

## PROJECT OBJECTIVES, DESCRIPTION, & REQUIREMENTS PROVIDED BY THE STATE FOR ALL 10 DSRIP PROJECTS

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

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

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

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

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

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

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

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

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

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

1. Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH PCPs in care coordination within the program.

2. Ensure all participating primary care providers in project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH or Advanced Primary Care accreditation by Demonstration Year 3.

3. Ensure that all participating providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.

4. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards.
5. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
6. Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.
7. Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.
8. Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).
9. Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.

### 2.b.i Ambulatory ICUs

**Project Objective:** To create Ambulatory ICUs for patients with multiple co-morbidities including non-physician interventions for stabilized patients with chronic care needs.

**Project Description:** An Ambulatory ICU will create a multi-provider team for patients with complex medical, behavioral conditions and social complexities. An Ambulatory ICU will also include community based non-physician care, complex specialty care (e.g., housing, rehab, etc.), for stable patients in need of additional social services. Clinical interoperability within the Ambulatory ICU will allow for efficient identification of patients and connect those patients in need of complex services by allocating levels of service only as needed.

It is expected that the applicant will implement this project at one or more sites consistent with the NukaModel which is endorsed by the Institute for Healthcare Improvement. The relationship-based Nuka System of Care is comprised of organizational strategies and processes; medical, behavioral, dental and traditional practices; and supporting infrastructure that work together - in relationship - to support wellness. Applicants should refer to the Nuka Model in developing the response:

[http://www.cmcgc.com/media/handouts/29IH01/M22\\_NukaModel\\_Eby.pdf](http://www.cmcgc.com/media/handouts/29IH01/M22_NukaModel_Eby.pdf)

**Project Requirements:** The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements**

**Milestones and Metrics,** which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Ensure Ambulatory ICU is staffed by or has access to a network of providers including medical, behavioral health, nutritional, rehabilitation and other necessary provider specialties that is sufficient to meet the needs of the target population.
2. Ensure Ambulatory ICU is integrated with all relevant Health Homes in the community.
3. Use EHRs and other technical platforms to track all patients engaged in the project, including collecting community data and Health Home referrals.
4. Establish care managers co-located at each Ambulatory ICU site.

5. Ensure that all safety net project participants 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.
6. Ensure that EHR systems used by participating providers meet Meaningful Use and PCMH Level 3 standards.
7. Implement a secure patient portal that supports patient communication and engagement as well as provides assistance for self-management.
8. Establish a multi-disciplinary, team-based care review and planning process to ensure that all Ambulatory ICU patients benefit from the input of multiple providers.
9. Deploy a provider notification/secure messaging system to alert care managers and Health Homes of important developments in patient care and utilization.
10. Use EHRs and other technical platforms to track all patients engaged in the project

#### 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 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](http://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.

### 3.a.i Integration of Primary Care and Behavioral Health Services

**Project Objective:** Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.

**Project Description:** Integration of behavioral health and primary care services can serve 1) to identify behavioral health diagnoses early, allowing rapid treatment, 2) to ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects, and 3) to de-stigmatize treatment for behavioral health diagnoses. Care for all conditions delivered under one roof by known healthcare providers is the goal of this project.

The project goal can be achieved by 1) integration of behavioral health specialists into primary care clinics using the collaborative care model and supporting the PCMH model, or 2) integration of primary care services into established behavioral health sites such as clinics and Crisis Centers. When onsite coordination is not possible, then in model 3) behavioral health specialists can be incorporated into primary care coordination teams (see project IMPACT described below).

**Project Requirements:** The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones**

**& Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

There are three project areas outlined in the list below. Performing Provider Systems (PPSs) may implement one, two, or all three of the initiatives if they are supported by the Community Needs Assessment.

Any PPS undertaking one of these projects is recommended to review the resources available at <http://www.integration.samhsa.gov/integrated-care-models>.

*A. PCMH Service Site:*

1. Co-locate behavioral health services at primary care practice sites. All participating primary care providers must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by Demonstration Year (DY) 3.
2. Develop collaborative evidence-based standards of care including medication management and care engagement process.
3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
4. Use EHRs or other technical platforms to track all patients engaged in this project.

*B. Behavioral Health Service Site:*

1. Co-locate primary care services at behavioral health sites.
2. Develop collaborative evidence-based standards of care including medication management and care engagement process.

3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
  4. Use EHRs or other technical platforms to track all patients engaged in this project.
- C. *IMPACT*: This is an integration project based on the Improving Mood - Providing Access to Collaborative Treatment (IMPACT) model. IMPACT Model requirements include:
1. Implement IMPACT Model at Primary Care Sites.
  2. Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.
  3. Employ a trained Depression Care Manager meeting requirements of the IMPACT model.
  4. Designate a Psychiatrist meeting requirements of the IMPACT Model.
  5. Measure outcomes as required in the IMPACT Model.
  6. Provide "stepped care" as required by the IMPACT Model.
  7. Use EHRs or other technical platforms to track all patients engaged in this project.

### 3.c.i Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease—Primary and Secondary Prevention Projects (Adults Only)

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

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

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

1. Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.
2. Engage at least 80% of primary care practices within the PPS in the implementation of disease management evidence-based best practices.
3. Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.
4. Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.
5. Ensure coordination with the Medicaid Managed Care organizations serving the target

population.

6. Use EHRs or other technical platforms to track all patients engaged in this project.
7. Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3 for HER systems used by participating safety net providers.

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

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

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

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

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

### 3.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies)

**Project Objective:** To reduce avoidable poor pregnancy outcomes and subsequent hospitalization as well as improve maternal and child health through the first two years of the child's life.

**Project Description:** High risk pregnancies do not end with the birth of the child, but can continue with high risk parenting situations. Women with high risk pregnancies due to age, social situation or

concurrent medical or behavioral health conditions may need significant support beyond obstetrical care to grow a healthy child. Nuclear families and single mothers may not have access to functional parenting skill advice to assist them in the crucial first two years of a child's life.

**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.

For performing partner systems where the community assessment identifies significant high risk obstetrical/parenting cases, there are **three models** for intervention that may be utilized for this project.

Systems should choose one primary project but may also choose requirements from the other two projects to add as part of their project.

*Model 1: Implementation of an evidence-based home visiting model for pregnant high risk mothers including high risk first time mothers. Potential programs include Nurse Family Partnership.*

1. Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high-risk mothers including high-risk first time mothers.
2. Develop a referral system for early identification of women who are or may be at high risk.
3. Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.
4. Use EHRs or other technical platforms to track all patients engaged in this project.

*Model 2: Establish a care/referral community network based upon a regional center of excellence for high risk pregnancies and infants.*

1. Identify and engage a regional medical center with expertise in management of high risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).
2. Develop a multidisciplinary team of experts with clinical and social support expertise who will comanage care of the high risk mother and infant with local community obstetricians and pediatric providers.
3. Develop service MOUs between the multidisciplinary team and OB/GYN providers.
4. Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.
5. Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.
6. Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.
7. Use EHRs or other IT platforms to track all patients engaged in this project.

*Model 3: Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program.*

1. Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.
2. Employ a Community Health Worker Coordinator responsible for supervision of 4 – 6 community health workers. Duties and qualifications are per NYS DOH criteria.



3. Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.
4. Establish protocols for deployment of CHW.
5. Coordinate with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other IT platforms to track all patients engaged in this project.

#### 4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems

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

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

**Project Requirements:** The PPS must show implementation of three of the four sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, specific potential interventions are identified on the Preventive Agenda website under “Interventions to Promote Mental Health and Prevent Substance Abuse”

([http://www.health.ny.gov/prevention/prevention\\_agenda/2013-2017/plan/mhsa/interventions.htm](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.

#### 4.c.ii Increase early access to, and retention in, HIV care

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

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

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

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

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