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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 providedin a separate Excel document. You must use this separate documentto 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-basedto 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 aspreparing 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 providerswithinthe PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.
2. Utilizepartnering 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.

STRIPPS used existing utilization data and County DOH CNAs, to develop a common understanding of utilization patterns in the PPS service area. The data for avoidable admissions and ED use indicated that 5 counties in the southern tier portion of the service area were performing well below the Upstate NY avoidable admissions rate of 1,743 per 100,000. The 4 northern counties had rates exceeding the upstate NY rate. When the same analysis was performed for avoidable ED care, utilization throughout the service area was consistently higher, especially in rural counties. There was also a lower rate of primary care visits per 1000 compared to NYC and upstate, which correlates with the high ED use. When the DSRIP 25% improvement target was applied to the data, there was a potential opportunity for reduction in avoidable inpatient use of 2,260 discharges and 39,328 ED visits.
To gain insight into the observed trends, a comprehensive qualitative /quantitative CNA was conducted. In the research, participants confirmed the ED was highly relied upon for care by Medicaid beneficiaries and the uninsured. Participants identified lack of access to a PCP as a key reason. Specific access issues identified included availability of PCPs, hours of service, inability to make a timely appointment, transportation, and the need for child care. Behavioral health conditions also contributed to ED use patterns. High utilizing patients with >50 visits /year, had fewer visits to a PCP, concurrent drug abuse/behavioral health issues and a history of seeking episodic care from multiple providers.

Implementing the IDS infrastructure enables the creation and operation of a well-coordinated network of care with the support of system delivery components that are currently missing or fragmented, specifically: outreach and navigation services for beneficiary engagement, organized care coordination efforts, population health analytics and risk stratification to effectively target care coordination; assistance to PCPs for achievement of PCMH Level 3, implementation of Telehealth, and development of EMR and IT connectivity among providers to support shared clinical information and the development of a clinical data repository to track and measure progress toward targeted reductions in avoidable hospital and ED utilization. The IDS functionality provides a mechanism for collaborative planning and coordinated decision-making at the care delivery network level which will:improve access to primary care and behavioral health services, encourage improved models for PCP care delivery using advanced practice providers, and the development of a PCMH network. Additionally, The IDS is also in a position to efficiently address PCP supply issues and coordinate the recruitment of additional PCPs across partners, channeling resources to areas of highest need.

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.

STRIPPS is comprised of a comprehensive array care delivery partners who use a variety of care delivery models. Partners include Medicaid Health Homes, organized primary and specialty physician care networks, hospitals, home health care providers, hospice providers, long term care facilities, an FQHC network, behavioral health programs, community based social service agencies, a FTC approved Clinically Integrated Network that combines hospital and private practice physicians and two RHIOs. Within the service area there are distinct patient care communities whose providers and agencies are well known to each other and within which patients receive the majority (>90%) of their care. Yet, despite these existing resources, there are still times when the care is quite fragmented and delivered by unaligned and separate economic entities.
A key new resource to be developed is the IDS, which will leverage and coordinate key IDS competencies, existing within the partner network, PPS-wide. STRIPPS partners and care communities have all agreed to come together and form a partnership to coordinate and enhance the care delivered to Medicaid patients within the 9 county area. The addition of centralized IDS functionality enables STRIPPS to establish a common set of evidence-based quality guidelines for all partners with the ability to monitor and track evidence-based clinical indicators against quality standards. The shared mechanics of network management also facilitates the development of an aligned incentive structure to reward providers who outperform the metrics and remediation plans for providers who struggle to meet expectations. The IDS can also coordinate the implementation of a PPS-wide approach to creation and distribution of behavioral health care, expansion of access to primary care services, development of care coordination and a coordinated project management approach for the implementation of DSRIP projects.
The hospital based providers and the Medicaid Health Homes have developed competencies in care coordination and population health that can be scaled for PPS wide functionality. Integral to the IDS is a robust PCMH certification program. Many of the practices of the larger hospital systems are already PCMH certified under the 2011 guideline, and this experience can be leveraged to assist in advancing certification efforts to the 2014 guidelines. For the approximately

50% of the PCP's in STRIPPS who are not currently PCMH certified, the backbone of current STRIPPS PCMH practices who are certified can be used to accelerate the preparation of practices for PCMH certification.
The RHIOs have actively assisted STRIPPS in the assessment of IT functionality within network providers for development of the DSRIP application. RHIO connectivity and resources for implementation are assets to be utilized on a PPS-wide basis.
Finally, within the STRIPPS network there is experience with single signature network contracting through Cayuga Area Plan / Cayuga Area Preferred (CAP), the physician hospital organization in Tompkins County that represents Cayuga Medical Center and the Cayuga Area Physician's Alliance. The STRIPPS will leverage CAP's experience with commercial payer contracting and apply this to future contracts with Medicaid MCOs. Additionally, CAP is in the process of implementing a population health management solution for targeted populations within their existing covered lives. The STRIPPS will apply components of this methodology in the course of IDS implementation.

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.

1) Access barriers related to PCP and behavioral health providers. Patients have become conditioned to use the ED for reliably accessible one-stop services. Several initiatives will need to be used to modify the mindset behind this behavior. Key among them will be actively engaging patients in care coordination. This connection is central to the process of shifting patient behavior and building connections with community based resources. Medicaid Health Home experience has revealed many patient resistance factors to engaging patients in care coordination. Cultivating warm referrals into care coordination from patient trusted sources will be key to overcoming this barrier. The care coordination resource is also essential to changing provider tendencies to refer routine care to the EDs. STRIPPS will use care standards tied to incentives to increase access through open scheduling, additional/alternative hours, use of advanced practice providers, telemedicine, and the development of behavioral health services in non-traditional settings.
2) Lack of navigation services to assist patients as they move through the healthcare system is another challenge. The IDS will develop a health navigator program utilizing the current 211 system as an easy entry point for patients.
3) Communication between providers has not advanced beyond the pre-EHR days. Providers generally do not have access to clinical information from other providers limiting care coordination. The IDS will foster the development of a RHIO based communication system that will allow rapid communication directly between providers and access to a common treatment plan allowing providers to work together when a patient needs intervention.

4) Police transfers to the ED are also an issue in ED use. Lacking knowledge of care alternatives and skills for dealing with decompensating behavioral health patients, they transport patients to ED settings. For every 1000 transports, 70% are not medically necessary. Training and intervention with first responders will be essential.
5) Shifting from fee-for-service to performance-based reimbursement. Engaging providers across the network and keeping them engaged throughout the DSRIP term and beyond will be critical to the success of the IDS and ultimate payment reform objectives.

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.

STRIPPS currently overlaps with 3 adjacent PPS: Central NY, FLPPS and Leatherstocking. Lines of communication with each adjacent PPS were opened during application preparation. During the CNA implementation, there was data exchange and discussion with Leatherstocking. There was also dialogue with Central NY on changes in PPS services areas and governance. More recently, there has been dialog with FLIPPS regarding specific projects, including this project. The dialogue with FLPPS fostered a general plan for adjacent PPS collaboration. During implementation planning STRIPPS will meet with the project management leadership of each adjacent PPS to identify the opportunities for collaborative planning around common projects, common providers, and common training needs. Once identified, integrated teams will be formed chartered with specific deliverables aimed at simplifying implementation of projects, using common PPS infrastructure, achieving economies of scale with respect to resources for overlapping projects and geography. To the extent that there are common RHIOs, effort will be made to achieve a coordinated approach with providers regarding EMR and IT connectivity.

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

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

The vision of STRIPPS is to optimize the health outcomes of Medicaid beneficiaries by engaging them in coordinated delivery of care that utilizes the most appropriate, cost effective setting given medical, behavioral, and social needs. Achievement of the vision requires STRIPPS to develop and implement a shared model of care that right sizes, realigns, and integrates the continuum of community based and institutional services to achieve DSRIP goals, improving access to care while simultaneously reducing patient ED visits, re-admissions, and preventable admissions, thereby reducing costs. Inherent in transforming to this type of care delivery, STRIPPS recognizes the need to:

1) Retrain and redeploy the healthcare workforce to align with and support the transformed service delivery model;
2) Implement community based care coordination to deploy early intervention and prevention to people with rising risk for chronic illness and facilitate movement through care settings in the service continuum, and;
3) Buildorganizational infrastructure for population health management, financial operations, contracting and electronic information management needed to support the PPS in the achievement DSRIP quality and utilization goals.
The foundation of the action plan supporting this vision is the development of a sustained commitment of the partners who make up STRIPPS. Over the course of building the application, STRIPPS has cultivated sustained participation in both organizational and project planning which led to the formation of a well-structured governance model that assures diverse representation and engagement of both institutional and community based organizations (CBO). The leadership of STRIPPS is committed to a common vision that supports a more integrated delivery of care system and recognizes the natural outcome of reduced institutional utilization and increased community based service.
During the first two years, STRIPPS will be focused on several formative milestones developing shared organizational capacity to manage care delivery performance and implementation of the selected DSRIP projects to reduce service gaps. Key milestones of early implementation include the development of population health analytics and the activation of the Clinical Performance Domain (CPD) and Regional Performance Units (RPUs). The CPD will review population health data to establish the targets, by RPU, that are calibrated to achieve DSRIP goals. With performance targets in place, the CPD will work with RPUs to establish clinical standards and evidence based protocols to support achievement of performance targets. The RPUs will be the organizational unit that works with providers, in their communities, to develop tailored action plans that support performance improvement. Concurrent with the development of performance management processes, STRIPPS will implement a project management function to support the execution of the implementation plans for the 11 selected DSRIP projects customized to each RPU. Collectively, the implementation of the projects creates the community based service expansion needed to ultimately drive down ED and inpatient avoidable use.
There are several PPS-wide IDS functions that also need to be implemented in the first two years that support the achievement of the DSRIP utilization goals and successful implementation of the projects. Key milestones include: achievement of targeted levels for PCMH certification, effectively deploying navigation services and the care coordination function, implementation of telehealth to overcome transportation/access barriers, development of outreach to engage beneficiaries, development of provider relations, implementation of incentive pools and EMR implementation and connectivity that supports the flow of clinical data for coordinated patient management and development of a rich clinical database for population health management.
Fund management will initially be focused on appropriate fund distribution for project implementation and the development of IDS functions. A significant milestone is implementing a methodology to adjust and calibrate fund distribution to performance based fund inflow. Additional development milestones include monitoring of revenue loss due to impacts of DSRIP initiatives and development of DSRIP contingency and sustainability reserve funding to accommodate fluctuations fund flow.

Workforce Transition action plans will be focused on the development of human resource infrastructure such as job descriptions, training programs, and community based organizational development plans to accommodate the anticipated shifts and growth of workforce in community based settings (see section 5).
As STRIPPS moves into the performance years of DSRIP, the projects and IDS functionality are expected to yield the targeted changes in utilization performance. The business of STRIPPS is much less developmental and is more focused on maximizing performance management and achievement of performance to targets. Action plans during this stage are focused on specific metric improvement. It is expected that avoidable ED visits and hospitalizations will decrease and STRIPPS hospitals will increasingly shift service delivery to community based services. Given baseline data, STRIPPS has considerably more opportunity with the reduction in ED utilization. Driving down the avoidable ED use will depend on the milestone achievement related to project implementation and expansion of PCP and behavioral health services.
As the business model continues to migrate toward value based payment, performance management mechanisms become increasingly important. Key milestones in IDS operations for the second half of DSRIP include increasing engagement of beneficiaries, increasing the use population health risk stratification to refine the delivery of care coordination resources and manage increasing numbers of patients in community based settings, and routine use of performance management processes to maintain a high performing provider network. As performance targets are achieved, fund management incentive programs will be used to increase momentum to provide and support for further expansion of PCMH adoption and IT connectivity.
As DSRIP funding moves toward conclusion, a key milestone for STRIPPS will be the development and implementation of a financial sustainability plan that anticipates that 90% of Medicaid revenue flow will be derived from value based payment.

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 tools and processes designed in the IDS are the integration elements for achievement of uniform performance across diverse providers. The partner base of STRIPPS has considerable variability in terms of tools and readiness to support performance based care management and payment. Some providers share clinical information through the RHIO's, but most physician practices do not. Some already have developed system-wide clinical guidelines. Few share information with entities outside of their organization unless there is an existing structure for this such as a Health Home. Population health management is in an early nascent stage. While there is unevenness in structure, process and readiness across the STRIPPS partner base, it is critical for the evolution of the shared commitment necessary for DSRIP success, to leverage existing structure and processes of partner organizations who have invested and developed some of these functions within their own organizations.
There are 3 major milestones of governance development in the journey to true integration among the partners:
1) Establishment of overall governance for STRIPPS. STRIPPS has elected to adopt the delegated governance model and establish a new organization to oversee PPS operations and performance.

The governing body is balanced in composition, comprised of all 5 health system partners, the FQHC, and 5 community based organization representatives. Decision-making is based on simple majority. The governing body is supported by three domains: Finance, Clinical Performance and IT/Data Governance. These domains are working committees or integrated forums of expertise contributed from STRIPPS partners. These working committees shape relevant recommendations from each content area for STRIPPS governing body.

The likely progression of development within this milestone includes:

- Establishing evidence based clinical guidelines as the standard for the network (DY1 Q2);
- Determination of metrics to be used to measure performance (DY Q2,Q3);
- Development of mechanisms to reward above average performance and remediate below average performance within the network. (DY2-4);
- Development of a process for continuous improvement that includes new evidence based guidelines to close performance gaps.(DY 2 -4);
- Development of population analytics in partnership with regional Health Homes (DY 2), and;
- Oversight of the plan for PCMH certification within the network (DY 2-3).

2) Development of operating structure to support the core IDS functions. This includes PPS staff for project management, population health analytics/risk stratification/care coordination, PCMH implementation, IT/Data management and connectivity, financial analysis.

The likely progression of development within this milestone includes:

- Development of a plan for all PCP providers to become and/or maintain PCMH level 3 certification by year 3 (DY1);
- STRIPPS staff will work with PCMH teams in each region to assure implementation and provide assistance (DY1-3);
- Development of a plan for connectivity between providers using the RHIO's that ensures that providers are actively sharing information and using secure messaging by the end of Year 3 (DY1-3), and;
- Implementation of clinical communication between all providers to include coordination of care, hand offs between providers that assists in care management.(DY1)

3) Establish the STRIPPS Regional Performance Units (RPUs). Each RPU is based around existing structures/organizations/systems and medical communities where patients within a RPU will receive >90% of their health care. The RPU is the fundamental building block for performance management in the IDS. Each RPU has a clinical governance committee with members representing various clinical services in the communities. Providers will engage with this committee on clinical issues. Regional committees may set up separate work groups for projects or specific performance improvement initiatives. These regional work groups may integrate or become part of partner organization's work committee structure so that there is not a duplication of effort between STRIPPS and the organization's internal clinical committees. Over time, as trust

and working relationships develop, many of these efforts will become organized through the IDS rather than individual hospitals or organizations.
Each region's clinical governance committee will have 2-3 representatives on the STRIPPS Clinical Domain governance body, whose role is to coordinate activities between the regions and the executive governance body. This group will manage system resources to regions that are not achieving expected results.

The likely progression of development within this milestone includes:

- Distribution of standardized guidelines to practitioners in the network (DY1 Q2-4);
- Monitor metrics for the region and identify areas of concern or poor compliance for additional resources (DY 1-4);
- Development of remediation plans for low performing practitioners(DY1-4);
- Implementation of population health management at local level (DY1-4);
- Assistance to the PCMH Team at the practice level (DY1-4), and;

• Development of work groups for specific projects as needed (DY1-4).
As the clinical governance groups begin working together they will establish stronger ties that will encourage more collaborative projects across the region and among providers. These projects will strengthen and extend the clinical network, especially the inclusion of providers not usually considered to be part of the medical community, evolving into a more cohesive care community with enhanced services provided in a more collaborative manner.

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

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

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

4. <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 patientswill 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.

During preparation of the application a resource analysis was conducted to determine the readiness for PCMH, telemedicine and EMR / IT connectivity needed for basic operations of the IDS as well as many for the projects. The anticipated capital need for this project includes: PCMH implementation resources, IT infrastructure to support functionality required for PCMH Level 3 certification and IT connectivity to RHIOs, and Telemedicine to ameliorate access to care barriers presented by lack of transportation and specialty shortages. For STRIPPS, the IDS is in the best position to efficiently manage the infrastructure and tools needed to support the integration of care delivery necessary to achieve DSRIP Goals

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
UHS Hospital	Medicaid Health Home	Phase Three. 2013		Care Coordination

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Catholic Charities of Broome County	Medicaid Health Home	Phase Three. 2013		Care Coordination

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 NYS Medicaid Health Home was approved under a State Plan Amendment (SPA) in 2011. The health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is done

primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home." The Health Home was targeted for Medicaid population groups who have complex medical, behavioral, and long term care needs that drive a high volume of high cost services including inpatient and long term institutional care.

In DSRIP, this project, the development of the IDS, builds on the Heath Home infrastructure for outreach, patient engagement and care coordination and expands those competencies to the overall population of Medicaid beneficiaries.

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 theIDS 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 challengesas well asimplementation 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.

The CNA shows that chronic disease such as hypertension (HTN), diabetes, mental health disorders, and cardiovascular diseases are the leading cause for hospitalizations and ED visits within the STRIPPS region (Region). Within the STRIPPS population the percentage of counties where a health indicator exceeds the Prevention Agenda objective are as follows: 89% for HTN, 44% for diabetes, and 90% for the prevalence of obesity. Prevention Quality Indicators (PQI) from 2012 indicate that for Medicaid beneficiaries within STRIPPS, adjusted hospitalization rates were higher than the NYS average for all acute conditions as well as short-term complications related to chronic disease (diabetes, COPD, asthma, and heart failure).
While in its entirety the STRIPPS Region has fewer avoidable hospitalizations due to chronic disease (CD) than the State average in 4 of 9 counties, the number is higher than the State average, suggesting that a care transitions intervention model to reduce 30-day readmissions for CD is a critical project for STRIPPS.
Further supporting the need for this project, interviews with healthcare providers revealed that 68% perceived an issue with 30-day readmissions across the Region and 41% perceived that readmissions were more prevalent for Medicaid beneficiaries. In the Medicaid focus groups, participants felt that not enough time was spent with them explaining their condition(s) and how to effectively manage their diagnoses.
The STRIPPS Care Transitions Program (CTP) involves coordinated care efforts across health care agencies to better support patients, and their caregivers, across the care continuum. Beginning with identification of patient participants prior to discharge, the CTP will continue with a combination of home visits and follow-up phone calls by a registered nurse in coordination with the patients' primary care provider. The program design addresses concerns identified in the CNA: patient education on disease and community resources; patient engagement and activation in primary and preventative health; patient responsibility; medication management; and transportation alternatives.
The STRIPPS CTP proposes a six-step approach to accomplish overall project goals (reduce avoidable 30 day hospital readmissions and ED admissions among Medicaid beneficiaries with chronic health conditions):

1. Ensure clinical partners are fully aware and appropriately engaged in the CTP program. Special attention will be made to ensure physician, discharge planning, nursing, and behavioral health teams are well-informed advocates of the CTP program.

2. Routine case identification of Medicaid participants is necessary for program enrollment. A CTP representative will be present for facility discharge planning and introduce themselves to identified participants promptly upon hospital admission.

3. Hospice has been recognized by the Institute of Medicine as an effective means to reduce acute care visits. In 2013, NY was 48th out of 51 states and the District of Columbia in hospice utilization. More timely identification and referrals for hospice candidates will support project goals.

4. Home visits by a CTP RN will be scheduled prior to patient discharge and focus on:

i. Medication Management

ii. Chronic Disease Teaching

iii. Home Safety

iv. Caregiver support

v. Community Referrals

5. Timely follow up with care providers following a hospitalization are known to improve patient outcomes, reduce unnecessary readmissions and reduce health care expenditures. The CTP RN will work with the patient to overcome identified barriers to making those appointments (transportation, etc.), utilizing available community resources.

6. Remote Patient Monitoring (RPM) services have proven to be effective in the management of chronic conditions. RPM is important to increase access for both rural and urban populations and for monitoring care compliance for those populations targeted.

b. Please define the patient populationexpected 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 through the implementation of project 2biv includes any of the nearly 24,000 Medicaid patients living with chronic illness within the Region. Specifically, those patients with inpatient admissions will be targeted through the program. In 2013, there were over 7,000 unique Medicaid beneficiaries attributed to STRIPPS who were diagnosed with a chronic disease and were admitted to the hospital. The STRIPPS CNA reported that 29% of MCD/UI respondents are living with chronic mental health conditions and 6% are dealing with chronic substance abuse. Medicaid beneficiaries living with mental health conditions and those who are dealing with chronic substance abuse will be included as eligible participants in care transitions programming.

The exception to program qualification are those patients being discharged to a skilled nursing facility (SNF) as it is implied that those residential nurses are performing the services being offered through STRIPPS care transitions programming and therefore the CTP would be duplication of services and potentially confusing to the patient and their caregivers. Given the advent of the INTERACT (2bvii), Integration of Palliative Care (3gi), and Community-Based Navigation Services (2ci), those patients being discharged to SNFs are eligible to benefit from additional STRIPPS programming.

Preliminary results of an alternative transitional programming within the STRIPPS, that was developed to support Medicaid patients across the care continuum, show a 34% acceptance rate. Through an extensive two-pronged marketing campaign designed to promote community and provider awareness, and through enhanced collaboration with inpatient care providers (at all levels of the care team) the STRIPPS transitions team anticipates a 25% acceptance rate in year one of program implementation. Through care evaluation, patient feedback and collaboration with community case management teams, that number is anticipated to grow with the program over the course of time.

Of the MCD/UI survey respondents in the STRIPPS CNA, 70% reported they do not utilize community resources despite living with chronic conditions. Those patients who decline program enrollment will be referred to the community based navigation program (2ci) for additional assistance upon discharge as needed to access available community resources.

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

The 5 health systems throughout STRIPPS (UHS, Guthrie, Cayuga Health System, Cortland Regional and Our Lady of Lourdes) have varying degrees of programming in place to support patients across the continuum of care. These programs range in operations, services provided, population served, and data management to measure outcomes. However, they all share one thing in common: the goal to set patients up for optimal health outcomes through appropriate care teaching and navigation, while preventing unnecessary ED visits and inpatient admissions.
Of noted success, and perhaps the biggest asset to the STRIPSS care transitions team, is the Transitions program in Tompkins County. Transitions is a Coleman-like model, still in pilot form, that began enrolling patients in September of 2014. Transitions is a collaborative effort amongst the local Physician Hospital Organization (CAP), the county's Office for the Aging, and Visiting Nurses Services of Tompkins County - a certified home health agency. All patients eligible for the Transitions program - which involves a combination of home visits and follow-up phone calls much as described in section A. above - are being monitored for ED visits, inpatient admissions and inpatient days after discharge. In its first two months of existence, the Transitions program saw an 81% decrease in ED visits for those patients enrolled versus those patients who declined participation. There is a similar pattern for inpatient admissions and inpatient days as well, with respective 76% and 66% decreases for those patients who were enrolled versus those who declined participation.
The CTP transitions team is hopeful to replicate the Tompkins County Transitions team outcomes, as they are in direct alignment with DSRIP goals. Another supporting factor to the Transitions program is the amount of time spent educating care teams (physicians, discharge planners, etc.) prior to, and continued throughout, program enrollment. Care decision algorithms, inclusive of additional available area programming/services, were developed to help representatives form case management/discharge planning to make referrals to appropriate post-acute programming. Ongoing communication with physician practices has been identified as an integral step to garner additional support from patients, and bring additional referrals from outpatient physicians.
An additional asset to the Transitions team has been the ability to have consistency of RN interaction so that he/she who is introducing the program to the patient and their caregivers is the same RN who makes the initial contact with the patient upon discharge. That same RN then follows the patient throughout the course of program enrollment. This consistency in personnel has allowed for better care and communication, laying the foundation for a productive working relationship beginning at program introduction. This same approach will be utilized with the implementation of project 2biv.
Some hospitals within STRIPPS have transitions nurses currently in place, or are currently developing their roles. However, given the varying degrees of coordinated care efforts across the STRIPPS region that although the protocols for identification, enrollment, and ongoing care from the Transitions program can easily be replicated to fit the needs of the STRIPPS

team, the manner in which care transitions RNs are employed may vary depending on agency licensure and availability of resources currently in place.
Admission/discharge/transfer feeds and EMR connectivity will play an important role in the success of the STRIPPS CTP for monitoring of patients across the care continuum. It will be important for RNs coordinating the care of the patient participants to be aware, in real time, of missed appointments and also ED visitations so that they can intervene and participate in subsequent care planning to best support the patient (and respective care teams) to avoid unnecessary inpatient admissions.

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.

Marketing is an essential component in the success of any programming. Lack of program awareness could easily challenge the success of this project if not done thoroughly and thoughtfully. Education of and communication surrounding the transitions program will be targeted at both inpatient and outpatient care providers as well as to the patients and their extended care team(s). Physician recommendation is one of the most significant predictors of colorectal cancer screening and predictably the same could be said for recommendation for other such health promotion activities. In addition to physician teams, inpatient RNs and case management teams will need to have a strong grasp of the program design and intended benefits as hospital discharge planning begins on day 1 of admission.
Program acceptance is anticipated to be one of the biggest challenges based on participation rates of previous care transitions programming within the STRIPPS (12% with a former Coleman Model initiative that targeted Medicare patients with chronic disease and 30% acceptance for a Coleman-like model geared at all Medicaid patients). Program availability does not guarantee patient participation and there is much to be learned about the type of programming that appeals most to those patients who qualify for enrollment. In efforts to eliminate health literacy as a barrier, program outreach, communications, and other areas of marketing will be designed and/or scripted to be easily interpreted by the populations being targeted. Again, effective marketing and communication are essential components to CTP acceptance and success.
Geographic location can be a challenge to both program capacity as well as outcomes. Remote patient monitoring capabilities will allow the CTP nurse to garner better understanding on how the patient is following their intended care plan in-between visits. The CTP RN will act as coach in working with the patients' extended care team to ensure the patient is set up for optimal health outcomes (ensuring the availability of someone to pick up needed medications and supplies, access to community-based transportation opportunities, etc.).

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.

Five of the nine counties within the Region overlap with an alternate PPS. Effective communication with those PPS teams will be imperative to the development of strategies to best serve those patients residing in areas of geographic overlap. The STRIPPS CTP team will need to understand which of those overlapping areas are developing transitions of care

programming and what that looks like to help eliminate and confusion or misperception amongst patients, caregivers, and providers in the development of marketing materials. Likewise, open communication with sending counties will be important in the development of care referral algorithms so that the patients receive optimal post-acute support. For example, STRIPPS overlaps with FLPPS on project 2biv specifically in the counties of Chemung and Steuben. It will be important for STRIPPS and FLPPS to coordinate on the RPU that includes Chemung and Steuben counties so that duplication of care transitions work and training does not occur. As mentioned in previous projects, STRIPPS has connected with FLPPS to begin the dialogue about overlap and will continue to meet at regular intervals with the FLPPS PMO during implementation in 2015.
Understanding access patterns for the various regions, and certainly the individuals enrolled in care transitions programming will be a necessary step for the nurses deployed in the role of case manager for patients in STRIPPS-related transitional programming. Given the geographical span of the STRIPSS across 9 counties, there are three identified RHIOs and four times as many EMRs. Again, connectivity will play in integral role in the monitoring of enrollee care plans.

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 patientswill 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.

Capital needs for this project will be captured through the IDS project (2ai).

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 relatedto 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
Cayuga Medical Center	Balanced Incentive Program (Tompkins County Transitions Support Program - BIP)	8/1/14	Sept 2015	The BIP Innovation Fund supports projects that help mitigate barriers to community-based LTSS . The focus is to: • Increase the number of individuals served in non-institutional settings; • Improve access to community-based LTSS services; • Provide stakeholders a role in creating service solutions that have a lasting impact on the LTSS delivery system; and • Promote provider expertise by of by offering

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				opportunities for providers to address barriers in transition for institutional to CBO.
VNS Tompkins County	same as above			
Tompkins Co Office for Aging	same as above			
Schuyler Hospital	same as above			
Beechtree Care Center	same as above			
Cayuga Ridge	same as above			
Seneca View	same as above			

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 BIP grant serves only a subset of Medicaid patients in Tompkins, Cortland, Tioga and Schuyler counties through the Fall of 2015. DSRIP funding will be used to expand this model into the remaining5 counties within the Region and to support program activities in Tompkins, Cortland, Tioga and Schuyler counties beyond 2015.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

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

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

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

It is a common (anecdotal) thread amongst leadership of the 23 skilled nursing facilities (SNFs) within STRIPPS that lack of resources to identify and manage acute care needs amongst residents frequently leads to ED visits (and subsequent inpatient days) that otherwise might have been avoided. Long term care CNA survey participants stated better nursing home care as one of the most pressing healthcare needs for the STRIPPS community. STRIPPS estimates that nearly 70% of skilled nursing facility (SNF) residents in the Region are either Medicaid or dual eligible, prompting a rationale for the support of Medicaid populations via implementation of INTERACT in these facilities. The prevalence of certified and licensed home health agencies exist to support health maintenance in the home, allowing many to retain some level of independent living as the age. This supports national trends indicating that people are staying in their homes longer, and are generally older and frailer at the time they enter a SNF, regardless of diagnosis. The INTERACT quality improvement program will assist in the early identification, evaluation, management, documentation, and communication about acute changes in condition for SNF residents. This type of process promotes the types of early intervention (diabetes management, physical therapy consultation, use of intermittent diuretics to control blood pressure, etc.), in collaboration with patient care teams, that are vital to the prevention of unnecessary ED visits and subsequent inpatient admissions that are not only financially costly the payer, but also financially and emotionally burdensome to the patient and their loved ones. In an evidenced based study of INTERACT program published by The American Geriatrics Society in 2011, nursing homes that deployed INTERACT saw a 25% decrease in their patients' 30-day (inpatient) readmission rates. While proven successful in the lowering of 30-day readmissions, this does not come without care planning, team member education, and shifts in staffing patterns to allow for appropriate (24/7) care team coverage.
INTERACT implementation within STRIPPS will require the addition of care team resources (RNs, nursing assistants / patient care technicians, NPs, pharmacy) to provide a setting within the SNF that allows for the diagnostic and treatment required to avert avoidable ED visits upon identification of an acute care need. The development of standardized protocols and care algorithms will provide SNF care teams the tools needed to escalate patient needs to the appropriate care team and setting upon identification of a change in condition. Resource allocation will be supported through DSRIP funding to ensure the availability of additional licensed care professionals within the SNF setting to help triage and treat patients as indicated. The use of licensed INTERACT tools such as "Stop and Watch," "SBAR," and the "Hospital Transfer Form," will assist facility care teams to accurately assess patients and to communicate efficiently and effectively with off-site providers to determine the appropriate care pathway for that specific patient.

Equipping SNFs with the appropriate tools (resources, education of protocols and are decision algorithms, medication and supplies, medical equipment such as IV poles and tubing, etc.) will allow their care teams to care for patients in acute crisis on site without the need for transfer to a higher level of care. Facilities that maintain dedicated care coordination efforts in collaboration with the INTERACT processes and tools have seen a decrease in their hospital transfers. The use of telemedicine and remote patient monitoring will further support SNF care teams to triage patients accordingly to prevent unnecessary transfers to the ED and inpatient setting.

b. Please define the patient populationexpected 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 includes approximately 2500 Medicaid and dual eligible patients residing in skilled nursing facilities throughout the STRIPSS region. Due to the nature of this program and the intended implementation of facility-wide protocols for care, the population affected by this particular project will be expanded to include all SNF residents within STRIPSS. Currently over 30% of nursing home residents have at least one visit to the ED or hospital each year. The breakdown of attributed lives for Long Term Care by county is as follows: Broome: 1,326, Chenango: 87, Cortland: 351, Schuyler: 100, Steuben: 126, Tioga: 154, and Tompkins: 347 which represent 53.2%, 3.5%,14.1%, 4%, 5.1%, 6.2%, and 13.9% of the total STRIPPS SNF resident population, respectively.
The majority of the STRIPPS SNF population suffers from one or more medical chronic conditions including: hypertension, dementia, heart disease, depression, diabetes and COPD. Enhanced communication and collaborative care efforts via implemented INTERACT protocols and care decision algorithms will support SNF care teams to better recognize the signs and symptoms of worsening condition and intervene quickly to treat accordingly within the walls of the SNF, avoiding unnecessary ED/hospital inpatient transfers. Early intervention to manage chronic conditions on site will be pertinent for those living with chronic disease to avoid exacerbation of complications related to delay in care (during transfer) as well as avoidable inpatient complications including hospital-acquired conditions (pneumonia, injury due to fall, infections disease, etc.).

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.

Over 50% of the 23 STRIPPS SNF partners have or are in the process of implementing electronic medical records that house INTERACT tools within their software packages. Nearly 25% of the STRIPPS SNFs have already begun to initiate components of the INTERACT program. STRIPPS will partner with skilled nursing facilities who have successfully implemented INTERACT as a resource to train SNFs within STRIPPS. In addition to implementing an EMR/EMR-Lite for SNFs whose medical records are currently on paper, establishing an EMR interface through the RHIO will require additional IT support for facilities.

Participating hospitals, especially their emergency departments, are an integral player in the implementation of INTERACT and a collaborative environment between SNF and hospital care teams is critical to program success. Hospital work with SNFs to develop relationships that can support the deployment of skilled personnel as needed for appropriate care triage and delivery within the SNFs (lab techs, RNs, NPs, etc.). STRIPPS will hire a dedicated care coordination team that will support current SNF teams in managing the care of residents, as well as ensuring that existing SNF staff are appropriately trained prior to the implementation of INTERACT tools.
Finally, STRIPPS will implement a network-wide telemedicine strategy that will include the deployment in the SNFs. Increased use of telemedicine in the SNFs will help achieve the desired decrease in hospital transfers by allowing higher-level providers to assess patients as they remain in the facility, a type of assessment that, prior to INTERACT, would have required a hospital transfer. Appropriate use of remote patient monitoring, and interactive video conferencing between offsite providers and the SNF patient will allow for more timely assessments and respective care interventions.

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

IT connectively will pose a challenge for INTERACT implementation and communication between participating facilities for those SNFS within STRIPPS who currently do not utilize an EMR. The INTERACT program works to improve communication and data sharing as a way to reduce avoidable hospital transfer and subsequent admissions, but the program can only be successful if facilities have an efficient way to share health information. For the approximate 50% of STRIPPS SNFs who do not have an EMR, STRIPPS will subsidize the funding necessary to implement an "EMR-Lite" medical record solution, enabling the most critical components of each patient's health record to be shared via the RHIOs.
Lack of on-site diagnostics, pharmaceuticals and availability of medical equipment to delivery care (IV pumps and tubing, wound vacs, etc.) is a challenge for SNFs in the onset phases of INTERACT implementation. Lack of resources available for care delivery can lead to a delay in diagnosis and treatment for SNF residents and therefore would increase the probability of an acute care transfer and admission. Hospital resources (i.e. pharmacy, lab) will support SNF care teams to triage and treat conditions that would otherwise need to be transferred to an acute care setting. The addition of telemedicine in the facilities will also assist in overcoming the lack of onsite services - allowing physicians and NPs to assess the patient in real time, eliminating the need for transfer and delays due to transfers.
Education and training of current SNF staff and other care providers pose challenge to INTERACT implementation. SNF employees and management teams will need to work with acute care settings and educational institutions to ensure care team skill sets are up to date and inclusionary of those they did not utilize in the SNF setting prior to INTERACT implementation (IV insertion and maintenance, EKGs, advanced wound care, etc.).
Advance care planning is also an area of opportunity in avoiding unnecessary SNF transfers. Having current advance directives in place is an integral component of collaborative long term care delivery. Implementation of tools such as the eMOLST through project 3gi will be expanded

to the INTERACT program and will allow residents to have their wishes for care not only addressed, but updated regularly to reflect their choices.

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

The INTERACT development team will need to take in to account access and referral patterns amongst STRIPPS and other PPS regions to ensure program development is inclusionary of necessary facilities. Educational efforts and program roll-out may need to be done in collaboration with additional PPS regions. For example, a SNF outside of STRIPPS that is geographically closest to a STRIPPS hospital and therefore typical transfer residents to that facility and vice-versa. To eliminate confusion amongst hospital care teams, care evaluation of area INTERACT implementation (within and beyond STRIPPS) will need to take place.

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

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

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

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

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patientswill 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.

STRIPPS will need to provide supplemental funding to SNFs within the network who rely on paper medical records to implement, at a minimum, the EMR functionality required to streamline care coordination and transfer avoidance efforts through implementation of the project.

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 relatedto this project's objective?

Yes	No
☐	☒

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

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

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

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

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

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

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

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

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed

by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

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

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

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

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

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

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

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

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

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

The CNA identified three primary opportunities for enhanced care delivery that would be addressed through the development of the Community Based Health Navigator Service Program (CBHNSP): 1) Lack of awareness of resources available in the community, 2) Inappropriate utilization of the ED as a resource for primary care, and 3) Medicaid patients' perception of the ED as the most accessible health care service. CNA findings demonstrated that the MCD/UI populations are for the most part unaware of alternative health care options that can be accessed in the community and equally unfamiliar with supportive community health resources (such as 211) that can serve as a linkage to information about services in the community. Participants in the MCD focus groups indicated the ED was most often utilized as a resource for primary medical care on account availability of access (as a 24/7 operation) and also the availability of access via transportation (ambulance rides via a simple call to 911 are perceived as easy and "free").
The STRIPPS CBHNP will address these issues by creating a program with two main goals:
1. Increase awareness and utilization of community-based services by the MCD/UI populations, which will provide support needed to reduce avoidable ED visits and hospitalizations; and
2. Provide direct support services which assist individuals to appropriately access health care.
Increased awareness and utilization of existing services (as well as those to be implemented as a product of DSRIP) will be leveraged using the current 211 infrastructure within STRIPPS. This structure will be enhanced and strengthened to be better targeting MCD/UI populations and in order to increase user activity.
The CBHNP team will devise an implementation schematic that is inclusionary of two levels of community navigators: 211 Navigators and Community Health Navigators (CHN).The 211 Navigators will provide resource information to targeted populations (Medicaid and duel eligible patients, the uninsured, and MCD low utilizers) by screening for MCD/UI callers and building protocols to appropriately triage and escalate issues when unable to directly resolve them. Community Health Navigators (CHN) will provide direct services and coordinate the connection to clinical services (including health home referral, care transitions, diabetes management, and PCP referral) and non-clinical resources such as transportation and housing. Information about community resources (housing, transportation, care transitions, food security, urgent Rx participants, free clinics, chronic disease management, financial assistance, dental care, etc.) will be routinely updated and stored in data bases, categorized by county. CHNs will have access to these databases for the purpose of aligning patients with services. IT enhancements will be implemented to allow access to service information via direct entry applications.
The CHN will additionally be point of entry for the connecting of MCD/UI individuals to community services, both clinical and non-clinical. For example, a Medicaid recipient that is referred for care transitions (project 2.b.iv) but has declined participation will instead be referred to the CHN by

the transitions RN for follow-up. The CHN will then contact the patient in attempt to align him/her with alternative community resources that may be of benefit to them while supporting them to modify patient behaviors for optimal clinical outcomes. CHNs will have ongoing contact with MCD/UI populations to via face-to-face and/or telephonic meetings to connect them with available resources, assist them to fill out qualifying forms, and support them to appropriately utilize the health care system.

b. Please define the patient populationexpected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria.This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.
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The patient population expected to be engaged by the CHNs are those living with chronic disease or health issues not already served by an existing navigation program such as the Medicaid Health Home. The rationale for this is (using the example of the health home) that those care teams would already be supporting the patient in a manner beyond that which the CHN would be and additional referral to the CHN would be duplication of services and potentially confusing for the patient. The number of unique patients attributed to STRIPPS with any chronic condition, according to the Salient claims data, totaled approximately 24,000. Combined, this population had 36,827 ED visits and 10,382 inpatient discharges in 2013 alone. The variation in ED visits and subsequent inpatient accounts indicates that a large percentage of those ED visits were likely due to conditions that could have been better managed in the outpatient setting through enhanced coordination of care services and engaged relations with primary care physicians. CHN provide the support needed to assist patient to better navigate the health system to build care team relationships and avoid these types of unnecessary visits.
Broome County accounts for 48 % of above-mentioned Medicaid population with 52% utilization of ED visits and 49% of inpatient discharges. Like Broome County, many counties with STRIPPS are considered hard to serve areas on account of their rural geographic nature. Effective community health navigation can help patients to integrate community resources, regardless rural location, to promote effective self-management.

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

The existing 211 infrastructure will be of advantage as the STRIPPS works to expand their services and heighten community awareness (with regards to available resources). Currently within STRIPPS there are 11 Navigators, handling 95,000 calls per year throughout the nine counties. Staff is located in three agencies: United Way of Broome County servicing Broome, Delaware, Tioga and Chenango Counties; the Institute for Human Services servicing Chemung, Schuyler and Steuben counties; and the Human Services Coalition of Tompkins County servicing Tompkins and Cortland counties. Additional personnel will be hired to command an anticipated 24,500 calls per year. Within STRIPPS there exist additional service agencies that currently provide some level of navigational service (meaning they support patients to access needed care) including: Mothers and Babies of South Central NY and Rural Health Network of South Central NY servicing Broome

County, Cortland, Tioga and Delaware; S2AY servicing Chemung, Schuyler and Steuben counties; Chenango Health Network servicing Chenango County; and the Human Services Coalition of Tompkins County servicing Tompkins County.
The onboarding of CHNs and additional 211 staff will be completed with careful consideration to previous working knowledge and relationships with other CBOs. Navigator candidates with previous knowledge of community resources and organizations within STRIPPS, as well as strong communication skills and a working knowledge of database management will have an advantage over those who do not, as it is anticipated they will require less training and ideally be up and functioning at full capacity sooner than their counterparts. Additional training specific to customer service and sensitivity will be made available as part of workforce development team efforts.

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

The eminent challenge for the CBHNP team will be to increase awareness and utilization of community-based resources for the MCD/UI/LU populations. The CNA indicated that MCD individuals within STRIPPS are not familiar with 211 services. Likewise, current 211 providers indicated that very little outreach or marketing has been done of 211services since inception. STRIPPS will devote significant resources to marketing 211 services in a manner that reaches the target populations. Social media (Facebook) was used very successfully during the CNA to connect with the MCD population, and will be moving forward in the promotion of 211 services. Additionally, cultural sensitivity and health literacy concepts will be used in both CBHNSP marketing efforts as well as Navigator customer service training.
Ensuring that community resource guides are up to date and accurate and that the 211 database reflects this will be a critical challenge to the CBHNSP program. The CBHNP team will develop protocols and implement efficient processes for routine solicitation, updating, and uploading of information to the system database.
An additional challenge to this project includes a lack of defined roles within the STRIPPS partner network. Understanding organizational roles will be helpful to prevent duplication of efforts. Through targeted strategic planning in the development stages, STRIPPS will develop a system for identifying, managing, and communicating partner roles and responsibilities. The CMHNSP project leader will coordinate and communicate these developments on behalf of 211 and CHN organizations.
The outcome of program success ultimately lies in the ability of CNHs to drive behavioral change for the MCD/UI populations. In order for STRIPPS to be successful, the target population must be available, accountable, engaged and taking active steps toward health outcome improvement via enhanced self-management. The CHNs will be pivotal to educate, empower, and coach the MCD/UI populations toward positive behavioral change. Additional training in patient activation (through project 2di), health literacy, understanding health insurance barriers, and communication skills will be key factors to overcoming this challenge.

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

The Region overlaps with FLPPS in Chemung and Steuben counties, the Leatherstocking PPS in Chenango County and has an overlap in Delaware County. 211 staff and CHNs will be employed in the same agencies that cover multiple PPS and as such, will cover patients attributed to multiple PPS programs. All patients will be treated the same and provided services within the county regardless of the PPS to which they are attributed.

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 patientswill 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.

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 relatedto this project's objective?

Yes	No
☐	☒

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

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

2.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. <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. The project description should consider three primary activation concepts: *patient activation*, *financially accessible health care resources*, and *partnerships with primary and preventive care services.*

Project 2di will have a significant impact on the reduction in avoidable ED utilization and an increase in primary and preventive services provided in the region. The objectives of the project will be accomplished through the deployment of a patient activation outreach team (PAOT), a patient activation training team (PATT), and direct linkage and collaboration with the Community Based Health Navigation Team (CBHNP - project 2ci). These targeted resources will ensure that the NU/LU/UI populations will be connected to the STRIPPS network, informed about all services available and will be engaged in dialogue and interactions that result in increased activation. The project will coordinate activation strategies with all other STRIPPS projects through the use of a broad-reaching, geographically diverse outreach team (PAOT) and project management team that will address the three primary activation concepts of patient activation, financially accessible healthcare resources, and partnerships with primary and preventive services through the following objectives:

1. Engagement of individuals who have little or no contact with the healthcare system through optimization of existing community-based resources for proactive outreach and patient activation;

2. Linkage to community resources that will minimize the financial deterrent to utilizing healthcare services in the region;

3. Collaboration with providers and CBOs to facilitation utilization of primary and preventive services.

CNA research and feedback across the Region substantiated the need for this project through the identification of gaps to achieve desired outcomes including: increasing the level of engagement of the targeted populations, increasing the amount of primary care and preventive care services provided to the NU and LU population, and decreasing the volume of ED visits for the UI population. Of the UI respondents in the STRIPPS CNA, 43% indicated that they or someone in their household visited the ED in the past 12 months. Data from SPARCS showed there were 29,000 UI patient visits to STRIPPS EDs in 2013. The community leader IDI audience (see section 3) stated that UI patients accessed the ED due to lack of alternative affordable choices. Many UI patients consider the ED their sole option for care, especially for after-hours care (68% of Medicaid [MCD] and UI CNA participants have never received after hours care at a location other than the ED). According to CNA results, only 30% of the UI/LU/NU respondents felt their most recent ED visit was for a life-threatening condition, while 50% never considered alternative treatment options. These numbers support the need for the STRIPPS to increase the number and type of available ED alternatives for the UI/LU/NU population, and to utilize community navigation (project 2ci) to ensure these patients are knowledgeable about how to access these and other available community resources.
The NU population represents 20.5% of the Region's MCD which is higher than the NYS-observed rate (17%). The Region's LU is approximately 12.3% of the total attributed lives, which is about the same as the NYS rate. These numbers indicate that patients with MCD in the STRIPPS Region access services less frequently than the other parts of the State. The CNA focus groups pointed out that while the MCD population expressed a desire to take hold of their health care, they faced two key barriers: 1) complication of navigating the Medicaid system, and 2) social determinants to health such as transportation and affordable housing. These responses confirm the need to provide patient activation and engagement outreach to the NU/LU populations and educate providers throughout the PPS to further engage and activate all Medicaid beneficiaries. Additionally, STRIPPS will address some of the social determinants such as transportation and housing, for those with the most critical need, coordinating with project 2ci.

b. Please define the patient populationexpected 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.

There are 54,743 UI in the Region attributed to STRIPPS. The breakdown of the UI population by county is as follows: Broome (15,923, 29.1%), Steuben (8,759, 16%), Tompkins (7,503, 13.7%), Chemung (5,752, 10.5%), Chenango (4,336, 7.9%), Delaware (3,956, 7.2%), Tioga (3,573, 6.5%), Cortland (3,428, 6.3%), and Schuyler (1,512, 2.8%). The NU population includes 19,428 lives, or 20.5% of the attributed lives for STRIPPS, while the LU population includes 11,601 lives, 12.3% of total patient attribution. When compared to the NYS observed rate, the STRIPPS population has a higher percentage of NU members. Interventional strategies will be implemented to impact all three target groups (UI, LU, and NU) based on geographic concentration, disease type, and a specific focus on those patients who do not have an identified primary care giver.

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.

Patient activation will be accomplished through targeted outreach and training in patient activation techniques and concepts. The STRIPPS will contract with community-based organizations (health departments, home health agencies, Human Services Coalition, etc.) to implement the patient activation outreach team (PAOT) and patient activation training team (PATT) and outcome-based incentive models will be implemented as appropriate. The STRIPPS will issue an RFP as part of the implementation plan to identify the appropriate organizations to manage and deploy outreach workers and training teams. These partnerships may include one or more of the Rural Health Networks in STRIPPS, and/or other community-based providers who have demonstrated experience and success with community outreach and education. This coordinated approach, which expands on the existing infrastructures within the Region, will ensure that project requirements are implemented expeditiously and that the ultimate goals of reducing the number of ED visits for patients without insurance, and increasing the volume of primary and preventive services provided to the LU/NU populations are met.
Project 2di, as it is planned for the Region, will be interdependent and complimentary of project 2ci. While 2di shares the requirement of creating a specialized community navigation team, the broad geographic span of the Region warrants additional focused resources around community navigation. The project team envisions that the CBHNP developed as part of project 2ci will serve as a referral source for the PAOT and vice versa. As the targeted population connects with the CBHNP, the CHN will connect these individuals with the PAOT to ensure that patient activation measurement and engagement is streamlined and seamless process. The STRIPPS will utilize the PATT to train the CHN in patient activation awareness to ensure optimal engagement of patients.
Additional primary and preventive care infrastructure is required to meet the needs of this population and effectively reduce avoidable ED visits. Regional healthcare system medical staff development plans show a shortage of primary care providers. The STRIPPS region is largely rural (89% as defined by the NYS Office of Rural Health) and is further a HPSA shortage area for primary care. However, the STRIPPS Operating Council anticipates the ability to address MCD access because each of the hospital systems in the Region has: 1. experienced a downward trend in outpatient volumes in recent years, demonstrating that some capacity does exist in the network; 2. hired an increased number of physicians and advanced practice nurses; and 3. implemented productivity strategies.
Appropriate staffing models will be influenced by project success. Seventy six percent of the healthcare audience indicated their practice accepts UI, but only 56% currently serve UI (approximately 8% of their payer mix is UI), suggesting additional capacity can be mobilized through implementation of project 2di.
During implementation, healthcare and community partners will be surveyed regarding capacity to take on additional volume, administer the PAM and work with patients and providers in patient activation techniques. More than 81% of Medicaid patients in the CNA stated that they would like to participate on a Patient Advisory Panel. The Patient Advisory Panel will provide feedback on strategies to address patient barriers to care (care coordination challenges, language barriers, literacy, etc.). The CNA resource inventory and barriers for the UI/LU/NU population will be

reviewed within the Region and at the RPU level. Additional resources needed to successfully implement this project and to identify people to connect the locations, persons, and resources that best reach the targeted population.

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

There are two primary challenges to be addressed during the implementation of project 2di:
1) Identify and connect with the targeted populations. STRIPPS teams will leverage existing relationships the NU/LU populations have with community based organizations, including community agencies who do not provide health care services, to make contact with the NU/LU populations. Examples of these organizations include the health exchange enrollment programs, the two free clinics located in the Region, the Rural Health Network, the Perinatal Network, food banks, Hope Dispensaries and naturally occurring places of congregation (schools, churches, etc.) to initiate the PAM. Health literacy will be addressed through these relationships. Patient activation will evolve over time during project implementation. For the UI population, the STRIPPS will focus outreach efforts primarily in the EDs, inpatient units, and free clinics for the first year of implementation. The UI population presents a unique challenge due to access and the inability for PHI to be shared. STRIPPS will utilize a project manager and communications coordinator to develop a coordinated strategy for tracking all three populations as they come in contact with PAOT and other providers, and will expand outreach as additional areas of concentrated presence for these populations are identified.
2) Make health care services accessible to the UI/NU/LU populations. CNA research participants indicated that the supply of providers in the Region who accept self-pay patients is too small relative to the demand, particularly in key specialty, sub-specialty, and dental care. STRIPPS will need to ensure that there is sufficient capacity in the Region to increase the amount of primary and preventive care services available to the UI population in an effort to reduce avoidable ED utilization. This will be accomplished through provider incentives and an increase in the number of mid-level providers in the Region. For the UI population, education and marketing about the availability of free or reduced cost health care options in the Region, such as free clinics or reduced-fee walk-ins will be critical to the success of the project. Based on the fact that the majority of STRIPPS patient participants in the CNA were recruited via Facebook, social media does appear to be an effective means of targeting populations who do n

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.

STRIPPS overlaps with FLPPS on project 2di in the counties of Chemung and Steuben. It will be important for STRIPPS and FLPPS to coordinate on the RPU that includes Chemung and Steuben counties so that duplication of patient activation outreach, assessment and training work does not occur. As mentioned in previous projects, STRIPPS has connected with FLPPS to begin the dialogue about overlap and will continue to meet at regular intervals with the FLPPS PMO during implementation in 2015.

Additionally, where other STRIPPS counties border adjacent PPS, STRIPPS will work with these PPS during the implementation stage to develop processes for coordinating efforts of the NU/LU/UI populations in terms of identification, assessment and activation activities.

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 patientswill 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.

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 relatedto this project's objective?

Yes	No
☐	☒

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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 essential issue present in support of this project is the lack of shared accountability between behavioral health providers and their primary care counterparts for the holistic health outcomes of the patients whose care they share. The CNA identified both a gap in access to behavioral health support in the Region and a perception by recipients that they do not receive the needed attention from their primary care providers for co-morbid physical and behavioral health conditions. CNA research feedback across the STRIPPS region supported the need for this project. In the in-depth interview (IDI) portion of the CNA research, participants in both the healthcare and community leader audiences confirmed that there were significant gaps in care coordination between primary care physicians (PCPs) and behavioral health providers. Forty three percent of healthcare providers participating in the IDIs referenced the availability of mental health services as the most critical healthcare need for the MCD/UI populations. In addition, both the healthcare and community respondents believed that mental health and substance abuse conditions were the number one reason for ED visits and readmissions among the MCD/UI populations. Regional rates of self-inflicted injury hospitalizations, self-reported poor mental health, and binge drinking were higher than state averages in more than half of the PPS counties. Similarly, the proportion

of those with both mental and physical health disorders is higher among Medicaid beneficiaries particularly for diabetes, cardiovascular, and obstructive respiratory conditions. Medicaid claims data for STRIPPS indicated that 16,253 unique patients who utilized services (excluding non-utilizing) had a behavioral health or substance abuse condition, which represents approximately 18% of the attributed population.

The project team identified significant gaps in the current delivery system including: 1) all 9 of the STRIPPS counties are designated primary shortage areas for psychiatry; 2) there are only 73 psychiatrists for the 94,000 attributed Medicaid recipients in our region. In Broome County, which has the largest number of recipients in our PPS, the County Mental Health Clinic is slated to close. Only three STRIPPS partners have any experience with integrating BH and PCP services in a formal way.

The CNA reveals a profound imbalance between overutilization of the ED and underutilization of PCP's. The "one-stop-shopping" aspect of the ED is perceived as appealing by Medicaid recipients, and this project seeks to make PCP's and behavioral health clinics equally appealing. To increase access to BH and PCP for the Medicaid population, this project will focus on a delivery model that integrates Behavioral Health (BH) into Patient-Centered Medical Homes (PCMH) and PCPs to better serve patients under one roof. In addition, recipients who receive behavioral health treatment at licensed mental health or substance abuse clinics, and do not have a primary care provider, will be engaged and offered primary medical care screens and other services to support medication and lifestyle change compliance. The third component of the project will be to work with ED providers to improve the notification of PCP and BH providers when a recipient accesses ED services that may be avoidable. By integrating Behavioral Health into Primary Care and vice versa, Medicaid recipients will receive more patient centered, coordinated care for all health related conditions. The goal of integration will be to ensure that the “no wrong door” concept is provided to care for the whole person regardless of where they seek care. By identifying MH/SA conditions earlier (including potential suicidality and addiction) appropriate evidenced based interventions can be implemented.

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 includes Medicaid recipients who: 1) receive primary care at PCMH sites in our PPS but who are not receiving appropriate behavioral health or mental health services. For example, recipients may not have been screened for a mental disorder, so any existing mental disorder is undiagnosed and/or untreated, or the patient may have a diagnosed mental disorder but are not engaged in supportive counseling needed to effect behavioral lifestyle changes that can reduce the impact of the mental disorder in their life. 2) receive services at licensed mental health or substance abuse clinics and lack an effective PCP relationship, 3) are seeking their medical and behavioral health services in hospital emergency departments, or 4) are being discharged from inpatient psychiatry or crisis stabilization programs (CPEP) who have co-morbid medical and behavioral health conditions.

The breakdown of patients with MCD who have a co-morbid medical and behavioral health condition by county is below. Please note: this data was generated from the Salient tool (MCD claims) and includes the utilizing population only (excludes non-utilizing population). Broome: 3,330 (40.0%); Tompkins: 1,165 (12.2%); Cortland: 1,015 (14.0%); Tioga: 671 (8.1%); Chenango: 470 (5.6%); Chemung: 305 (3.7%); Delaware: 303 (3.6%); Schuyler: 244 (2.9%); Steuben: 235 (2.8%); Other (non-STRIPPS) county: 597 (7.2%); Total: 8,335

This data indicates that for the MCD patients attributed to STRIPPS who are utilizing services and have a behavioral health or substance abuse condition (N=16,253), greater than 51% also have a co-morbid medical condition (N=8,335).

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.

Focused behavioral health programs and services in our PPS include: 1) 16 NYS OMH Licensed Clinics; 28 OASAS Licensed Treatment Programs; 2) 132 Psychiatric beds in Article 28/31 Hospitals 3) 35 Mental Health Support Programs and 4) 70 Targeted Case Management Programs. Two STRIPPS partners have experience integrating behavioral health into a primary care setting, with routine mental health screening a standard of practice. In addition, one partner in our PPS is also working to integrate primary care into its mental health/chemical dependence clinic through the creation of a partnership with the FQHC in the rural community in which both organizations provide services.

In order to meet the Project Requirements Milestones and Metrics of 100% of Medicaid recipients screened by their primary care physicians for behavioral health issues, the project will require dedicated resources to provide training and behavioral health consultation in PCPs. The model proposed embeds behavioral health consultants (BHC) and Care Managers (CM) into PCPs in order to coordinate the care of patients who screen positive for BH/SA concerns identified in the course of a visit. CMs will assist patients with navigating social service agencies to address the social determinants impacting their health. In this section of the project, psychiatric providers will be available for consultation with the PCP, providing education and support to increase comfort and competence in providing psychotropic medication management in PCPs. In addition, PCP resources will need to be added to provide services in licensed mental health and substance abuse clinics.

Cherokee Health Systems developed a model that has achieved integration by placing behavioral health consultants (BHC) in primary care centers to provide real time collaboration between medical and behavioral health. Their model demonstrated a reduction in the use of hospital based services as well as formal counseling and psychiatric services after introduction of the BHC model. With the implementation of a similar model in STRIPPS, capacity could improve across the full spectrum of behavioral health services, and the opportunity may develop to repurpose hospital social work and/or care manager FTEs from the Acute Care hospital facilities or licensed mental health or substance abuse clinics to primary care sites. This project will promote open

communication and necessary culture change, reducing the stigma associated with mental health conditions and helping providers and patients identify the linkage between physical symptoms and behavioral issues/conditions. Remote and smaller clinic needs may be met through telephone and video consultation with providers and patients. For screening patients in primary care, the project will use an evidenced based screening tool such as Behavior Works screen or the PHQ2 and PHQ9 using tablets and an evidenced based screening tool that allow for efficient and targeted PCP action. Outcomes of electronically completed screens will be available in real time for the PCP to review during the visit. In addition, data from all screens will be aggregated by site and region to advise the PPS on variations in need across the region and to inform project growth and focus activities.

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

The most significant barriers to this project are regulatory. For example, the project calls for an integrated medical record, but the current OASAS and OMH regulations specifically require separate and distinct medical records for all behavioral health care. It is unclear whether BHC documentation would fall under this requirement; if so, this challenge cannot be overcome without regulatory relief. Additionally this project will encounter challenges with communication and delivery system integration issues. Only two-thirds of Medicaid recipients or those without insurance visit a PCP on a regular basis. This could impact the number of patients screened via their PCP. However, if they are BH patients, PC availability at the BH clinic will improve engagement in the project. Providing the appropriate tools to address behavioral health concerns in conjunction with routine primary care will enable physicians to spend more time with Medicaid recipients. PCPs will need to be provided with appropriate support, training and the tools necessary in order to embrace this model of care. Our PPS will encounter the challenge of a widely diverse geographic area with varying resources. The PPS will also encounter some level of provider resistance to, or uncertainty about integration in both the primary care and behavioral health arenas. Another challenge the project will face is that PCP's are faced with three simultaneous changes: implementation of an EHR, achieving PCMH designation and the implementation of this project and other DSRIP projects that may impact their practices.

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.

STRIPPS overlaps with FLPPS on project 3ai in the counties of Chemung and Steuben. It will be important for STRIPPS and FLPPS to coordinate on efforts in the counties of Chemung and Steuben so that duplication of services and resources does not occur. As mentioned in previous projects,

STRIPPS has connected with FLPPS to begin the dialogue about overlap and will continue to meet at regular intervals with the FLPPS PMO during implementation in 2015.

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

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

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

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

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patientswill 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 relatedto this project's objective?

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

3.a.ii Behavioral Health Community Crisis Stabilization Services

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

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

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

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

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

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

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

The CNA identified psychiatric conditions, including depression, chronic stress and anxiety, schizophrenia, bipolar disorders, depressive and other psychotic disorders and chronic alcohol abuse as 6 of the top 10 reasons for emergency room visits. Regional rates of self-inflicted injury, self-reported mental health, and binge drinking were higher than the state average in two-thirds of the counties. Rates of individuals with both serious mental illness and chronic physical conditions represent a higher rate of those visiting the emergency room. The proposed model includes a layered continuum of crisis stabilization services within the 9 counties that will provide both a consistent response and an appropriate intervention for the level of care that is needed to effectively de-escalate a crisis situation and divert unnecessary transports to the emergency departments. The CNA focus groups stated that having a behavioral health crisis stabilization team would be helpful to diffuse and address situations that occurred specifically due to behavioral health issues, and some providers indicated that this type of project would be appropriate due to lack of after-hours care available for Medicaid recipients.

The primary elements of this model will include a crisis phone intervention as first line response. Development of standardized, evidence based protocols for assessment and determination of level of care needed will be developed. Three 24/7 mobile crisis teams, each staffed with at least one licensed professional will be activated when needed to intervene in the individual's home, work, school, or community setting to de-escalate a crisis and to assess, through standardized assessment tools, whether individual needs higher level of care, such as respite bed, observation bed, or transport to emergency room. These teams will be connected to the 9.39 hospitals who have expertise in behavioral health. The model includes follow up visits to ensure stabilization and connection with appropriate services. Community based short term, intensive respite beds will be developed in each county and used for individuals experiencing a behavioral health crisis that cannot be managed at home or in the community but do not rise to the level of need for inpatient hospitalization. These respite homes could be managed by the local OMH housing providers and staffed through a combination of professionals and peers. The highest level of outpatient crisis stabilization intervention will be extended observation beds that will be located at the three 9.39 hospitals. These beds will provide intensive monitoring of those individuals who may be extremely suicidal/homicidal (without ability to develop safety plan), monitor those who are unstable due to excessive substance use, or present with serious symptoms of mental illness or developmental disabilities that cannot be stabilized within the community.

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 consists of those Medicaid recipients experiencing behavioral health or substance abuse symptoms that do not require inpatient treatment. In 2013 less than 25% of the individuals who presented at the emergency room with symptoms of depression(6,139/23,592), chronic stress and anxiety(2765/12,823), or schizophrenia (2,635/10,239) were admitted to the hospital. Less than 50% of those with depressive and other psychosis (2,931/7,988) or chronic alcohol abuse (3,171/6,843)were admitted. This indicates that there is an opportunity to provide a community based therapeutic intervention that is ultimately more efficient and cost effective for 50-75% of those individuals currently presenting at the emergency room with these disorders. STRIPPS estimates that approximately 20% of the nearly 17,000 attributed lives who suffer from a behavioral health and/or substance abuse condition will receive crisis stabilization services through this project.

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

There is one hospital (UHS) within the PPS that is licensed as an OMH CPEP, which includes established extended observation beds and can monitor individuals for at least 48 hours. UHS has the ability to serve children, adolescents and adults although not simultaneously. Two other 9.39 hospitals (Cayuga Medical Center and Cortland Regional) have inpatient behavioral health beds and both are interested in establishing extended observation beds for this project. The Greater Binghamton Health Center operates an adolescent crisis residence which has proven problematic in many situations as it is completely voluntary and recipients often leave the facility causing further research expense to locate and return them to their families. Throughout the region there are a multitude of behavioral health crisis lines, and warm lines, to assist individuals with a behavioral health crisis. These lines will need to be integrated into this project and several are supportive of having options other than transport to emergency room. Mental Health and substance abuse respite beds are not generally accessible outside of the provider agency. Each county has an OMH housing provider which offers a variety of housing options for those with mental illness. These providers have the infrastructure to develop, staff and bill for this type of resource when the 1915i waiver is approved by CMS. In addition, some counties have access to respite services for those individuals with developmental disabilities. Again, these providers have the infrastructure to establish this service and STRIPPS has been working with these providers throughout the planning phase to include them in the design of this project. Additionally, mobile crisis teams similar to the CPEP mobile crisis team will need to be established to cover the PPS region. Finally, consideration for the creation of a Wet House for housing substance abuse patients who are in crisis or repeatedly taken to the ED will be addressed during the implementation phase.

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 region is diverse in geography with a large rural component which makes transportation to appropriate care challenging. Extensive education of law enforcement, providers, hospitals, and community members regarding this model of crisis stabilization will be necessary to ensure success. The current lack of adequate resources for medically monitored detoxification for alcohol and other substances results in transports to local emergency rooms. Security of protected health information will need to be ensured and monitored. Coordination with other State initiatives, such as OMH community integration teams that are not yet clearly defined will need to occur. Integration of existing community based crisis services into this model will require outreach and engagement prior to implementation. Identification/development of evidence based assessment tools and protocols will be necessary. Finally, the current regulatory structure related to the confidentiality of behavioral health records and the requirement for separate and distinct records for behavioral health conditions are challenges that require regulatory relief to be overcome.

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.

Discussion and appropriate agreements will need to be established in order to ensure that those in crisis receive appropriate services no matter their location or PPS. STRIPPS overlaps with FLPPS on project 3aii in the counties of Chemung and Steuben. STRIPPS intends to implement three crisis stabilization programs based on the RPU structure of the PPS. Therefore, it will be important for STRIPPS and FLPPS to coordinate on the RPU that includes Chemung and Steuben counties so that duplication of crisis stabilization services does not occur. As mentioned in previous projects, STRIPPS has connected with FLPPS to begin the dialogue about overlap and will continue to meet at regular intervals with the FLPPS PMO during implementation in 2015.

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 patientswill 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.

Funding may be needed to support the development of Extended Observation Beds (EOB) for Cayuga Medical Center and Cortland Regional Medical Center as a component of the most intensive crisis stabilization services that will be provided through project 3aii.

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 relatedto this project's objective?

Yes	No
☐	☒

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

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

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

Improve Medication Adherence:

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

Actions to Optimize Patient Reminders and Supports:

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

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

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

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

CNA findings substantiated the need for this project, identifying opportunities to build programming to support the CNA research (data, focus groups, online survey and in-depth interviews) feedback across STRIPPS, and achievement of metric outcomes. Among the MCD/UI survey respondents, 29% are living with hypertension and another 12% have other heart disease, yet only 11% visit a cardiologist regularly. In general, the prevalence of cardiovascular disease is higher in the STRIPPS region than all of NYS. The prevalence of both hypertension among adults and the prevalence of smoking (a leading cause of hypertension and other heart disease) is higher in 89% of STRIPPS counties. The presence of comorbid conditions (such as COPD, diabetes, adrenal disorders, and chronic kidney disease) and other risk factors (including smoking, high fat/salt diet, lack of physical activity, and stress) contribute to the morbidity and mortality among residents in the region living with cardiovascular (CV) disease.

Prevention Quality Indicators (PQI) indicate that throughout STRIPPS, with the exception of Schuyler County at 44%, over 50% of avoidable admissions are related to chronic disease. Approximately 20% of these admissions for chronic disease are due to cardiovascular conditions. Salient data shows 12% of ER visits (9,468) in 2013 were related to cardiovascular disease.

The focus throughout development and implementation of 3bi is to ensure clinical practices in the community and ambulatory care settings use evidenced based strategies to improve the management of cardiovascular disease among the adult population identified as being at rising risk (using Stanford's model for risk stratification). The project places additional focus on population health management for those living with CV disease and the adoption of activities that increase patient self-efficacy and self-management. Active engagement of primary care providers will be critical to accomplishing program goals; presently greater than 50% have some level of PCMH certification.

Additional strategies in the implementation of this project include: development and use of patient registries, provider alerts in the EMR to promote standardized treatment practices for hypertension, cholesterol monitoring, follow up blood pressure management, utilization of remote patient monitoring, and resources to support patient engagement and adherence to their plan of care. Careful attention will be made to identify and address patient barriers to care plan compliance (financial constraints, medication reconciliation, lack of transportation, knowledge and reception of community services, etc.). Interventional management will occur throughout the continuum by primary care, homecare, MCD health homes, nursing homes, and other CBOs including those incorporating the work of projects 2biv, 2bvii and 2ci.

The utilizing MCD will be risk stratified utilizing the Stanford model for chronic disease management to determine the level of care needed to maintain/achieve/promote CV wellness in the community. Outpatient supports throughout STRIPPS will support efforts of population health within the community.

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 impacted by this project are the MCD identified throughout STRIPPS with chronic cardiovascular conditions (hypertension, congestive heart failure, coronary artery disease, peripheral artery disease, congenital heart disease, cardiomyopathy, etc.). For the MCD population, adjusted hospitalization rates were higher than NYS for all acute conditions. Among MCD beneficiaries, hypertension and coronary atherosclerosis are among the top ten underlying causes of these hospitalizations. Approximately 7,000 of the utilizing populaton of iattributed lives are individuals with cardiovascular conditions.

The MCD population will be targeted through a risk stratification assessment: a) those that are healthy, b) those at risk who are noted to have borderline hypertension, elevated cholesterol, pre-diabetes, obesity, and smokers, c)those at rising risk who have been diagnosed with cardiovascular disease and also have an additional comorbidity, and d)those that are high cost utilizers with poorly controlled cardiovascular disease and multiple comorbidities.

The risk stratification assessment will be completed throughout the various levels of patient contact with the healthcare system. MCD beneficiaries that have contact with the acute care systems (ED, Hospital), nursing homes, home care, MCD health homes and primary care sites in

the PPS provide an opportunity for this assessment to be completed. The PPS will also identify methods to engage the MCD beneficiaries currently not connected with the healthcare system to provide a setting for this screening to occur.

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 resources that will be engaged include hospitals, primary care providers, specialty providers, case managers, nutritionists, registered dieticians, exercise therapists, physical therapists, home health agencies, MCD health homes, pharmacists, and parish nurses. Various levels of disease management programs exist throughout STRIPPS and will need to be coordinated, focusing efforts on standardized methods for CV disease management. Primary care resources will be supported to achieve PCMH Level 3 (project 2ai), promoting care management services developed through this project initiative. IT interfacing will need to be upgraded to better coordinate care between acute care, outpatient and community based settings (project 2ai).

The availability of healthy lifestyle and wellness services and support will need to be expanded. Current community based resources include the YMCA of Broome County, five Rural Health Networks, and several Chronic Disease Self-Management Programs (CDSMP), Master Trainers and Peer Leaders within the region. NYS Center for Excellence in Aging and Community Wellness Quality Training & Assistance Center (QTAC) provides technical assistance and training for evidence based health programs including CDSMP. Regional planning and coordination by STRIPPS will require assessing current capacity for delivering CDSMP intervention for MCD members at identified hotspots across the region. Coordinating schedules for CDSMP cohorts and assuring appropriate class sizes will occur to maximize deployment of two Peer Leaders to bordering rural communities to register participants within the PPS.

Socioeconomic barriers to managing chronic disease (transportation, childcare, food, etc.) will be targeted through the mobilization of resources into “hot spot” neighborhoods to reduce their impact. Community supports would include the addition of a call center to provide connection with resources including chronic disease management (project 2ci), and the expansion of tele-medicine/tele-health to connect those in rural areas or those with a lack of transportation to healthcare resources (project 2ai and 2biv).

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.

Program challenges include provider utilization of EMRs, the requirements of PCMH, evidence based protocols and related financial investments, changes in workflow, and ongoing patient management. The PPS will seek funding opportunities to support the addition of EMRs, identify

processes to incentivize providers for improved patient outcomes, and increase multidisciplinary support staff in the Primary Care setting.Program challenges include provider utilization of EMRs, the requirements of PCMH, evidence based protocols and related financial investments, changes in workflow, and ongoing patient management. The PPS will seek funding opportunities to support the addition of EMRs, identify processes to incentivize providers for improved patient outcomes, and increase multidisciplinary support staff in the Primary Care setting.

A final challenge will be engagement of those beneficiaries currently not engaged with the health care system. It is vital for patients to have an established relationship and routine follow up with a primary care provider for longitudinal care. Lack of a consistent primary care provider leads to fragmented care, which increases the risk of failure to effectively control chronic disease and improve a person's health. Engagement will be accomplished through project 2di as well as outreach conducted through this project.

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.

CDSMP projects exist in neighboring PPS to the north (Onondaga, Oneida, Yates) , east (Otsego, Sullivan, Ulster) and west (Alleghany, Chemung, Steuben) of STRIPPS which offers regional opportunities for collaborative scheduling of classes and staffing of peer leaders to create economies of scale rather than duplication of efforts. STRIPPS will be in contact with the PMO leadership and teams for all bordering PPS to coordinate efforts. As mentioned in previous projects, STRIPPS has already been in contact with FLPPS regarding project overlap and will continue to meet regularly throughout implementation.

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 patientswill 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 relatedto this project's objective?

Yes	No
☐	☒

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Community Needs Assessment (CNA) rated palliative care as highly important, particularly for the relief of unnecessary pain and for limiting the overuse of ED resources for pain management services. The referral to palliative care at the first point when a medical

intervention is not predicted to restore substantial wellness to a patient may initiate years of useful palliative treatment before the patient's condition meets the clinical eligibility for hospice (if ever).

The project team identified gaps in the system as follows: 1) the availability and extent of formal palliative care programs in the STRIPPS region is widely inconsistent, ranging from sophisticated inpatient systems to almost no services at all; 2) clearly defined goals for patient care are not documented in advance directives; and 3) consistent expert pain and symptom management is lacking in patient care plans. The project goal is to introduce palliative care services in every community on a consistent, continuous, coordinated and timely basis to all suffering from serious or chronic disease in the STRIPPS nine-county area through patient-centered medical homes (PCMH) with the following primary aims: 1) reducing emergency department visits, hospitalizations and readmissions, 2) determining safe, sustainable and effective caregiving arrangements for each patient 3)centering the care in the PCMH to assure more consistent and coordinated management than is currently available.

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 consists of those patients with: a) chronic and advanced disease with limited health prognosis (i.e. cancer, ALS, multiple organ system failure, advanced COPD and CHF), b) poorly controlled pain or symptoms that accompany serious disease (i.e. cancer, digestive illnesses and any condition or disease in which pain, dyspnea, anxiety or nausea is a significant or persistent symptom) and c) end stage disease (i.e. end-stage renal disease, patients no longer seeking chemotherapy or other curative treatment) who choose to limit inpatient care. In STRIPPS, the presence of a chronic disease is roughly 23% of the total attributed Medicaid lives, for those who utilize services (excludes non-utilizing). The leading causes of hospitalizations are the chronic diseases that are susceptible to effective treatment through palliative care.

The project will be incorporated into a community-wide standard of PCMH primary care, meaning that all providers should expect their performance and results to be monitored and evaluated against community benchmarks. At discharge from the inpatient setting or at the primary care office setting there will be a number of referral triggers based on clinical status, diagnosis, prognosis, frequent ER visits or other criteria (to be determined by the PCMHs themselves), but in all cases the presence of a trigger will require a referral or will demand an explanation for an opt-out. Upon a triggering of a referral, a hospice-based outpatient palliative care program will provide direct services to the patient at that patient's residence.

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.

Palliative care programs (both inpatient and outpatient and provided in hospital and home settings) are offered in at least half of the counties in the STRIPPS service area and are useful in earlier initiation of end-of-life decision-making in a non-crisis setting, in managing pain and other symptoms (such as anxiety, nausea and dyspnea) outside the hospital, and in beginning consideration of hospice sooner. These resources will be engaged in the development of the Project and the expansion of palliative care across the STRIPPS coverage area where palliative care programs are not yet in existence.

This project may require new resources in the form of mid-level providers with palliative care expertise. These additional resources may be either redeployed from existing acute care service locations or new to the system based on the actual growth rate of palliative care integration. There will also be a need for provider education across the healthcare system and engagement of multiple media outlets to raise awareness of the benefits of palliative care.

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.

Project challenges include 1) Implementation and training in the use of eMOLST. Response: an eMOLST-provided training program for PCMH and the field staff of the local hospices. 2) Development of standardized clinical triggers to be utilized across the PPS. Response: developed by the medical staffs of the PCMHs with guidance from such sources as the Center for the Advancement of Palliative Care (CAPC) 3) Effective and efficient coordination with other DSRIPP projects in adjacent service areas (such as 2biv, 2bvii, 2ci, and 4bi). Response: a PPS-wide set of algorithms that will assure that each patients needs are appropriately addressed at the right time and that as needs change migration through the programs is seamless. The development of algorithms will be undertaken by the STRIPPS Clinical Performance Domain described in project 2ai.

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.

STRIPPS collaborated with the director of hospice services for the Leatherstocking PPS in the development of the project 3gi plan and will ensure that no overlap or duplication of services occurs in the bordering counties. STRIPPS has been in contact with the FLPPS PMO leadership and while project 3gi does not overlap with the FLPPS efforts, STRIPPS will ensure that collaboration and communication occurs on all projects for bordering PPS.

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

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

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

3. 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 patientswill 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.

STRIPPS will implement an electronic version of the MOLST (Medical Orders for Life-Sustaining Treatment) known as the "eMOLST" as part of project 3gi. eMOLST is a secure web-based application that permits providers to complete advanced care directives for patients, ensuring their end-of-life care wishes are known. eMOLST will be available as part of the patient medical record for all participating PCP practices within the STRIPPS network. Streamlining the advanced care directive forms will help to reduce avoidable hospital utilization. In addition to project 3gi, the eMOLST will be available to participating skilled nursing facilities for implementation of the INTERACT project 2bvii.

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 relatedto 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
None				

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

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

Domain 4 Projects

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

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

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

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

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

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

Entity Name

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

1. Project Justification, Assets, Challenges, and Needed Resources (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.

The field of MEB is new with limited baseline data. Despite the paucity of data, the CNA revealed that in self-reported poor mental days of 14 or more days in past year, self-inflicted injury hospitalization, self-inflicted injury hospitalization ages 15-19 yrs. and suicide mortality rate per 100,000 the PPS exceeded the state average. These findings indicate a need across the PPS region to strengthen the mental health and substance abuse prevention and early intervention infrastructure across systems in four areas for both adolescents and adults: 1) Suicide risk assessment 2) Substance abuse screening 3) Depression screening and 4) Screening for chronic stress / anxiety. Focus groups held across the PPS region as part of the CNA reinforced the need to address these four areas and to improve not only early detection, but to advise the implementation of MEB health promotion and targeted interventions for persons identified as being at risk in one of the four target areas. The CDC reports that in 2012 there were 40,600 deaths by suicide and 494,169 emergency room visits for treatment of self-inflicted injuries. The CDC also reports that almost 20% of all suicides are persons between 45 and 59 years old and 17% were persons over age 75. Given that 37% of all suicides occur in persons over the age of 45 and the primary screening efforts are aimed at adolescents the PPS has identified the lack of consistent screening for depression and suicide risk in adults as a gap in the current infrastructure. The CNA reflects national findings. The CDC reports suicide is the third largest cause of death in persons aged 10 – 24. In addition to the 4,600 annual suicide deaths in persons aged 10-24, there are 157,000 episodes of medical treatment for self-inflicted injuries in the same cohort. In the 9 counties covered by the PPS there were significant admissions to hospitals and emergency departments for each of the four target areas.

The current assets and resources listed below are evidence based and focused primarily on early detection and intervention for children and adolescents. There are very few examples of active processes related to screening for the aforementioned conditions in adults. There are currently no resources screening recipients for chronic stress and anxiety related disorders, yet they account for a substantial portion of emergency room visits and hospital admissions, which reflects another service gap in the PPS region.

The PPS will work to develop a standardized on-line screening capability that will afford individuals the opportunity to participate in the screening process from any computer and then submit their results to a central hub where they will be reviewed and outreach services will be coordinated for the individual. There are limited resources to provide evidence based targeted intervention services that may be indicated when a person who is screened is found to be at risk. The PPS will work with schools, medical and behavioral health providers, local Departments of Social Services Offices, senior centers and senior living centers to expand screening practices in clinical and non-clinical settings and to increase the availability of evidence based targeted interventions. This project will be structured through a combination of new resources and re-deployment of existing resources as the utilization of inpatient and emergency department services decline. A representative PPS-wide group of providers will make the necessary choices of standardized

screening tools, intervention approaches, data collection methods, IT and communication assets, and evaluation systems.

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.*

As a population health project, project 4aiii will target all Medicaid recipients and the uninsured persons within the PPS coverage area. Targeted intervention techniques will be applied only to those individuals who are found to be at risk in any of the four target areas. The project anticipates that it will provide screening for the four targeted areas to 50% of the targeted population. The PPS also anticipates that of the persons screened approximately 10% will screen at risk in one of the four areas and will then be provided with targeted interventions aimed at reducing the risk of progression into a chronic mental health or substance use disorder. It is important to note that the percentages for this impact are stated at 50% due to the anticipated overlap with project 3ai, which will conduct similar screening activities in PCMH provider locations.

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

The current resources identified within the PPS region that address part of this project's focus were explored and evaluated. There were more than 15 programs that were identified across the 9 county region. The project team noted that almost all the programs were aimed at adolescents and none were offered in more than two of the nine counties. The lack of a consistent prevention and early intervention process across the entire region underscores the significance of the service gap. Samples of the resources currently in place include: Teen-Intervene, SBIRT, AUDIT, Prime for Life, Sources of Strength and Too Good for Drugs.

A PPS-wide group of providers will identify those screening tools and practices currently in place that have the strongest evidentiary base and will expand their use across PPS partner locations. Tools from the list above that do not render strong evidentiary results will be considered for replacement with more effective tools. The PPS will develop and implement routine evidenced based screening for depression, suicide risk, substance use disorders and stress/anxiety. The PPS will supplement existing resources to add targeted intervention services for depression, suicide risk, substance use and stress/anxiety management.

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 will encounter several challenges with this project.
1: Feared delays in throughput in primary and specialty care practices
Response: The PPS will work with sites within the PPS who are already using the screening tools proposed by the project and will measure throughput to reflect actual changes and use that

data to ease the concerns of the providers that will be added to the project through the life of DSRIP
2: Provider resistance to including the screening process in their practices and embracing the relevance of each to the medical care they provide.
Response: The PPS will develop a structured communication process with providers that supplies ongoing education to each provider related to the interplay between physical and behavioral health disorders. As positive outcomes are produced the resistance will reduce.
3: Implementation of consistent targeted interventions across the PPS region.
Response: The targeted interventions provided will be selected from evidence based practices to ensure that interventions are consistently applied which will ensure that the efficacy a particular intervention is measured accurately.
4: Consistent collection of data to evaluate the project components and to advise future efforts
Response: The project team will select specific tools and provide targeted training to practice staff who will administer the screening tools. The data collected and reported will be evaluated for inter rater reliability and consistency across regions.
5: Aggregation of all collected data for reporting to DOH / OMH / OASAS to advise the expansion of coordinated care as outlined in sector 2 of the project requirements.
Response: The aggregation of data screening data poses little challenge. The transformation of that data into information that can be used to generate meaningful sustainable change in the health care delivery system will be the larger challenge. The PPS will address this by assembling a team of providers from across the PPS who will evaluate the data collected, determine trends and patterns. Their findings will be assembled into best practice documents that will be shared with DOH / OMH / OASAS to demonstrate both the benefits of coordinated care and the barriers that are encountered in efforts to coordinate care across systems.

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.

STRIPPS overlaps with FLPPS on project 4aiii in the counties of Chemung and Steuben. Where possible, STRIPPS will share training and other resources to ensure the most efficient implementation of this project across the two PPS. As mentioned in previous projects, STRIPPS has connected with FLPPS to begin dialogue about overlap and will continue to meet at regular intervals with the FLPPS PMO during implementation in 2015. If the two PPS determine there are shared partners that are included in project 4aiii, STRIPPS and FLPPS will ensure that resources and efforts are not duplicated.

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

The project milestones:
A) Select screening tool for the project: June, 2015
B) Identify sites willing to engage in the screening process and begin education: End of DSRIP yr. 1.

C) Select and procure evidence based intervention strategies for each target cohort. End of DSRIP yr. 1. D) Engage partner agencies in providing intervention services. DSRIP yr. 1.5. E) Develop mechanism for collection and aggregation of data as project components are implemented. End of DSRIP yr. 2 F) Assemble a team of providers to evaluate the project function and efficacy. End of DSRIP yr. 1 G) Engage DOH / OMH/ OASAS in discussions to further enhance coordination of care across the system. DSRIP yr. 4.

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

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

Yes	No
☐	☒

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

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

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

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

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

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

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

Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements.

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

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

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

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

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

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

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

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

Entity Name
American Lung Association
NYS Quit Line
Broome Tioga Tobacco Free Coalition
NYS Center for Excellence in Aging and Community Wellness Training & Technical Assistance Center (QTAC)
Other Rural Health Networks outside STRIPPS Region
Other Public Health Departments outside STRIPPS Region

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.

STRIPPS Medicaid members who participated in CNA focus groups indicated the following as negatively impacting chronic both prevention and management of chronic disease:

- Limited access to primary care services (high level providers, hours of operation, timely appointments, contact time and communication constraints)
- Reliable time efficient transportation (8/9 STRIPPS counties are considered rural), and
- Affordability of medications/copays.

Even though 66% of those Medicaid members surveyed visit a PCP regularly, 100% acknowledged their over utilization of emergency rooms on account of accessibility and convenience. Emergency rooms are open 24/7, staffed with physicians, and have readily-available transportation via ambulance - a simple 911 call away.

Medicaid CNA participants additionally expressed mistrust of health care providers and it is their perception that on account of their Medicaid status they typically receive lower quality, and sometimes inappropriate, care. They also expressed a lack of time available to discuss health prevention options with their provider during visits (beyond treatment of the condition warranting the visit). The CNA showed further gaps in self-management, chronic disease education, the ability to effectively utilize primary care, the filling/re-filling of prescriptions, durable medical equipment usage, care coordination and community resource utilization. In order to seek prevention services, patients incur out of pocket expenses for loss of work and transportation. Lack of preventative care leads to greater health care systems costs when patients are inevitably hospitalized.

In order to promote trusting patient-provider relationships and empower the Medicaid and uninsured populations as capable self-managers, primary care medical home care coordination will be reinforced by public health, consumer education, and rural/urban community level

approaches to delivering evidence based interventions such as in Stanford University's Chronic Disease Self- Management Program (CDSMP). Through an individualized care plan housed in the patient's electronic medical record, clinical care disease managers and PCMH case managers can simultaneously address self-management goals, physical health indicators and behavioral risk factors including social determinants of health and primary causes of COPD (poor housing conditions, pollution, smoking). An interdisciplinary care team approach will strengthen communication, while supporting a focus on patient outcomes and satisfaction. This will be a change from the lack of screening and standardized evidence based protocols to manage COPD currently lacking in STRIPPS clinical settings.

Through the advent of this project, COPD patient cases will be managed in clinical settings through population health model that is inclusive of risk stratification, care coordination, PCMH Level 3 standards, EMR connectivity, improved self-management toolsets and evidence based interventions. According to the Salient data in 2012, approximately 940 potentially preventable admissions and 11,000 emergency room visits were the result of COPD and related complications. Designated case management can guide patients living with COPD are taking the prevention measures to negate disease exacerbation that could lead to additional illness and the need for acute symptom and/or disease management in the inpatient setting (i.e. smoking cessation and up to date influenza, pneumococcal, and pertussis vaccination). STRIPPS aims to reduce the number of avoidable inpatient admissions and ED visits for Medicaid patients living with COPD by 25% through the implementation of preventative care services and appropriate resource linkage to additional STRIPPS programming.

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.*

Claims data from 2013 shows 11,423 unique individuals living with COPD within the STRIPPS attributed lives - roughly 12% of the total attributed lives. Depending on the county, anywhere between 33% and 65 % of those patients living with COPD (in any given county) had at least one emergency room visit that same year. Likewise, between 16% and 26% of those patients experienced at least one inpatient admission.

Cigarette smoking is the leading cause of COPD, and a catalyst for disease exacerbation for those living with the disease. Additional social determinants to respiratory health include poverty, housing conditions, quality of indoor air, age, education level, and exposure to second hand smoke. Other regional risk factors include educational attainment of high school graduation/equivalency or less accounting for greater than 33% of STRIPPS total population and an older population (17% compared to 14% statewide). Knowing the risk factors for disease will help care coordinators to better stratify those patients living with COPD into risk categories so they can work with the patients and their care teams with the goal of modifying patient behaviors for better clinical outcomes.

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.

This project correlates with a number of additional STRIPPS initiatives (care transitions, integrated delivery system, community-based navigation) in following population health management model through risk stratification of Medicaid patients and allocation of clinical and community based resources to best support the beneficiary as an engaged self-manager. Effective care coordination is a multidisciplinary team approach to prevention and disease management. It is the intention with this project that primary care patient centered medical homes will be guiding the process. Care transitions allows for medication reconciliation and management, and also the compliance with care planning vial remote patient monitoring capabilities. Tele-health services via care transitions will provide additional outlets for compliance with routine and follow-up visits with primary care for the management of chronic illness. Likewise, the advent of EMR connectivity through active RHIO connectivity will allow care managers to better coordinate and ensure application of individualized are plans across the patient care continuum.

Current clinical resources that will be integral to the success of this project include nurse case managers, social workers, and self- management educators located in hospitals, nursing homes, home care agencies, and Medicaid Health Homes. The need to evaluate the care teams at these agencies to insure role development and appropriate resource allocation/management will be necessary. Community based settings such as Rural Health Networks, Mothers and Babies Network, Tobacco Free Coalitions and County Health Departments will promote prevention, provide access and navigation services and conduct disease education as designed in the CDSMP.

Nursing care managers will be the primary point of contact for those patients living with COPD as they work together to build care plans that eventually will steer patients into lower risk category groups. The STRIPPS communities are resource rich when it comes to community health advocacy groups who work to educate those on chronic disease prevention and management. Additional care team member engagement will include: social workers, pharmacists, physicians, and community social services and health educators. Care managers will complete intensive training in coaching patients (and caregivers) with chronic disease.

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.

Eight of nine counties within STRIPPS are defined by the NYS Office of Rural Health as purely rural. Residents of these counties often face barriers to accessing primary care and preventative services. Additional challenges include lack of providers, convenient hours of service, transportation, and patient understanding of the importance of the management of COPD as a chronic disease. Resources will be needed to develop “mobile health clinics” to provide services to the beneficiaries where they live to include education, testing/screening and care coordination. This would eliminate the transportation barrier and promote patient-provider relationships in efforts to mitigate mistrust in providers, or the healthcare system as a whole.

Similar to project 3bi, provider buy-in to the benefits of evidence-based protocols will be a challenge within STRIPPS. Such unique methodologies to care delivery have the potential to alter work flow in the office setting, a concept that is overwhelming to physicians who are already pressured for time. Enhanced multidisciplinary care management will promote effectiveness of patient-provider communications. Through the advent of an integrated care delivery system, processes will be built to incentivize providers for improved patient outcomes which will help focus the time spent with the patients to focus on all aspects of patient health. The addition of support staff in the primary care setting and throughout the community will be necessary to support this change.

Additional challenges will be beneficiary engagement in COPD self -management and lifestyle changes. The PPS recognizes that basic needs such as food, shelter, clothing and transportation are often priority over disease prevention or self-management. Solutions to these basic needs will be supported with the community-based navigation project, the health advocate approach and referrals from 2-1-1 and mobility management services to resources within the local communities. Developing a risk stratification model will allocate additional resources to those with the highest needs and improve access to and communication with primary care providers. Medicaid beneficiary support will occur through a multidisciplinary approach to improve health outcomes and shared accountability with clinicians, community based providers and beneficiaries.

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.

STRIPPS overlaps with FLPPS on project 4bii in the counties of Chemung and Steuben. Where possible, STRIPPS will share training and other resources to ensure the most efficient implementation of this project across the two PPS. As mentioned in previous projects, STRIPPS has connected with FLPPS to begin the dialogue about overlap and will continue to meet at regular intervals with the FLPPS PMO during implementation in 2015. If the two PPS determine there are shared partners that are included in project 4bii, STRIPPS and FLPPS will ensure that resources and efforts are not duplicated.

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.

NYS Prevention Agenda Focus Area 3 objective is to increase access to high quality chronic disease preventive care and management in both clinical and community settings. Project goals are 1) increase COPD screening rates; 2) identify hot spots and promote evidence-based care; 3) promote CDSMP and culturally relevant education. Clinical milestones include increase in: medically assisted smoking cessation to Medicaid Adults 18-64 years old without COPD and COPD screening rates. Community milestones will be CDSMP graduation rates for Medicaid COPD patients. Support for behavioral/lifestyle changes will occur in all settings. Care Managers will complete COPD care plan and the EMRs will house patient goals and results. Timeline will parallell IDS implementation (2ai).

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

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

Yes	No
☐	☒

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

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
Broome &Tioga County Health Departments	Healthy Neighborhoods Grant Via NYSDOH funding	Fall 2014	Fall 2019	Improves indoor air quality by addressing smoking, carbon monoxide, radon, and mold. Participants receive education, demonstrations & supplies. Houses are identified in high-risk areas through housing, health and socioeconomic indicators from census and surveillance data. HNP uses a combination of door-to-door canvassing (67%) and referrals (32%) to reach residents

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

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

Healthy Neighborhood Grants are limited to Tioga County and Broome County only. In Broome County the included census tracts 9 and 18 are in zip codes 13903 and census tracts 139 and 140 in 13790. Geographically the Healthy Neighborhood Grant is restricted to Broome County areas of Binghamton and Johnson City. STRIPPS spans 7 other counties outside Broome and Tioga. Healthy Neighborhood Grants are not limited to Medicaid families.

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.