistically appropriate additionally, patient education materials will be sensitive to the diverse health literacy levels of the patients. In addition there are numerous examples of other key resources, current assets and practices that will continue and will serve as a "learning lab" to help the PPS identify and implement new best practices in the TOC process that will further improve outcomes: Southside Hospital and Brentwood Family Health Center have CM for PCP follow-up and home visits for high risk patients and a relationship with Family Service League for patients in their ED with behavioral health concerns. Mather has interdisciplinary rounding each morning where the question is asked, "Why is this patient still here?" Discharge rounding like this would be useful, we will use it as a model for other sites. StonyBrook University Hospital (SBUH) has a "BOOST" program that includes a nursing/social worker team that provides discharge transition care and at least one post-discharge home visit. SBUH's IT platform ensures communication from the inpatient setting to the outpatient setting, regardless of the PCP's affiliation.

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.

PATIENT CHALLENGES 1)Lack of transportation results in missed follow-up appointments post hospital discharge. 2)Many patients need to be discharged to a SNF, however a number of long-term care facilities are reluctant to take Medicaid patients which delays the patient's disposition. 3)Homelessness places patients at risk of readmission. PATIENT REMEDIES: 1)Expansion of Suffolk County Accessible Transportation (SCAT) program; work to streamline the process to make transportation services more accessible to the patient. 2)Forge relationships with all PPS SNFs. Ensure that the payment model creates alignment of the SNFs with the purpose of the PPS. 3)Multi-disciplinary teaming that includes a SW from the time of admission will be built to address these potential issues.

PROVIDER CHALLENGES: 1)Lack of available PCP or BH appointments for post-discharge visits. 2)Coordination of handoffs between multiple entities can be difficult and the patient may receive conflicting messages. PROVIDER REMEDIES: 1)Additional appointments will be available as practices become more efficient through PCMH implementation. PCP recruiting efforts will occur and the collaborative with BH providers will ensure improved access. 2)Protocols will be established to ensure early notification and avoid duplication of effort: a)Hospital must alert PCP office, Health Homes and CM b)Discharge summaries transmitted electronically within 24 hours c)The PCP – Hospitalist communication exceeds simply the discharge summary.

INFRASTRUCTURE CHALLENGES: 1)Difficulty redeploying or hiring the CMs required for the program 2)Lack of interconnectivity and use between existing EHRs and the RHIO. INFRASTRUCTURE REMEDIES: 1)The PPS will leverage existing Health Homes capability/capacity and then work together as a PPS to identify sources of CM's to redeploy and to hire. Overarching

management structure will ensure appropriate risk stratification and effective use of CM resources. 2)Effective implementation of the PPS's IDS IT strategy to create this route for information sharing and communication.

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.

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.

Technology: Upgrades to EMR platforms that are needed to track all patients engaged in the project and enable integration with care plans.

Population Analytics Tools – Investments in risk stratification tools such as LACE for identifying cohorts of patients at the highest risk of readmissions.
Physical UCC facilities: Creation of an ambulatory care/urgent care center (UCC) for people in immediate crisis while connecting them to ongoing care.
Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.

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
Central Island healthcare & Daleview Care Center				NuHealth DSRIP
Outreach Development Corp.				Care Coordination Program with FEGs Health Home
Sagamore Children's' Center	Reinvestment $ from Sagamore building mobile integration teams	began 10/14		Mobile team to prevent hospitalizations, ensure aftercare follow-up, parent teaching/coaching to respite
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination
Sayville Project - Stony Brook University	NYS Medicaid Health Home Initiative			Care management to persons w/ chronic health and behavioral health population
Sayville Project - Stony Brook University	Suffolk County Discharge Planning - Care Coordination Initiative			Assist to improve outcomes for persons discharged from inpatient psych hospital units to Care management in the community
Dominican Sisters Family Health Service				Designated Community Based Organization for CMS:CCTP (Community Based Care Transitions Program for high risk Medicare beneficiaries being discharged from Stony Brook University Hospital and Southampton hospital. High Risk patients receive the Care Transitions Intervention. Care Transitions Coach makes a hospital visit initiating the CTI, one home visit and weekly follow-up calls
Central Nassau Guidance & Counseling Service	Beloved Incentive Program Funding		Funding until 8/2015	Home and Community based care transition to SMI

PROHEALTH Care Associates, LLP	Medicare Shared Savings			In addition to Medicare Shared Savings program, PROHEALTH also has several value-based incentive programs that focus on their Managed Medicaid population
St. James Rehabilitation and Healthcare Center	NY RAH Project	September 23, 2012	September 22nd, 2016	Reducing Avoidable Hospitalizations

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

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

2.b.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.

8. Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.
9. Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.
10. 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.
11. Educate all staff on care pathways and INTERACT principles.
12. 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.
13. Create coaching program to facilitate and support implementation.
14. Educate patient and family/caretakers, to facilitate participation in planning of care.
15. Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.
16. Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.
17. Use EHRs and other technical platforms to track all patients engaged in the project.

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

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

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

Analyses suggest that a high percentage of hospitalizations from SNFs are avoidable. Most studies use ambulatory care sensitive conditions - pneumonia, UTI, CHF etc. - to estimate numbers of avoidable hospitalizations. In one, 23% of $972,000,000 spent on hospitalization of NY SNF residents was attributable to ACS conditions. In another, 37% of hospitalizations from SNF were for ACS and potentially avoidable. The USDHHS OIG estimates that nationally, 25% of SNF patients are transferred into acute care, up 154% from 1996 to 2010. In addition to increasing cost, SNF to hospital transfers increase risk of negative patient outcomes. Locally, a SNF transfer avoidance project (NYRAH) reports that +/- 70% of residents are admitted when transferred to the hospital. Although the PPS was unable to document the percentage of SNF transfer patients that could have been returned to SNF, the planning group indicated this number was significant. A national study documented that through use of INTERACT tools, readmissions can be reduced by 17-24%, and so to reduce the number of admissions from SNFs, the PPS will fully implement INTERACT in all partner SNFs and hospitals. The PPS will build/deploy a team of trainers to fully implement INTERACT among SNFs. These RNs will train SNF inservice staff, preparing them to train/update all staff (all shifts). The team will monitor and evaluate use of the tools, conducting chart reviews to ensure that tools are used for all acute changes of condition (not just those resulting in transfer). To improve off-hour shift compliance, engagement and training at per diem agencies will be pursued. SNF Nursing Directors will be “facility champions,” oversee implementation, and instill the value of INTERACT among all staff. “Champions” will work with Medical Directors to build acceptance among SNF and community physicians. SNF staff will be trained in INTERACT Care Pathways, to ensure consistent patient monitoring, early identification of potential instability, and intervention to avoid transfer. SNFs will complete and share the Capabilities List with relevant staff at partner hospitals to ensure understanding of what conditions can be treated within SNFs to avoid admission.Using a “learning collaborative”, SNF and hospital representatives will meet regularly, share successes and difficulties, evaluate ideas and monitor outcomes. Working together, SNF, ED, hospitalists and discharge planners will build understanding of capabilities and reduce readmission. This group will monitor outcomes, including cause of transfer, using the Quality Improvement Tool, to identify opportunities for improvement. ED visits by SNF patients will be reviewed routinely to determine if service or staffing enhancements at SNFs or other strategies - mobile diagnostics, clinical consultation teams and “captive staffing agencies” - could reduce ED use. Use of INTERACT tools will be monitored to ensure that all staff flag potential status changes, reporting these to nursing, and that SBAR is used consistently to alert physicians to status changes and reviewed at the facility’s “24-hour report”. SNFs will implement the INTERACT Advance Care Planning tools or NYS DOH-approved MOLST forms to

assist patients/families in documenting/expressing wishes regarding end of life care, to avoid unnecessary transfers.

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.

While 76% of SNF patient days in NY are paid for by Medicaid, INTERACT implementation will effectively target all partner SNF patients, as policies will be instituted regardless of payor source. The project will target both short-stay patients and long-stay residents at all of the SNFs in the PPS. This will include Medicaid beneficiaries, Medicare beneficiaries, dual-eligibles, those who are receiving Veterans' benefits, and those who are private pay and/or currently uninsured. Over the course of the project, the PPS SNFs expect to engage 100% of their patients through the INTERACT protocol implementation.

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

Medical Directors, Directors of Nursing (DONs), and in-service staff at all facilities will be mobilized to develop and deploy comprehensive training in and monitoring of INTERACT implementation. The PPS will designate the SNF DON as the facility champion at each SNF, and this individual will become familiar with and conversant in all aspects of the program. Working with the PPS training team and the DON, the in-service staff will train all SNF staff in the use of the complete INTERACT toolkit. The DON and SNF Medical Director will engage all admitting and covering physicians in the project, its function and impact. Achieving support and buy-in of these physicians will be critical to achieving success in reducing admission from SNF to acute care. SNF admission staff will also engage with patients and families to build understanding of the value of "treating in place" for SNF residents. Each hospital Emergency Room (ER) will designate a staff person(s) as SNF transfer liaison. Each time a transfer is in process, this individual will be contacted by the SNF, alerted as to the reason for transfer, and given pertinent clinical details. As the patient is evaluated at the ER, the liaison will communicate with SNF personnel to advise them of patient status, and discuss any questions regarding the SNF's ability to address the patient's needs upon return to SNF. As necessary, ER physician to SNF Medical Director communication will be facilitated.

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 PPS conducted several surveys of the SNFs to inform project development. According to the survey results, 74% of the partner SNFs have some experience using the INTERACT program. Of these, however, not surprisingly, regular use of program tools varies greatly, and during project planning it became clear that most – if not all – of the SNFs that have experience with INTERACT tools have not thoroughly embedded the tools consistently within their operations to maximize impact. For example, some SNFs complete the SBAR only when a hospital transfer occurs, diluting

its impact to avoid a hospital transfer. In summary, every SNF will benefit from a more thorough and robust training and monitoring protocol on the use of the various INTERACT tools. INTERACT implementation will address the fact that partner SNFs are at varying stages of EHR adoption. At present, 91% of partner SNFs have or plan to have an EHR in place by April 1, 2015. Among these facilities, many different EHR platforms are utilized. The vast majority of those who use INTERACT tools, do so on paper. Bringing all SNFs onto EHR and creating system-wide connectivity will take time and training. The PPS will develop a simple interface (e.g., using Direct Messaging) to link SNFs to hospital partners in the short term and this will be built upon as full connectivity becomes more or a reality. Consistent with PPS goals, electronic connectivity with hospital partners will be completed over the project lifetime. The SNFs will work with the local RHIO to ensure useful electronic communication. As INTERACT tools are embedded in EHR products, SNFs will move from paper to electronic use of these tools. Efforts to engage the multiple staffing agencies relied upon by SNFs for weekend coverage to ensure that these weekend staff learn to properly use INTERACT tools may prove cumbersome, but will be pursued. Because many family members believe that quality of care is associated with the level of clinical intervention, acceptance by patients/families of the benefits of avoiding readmission may be a significant challenge to project success. All SNFs will provide orientation materials at facility admission outlining the policies and benefits of transfer avoidance, as well as materials on advance care planning.

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.

There is no other PPS within the service area.

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.

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
Gurwin Jewish Nursing and Rehab	NY-RAH	9/23/12	9/22/16	Reducing Avoidable Hospitalizations
Riverhead Care Center	NY-RAH	9/23/12	9/22/16	Reducing Avoidable Hospitalizations
St. James Rehab. and Healthcare Center	Ny-RAH	9/23/12	9/22/16	Reducing Avoidable Hospitalizations
Long Island Association of AIDS Care	Health Homes			case management
Suffolk Center for Rehab and Nursing	NY-RAH	9/23/12	9/22/16	Reducing Avoidable Hospitalizations

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

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

2.b.ix Implementation of Observational Programs in Hospitals

Project Objective: This project will reduce inpatient admissions vis-à-vis the creation of dedicated observation (OBS) units for patients presenting to emergency departments (EDs) whose need for inpatient services is not clearly defined or who need limited extended services for stabilization and discharge.

Project Description: While observation beds are not new to hospitals, the goal of this project is to bring care coordination services to the unit in order to ensure continuity of care with community services. Short stay hospitalizations are often related to ambulatory-sensitive diagnoses. These admissions can be avoided with improved access to primary care and behavioral health services, as well as with compliance to evidence-based clinical guidelines by the practitioner and patient. Health literacy, community values, and language may be barriers to connectivity of the patient with necessary health care services. Appropriate communication may assist with removing these barriers.

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

18. Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.
19. Create clinical and financial model to support the need for the unit.
20. Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.
21. 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.
22. Use EHRs and other technical platforms to track all patients engaged in the project.

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

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

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

CNA data indicates the need for additional medical observation units because: 1)27% of Medicaid admissions are short-stay 2)Top drivers of short-hospital stays for Medicaid patients are non-specific chest pain, epilepsy, asthma, and behavioral health where a 72 hour stay is considered short. Key Informant Interviews conducted with community-based organizations and with PPS PAC meeting participants provided the following information regarding gaps in care: 1)The current process for observation status commonly caused situations in which: "the patient got lost up on the floor" or "stayed longer than they needed to", highlighting the need for a dedicated approach. 2)Case management (CM) and social work (SW) support are not targeted toward the OBS population, nor are there direct links back to the primary care physicians (PCP), behavioral health (BH) provider or skilled nursing facility (SNF) CNA data indicates the need for additional psychiatric observation units: 1)15%-20% of patients admitted to psychiatric units across the PPS had a short stay. 2)At South Oaks Hospital, 21% of all adults and 18% of adolescents had a stay < 4 days (Extended Observation Beds (EOB) is categorized by OMH as 72 hours). Key Informant Interviews provided information that additional EOBs are needed, because there is: 1)A trend in Behavioral Health (BH) toward reduced length-of-stay, making EOBs an effective option. 2)Unnecessary transports of patients from Comprehensive Psychiatric Emergency Programs (CPEP) to other hospitals due to the lack of an EOB option. 3)A reduction of BH beds across the County, resulting in a need to reserve inpatient unit capacity for only those who need a longer

OVERVIEW OF PROJECT: Develop effective observation unit processes that enhance care coordination and implement standard protocols to address patient needs, thereby reducing unnecessary admissions. Identify patients who need observation services and provide a team-based process either in a dedicated or virtual observation unit. There will be 2 components: 1) implementation of best practices in observation care and CM services; 2) interventions in several targeted hospitals to create dedicated observation units.

ADDRESSING IDENTIFIED GAPS: To promote best practices, standardized processes will be established including: screening tools, risk assessments, and standard workflows. 1)Centralized bed admission process with level of care screening criteria (including education for ED and admitting physicians). 2)Direct admission to observation unit from PCPs and SNFs. 3)Patient risk stratification tool to identify need to escalate to higher level of intervention. 4)Standards for CM and SW interventions. 5)In-hospital processes for rapid testing, short turnaround times for diagnostic studies. 6)Multi-disciplinary rounds 2x/day with multidisciplinary team. 7)Discharge process which includes enhanced communication: hospital to PCP/BH provider, SNF or Health Home. 8)24/7 discharge capability to address all discharge barriers such as transportation, Home Health and Durable Medical Equipment (DME). 9)Advanced arrangements established with SNFs for timely acceptance of patients.

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 first component of the project is to implement best practices in observation care in virtual or dedicated units. This will include a focus on Suffolk County residents who are: 1)Medicaid beneficiaries 2)Admissions designated as observation status in all PPS participating hospitals

3)Cases that would be avoidable IP short stays, particularly those due to ambulatory sensitive conditions.

We will develop a methodology of identifying ED patients who need further care but whose anticipated stay makes the patient a candidate for observation. This methodology will include an electronic tool to identify these patients based upon validated criteria such as the Emory Model and Milliman criteria. The second component of the project to create dedicated medical observation units or EOBs will target patients at the following facilities due to identified need in those locations: 1)StonyBrook University Hospital (SBUH) and Southside Hospital (SSH) will develop specific units for medical observation. These hospitals have a large number of short stay admissions amongst the Medicaid population. 2)Southside Hospital (SH) will develop an approximate 12-bed unit for medical observation. 3)Stony Brook University Hospital (SBUH) will expand from a 10 to 30-bed unit.

SBUH, SSH and Sagamore will develop or expand EOBs. 1)EOBs at SBUH will be expanded from 6 to 12 beds. SBUH will ask for a waiver to locate the beds in a discrete unit where care coordination will be a primary focus. 2)SSH will establish 6 EOBs and 3)Sagamore will establish 3 EOB's. Since Southside and Sagamore do not have a CPEP, both will request a waiver of the requirement that EOBs be located in/adjacent to CPEP. SSH has an established relationship with Family Service League in Bayshore to take warm handoffs from the ED. This relationship would extend to these EOBs.

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 Inpatient CM and Social Work (SW) support is currently available at all hospitals and will be leveraged to support this project. The care management team for a dedicated/virtual observation unit will be composed of a CM, SW, pharmacist and hospitalist/ED physician with linkage to a BH resource. Assigned CM and social support staff will be hospital-based, employed by the hospital – but linked tightly to PPS care management governance that ties them to CM staff involved in TOC and in the Outpatient/PCP office CM processes. The presence of the SW on the team will allow hospitals to address issues of housing, transportation, etc. which impacts success. Additional staff for the development of specific Medical OBs units and EOBs will come from: redeployment of staff from IP units or UM departments. A reduction in admissions over time will allow some of these staff to be re-deployed to the team that focuses on observation admits. Newly hired/trained physicians, nurses, support staff and CM and SW staff will then be additionally needed to meet the needs of the project. Three Health Homes currently exist to serve the complex health needs of this population. Their CMs will be leveraged to provide input on discharge planning and necessary follow-up as an outpatient. This will include visits to the inpatient setting to see the patient prior to their discharge. They will also be a source to learn from with their current knowledge of the community and community-based resources that may help to meet the patient's needs after discharge. For the new or expanded EOBs, existing hospital space will also be leveraged with modifications as needed. Existing staff, supplemented with new staff, in Stony Brook and Southside with psychiatric expertise will be deployed/redeployed to support the program. The existing relationship between Southside Hospital's ED and Family Service League will be leveraged and expanded to ensure appropriate OP follow-up is in place for the patient after the EOB admission. Hudson River HealthCare, an organization managing

Federally Qualified Heath Centers (FQHCs) across multiple NY counties, is a key asset in this observation care process with its current plans to assume management of all six former Suffolk County DOH clinics. With the high volume of Medicaid and Uninsured patients they serve in the primary care setting, they will be leveraged to create strong connections from the Observation care team back to the primary care medical home.

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.

INFRASTRUCTURE CHALLENGES: 1)Ability to implement best practices across the PPS. 2)Limited communication across diverse providers. INFRASTRUCTURE REMEDIES: 1)Focus on staff/physician training to ensure best practices, a performance management process within the Quality Assurance program will be developed. 2)Optimization of EHR and the RHIO to provide for better communication between hospital and PCP or SNF or Intermediate Care Facility will create better communication linkages across the PPS.

PROVIDER CHALLENGES: 1)Significant variation between hospitals for definition of OBS status 2)Facilities where even a "virtual" OBS unit can create issues with staffing and economies of scale due to their low volume of admissions. 3)Limited access to primary care visits, particularly in underserved areas. 4)The need for effective communication with a population with limited health literacy. 5) Overall provider participation. PROVIDER REMEDIES: 1)Establish protocols for identifying patients who qualify as OBS utilizing an IT system for decision-making for OBS status admission. 2)Share best practices in the effective use of existing resources, including redeployed staff from other functions. 3)Increase primary care capacity through support by safety net PPS PCPs such as Hudson River Health. Additional PCP access will be available as practices become more efficient through implementation of PCMH/Advanced Medical Home. 4)Staff training on cultural competency, translate patient education materials and ensure 5th grade reading level. 5) Align providers through pay for performance incentive

PATIENT CHALLENGES: 1)Challenging socio-economic barriers and disparities in care. 2)Potential patient "no-shows" for post discharge appointments. 3) Issues with transportation that may delay an effective discharge. PATIENT REMEDIES: 1)Multidisciplinary teaming that includes a SW from the time of admission can address these issues. 2)Link into an effective PPS 30-day TOC process. Leverage the relationship with Health Homes and with FQHCs who care for a significant volume of these patients. 3)Expansion of Suffolk County Accessible Transportation, help streamline the process to arrange transportation assistance to make it more accessible to the patients.

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.

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

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in

scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

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

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

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

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

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

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

Yes	No
☒	☐

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

The current observation unit infrastructure in Suffolk County needs an overhaul. This extends to the extended observation needed for psychiatric patients. We anticipate capital costs as listed below:
Facility Costs - For Stony Brook Hospital will require finding for the development of a dedicated 20 bed medical observation unit. Southside Hospital will require funding to develop their 12 bed medical observation unit.
EOB Facility Costs – EOBs will be expanded at Stony Brook (approx. 6 beds) and created at Southside Hospital and at Sagamore Hospital (if CPEP waivers are received). For Stony Brook's expansion of psychiatric Extended Observation Beds (EOBs), capital is required for the renovation of an existing unit where space will be made available for the relocation of 6 current EOBs and for the add-on of 6 more, totaling 12 EOBs. The unit will have to be reestablished as in inpatient-like unit to meet required codes, including the elimination of all loopable hazards and appropriate program and clinical space. For Southside's expansion, the capital is also requried all of the reasons stated above. At Sagamore funding is needed in order to make minor alterations to the facility.

Technology: Capital equipment/ modalities (e.g., telemetry instrumentation) needed to equip an observation unit adequately will be needed for equipment such as telemetry monitoring for all beds. Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination

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

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Simply having health insurance is not enough to ensure improved health outcomes or appropriate use of the health system. A lack of familiarity with that system, coupled with social and cultural barriers to care, results in avoidable utilization of high-cost health care resources among some uninsured (UI), and/or low- and non-utilizing Medicaid recipients (LU/NU). To reduce avoidable ER visits and admissions (and address the overall DSRIP goal of a 25% reduction in avoidable hospital use), individuals must actively engage in managing their own health. The implementation of this project will assist individuals to take charge of their health ("activation") and move along a continuum to better health, reducing avoidable ER use and hospital admissions. The CNA documented barriers to access among uninsured and Medicaid recipients. By comparing Medicaid and uninsured respondents to countywide findings, significant disparities became evident. These populations have difficulty accessing healthcare because of the cost of physician visits and prescriptions; inconvenient office hours/appointment availability; difficulties finding physicians; and lack of transportation. Additionally, both cultural and linguistic barriers exist for many. These individuals experience greater levels of mental health problems and childhood obesity, and report a lack of leisure time. They are also more likely to skip/stretch prescription doses, use the ER and have difficulty getting care for their children. In regard to ER usage, Medicaid members had 119,932 total visits, of which 72% were potentially avoidable. Comparing the target population to the general population, 39.4% vs. 16.9% are in fair/poor health.While reaching this population can be difficult, the success of the PPS CBOs in doing so will strengthen this project. In collaboration with CBOs, navigators will be placed in community

settings (housing sites, welfare offices, churches, barber shops, markets, etc.) in identified hot spots, to reach individuals who have limited contact with the healthcare system. Navigators will assess individuals using PAM to determine their knowledge, skills and confidence for managing their health and healthcare, and monitor that level of activation. Navigators and peer counselors, trained in the Coaching for Activation method, will work with individuals to build awareness of the importance of prevention and early intervention among uninsured and LU/NU Medicaid recipients, and increase their confidence in using and managing their care. Navigators will connect those individuals with case management as necessary, and with their existing PCPs (if they have them) or financially and geographically accessible PCPs in private practice and community health clinics, all of whom will be trained in the concepts of patient activation and engagement. Culturally competent PPS CBOs will collaborate with and train other PPS members to ensure that once these linkages have been made, the connection will hold and individuals will advance in their activation and engagement. Additionally, uninsured individuals will be connected to appropriate insurance products to improve the financial accessibility of care.

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

With a population of 1.5 million, Suffolk County has approximately 240,000 Medicaid members and 168,618 uninsured. It is reported that about 29% of Medicaid recipients are NU, or LU. This equates to 69,381 for the PPS, bringing the total target population to 237,999. 36.2% of Medicaid recipients, 17.6% of uninsured and 9.0% of commercially insured have used an ER more than once in the past year. 8.9% of the target population relies on the ER for care vs. 3.3% of the total population. Medicaid members had a total of 119,932 ED visits, of which 72% (86,435) were potentially avoidable.There are four identified hot spots within Suffolk County where the majority of uninsured and Medicaid recipients reside: Riverhead/Hampton Bays reflects a particularly high level of need. Riverhead has seen significant growth in the Hispanic population over the past ten years. The area also has a substantial seasonal migrant farm worker population, many of whom are undocumented. Brentwood/Bay Shore/Central Islip has one of the highest Medicaid concentrations. Another hotspot for healthcare needs and unnecessary utilization is Huntington Station, a multi-cultural African-American, Hispanic, and White community that is less prosperous than Suffolk County in general. Patchogue has the highest concentration of total population living below the Federal Poverty Line of any community in Suffolk County. There is a high Hispanic population and the area has limited public transportation with particularly restricted hours on weekends. For the purposes of this project, efforts to activate and engage patients will be targeted to the hot spot communities through our network of participating CBOs, using navigators to identify, assess and triage individuals to case managers and PCPs based on their level of activation as measured by the PAM scale.

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

populations. In addition, identify any needed community resources to be developed or repurposed.

Participating in this project are over 40 PPS members from across the continuum of care. PPS CBOs have demonstrated experience in successful outreach to the target population, and provide their services in a culturally competent manner. Building upon these resources, the PPS will expand and enhance the navigator/peer coaching staff, building on the current capacity of CBOs to reach more deeply into the target population. CBOs, already versed in cultural competency, will assist in providing training in cultural competence across the system. Efforts will be directed to navigators/coaches, case managers, PCPs, and ER staff. With the IDS project initiative developing a centralized case management function, the PPS will have the opportunity to enhance and coordinate existing community-based and MCO case management efforts to address the needs of the target population. Case-finding will be multi-directional, with referrals coming from each "sector" - navigator-coaches, ER, case management and primary care – to the appropriate resources for follow-up, activation and management. As navigators identify and assess UI, LU and NU individuals on the PAM scale, the approach and appropriate level of follow-up will be determined. Navigators-coaches will ensure that those individuals who score at the higher levels of activation (3 or 4) will have or be linked to a PCP. Those who score at 1 or 2 will continue with peer coaching and be linked to case management and primary care. For individuals without PCPs, they will be linked with primary care resources based on geography, cultural match, and financial accessibility. Navigators-coaches and PCP staff will reassess individuals using PAM on a semi-annual basis to determine changes in activation and engagement. If PCPs identify individuals in need of case management and/or coaching, referral to the appropriate resource will be made. Oversight of the project will remain with the PAC Executive Committee to ensure that coordination continues across the entire system.

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 difficulty of activating and engaging the UI, LU and NU populations cannot be underestimated. It will require extensive coordination and communication across the system, dedication to all aspects of "case-finding", assessment, triage and case management, and ensuring that financially accessible primary care is available across the county.Case-finding: Navigator-coaches will be recruited from and deployed to sites in hot-spots. They will be trained in outreach and PAM, and will have educational materials that are designed to address and improve health literacy. Additionally, all PPS partners will be engaged in identifying UI, LU and NU individuals, and linking them to navigators and/or case managers. Assessment/triage: Navigator-coaches, case managers and primary care staff will be trained in the use of PAM and the appropriate follow-up for individuals based on their PAM score. Case management: Current case management is siloed at the hospitals, CBOs and other PPS partners. Creating an overarching case management infrastructure will better equip the PPS to ensure such services are provided in an integrated fashion to individuals regardless of where they "touch" the system, and that resources are deployed to the venues where they are most needed. Additionally, there is a need to engage the MCOS to ensure that services are coordinated and duplication eliminated.Financially accessible PCPs: The PPS will need to engage PCPs across the county. Where gaps exist, the PPS will need to

recruit practitioners and place them in those communities. This will be done collaboratively with clinics, health centers and existing practices.Communication: To ensure that communication is maximized across the system, all partners will be linked electronically. Regular meetings among CBOs, PCPs and case management will occur.MCO collaboration: To date, MCO responsiveness to project engagement has been limited. Efforts to address this will be a high priority during implementation planning.

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.

There is no other PPS within the service area.

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.

Tablets for outreach workers

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
Outreach Development Corp	Health Home			Care Management
Suffolk County DOH	NYSDOH Maternal Infant Community Health Collaborative	10/1/13	9/30/18	Using CHWs to target high risk women of childbearing age
The Sayville Project	Health Home			Care Management
The Sayville Project	SC Discharge Planning Care Coordination Initiative			Improve Care Coordination

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

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this 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.

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.

PCMH SITES: CNA survey reports 54.7% of the target Suffolk County Medicaid population reported chronic symptoms of depression (total population 27.3%). In a survey of providers, 72% reported mental health (MH) issues and 60% reported substance use disorders (SUD) as major clinical gaps in the County. Medicaid claims indicate that significant MH issues are the most prevalent condition in Suffolk. SPARCS data indicate the primary driver of hospital admissions is all behavioral health (BH) conditions combined, while MH issues are the number one driver of emergency department (ED) visits, with SUDs second. In 2012 Stony Brook's Omnibus Survey indicated only 35%-45% of survey respondents were asked by their primary care provider (PCP) about emotional health and/or alcohol use, with lower percentages for Blacks and Latinos. BH resources across disciplines are fewer per 100,000 than other areas of NY. We will expand BH resources and co-locate BH providers in 40 PCP sites meeting NCQA PCMH standards by DY3. Standards of care will be applied and collaboration fostered through communication and EHR protocols, including dedicated coordination with existing Health Home resources. Through the use of evidence-based screening (PHQ/SBIRT), individuals will be identified, educated, tracked

through EHR and connected to services. Training, like that offered by The Reach Institute, will be leveraged to educate PCPs about prescribing for BH conditions.
BH SITES: Key informant interviews and Office of Mental Health (OMH) Patient Characteristic Survey data indicate that individuals with serious mental illness are not routinely engaged in primary care. Approximately 50% of those attending OMH programs have a chronic medical condition. OMH Behavioral Health Organization (BHO) data notes only 50-60% of those with medical needs at discharge have a medical appointment within 45 days. We will co-locate primary care at 8 BH sites to improve access and outcomes and ensure integration. The same standardization of care and use of IT platform/EHR protocols noted above will be applied in these settings.

IMPACT SITES: Because not all sites will be able to accommodate co-location, a collaborative care model will be used to foster coordination based on geography and practice needs. The roll-out will be established with fidelity to the model, including screenings, designated case manager (CM), dedicated psychiatrist time based on practice needs, treatment options, and appointments available with BH specialists within 4 weeks. Standardization of care and use of IT platform/EHR protocols noted above will also be applied in these settings.

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.

PCMH/IMPACT SITES: The target population includes all Medicaid patients in the participating safety net primary care and Federally Qualified Health Center (FQHC) practices. The project will be rolled-out first to primary care sites with high Medicaid population volumes and geographies that have been identified from CNA data as hotspots for disparities (Wyandanch, Brentwood, Patchogue and Southampton), where significantly higher percentages of residents are Black and Latino. This project will then expand to include patients in lower volume and non-safety net PCP sites as the project progresses.

BH SITES: Targeted population will be Medicaid patients who are cared for at 8 participating OMH/Office of Alcoholism and Substance Abuse Services (OASAS) licensed programs; including patients being discharged from hospitals to OMH/OASAS licensed programs who are not currently receiving primary care. These care sites provide care and resources for a high volume of Medicaid patients, particularly in the geographies as noted above where high disparities in care exist. The target population will increase over time as a result of the efforts to engage the uninsured population. We will work collaboratively to ensure those who have recently become eligible for Medicaid, i.e. those released from jail, to ensure they have proper follow-up 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.

County resources include: 4 Article 31 and 11 Article 28 hospitals,7 Assertive Community Treatment teams and mobile crisis,1 Comprehensive Psychiatric Emergency Program, 27 OMH clinics, 15 Personalized Recovery Oriented Services, 1 children's MH day program, 2 psychiatric partial hospitals, 2000+ Residential congregate, apartment and supported housing sites, 42 OASAS clinics/satellites, 5 hospitals providing detox and rehab, 4 Methadone Maintenance clinics, 74 voluntary Office for People With Developmental Disabilities (OPWDD) agencies, 385 psychiatrists, 872 psychologists, 2,349 social workers, 353 licensed mental health counselors, 22 licensed behavior analysts, 3 Health Homes with legacy CM providers.

ASSETS/RESOURCES PCMH/IMPACT SITES: 1)Hampton Community Health Care, East End Pediatrics, South Oaks, Family Service League and Association for Mental Health and Wellness (MHAW) have all piloted integration models. We will leverage/mobilize their expertise for training/mentoring and will be among the first sites implemented within the program. 2) Brookhaven has conducted collaborative care for 5 years in a PCMH level 2 and is rolling out the model in other PCP practice and will implement a PCMH at their recently-opened Bellport Primary Care Center. Brookhaven's Mental Health/Chemical Dependency clinics in Shirley and Patchogue are already referring patients needing a PCP. 3)HRHCare, an FQHC network with PCMH level 3 standing in sites outside Suffolk, is operating or taking over 11 primary care clinics in Suffolk to be transformed into PCMH/FQHCs leveraging HRH's experience. 4)6 OPWDD licensed Article 28 diagnostic and treatment centers have some co-located BH services and will become PCMHs/FQHCs with expanded capacity.

ASSETS/RESOURCES BH SITES: 1)MHAW has peer staff and one supervisor practicing as Peer Health coaches using SAMHSA's Wellness Health Action Management. This training/expertise will be leveraged/mobilized to expand this resource. 2)OMH licensed programs with current integration models will expand this capability to other sites and provide technical assistance to others developing this "reverse" integration model. 3)The Quality Consortium, a coalition of OASAS providers including many PPS members, will be leveraged to continue campaigns with hospitals/PCPs to promote screening and heighten awareness of resources. 4)Local BH experts have presented on integration locally/nationally and will be mobilized to deliver training/mentoring. Three Health Homes in Suffolk County are enrolling patients who are receiving treatment in these same care settings. The Health Home CMs will be leveraged to continue their foundational support for this highest risk population as well as to learn from their knowledge of the community and community based resources.

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.

INFRASTRUCTURE CHALLENGES: 1)Hire more BH staff, existing staff must adjust to new model. 2)Agencies may not be able to meet the demand as additional people in need are identified. 3)Demand for CM outstrips supply. REMEDIES: 1) Experienced staff will train providers and develop curricula for future workforce. Stony Brook's Psychiatry Residency is developing a community-based Residency to expand the number of psychiatrists. 2)Address through workforce training and a web-based platform for disease self-management and telepsychiatry. 3)CM structure and workforce strategy is planned under project 2.a.i.

PROVIDER CHALLENGES: 1) PCPs/FQHCs may struggle with PCMH standards. 2)PCPs lack understanding of antidepressant medication management (AMM), documentation and treatment of BH conditions. 3) Overall provider participation. REMEDIES: 1)Leverage Current PCMH providers to provide technical assistance. 2)Engage prescribing experts to provide education and work with payers to improve AMM HEDIS measures. 3) Align providers through pay for performance incentive.

PATIENT CHALLENGES: 1)Language, health literacy, cultural competency barriers 2)Food/housing issues for target population 3) Transportation and health care access challenges. REMEDIES: 1)Provide access to Spanish speaking providers, patient materials translated, and at 5th grade reading level .Staff training on cultural competency 2)Address through geographic collaboratives linking sites with CM, housing providers, food pantries. 3)CM Service Dollars for legacy providers available for medical/non-medical transportation, but will build additional resources.

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.

3. <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.

Facility Costs - The project will require renovations/reconfiguration of space in several of the sites. An additional capital expense is anticipated for an expansion of a specific behavioral health site to increase its capacity to deliver on-site primary care/wellness services to the target population in a high volume region of Suffolk.
Equipment - Furthermore, it is anticipated that office furniture, computer stations and/or tablets will be needed in a number of sites for the co-located staff.
Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid /Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination
Gurwin Jewish Nursing & Rehabilitation Center	GNYHA NY-RAH	9/23/ 2012	9/22/ 2012	To increase tool usage, Stop & Watch SBAR to recognize ACOC to reduce avoidable hospitalizations in the LT population
St. Christophers Inn				Bx LEB PPS
Central Nassau Guidance & Counseling Service				3-year grant for on-site primary care; also received OMH funding for short-term crisis respite -hospital division - 2 years
Town of Babylon Division of Drug and Alcohol Services: Beacon Family Wellness Center				Prevent SA in town of Babylon residents through education and treatment services and partnership in community coalitions. Reduce/prev ent mental illness symptoms in patients in SA programs. Provide smoking cessation education/re sources to town of Babylon residents and patients in SA program
Town of Smithtown Horizons Counseling and Education Center	Federal BLOCK grant preceded Medicaid redesign; also participating in "Reconnecting Youth" Program			Reduce smoking among patients with MEB disorders

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

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

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

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

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

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

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

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

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

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

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

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

Improve Medication Adherence:

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

Actions to Optimize Patient Reminders and Supports:

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

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

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

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

Cardiovascular disease (CVD) is a significant issue in Suffolk County. Of all Medicaid beneficiaries with a cardiovascular condition, 25,403 were admitted to the hospital and 19,717 visited the ER for this condition in one year. Ten percent of Medicaid admissions are related to Cardiac Disorders or Hypertension, 49.3% of total admissions have either a primary or secondary diagnosis of CVD including Hypertension. CVD is the 3rd leading cause of avoidable admissions in Suffolk County. The areas with the highest number of Medicaid beneficiaries with CVD are: Brentwood, Bay Shore, Huntington Station, Patchogue, Riverhead and Lindenhurst according to Health Data NY. Community Health Survey Data revealed that almost three quarters of the Medicaid population in Suffolk County is overweight or obese, 15.6% report that they suffer from or have been diagnosed with heart disease (Total Suffolk County 6.2%), 36.4% of the Medicaid population has high cholesterol (Total Suffolk County 31.1%) and 31% of the Medicaid population are current smokers (Total Suffolk County 15.9%).

OVERVIEW: To help close these identified gaps, this project seeks to engage 80% of participating primary care practices to focus on the development of 1) a case management (CM) approach for patients with hypertension/CVD risk and 2) a PPS-developed practice support model to improve

and automate their office practices within the context of PCMH/Advanced Medical Home, targeted toward best-practice clinical care for CVD.

The CM approach will use designated Health Managers (commonly nurses), lay care associates, and existing care/education resources in the County. These resources, in conjunction with the embedded and regional CM resources developed within the PPS care management structure (see project 2A1) for all projects, will use evidence-based prevention and disease management techniques, like those used in the Million Hearts Campaign, to better manage the population of patients with Hypertension and CVD risk. The Stanford Chronic Disease Self-Management program will be implemented in a targeted population of high-risk individuals. CM staff will be responsible for developing linkages with Health Homes to identify and manage high-risk populations.

The primary care practice support model will leverage the Million Hearts physician recommended interventions. The practices will build new processes to manage hypertension and CVD risk factors with standard protocols and automation through the EHR for patient tracking, alerts for abnormal readings and for care gaps. Health literacy and self-efficacy will be addressed through targeted education and self-management techniques and a self-management plan for each patient will be created; documented in the EHR.

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 patient population expected to be engaged is 1) adult Suffolk County residents, 2) who are Medicaid and, 3) have a cardiovascular disorder, HTN and/or hypercholesterolemia. The population will be risk-stratified into high, medium and low risk with the high risk category targeted for more in-depth CM support and/or alignment with the Health Home as appropriate. In addition, key zip codes with high burden of illness and utilization will be the first targeted patient populations for implementation of this project (Brentwood, Bay Shore, Huntington Station, Patchogue, Riverhead and Lindenhurst). The primary care practice support model will be first rolled out in DY 1 and 2 to those practices serving these geographic locations with the highest burden of illness, then spread to other PCP sites moving them all to Level 3 PCMH by the end of DY 3. Particularly in Riverhead, the CNA showed a higher proportion of Spanish-speaking, immigrant population. This region will be targeted for initial focus on piloting culturally sensitive and translated educational materials for patients and educational sessions related to cultural sensitivity and health literacy for primary care practice staff.

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.

Hudson River Health (HRH) has implemented the Million Hearts Campaign in counties outside of Suffolk with great success. HRH plans on rolling this campaign out to its Suffolk County sites and will be mobilized as a resource to mentor other participating providers.

King Kullen Pharmacies has been involved in Medication Therapy Management for Medicare Part D patients since the program's inception. King Kullen has agreed to become a partner in developing a program to coordinate and integrate care outcomes. Many of the participating King Kullen Pharmacies are located in the top locations of Medicaid CV discharges.

The Medication Adherence Project is an existing collaborative team of providers that utilizes technology to ensure medication adherence. Project members include: retail and hospital based pharmacists, clinicians representing hospital, skilled nursing, rehabilitation, and community organizations, patient care providers, behavioral and cognitive psychologists, as well as bioinformatics and IT infrastructure specialists. This team will be leveraged by the PPS project team to help implement both patient and provider interventions designed to create more effective use of medication to treat hypertension and hypercholesterolemia.

The Suffolk County Department on Aging sponsors two central locations that provide resources for the integration of the Stanford Chronic Disease Self-Management Program into the community. This will be leveraged as a resource for patient interventions and will be expanded to include additional trainers and sites.

There are several other participating organizations that currently provide health screenings and programs that support the aims of this project and will be leveraged as part of a "resource catalog" that will be created for easy reference of available resources for use by participating providers. The Ed & Phyllis Davis Wellness Institute at Southampton Hospital, runs several applicable programs for weight loss and smoking cessation. The NYS Quitline "Opt-to-Quit" program, currently being piloted at Stony Brook will be leveraged as one method to provide support to those seeking to quit. The Suffolk DOH and Association for Mental Health and Wellness have partnered in the past to train staff and pilot smoke free policies in OMH programs. The NYS funded smoking cessation center operating out of NSLIJ will provide an additional source of training and resources. Stony Brook's web-based self-management platform will also include smoking cessation components.

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.

PATIENT CHALLENGES: 1)Large disparities in race, ethnicity, language and other cultural factors results in the need for diverse health literacy and patient education materials. 2)Lack of public transportation and limited transportation provided by community organizations results in missed follow-up appointments. REMEDIES: 1)Patient education materials at a 5th grade reading level. Translation services at health screenings and workshops. Use available resources such as Dr.

Harold Fernandez, co-director of Stony Brook University Heart Institute, who can provide assistance in partnering with community leaders regarding solutions to address disparities. 2)Expansion of Suffolk County Accessible Transportation (SCAT), streamline process to make it more accessible. Outreach and educational efforts will be held in the community where these patients live.

PROVIDER CHALLENGES: 1)Communication and coordination at handoffs between multiple entities who will touch the patient. 2) Providers have difficulty impacting smoking; other attempts to address blood pressure are likely to be unsuccessful without addressing smoking first. 3)Getting PCPs to participate REMEDIES: 1)Develop a more effective OP CM structure and documentation platform with a dedicated practice support team to ensure accurate tracking, care coordination and follow-up of all targeted patients across the continuum of PPS providers. 2)Partner with community organizations that currently have successful smoking cessation programs. 3)Use financial incentives through flow of funds to increase PCP participation.

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.

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.

Technology: Licenses costs associated with helping practices achieve PCMH Level 3 certification, including EMR-upgrade investments to meet EMR MU standards. Physical PC facilities: Space considerations for implementing aspects of the 'Million Hearts' campaign e.g., tobacco cessation programs and counseling, nutrition counselors. Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.

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
PROHEALTH Care Associates, LLP	Medicare Shared Savings			In addition to Medicare Shared Savings program, PROHEALTH also has several value-based incentive programs that focus on their Managed Medicaid population
St. James Rehabilitation and Healthcare Center	Cardio Rehab program with North Suffolk Cardiology			Telemonitored rehab/discharge follow-up
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination

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

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs; they are complimentary. In particular, all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

Project Description: The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of diabetes. Specifically, this includes improving practitioner population management, increasing patient self-efficacy and confidence in self-management, and implementing diabetes management evidence based guidelines.

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

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

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

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

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

Diabetes prevalence among Medicaid beneficiaries in Suffolk County (19.3%) significantly exceeds the County as a whole (11%). Suffolk exceeds statewide PDI and PQI rates in all but one category. While short-term complications of diabetes (PQI 01) were similar for both Suffolk and New York, rates of long-term complications and uncontrolled diabetes were demonstrably higher countywide. Diabetes drives more unnecessary admissions in Suffolk than NYS as a whole. Four zip codes drive diabetes admissions and ED visits: Brentwood, Bay Shore, East Patchogue, and Central Islip.

Suffolk is the second largest NYS County (geographically) and public transportation is limited. Among the Target Population, 20.5% report that lack of transportation hindered their medical care last year. Although transportation proves challenging, only 37.3% of 51 PPS partners surveyed offered point-of-care (POC) HbA1c testing to their patients. Low basic literacy, health literacy and limited English proficiency is also a problem for this population.

A survey of 51 PPS members revealed only 41.2% offered diabetes education based on nationally-recognized curricula (ADA, AADE, Stanford Model). Further, according to the AADE, there are currently only 122 Certified Diabetes Educators (CDE) living in Suffolk County with a lower than expected ratio of 0.7 CDEs per 1,000 people with diabetes.

OVERVIEW: This project will close the above identified gaps by engaging at least 80% of primary care practices to focus on the development of a care management (CM) approach for patients with diabetes utilizing designated Health Managers, lay care associates, and existing diabetes care/education resources in the county who will focus on providing culturally competent service support. These resources, with the embedded or regional CM resources developed as a component of the PPS care management structure to support all projects, will create a comprehensive strategy that incorporates Identification, Management, Education and Empowerment of target population's "high risk" patients with diabetes, as well as meet the needs of those at medium or low risk; consistent with DSRIP 3.c.i requirements.

The project will leverage population management registries and care management tools as well as expand on current under-resourced educational initiatives and community resources. Primary care practices in the PPS will be engaged to redesign care delivery processes in the context of moving toward Level 3 NCQA PCMH recognition and the Advanced Medical Home model. Redesign regarding diabetes care will include integration of best practice clinical guidelines and leveraging the EHR to effectively identify and close care gaps in the patient population with diabetes.

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

The target patient population is: 1) Suffolk County residents, 2) Medicaid patients, 3) who have been diagnosed with Type 1 or Type 2 diabetes mellitus (T1DM/T2DM). The project seeks to

target areas with greatest potential for impact: areas with 1) highest prevalence of diabetes 2) highest utilization of ED and inpatient care and 3) where there is an overlap of patients with the highest level of comorbidity. Regions with high burden of illness and utilization will be the first targeted patient populations for implementation of this project (Brentwood, Bay Shore, East Patchogue, and Central Islip). The primary care practice support model will be first rolled out in DY 1 to those practices serving these geographic locations, then spread to other PCP sites moving them all to Level 3 PCMH by the end of DY 3.

The targeted "high-risk" patients include those with multiple co-morbidities (CHF, CKD, COPD, CAD), elevated HbA1c, polypharmacy and/or insulin use. Based on Stony Brook population data, prevalence of concurrent diabetes and comorbid cardiovascular disease, CKD and behavioral health disorders are markedly higher in the Medicaid/Uninsured population in Suffolk County. Presence of one or more comorbidities increases the risk of ED visit, hospitalization and 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.

All 8 participating hospitals in Suffolk serve as core resources with some existing form of diabetes education and prevention classes (Eastern Long Island Hospital, NSLIJ, Stony Brook, Brookhaven and Southampton hospitals all offer free diabetes prevention classes to the community). These resources implement current best-practices in diabetes education (i.e. Stanford Model, AADE curricula), however access is extremely limited and resources are underutilized, due in part to limited availability in high prevalence areas. The current educational assets and resources to be enhanced and expanded are located at these Hospitals, 6 Suffolk County Health Centers currently run by the SCDOH and Hudson River Health, in addition to multiple privately/publicly offered programs (i.e. YMCA, Suffolk County Department of Aging, Diabetes Resource Coalition of Long Island and Suffolk County Department of Health Services in collaboration with Cornell Cooperative Extension of Suffolk County). We plan to expand and better resource current education initiatives in the county and redirect to highest-risk patients by geographic need. This will be accomplished by increasing the number of CDEs and Stanford Model-trained educators, along with disseminating nationally-recognized diabetes education materials and resources in multi-lingual, culturally-sensitive formats. Resources available through IDS project 2A1 will be leveraged for this project

There are several other organizations that currently provide health screenings and programs that support the aims of this project, which along with the entities noted above will be leveraged as part of a "resource catalogue" that will be created for an easy provider reference of available resources. These include Suffolk County government which offers free disease prevention classes at the Southampton Town Center, Southold Free library, Wyandanch Senior Nutrition Center and Southside Hospital, and the "Creating Healthy Places in Suffolk County" initiative aimed at improving access to healthier food choices and increasing physical activity.

Three Health Homes currently exist to serve the complex health needs of this population and will be leveraged to continue their foundational support for the highest risk population as well as to learn from their current knowledge of the community and community based resources.

Hudson River Health (HRH), an organization managing Federally Qualified Heath Centers (FQHCs) across multiple NY counties, is a key asset in this diabetes management project with its current plans to assume management of all six former Suffolk County DOH clinics. They will be leveraged as high-volume sites for early implementation of CM and practice redesign efforts around diabetes care with the Medicaid population that they serve.

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.

CHALLENGES: 1)Engagement of 80% of primary care practices within the PPS. 2)Difficulty addressing issues with medication errors: omissions, duplications, dosing errors or drug interactions. 3)Ability to achieve PMCH Level 3 recognition by DY 03. 4) Address growing epidemic of Diabetes and Obesity. 5)Lack of available public transportation. 6)PCP participation

REMEDIES: 1)Show value to PCPs by improving access to comprehensive diabetes education and point-of-care testing (POC-HbA1c). Provide effective care management support. 2)Build medication reconciliation into diabetes care management program to occur at every transition of care: when new medications are ordered, existing orders are adjusted or patients report non-prescriptive medications. Medication adherence will be embedded in all case management protocols, pharmacist support, and will be part of the Stanford Chronic Care educational platform. 3)Provide practice support teams to engage PPS primary care practices to redesign their care delivery processes to move to Level 3 and Advanced Medical Home model. 4)Increase Stanford education resources and also increase CDE resources at a ratio of 2 CDEs to 1,000 people with diabetes in the target population (doubling current capacity in the county) 5)Deployment of POC-testing will prevent patients from extra traveling to physician's offices or clinical laboratories, enhancing compliance with national guidelines for regular testing/monitoring. 6) Align PCPs through pay for performance incentives.

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.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

Technology: Licenses costs associated with helping practices achieve PCMH Level 3 certification, including EMR-upgrade investments to meet EMR MU standards.
Physical PC facilities: Space considerations for implementing aspects of the outreach campaign e.g., tobacco cessation programs and counseling, nutrition counselors.
Space Rentals – Rent space in community centers and other venues to outreach to the general population with key messages re: diabetes prevention and management.
Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.
Additional Resources – There will also be a need for point-of-care HbA1c machines as well as associated supplies

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination
PROHEALTH Care Associates, LLP	Medicare Shared Savings			In addition to Medicare Shared Savings program, PROHEALTH also has several value- based incentive programs that focus on their Managed Medicaid population
Central Nassau Guidance & Counseling Service				3-year grant for on-site primary care; also received OMH funding for short-term crisis respite - hospital division - 2 years

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

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of

community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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.

The CNA reveals some of the greatest health disparities affecting Medicaid populations are in respiratory disease. Childhood asthma prevalence in Suffolk County (SC) is 13.3% among the Medicaid vs. 4.5% among the total population. 72% of key informants in the CNA characterized asthma as a major or moderate problem. Reasons cited include factors such as increased exposure to environmental triggers, poor adherence to treatment, and housing conditions. Medicaid claims show that asthma is one of the eight most prevalent chronic conditions in SC. SPARCS data indicate that asthma is one of the top ten drivers of SC hospital admissions, readmissions and ED visits. 2012 Health Data NY document 13457 SC Medicaid members with asthma ; 6879 Medicaid members with asthma generated 18786 ED visits in one year; 3704 individuals were hospitalized with asthma generating 6796 admissions. These data demonstrate that some individuals have multiple hospitalizations for asthma. Total PDI annual admissions data show asthma in young adults and children is a significant cause of avoidable admissions, especially in comparison to other conditions.

We propose a medical home program enriched with home visits by trained community health workers (CHWs) leveraging the strengths of the existing Pediatrics Keeping Family Healthy (KFH) program at a current Level 3 PCMH site. Patients will be stratified into three risk categories: high, moderate and low. All high-risk patients will be referred for home visits. Families will receive ~4-5 CHW home visits over 6 months, with calls/text reminders as needed between visits, especially after ED/hospital visits, to provide patients with root cause analysis and avoid future incidents. CHWs will follow a protocol to guide visit content focused on home environmental trigger reduction, self-monitoring and self-management of asthma symptoms, asthma medication use, and medical follow-up. CHWs will link patients to resources for trigger reductioni nterventions, especially to change the indoor environment. A visit summary will be sent to all care team members (e.g., clinicians, Medicaid Managed Care plans, Health Home care managers, school nurses, etc.) via interoperable EHR and PPS-wide care management platforms created to support integrated care delivery.

Low/medium-risk patients will receive education and support from case managers at the medical home and benefit from PPS-wide care management platforms whereby pertinent disease-management information, such as Asthma Action Plan, is accessible to all care team members. Initial implementation will occur in known asthma “hot-spots” (i.e. Islip, Patchogue, Brentwood, Bayshore, and Mastic) followed by expansion throughout SC.

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

We expect to engage patients with the following criteria for this project: 1) SC residents, 2) diagnosed with asthma 3) aged ≤25, and 4) Medicaid. 2012 Medicaid Data show the total SC Medicaid population is 266,450; 13,596 of those have asthma and are ≤25 years old. We include patients through age 25 because this project will support care transition for children with asthma from pediatricians to adult providers. Targeted patients will be stratified into three risk categories:

high, moderate and low; with each group receiving a specific set of interventions designed to improve their care- such that home visits provide the more intense support required for the high risk group. The project will first be implemented for patients and providers in known asthma "hot-spots" (Islip, Patchogue, Brentwood, Bayshore, and Mastic) followed by expansion throughout SC. Patients from all racial/ethnic groups will be engaged in this project, with special attention paid to making services more accessible for linguistically isolated groups. Groups with high smoking prevalence will be targeted for additional support due to the causal link between tobacco use and COPD, cancer, and asthma.

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.

Since July 2011, the KFH program at Stony Brook Children's has provided over 2800 home visits to more than 750 children broadly deemed by clinicians to be "at-risk" for poor health outcomes; of these, 64% have Medicaid and the majority reside in known asthma "hot-spots". Currently KFH has 2 Full-time CHWs and 8 Part-time CHWs(including 3 Spanish-speaking CHWs), with clinicians providing asthma health education training to all CHWs in the following areas: 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 use of written asthma action plans. The program sends trained CHWs into the home for scheduled visits to focus on improving communication between health care providers and child's caregiver(s). The CHWs act as a direct extension of the pediatrician's office/medical home to support families in adhering to recommended care following the National Heart, Lung, and Blood Institute (NHLBI) guidelines by building healthcare navigation and health literacy skills. In addition, the program links families with appropriate community resources based on need, including additional healthcare services, food assistance, transportation services, childcare services, family services, and counseling.

The main new resource that will need to be expanded and developed for the PPS's strategy for this project is to hire and train the necessary CHW workforce from the communities in which they live and work in order to ensure cultural competency and accessibility in asthma care and management for the target population. The CHWs will need to be equipped with Wi-Fi enabled secure tablet devices and cellular telephones to assist them in providing appropriate services to the patients and families. These devices will allow CHWs to quickly and securely communicate remotely with primary care providers and the entire care team involved in providing patient care.

The PPS project team will also need to mobilize existing asthma educators, including nursing staff in pulmonary and allergy/immunology offices, primary care or Federally Qualified Health Centers (FQHC) certified staff, hospital-based asthma educators, existing Medicaid Managed Care Organizations (MCOs) staff, and Health Homes (HH); all can help with expansion of the model. Notably, grant funding for the existing KFH program will end in April 2015 such that DSRIP funding will allow for continuation of the program.

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.

PATIENT CHALLENGES: Families eligible for Medicaid/uninsured are more likely to have challenges (e.g., low health literacy, difficulty obtaining medications, transportation problems, etc.) that contribute to increased risk for poor asthma-related health outcomes. PATIENT REMEDIES: Our multi-disciplinary teams will provide consistent asthma education at each encounter within the PPS (i.e. hospital/ED, office, home visit) and tailor interventions to address the unique challenges faced by each patient. PROVIDER CHALLENGES: 1)Some PPS providers will experience barriers in implementing NHLBI asthma guidelines. 2) Some PPS providers may not have resources to address the cultural/linguistic needs of the diverse Suffolk County population. 3) Provider participation PROVIDER REMEDIES: 1) The project team will offer all PPS providers education and care redesign support required to meet project goals. 2)The PCP practice support teams will offer cultural competency training, including interpretation services use, for all practice staff. 3)Align providers through pay for performance incentives. INFRASTRUCTURE CHALLENGES: 1)Consistency in hiring, training, and supervision of CHWs. 2) Building relationships with a diverse group of community partners. INFRASTRUCTURE REMEDIES: 1)Building upon our existing program, we will hire and train additional management personnel to provide consistent workforce training and supervision. 2)The project team will hold monthly meetings with all project participants, including community partners, to monitor progress and implement shared governance.

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.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

The project will require 1) equipment and hardware including computers for all workforce members and asthma "tool kits" for patients/families (includes spacers, dust mite covers for pillows and mattress, binders for families to keep medical information, and tote bags); 2) space rental at the Federation of Organizations, Inc. for CHW meetings & storing supplies, and 3) health information system configuration and connections for all relevant care team members, including specific purchase of software licenses necessary for project operations.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination
Hospital Medical Home (H-MH) Demonstration Program	The HMH Demonstration Program is a health care quality and safety improvement program for Medicaid management	10/2012	04/2015	The focus of the Hospital-Medical Home Demonstration is to improve health care provided to Medicaid members in sites that train residents to become primary care physicians. Those sites are required to become recognized as Patient Centered Medical Homes by the National Committee on Quality Assurance. Hospitals are required to work on specific projects related to improving resident training, measuring health outcomes, care coordination and improving the quality and safety of inpatient health care.
Asthma Coalition of Long Island (ACLI)	ACLI is one of eight regional asthma coalitions funded by a grant called "A Systems Approach to Reduction	2012	2016	ACLI aims to reduce the burden of asthma in Long Island by bringing together regional stakeholders to apply a population- based systems change approach that translates the NHLBI guidelines into practice. ACLI does not directly provide any clinical care.

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

The funding for the Hospital Medical Home Demonstration Program will end in April of 2015, which will eliminate any potential duplication of services to PPS members through funding of this project. In addition, the programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of

information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

Domain 4 Projects

4.a.ii Prevent Substance Abuse and Other Mental Emotional Disorders (Focus Area 2)

Project Objective: This project will help to prevent substance abuse and other mental emotional disorders.

Project Description: Implement strategies to prevent underage drinking, non-medical use of prescription medications, excessive alcohol consumption by adults, and reduce tobacco use among adults who report poor mental health. Substance abuse, depression, and other MEB disorders hurt the health, public safety, welfare, education, and functioning of New York State residents. In addition to evidence that substance abuse and other MEB disorders can be prevented, there is confirmation that early identification and adequate societal support can prevent and alleviate serious consequences such as death, poor functioning, and chronic illness.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements. The PPS must show implementation of two of the three sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, there is a list of potential interventions that the PPS can use to develop its project. These interventions are found on the Prevention Agenda website under "Interventions to Promote Mental Health and Prevent Substance Abuse" (http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/interventions.htm).

1. Identify and implement evidence-based practices and environmental strategies to prevent underage drinking, substance abuse, and other MEB disorders.
2. Consider evidence based strategies to reduce underage drinking such as those promulgated by the U.S. Surgeon General and the Centers for Disease Control and Prevention.
3. Increase understanding of evidence-based practices for smoking cessation among individuals with mental illness and/or substance abuse disorder.

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

Entity Name
Nassau/Suffolk County Hospital Council

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.

This project addresses all three sector projects to Prevent Substance Abuse and other MEB Disorders.

PROJECT ASSERT/SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT):
Medicaid data indicate that mental health (MH) and substance use disorders (SUD) are the highest drivers of Suffolk emergency department (ED) visits. SPARCS data indicate that all behavioral health (BH) conditions combined are the primary hospital admission driver. CNA data shows that Suffolk binge (20.7%) and chronic drinking (7.4%) are higher than state (binge/18.1%) and national rates (chronic/5.2%). Suicide rates are above the state level and rose by 45% between 2009-2012. Hospitals report 40-50% of ED patients or admissions to medicine units have a BH disorder. 60% of key informants reported SUDs are a major problem in Suffolk, yet only one hospital of 11 uses SBIRT in the ED and only one uses it for admitted patients. Training individuals working in the EDs on the use of ASSERT/SBIRT will expand each hospital ED's expertise. Inpatient discharge planners will be trained in Project ASSERT/SBIRT for admitted patients. Geographic linkages between hospitals and Office of Alcoholism and Substance Abuse Services (OASAS)/Office of Mental Health (OMH) providers will improve collaboration and patient engagement, while reducing appointment wait-times.
PREVENT/REDUCE UNDERAGE DRINKING: OASAS 2010-2011 Youth Development Survey Suffolk results indicate that 56.7% of 12th graders reported alcohol use in the past 30 days (national average: 41.2%). Nearly 35% of 11th/12th graders reported heavy alcohol use, and the average age where alcohol use became routine was 14.7. Alcohol is the gateway "drug" to the use of other substances. The Suffolk Criminal Justice Coordinating Council, jail study draft results indicate 838 youth, 16-19 years old, entered jail during a 12-month period with 23% seen for SUD or MH reasons. Of those, 59% were identified with a SUD, with 69% identifying marijuana as their primary drug, 13% heroin and 9% other opiates. In 2011, a school-based survey of drug use and perception of risk in the Bellport/South Country School District indicated 8th, 10th & 12th graders demonstrate above national norms for past 30 day use of any substance, lifetime use of alcohol, marijuana or inhalants, and binge drinking. The survey showed a decreasing age of 'first use' of any substance, to 7th grade. OASAS and Suffolk DOH fund the Prevention Resource Center (PRC) at South Oaks. The PRC will expand and partner with the Bellport Boys and Girls Club to address underage drinking and drug use. The PRC's mission involves creating community-wide involvement through coalition development to make safer and healthier places to live and work.
SMOKING CESSATION IN OMH PROGRAMS: Nearly half of all those between age 18-64 enrolled in OMH programs report tobacco use. Key informants reported that, although some MH and SUD inpatient facilities have adopted and enforce smoke free policies, many ambulatory and residential programs have not. These disparities will be addressed through provider education, establishment of policies and support for smoke-free initiatives in OMH licensed programs. We will leverage OMH and OASAS providers in the PPS with expertise in this area.

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

PROJECT ASSERT/SBIRT: Includes all Suffolk County residents over age 10 utilizing hospital EDs including those who are admitted.

PREVENT/REDUCE UNDERAGE DRINKING: Includes All Suffolk County residents under the age of 21 who live in the greater Bellport region which includes Bellport, North Bellport, parts of East Patchogue, Medford and Yaphank, along with Native Americans from the Shinnecock Nation. The area is known to the Suffolk Youth Bureau as 'high need'; with the highest numbers of reported cases of Child Abuse/Maltreatment, juvenile offenses, juvenile delinquents and Persons In Need of Supervision on Probation. The PPS will resource and support the expansion of PRC effort throughout the county as the project progresses.

TOBACCO CESSATION: Includes all Suffolk County residents who utilize the participating OMH programs where policies and cessation intervention options will be established. These include approximately: 27 OMH licensed clinics, 15 Personalized Recovery Oriented Services (PROS) programs, 1 children's MH day treatment program , 2 psychiatric partial hospitalization programs, 4 Article 31 hospitals and 7 Article 28 hospitals (with a psychiatric unit) where policy reinforcement and cessation options will be expanded,7 Assertive Community Treatment teams and mobile crisis teams that will encourage quitting, 1 Comprehensive Psychiatric Emergency Program where cessation support/options will be offered. In addition to identifying those with at-risk levels of substance use, we will work with the sub-population coming to the ED as a result of substance use. We will ensure the County DOH is informed of Narcan overdose reversals in PPS hospital EDs so follow-up phone calls can be made by the County to connect this sub-population to services. The County is already completing these calls when a Narcan reversal is done by a police officer outside of a medical setting and is committed to expand their efforts as a stop-gap measure to help those in need.

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

PROJECT ASSERT/SBIRT: Southside Hospital implemented Project ASSERT/SBIRT in the ED and Stony Brook has implemented it targeting alcoholism for admitted patients. Both will provide technical assistance to other hospitals as they begin implementation. The Quality Consortium (QC), a coalition of OASAS providers, has worked with hospitals/primary care providers to promote Project ASSERT/SBIRT and will continue to do so. Seafield Center, Bridge Back to Life and Horizons have Project ASSERT/SBIRT expertise and will be deployed to provide support. Geographic collaboratives between hospitals and OASAS/OMH providers will be developed to capture patients who are identified as needing services and to close referral gaps. The Suicide Prevention Coalition of LI will be leveraged to provide training to Hospital/OASAS providers about how to intervene. The Long Island Recovery Association, National Alliance for the Mentally Ill and Hands Across LI all have strong local chapters and trained Peers Specialists will be engaged to develop methods to partner Peers with PPS organizations.

PREVENT/REDUCE UNDERAGE DRINKING: The PRC has five years' experience collaborating with/educating community-based providers to form strong coalitions, and functions as a clearinghouse of resources. They utilize the national Strategic Prevention Planning Framework to reduce risk factors/promote protective factors and will be expanded. The PRC coordinates a county-wide collaborative among prevention providers and will be mobilized to provide further education to schools.

TOBACCO CESSATION: Significant experience exists among PPS partners with tobacco cessation, including specific expertise in serving those with mental illness; however, further training of OMH providers will need to be completed. The Suffolk DOH and Association for Mental Health and Wellness have previously partnered to train staff and pilot smoke-free policies in OMH programs, and will be deployed to assist. The NYS Quitline "Opt-to-Quit" program will be leveraged to provide support to those seeking to quit, and will be implemented across multiple providers. The NYS-funded smoking cessation center operating out of NSLIJ will provide training/resources. Stony Brook's web-based self-management platform will be developed to include smoking cessation components. OASAS providers who have implemented policies will be asked to share experience/expertise with OMH providers.

ACROSS ALL THREE COMPONENTS: Long Island Health Collaborative (LIHC); an initiative coordinated by the Nassau/Suffolk Hospital Council, focuses on reducing the burden of chronic diseases based on the NYS prevention agenda specific needs identified in Suffolk and will be leveraged to guide efforts among subgroups. LIHC has already instituted some chronic disease management/prevention programs, disease surveillance, data collection, and public outreach/education. Significant IT/informatics/data analysis capabilities will be further expanded to serve the PPS.

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.

INFRASTRUCTURE CHALLENGES: 1)Recruiting staff to meet demand and staff's adjustment to Project ASSERT/SBIRT will take time. To be addressed through existing/future workforce training, ongoing mentoring/technical assistance, engagement of Peers and establishment of web-based platform for disease self-management/tele-health. 2)Workflow issues in ED settings where time is a significant factor in throughput. IT can be leveraged to help. 3)The project will need to consider the role of parents/ caregivers/coalitions /teachers/lawmakers/ pastors/youth /peers, etc. The following actions can be taken: a)Work with schools to promote prevention activities/referral relationships. b)Leverage existing health educators to raise awareness of available resources. c)Leverage existing community health workers to address health literacy. d)Leverage community coalitions/prevention providers to support environmental strategies and the building of protective factors while reducing risk factors. e)Leverage a nationally competitive Drug Free Communities grants to promote sustainability.

PROVIDER CHALLENGES: 1)ED/Hospital physicians will need re-training about documentation of SUD/MEB so screening/intervention processes are on claims. Integration/coding/billing experts

will be engaged. 2)Engagement of teens in treatment for SUDs. Contingency Management/Harm Reduction approaches will be used as possible solutions/motivators. 3)Overcoming myths/attitudes about smoking cessation among those with mental illness and will be overcome through education. 4)Psychiatrists/Psychiatric Nurse Practitioners will need education about smoking cessation medications/prescriptions. 5)Providers will be encouraged and supported to participate through financial incentives, e.g. pay for performance.

PATIENT CHALLENGES: 1) Encouraging people to accept help and/or education (i.e. risking drinking/signs of depression needing to be addressed). 2)Language, health literacy, cultural competency barriers need to be overcome. Provide access to Spanish speaking providers, translated patient materials and materials at a 5th grade reading level. Provide staff training on cultural competency. 3)Transportation to/from appointments in order to engage in care. Capacity to conduct offsite/home visits will be developed by treatment providers.

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.

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.

Facilitate collaboration, communication, sustainability between PPS partners through contracts, affiliations in DYs 1-2. Project ASSERT/SBIRT planning, hiring, training, implementation in DYs 1-2. IT connectivity for greater communication in DY2. Expansion of PRC efforts in target communities in DY2. Development of smoking cessation policies and training in DY1, roll out in OMH programs by DY2. Disease self-management apps/modules introduced through the PPS patient portal by DY2. Create incentive programs for high-quality care while reducing out-of-pocket costs for clinical, community preventive services by DYs 3- 4. Community-based prevention programs enhanced, supported, expanded to ensure access to all populations DYs1-5.

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

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

Yes	No
☒	☐

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

It is anticipated that approximately 5 iPads/tablets per PPS hospital will need to be used in the ED to ensure efficiency with the Project ASSERT/SBIRT protocol. Minor equipment/supplies to support the expansion of the PRC will be needed. Smoking Cessation training materials and initial patient supplies will be needed.

Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.

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
Long Island Association for AIDS Care				Case management / care coordination
Association for Mental health and Wellness				Roll-out of smoking cessation as a PROS service
Outreach Development Corp.				Outpatient Day Rehab adult and adolescent outpatient program in Bellport (OASAS)
Central Nassau Guidance & Counseling Service				3-year grant for on-site primary care; also received OMH funding for short- term crisis respite - hospital division - 2 years

Town of Smithtown Horizons Counseling and Education Center	Federal BLOCK grant preceded Medicaid redesign; also participating in "Reconnecting Youth" Program			Reduce smoking among patients with MEB disorders
Town of Babylon Division of Drug and Alcohol Services: Beacon Family Wellness Center				Prevent SA in town of Babylon residents through education and treatment services and partnership in community coalitions. Reduce/prevent mental illness symptoms in patients in SA programs. Provide smoking cessation education/resources to town of Babylon residents and patients in SA program

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

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

3. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

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

Entity Name
Nassau/Suffolk Hospital Council

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.

Three of the top five causes of death in 2014 in Suffolk were chronic diseases including heart disease, cancer and chronic lower respiratory disease. Smoking contributes to all these diseases.

OBESITY: Weight is a serious health concern for adults in Suffolk and, to an even greater degree, the Medicaid/uninsured. The CNA reports that ~7 of 10 adults are overweight, higher than the NYS and national averages.

CANCER: Lung cancer is the leading cause of cancer death in Suffolk. The Suffolk age-adjusted death rate from lung cancer (44.9) exceeds the NYS age-adjusted death rate (41.9). The incidence of lung cancer in Suffolk County (74.0/100,000) exceeds the NYS incidence (64.2/100,000). Female breast cancer has a significantly higher incidence rate in Suffolk compared to NYS, and the US. Colorectal cancer accounts for 9.9% of all cancer cases and 10.2% of all cancer deaths in Suffolk County. Mortality rates for Suffolk County are slightly higher than NYC: NYC male rate is 20.7%, and female rate is 14.8%, compared to Suffolk County rates with males at 21.4% and females at 16.4%.

SMOKING CESSATION: Smoking (adult and pediatric) is a significant contributor to asthma, chronic lower respiratory diseases and cancer in Suffolk. The age-adjusted death rate from Chronic Lower Respiratory Disease for Suffolk County is 33.1 (NYS is 31.4). These gaps will be addressed through the following: 1)Expand efforts of the Long Island Health Collaborative (LIHC); an initiative coordinated by the Nassau/Suffolk Hospital Council focused on reducing the burden of chronic disease based on the NYS prevention agenda goals. LIHC partners with all PPS hospitals, Suffolk/Nassau county health departments, regional governmental agencies, the business community, IT providers, community-based health and human service organizations, and schools. The PPS and LIHC will implement strategies to accomplish goals specific to diseases noted including a public awareness campaign, use of social media/traditional media outlets, legislative policy development and implementation of best practices. 2)Ensure that underserved residents receive screenings in a culturally-sensitive way, with reduction of inherent barriers including out-of-pocket costs, lack of transportation and limitations in health literacy. Incorporate free screening/educational events to reach the largest population. Bring resources into the community such as mobile CT scan for lung cancer screening, mobile mammography, colorectal screening education, and BMI screening. Create a Community "coalition" that includes community member representation to oversee and provide input to all aspects of these events, with aligned goals built into all hospital Community Service Plans. 3)Build IT platform (Integrated Delivery System project)

that will include EHR clinical decision supports, provider/patient alerts, disease self-management, educational materials and self-learning modules. 4)Adoption of the electronic NYS Quitline "Opt-to-Quit" protocol by all PPS providers. 5)Leverage Stony Brook University Hospital's (SBUH) Preventive Medicine, Biomedical Informatics and Population Health Departments to provide data analyses, training and technical assistance. 6)Work with payers to establish education/screening efforts as key components of PPS reimbursement models/risk-based contracts. Share performance data with clinicians within the patient-centered medical home model; align their reimbursement models to drive improvement in preventive measure performance.

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.*

All Suffolk County residents will be targeted to address obesity and smoking as top priorities across all areas of the county, leveraging existing resources to roll-out effective outreach events, starting in high patient volume, high Medicaid /Uninsured population geographies where the majority of chronic disease and disparities are noted in the CNA.

Cancer prevention/screening will be addressed as an overarching strategy for all Suffolk residents beginning in locations with high cancer prevalence and volume of underserved population and then expanding to other sites across the county. On-site events and work with primary care physicians/PCMHs will target all prevention topics and cancer types, but will particularly emphasize the higher incidence issues in each specific location to make the events more tailored to the needs of that population.

For lung cancer, individuals with a history of smoking who meet the current guidelines for screening will be targeted in specific regions with high lung cancer incidence rates including: Lindenhurst Patchogue, Ronkonkoma, West Babylon, Riverhead, Deer Park and Medford. For colorectal screening the focus will be on educational efforts and reduction to barriers in screening for the population over age 50 or those otherwise with a family history of colon cancer. Specific regions of high cancer incidence will be initially targeted including Blue Point, Medford, Oakdale, Sound Beach, North Babylon, Brentwood, Centereach, Central Islip, Mastic, Mastic Beach, Mattituck and Mount Sinai.

For breast cancer screening, the target population is women aged 40 or older starting in specific high breast cancer prevalence regions; Oakdale, North/West Babylon, Bellport, Commack, Coram, East/West Islip, Huntington and East Hampton. The goal is to initiate activity in high prevalence regions and eventually expand efforts to include the entire county.

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.

POPULATION HEALTH/PREVENTION: 1)SBUH's Program in Public Health assists LIHC with development of metrics for population-level monitoring of wellness outcomes including smoking cessation and alcohol/other drug misuse. SBUH IT created a secure web-based data entry portal that allows each LIHC "member" to enter site and/or health system specific data at the patient

level (de-identified) for pre- and post-intervention metrics. SBUH will be leveraged by the PPS to analyze the population-wide data sorted by type of health issue, by geographic area, and population type (age, gender, race/ethnicity, other). Reports will be shared with LIHC members to assist with population-level planning and integration into hospital Community Service Plans. 2)Nurses across school districts meet regularly for educational forums and sharing of information. This group will be leveraged to facilitate the dissemination of best practices (particularly around obesity and smoking) and engage the districts in Suffolk who serve approximately 260,000 youth. 3)Hospitals/other PPS partners currently collaborate to build public awareness about prevention, i.e. the annual "Paint Brookhaven Pink" initiative to promote breast cancer screening. Learnings from these events will be used to optimize the outcomes of planned PPS events. 4)Leverage current hospital relationships with payers to encourage the use of routine prevention protocols and provider incentives to help achieve prevention goals.

DISEASE SCREENING/SUPPORT: 1)NYSDOH operates a Cancer Services Program (CSP) in Suffolk that provides breast, cervical, and colorectal cancer screening. CSP provides free screenings and reimburses providers to coordinate screening services. The NYSDOH provides online educational materials in multiple languages to raise awareness of the CSP and to inform potential users about eligibility/expected costs. 2)SBUH Professionals/community members have access to the most up-to-date prevention, education/training and treatment protocols/interventions to prevent/manage disease. In 2017 SBUH will open its "MART" tower (Medical/Academic Research Tower), dedicated to bringing research to practice. 3)Health Home, PCMH and FQHC PPS partners who have prevention models built into their current protocols will serve as best practice models for other practices and will be further developed to use evidence-based protocols and optimize the use of their EHRs. 4)Stony Brook School of Dental Medicine mobile dental clinic brings outreach, screenings and treatment to underserved communities and schools. The Dental School can leverage its van at community screening events to do BMIs, provide basic counseling and appropriately refer patients to obesity specialists. 5)The WIC program provides screening and nutrition/education counseling for obesity and will be included in planning for on-site events. The Cornell Cooperative Extension/Expanded Food and Nutrition Education Program assists participants to change attitudes and behavior necessary to improve diet, health and general well-being.

DISEASE MANAGEMENT: 1)Significant RHIO/IT data exchange/analysis/educational capabilities will be expanded through the Integrated Delivery System project. Comprehensive health literacy/patient education efforts will be brought to the community through multiple mediums, including IT and web-based tools to facilitate culturally sensitive population education/disease management. 2)Health Home and Case Management (CM) capabilities currently serve many County residents. The PPS will develop and expand all CM efforts to connect patients with resources and eliminate barriers to prevention of the target chronic conditions.

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.

PATIENT/SOCIOECONOMIC ISSUES: 1)Limited public transportation results in patients not receiving preventive services, cancer prevention screenings, and missing follow-up appointments. SOLUTION: Convenient locations developed for on-site education/screening events, leverage the use of mobile screening resources, and engagement of transportation companies to expand availability of transport resources. 2)Large disparities in Race/Ethnicity/Language and other cultural factors results in need for diverse health literacy/patient education materials that are not being met. SOLUTION: Explore and obtain existing resources and develop those needed with the assistance of national/state experts and PPS partners who know the community.

PRACTICE EFFECTIVENESS: 1)Lack of expanded hours to help improve access to education and screening services. SOLUTION: Work with providers to expand access/hours through the efficiencies recognized within the implementation of the Patient Centered Medical Home model; leverage on-call systems and telehealth options. 2)Trend of clinical office staff not practicing at "top of license" to do education and schedule necessary screenings, which contributes to access issues. SOLUTION: Workforce training/mentoring and build efficiencies into workflows with clearer role definitions to be sure that the necessary education and screenings get accomplished. 3)Lack of education and awareness on the part of providers of current best practice prevention recommendations and community resources. SOLUTION: Provider and office staff education on current recommendations; create tool kits that providers can use to refer patients to available free or low cost education and screening resources in the community. 4)Lack of resources for PCPs to tackle myriad issues. SOLUTION: Align PCPs through pay for performance incentives.

CARE MANAGEMENT: 1)Few warm handoffs or standard routes of communication or registries regarding patients who may be in need of education or screenings. SOLUTION: Leverage a PPS-wide care management documentation platform that includes a registry function and ultimately links with EHRs/RHIO. This will ensure that at every opportunity an individual who is in need of services can be easily identified.

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.

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.

Solidify formal relationships through contracts and affiliations. (DYs 1-2). IT connectivity to allow for greater electronic communication among all partners (DY2). Disease self-management apps and modules made available through PPS patent portal (DY2). Increased utilization of screening protocols within hospitals, PCMHs and FQHCs (DYs 2-3). Payer negotiations around improving HEDIS measure, creating quality incentive programs for providers, better provider rewards for high-quality care while reducing out-of-pocket costs for clinical and community preventive services (DY 3- 4). Community-based prevention programs and coalitions will be enhanced/ to ensure access to all populations (DYs1-5).

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

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

Yes	No
☒	☐

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

Technology: Tele-health tablets for care managers and community health resources to undertake remote screenings on a mass scale.
Space Rentals – Rent space in community centers and other venues to outreach to the general population with key messages re: obesity, smoking etc.
Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.
Equipment: Purchase of mobile van to conduct mammography screening; purchase of mobile van to conduct lung cancer screening (both requiring necessary equipment for screening)
Supplies: Purchase of brochures, pamphlets, educational materials to be distributed at wellness events

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
Nassau/Suffolk Hospital Council	The hospital council sponsors the Long Island Health Collaborative (LIHC)	12/2014	12/2016	PHIP contractors will be regional data, education, and training resources for their regions and will help guide regional health improvement efforts among a variety of stakeholders – hospitals, the county health departments, community-based social and human services organizations, academic institutions, health plans, unions, home care agencies, nursing homes, behavioral health providers and even the business sector.
PROHEALTH Care Associates, LLP	Medicare Shared Savings			In addition to Medicare Shared Savings program, PROHEALTH also has several value-based incentive programs that focus on their Managed Medicaid population
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination

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

The resources of the PHIP will assist Performing Provider Systems, as they move through the DSRIP process. The specific funding for the 4.b.ii project will be used to go more in-depth than the existing LIHC initiative in the provision of education, on site screening, and reduction of barriers to chronic prevention in the locations within the county that have been identified through the CNA as having high volume/high clinical gaps and evidence of significant disparities in care. Activities will focus on the targeted areas of obesity, smoking and cancer prevention as noted above in the project description. The DSRIP resource dollars will be used for outreach staff, clinical education support, educational materials, costs related to locations for events and costs for the clinical screenings.

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